Screening Patients for Substance Use in Your Practice Setting

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Learning Objectives

By the end of this session, participants will—

- Understand the rationale for universal screening.
- Identify potential health impact of substance misuse and abuse.
- Identify substance use risk limits.
- Identify how screening is conducted in a practice setting, including prescreening and screening.
- Practice how to use two screening tools.
- Understand how screening is used in brief intervention.
Epidemiologic Studies

  - The surveys included questions regarding the frequency with which people drank more than five drinks in a given day.
  - Findings indicated that exceeding these drinking limits can significantly increase alcohol-related health problems.

- SAMHSA conducts an annual survey: the National Survey on Drug Use and Health
## Prevalence of Substance Use

<table>
<thead>
<tr>
<th>Substance</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco</td>
<td>20.9%</td>
<td>33%</td>
</tr>
<tr>
<td>Alcohol (current drinkers)</td>
<td>47.9%</td>
<td>56.7%</td>
</tr>
<tr>
<td>Illicit Drugs</td>
<td>6.9%</td>
<td>11.6%</td>
</tr>
<tr>
<td>Misuse of Prescription Drugs</td>
<td>2.4%</td>
<td>2.8%</td>
</tr>
</tbody>
</table>

SAMHSA, National Survey on Drug Use and Health, 2012, Ages 12+ in the US, past month use
Level of Alcohol Use

SAMHSA, National Survey on Drug Use and Health, 2012, Ages 12+ in the US, past month use
Prescription Drug Misuse

Although many people take medications that are not prescribed to them, we are primarily concerned with —

- Opioids (oxycodone, hydrocodone, fentanyl, methadone)
- Benzodiazepines (clonazepam, alprazolam, diazepam)
- Stimulants (amphetamine, dextroamphetamine, methylphenidate)
- Sleep aids (zolpidem, zaleplon, eszopiclone)
- Other assorted (clonidine, carisoprodol)
Evidence Behind the Numbers

- The 5+/4+ drinking limits accurately reflect the amount of alcohol consumed at which psychomotor and cognitive impairment is notably increased in both men and women.
- As the frequency of exceeding NIAAA’S guidelines increases, the likelihood of developing problems increases.

Source: NIAAA (2007)
Harms Related to Hazardous Alcohol and Substance Use

- Increased risk for—
  - Injury/trauma
  - Criminal justice involvement
  - Social problems
  - Mental health consequences (e.g., anxiety, depression)
  - Increased absenteeism and accidents in the workplace

- > 65 diseases/conditions associated with or caused by harmful use of alcohol. (Warren & Murray, 2013)

CDC Vital Signs: Binge Drinking

- **Binge drinking (5+/4+ drinks per day)** is a dangerous and costly public health problem

- **1 in 6 adults**: More than 38 million US adults binge drink.

- **Average frequency=4X**: Binge drinkers do so about 4 times a month.

- **Average maximum # of drinks=8**: The largest number of drinks per binge is on average 8.

*CDC: Vital Signs, January 7, 2014*
Rationale for Universal Screening

- Drinking and drug use are common.
- Drinking and drug use can increase the risk for health problems, safety risks, and a host of other issues.
- Drinking and drug use often go undetected.
- People are more open to change than you might expect (60% of risky drinkers reduce their drinking after brief intervention).
Why Screen Universally?

- Detect current health problems related to at-risk alcohol and substance use at an early stage—before they result in more serious disease or other health problems.
- Detect alcohol and substance use patterns that can increase future injury or illness risks.
- Intervene and educate about at-risk alcohol and other substance use.
- Research has shown that approximately 90 percent of substance use disorders go untreated (NSDUH, 2007).
Detecting Risk Factors Early

Screening can be a significant step toward effective intervention:

- The nurse is often the first point of contact.
- Early identification and intervention lead to better outcomes.
- Patients are often seen by a nurse because of a related physical problem.

