# The Role of General Practitioners and Other Healthcare Providers in Preventing and Screening For Substance Abuse[1]

By Winnifred I. Mitchell-Frable

In 1999, at the request of the US State Department, the US Substance Abuse and Mental Health Services Administration (SAMHSA) worked with NIS colleagues to develop a two-part effort to prevent the use of illegal drugs in the NIS region. One part, which is the focus of this article, was the development of a training curriculum for primary care providers on substance abuse prevention, *Substance Abuse Prevention and Treatment for Healthcare Providers and Others Involved in Fighting Drugs.* The other part was a set of materials called "Useful Skills," discussed near the end of this article, which were developed for children in grades 5-7 to help them resist drugs and make healthy lifestyle choices.

By many accounts, illegal drug use is an especially severe problem in the NIS. Over the past three to four years, the use of cocaine, heroin, amphetamines, inhalants, and "synthetics" has increased threefold, and the average life expectancy for drug addicts is only 4-4.5 years after they begin use. Injection drug use is of particular concern in the NIS, because it is the principal mode of HIV infection in these countries.[2]

Three trainings based on this curriculum were held for AIHA partners—in Washington, DC at the 1999 AIHA Partnership Conference; in Moscow in December 1999; and in Sarov in April 2000. The general justification for conducting such prevention training workshops for healthcare providers is that medical providers are often the principal source of substance abuse prevention information for a patient and his or her family. Additionally, practitioners can intervene to prevent alcohol and drug problems or to address them at their earliest stages.[3] More than 30 studies conducted throughout the world, including a large clinical trial published in the *Journal of the American Medical Association* in April 1997,[4] demonstrate this assertion. The purpose of this article is to highlight key ideas presented through the curriculum, specifically the ways in which the providers—general practitioners, pediatricians, gynecologists, feldshers, nurses, etc.—can respond effectively to their patients' needs.

## The General Practitioner and Prevention

The curriculum comprises of eight modules: introduction and statistics; risk and resiliency; screening; the healthcare clinic; prevention outside the clinic; common drugs of abuse; family and adolescent issues; and dual diagnosis. After defining substance abuse and listing some statistics, the course begins with a discussion of prevention, "an anticipatory process that prepares and supports individuals, families, communities, and systems in the creation and reinforcement of healthy behaviors and lifestyles, and the conditions that promote them." The core concepts of prevention are that it

- involves a public health approach that is culturally relevant;
- uses resiliency, multiple strategies, and models of change to address risk factors;
- addresses the whole system;
- and relies on community involvement.

Primary, secondary, and tertiary prevention models developed by the US Institute of Medicine are then explained to refine participants' understanding of the process. Primary prevention occurs before there is a problem, such as through educational health messages for children. Secondary prevention happens at the earliest signs of a problem, for instance when a patient indicates concern about his or her alcohol or drug use in response to a few key questions. And, tertiary prevention occurs when a problem is much worse and the patient requires specialized treatment. Primary care providers play a critical role in both primary and secondary prevention, both of which are discussed below.[5]

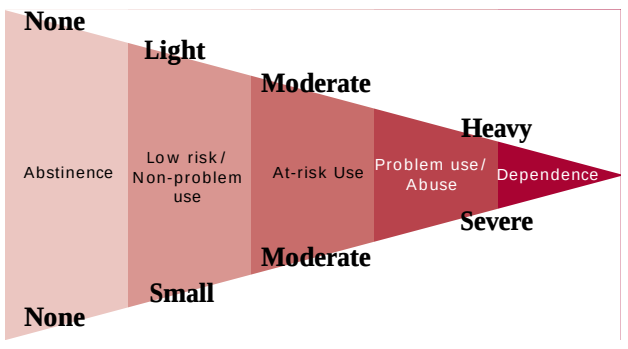


Figure 1. This diagram illustrates the progression from no use—abstinence—to dependence as a way to help a provider determine the nature of the prevention and intervention messages that are needed.



Patients' needs can be arrayed across the Triangle Diagram of Alcohol Use (see Fig. 1, previous page) developed by the Medical Specialists Program.[6] Although developed for alcohol use, illegal drugs use can be characterized in much the same way, with a key distinction: Any use of illegal drugs—marijuana, cocaine, other stimulants, heroin, inhalants—is risky, both in terms of their illegality and even if, as in the case of cocaine or inhalants, they are used only once. Therefore, the curriculum calls for a "clear recommendation against the use of these drugs [with no definition of 'safe' use]."[7]

Participants also learn how different cultures

- label and communicate concerns and symptoms of pain;
- determine the cause of substance abuse disorders;
- perceive healthcare providers;
- respond to or use treatment options; and
- influence personal involvement and responsibility.

