

**BARRIERS TO PHYSICIAN IDENTIFICATION OF PROBLEM ALCOHOL AND
DRUG USE: RESULTS OF STATEWIDE FOCUS GROUPS**

by

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Substance abuse is related to many other health problems, thus making the topic of great public health significance. The scope of this study is the results of focus groups conducted with physicians across the state of Pennsylvania; specifically Harrisburg, Pittsburgh, and Philadelphia. The purpose was to ascertain the barriers to identifying problem alcohol and drug use in patients by practicing physicians. Physicians statewide acknowledged key barriers to screening; time, access to treatment and financial reasons, both patient financial issues or problems and reimbursement from insurers or commercial payers. Additional barriers that were identified as a result of the focus groups included stigmatizing attitude toward substance use, physicians' lack of self-efficacy in managing substance use disorders, and lack of knowledge in this area, among others. The study discusses the results of the focus groups and explores the education that could be offered to physicians in order to increase their knowledge in the area of screening and the identification of problem drug or alcohol use.

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PREFACE

The focus groups were a part of the Pennsylvania Screening, Brief Intervention and Referral to Treatment (PA SBIRT) grant. The grant was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), grant number TI 15977. This paper is dedicated to my sister, Deborah Joyce Gibbon-Braun. You are deeply missed every day.

1.0 INTRODUCTION

Substance abuse can have a major impact on the lives of individuals, their families, their communities, and on their physical health. It is estimated that substance abuse costs the United States approximately \$328 billion a year, which is more than heart disease or cancer. Alcohol abuse has been estimated to be responsible for 15% of the nation's health care costs. The years of life lost (YLL) for an individual with alcohol related liver disease ranges from nine to twenty-two years of life lost, a much greater level of life lost compared to two years of life lost for cancer and four years for heart disease (Harwood, Fountain & Livermore, 1998; Israel et al., 1996). In 2005, 16,685 individuals in the United States died in an alcohol related traffic accident, representing 39% of all traffic related deaths (NHTSA, 2006). Problems associated with substance use are avoidable with proper prevention, intervention and attention. One of the most effective, well-positioned groups of people to address the problem of substance use disorders is primary care physicians and providers, as many individuals who have substance use problems (particularly alcohol) are encountered in high-volume health care settings (Miller et al., 2006). Primary care providers' influence with their patients can directly facilitate effective intervention. During routine visits, physicians screen their patients for various diseases and conditions including types of cancers, osteoporosis, and blood pressure, in addition to many others. However, the practice of screening patients for substance use remains an atypical function and under-practiced method of the primary care provider (Friedman et al., 2000).

Both the National Institute on Alcoholism and Alcohol Abuse (NIAAA) and the United States Preventive Services Task Force (USPSTF) recommend that physicians ask all of their patients about the use of substances, including alcohol. However, recent research has determined that a large majority of physicians are not consistently or regularly screening their patients for substance use (Friedman et al. 2000). In relation to screenings not being consistently performed, there are several problems and issues associated with physicians screening for substance use disorders. About one third of physicians (30-40%) report they do not feel prepared to deal with alcohol-related problems of their patients and an even larger proportion (70%) report that time limitations prevent them from consistently performing substance use disorder screenings and treatment or addressing the problem with their patients (Israel, et al., 1996).

This paper presents the results of focus groups conducted with physicians across the state of Pennsylvania. The focus groups were conducted as part of the Pennsylvania Screening, Brief Intervention and Referral to Treatment Project or PA SBIRT. Pennsylvania was one of seven states given federal funding in 2002 from The Center for Substance Abuse Treatment (CSAT), a division of the Substance Abuse and Mental Health Services Administration (SAMHSA). The PA SBIRT project aims to train physicians and other medical personnel such as nurses, physician assistants, medical assistants and healthcare educators, on how to screen patients for substance use/misuse or hazardous substance use and follow up with an appropriate intervention based on the score or results of the screening. The end result would be a paradigm shift in the medical field in the adoption of the regular screening of patients for substance use disorders. The SBIRT project has been implemented in a variety of medical settings, including family practices, emergency departments, clinics and general practices, in three counties in the state: Allegheny, Bucks and Philadelphia.

The focus groups concerned the screening, identification, treatment and referral of patients in their practices for substance use. Physicians in the groups identified barriers that prohibit them from the regular practice of screening patients for substance use. These barriers include time, access to treatment and financial reasons, both personal to patients such as the inability to pay for treatment, and insurance companies not paying or reimbursing for treatment.

The results of the focus groups give important insight as to: 1) why the practice of regular screening for substance use disorders has not been readily adopted by primary care physicians or what barriers prevent the regular practice of screening; and 2) what steps might be implemented in order to make substance use disorder screening a more integral practice in the primary care setting. The results also indicate key areas to provide education, information or training to physicians in Pennsylvania in order to increase the probability of their undertaking regular screening and intervention with their patients, thus promoting better health and preventing possible various negative health consequences. These key areas of education include: basic addiction education, community treatment resources, state laws and regulations, reimbursement possibilities and pharmacology. Further, these results can be utilized as a framework for physicians in other states to use when screening their patients for substance use.

2.0 LITERATURE REVIEW

Current literature strongly supports physician screening of patients for substance use. In 1980, The World Health Organization (WHO) requested development of ways to identify individuals with harmful levels of alcohol consumption prior to health and/or social issues becoming problematic. Since that time, many other organizations have moved toward and supported regular screening of patients for substance abuse in primary care settings (Gordon, 2006). To date, many inexpensive, brief and useful screening tools have been developed for use by physicians and other medical personnel. However, overall physicians are not regularly screening patients for substance use even though it has been proven effective in reducing substance use, producing healthier patient outcomes and the practice is cost-effective. The literature shows that physicians utilize a method called “case finding” to identify patients who may have a substance use problems. This process involves asking questions and using test results, which may indicate a “red flag” for a substance issue. Examples of a “red flag” include various medical conditions such as hypertension, a recent physical injury, social history (e.g., recent arrest for drunk driving) or abnormal laboratory values. In contrast, a formal screening instrument administered by a physician will identify a substance abuse problem, regardless of the physician’s intuition or suspicion. Thus, the use of formal validated screenings or screening questionnaires is a superior method for the detection of substance use problems in patients presenting in primary care settings (Gordon, 2006).

There are many diseases, conditions and deaths associated with substance use problems such as cirrhosis, hypertension or high blood pressure, and injuries or fatalities due to substance related accidents. Many instances of such disease, injuries and fatalities could be prevented if physicians intervened with their patients regarding their substance use. In addition, a decrease in alcohol or substance use would be beneficial to the health of the patients (Babor & Kadden, 2005). Problem substance use meets the criteria for screening in primary care settings much like other diseases as it is: 1) harmful to patients, 2) prevalent in patients who visit primary care settings where the screening will take place, 3) treatable in an outpatient primary care setting, and 4) identifiable through effective, efficient, and practical screening methods that are readily available to physicians. An estimated 20% of patients who present at primary care settings consume alcohol at a level considered to be problematic. However, a vast majority of physicians are unprepared, untrained or do not identify the substance use problem with their patients even though several recent studies have demonstrated that integrating primary care and addiction treatment realizes actual benefits, including addiction outcomes (Babor et al., 2006; Gordon, 2006; Saitz et al., 2004). Studies have shown decreases in the average number of drinks per week and frequency of excessive drinking following two 10-15 minutes sessions with a primary care physician. Reduction in the number of drinks per week and the number of binge drinking episodes has also been documented following a patient receiving a 5-10 minute session during a regular office visit to his/her primary care physician (Fleming et al., 1997; Ockene et al., 1999).

