Screening, Detection, and Diagnosis of Opioid Use Disorder

Screening for Opioid Use Disorder (OUD)

Overview of Screening for OUD

Patients should have a diagnosis of opioid use disorder in order to be considered for buprenorphine treatment unless they are being transferred from another medication-assisted treatment. This module discusses how to screen patients for possible opioid use disorder and further assess them to make the diagnosis.

Building rapport and motivating patients is an important skill when treating addiction, especially in the early phases of treatment. This module discusses counseling skills that can be effective for that purpose.

You can screen for opioid and other substance use problems:

- As part of routine history taking, for example, on a self-administered intake questionnaire at the start of every appointment
- When the patient’s presenting complaint could be a direct or indirect result of a substance use problem

Several organizations recommend or require substance use screening of all patients.

- The U.S. Preventive Services Task Force (USPSTF) recommended the screening of all patients 18 and older for unhealthy drug use, regardless of risk factors, along with screening for tobacco and alcohol use.
- The National Institute for Drug Abuse encourages drug use screening (including tobacco, alcohol, illicit drugs, and nonmedical use of prescription drugs) and brief intervention in practices.
- Several professional organizations support substance abuse screening as a standard part of every adolescent and adult patient interview (AMA, ASAM, CSAT, AAP, NIAAA).
- The SUPPORT law of 2018 required screening for opioid use disorder for every new Medicare patient.

Substance Use Disorder Terminology
The concepts of tolerance, physical dependence, and withdrawal are important to understand for anyone attempting to detect opioid use disorder. Opioid physical dependence and tolerance are not synonymous with opioid addiction or Opioid Use Disorder.

**Opioid Physical Dependence**

Dependence is the “state of biologic adaptation that is evidenced by a class-specific withdrawal syndrome when the drug is abruptly discontinued or the dose rapidly reduced, and/or by the administration of an antagonist”\(^5\).

- If withdrawal occurs after a person reduces or stops drug use, it suggests physical dependence, which is common with chronic opioid use.
- Users are not likely to experience withdrawal symptoms until they have used opioids regularly for at least two weeks.
- Physical dependence is not a diagnosis, but instead a description of a physiological state.
- Physical dependence is considered normal with chronic opioid therapy and is NOT an indication of a diagnosis of Opioid Use Disorder in this context.\(^9\)

**Tolerance**

Physiologic adaptation to a drug resulting in decreased effects over time\(^5\). With tolerance, a drug user needs more of the drug to feel the same effects or feels less effect with a constant dose.

**Opioid Withdrawal**

Opioid withdrawal is a dysphoric and physically uncomfortable, non-fatal state that occurs when a physically dependent individual stops using opioids or markedly reduces their dose.\(^9,10\)

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**PRACTICE TIP**

Patients taking prescription opioids for pain and who are under-medicated can appear to meet the criteria for opioid use disorder. For example, they may exhibit diagnostic criteria, such as tolerance, withdrawal, and a lot of time spent seeking opioids. They may not necessarily have opioid use disorder; the apparent opioid use disorder may disappear once the patient is adequately medicated. This phenomenon is sometimes called pseudo-addiction\(^11\).

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**Bringing Up the Topic of Substance Use**
Effective screening for opioid use disorder and other substance use problems requires that you bring up the topic with all patients. Any of your patients may have a substance use problem, not just the ones that come in seeking treatment. Be careful not to make assumptions about your patients.

**PRACTICE ACTION**

Routinely screen all patients for substance abuse or misuse along with other questions related to behavior and lifestyle, as part of the questions about comprehensive health. If you let patients know that you do it for everyone, it may help reduce the stigma and reduce patient anxiety.

**FYI:**

Evidence supports screening all patients who are on chronic opioid therapy for opioid use disorder. Many studies have found high rates, as high as 50%, of aberrant drug-related behaviors, drug abuse, or misuse in patients on opioids for chronic non-cancer pain.