Screening in a Practice Setting

* Most practices use a teaming approach

Front desk gives patient a health and wellness screen with imbedded initial screen questions

Medical assistant takes patient to examining room. Reviews screen

Positive screen

Patient asked to complete AUDIT or DAST

Clinician reviews results of screening tool and delivers brief intervention

No

No further activity

Yes

Patient in need of treatment

Referral to Treatment made at that time

No

Clinician follow up scheduled

Patient encounter documented in EMR

Yes

* Most practices use a teaming approach
Alcohol Initial Screening

Prescreen: Do you sometimes drink beer, wine, or other alcoholic beverages?

- **NO**
- **YES**

NIAAA Single Screener: How many times in the past year have you had five (men) or four (women or patients over age 65) drinks or more in a day?

- Positive score=one or more times → move on to full screen.

**Sensitivity/Specificity: 82%/79%**

When Screening, It’s Useful To Clarify What One Drink Is!
How Much Is “One Drink”? 

5-oz glass of wine (5 glasses in one bottle)

12-oz glass of beer (one can)

1.5-oz spirits 80-proof 1 jigger

Equivalent to 14 grams pure alcohol
Initial Screening Strategy

Use brief yet valid prescreening questions:

- The NIAAA Single-Question Screen or the AUDIT C
- The NIDA Single-Question Drug Screen

Negative
- Based on previous experiences with SBIRT, screening will yield 75-90% negative responses.

Positive
- If you get a positive screen, you should ask further assessment questions.

NIAAA (2007)
http://www.drugabuse.gov/publications/resourc-guide
Initial Screening Drinking Limits

To determine the average drinks per day and average drinks per week—ask:

- On average, how many days a week do you have an alcoholic drink?
- On a typical drinking day, how many drinks do you have? (**Daily average**)

**Weekly average = days \times drinks**

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**NIAAA Recommended Limits**

Men = no more than 4 in a day AND no more than 14 in a week.

Women & anyone 65+ = No more than 3 drinks in a day AND no more than 7 drinks in a week.

> Recommended limits = at-risk drinker
A Positive Alcohol Screen = At-Risk Drinker

Heavy drinking days
(in a day ≥5 for men or ≥4 for women & anyone 65+)

or patient exceeds regular limits?

Men = no more than 4 in a day AND no more than 14 in a week; Women/anyone 65+ = No more than 3 drinks in a day AND no more than 7 drinks in a week

> Recommended limits = at-risk drinker

NO
Patient is at low risk.

YES
Patient is at risk. Screen for maladaptive pattern of use and clinically significant alcohol impairment using AUDIT.
Step 2: Administer the AUDIT
Alcohol Use Disorders Identification Test

- What is it?

- Ten questions, self-administered or through an interview; addresses recent alcohol use, alcohol dependence symptoms, and alcohol-related problems
- Developed by World Health Organization (WHO)
AUDIT
Alcohol Use Disorders Identification Test

- What are the strengths?
  - Public domain—test and manual are free
  - Validated in multiple settings, including primary care
  - Brief, flexible
  - Focuses on recent alcohol use
  - Consistent with ICD-10 and DSM V definitions of alcohol disorders

- Limitations?
  - Does not screen for drug use or abuse, only alcohol
Introducing the AUDIT in Clinical Setting

*Scenario 1, Oral Interview:* “Now I am going to ask you some questions about your use of alcoholic beverages during the past year. Because alcohol use can affect many areas of health (and may interfere with certain medications), it is important for us to know how much you usually drink and whether you have experienced any problems with your drinking. Please try to be as honest and as accurate as you can be.”

*Scenario 2, Self Report Questionnaire:* “As part of our health service it is important to examine lifestyle issues likely to affect the health of our patients. This information will assist in giving you the best treatment and highest possible standard of care. Therefore, we ask that you complete this questionnaire that asks about your use of alcoholic beverages during the past year. Please answer as accurately and honestly as possible. Your health worker will discuss this issue with you. All information will be treated in strict confidence.”
# AUDIT Questionnaire

## The Alcohol Use Disorders Identification Test: Interview Version

Read questions as written. Record answers carefully. Begin the AUDIT by saying “Now I am going to ask you some questions about your use of alcoholic beverages during this past year.” Explain what is meant by “alcoholic beverages” by using local examples of beer, wine, vodka, etc. Code answers in terms of “standard drinks”. Place the correct answer number in the box at the right.