The literature identifies several major barriers that have been associated with the adoption of screening procedures by primary care physicians. These include the stigmatizing attitude towards substance abuse patients, physicians' lack of self-efficacy in managing alcohol or substance disorders among patients, pessimism about the effectiveness of intervention, and time

constraints. Additionally inappropriate patient education materials and other intervention resources have been cited as barriers (Bradley et al. 1995). There has been little research conducted to identify why primary care physicians are not engaging in screening activities and why they are not providing screening services to their patients even though these techniques and procedures have been proven effective for reducing substance use. There is a gap in the current literature on the reasons why physicians do not perform screenings and the barriers they encounter and possible solutions to barriers are not documented in the current literature. More research needs to be conducted specifically with physicians to ascertain current levels of screening patients, barriers to screening, incentives or motivation that would increase screening, and education that could be provided to physicians to consistently incorporate substance use screening into their treatment of patients.

3.0 METHODS

Three focus groups were conducted in major cities across the state of Pennsylvania; Pittsburgh, Harrisburg and Philadelphia. Focus groups are an exploratory form of qualitative research. They are typically conducted to generate hypotheses and to ascertain opinions and or attitudes regarding a certain topic. The lack of a rigid structure encourages focus group participants to be spontaneous, and share ideas and thoughts. A reaction or statement from one respondent may create a reaction from another, creating an interactive environment rich with information and qualitative data for researchers (Gilmore & Campbell, 2005).

Focus groups in general involve between six and twelve participants and take place in a relaxed atmosphere with a facilitator and last approximately one to two hours. The facilitator focuses and directs the discussion and attempts to keep the participants on topic in addition to probing for additional information or feedback when necessary.

3.1.1 Selection of Focus Group Participants & Sites

The focus groups on which this paper is based were designed and facilitated by staff from the Pennsylvania Medical Society (PMS). Physicians were reimbursed for their participation (market rate was applied for each city) and a light dinner was served at each of the groups. The groups were approximately two hours in length.

The three cities were selected as they are major urban centers in three separate areas of the state of Pennsylvania. The focus groups were conducted in urban settings as that is the primary focus of the PA SBIRT project. A randomized listing of physicians was utilized to select possible participants for the focus groups. The list was randomized by zip code and specialty areas (e.g., general practice, internal medicine, family medicine, emergency medicine). Physicians from various specialties were invited to participate in the groups in each city resulting in groups that were well-rounded and representative combination of practicing physicians. A final list of twelve participants was selected with the intention of involving at least ten physicians from each area. In Pittsburgh, all twelve physicians participated; eight physicians attended the group in Harrisburg, and nine physicians participated in Philadelphia. Each participant signed a consent form to allow the focus groups to be tape recorded and the results published. The names and affiliations of the physicians were not included in the report and their identities were kept confidential. The groups were conducted from September to November of 2006.

3.1.2 Facilitator

The facilitator of the focus groups was a senior staff member from the Pennsylvania Medical Society. Her professional background includes a B.S. in Business Administration and Marketing. She also attended the Allentown Hospital School of Nursing and has experience in a medical setting in addition to her marketing background. She spent a significant amount of time working in a research setting, and had extensive experience in conducting qualitative research with a concentration on the facilitation, script writing, and reporting of focus groups.

3.1.3 Data Collection and Analysis

As previously mentioned, the focus groups were conducted as part of the Pennsylvania Screening, Brief Intervention, and Referral to Treatment project (PA SBIRT). The project has been implemented in over fifteen sites across the state. Current sites include family practices, health clinics, planned parenthood locations and emergency departments. The medical staff at the participating locations have been trained by PA SBIRT project staff as to how to screen patients for substance use and utilize motivational interviewing techniques to assist and motivate patients to decrease or cease their substance use. Throughout the four years of the project, the project team has worked closely with physicians in order to understand why they do or do not regularly perform screenings on their patients for substance use. Following implementation of SBIRT across the state, project leadership wanted to further explore barriers that had been identified by several physicians participating in the project. Barriers had been identified and discussed by physicians who either refused to participate in the SBIRT project, or who had agreed to participate but had ended their participation before the completion of the project. It was decided that focus groups would be the most effective method to gather information on the barriers to implementing and providing SBIRT services and the groups would be conducted in two of the current SBIRT counties and Harrisburg in order to gather information from different areas of the state. The sessions were tape recorded for documentation purposes and notes were taken by an individual who was not the facilitator of the group. Qualitative data analysis was conducted following completion of the groups, including the identification of common themes and coding in order to identify key issues and major findings. A final report containing the results of the focus groups was completed by the facilitator and shared with the leadership of the SBIRT project as well as the participating site staff, including physicians. The report has not

been released to the public or published, nor does it identify or reveal the identities of the physicians who participated. IRB approval was not necessary for the purpose of this paper because it is considered to be secondary data analysis. Because the author was not present during the focus groups that were conducted and because no identifying information was recorded the author cannot identify any of the participants. Permission was granted by the PA Medical Society and the funders of the PA SBIRT project for the use of the results to be the focus of this paper.

4.0 RESULTS AND FINDINGS

This section will discuss each of the objectives and the findings on the key topics from the three focus groups. As recognized in the review of the literature, physicians have identified what they perceive as barriers to providing substance use disorder screenings to their patients. Barriers include stigmatizing attitude towards substance use disorder patients, physicians' lack of self efficacy in managing alcohol or substance disorders, physician lack of knowledge in this area, pessimism about the effectiveness of intervention, and time constraints. In order to gather information regarding how Pennsylvania physicians perceived screening for substance use disorders, eleven objectives were identified by the evaluators and researchers involved in the project. Objectives included researching physician attitudes towards substance use, their education level about addictions, their comfort level with discussing substance use with patients and what were the best methods or assistance they could receive that would encourage them to participate in the regular screening of their patients. The objectives were also developed to assist in determining the level of educational outreach necessary to remove the barriers physicians identified and to effectively and consistently provide screening for their patients in primary care and other medical settings.

Participants in Pennsylvania focus groups did not reflect the same physician barriers, attitudes or beliefs identified in the literature with the exception of time constraints. Rather, two different key barriers were identified from the focus groups conducted with Pennsylvania

physicians, which were access to treatment for substance use disorders, and financial reasons (both patient financial reasons and reimbursement from insurances). These barriers, physician attitudes and beliefs were identified as themes in many of the objective areas.

4.1 PERCEPTION OF ALCOHOL ABUSE AS ILLNESS

The physicians were introduced to several vignettes (see Appendix A), describing patients at varying levels of substance use and experiencing different issues including difficulties at work, psychosocial problems, driving under the influence and domestic abuse. The purpose of utilizing the vignettes was to understand the physicians' viewpoint or personal feelings in relation to substance use and addiction. Following the presentation of the patient vignettes, physicians were asked if they felt the patients were behaving improperly or if they felt the patients were exhibiting signs of abuse. Overall, responses and perceptions of drinking and what constituted inappropriate behavior or substance use varied greatly across all of the groups. However, many of the physicians were able to identify risky behaviors in each of the vignettes presented. Generally, physicians from all groups felt the patients were behaving inappropriately and were possibly exhibiting signs of abuse. Physicians stated they would have spent more time with these patients, probing as to why they were drinking at the levels reported in the vignettes. There was discussion in all three groups regarding the importance of paying attention to the psychosocial aspects of patients and noting that this may lead to identification of possible problems that are attributed to substance use. While it is important to screen patients formally with an instrument, talking one-on-one with patients about what is occurring in their lives that may be contributing to stress and substance use is crucial to developing trust with the patient.