**Tips for Bringing Up the Sensitive Subject of Opioid Use Disorder**

Some patients will volunteer their substance use, and others will not. If you suspect substance abuse, you will need to ask about it. Try these sensitive interviewing techniques when asking patients about their drug use:

- Explain to patients that you need to discuss drug use because you care about their health.
- Remain nonjudgmental – This will build patients’ self-esteem and prevent them from telling you only what they think you want to hear.
- Convey empathy – Let patients know that you understand that it is difficult to stop using drugs and that you want to help.
- Speak with confidence and knowledge about substance abuse patients often respond more positively to clinicians they deem to be competent and interested.
- Maintain the patient’s privacy and assure them of confidentiality – conduct the interview in private and do not bring up the substance abuse around other staff members without the patient’s permission.
- Ask simple, open-ended questions, which will elicit the most honest responses.

**Case: Screening for Opioid Use Disorder**

**Mr. Adams, Age 26**
Mr. Adams is here to get a refill of his asthma inhaler.

This case will illustrate the screening of patients for opioid use disorder and the use of motivational interviewing to facilitate patient communications in this process.

**Intake Nurse:** Thank you for filling out our intake questionnaire. You answered that you do use alcohol and have "a little" drug use. Can you tell me which drug or drugs you use?

**Mr. Adams:** Just some I had around. I had a prescription for some hydrocodone plus acetaminophen from a dental visit. They're not illegal or anything.

**Intake Nurse:** Okay. I have a few more questions to ask to get a good understanding of how much you use of each substance and whether your health is affected or there are other risks.

**Mr. Adams:** All right.

This dialogue will be continued below in the section on Screening Instruments (CAGE-AID).

**Screening During the Patient Interview**

**First Step: Simply Ask**

An easy, straightforward, direct approach requires only a single question asked during the patient interview, such as the following:

“How many times in the past year have you used an illegal drug or misused a prescription medication?”

13
Questions About Prescription Drug Use

There are a variety of approaches to screen for prescription drug misuse. SAMHSA (2008) suggests asking your patients the following questions:

- Do you see more than one health care provider regularly? Why?
- Have you switched providers recently? Why?
- What prescription drugs are you taking, and how many providers prescribe them? Verify the number of providers prescribing opioids using your state’s prescription drug monitoring program.
- Are the medications used as prescribed?
- Are you having any problems with them?
- Where do you get your prescriptions filled? Do you go to more than one pharmacy?
- Do you use any other non-prescription medications? If so, what, why, how much, how often, and how long have you been taking them?

Quiz: The challenge of asking questions that get answers.

Some clinicians ask their patients about harmful health behavior, with questions that assume their patient does not do them, such as, “And you don’t use drugs, right?” This approach is not likely to get an honest answer if they do use drugs. Some patients provide a more accurate and complete response if your question assumes they use drugs “What drugs do you use?” while other patients find this approach offensive.

Which of the following is a question that would be most effective at getting information while minimizing offensiveness.

“Have you been using heroin?”

Incorrect. This yes/no approach gives patients an opportunity to deny using drugs. If they say “No,” it is a dead-end in the patient interview.

“When was the last time you used heroin?”

Incorrect. This assumption that they have used heroin may be offensive to many patients.
“I see that you have needle tracks on your arm – have you been injecting heroin?”

Incorrect. This yes/no question is a dead end in the patient interview.

“What experience do you have with heroin?”

**Correct.** This open-ended question invites some dialogue without making an assumption that the patient uses heroin, only that it is a possibility.

**Video Illustrating Substance Use Screening**

A video that illustrates a primary care physician conducting a health risk screening for substance use can be found at: [https://youtu.be/5LjhAJMTwmI](https://youtu.be/5LjhAJMTwmI)

**TAPS – A Screening Tool for All Substances**
TAPS [Tobacco, Alcohol, Prescription Medication, and Other Substance Use]) includes questions about nonmedical use of prescription drugs.\(^\text{15}\)

**NIDA Quick Screen**

NIDA recommends using their Quick Screen, which is similar to the single question above but asks about specific substances. It is available online.

**In the past year, how many times have you used the following?**

- Alcohol – Men: > 5 drinks/day, Women: > 4 drinks/day
- Tobacco products
- Misused prescription drugs
- Illegal drugs

**Potential Answers** – Never/Once or Twice/Monthly/Weekly/Daily or almost Daily

Affirmative answers should be followed up with more questions, such as those presented online after a positive NIDA Quick Screen, or using another structured screening tool.

