

Use of Illegal Drugs and Alcohol How to Detect Them and Begin Treatment?

Most medical professionals who are being sought out to provide treatment are not sufficiently trained or experienced to diagnose or treat addiction.

NATIONAL CENTER ON ADDICTION AND SUBSTANCE ABUSE
(Columbia University)

INTRODUCTION

In spite of doctors' unawareness, diseases due to the use of illegal substances substantially contribute to the "burden of disease". In very recent communications the overall burden of disease attributable to mental disorders and substance use (including alcohol) accounts for 7.4% (95% CI 6.2% to 8.6%) disability-adjusted life years lost, (DALYs) by 2010, the fifth leading cause after cardiovascular diseases, infectious diseases, neonatal disorders and cancer, in that order. Furthermore, with 22.9% (18.6% to 21.2%) it is the leading cause of years lived with disability, (YLDs) worldwide. (1)

Degenhardt et al. reported that, despite a relatively low overall prevalence of illegal drug use, these conditions have a substantial contribution to overall mortality, accounting for 0.8% (0.6% to 1.0%) of all overall causes of DALYs in 2010. (2)

Given the debilitating nature and severity of mental disorders and illegal drug use which significantly contribute to overall disease and concomitant economic burden, it is perhaps surprising that hitherto research on the prevalence and risks associated with these disorders has been so scarce. (3)

Worse still, many of us, the so-called medical community fail in the diagnosis and treatment of substance use disorders, largely due to the failure of educating physicians in addiction medicine.

In recent decades there has been progress in our understanding of addiction biology, which has led to the recognition that drug and alcohol addiction are chronic and relapsing brain diseases resulting from different drug effects on brain control and reward circuits. These effects involve neural adaptations following chronic drug exposure and finally work by altering the functioning of the brain regions engaged with motivation and self-control. (4)

The underlying neurobiology understanding of addictive behaviors and the effects of psychoactive substances at the level of neuropeptides, neurotransmitters and receptors, have contributed to the development of medications that could improve outcomes in individuals who abuse these substances. Among the

especially effective medications are those for treating opioid addictions (opioid agonist and antagonist medications). There are also effective medications for the treatment of common addictions to nicotine and alcohol. Although no medications have been currently approved for the treatment of stimulant drug addictions (e.g. cocaine and methamphetamine), cannabis, or sedative / hypnotic drugs (e.g., benzodiazepines, barbiturates), there are behavioral interventions for these situations that have proven to be effective in reducing their use. These include health professional and psychosocial interventions that influence specialized treatment programs.

Advances in recent decades have turned the traditional view of addiction as mainly a matter of individual principles (a vice or moral weakness) into an outdated model. New therapies have the potential to induce a change in today's society, by which addiction is now seen primarily as a health issue, capable of undergoing prevention and treatment.

The quality of addiction care reported in the United States differs substantially from other medical conditions and, the approximately 10% of care recommendation concerning alcohol addiction is as low as that to quit smoking.

Both sub-prescription and over-prescription of opioid drugs, negatively illustrates the inappropriate use of these medications. This deficiency in medical training contributes both to inadequate pain management and to the promotion of opioid analgesic addiction, which is epidemic in the United States.

The failure of educational systems to train physicians in addiction medicine is the key explanation to why this happens and is still poorly understood even among the medical community. Traditionally there have been exceptional and few opportunities for doctors to obtain skills and abilities in this area.

Therefore addiction care is often provided by untrained laymen, i.e. individuals without the mental or medical health training skills required to provide effective interventions based on clinical evidence.

This enormous opportunity loss is due to the failure of the medical profession at all levels, in medical school, residence training, continuing education and practice, to confront with an increasing disease burden.

It is because of this context that the American Board of Addiction Medicine (ABAM) has created guidelines and standards for the development of grant

programs in addiction medicine.

Because most patients with addiction will continue to be detected and cared for by primary care physicians, the necessary efforts should be made in order to avoid a subspecialty that makes the treatment of addictions, existing and new, inaccessible to individuals who are seen in primary care.