All of these factors are important to understanding when developing effective strategies for talking with patients and establishing support services for them.

## Protective Factors

Individual: Social skills, flexibility, positive self-image, attachment to parents, sense of purpose and future.

Family: Positive bonding, clear rules, high expectations, warmth and trust.

School: Caring and support, high expectations and clear standards, youth participation in school tasks and decisions.

Community: Caring and support, high expectations, opportunities for participation.

## Risk Factors

Individual: Early aggressive behavior, impulsivity and hostility; alienation.

Family: Marital discord, economic deprivation; poor family management, discipline, and problem-solving.

School: Negative and disorderly climate; low teacher expectations; lack of clear school policies on alcohol and drug use.

Community: Permissive norms that promote or permit alcohol and drug use; poverty; lack of community bonding.

Figure 2. Definitions of individual, family, school, and community protective and risk factors.

### Primary Prevention

As stated above, one way healthcare providers can play an important role in the primary prevention process is by encouraging strong familial relationships. In the United States, research has shown that the best prevention programs and interventions focus on building caring and supportive relationships, known as "protective factors." Examples include parental warmth and involvement in homework and school-related activities, high expectations on the part of the parent and the school about what the child can accomplish and who he can be in the future, and a sense of connection to a supportive family, school, and community on the part of the child.[8] Preventive concepts should also strive to reduce "risk factors" (see Fig. 2).[9]

Some specific examples of what a provider can do are:[10]

- Incorporate age-, gender-, and culturally-appropriate prevention activities into each visit. For example, encourage a busy mother to take some time for herself or a troubled teenager to talk to a trusted friend.
- Express concern about health problems and life consequences related to substance use as a way to increase awareness about the risks attached to alcohol and drug use.
- Allow patients to give their suggestions for healthy behaviors.
- Establish trust.

### Secondary Prevention

In terms of secondary prevention, providers should ask all adolescent and adult patients, "Do you drink alcohol or use drugs?" To determine whether or not intervention is appropriate or needed, at the first sign of a problem with alcohol or drug use, providers can ask the following questions. They have been tested in the United States in primary care settings.[11]

- Have you felt you ought to cut down on your drinking or drug use?
- Have people annoyed you by criticizing your drinking or drug use?
- Have you felt bad or guilty about your drinking or drug use?
- Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover?

In following up on these questions, open-ended questions, such as "When is the last time you had a drink?" versus close-ended questions such as "Did you have a drink last night?" work best. It is also important to encourage the patient to go into greater detail by saying, for example, "Tell me more about your drinking." After a wider discussion with the patient prompted by a question such as "What else is bothering you?," the provider can discuss the

consequences of substance abuse and, if appropriate, work with the patient to set goals. Finally, the provider can clarify and set direction by restating the problem and the desired solutions, then summarizing the next steps for the patient. For example, the provider might say, "As I understand what you are saying, you are worried about the amount of alcohol you drink each day, and to address this issue you are going to limit yourself to drinking only one or two glasses on Friday and Saturday nights. If you find you have difficulty doing that, you can come back and see me and we will work on a solution together." Critical to this interaction is an empathetic and nonjudgmental tone and concern for the patient shown by the provider. It is also important to offer choices, to emphasize your patient's responsibility for making changes, and to express confidence in your patient's ability to do so.[12]

This kind of provider-patient interaction is the basis for a role-play exercise in the curriculum, and is critical to intervening effectively with patients on alcohol and drug issues. In these exercises, participants play a variety of roles—both as provider and as patient presenting different substance abuse concerns—to learn and practice the nonjudgmental ways providers can elicit concerns and help the patient find an appropriate solution to the problem. Participants also learn that this kind of brief intervention can be done in the office setting and is inexpensive, involving provider-patient contact time of 10-15 minutes, a limited number of sessions, and requiring no additional expensive testing.

## Referral to Treatment

In certain instances, the provider may need to refer the patient for further assessment and treatment.[13] Patients who have evidence of physical dependence, severe substance-related health problems, inability to change substance use behavior; or concern about a family member with substance use problem(s) should be refered to an appropriate treatment or counseling center (see sidebar).

## The Provider's Prevention Role in the Community

After a discussion of how clinics can change internal systems to better facilitate substance abuse awareness—such as by putting up prevention posters, displaying pamphlets, making the office smoke-free, collecting data on substance-related incidents and making this information available to the community—curriculum participants learn about the importance of community-based prevention.

