Welcome to the Recovery U module on making referrals.

Module Goals

1. Describe referral resource options for patients with SUDs.
2. Explain shared decision making (SDM), an approach to helping patients decide on treatment options.

By the end of this learning module, you’ll be able to describe referral resource options for patients with substance use disorders, and you’ll be able to explain a shared decision making approach to helping patients decide on treatment options according to their own goals, values, and preferences.
First, let’s discuss which patients are candidates for referral. They are patients who have a moderate or severe substance use disorder, also known as SUDS, as defined by the DSM-5 criteria shown on this slide.

There are two categories of symptoms of substance use disorders. One category of symptoms pertains to problem use or negative consequences of substance use. That’s when substance use interferes with important activities, hinders attendance at work or school, continues despite personal, social, or health problems, or occurs in hazardous situations such as driving or operating heavy machinery.

The second category of symptoms is loss of control or other changes in the brain. Loss of control may manifest as unsuccessful attempts to quit or using more than intended. Patients may experience urges or cravings to use, and they spend increased time and effort to obtain substances. They may experience tolerance, where a larger dose of substances is required to obtain desired effects. They may also experience withdrawal.

Patients with none or one of these symptoms do not have a disorder. Patients with two or three symptoms have a mild disorder. Those with four or five symptoms have a moderate disorder, and those with more symptoms have a severe disorder.

Because peer support providers are not clinical providers, there won’t be an emphasis on clinical diagnosis for the recovery coach or peer support provider role.
Here are some categories of resources that may be helpful to patients with SUDs. One category is professionally administered SUDs treatment, which is aimed directly at addressing substance use disorders. A second category is resources that involve mutual support, typically involving support from other people with SUDs that are either active or in remission, or self-help, not involving any other people. A third category is resources for other needs which, if not addressed, can make recovery from SUDs more difficult.

Here are the typical steps of SUDs treatment. In the first step, detox, the goal is to safely and comfortably help patients rid their bodies of substances. Alcohol and sedatives are the most dangerous substances to withdraw from. Acute alcohol withdrawal can last up to seven days after patients stop drinking. Severe withdrawal can include seizures, agitation, hallucinations and changes in body chemistry that can cause abnormal heart rhythms and death.

Moderate to severe alcohol withdrawal is best treated in hospitals. Mild to moderate
withdrawal is best treated in community detox settings. Patients with mild withdrawal can also be treated at home if supportive individuals can help oversee medication use and if healthcare professionals can check patients daily. Often, sedatives must be tapered off gradually over weeks to months to prevent seizures, and detox is typically conducted on an outpatient basis. Opioid withdrawal can be extremely uncomfortable but is only dangerous if patients have other medical conditions, such as insulin-dependent diabetes or heart disease.

Most patients can withdraw safely at home, but a supervised setting can provide greater comfort and assurance that patients will complete their detox rather than go back to using. Typical symptoms of stimulant withdrawal are low energy and low mood. Unless suicidality occurs, patients can withdraw from stimulants at home.

To benefit from behavioral treatments, patients must be alert and focused. Many patients cannot participate well in behavioral treatment until detox is completed. Detox itself is not a SUDs treatment. It prepares patients to be able to participate in treatment.

After detox, the next step is treatment itself. Depending on the severity of a patient’s substance use disorder, treatment can last from several weeks to many months and beyond. You’ll hear about various kinds of behavioral and pharmacologic treatments next.

After initial treatment, long-term support is often helpful to maximize patients’ chances for long-term remission.

For patients with mild SUDs, brief interventions and one to three brief follow-up sessions may be sufficient to help patients quit or cut down and avoid negative health and social consequences of substance use. Patients with moderate to severe SUDs should receive more intensive treatment.

One such treatment is motivational interviewing or MI, an empathic, collaborative approach to
helping patients strengthen their commitment to change. Patients with SUDs typically have ambivalence about their substance use, and MI helps patients identify and strengthen their perceptions of the importance of changing and their confidence to change. MI helps patients who are committed to change design behavior change plans and refine them over time to meet their goals.