**Screening Instruments**

Using a validated screening instrument can enhance the likelihood of detecting opioid use disorder. There are several validated screening instruments, with a varied range of:

- Sensitivity and specificity
- Cost
- Ease of administration

Studies have shown that screening instruments detect substance use problems more accurately than clinical judgment\(^\text{16}\). Therefore, even providers experienced in diagnosing and treating substance use disorders can benefit from using a formal screening instrument.

**CAGE-AID**

One of the most commonly used standardized screening tools for detecting drug use problems is the CAGE-AID. It is a variation on the CAGE instrument that was originally created to screen for alcohol use. The CAGE questionnaire was modified to add screening for drug use\(^\text{17}\). “AID” stands for “adapted to include drugs.” The authors were able to obtain 70.9% sensitivity and 75.7% specificity with this modified scale.
Each letter in the acronym CAGE represents one question in the 4-item scale:

- **C**: Cut down – Have you ever felt you ought to cut down on your drinking or drug use?
- **A**: Annoyed – Have people annoyed you by criticizing your drinking or drug use?
- **G**: Guilty – Have you ever felt bad or guilty about your drinking or drug use?
- **E**: Eye-opener – Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?

**CAGE-AID Scoring**: Of the 4 items, a “yes” answer to one item indicates a possible substance use disorder and a need for further evaluation.

**Other Drug Screening Instruments**

- **Two-Item Conjoint Screening (TICS)**: Brown et al.\(^\text{17}\) also created the TICS instrument to screen for substance use disorder in a primary care population. Screens for both alcohol and drug use and is designed to detect *current* substance use, NOT a history of use.
- **NIDA-Modified Alcohol, Smoking, and Substance Involvement Screening Test (NMASSIST)**: Used to further assess drug use after a positive NIDA Quick Screen.
- **Drug Abuse Screening Test-10 (DAST-10)**: A short version of the Drug Abuse Screening Test often used as a screening and diagnostic tool in primary care.

**AUDIT**: For alcohol, the Alcohol Use Disorders Identification Test, (AUDIT), is often used in primary care for brief screening\(^\text{18}\).

**Case Illustration: Screening/Assessing Mr. Adams’ Substance Use**

**Mr. Adams, Age 26**

Mr. Adams, who is in the office to obtain a refill on his asthma inhaler, has admitted at intake to alcohol use and “a little” use of hydrocodone plus acetaminophen. The intake nurse confirmed this positive intake above and now explores his substance use further by using the CAGE-AID questionnaire and then asking a few focused questions afterward.

**Intake Nurse**: Have you ever felt you ought to cut down on your drinking or drug use?
Mr. Adams: Not really. I just drink a few beers now and then with friends. And I just take the opioids once in a while to feel good.

Intake Nurse: I appreciate your honesty. Have people annoyed you by criticizing your drinking or drug use?

Mr. Adams: Nope.

Intake Nurse: Have you ever felt bad or guilty about your drinking or drug use?

Mr. Adams: Maybe. I mean I took those leftover opioids just to see what it feels like. It was probably stupid.

Intake Nurse: It sounds like you have heard some about how risky opioids are – they can lead to addiction and overdose. The doctor will talk with you a little more about safe opioid disposal.

Mr. Adams: Okay.

Intake Nurse: Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?

Mr. Adams: No, it's not like that at all.

Quiz: Mr. Adam’s CAGE-AID score is ____ out of a possible 4 points.

0
Correct. Mr. Adams’ response to the question about guilt ("G") of “Maybe” seems like it should be counted as a positive since he ended his statement by saying his actions were “stupid”.
Withdrawal from opioids generally poses no serious medical risks. It is a very uncomfortable process that often continues (sometimes for months) in a more moderate form and can entail fatigue, depression, and difficulty sleeping. Withdrawal symptoms are a major reason why many former users find it problematic to remain abstinent. Many patients will present to their first appointment already in opioid withdrawal because they already understand that to start buprenorphine they need to be in early withdrawal.

Protracted withdrawal is probably the main reason for relapse after abstinence has been achieved – as in institutional abstinence, for example, after being released from jail.

**Opioid Withdrawal Diagnosis**

**WITHDRAWAL**, classified as a substance-induced disorder by the DSM, is a pattern of physiological, psychological, and behavioral changes precipitated by the decline in an individual’s bodily levels of a substance. It generally begins between a few hours and a half a day after the last use of heroin.