With the wider adoption of addiction medicine in the spectrum of medical training, patients will receive a better attention, narrowing the quality gap in health care management of substance abuse, detecting and treating those addicted to alcohol and drugs with compassion and appropriate care and away from excessive reliance on punitive approaches that have not served patients' interests, public health or the general public. (4)

EPIDEMIOLOGIC IMPACT OF MENTAL DISORDERS, ILLEGAL SUBSTANCE AND ALCOHOL USE

In 2010, mental disorders and substance use accounted for 183.9 million years of life lost in the number of DALYs representing 7.4% (CI 95% 6.2% to 8.6%) worldwide.

Of the total number of years lost in the number of DALYs, the largest relative ratio is represented by depressive illness: 40.5% (31.7% - 49.2%), followed by anxiety disorders: 14.6% (11.2% - 18.4%), use of illegal drugs: 10.9% (8.9% - 13.2%), alcohol: 9.6% (7.7% - 11.8%), schizophrenia: 7.4% (5.0% - 9.8%), and bipolar disorders: 7.0% (4.4% - 10.3%). (1)

Men have a greater burden than women of illegal drug use at all ages.

The largest proportion of DALYs occurred from adolescence and youth to middle-aged adults (10-29 years). For alcohol use the highest burden occurred at 25-50 years, followed by a gradual decline.

DALYs for using alcohol consumption varied more than 10 times between regions.

From 1990 to 2010 the burden of mental disorders and substance use increased 37.6%, this change was mainly due to population growth and changes in the age structure.

The prevalence of alcohol dependence, opioid and cocaine increased significantly between 1990 and 2010, compared to most mental disorders.

Whiteford says: "The combination of stigma and the very large treatment gaps contributes to social exclusion and breaches of basic human rights of individuals with mental disorders." (1)

The highest cocaine dependence occurs in high-income countries of North America, followed immediately by Latin America. Australasia has the highest prevalence of opioid dependence, although the largest population is in eastern and southern Asia. The highest prevalence of synthetic amphetamine derivatives use occurs in Southeast Asia and Australasia, followed by Latin America. The estimated prevalence of illegal drugs was lower in Africa.

Opioid dependence grew 42% in 20 years, with a total increase of 74%. Out of approximately 78000

deaths due to illegal drugs in 2010, more than half (55%) were due to opioid dependence. (2)

Injecting drug use as a risk factor for HIV accounted for 2.1 million DALYs and for HCV (Hepatitis C Virus) 502000 DALYs.

DETECTION OF ABUSE AND DEPENDENCE OF ILLEGAL DRUGS AND ALCOHOL

Since more than half a century ago, illegal drugs are those banned by international drug control treaties when not used for medical purposes and they are categorized as illegal drugs because they are believed to pose an unacceptable addiction risk for those who use them. The international control spread from drugs derived from plants - heroin, cocaine and cannabis - to synthetic drugs such as amphetamines, methamphetamines and pharmaceutical drugs such as buprenorphine, methadone and benzodiazepines. (5)

PREVALENCE OF ILLEGAL DRUG USE AND DEPENDENCE

Precise prevalence estimation of those who use illegal and stigmatized drugs is a real challenge, even more so, in those cultures where to tell another person the use of illegal drugs can lead to imprisonment, preventing research participants of feeling confident in their privacy and free from retaliation for disclosing their behavior with drugs. Therefore the methods for the prevalence of use estimation have different degrees of imperfection which increase in drug dependence estimation. The best available data come from developed countries of Europe, North America and Australasia.

UNODC (United Nations Office on Drugs and Crime) estimated that between 149 and 271 million people aged 15-64, 3.3% to 6.1% of the world population have used an illegal drug at least once in 2009.

The use of drugs varies substantially between regions and countries and these numbers are not mutually exclusive, because many people use more than one type of drug.

There is a shortage of credible estimations and therefore there is greater uncertainty in estimating the prevalence of cannabis and amphetamines than that of cocaine and opioids.

The total number of those using cannabis was estimated between 125 to 203 million people, 2.8% to 4.5% of the global population. The highest levels are in the market economies of developed countries.