Cognitive behavioral therapy or CBT helps patients identify the cues to substance use and how to avoid or manage those cues. Patients learn to recognize the thoughts, feelings and situations that prompt substance use and to engage in other thoughts and behaviors to avoid using.

Family therapy involves meeting regularly with a patient and their loved ones to identify and change patterns of communication and other behaviors among the group that often trigger substance use in the patient. Typically, each family member commits to changing behaviors that often lead to maladaptive behaviors by their loved ones so that all family members benefit.

Contingency management involves using positive reinforcement, such as material rewards, to encourage and reward abstinence.

Twelve-step facilitation is a kind of counseling that helps facilitate patient involvement in and benefit from twelve-step groups, such as Alcoholics Anonymous and Narcotics Anonymous.

Psycho-education involves providing information to help patients acquire knowledge and attitudes that will help them avoid substance use.

When professionally administered substance use disorder treatment first became available, in the mid-1900s, much of it was focused on twelve-step facilitation and psycho-education. Some treatment programs continue to rely on these approaches, which have clearly been helpful for many people. Since then, lots of research has found that other newer treatments are more effective for most people.
Behavioral treatment for SUDs can be delivered in a variety of venues. Brief intervention is typically delivered in primary care settings, emergency departments or general hospital units.

Other kinds of treatment are usually delivered in specialized treatment venues.

Most treatment is delivered in outpatient settings, where patients come for one to several hours per day and then return home every night. Intensive outpatient programs typically involve at least 20 hours of treatment activities per week.

Other settings are residential, where patients stay overnight. They may stay for up to several weeks in a short-term residential facility. They may stay for several months to a year or two in therapeutic communities with ongoing, intensive treatment. When they’re ready, patients in therapeutic communities spend increasing amounts of time in the community doing volunteer or paid work and getting connected with other support services, planning eventually to move back into a community-based setting.

Recovery housing typically helps support people in making a transition from residential treatment back to living in communities. The National Alliance for Recovery Residences defines a recovery residence as a “sober, safe and healthy living environment that promotes recovery” from SUDs. Some venues that are now called recovery houses were formerly called halfway houses. Recovery houses typically have fewer treatment resources than other residential facilities.

There have been multiple national efforts to develop criteria to guide placement of patients into treatment for substance use disorder. Perhaps the most commonly used criteria for placing patients in appropriate treatment programs is the American Society of Addiction Medicine’s Patient Placement Criteria. For publicly funded treatment in Wisconsin, the Wisconsin Uniform Placement Criteria, or UPC, guides such decisions.

### Wisconsin Uniform Placement Criteria (UPC)

- Severity of withdrawal symptoms
- Family support to manage withdrawal at home
- Kindness and severity of recent psychosocial consequences
- Severity of physical and mental health conditions
- Cognitive status
- Ability to remain substance-free as outpatient
- Ability to attend outpatient services
- Family, friends and workplace support for recovery

After interviewing patients, trained individuals complete a UPC form that guides determination of the optimal treatment venue. Here is some of the information, presented in summary form, that the UPC considers to help a patient determine their preferred treatment venue: severity of withdrawal symptoms; degree of family support to manage withdrawal at home; kinds and severity of recent psychosocial consequences; severity of physical and mental health that may or may not be related to the substance use disorder; cognitive status; the patient’s ability to remain substance-free as an outpatient; the patient’s ability to attend outpatient services; and support for recovery among patients’ family members, friends, and co-workers.

You can get a copy of the Wisconsin Uniform Placement Criteria via the link at the bottom of this screen.

As a peer recovery supporter, you won’t help complete this form, and you won’t determine the intensity of treatment that patients should receive. However, what you can do is acquaint patients with the different kinds of treatment and start them thinking about what treatment they would prefer, so they can be well prepared to ask questions and advocate for their preferences when they undergo initial assessment by substance use disorder treatment experts.