One physician stated, “*Screening tools are a bad substitute for us developing a good relationship with our patients.*” Physicians noted building trusting relationships with patients subsequently allows them to address sensitive issues such as substance use in a less uncomfortable manner and openly discuss more personal topics such as psychosocial problems such as domestic abuse, relationships or possible problems in the workplace.

4.2 PHYSICIAN DEFINITION OF DRINKING LEVELS

It was essential to comprehend how physicians define various levels of substance use - use, misuse, abuse and dependence. All three groups had a difficult time clearly defining and identifying the differences between misuse, abuse and dependence. Both the Harrisburg and Pittsburgh groups noted that an alcohol use disorder included all three levels; misuse, abuse and dependence while the Philadelphia group responded that alcohol use was a continuum and was based more on how the use was influencing the patient’s life, not the quantity that was being consumed. Most physicians did agree however, that patients who used substances on a continual basis and were dependent and/or addicted. These patients were in need of additional treatment to specifically address their substance use that they, as medical physicians, felt that they could not provide.

Respondents from each of the groups felt regardless of the results of a patient’s screening, they always attempt to be aware of the effect substance use might be having on a patient’s life, socially, physically, and emotionally, in order to assist he/she in determining the extent of the substance use. One Philadelphia physician stated, “*We are missing a lot of individuals who don’t have the health effects*”, indicating that some patients who are utilizing

substances are not manifesting physical symptoms as a result of their use. Although there are physical health cues of alcohol use, such as abnormal liver tests and urine analysis, the physicians noted that a patient who reports recently losing a job, ending a relationship or is exhibiting signs of depression may also “tip off” or identify possible substance use issues and this may lead to a discussion with the patient regarding their current drinking level or usage of illicit drugs.

In addition to defining various levels of drinking and usage, the physicians were asked about the definition of what constitutes one drink of beer, wine or liquor. All three groups responded the same definition of a standard drink size: five ounces of wine, twelve ounces of beer and one shot of liquor. Although there was agreement on and knowledge of the standard drink size, there were some differences as to what quantity consumed would be considered problematic. Overall, physicians in each of the three groups would look towards social, behavioral and psychological issues of the patient to determine the level of usage. Physicians reported not always utilizing simply screening results or the patient-reported quantity and frequency as a means to determine the level of abuse or how problematic the use may be for the patient. They would take into consideration other social, behavioral or psychological information gathered from the patient as an indication of how problematic the patient’s use may be and its impact on his/her life and health. Additionally, the frequency of drinking and the patient’s tolerance level were noted as being more important than drink size.

4.3 LEVEL OF SCREENING CURRENTLY BEING CONDUCTED

In order to determine how invested physicians are in utilizing screening mechanisms for substance use, the groups were asked about the level at which they currently screen their patients. Physicians in all three groups reported that they routinely screened all new patients for substance use; however, after the initial visit, they did not re-screen or re-administer substance use screening tools with their patients. Participants in all three groups, however, reported that they felt that patients should be screened annually for substance use disorders. One physician from Philadelphia stated, *“I think this is where we sometimes fall down, we miss it (substance use)”*. Physicians agreed that substance use can be overlooked as a result of not performing regular screening with patients outside initial appointments. Not performing regular screening with patients is directly related to the time issue and financial barriers identified across the focus groups. Physicians felt there was a lack of time during routine office visits and due to time constraints, they believe they were unable to routinely screen their patients for substance use consistently or during subsequent offices visits. Additionally, physicians discussed that they want to be reimbursed for screenings if they are going to commit the time to performing the activities. A physician from Harrisburg stated, *“How do you choose? As generalists, people come to us for many things, if I had an hour for each patient it would be different, but I must identify where I will get the most bang for the buck.”* Several physicians noted that screening should occur at more than just the initial or yearly/annual office visit and they needed to be more vigilant.

Some of the physicians also reported that the underlying presence of medical conditions such as high blood pressure or psychosocial problems such as evidence of domestic violence, would prompt them to probe the patient further about substance use during subsequent visits.

But for the majority of physicians, the initial or annual screen was the only one completed with their patients. Respondents in both the Harrisburg and Pittsburgh groups noted that if a patient were exhibiting symptoms of any type of abuse, they would be more probative; however, time was of the essence and they could not address all issues with patients in a single visit. They additionally noted that they are required to screen for so many conditions and diseases, they did not feel they had the time to effectively screen their patients for substance use disorders.

Another theme was that insurance reimbursement for screening of substance use disorders, affects day-to-day practice and decisions to screen their patients. Physicians in both the Harrisburg and Pittsburgh groups were optimistic and hopeful that Medicaid would soon also reimburse for alcohol and drug screenings. They noted they were screening their patients more regularly as a result of being reimbursed. However, physicians in the Philadelphia group were not as positive. A majority of patients in their area are covered by HMOs that pay or reimburse utilizing a per capita rate. Thus, it is irrelevant if the screening is completed or recognized as a preventative service; the physicians are reimbursed in the same amounts. One Philadelphia physician stated in response to being questioned about providing the screening part of quality health care, "*We get paid the same for a crappy job or a stellar job.*" Additionally, Philadelphia physicians felt that it was the responsibility of employers and communities, not them, to identify and refer patients in need of assistance with substance issues to treatment or counseling. This issue was one of the major findings of the focus groups and will be addressed further in the discussion section.

4.4 AWARENESS OF SCREENING TOOLS

To determine physician awareness of screening tools available to test for drug and alcohol use, physicians were asked if they could identify any screening tools. They were then given a packet that contained several screening instruments, including the AUDIT (Alcohol Use Disorders Identification Test), DAST (Drug Abuse Severity Test) and several others (See Appendix C). A majority of the physicians from each of the three groups were aware of one or some of the screening tools available for substance use. Respondents in all of the groups were familiar with the CAGE and noted that it was short, user-friendly, and could easily be integrated into discussions with patients. The CAGE questions are as follows:

C - Have you ever felt that you should Cut down on your drinking?

A - Have people Annoyed you by criticizing your drinking?

G - Have you ever felt Guilty or bad about drinking?

E - Have you ever had a drink first thing in the morning as an Eye-opener or to steady your nerves or get rid of a hangover?

A majority of the respondents across all three groups felt that the other screening tools in the packet were too long and that patients would not respond honestly to the questions. Physicians did not want more tools or questions to ask their patients, but rather information on how to better address these substance use issues with their patients in a non-formal (performing without utilizing a screening instrument) manner as they felt this approach would be more effective. One Philadelphia physician stated “*You get more information when you ask the patient rather than using just written [questions].*” Many of the other physicians noted that they do ask their patients about substance use, however, without the use of formalized screening instruments or tools.

