Research

The Role of Complementary and Alternative Health Care Providers in Recognizing Misuse and Abuse of Medications and Addiction

Mark T. Pfefer, RN, MS, DC[1*], Jon D. Wilson, DC[2], Richard Strunk, DC, MS[3].

Address: [1]Professor and Director of Research, Cleveland Chiropractic College, Overland Park ,KS , USA, [2]Instructor, Cleveland Chiropractic College, Overland Park, KS, USA, [3]Assistant Professor, Clinical Sciences/Research, Cleveland Chiropractic College, Overland Park, KS, USA.

E-mail: Mark T. Pfefer, RN, MS, DC – Mark.Pfefer@cleveland.edu

*Corresponding author

Topics in Integrative Health Care **2011, Vol. 3(2) ID: 3.2006**

Published on **June 30, 2012 | Link to Document on the Web**

Abstract

Chronic pain and addictive disorders present significant public health problems. Both are underdiagnosed and undertreated. Complementary and alternative health care providers frequently encounter patients who suffer from pain and need to be aware of the potential for addiction in this population. These health care providers should play a role in screening, brief management, or recommending appropriate referral for patients with substance abuse problems. It is important for health care providers to be aware of barriers to screening and to understand that addiction is a treatable disease. Complementary and alternative health care providers should have knowledge of addiction resources, understand the process of screening, and should be able to recognize addiction and help direct patients to programs that can meet their treatment needs.

Introduction

Chronic pain and addictive disorders present significant public health problems. Both are underdiagnosed and undertreated.[1] Complementary and alternative health care practitioners frequently encounter patients who suffer from acute and chronic pain and need to be aware of the potential for

addiction in this population. All health care providers need to be able to identify and appropriately manage or co-manage patients with addiction. Drug addiction is a chronic relapsing disorder. Neurobiological changes are the basis for compulsive drug-taking, accompanied by loss of control over drug intake and the emergence of a negative emotional state when access to the drug is blocked.[2,3]

According to current guidelines, opioids should not be used as first-line medications for back pain.[4] Opioid analgesics are an option when used judiciously in patients with acute or chronic low back pain who have severe, disabling pain that is not controlled with acetaminophen and NSAIDs.[4] Because of substantial risk, including aberrant drug-related behavior with long-term use in patients vulnerable or potentially vulnerable to abuse or addiction, potential benefits and harm of opioid analgesics should be carefully weighed before use.[4] In spite of these published guidelines, a recent study demonstrated that there were high rates (80%) of opioid use for mechanical low back pain among patients treated by their family physicians.[5] Substance use disorders are common in patients taking opioids for back pain and aberrant medication-taking behavior occurs in up to 24% of cases.[6] Although the relationship between alcohol and pain has been less studied, alcohol use disorders are also prevalent among chronic pain patients.[1]

Dramatic shifts have been seen in opiate overdose demographics in recent years. Rates of hospital admissions for prescription opiate overdosage from 1993 to 2007 far exceeded heroin overdoses, rising by as much as 291%. The shift included a sharp increase in admission of whites and middle-aged women.[6] Prescription opioids used for pain management may make a substantial contribution as a source of overused and abused substances.[7] Evidence supports that during opioid treatment for severe or short-term pain, addiction arises rarely. However, when opioids are extended to patients with chronic pain, compulsive opioid seeking and addiction arising directly from opioid treatment of pain become more visible.[8]

Screening and brief intervention has been shown to decrease the frequency of alcohol and drug abuse, reduce the risk of trauma and increase the percentage of patients who enter substance abuse treatment, according to the U.S. Substance Abuse and Mental Health Services Administration.[9] According to SAMHSA, more than one million Americans meet the medical definition of alcohol or drug abuse, but about 94% of them are unaware that they need help and have not sought treatment. Screening and brief intervention is an ideal way to reach those at risk and provide options to initiate therapeutic intervention.

Screening

Health care providers should ask detailed questions about drug use including current prescription medications as well as use of non-prescribed drugs. Questions about alcohol and other drug use are most appropriately asked as part of the history of personal habits, such as smoking, coffee and soda drinking. Questions should be asked openly and in a non-judgmental way to avoid engendering defensiveness on the part of the patient. Prior to attempting to assess or discuss a patient's alcohol or

drug use, the clinician should attempt to establish rapport and trust with the patient.[10] Assessing adolescents for alcohol and other drug problems is particularly challenging.

It is unclear how many complementary and alternative health care practitioners ask about alcohol and drug use but they should ask specific questions about quantity and frequency of tobacco, alcohol, and drug use. Unhealthy alcohol and drug use is prevalent but under-diagnosed in primary care settings and practice guidelines recommend universal screening. The single screening question recommended by the National Institute on Alcohol Abuse and Alcoholism was found to accurately identify unhealthy alcohol use in a sample of primary care patients.[11] The sensitivity and specificity of this single question was comparable to that reported for longer instruments in other studies. Patients should be asked "How often in the past year have you had more than **4** drinks on a single occasion (more than **3** drinks for women)? Some patients who report even one occurrence to this single question may have severe alcohol use disorders requiring referral to substance abuse treatment, while those who consume excessive amounts of but have not experienced severe health or interpersonal problems would benefit from brief intervention by the primary care provider.