### Kinds of Pharmacologic Treatment

<table>
<thead>
<tr>
<th>Alcohol:</th>
<th>Opioids:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disulfiram</td>
<td>Naltrexone</td>
</tr>
<tr>
<td>makes drinking uncomfortable and dangerous</td>
<td>blocks the effect of opioids</td>
</tr>
<tr>
<td>Acamprosate</td>
<td>Methadone</td>
</tr>
<tr>
<td>treats agitation and insomnia</td>
<td>opioid agonist (federally licensed clinics only)</td>
</tr>
<tr>
<td>Naltrexone</td>
<td>Buprenorphine</td>
</tr>
<tr>
<td>reduces urges and cravings to drink</td>
<td>opioid agonist (any physician, nurse practitioner or physician assistant who completes training)</td>
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</table>

Pharmacologic treatment, meaning treatment with medications, can be added to behavioral treatments for alcohol and opioid use disorders. This slide shows the medications that the US Food and Drug Administration has approved for the treatment of these disorders.

Disulfiram is taken once a day. If someone who took disulfiram drinks alcohol in the next day or two, they usually suffer a severe reaction, consisting of flushing, headache, nausea and vomiting, and possibly death. Taking disulfiram once every morning can help people resist urges, cravings, and other cues to drink later in the day.
Earlier we mentioned that acute alcohol withdrawal symptoms subside within seven days of one’s last drink. Many people continue to experience subacute withdrawal symptoms for many months thereafter, including agitation, restlessness and difficulty sleeping. Acamprosate can help reduce these ongoing subacute withdrawal symptoms, making it easier for people to avoid drinking.

For some patients with moderate to severe alcohol use disorder, naltrexone reduces urges and cravings to drink.

For patients with opioid use disorder, naltrexone blocks the effects of opioids, so that people can no longer experience a high.

Methadone and buprenorphine are opioid agonists, meaning that they act like opioids. When people take these opioids, they have greatly reduced urges and cravings to take other opioids, such as heroin and opioid pain pills.

Pharmacologic and behavioral treatments together are more effective than either alone. All patients receiving pharmacologic treatment should also receive behavioral treatment.

In another module, you can learn more about these medications.

Mutual support and self-help services are different from the previous treatments in that these services are not administered by trained professionals.

One kind of mutual support is twelve-step groups, such as Alcoholics Anonymous and Narcotics Anonymous, which host meetings for free in most communities. AA and its offshoots were started by two individuals who suffered from alcoholism in 1935, when professionally administered treatment didn’t yet exist. Meetings are run by volunteers who are in recovery. All interested parties are welcome to attend open meetings. Closed meetings are intended only
for those who wish to stop drinking. Many closed meetings focus in depth on one of the twelve steps recommended for recovery.

The AA approach is considered spiritual but not religious. Although certain of the twelve steps require that people recognize a “higher power,” that “higher power” need not be a religious god. According to the American Psychological Association, the 12 Steps involve admitting a problem that’s out of control, recognizing a higher power that can give you strength, examining past errors with the help of a sponsor, making amends for those past errors, learning to live a new life according to a new behavior code, and helping others recover. You can find out more about AA, NA and where to find meetings at aa.org and na.org.

Another kind of mutual support group is SMART Recovery, which hosts meetings for free in many communities. SMART is an acronym for Self-Management And Recovery Training. Whereas twelve-step programs involve surrendering to a higher power, SMART Recovery involves taking charge of one’s life. Its approach is more psychological than spiritual, borrowing from aspects of motivational interviewing and cognitive behavioral therapy. The four-point program emphasizes building and maintaining motivation, coping with urges, managing thoughts, feelings and behaviors, and living a balanced life. You can learn more about SMART Recovery and where to find meetings at smartrecovery.org.
And then there are many kinds of self-help programs, such as the examples you see listed here. Some are offered by workbook and are available at online and regular bookstores. Others are offered as online programs.

Many patients in need of substance use disorder treatment have other important needs relating to housing, food, physical health, mental health, employment, education, legal troubles, and financial strain. If such needs are not met, then recovery becomes much more difficult. If any of these needs become clear, it’s helpful to be able to refer patients for resources. In hospitals, social workers can help with such referrals.
Research and most experts suggest that professionally administered programs are most effective.