4.5 PHYSICIAN COMFORT LEVEL WITH SCREENING

Physicians were questioned about their comfort level while screening patients. It was posed only to the Harrisburg and Pittsburgh groups as time expired at the Philadelphia group. Harrisburg and Pittsburgh physicians both agreed that, when questioning patients about their substance use, it was important not to be judgmental and to take into consideration the ethnic and religious background of the patient in order to be culturally sensitive while discussing substances. A majority of physicians in both groups identified feeling comfortable discussing alcohol with patients. Additionally, physicians distinguished inquiring about and discussing drug use from inquiring about alcohol use because alcohol is a legal substance; there is a great deal of negative stigma attached to drug use that does not exist with alcohol usage. Many physicians also noted that when they are questioning patients about drug use, they utilize the phrase “recreational drug use” as it appears to evoke a better and more honest response. Overall, younger physicians seemed to be less comfortable discussing substance use with their patients as they become intimidated when a patient “argues back.”

Respondents in each group noted that patients, particularly adolescents, are utilizing prescription drugs at an all time high rate and that this is not perceived by patients as drug or illegal drug use as it is use of prescription drugs and not illegal drugs. Finally, physicians identified that it was essential and important to know the patients. If the physicians had developed rapport or comfort level with the patient, asking about substance use was not as uncomfortable and they perceived that patients were more honest. Physicians were more comfortable with creating trusting relationships with their patients, having one-on-one interactions and utilizing their own observations to assess patients for drug and/or alcohol use than employing a formal screening tool.

4.6 ACCURACY OF PATIENT RESPONSES

To accurately assess consumption, the majority of physicians in all three groups stated that they typically double the amount of drug or alcohol that patients report using. They were taught this in medical school and for the most part it appears to be true and applicable. Patients under-report drug and alcohol use to physicians and it is the physician's responsibility to determine the actual amount being utilized as there may be a drug interaction or a health condition that could seriously affect the patient's health and well being.

Over all, physicians across all three groups did not answer the question regarding patient truthfulness directly. Rather, they described various methods by which they screen or talk with their patients in order to elicit the most honest or accurate responses regarding how much of a substance the patient is using. While there were different methods for questioning patients about drug use discussed in the group, several were mentioned more than once. Several physicians from Harrisburg communicated that they often ask patients if they are using drugs because they do not want to prescribe a medication that will have an interaction. This typically scares the patients and as a result, they are more open regarding their drug use. Pittsburgh physicians discussed how they may begin asking about tobacco use, then alcohol, and then inquire if they use recreational substances. The first substance they will ask about is marijuana and if the response is positive, they continue to ask about others. Another approach utilized by the Pittsburgh physicians was to ask if family members or friends utilized alcohol or recreational substances and if yes, to ask if the patient participated. A majority of the physicians felt that if the patients report utilizing any substances, they need to be vigilant to determine why they are using (the social, emotional or psychological reasons the patient may be using substances). As for the abuse of prescription drugs, physicians felt they had a better idea of identifying this

regardless of the patient's truthfulness as they are contacted by the pharmacy, can assess the frequency of refills of medications or patient requests for additional prescriptions or refills.

One of the issues that came up during this discussion was the documentation of use in patients' medical charts. The physicians across the three groups were mixed in their responses regarding documenting the patient's substance use in their charts. Some felt that this practice was stigmatizing and that, because many people have access to charts such as employers and insurers, recording this information is a violation of the patient's confidentiality. Others felt that ethically, use must be charted. One physician stated, *"if the patient has a coronary and his notes did not reveal alcohol or drug use, a drug or alcohol interaction with medications could result in the patient losing their life. Your job is to save their life despite the cost to them regarding their job or insurance."*

4.7 BARRIERS TO UTILIZING SCREENING TOOLS

The question was asked of all three groups as to what barriers existed to using screening tools in their practices. Attendees at the three groups noted that time is a critical barrier to providing screening to their patients on a regular basis. They also felt that available screening tools were too long, too cumbersome and too time consuming, not to mention intimidating to patients. They again identified trust as one of the most important elements of their relationship with patients and this sometimes takes years to develop. If they do not have this trusting relationship with a particular patient and ask about substance use, the patient is not apt to be honest, thus making the time and effort spent ineffective for both the patient and physician.

Philadelphia physicians overall felt frustrated and unmotivated to committing time to screening their patients because of their inability to assist patients in accessing the appropriate level of treatment to address identified substance use. They felt one of the major barriers to screening was not knowing what to do if a patient screened positively. Some were uneducated on what substance use treatment resources were available in their county, while other physicians who were aware and knowledgeable of the treatment resources had been unable to effectively get their patients into treatment. They felt the treatment system in their area was vastly ineffective and several noted personal experiences of spending large amounts of time attempting to get a patient into treatment, but being ultimately unsuccessful. Physicians were queried as to whether they felt there was a more appropriate setting in which individuals could be screened for substance use, specifically in a health fair setting. Some of the physicians felt that this venue may increase awareness of substance use, particularly if a patient self-administered a screening tool and were subsequently introspective about the results and encouraged to discuss them with their physician. However, support for this idea was not overwhelming, with one physician stating, *“Alcoholics do not go to health fairs. They are just regular people and think they are going to get a free cholesterol, blood pressure, and bone density check-up.”*

4.8 PATIENT READINESS TO CHANGE

Physicians in the Harrisburg group noted that it was important to provide patients with information and to follow up with them as well. They felt that if you did not follow up with the patient, then the time and energy spent trying to change their behavior was lost. Participants in both the Harrisburg and Pittsburgh groups indicated that linking substance use to health (e.g.,

liver disease, diabetes management) is more successful in reaching the patients because the potential for serious medical conditions alarms patients and motivates them more to change their behavior. Although the approach utilized will be different from patient to patient, an example would be to reinforce that, unless a patient quits drinking, his/her liver disease will become worse, and the patient will not be around to spend time with his/her family or grandchildren. Such conversations need to be conducted so that the patient realizes his/her choices, is willing to change, and does not become hesitant to return for subsequent appointments. A similar method is approaching the patient from an educational standpoint. For example, discussing the number of calories a patient is ingesting when he/she drinks, how this causes weight gain and is also having a negative impact on his/her diabetes. Several of the physicians agreed that this approach was effective.

Various other comments were made by physicians from all three groups. One physician noted that you had to wait until a patient hit “rock bottom” in order to have any impact on them and persuade them to change their drinking or drug behavior. A physician stated *“Unless patients are feeling some pain in their lives, either physical or emotional, they are not going to be willing to quit using or drinking. If the individual is not ready, you could give them all the resources you have, but it is not going to help. These people have moments of clarity that do not last.”*

Emergency department physicians utilized noticeably different tactics with patients as they see patients when they are either in trauma or very ill. Decisions need to be made quickly and the emergency room setting did not allow for the time to assess the patient’s willingness or readiness to change.

4.9 BARRIERS, EFFECTIVENESS OF TREATMENT, RESOURCES FOR ALCOHOL AND DRUG DISORDERS

Some of the major barriers to referring patients to treatment included; insurance company reimbursement policies, lack of reimbursement for the appropriate amount of and time in treatment, lack of treatment centers, the need for more specialists in this area (e.g., social workers, physicians who specialize in addictions), and the patients' inability or lack of motivation to get assistance.