1. **How often do you have a drinking- obtaining alcohol?**
   - (0) Never [Skip to Qs 9-10]
   - (1) Monthly or less
   - (2) 2 to 4 times a month
   - (3) 2 to 3 times a week
   - (4) 4 or more times a week

2. **How many drinks containing alcohol do you have on a typical day when you are drinking?**
   - (0) 1 or 2
   - (1) 3 or 6
   - (2) 5 or 6
   - (3) 7, 8, or 9
   - (4) 10 or more

3. **How often do you have six or more drinks on one occasion?**
   - (0) Never
   - (1) Less than monthly
   - (2) Monthly
   - (3) Weekly
   - (4) Daily or almost daily

4. **How often during the last year have you found that you were not able to stop drinking once you had started?**
   - (0) Never
   - (1) Less than monthly
   - (2) Monthly
   - (3) Weekly
   - (4) Daily or almost daily

5. **How often during the last year have you failed to do what was normally expected from you because of drinking?**
   - (0) Never
   - (1) Less than monthly
   - (2) Monthly
   - (3) Weekly
   - (4) Daily or almost daily

6. **How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?**
   - (0) Never
   - (1) Less than monthly
   - (2) Monthly
   - (3) Weekly
   - (4) Daily or almost daily

7. **How often during the last year have you had a feeling of guilt or remorse after drinking?**
   - (0) Never
   - (1) Less than monthly
   - (2) Monthly
   - (3) Weekly
   - (4) Daily or almost daily

8. **How often during the last year have you been unable to remember what happened the night before you had been drinking?**
   - (0) Never
   - (1) Less than monthly
   - (2) Monthly
   - (3) Weekly
   - (4) Daily or almost daily

9. **Have you or someone else been injured as a result of your drinking?**
   - (0) No
   - (1) Yes, but not in the last year
   - (2) Yes, during the last year

10. **Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?**
    - (0) No
    - (1) Yes, but not in the last year
    - (2) Yes, during the last year

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Record total of specific items here. If total is greater than recommended cut-off, consult User’s Manual.

Source: 
## AUDIT Domain

<table>
<thead>
<tr>
<th>Domains</th>
<th>Question Number</th>
<th>Item Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hazardous</td>
<td>1</td>
<td>Frequency of drinking</td>
</tr>
<tr>
<td>Alcohol</td>
<td>2</td>
<td>Typical quantity</td>
</tr>
<tr>
<td>Use</td>
<td>3</td>
<td>Frequency of heavy drinking</td>
</tr>
<tr>
<td>Dependence</td>
<td>4</td>
<td>Impaired control over drinking</td>
</tr>
<tr>
<td>Symptoms</td>
<td>5</td>
<td>Increased salience of drinking</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Morning drinking</td>
</tr>
<tr>
<td>Harmful</td>
<td>7</td>
<td>Guilt after drinking</td>
</tr>
<tr>
<td>Alcohol</td>
<td>8</td>
<td>Blackouts</td>
</tr>
<tr>
<td>Use</td>
<td>9</td>
<td>Alcohol-related injuries</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>Others concerned about drinking</td>
</tr>
</tbody>
</table>

Babor, Higgins-Biddle, Suanders & Monteiro, 2001
Scoring the AUDIT

≥ 14 referral to treatment

4-13 Brief intervention

< 4 low risk

Optional Screener: CAGE

- Have you ever felt you should CUT DOWN on your drinking?
- Have people ANNOYED you by criticizing your drinking?
- Have you ever felt bad or GUILTY about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (EYE-OPENER)?

Positive screen: 1 or more positive responses  
Ewing, 1984
CAGE: Pro’s and Con’s

**Advantages**
- Easy to remember
- Brief
- Useful quick screen for detecting many patients with alcohol use disorder (60-75% sensitivity)

**Disadvantages**
- Does not identify current vs. past behavior
- Focuses on alcohol use disorder (9% of population)
- Misses at-risk drinkers (19% of population)
Initial Screening for Drugs

“How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?” (…for instance because of the experience or feeling it caused)

Positive screen: 1 or more times. (If response is, “None,” screening is complete).