Associated with:

- Long history of use.
- Ceasing or substantially decreasing opioid use.
- Administration of an opiate antagonist, such as naltrexone, which blocks opioid receptors

Consideration of the diagnostic criteria for opioid withdrawal may be helpful when evaluating a patient’s state of withdrawal prior to buprenorphine induction.

**DSM Criteria for Opioid Withdrawal**

A. **Either** of the following:

1. Cessation of (or reduction) opioid use that has been heavy and prolonged (several weeks or longer)
2. After the administration of an opioid antagonist (such as naloxone) preceding a period of opioid use

B. **Three (or more)** of the following, developing within minutes to several days after Criterion A:

1. Dysphoric mood
2. Nausea or vomiting
3. Muscle aches
4. Lacrimation or rhinorrhea
5. Pupillary dilation, piloerection, or sweating
6. Diarrhea
7. Yawning
8. Fever
9. Insomnia

C. The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

Most withdrawal scales used clinically, such as the SOWS, are broader than the DSM 5 criteria for withdrawal. For example, withdrawal scales often include all vital signs, including respiration (yawning). Also, withdrawal symptoms in these withdrawal scales are not grouped exactly the same as in the DSM list.

**Quiz: Review of some signs and symptoms of opioid withdrawal:**

Choose the statement that finishes this correctly: “Opioid withdrawal is characterized by:

<table>
<thead>
<tr>
<th>Correct</th>
<th>Incorrect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased pulse rate</td>
<td>Decreased pulse rate</td>
</tr>
<tr>
<td>Enlarged Pupils</td>
<td>Pinpoint pupils</td>
</tr>
<tr>
<td>Dysphoria</td>
<td>Typically no mood change</td>
</tr>
<tr>
<td>Lacrimation or rhinorrhea</td>
<td>Dry eyes</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Constipation</td>
</tr>
<tr>
<td>Insomnia</td>
<td>Severe drowsiness</td>
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</tbody>
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**Case: Mrs. Thomas – Discuss Withdrawal Symptoms**

**Provider:** You said that if you reduce your dose, you feel some pain and don’t feel good. Can you tell me more about how you feel then?
Recognizing withdrawal is crucial since patients should be in moderate withdrawal immediately before their first dose of buprenorphine during induction (discussed in detail later in the activity). Most patients are very familiar with their symptoms of withdrawal and will be able to tell you about it.

**Withdrawal Assessment Scales**

The following is the classification of opioid withdrawal syndrome severity that may prove useful in general practice:

**Grade 0:** Drug craving, anxiety, and drug-seeking behavior

**Grade 1:** Yawning, sweating, watery eyes, and runny nose

**Grade 2:** Excessive or prolonged pupillary dilation, goosebumps, muscle twitching, and anorexia

**Grade 3:** Insomnia; increased pulse, respiratory rate, and blood pressure; abdominal cramps; vomiting; diarrhea; and weakness

Increasingly unpleasant withdrawal symptoms appear with higher levels of physical dependence on opioids.

**Opioid Withdrawal Scales**

Other opioid withdrawal scales include:

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**Mrs. Thomas:** A little achy, like I’m coming down with something, and a little sick to my stomach. I feel sleepy, but then I can’t sleep well at night. Mostly the problem is just feeling very low, sort of like I need it to feel all right.

**Provider:** That sounds pretty miserable. All of those symptoms could be coming from withdrawal from opioids. It sounds like your body has become dependent on it to feel normal.
- Clinical Opioid Withdrawal Scale (COWS) – See COWS calculator in Resources at the end of this activity
- Objective Opiate Withdrawal Scale (OOWS)
- Subjective Opiate Withdrawal Scale (SOWS)

**FYI:**

There is a comparable withdrawal assessment tool for alcohol withdrawal, the Clinical Institute Withdrawal Assessment of Alcohol (CIWA-Ar)\(^2\).

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**Motivational Interviewing (MI)**

Motivational interviewing is a patient-centered intervention approach that has been shown to help establish rapport with patients having substance use problems\(^2\). It is used to motivate patients to make the changes needed to recover. These techniques, originally developed for substance abuse counseling, have been shown to be effective in medical settings and to improve healthcare outcomes\(^3\).