Participants in all three groups discussed their frustration with insurance companies. They felt that patients were not getting the type and amount of treatment they needed and that the rules, legal documentation and paper work were so confusing that it was not surprising that patients would give up on getting themselves into treatment. One physician stated that insurance companies "*make it very difficult for the physician to get patients into a quality facility.*" Physicians noted that the capitated system utilized by the insurance companies that limits the amount of services a patient can access does not provide enough money for quality health care, medical or substance use treatment. The co-payments patients are required to pay are also too expensive and patients are therefore unable to afford treatment.

Physicians across all groups stated there were not enough reputable treatment facilities in their area, and that due to extensive waiting lists, it was difficult to get patients into these treatment facilities. As a result, many physicians are deterred from getting involved with referring patients for treatment. Physicians were adamant that without proper referral or access to treatment, there was no rationale for screening patients.

The Philadelphia group noted that even when patients get into treatment and receive the amount and length of treatment appropriate for their level of use, there is no guarantee that the

patient will change his/her behavior, particularly if he/she return to the environment or neighborhood where he/she were using substances and fall into old habits.

4.10 PHARMACOTHERAPY

Physicians were queried about their level of comfort treating patients they know for certain have a drug and/or alcohol problem. Respondents from both the Harrisburg and Pittsburgh groups were interested in additional information regarding drug therapies and gaining more knowledge in the area of pharmacotherapy. They felt that if they had good information regarding drug interactions, they would be more comfortable treating and prescribing for those patients who were using drugs and/or alcohol.

The Philadelphia group had many comments and a great deal of discussion on this topic. They did not feel comfortable treating patients who were using substances. They were further asked how they would handle a patient a patient who complained of feeling tired and who was taking a beta blocker and ACE inhibitor in addition to using both alcohol and drugs. Specifically they were asked how they would differentiate between the use and the actual side effects of the medications as they are identical. One physician responded, *“We don’t. The danger is if you even discuss these issues with the patient, they will choose to drink and stop medication rather than the alcohol.”* Philadelphia physicians felt it would be more effective to have an infrastructure within their practices that included individuals who were trained and knowledgeable on the topic of addictions and pharmacotherapy. These individuals would be available to counsel the patient on pharmacotherapy issues and the physicians would not be responsible. Additionally, they wanted more resources available to them that would assist those

patients who were ready to stop using or drinking, such as an 800 number physicians could call and refer patients to treatment.

Philadelphia physicians stated they felt the burden of addressing addictions was inappropriately placed on them and that the community, employers, and insurers needed to take some responsibility and an active role for educating people on the subject. They felt that insurance companies did not pay for treatment and that employers need to be willing to give employees time off in order to get the care they need. They felt strongly that there was a great deal of stigma attached to using substances or being addicted to drugs and/or alcohol and this attitude needed the change. The physicians also noted they wanted more public service announcements and television shows that addressed the consequences of drug and/or alcohol use.

4.11 CONTINUING MEDICAL EDUCATION

The physicians in Philadelphia were not asked by the facilitator about the topic of continuing medical education as they had repeatedly expressed throughout the focus group that they were not interested nor did they need additional information on this topic. However, there were some similarities and notable differences between the Harrisburg and Pittsburgh groups regarding the topic of continuing medical education. Both the Harrisburg and Pittsburgh groups identified that a one to two day conference on the topic that was offered free to physicians and with continuing medical education credits would be well received. Both of these groups discussed the importance of offering continuing medical education credits for their time and if these were not offered to physicians, interest would be minimal. The concept of the conference and the continuing education credits however, were the only similarities between these two groups.

The Harrisburg group was receptive to a CD-ROM or comparable interactive learning materials, including web-based tools. Harrisburg physicians felt that those who had been in practice less than ten years would prefer materials that covered the basic principles and knowledge on addictions while those who had been practice for longer than ten years and had more knowledge on the topic, would want only new or cutting edge information and data. The Harrisburg physicians also indicated that a DVD or some type of video that they could show in their waiting rooms or show to patients would be helpful. Whether it directed patients to discuss their alcohol or drug problems with the physician, directed them to other agencies or resources at which to find assistance, or offered messages of hope in addiction, it would be a useful tool in their practices.

The Pittsburgh group was interested in a monograph or other written materials and had no interest in the CD-ROM or web-based materials. They suggested that evening meetings be conducted on the topic, similar to the format of the focus group. They offered only one additional suggestion, that of including patient safety credits in addition to the continuing medical education credits. Physicians are required to complete a certain amount of continuing education credits each year, including credits in patient safety, a newer area of education required. Patient safety covers topics such as pharmacology, drug interactions and contraindications for medications. It is critical for physicians to have knowledge in these areas, particularly if a patient is utilizing substances. They need to be educated on how alcohol and or drugs will interact with the medications they prescribe or may prescribe for a patient. Patient safety education tracks are beginning to have concentrations in this area and classes available for physicians. Thus, there was a large number of physicians interested in patient safety continuing education credits.

5.0 DISCUSSION

The focus groups revealed a wealth of information about how physicians feel about screening patients for substance use, in addition to many other issues that impact if, how, and to what extent physicians address substance use in their practices. Furthermore, barriers to providing these services were identified.

The literature cites four major barriers that physicians have identified in relation to screening for substance use. They are stigmatizing attitude towards substance abuse patients, physicians' lack of self-efficacy in managing alcohol or substance disorders among patients, pessimism about the effectiveness of intervention, and time constraints. The physicians in these focus groups also identified time as a major barrier towards screening patients, but identified several other barriers that were different than those cited in the literature. They discussed access to treatment and financial issues as major issues in being motivated to screen patients for substance use.

5.1 BARRIER 1: TIME

Time was discussed at length during all three focus groups. Physicians are under tremendous pressure to screen their patients for many diseases and conditions and feel overwhelmed and pressured attempting to complete all of the screenings and perform all the routine activities

necessary during a normal office visit. If a patient exhibited some symptom, such as high blood pressure, or if the patient had recently lost a job or been involved in an automobile accident, the physician would be more motivated to spend the time to screen the patient for substance use as a result of one of the symptoms or psychological cues. A patient has his/her blood pressure and other vital statistics taken each time he/she visits a physician and this medical information provides information to the physician as to the current status of the patient's health. By noting a problem with laboratory results or vitals, the physician is motivated to address the issue and the patient can begin a treatment (e.g., medication, exercise, behavior change) and avoid negative health problems or incidents. The same approach can be applied to the regular and consistent screening of patients for substance use if physicians would utilize the formal screening tools that are available to them. However, with the time constraints they feel, many physicians do not conduct formal screenings.

Due to lack of time during an office visit, physicians across the state admitted that they only screen new patients and existing patients annually and do not regularly practice screening. By not screening patients at each of their appointments, physicians may be missing those who are currently abusing substances. They may also not be identifying those who are just becoming involved with substance use prior to their use becoming problematic. Very few physicians have a protocol in place within their practices for screening of patients. It is estimated that approximately three quarters of patients seen in primary care settings who are abusing substances escape detection (Gordon, 2006). If physicians screened their patients, more of those who were using substances in a harmful manner would be identified.

Alcohol consumption was the third leading actual cause of death in the United States in 2000 (85,000 deaths) while the total number of deaths attributable to alcohol was 103,350.

While these numbers may not seem particularly large, the 85,000 deaths due to alcohol consumption accounted for 3.5% of the total deaths in 2000 (Mokdad, et al. 2004). Many of these deaths could have been prevented if physicians had taken the time to regularly screen their patients for substance use. Primary care and other medical settings give access to individuals who may be utilizing substances in a harmful manner. This population of individuals may be more motivated by general health problems or concerns to change their drug or alcohol use when other approaches have failed. Additionally, there is less stigma attached to discussing drugs and alcohol with a physician than a counselor or drug/alcohol/addictions professional (Curry, Grothaus & Kim 2003).