Next most effective are mutual help programs, and then self-help programs.

A combination of different kinds of problems is probably more effective than either program alone, as long as the programs are compatible.

The most effective combination would be a professionally administered program and a mutual help program.

These conclusions are true, on average, across large groups of people. For any given individual, however, results can vary. For example, a program that is less effective for most people but appeals to a certain individual would be more helpful than a program that’s highly effective for most people but not at all appealing for the individual. How to take into account patient choice in making referrals is our next focus.

For more information about drug treatment, you can visit the websites of the National Institute on Drug Abuse and the Substance Abuse and Mental Health Services Administration.
The approach we’ll talk about is Shared Decision Making or SDM. SDM is defined as “an approach where clinicians and patients share the best available scientific evidence when faced with the task of making decisions, and where patients are supported to consider options, to achieve informed preferences.”

This approach can certainly be applied to scenarios where patients are considering what to do, if anything, about a substance use disorder.

Inherent in this approach is the assumption that patients will make the final decision according to their goals, values, and preferences. Our job as clinicians or peer support specialists is to help them understand the options, the best scientific evidence on what options are most likely to be helpful, and how the options fit with what patients want for themselves.

To read more about this approach, the slide shows where you can download a free article from the Journal of General Internal Medicine.
One rationale for using shared decision making is its adherence to principles of medical ethics. The four main principles of medical ethics are honoring patient autonomy, acting in the best interest of the patient, not harming the patient, and providing care equitably among patients. With shared decision making, we adhere to three of these principles. We honor patient autonomy—patients’ rights to make their own choices—and we provide guidance so patients can make decisions that will most likely serve their interests and avoid harming themselves.

Another rationale is that shared decision making improves health outcomes. Dozens of studies on a variety of health topics compared the results of SDM versus conventional paternalistic decision making by clinicians. Those studies found that SDM resulted in health outcomes that patients were happier with and better objective health outcomes as well, such as better control of chronic diseases.

There are two steps in SDM. Step one is to provide information that patients may wish to
consider in making their choices. Step two is to help patients consider the options in light of their goals, values, and preferences.

When providing information, these five sub-steps are recommended. First, ask patients what they already know about the topic. This step can be helpful, because it can prevent you from wasting time and alienating patients by telling them what they already know. It can also be helpful in identifying when patients might possess faulty beliefs and how they acquired those beliefs. If the patient highly values the source of their misinformation, it’s helpful to know that we may need to be careful as we try to present an alternative point of view.

For example, perhaps you are about to explain to a patient how their drug use might have resulted in addiction. If a young man believes that his addiction is punishment for sins he committed against his mother, that his mother told him this would happen, and he fully believes his mother, you might wish to present a biological explanation of addiction as compatible with his belief rather than as the sole, truthful explanation. When delivering information, it’s best to avoid arguments and to honor patients’ strongly held beliefs if at all possible.

Next, ask the patient if it’s okay for you to provide some information. For example, you could ask, “Would it be helpful if I explained some of the options for you to get help to quit heroin?”

If the patient agrees, then go ahead and deliver your information. Take care to deliver information in language that patients can understand, and in small chunks that patients can easily absorb.

To assess whether patients have absorbed the information, ask them to repeat it back to you. Some self-deprecation can help you avoid coming across like you’re testing patients. For example, you could say “I’m not sure I explained that very clearly. Would you please do me a favor and say what you’re taking away from what I just tried to explain?”
And finally, we want to help the patients process the information—to weigh the information in light of the decision they face about treatment. For example, you could say “So now that we’ve talked about methadone and buprenorphine, I wonder what relevance this might have for you.”

The next step is to help patients to deliberate about their decision.

First, be clear that there are always choices regarding what to do about an alcohol or drug issue, and the patient is the ultimate decision maker. Explain your role as helping the patient make the best choice for themselves, given what’s most important to them.