If response contains suspicious clues, inquire further.

Sensitivity/Specificity: 100%/74%

A Positive Drug Screen

ANY positive on the drug prescreen question puts the patient in an “at-risk” category. The followup questions are used to assess impact and whether substance use is serious enough to warrant a substance use disorder diagnosis.

- Ask which drugs the patient has been using, such as cocaine, meth, heroin, ecstasy, marijuana, opioids, etc.
- Determine frequency and quantity.
- Ask about negative impacts.
Drug Abuse Screening Test (DAST 10)

- **What is it?**
  - Yields a quantitative index of problems related to drug misuse

- **What are the strengths?**
  - Sensitive screening tool for at-risk drug use

- **What are the weaknesses?**
  - Does not include alcohol use
  - Focus on dependence
  - Does not distinguish between active and inactive use
  - Does not include quantity, frequency, pattern, duration or type of drug used.
### DAST(10) Questionnaire

**These Questions Refer to the Past 12 Months**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you used drugs other than those required for medical reasons?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Do you abuse more than one drug at a time?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Are you unable to stop using drugs when you want to?</td>
<td></td>
<td></td>
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<tr>
<td>4. Have you ever had blackouts or flashbacks as a result of drug use?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Do you ever feel bad or guilty about your drug use?</td>
<td></td>
<td></td>
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<tr>
<td>6. Does your spouse (or parents) ever complain about your involvement with drugs?</td>
<td></td>
<td></td>
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<tr>
<td>7. Have you neglected your family because of your use of drugs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Have you engaged in illegal activities in order to obtain drugs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Yudko et al., 2007
3-10 high risk, BI & attempt referral

1-2 at-risk, perform BI (brief intervention), reassess at a later date

0 abstainer

Addiction Research Foundation, 1982; Yudko et al, 2007
Practice Session in Pairs

Provider: Screen Using the Single Question Screens for Tobacco, Alcohol and Drugs and give patient the AUDIT or DAST as needed & score it

Patient 1: Positive on Single alcohol question, 4 one-point answers on AUDIT

Patient 2: Positive on Single drug question, 2 positive answers on DAST
Prescreen Questions (Adults)

1. Have you used any tobacco products in the past 12 months?
   □ Yes    □ No

2. Do you sometimes drink beer, wine or other alcoholic beverages?
   □ Yes    □ No

   (If yes) Look at this card which shows the size of standard drinks:

   Women: How many times in the past 12 months have you had
   4 or more drinks in a day?
   □ None    □ 1 or more

   Men: How many times in the past 12 months have you had
   5 or more drinks in a day?
   □ None    □ 1 or more

3. How many times in the past year have you used an illegal drug or
   used a prescription medication for non-medical reasons?
   □ None 1    □ 1 or more
Screening and Assessment

Screen
current and past use

No/Low Risk
Never used/At or below recommended limits

Advise

Health risk:
current and past use

Past use:
Further Assessment for adverse outcomes

Current use:
Brief Negotiated Intervention
Referral to Treatment

Potential for Withdrawal
current use

Manage Withdrawal
Referral to Treatment

Source: Savage & Finnell (2013)
Duration of Use

- Screening and assessment tools screen for current use.
- As with smoking, determining lifetime use is important in order to identify
  - The risk of health consequences associated with long term use
  - Those who are in recovery and may benefit from ongoing support
Key Points for Screening

- Screen everyone.

- Screen for current and lifetime use of both alcohol and drug use including prescription drug abuse and tobacco.

- Use a validated tool and ask questions verbatim.

- Prescreening is usually part of another health and wellness survey.

- Explore each substance; many patients use more than one.

- Follow up positives or "red flags" by assessing details and consequences of use.

- Use your MI skills and show nonjudgmental, empathic verbal and nonverbal behaviors during screening.
Screening: Summary

- Screening is the first step of the SBIRT process and determines the severity and risk level of the patient’s substance use.
- The result of a screen allows the provider to determine if a brief intervention or referral to treatment is a necessary next step for the patient.
QUESTIONS?