The length of the screening tools available to physicians was seen as a barrier related to time as well. They felt that the questions contained in the instruments were too numerous and that their patients would be intimidated by such long questionnaires. There are several shorter screening tools available, such as the CAGE, that are still useful assessment tools that effectively identify harmful or hazardous substance use.

5.2 BARRIER 2: ACCESS TO TREATMENT

Another major barrier that was identified was access to treatment. When patients screened positively and needed substance use treatment, physicians in all three cities felt frustrated about the lack of an effective referral system and the inability to get patients into treatment when necessary. Physicians across the state felt that if they could not get their patients into treatment, there was no basis or argument for screening.

Several factors contribute to the problem of access to treatment. First, some physicians in the groups admitted they were not familiar with the facilities, services or treatment system in their area that dealt with substance use, making the process of referring a patient more difficult. Physicians in all areas should be aware of and familiar with the drug and alcohol treatment resources available to their patients and community, as their lack of knowledge could prohibit the proper referral of patients to treatment. A solution to this problem would be to create a formal linkage between the addiction and medical systems, allowing for more referrals to be made and patients getting the treatment they need. Several studies have demonstrated that integrating medical care and addiction treatment realized actual benefits, in particular, improving addiction outcomes (Saitz et al. 2005).

Another issue related to access to treatment that was discussed by the physicians in all three groups was insurance restrictions. Many insurance companies will not pay for addiction treatment, or they will pay for a portion of treatment such as several days in a residential program when research has proven that thirty days of inpatient or residential treatment is most effective. When patients do not receive the appropriate amount of treatment, recovery is more difficult (Babor & Kadden, 2005). Additionally, many times patients have exceeded their pre-determined rate or receipt of services and insurance companies reject the request for the treatment or claims. Furthermore, co-payments are unaffordable and patients do not go to treatment due to the expense. All of these issues relate to the impact of the insurance industry on a patient's access to treatment. The physicians across all groups expressed frustration with insurance and its influence on whether or not they screened their patients. If they felt the patient was not going to be able to access treatment due to their insurance, they were not going to commit the time to screening.

Pennsylvania has an act in place that requires insurance companies to pay for the full amount of time patients should receive in addictions treatment. Act 106 was established in 1989 and is not well known to the physicians throughout the state. The act requires comprehensive coverage of addiction treatment under various commercial group health plans, health maintenance organizations and the Children's Health Insurance Program (CHIP). The act requires patients identified as needing detoxification services to receive up to seven days of treatment per admission, with a maximum of four detoxification admissions per lifetime. It requires that patients identified as needing placement in a residential or inpatient treatment program receive a minimum of thirty days of treatment, with a total lifetime maximum of ninety days. Finally, the act requires that those patients in need of outpatient treatment receive a minimum of thirty days or sessions of outpatient or partial treatment, with a maximum of 120 days per lifetime (PRO-ACT, 2007). Under Act 106, a physician or licensed psychologist can determine the length of treatment needed for a patient and insurance companies must comply with the assessment or determination. The Pennsylvania Department of Insurance has jurisdiction to enforce Act 106 and has pledged to take action within the state against insurance companies that deny requests from patients in need to substance use treatment. While this law does not apply to all insurance carriers or HMOs, it is a vehicle to gain access to treatment for many patients who are denied services. Physicians need to be educated and aware that such laws exist within the state of Pennsylvania and that their patients have rights as to the amount of substance use treatment they are entitled to receive. It is suggested that an education program be developed to educate Pennsylvania physicians as to the state laws and Act 106 as it would assist them in referring their patients to treatment and attempt to address the barrier of insurance companies influencing or preventing access to treatment for patients in need.

5.3 FINANCIAL ISSUES

Many of the physicians who participated in the focus groups had a negative perception of insurance companies and payers. They described not having the appropriate knowledge of which insurers would pay for certain services related to substance use because of the many varying health coverage plans, making it difficult to know what would even be available to the patient based on his/her insurance. Physicians should have the resources available to them that would permit them to have access to what insurers will and will not cover, including substance use treatment.

Physicians complained that they were not adequately reimbursed for providing screening or preventative services. They feel growing pressure to accept more responsibility, yet the financial benefits are not commensurate with the additional expectations placed on physicians. Recently, Medicaid has created codes for the reimbursement of screening for substance use in medical settings. These codes need to be activated by the state of Pennsylvania in order for them to become active. Until this occurs, physicians cannot be reimbursed for performing screenings. This is a deterrent for physicians to provide appropriate procedures with their patients. They feel that since there are too many requirements and expectation and not enough financial incentives, they are not going to perform screenings that ultimately would be beneficial to the patient and cost the healthcare system less money in the long run. Fleming et al. (2002) conducted research on the cost benefit of providing screening and brief advice for patients. They found an average medical care saving in emergency room visits and hospitalization totaled \$712 per patient. This

supports regular screening of patients as the savings resulting from such preventative service appear to be significant.

6.0 CONCLUSIONS

There are several limitations to the findings of the focus groups. First, the groups were conducted in only three of the many counties in Pennsylvania. These counties are quite different from one another as well as from the other counties in the state. The substance use disorder systems in each county are also quite different and, therefore the findings cannot be generalized across all groups, but were specific to the county in which the physicians practiced. Additionally, the groups were conducted in large urban settings or cities which differ significantly from smaller or more rural locations. Findings from similar focus groups conducted in other smaller counties throughout the state may not produce similar results and therefore the findings cannot be generalized for all counties within Pennsylvania. Rural treatment sites, with a different patient population, may have a different treatment culture and could be the focus or topic of further research. However, the findings suggested that there are steps that could be implemented in order to make screening a more integral practice in primary care and other medical settings. In addition, there is a great deal of education that could be provided to address the barriers and issues related to physicians screening patients for substance use.

One of the goals of the focus groups was to identify areas in which education could be provided to physicians across the state to increase their knowledge of addictions and promote the practice of screening services. In addition to barriers that were identified and previously discussed, there were various areas identified areas in which education could be applied as

physicians lacked both knowledge and formal training. In general, the physicians that participated did not have formal education on substance use and addictions. Formal training for the identification and management of substance use disorders currently and typically is not part of medical residency programs (D'Amico et al. 2005). Physicians noted receiving several class sessions dedicated to addictions in medical school, but apart from minimal information and class time, the topic is not formally a part of their training. Training or medical school time devoted to the topic of addictions would provide physicians with the knowledge, skills and background needed to better understand substance use and screening and how screening for substance use can be important to their patients' health and well-being. Additionally, the formal education would make physicians more comfortable addressing the topic with their patients as many physicians who participated in the focus groups noted being uncomfortable addressing the issue and felt they were not properly educated on addictions.