It is estimated that between 14 and 56 million people aged 15-64 use stimulants such as amphetamines, i.e. 0.3% to 1.3% of the entire population. The highest use occurs close to the countries that produce amphetamines as in Southeast Asia.

The number of people who use cocaine worldwide is 14 to 21 million, 0.3% to 0.5% of the population aged 14-64 years, being the major markets in North America, Western Europe and Central and South America.

Global opioid users were estimated between 12 to 21 million people. More than half of them are in Asia, with the highest levels in major transit routes

Table 1. Main type of illegal drugs

<p>Drugs derived from plants</p> <ul style="list-style-type: none"> <p>Cannabis It is the generic term for such preparations as marijuana, hashish and has oil. <i>Consequences:</i> the cannabis sativa plant produces euphoria and relaxation, enhances sensations and increases sociability.</p> <p>Cocaine It derives from the coca plant, called erythroxylyun coca. <i>Consequences:</i> It is an alkaloid with a powerful stimulant effect on the central nervous system.</p> <p>Opioids It includes opium poppy derivatives, called papaver somniferum, such as heroin and morphine as well as synthetic analogues like methadone and fentanyl. <i>Consequences:</i> Opioids relieve pain, produce euphoria and can cause coma and respiratory depression at high doses.</p>
<p>Synthetic drugs</p> <ul style="list-style-type: none"> <p>Amphetamine type stimulants They are synthetic chemical drugs, of the sympathetic - mimetic amine type. <i>Consequences:</i> They have a powerful stimulating effect on the central nervous system.</p>

exiting Afghanistan.

In Argentina, a study by the Office on Drugs and Crime United Nations says *"the more frequent use of cocaine (2.7%) and cannabis (7.2%) was observed among 15 - 64 years."* (6)

These figures reveal that Argentina has the *"second number of cocaine users in the region, 600000 people, just behind Brazil"*. (6)

The same article says: *"with respect to paco consumption in Argentina, it mainly occurs among the most impoverished and relegated sectors of society."* (6)

SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT. A STANDARD PRACTICE THAT RESULTS IN BETTER HEALTH CARE

Screening, Brief Intervention and Referral to Treatment (SBIRT) is a public health approach based on evidence that identifies through a universal, comprehensive and integrated screening patients who need an early intervention, because their patterns of alcohol and / or drug use endangers their health. (7-8)

SBIRT components are :

1. Universal screening using a brief validated questionnaire to determine alcohol severity and use, illegal drug abuse in order to meet the appropriate level of intervention without urine or blood tests; 75% - 85% of respondents will be negative, completing 3-4 simple questions, which only take 1-2 minutes.
2. Brief intervention to provide feedback on the use of unhealthy substances. Focusing on education and increasing insight and awareness of the risks related to their use, while improving motivation towards healthy behavior changes. The brief intervention is carried out in the same site after screening and takes 5 to 30 minutes.
3. Referral to treatment for people at high risk or sub-

stance use dependence is an important aid to facilitate access to evaluation and addiction treatment. About 5% of the population who performed the screenings was referred to treatment.

Where can SBIRT be implemented? In primary care centers, doctors' offices, hospitals, emergency departments, trauma centers, colleges and schools.

Who can perform SBIRT? Doctors, nurses, medical assistants, health counselors or substance use prevention specialists and other members of the health team.

Is SBIRT effective? As demonstrated by Madras BK et al. (9) SBIRT decreased the harmful use of alcohol 39% and illegal drug use 68%; expensive health care events such as visits to the Emergency Department and Hospitalization were also reduced.

It also shows that those who completed the SBIRT reported fewer arrests, fewer street situations, increased employment and self-assessed improvement in overall health and fewer mental health problems. (9)

The investigation showed that the percentage of people who attended the first clinic appointment for alcohol abuse increased from 5% in controls to 55% - 65% in those receiving SBIRT services and to 90% - 95% when some kind of treatment for alcohol abuse or 12 steps follow-up meetings was continued. (10)

Who supports SBIRT use? WHO, United States Prevention Services Task Force (USPSTF), the American Medical Association, the American College of Surgeons and the American Academy of Pediatrics support SBIRT performance in health care sites. Of the 21 preventive services recommended by the USPSTF, SBIRT is among the top 5 based on cost-benefit effectiveness, higher than high blood pressure, high cholesterol, breast, colon and cervical cancer and osteoporosis screening. (11)

BRIEF INTERVIEW

What is a Brief Interview?