Ideally, each segment of the community—clinics, schools, families, law enforcement organizations, and political and religious institutions—plays a role in substance abuse prevention by using and reinforcing the same prevention and healthy

## Substance Abuse Treatment Options

*A wide variety of substance abuse treatment approaches exist, and the NIS has a well developed network of narcologists and other specialists. As an example of the range of treatment options, the following list of those found in the United States is given.*[16]

Detoxification, 24-hour service, hospital inpatient—24-hours-per-day medical acute care services for detoxification for persons with severe medical complications associated with withdrawal.

Detoxification, 24-hour service, free-standing residential—24-hours-per-day services in a non-hospital setting that provides a place for safe withdrawal and transition to ongoing treatment.

Rehabilitation/residential, hospital (other than detoxification)—24-hours-per-day medical care in a hospital facility in conjunction with treatment services for alcohol and other drug abuse and dependency.

Rehabilitation/residential, short-term (30 days or fewer)—Typically 30 days or less of non-acute care in a setting with treatment services for alcohol and other drug abuse and dependency.

Rehabilitation/residential, long-term (more than 30 days)—Typically more than 30 days of non-acute care in a setting with treatment services for alcohol and other drug abuse and dependency; this may include transitional living arrangements such as halfway houses.

Ambulatory, intensive outpatient—At a minimum, the client must receive treatment lasting two or more hours per day, three or more days per week.

Ambulatory, non-intensive outpatient—Ambulatory treatment services including individual, family, and/or group services; may also include pharmacological therapies.

Ambulatory, detoxification—Outpatient treatment services providing for safe withdrawal in an ambulatory setting (pharmacological or non-pharmacological).

*Information on these treatment approaches and others, including psycho-therapeutic treatments and medications for specific drugs such as heroin and methamphetamines, is available under SAMHSA's Center for Substance Abuse Treatment at www.samhsa.gov.*



lifestyle messages and by working together on specific campaigns and activities to build communities and promote culture. Healthcare providers should be involved in all of these efforts.

Substance abuse is linked to many other behavioral problems, including HIV/AIDS, early and high-risk sex, dropping out of school, and family violence. By effectively preventing substance abuse, a community helps prevent these other social problems and viceversa. Prevention is prevention is prevention, and community involvement is a critical component of any effective prevention program. In particular, participation by healthcare providers lends credibility and extends the reach of any prevention effort.

The Curriculum contains an exhaustive list of "Prevention Opportunities in Communities" for healthcare providers,[14] including:

- meeting with school administrators to discuss school policies and potential collaborations;
- creating and distributing a directory of prevention resources in the community;
- speaking to civic groups about prevention;
- writing to local radio and TV stations to offer support and possible participation in substance abuse prevention programs;
- serving as a mentor to a young person; and
- writing an article on substance abuse prevention for your local paper.

### Useful Habits / Useful Skills

One example of a community outreach effort was developed concurrently with the curriculum by Dr. Olga Romanova of Project HOPE/Moscow. The "Useful Habits" and "Useful Skills" prevention program was developed for children in Grades 1-7, their teachers, and their families. In "Useful Habits," children in grades 1-3 learn about how to make decisions that will keep them healthy; "Useful Skill" builds upon these skills and provides specific information on inhalants and illegal drugs. The program addresses prevention by developing decision-making skills in the following way:[15]

***Useful Habits***

- **Grade 1:** The first grade curriculum helps children understand decision-making in order to stay healthy.
- **Grade 2:** Th children then learn to make decisions that keep them safe in dangerous situations.
- **Grade 3:** The focus of the third grade curriculum is to build children's confidence and help them stay confident when under pressure.
- **Grade 4:** And in fourth grade they learn to resist peer pressure and say "no" in risky situations.

***Useful Skills***

- **Grade 5:** In fifth grade, students explore different kinds of influences and pressures, their roles in these situations and ways to resist.
- **Grade 6:** They then work further on understanding ways people are manipulated and on how to resist such manipulation.
- **Grade 7:** Finally, young people address the issue of taking responsibility for one's actions.

The materials for this program have been approved by the Russian Ministry of Education for nationwide use starting in the Spring of 2001.

## Current Directions

SAMHSA is now focusing on the wide-spread dissemination of these materials for children and families, as well as promoting the curriculum cited throughout this article. Current plans are that regional dissemination trainings for Useful Skills will also include training for healthcare providers. In addition, SAMHSA plans to work with AIHA and others to add two modules to the healthcare provider training—one on HIV/AIDS and one on adolescents—and to provide a "Training of Trainers" session for AIHA partners in the Summer of 2001 so that the partners can conduct healthcare provider trainings using this curriculum.

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