Motivational interviewing differs from an advice-giving approach by\(^4\):

- Recognizing the expertise of the patient on his or her own motivations
- Guiding the patient to examine and resolve his/her ambivalence about the problem

The process of motivational interviewing moves through four basic steps:

1. Engage – Building rapport with the patient
2. Focusing on the topic
3. Evoking or eliciting the patient’s thoughts, emotions, and insights about the topic
4. Planning for change

In office-based opioid treatment, skills from motivational interviewing can facilitate connecting with patients for effective screening and diagnosis, as well as motivating patients to obtain treatment.

**Step 1: Engage – Building rapport with the patient**
In motivational interviewing, the patient’s readiness for change is increased through the following basic steps. The first step is building rapport and engaging the patient. Introduce the topic with openness, concern, and lack of judgment and establish rapport. Establishing a connection helps decrease the patient’s defensiveness and increase openness to the possibility of change, including treatment. Expressing acceptance and affirmation are important. Try opening the conversation without giving the option of a “no” response. For instance, say:

**Provider:** There were some signs of drug use in your medical exam. I’d like to explore ways I can help you with that. What can you tell me about it?

You walk a fine line when dealing with substance-abusing patients; you must respect their autonomy while also confronting them about drug use for the sake of their health.

When discussing the seriousness of substance misuse with patients:

- Do so without portraying a negative attitude or stigma
- Avoid making assumptions

The following techniques may help establish rapport and get patients to discuss their substance use openly and honestly.

**Ask open-ended questions**

**Provider:** Tell me more about your heroin use.

**Be sensitive to the patient's perspective**

**Provider:** Due to confidentiality laws, unless you sign a release of information, anything you say stays between us, so please feel free to be honest when answering my questions about your drinking and drug use.

**Listen effectively**

**Provider:** It sounds like your oxycodone and heroin use makes you feel isolated. How much do you think this contributes to your depression?

**Convey a non-judgmental attitude**
Case: Mr. Hughes

Name: Mr. Hughes

Age: 22 years old

Reason For Visit: He is in your office today for a physical required for work.

Drug-Related History So Far: Mr. Hughes remarked at intake that he “sometimes” uses oxycodone.

Physical Exam: The physical exam suggests that Mr. Hughes uses opioids and appears to be intoxicated currently. His signs and symptoms include pupillary constriction, slurred speech, poor attention, and slow respiratory rate.

However, he has no physical signs of injection drug use.

After assuring Mr. Hughes that your conversations are confidential, further discussion is required so that you can get a complete clinical picture.

Provider: I’m sorry that you are having a hard time answering these questions. If you think about your Vicodin use as a whole instead of trying to pinpoint each time you use, and why, it might help you answer the questions and see the bigger picture.

Provider: Mr. Hughes, I need more details about something that you noted on the intake questionnaire here so I can get a complete picture of your health. You indicated that you use street drugs – what drugs are you using currently?

Mr. Hughes: What? Oh, you know, a little of this, a little of that.

Provider: Heroin?
Practice Tips
When conducting a patient evaluation:

- Be non-judgmental and convey empathy
- Use motivational interviewing and brief interventions to increase patient motivation
- Use open-ended questions to elicit more thorough information from patients

Step 2: Focusing on the topic

Focus on a particular behavior to discuss in the session. For instance, gain a better understanding of the issue in terms of severity and the patient’s sense of importance or concern. The conversation could include bringing up the subject of drug use or treatment, or continuing counseling that started in a previous patient encounter.

One method of focusing is to assess motivation. This will help you focus interventions on their current stage of change. You can ask how important the change is for the patient on a scale of 1 to 10.

Provider: On a scale of 1 to 10, how ready are you to quit?
MR. HUGHES: Uh….I’d say a 4.

PROVIDER: Why not lower?

MR. HUGHES: Lower? Why not lower? Um, well, my job is important to me and if I don’t quit, I might lose it.

This question is likely to produce some statement of motivation; whereas asking, “Why not higher?” is likely to produce excuses. Gauge the patient’s confidence in his/her ability to change and readiness for change.

Case: Mrs. Thomas

Name: Mrs. Thomas
Age: 52 years old
Reason For Visit: Lower back pain. She is in your area for the winter and could not reach any of her regular providers. She decided that it would be best to have a provider nearby.
Patient History: Back pain started with a car accident 6 months ago. Mrs. Thomas has been seeing another provider who prescribed oxycodone, telling her that she would probably need it for about a month. She has been taking the medication for almost 6 months now, by visiting multiple providers and not informing them of the others. Although Mrs. Thomas reports feeling only slight back pain now, she is taking increasingly large doses of oxycodone every day to “stay ahead of the pain.”