A brief interview (BI) is a conversation in collaboration with the patient with the main purpose of aiding the motivation to achieve changes in his/her problem with alcohol and/or drug use. This conversation is based on the principles and skills of Motivational Interview, to extract the personal reasons each person would have to change. The BI conversation focuses on any small step that the patient is willing to take. It must be nonjudgmental, conducted in collaboration with the patient, with interest and curiosity for the patient’s perspective.

Is the BI focus different for persons using different substances?

The basic BI format and structure is the same, whether the focus is on alcohol use only, drug use only, or both. Patients with dangerous alcohol use should be encouraged to reduce drinking and patients using drugs will perhaps be willing to interrupt taking them for a period of time or start decreasing their use with the ultimate goal of abandoning them.

Abstinence should be considered in the following circumstances: (12)

- Patients > 21 years. For legal reasons and due to the possible detrimental effect on brain development.
- Pregnancy, planning conception or at risk of get-

ting pregnant.

- Prior consequences (e.g. substance-related damage)
- Failure of previous attempts to reduce its use.
- Physical or mental condition secondary to its use.
- Taking a medication which contraindicates any alcohol use (e.g. warfarin)
- Personal or family history of disorders in alcohol use.

Beyond the rationale of clinical trials on the efficacy of the “motivational interview”, recent advances have been made “looking under the bonnet” of brief interviews to understand the underlying mechanism which produce behavioral changes. Such specifications of practical aspects are vital for theoretical development and may improve the application of treatment and clinical training. William Miller postulates an emerging theory, emphasizing two specific active components: a relational component focused on the motivational interview empathy and interpersonal spirit and a technical component implying the recollection and the preferred reinforcement of the client’s conversation about change. This results in a causal chain model that joins the therapist, the therapist and the client’s answers during the treatment sessions and the treatment results. (14)

The discussion with the patient to make changes is almost a constant for any branch of medicine, be-

STEP 1: Enquire about alcohol and drugs use

PUTTING SBIRT INTO ACTION
Standard approach (ideal if the questions may be integrated into the Clinical History, even better if electronic).

ALCOHOL USE
One “drink ” is defined as : a can (350 ml) of beer, a glass (140 ml) of wine, a third of a cup (40 ml) of liquor.

AUDIT- C	0	1	2	3	4	Points
1. How often did you have a drink containing alcohol?	Never	Less than monthly	2-4 times per week	2-3 times per week	4 or more times per week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often did you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

SCORE

≥ 3 FEMALE	≥ 4 MAN
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If positive, go to STEP 2A with complete AUDIT.
Your patient has at least risky use of alcohol

If negative, strengthen your healthy decisions and continue with drug screening .

DRUG USE

Drug screen with single item

How many times have you used an illegal drug or prescribed medication for non-medical reasons? (if the meaning of non-medical reasons is asked, you may answer: for the experience or drug sensation)

SCORE

≥ 1 FEMALE AND MAN	POSITIVE DRUG
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If positive, go to STEP 2B with complete DAST-10.
 Your patient has at least RISKY use of drugs

If negative, strengthen your healthy decisions

STEP 2A: If AUDIT-C is positive, assess severity of alcohol use

Bring the initial score of the AUDIT- C questions, to add to the full AUDIT score

AUDIT- C	0	1	2	3	4	Points
AUDIT –C SCORE						
1. How often during the last year were you unable to stop drinking, once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
2. How often during the last year have you failed to do what was normally expected from you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
3. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year did you have a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year were you unable to recall what happened the night before due to drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. Have you or someone else been injured as a result of your drinking?	No		Yes, but not last year		Yes, during the last year	
7. Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not last year		Yes, during the last year	