Drug Abuse Screening. The National Institute on Drug Abuse (NIDA) provides an online Quick Reference Guide, Screening for Drug Use in General Medical Settings (www.drugabuse.gov). This publication provides a rationale for screening in general medical settings including identifying drug users early, enhancement of health care outcomes, and improving linkages between primary and secondary health care services and specialty drug and alcohol treatment services. The patient should be asked during screening if any of the mentioned following substances have been used during their lifetime. Recommended screening questions include asking the patient about past substance use including use of tobacco, alcoholic beverages, cannabis, cocaine, prescription stimulants, methamphetamine, inhalants, sedatives and sleeping pills, hallucinogens, street opioids, prescription opioids, or other substances.

If the patient reports no lifetime drug use then the provider should reinforce abstinence and screening is complete. If a patient reports lifetime use of one or more substances then additional questions should be asked. Additional information should be obtained as to use of substances recently (especially within the past 3 months) and information about friends or relatives expressing concern about use, attempts or failures to control or stop using, and a question about history of drug use by injection.

Tobacco and Alcohol Use Screening. Tobacco and alcohol use reported within the last 3 months should prompt the health care provider to ask more detailed questions about frequency and quantity. Any current use of tobacco places the patient at risk so advice should be given about quitting. Reported use of alcohol within the last 3 months should prompt use of the Single Screening Question.[11] A negative answer prompts encouragement of the patient to stay within these limits. The patient should be considered an at-risk drinker if there are reports of one or more times of heavy drinking within the last year and intervention is recommended. The patient should be encouraged to talk openly about alcohol use and any concerns it may raise and screening should repeated annually.

Aside from tobacco and alcohol, a risk level for each substance should be determined and appropriate intervention should follow. The health care provider should provide advice related to the patient's drug use and should assess the patient's readiness to change. Help should be offered based upon the patient's readiness to change and the health care provider should refer patient for specialty assessment and/or drug treatment if necessary.

Management Approaches

More than two thirds of people with addiction see a primary care or urgent care physician every 6 months, and many others are regularly seen by other medical specialists, including visits to complementary and alternative health care providers.[12,13] These physicians are therefore in a prime position to help patients who may have drug abuse problems by recognizing and diagnosing the addiction.[13] In spite of a reluctance to discuss addiction issues with patients, there have been advancements in understanding the nature of addiction and ways to effectively intervene and manage these conditions.[13]

The National Institute on Drug Abuse guidelines (see **Table 1**) emphasizes that addiction treatment can be effective and should be tailored to the specific needs of the individual patient. It should also be emphasized that the best treatment programs are multidimensional, including both behavioral and pharmacological treatments. The NIDA guide, *Principles of Drug Addiction Treatment* (NIDA) provides information for both health care providers and the general public to understand effective treatment approaches, based upon 2 decades of scientific research. Taken from this guide, the 13 major principles of effective drug addiction treatment are:

1. No single treatment is appropriate for all individuals.
2. Treatment needs to be readily available.
3. Effective treatment attends to multiple needs of the individual, not just his/her drug use.
4. An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.
5. Remaining in treatment for an adequate period of time is critical for treatment
6. Counseling and other behavioral therapies are critical components of effective treatment for addiction.
7. Medications are an important element of treatment for many patients, especially when combined with behavioral therapies.
8. Addicted or drug-abusing individual with coexisting mental disorders should have both disorders treated in an integrated way.
9. Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.
10. Treatment does not need to be voluntary to be effective.
11. Possible drug use during treatment must be monitored continuously.
12. Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place themselves or other at risk of infection.

13. Recovery for drug addiction can be a long-term process and frequently requires multiple episodes of treatment.

Table 1. Resources for health care professionals

NIDAMED
http://www.drugabuse.gov/NIDAMED

World Health Organization – The ASSIST Project
http://www.who.int/substance_abuse/activities/assist/en/index.html

Substance Abuse and Mental Health Services Administration SBIRT Web site
http://www.samhsa.gov/prevention/sbirt/

NIAAA's Helping Patients Who Drink Too Much: A Clinician's Guide
http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm

SAMHSA's Treatment Facility Locator
http://findtreatment.samhsa.gov/

NIDA's National Drug Abuse Treatment Clinical Trials Network List of Associated Community Treatment Programs
http://www.drugabuse.gov/CTN/ctps.html

AHRQ's Helping Smokers Quit: A Guide for Clinicians
http://www.ahrq.gov/clinic/tobacco/clinhlpsmksqt.htm

USPSTF. *Guide to Clinical Preventive Services.* Washington, DC: Agency for Healthcare Research and Quality (AHRQ); 2010.