Dialogue:

PROVIDER: I understand that you started taking oxycodone for back pain after a car accident 6 months ago. How much pain are you in now?
Mrs. Thomas: I still have some back pain if I don’t take my meds. If I reduce my dose, I have some pain and don’t feel good. I didn’t intend to take oxycodone for so long, but I need it to get me through the day.

Quiz Question: Initial Impressions

Which of Mrs. Thomas’s behaviors suggests a possible diagnosis of opioid use disorder? (Choose All That Apply)

Visiting multiple providers for prescriptions for opioids

Correct. By visiting multiple doctors, Mrs. Thomas is spending significant time and effort trying to obtain opioids, which is one of the DSM-5 criteria for substance use disorder.

Requiring a high dose of opioids every day to help her “stay ahead” of her back pain and “get through the day”

Possibly Correct. Needing a higher dose of opioids to achieve the desired effect, known as “tolerance”, is one of the DSM 5 criteria for substance use disorder. She would not meet this criterion if she was “taking opioids solely under appropriate medical supervision,” however, Mrs. Thomas’ “doctor shopping” does not qualify as “appropriate supervision.” Thus, she does not appear to qualify for this exclusion. However, it is possible that she is doctor shopping due to undertreated pain. To be certain of whether to count these criteria for Opioid Use Disorder, she would need to be interviewed further regarding these behaviors. Other criteria for the diagnosis and her back injury would need evaluation to ascertain whether this level of opioids is required.

Taking opioids for pain for longer than she anticipated
Correct. She has been taking opioids for longer than intended, which is a DSM 5 criterion for substance use disorder.

Step 3: Eliciting the patient’s thoughts emotions about the topic

Elicit statements of motivation and willingness to change. Use open-ended questioning and reflective listening to elicit the patient’s explanations for behaviors; recognition or concerns about a problem; and desire, intention, and ability to change. For example, say:

**Provider:** How is your oxycodone use affecting your life?

To support talk about change, you may have to help them get past ambivalent feelings. Evaluate and help them resolve their ambivalence. Patients often have a high degree of ambivalence about changing their addictive behavior; they want both the pleasures of indulgence and the benefits of restraint in substance use. Help the patient explore, articulate, and clarify any ambivalence he or she may have about the problem behavior. Highlight discrepancies in what the patient says in order to produce internal tension that can lead to change. For example, say:

**Provider:** So, from what you say, drinking is important to your social life, while at the same time, it is hurting your most important relationships.

Resolving the ambivalence might go like this:

**Provider:** On the one hand, you say drinking helps you relax, and on the other hand, you are concerned about your DWIs. Can we talk about the importance of each of these pros and cons for drinking?
Scenario: While reviewing the pros and cons of drinking, without prompting, Mr. Hughes admits to using both heroin and prescription opioids, including Percocet® and OxyContin®. He snorts the heroin instead of injecting because, in his words, “it’s a lot safer.” He uses opioids daily and also abuses other drugs when they are available, including alcohol, marijuana, and Ritalin®.

Clinician: When did you start using drugs?

Mrs. Thomas: Last year when I was having problems at school, I had a really demanding semester. I liked to relax with my friends on the weekends. Before that, I drank a lot but found that alcohol was not providing the “release” that I was seeking. Several of my friends introduced me to pills and eventually to heroin when I needed something stronger.

You have covered several key areas in your evaluation of Mr. Hughes, such as his medical history, drug use history, patterns of drug use, and tolerance.

Quiz Question: Clinical Choice Regarding Mr. Hughes’ Evaluation

Which of the following topics are an essential part of a thorough patient evaluation prior to diagnosing and treating Mr. Hughes? (Choose All That Apply)

Assess his craving and sense of control over his drug use.

Correct. It is important to assess Mr. Hughes’ craving and sense of control of his drug use.

Gauge his understanding of the consequences of drug use.
Correct. It is important to gauge Mr. Hughes' understanding of the consequences of drug use.

Discuss with him whether he will be able to avoid places and people where he obtained his drugs.