SCORE			
< 13 FEMALE < 15 MAN	DANGEROUS USE	≥ 13 FEMALE ≥ 15 MAN	More assessment referral
The AUDIT answer may be used in the brief intervention Go to Step 3 to perform the brief intervention.			
All patients should receive a brief intervention after the AUDIT			

STEP 2B: If AUDIT-C is positive, assess severity of drug use

DAST-10
 "The following questions concern information about your possible involvement with drugs, not including alcohol, during the past 12 months. In the following statements "drug abuse" means: 1) the use of prescription or over-the counter drugs exceeding the instructions and 2) any non-medical use of drugs. Different classes of drugs may include: cannabis (marijuana, hashish), cocaine, heroin, narcotic pain medication, sedatives (benzodiazepines), or stimulants (amphetamines). Please answer each question. If you have difficulty with the statement, choose the answer that seems most correct.

DAST – 10	0	1
In the last 12 months		
1. Have you used drugs not required for medical reasons? (if positive in step 1, then the answer is automatically yes)	No	Yes
2. Do you abuse more than one drug at a time?	No	Yes
3. Are you always able to stop using drugs when you want to?	No	Yes
4. Have you ever had "blackouts" or "flashbacks" as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty as a result of drug use?	No	Yes
6. Has your spouse (or parents) complain about your involvement with drugs?	No	Yes
7. Have you neglected your family as a result of drug use?	No	Yes
8. Have you engaged in illegal activities in order to get drugs?	No	Yes
9. Have you ever felt withdrawal symptoms (felt sick), when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of drug use (e.g., memory loss, hepatitis, convulsions, bleeding etc...)?	No	Yes

SCORE			
< 3 FEMALE AND MAN	DANGEROUS USE	≥ 3 FEMALE AND MAN	More assessment referral
The DAST – 10 answers may be used in the brief intervention Go to Step 3 to perform the brief intervention.			
All patients should receive a brief intervention after DAST – 10			

yond the “4 great” lifestyle habits (smoking, excess drinking, absence of exercise and unhealthy diet) and is also used to achieve objectives or goals, apparatus indications or medications.

Faced with an unmotivated or even ambivalent patient, the physician candidly uses a direct style that almost automatically generates resistance or a passive attitude in the patient. The motivational interview is an alternative approach to discuss behavioral changes favoring a constructive doctor-patient relationship which leads to more favorable results for the patient. (15)

The motivational interview implies helping the patients to tell why and how they can change and is based in the use of a guided style that follows 3 principles: a) engage with the patients and work in collaboration with them, b) emphasize they have autonomy in decision-making and c) elucidate their motivations for change. Three key skills are used: 1) “make open questions”, inviting the patient to consider how and why he can change; 2) “listen” to understand your patient’s experience, capturing his narrative with short summaries or declaration of reflective listening, as this expresses empathy and encourages the elaboration of the account and is the best pathway to oppose resistance; 3) “inform”, asking permission to provide information and then ask what implications they may have for the patient. The motivational interview should not be understood as a schematic method with a group of intelligent techniques that would make the patient do what he/she would otherwise refuse. It is not performed “to” the patient or “in” the patient, but “with” or “for” the patient. (15)

The brief motivational interview during the clinical visit to reduce cocaine and heroine use was positively evaluated in a controlled, randomized study performed in an ambulatory clinic of a teaching hospital. The inclusion criteria and the result at 6 months was assessed with hair radioimmunoassay by a blinded investigator. Only 5% (1232) of subjects undergoing screening were eligible and 1175 persons were enrolled in the study (average age 38 years).