Physicians need to be educated and aware of the resources they have in their communities, such as treatment facilities and the location of twelve step programs in the area. There was a lack of awareness across all three groups concerning the addiction treatment system in the physicians' respective counties/areas. Creating a formal linkage between the healthcare system and the substance use treatment system is essential for the success of the identification of problem use in medical settings. Patients are more willing to discuss their use with physicians as there is less stigma involved (Weisner et al., 2001). In return, physicians should know community resources available to them and their patients in the treatment and recovery from substance use. Developing a linkage between the medical and substance abuse systems in communities would allow physicians to gain knowledge of and have access to available treatment facilities, services and programs, support groups such as Alcoholics Anonymous and

psychological services. All of these services would benefit patients and reduce the physicians frustrations of being unaware of how to refer patients to needed services or what resources were available.

Physicians are required to complete a specific number of continuing medical education credits each year. The physicians who participated in the focus groups repeatedly suggested that making continuing medical education credits available via courses in addictions, screening and substance use would be beneficial as they need the education on these topics to better care for and treat patients. Providing continuing medical education could increase the chances of physicians regularly screening patients for substance use as they would be better educated, informed and feel prepared to deal with substance use issues. It would also be fulfilling the requirements of continuing medical education credits.

Educating physicians regarding any insurance requirements or legal issues related to substance use and treatment would also assist and possibly motivate physicians to want to address this issue with their patients. As noted, there are laws and acts in Pennsylvania that specifically address patients in need of treatment. This information should be widely distributed and shared with physicians across the Commonwealth. One of the barriers noted by physicians was that currently they are not reimbursed for screening services provided to patients. Physicians should be aware that recently Medicaid has created codes for the reimbursement of screening for substance use in medical care settings. However, the codes must be recognized and activated in each individual state, including Pennsylvania, by the legislature in order for reimbursement to begin. Support from physician is needed in order for the legislature to be motivated to instate or activate the codes. If the legislature was aware that physicians are supportive of providing screening and see it as a benefit to patient health and is cost effective,

then it is more likely that the codes will be approved and activated as it is a preventative service and could deflect future higher health care costs and insurance claims if patients are not screened and identified as needing assistance earlier.

There was a connection between education and physician attitude toward substance use treatment in general and specifically towards their interactions with patients with substance use problems. Those physicians who had greater amounts of formal education and training in addictions were more likely to address the issue and regularly screen patients. It was apparent that some physicians who were unable to overcome their own feelings of stigma or lack of education in addictions or substance use, were less likely to screen. Providing training on substance use, including the use of screening tools, patient vignettes and other useful techniques, could assist physicians in overcoming their own negativity or biases towards substance use and those patients that use drugs and alcohol. It is essential for physicians to treat patients impartially and not impose their own emotions onto patients. Continuing medical education credits or classes on these topics would be most effective in addressing the current lack of education and provide physicians with the knowledge they need to discuss substance use more effectively and comfortably with patients.

Another area in which education is needed by physicians is pharmacotherapy as drug interactions may be problematic for patients who abuse drugs and/or alcohol. Medications can interact with drugs or alcohol and be detrimental to patient's health or even result in death. There was a clear lack of knowledge on the topic across all three groups. Many of the physicians noted they were uncomfortable at times with patients in addressing all of the drug/alcohol interactions. Many noted that they would rather refer the patient elsewhere for additional assistance and not deal with or have that responsibility. Providing needed continuing medical

education credits in the area of pharmacology would allow physicians to gain knowledge regarding drug interactions and other related areas that would make them more comfortable prescribing for patients who were utilizing substances and less likely to avoid the issue, not prescribe necessary medications or want to refer patients elsewhere for assistance.

The most important finding of the focus groups was, although physicians identified multiple barriers and issues surrounding the practice of regularly screening patients for substance use, overall they were highly motivated to address substance use, screen, and provide the best care possible for their patients. It is important to capitalize on the motivation of the physicians and provide them with the tools and knowledge necessary for them to assist patients who have substance use disorders. Given the magnitude of substance use as a public health problem in this country, physicians play a significant role in identifying the problem and preventing serious health and psychosocial problems from occurring in patients with the application of a brief screen.

Future and additional research on the topic of physician screening for substance use in medical settings is warranted. Additional focus groups should be conducted in order to gain additional information and insight as to why physicians do or do not participate in screening patients for substance use. Due to the vast differences between the application of screening in various medical settings, future focus groups should be conducted so that all of the participants in the focus groups be from specific specialty areas such as family practice and emergency room physicians. Barriers to screening for substance use encountered by emergency room physicians will be different than those identified by family or general practice physicians. Additionally, it would be beneficial to conduct focus groups with physicians of varying ethnic backgrounds and also conduct groups separated upon the gender of physicians to ascertain differences across these

various groups, such as cultural attitudes towards substance use. The results from these focus groups and others on the same topic could be a vehicle for developing a physician survey that could be distributed nationally. A survey would allow for the understanding of the level to which screening is currently being conducted, barriers to screening that exist, and methods that could be applied in order to remove barriers and facilitate the regular screening of patients in primary and other medical settings across the county.

APPENDIX A: PATIENT VIGNETTES

A.1 PATIENT VIGNETTE #1

This 28 year-old Caucasian female is in your office for a yearly physical exam and Pap test. She is complaining of difficulty sleeping and vaginal itching. In the course of your conversation and history taking you discover she lost her high paying job 9 months ago, her husband has walked out on her, and she is about to lose her apartment because she cannot pay her rent. When you ask how she is coping with the stress in her life she confesses she has been spending a lot of time partying with her friends.

Should this individual be screened for alcohol use?

She admits to drinking at least two glasses of wine every evening at home, and when she goes out Thursday through Saturday, she has at least 5 drinks in a night.

Is this patient at risk for alcohol abuse?

The patient admits that while out at a local night spot one evening, she was encouraged to try some cocaine just to help her forget about her problems for a little while. She states she only tried it once.

Is this patient at risk for drug abuse?

A.2 PATIENT VIGNETTE #2

This 36 year-old Hispanic male is married and living with his wife and her elderly parents. He works hard all week and spends every Saturday night playing poker with the guys. Last Saturday night he had an automobile accident on his way home at 2am and spends Sunday morning in the emergency room receiving treatment for multiple bruises and lacerations. Today, he is in your office for follow up care to his lacerations.

Should this individual be screened for alcohol use?

When questioning him about the accident, you ask if he had been drinking. He becomes defensive and denies being an alcoholic like the bums on the street stating he only drinks on Saturday nights when he has a few beers with the guys. On further probing he admits to 9 or 10, twelve ounce cans.

Is this patient at risk for alcohol abuse?

A.3 PATIENT VIGNETTE #3

A new patient is seen by you today. This 50 year-old African American male is in for evaluation of an open sore on his left leg. His blood pressure is 172/96 and the ulcer on his leg hasn't healed in four months. He states he has never been sick a day in his life, has never seen a physician, and has no use for them. He said he cures what ails him with a shot of good whiskey. The only reason he is here is because his wife says she will leave him if he doesn't do something about his leg.

Should this individual be screened for alcohol misuse?

You have seen his wife as a patient for many years and have quizzed her often about how she received the many bruises and injuries that you have treated. Each time she has claimed being clumsy as the reason for her injury.

Should you consider that an alcohol use disorder is present here?

APPENDIX B FOCUS GROUP SCRIPT

B.1 ALCOHOL AND DRUG SCREENING FOCUS GROUP SCRIPT

B.1.1 Introduction

Introduce self.

Focus group concept.

Explanation of mike and taping, breaks and location of restrooms.

Encourage participation and consideration for person speaking.

Request cooperation with time constraints and focus of group.

Introduction of participants.