Ethical and Legal Issues

Health care providers may be reluctant for a variety of reasons to ask questions about substance abuse and intervene with patients suffering from substance abuse. Barriers include time constraints, concerns about liability, inadequate training, lack of awareness for positive outcomes of intervention and treatment, and lack of awareness of specialized treatment resources available in their communities.[14] Confidentiality should be strongly assured during consultation as, without this assurance, patients might be less likely to seek care and be honest about substance abuse problems, thus making appropriate care difficult or impossible.[15] Some confidential care for drug and alcohol abuse is protected specifically by

state and federal laws, so it is incumbent on the practitioner to know their state's statutes, especially in regard to juveniles. Currently more than 35 states specifically give juveniles the right to obtain alcohol or other drug treatment without requiring parental consent.[15] Federal and state rules also specify that information about a minor patient in a drug or alcohol treatment program can only be released with the patient's written and informed release, but the health care professional should be aware that specific planned destructive behavior or self-destructive behavior (suicide) should be evaluated as a potential for parental notification or notification of legal authorities.[15]

Conclusion

Patients with alcohol and drug dependence are often underrecognized and undertreated. Complementary and alternative health care providers should play a role in screening, brief management, or recommending appropriate referral for patients with substance abuse problems. It is important for health care providers to understand that addiction is a treatable disease. Complementary and alternative health care providers should have knowledge of addiction resources, understand the process of screening and should be able to recognize addiction and help direct patients to programs that can meet their treatment needs.

References

1. Modesto-Lowe V, Brooks D, Freedman K, Hargus E. Addiction and chronic pain: diagnostic and treatment dilemmas. *Conn Med* 2007;7(13):139-44.

2. Koob G, Kreek MJ. Stress, dysregulation of drug reward pathways, and the transition to drug dependence. *Am J Psychiatry* 2007;164:1149-1159.

3. Koob GF. The neurobiology of addiction: a neuroadaptational view relevant for diagnosis. *Addiction* 2006;101:23-30.

4. Chou R, Qaseem A, Snow V, et al. Diagnosis and treatment of low back pain: a joint clinical practice guideline from the American College of Physicians and the American Pain Society. *Ann Intern Med* 2007;147(7):478-491.

5. Bishop PB, Quon JA, Fisher CG, Dvorak M. The chiropractic hospital-based interventions research outcomes study: a randomized controlled trial on the effectiveness of clinical practice guidelines in the medical and chiropractic management of patients with acute mechanical low back pain. *Spine J* 2010;10:1055-1064.

6. Martell BA, O'Connor PG, Kerns RD, Becker WC, Morales KH, Kosten TR, Fiellin DA. Systematic review: opioid treatment for chronic back pain: prevalence, efficacy, and association with addiction. *Ann Intern Med* 2007; 146(2):116-27.

7. Kline AT, Smith MY, Haddox JD. Abuser-reported sources of illegally obtained opioid medications. *Proceedings of the American Pain Medicine 23rd Annual Meeting* 2007; New Orleans, Louisiana. Abstract 104.

8. Ballantyne JC, LaForge KS. Opioid dependence and addiction during opioid treatment of chronic pain. *Pain* 2007;129(3):235-55.

9. American Public Health Association. *Nations Health* 2007;37(10).

10. US Department of Health and Human Services, National Institute of Health, National Institute on Alcohol and Alcoholism. Helping Patients Who Drink Too Much: A Clinician's Guide Updated 2005 Edition. Bethesda, Md: National Institute on Alcohol Abuse and Alcoholism; 2005.

11. Schulz JE, Parran T. Principles of identification and intervention. In: Graham AW, Schultz TK, eds. *Principles of Addiction Medicine*, 2nd ed. Chevy Chase, MD: American Society of Addiction Medicine, Inc.; 1998:249.

12. Leshner AI. Science-based views of drug addiction and its treatment. *JAMA* 1999;282(14):1314-16.

13. Weisner C, Schmidt LA. Expanding the frame of health services research in the drug abuse field. *Health Services Res* 1995;30:707-726.

14. Comerci GD. The role of the primary care physician. In: Jacobs EA, Joffe A, Knight JR, Kulig J, Rogers P, William JF, eds. *Substance Abuse: A Guide for Health Professionals*. Elk Grove Village, Il: American Academy of Pediatrics; 2001:21.

15. Dubler NN, Quinn MM. Legal and ethical considerations. In: Jacobs EA, Joffe A, Knight JR, Kulig J, Rogers P, William JF, eds. *Substance Abuse A Guide for Health Professionals.* Elk Grove Village, Il: American Academy of Pediatrics; 2001:186.