The interview group was more frequently abstinent than the control group: for cocaine alone 22.3% vs. 16.9% ($p = 0.04$) for heroine alone 40.2% vs. 30.5% ($p = 0.05$) and for both drugs 17.4% vs. 12.8% ($p = 0.05$), with an adjusted OR of 1.51 to 1.57. The cocaine level in the hair was reduced by 29% in the interview group and only 4% in the control group. (16)

CONCLUSIONS

In Argentina, the presence of alcohol and drugs is almost invariably present behind many different types of crimes, as verified in the state of South Dakota (USA), where 59% of sentences for serious crimes were the direct result of alcohol or illicit drug dependence. In the last years, 70% and 47% of imprisoned men and women, respectively, were alcohol-dependent, 35% of men and 50% of women were methamphetamine-

dependent and many prisoners suffered multiple-drug and alcohol dependency. (17)

Because of the crimes committed under alcohol and drug abuse (traffic accidents, fights with lesions, etc), the parole or probation systems are overloaded with cases, and the lack of court resources that do not allow a daily contact loosens supervision to at most monthly presentations, with scarce possibility of a real rehabilitation. Half of them are newly arrested and are now prisoners heaped in overloaded jails where life conditions lead them to a criminal career with few possibilities of recovery.

In the last years an improved pathway was experienced to break this fatal string, the “Sobriety Project 24/7” (24 hours a day, 7 days of the week).

As reported by its director, the Office of National Drug Control Policy (which depends directly on President Obama) supports the efforts to reduce the prevalence of driving under drug effect, as current data show that 1 out of 8 weekend drivers have a positive test for illegal drugs, and praises the successful efforts of the South Dakota and Hawaii states with the “Sobriety Project 24/7” and “HOPE”. (18)

The usual message given to transgressors or criminals who drive under drug influence is: “if you do not stop drinking or taking drugs when you drive, we will make you stop driving” (hold the vehicle, withdraw the driving license, or imprison the driver in the presence of recurrences). The judicial system is not designed to treat the underlying problem of drug or alcohol dependency or addiction.

The message of Sobriety Project 24/7 is: “if you do not stop drinking or taking drugs when you drive, we will make you stop drinking or taking drugs”. (17) The intelligent innovation is requesting the offenders to stop being under the influence of drugs and alcohol, instead of stopping them driving. (19)

How does it work? First, it identifies the defendant with at least one previous sentence for being under the influence of drugs in the 10 previous years. He must sign an agreement on the following bail conditions: 1) the defendant must completely abstain from consuming alcohol and illicit drugs; 2) He/she must present at 7 AM and 7 PM to undergo an alcohol test (breath, blood) and on random days a urine test for illicit drugs (drug test kit sensitive to opiates, cocaine, marijuana and different prescription drugs); 3) the defendant that has a positive test or skips a control is immediately imprisoned for 24 hours for violation of the bail agreement signed voluntarily. (17-19)

As Barry Long says: “The design of the Sobriety Project 24/7 is based upon the electric fence or hot radiator principle. People who touch an electric fence or a hot radiator are immediately penalized with an electric shock or a burn. The sentence is not severe but is immediate and unavoidable. After once having a shock or a burn, they will avoid touching the fence or radiator a second time. The work group believes the participants of the 24/7 will give similar answers. Af-

STEP 3: Brief Interview (BI) components

Based in the Brief Negotiated Interview developed by the BNI-ART Institute (13).

Brief Interview sample for all the subjects positive for unhealthy alcohol and/or drug use.

In case the patient is positive for multiple substances, ask the patient if there is a particular substance for which he/she is more concerned to "focus" during the brief interview.