The topic for discussion is alcohol and drug use screening.

Narcotic analgesic abuse, based on emergency department visits of the Drug Abuse Warning Network (DAWN) report has more than doubled from 1994 to 2001.

Alcohol is the third leading cause of preventable death.

Preventing many of these deaths involves identification of patients before they become dependent on alcohol.

B.1.2 Patient Vignettes to begin discussion

Please listen to the following case histories and let's discuss whether or not you think these individuals should be screened for alcohol and/or drug misuse and are at risk of a substance use disorder.

(see patient vignettes in Appendix A).

B.1.3 Perceptions

-What is your definition of alcohol use disorder (misuse, abuse, or dependence)?

-What is considered one drink?

-How many drinks in one sitting do you believe constitute too many?

-How many drinks in one day? Week? (Handout chart after discussion).

-Would you describe alcohol use disorders as an illness or bad behavior?

-Is alcohol use disorder more like a chronic illness such as asthma or is it something that is more acute in nature like the flu? Why or why not?

-Preventing alcohol use disorders can lead to lower rates of disease, accidents, and decrease health care costs.

-Considering your previous comments how would you respond to the need to screen each of the cases now? Young woman at risk for HIV, Hispanic with binge drinking and automobile accident, and man with undiagnosed diabetes and wife with domestic violence?

-Third party payers are starting to take notice of the value of reimbursing for preventive services, Highmark is reimbursing for child obesity, CMS now allows billing via Medicaid for alcohol and drug screening and brief intervention.

-Considering the time frame of an average visit, how do you see alcohol and drug screening fitting into the discussion with your patient?

B.1.4 Identification

-How does a physician screen for alcohol and drug misuse?

-Include when you choose to screen and why, or why not.

-What types of questions do you ask?

-What is your confidence level that patients are telling you the truth about their drinking or drug use?

-Is there a difference in how truthful patients will be about alcohol use versus drug use ?

-Is there a difference in how comfortable you might be in asking about alcohol use versus drug use?

-When you suspect patient are hedging what do you say?

-Can you name any tools to screen patients for alcohol/drug abuse?

-Have you ever used any specific tools to screen patients for alcohol or drug misuse (Handout sample).

-How familiar are you with AUDIT?

-How familiar are you with CAGE?

-How familiar are you with CRAFFT?

- How familiar are you with DAST?
- After learning about these tools, do you think screening is possible in the context of an office visit?
- Would you consider using any of these tools in your office?
- Why or why not?
- What barriers prevent you from using them?
- Do you use laboratory tests, liver function test (LFTS) and gamma-glutamyl transpeptidase (GGTP) in blood and ethyl glucuronide (ETG) urine test to assist you in identifying alcohol misuse or intervening with a patient who denies a problem?
- Do you use urine of other types of screens to identify drug misuse for the same purpose?

B.1.5 Intervention

- How do you assess a patient's readiness for change?
- Have you ever heard of the transtheoretical stages of change? (Handout)
- Using the Drinkers Pyramid (use chart), what do you perceive as a doable intervention with each level?
 - Abstainers, Low-risk drinkers, high-risk drinkers, probable alcohol dependence? How many of your patients would fall in each of these classes of drinkers?
- What do you perceive as a doable intervention for drug use disorder?
- How effective is treatment for alcohol or drug use disorders?
- When you identify an alcohol or drug use problem, what do you usually do?
- What resources are available to you when you identify and want to refer a patient for assessment?

B.1.6 Pharmacotherapy

- Do you feel comfortable treating people who have an alcohol or drug use related problem?
- Are there medications available to assist in the treatment of alcohol or drug use disorder?
 - What are they?
 - How do they work?
- How would you measure your level of knowledge of interactions and contraindications of drugs and alcohol on a scale of 1-5 with 5 meaning excellent and 1 poor?
- Are there any specific drug classes you would like more information about in conjunctions with interactions and contraindications and drug/alcohol use? (Example: Warfarin, SSRIs, antipsychotics?)
- Is there a problem differentiating side effects from medications prescribed from alcohol and drug misuse side effects? (Ex: depression caused by alcohol versus the use of a beta blocker).
- How would you measure your level of knowledge of interactions of specific chronic illnesses with alcohol or drug use disorders on a scale of 1-5, with 5 meaning excellent and 1 poor? (Ex: Arthritis, diabetes, heart disease).
- What else would you like to know?

B.1.7 Continuing Medical Education (CME)

If a continuing medical education program was developed to address the screening, brief intervention, and referral to treatment for alcohol or drug misuse:

- What should it include?
- How is it best disseminated?

-What media should be used?

B.1.8 Screening tools

-If tools were provided would you screen more individuals?

-What tools would help? (Ex: AUDIT, CAGE, CRAFFT, laminated cards, posters, brochures)

In closing, we would like to invite each of you to be part of our ongoing effort to research how best to communicate with physicians and help them address this growing problem with their patients. Please give me your name if you do not wish to participate.

APPENDIX C: SCREENING TOOLS

THE AUDIT

1. How often do you have a drink containing alcohol?
 - (0) Never
 - (1) Monthly or less
 - (2) Two to four times a month
 - (3) Two to three time a week
 - (4) Four 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 4
 - (2) 5 or 6
 - (3) 7 to 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 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 because 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
 - (2) Yes, but no in the last year
 - (4) Yes, during the last year

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

AUDIT Scoring

The number for each response is the number of points. Answers for each question range from 0 to 4. There is no set cut-off point indicating harmful use. A score of 2 or more indicates some level of harmful use.

The particular score that warrants a further evaluation, depends in part on the situation, e.g., a score of 3 for someone scheduled for surgery would clearly warrant further evaluation, although this might not be as critical for the healthy individual who is seen during a routine annual physical. However, patient education/harm reduction efforts are indicated for anyone who scores over a 1.

AUDIT SENSITIVITY AND SPECIFICITY

	% those with score who have alcohol abuse/dependence	% all alcoholics with this score	% all alcoholics with lower score
Score 12	97%	28%	72%
Score 8	90%	61%	39%
Score 2	25%	97%	3%

CAGE Questionnaire

11. Have you ever felt that you should Cut down on your drinking?
12. Have people Annoyed you by criticizing your drinking?
13. Have you ever felt bad or Guilty about your drinking?
14. Have you had an Eye opener first thing in the morning to steady nerves or get rid of a hangover?

CAGE Scoring: One point for each positive answer. Score of 1-3 should create a high index of suspicion and warrants further evaluation.

Score of 1: 80% are alcohol dependent

Score of 2: 89% are alcohol dependent

Score of 3: 99% are alcohol dependent

Score of 4: 100% are alcohol dependent

CRAFFT Questionnaire

1. Have you ever ridden in a Car driven by someone (including yourself) who was high or had been using alcohol or drugs?
2. Do you ever use alcohol or drugs to Relax, feel better about yourself or fit in?
3. Do you ever use alcohol or drugs while you are by yourself, Alone?
4. Do you ever Forget things you did while using alcohol or drugs?
5. Do your Family or Friends ever tell you that you should cut down on your drinking or drug use?
6. Have you ever gotten into Trouble while you were using alcohol or drugs?

CRAFFT Scoring: 2 or more positive items indicate the need for further assessment. The CRAFFT is intended specifically for adolescents. It draws upon adult screening instruments, covers alcohol and other drugs, and call upon situations that are suited to adolescents.

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