Explain the options and possible pros and cons in general. Ask patients to identify pros and cons for them. Include “no treatment” as an option, being clear that all is up to the patient. Explicitly mentioning no treatment as an option and having patients explore the pros and cons of no treatment often helps them decide in favor of at least some treatment.

Then, of all the options discussed, ask the patient to name their leading options and why, comparing pros and cons of each.

Finally, help the patient to identify the option that yields the best balance of pros and cons given what’s important to them. Even when we disagree with the patient’s decision, our job is to support them in making decisions that seem right for them, not decisions that seem right for us.

There’s no single best way to have these conversations with patients. You might find that it works best to go back and forth between providing information, supporting deliberation, and the various sub-steps. The steps do not need to be delivered in sequence.
For some patients, this process will go quickly and easily. For those who have difficulty, offer more time for them to think about it. Also ask if there are other people who could help them make their decision.

Here’s a table that you might help patients fill in for themselves to help them make the best choices for themselves about how they will address their substance use disorder.

Let’s imagine that the patient you’re seeing, Anita, uses heroin, has an opioid use disorder, is contemplating treatment, has been talking to you for a while, and filled out the table as you see on the slide.

The table shows Anita’s perceptions of the short-term pros and cons of buprenorphine only, NA only, both treatments, and no treatment.

Anita concluded that buprenorphine would be beneficial in reducing her cravings for heroin, making it easier to stay quit. A disadvantage would be that she might have to pay a lot for the medication.

An advantage of attending Narcotics Anonymous meetings is that meetings are free. Disadvantages are that NA wouldn’t help much with her cravings, and it would take quite a bit of time for her to travel to and attend meetings.

The next row shows Anita’s perceptions of the pros and cons of combination treatment with both buprenorphine and NA.

The last row shows that no treatment would be easiest but would give the patient the worst chance of quitting.

In considering long-term pros and cons, Anita decided initially that she would take an all-or-
none approach. If she was going to get treatment, she would get the treatment that’s most helpful. She realized that although treatment might be costly and take quite a bit of time, it would give her the best chance of keeping her job and therefore give her the best financial prospects for the future. She also realized that her relationships with her partner and children were very strained, and treatment would give her the best chance of keeping her family intact. So, she ultimately decided, with your help, to seek buprenorphine and attend NA meetings.

In this module, we’ve covered how to make referrals for patients with moderate to severe substance use disorders—those who have symptoms of problem use, loss of control, and other changes in the brain.

We talked about different kinds of resources: treatment, mutual support, self-help, and services to address other needs, such as housing, mental health and employment.

We talked about the typical steps of treatment—detox, treatment, and long-term support. We talked about how detox prepares people for treatment. We talked about various behavioral approaches for SUDs and medications that can help patients with alcohol and opioid use disorders. We talked about how professionally administered treatment tends to be more effective than mutual support, including twelve-step programs and SMART Recovery, which is more effective than online self-help programs or workbooks.

However, we emphasized that patient preference plays an important role in determining what is most effective for particular individuals. When patients choose options they think are best for them, those options often are effective. And if the patient’s first attempt to get well doesn’t work, they can always reconsider other options.
We talked about a shared decision making approach, how it adheres well to principles of medical ethics, and how helping patients choose the best treatment options for them results in better treatment outcomes.

We talked about the two major steps in SDM—providing information and supporting deliberation.

In providing information, we talked about eliciting the patient’s perceptions, asking permission to share our perceptions, delivering the information in language that patients can understand and in small chunks that they can absorb. We talked about ensuring patient’s understanding and helping patients process the information by considering its relevance to their situation.

In supporting deliberation, we talked about emphasizing that the patient is in charge of making treatment decisions for themselves, explaining likely pros and cons of various options, asking patients to weigh those pros and cons in light of what’s important to them, identify leading options and why, and then make a final choice. Some patients might benefit from completing a list of short- and long-term pros and cons of each option. We talked about supporting patients in making the best choices for themselves even if we would choose differently.

By using this patient-centered approach in making referrals, you’re likely to help many patients take important steps towards recovery.