BI STEPS	DIALOGUE / PROCEDURES
<p>1. Understand the ways the patient views use Develop the discrepancies between the patient's objectives and values and the real conduct</p>	<p>For and against questions <i>"I would like to know more about your use of (X). Help me to understand what you enjoy when you use (X). What else?"</i> <i>"What do you enjoy less when you use (X) or regret when you use it?"</i></p> <p>For and against summary <i>"So, on the one hand you say you enjoy (X) due to..."</i> <i>"And on the other, you say...." repeat the negative consequences as declared by the patient.</i></p>
<p>2. Provide information / feedback Ask permission to provide feedback Use reflective listening</p>	<p>Review health risks <i>"Is it OK if we review some of the health risks for using (X)?"</i> <i>"Are you aware of the health risks associated to use of (X)?"</i> if YES: <i>"What do you know?"</i> if NO: Indicate the problems. You may refer to NIDA (National Institute of Drug Abuse in www.drugabuse.gov)</p> <p>If the focus is in the dangerous alcohol use and abstinence is not indicated <i>"Is it OK if we review what you consider safe drinking limit for your age and gender?"</i> (Not more than 4/3 drinks per day and not more than 14/7 drinks per week). <i>"Drinking more than this puts you at risk of suffering illnesses or injuries due to your use of alcohol."</i></p>
<p>3. Help the motivation for change Ask about Readiness and Confidence Scales</p>	<p>Readiness Scale <i>"Since we have been discussing, to help me better understand how do you feel about making a change in your use of (X)."</i> <i>In a scale from 0 to 10, how ready are to change any aspect related to your use of (X)? A 10 would mean that you are totally committed to change and 0 means that you are not at all willing to change."</i> Then, ask: <i>"Why did you choose that number and not a lower one like 1 or 2?"</i> The patient will explain the reasons to change. You also ask for other reasons to change. <i>"How does this fit in how you see yourself in the future? If you make these changes, what would be different in your life?"</i> If the patient answers "0" ask, <i>"What would you need to happen to be in a higher number?"</i></p> <p>Confidence Scale <i>"In a scale from 0 to 10, how confident do you feel to make these changes?"</i> <i>"A 10 would mean complete confidence and 0 would mean no confidence."</i> <i>"What do you need to happen to feel more confident? What has changed successfully in the past? How? You may use these methods to help you with the challenges of changing!"</i></p>
<p>4. Provide guidance and negotiate goals</p>	<p>Provide guidance Review the concerns, as discussed with the patient. Advice abstinence or decrease in use, with screening and valorization arrangement. Provide references for additional valorization, if appropriate.</p> <p>Negotiate goals <i>"What can you do to keep healthy and safe? Where does it go from here?"</i> SUMMARIZE: <i>"Let me summarize what we have been discussing. Is this exact?"</i> <i>Is there anything I have lost or you wish to add?"</i> Suggest discussing the plan's progress in the next visit</p>
<p>Closure: Thank the patient</p>	<p><i>"Thank you for taking the time to discuss this with me and for being so open."</i></p>

If time does not allow a structured BI during the current visit, the offer of a brief counsel including feedback, advice, and goal scenario is a good approach to acknowledge your concern and start a conversation that may continue in the next visit. Some important notions of a brief counsel are: **ask permission, use nonjudgmental language, declare concern as healthcare provider and establish goals** (e.g. decrease, abstain for a short period of time) to discuss in the next visit.

ter failing once and spending a day in prison they will remain sober to avoid being going to jail for a second time. The data collected from the participants showed positive results. Being sued because they had not been sober for decades, they were reporting twice daily and proving they were clean.”(17)

Researchers financed by the United States National Institute of Justice evaluated the HOPE program of Hawaii, comparing probationers with a usual control group. After a year the persons in probation were 55% less probable to be arrested for a new crime, 72% less likely of using drugs, 61% less probable to skip visits with the supervisor and 53% less likely to have the removal of their probation period. (18)

The Sobriety Project 24/7 has also an impressive adherence; approximately two-thirds of persons with two daily tests never have a single positive or lost test. This proportion increases to 94% when those with one or two positive or lost tests are included. The number of clean tests is 99.6% for the twice daily alcohol tests and 98% for the urine drug test twice weekly. (19)

These results may seem to contradict the dominant belief that addiction is a chronic recurrent cerebral disorder. Most become abstemious when the environment in which he/she moves becomes intolerant with the continuous use of alcohol and drugs. The small number who fails is a self-selected population for more intensive interviews. The purpose would then be quality treatment for a few, instead of inevitably mediocre treatments for all.

The healthcare system has to take responsibility in the detection of the dangerous alcohol or illicit drug use or dependency, initiating treatment with a brief motivational interview with reference of addicts to an integral treatment. Moreover, the system of justice should induce the adoption of sobriety, 24 hours a day and seven days a week, with frequent tests and immediate responsibility of his/her actions, accomplishing that men and women get rid by themselves of alcohol and drug dependency.

Dr. Hernán C. Dova^{MTSAC}
Director of the Argentine Journal of Cardiology

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