How to talk about substance use disorders with your patients

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Though it can be difficult, it's essential for physicians to speak with their patients about substance use disorders, proper use of opioid medications and medication-assisted treatment—doing so can be a key component to both pain management and overdose prevention. Find out how one physician in San Francisco approaches the conversation around preventing and treating substance use disorder with his patients while avoiding stigma in the process.

With 78 people dying from prescription opioid and heroin overdoses each day in the United States, having the conversation about the risk of substance use disorders and the need for treatment for those who have one is critical for patient safety.

"It's a challenging conversation to have," said Phillip O. Coffin, MD, director of substance use research at the San Francisco Department of Public Health and an internal medicine and infectious disease specialist. "I struggle with it myself all the time." But there are ways to approach the topic with your patients and partner with them in preventing misuse and overdose, or in getting treatment for a substance use disorder.

3 core components to the conversation

Dr. Coffin's expertise includes HIV management, viral hepatitis care, and substance use disorder treatment and research. Some of his patients have substance use disorders that involve prescription opioid medications or heroin, and he is working hard to make sure they are provided the best treatment possible.

"There is no easy answer," he said of his approach to the discussion of substance use disorders. "It's really about exploring it with the individual patient."

Dr. Coffin offered these three elements that should be part of the conversation about substance use disorders to avoid the stigma that could be a roadblock to patients taking the appropriate steps for

their health:

Honesty

“The most important piece of the story is to always be forthright and honest with your patients about the issues you’re addressing,” Dr. Coffin said. “It’s about patient-centered care, [and] it’s quite rare that patients are coming in looking to reduce their opioid dose.”

“I often speak about the limited role of opioids in management of many chronic pain indications, really focusing on management of their pain and how it affects their function,” he said. “It’s a talk about the first line, second line and third line options for pain management, which are rarely opioids.”

“The goal of the conversation may be, for example, to get them toward a point where opioids are something they use intermittently … instead of on a daily basis,” Dr. Coffin said.

Medication-assisted treatment

For patients with a substance use disorder, Dr. Coffin said he will “almost uniformly offer them buprenorphine and try to encourage them. There may be no interest initially, and it may take months or even years of speaking with patients to get them to consider and actually engage in a transition from full agonists or street opioids to buprenorphine.”

“I have seen remarkable success with this approach, but it can take a long time of working with a patient,” he said. “For example, you may have, or have inherited, a patient on opioid medications for pain who is very high risk for overdose, who has multiple unprescribed opioids and stimulants in urine studies and has raised concerns about medication diversion,” he said. “If you discontinue opioids but are able to keep the patient engaged, you spend time really worrying about the welfare of the patient because they’ve resumed or increased heroin use, and their life is more chaotic.”

“Every time you see them, you talk about buprenorphine, and each time they come back they have something positive to say about buprenorphine,” he said. “Sometimes what they come back with is what you told them six months ago, and other times what they’ve heard from talking to other people who have taken buprenorphine. Like with other therapies—such as insulin—over time you can eventually help them make a transition.

“I can’t emphasize enough how transformative buprenorphine maintenance can be,” Dr. Coffin said. “It can be a remarkably powerful intervention, and it also happens to be quite good for pain management. Not to say you do the prescription and then the problem is no longer an issue at all. Insulin for a person with severe diabetes remains a good analogy; Buprenorphine requires ongoing management, but it solves so much of the core problem.”

Treat substance use disorder as a disease

“You can [treat patients with] buprenorphine in the context of other substance use disorder treatment—behavioral or cognitive behavioral psychological therapy,” he said, “but it has also been shown to be highly effective when implemented in a regular medical setting with the counseling that you get from a primary provider.”

“It is important that you talk with your patient about their substance use on a regular basis when you prescribe them buprenorphine,” Dr. Coffin said. “You don’t just have them come in, renew their prescription, talk to them about their other medical conditions and ignore their substance use. You have to sit down and talk about it.”

“When I’ve started seeing patients already on opioids for pain who have multiple risks, opioid use disorder or concerning findings on urine toxicology, it’s really hard to do a 15-minute visit and actually address the issue,” he said. “The visits tend to be long and resource heavy, and hard to complete without a strong supportive team approach to care.”

“When you bring buprenorphine into the picture,” he said, “substance use becomes one of the three or four issues that you talk about in a patient visit and that, frankly, makes it much more like other diseases that a primary care doctor manages.”

“You want to ask them how they’re doing with their medication,” Dr. Coffin said. “Are they tolerating it, are they having any side effects, are they getting what they need out of the medication? Are they using any heroin? … And if the answer is ‘a little bit,’ then you ask them what you can do together to decrease how often that happens.”

“Think of it a lot like talking to a patient with diabetes about their sugar intake per day,” he said. “What can we do to try to reduce that and help you keep your disease under control?”

Reducing the stigma of substance use disorders and enhancing access to treatment for those who have a disorder is one of the five things physicians can do to prevent opioid abuse, recommended by the AMA Task Force to Reduce Opioid Abuse, which physicians convened to help the nation move closer to the goal of ending the opioid epidemic.

For more on efforts to end the opioid epidemic

- Learn how President Obama’s opioid initiatives align with the Task Force’s recommendations.
- Read a call to action for physicians to turn the tide of the opioid epidemic
- Find out what physicians are saying about the new Centers for Disease Control and Prevention opioid guidelines.