Incorrect. Determining where/how Mr. Hughes buys his drugs is not necessary to make a diagnosis but is relevant to determining the safety of his home environment in selecting a treatment setting. If his family or friends are his dealers, for example, separation from them could improve his chance of successful treatment. However, all of the other options are important steps in a thorough evaluation. You must fully evaluate his substance abuse before you can consider a diagnosis (or diagnoses) and possible treatment.

Gather complete medical, psychiatric, family, and social histories.

Correct. It is important to gather Mr. Hughes' complete medical, psychiatric, family, and social histories.

Step 4: Planning for change

Help patients make a plan for change. In motivational interviewing, the client comes up with his or her own plan for change. Elicit a plan from the patient for the next 30 to 90 days that uses affirming “change talk”, for example, “I will” rather than “I could.” The plan is based on the patient’s current stage of change and does not need to include quitting if the patient isn’t ready. For example, you could ask:
If they cannot think of any, ask if they can commit to a follow-up appointment to further discuss treatment.

An acronym for effective goals is SMART: Help patients develop goals that are:

- specific
- measurable
- appropriate
- reasonable
- time-based

If you believe the patient is a good candidate for buprenorphine, help the patient plan for moving away from opioid addiction and toward office-based treatment with buprenorphine.

**Case: Mr. Hughes – Summary and Plan**

**Summary**

You now have a complete clinical picture of Mr. Hughes’s drug use. He is dependent on opioids like heroin, Percocet®, and OxyContin®. Also, he sometimes abuses other drugs when they are available, including marijuana and Ritalin®. He has a history of alcohol use and may also have an alcohol use disorder. He meets the DSM 5 criteria for a diagnosis of “opioid use disorder.” Further evaluation revealed few behavioral changes, although he did admit to missing more classes recently (and not caring).

**Treatment Plan**

Mr. Hughes need immediate intervention. It is important to stress the urgency of this to him. He needs to understand both the short-term and the long-term physical, mental, and emotional implications of his opioid use disorder.

Explore treatment options with Mr. Hughes to find which options suit him best personally while also addressing his immediate medical situation. He may be a good candidate for office-based buprenorphine treatment. You can work with Mr. Hughes’ college to see what additional psychosocial services they can provide, assuming that Mr. Hughes is willing to participate in treatment.
Adding Motivational Interviewing to Your Practice

Discussing questionable substance use can strengthen your therapeutic relationship by demonstrating your concern for the patient. However, be prepared for potential defensiveness on the part of the patient upon questioning or disclosure of positive screening results. Using empathy and a non-judgmental attitude helps to minimize negative reactions from patients.

For patients with an established diagnosis, motivational interviewing can be used to provide short addiction interventions in an office setting. It also can be used to motivate the patient to follow-up with treatment.

Motivational interviewing increases the patient’s readiness for change by:

- Introducing the topic
- Assessing motivation
- Evaluating ambivalence
- Planning for change

Patients who meet the criteria for buprenorphine treatment but are resistant to quitting drug use may also benefit from motivational interviewing techniques.

Practice Tips

Motivational interviewing interventions can be brief.

- Other staff in the office can be trained in these techniques.
- Screening and/or brief interventions for substance use disorders are billable under many health plans.

Video: Motivational Interviewing

A video that illustrates the use of motivational interviewing in a patient interview regarding substance use can be found here: https://youtu.be/cOlb7ADwsMw.
If you watch the video, notice how the provider uses various techniques from motivational interviewing (MI), such as empathy, reflective listening, and open-ended questions, to achieve the four steps of MI:

1. Engage
2. Focus
3. Elicit
4. Plan

Note: Other modules in the program cover how to navigate the treatment of patients with challenges such as those of the patient in the video. For example, this provider needs to determine whether she will prescribe 2 weeks of Vicodin, start a taper and alternative pain management treatment with or without medication-assisted treatment such as buprenorphine, encourage the patient to return to the last prescribing provider, or let the patient either suffer withdrawal or continue to obtain the medication from “friends.”

Applying Motivational Interviewing in Screening

In approaching your patients to screen for substance use, it is important to:

1. Develop rapport—Patients will be more likely to reveal a substance use problem if you connect with them.
2. Establish trust
3. Engage with the patient
4. Acknowledge addiction as a disease
5. Thank them for talking with you
6. Acknowledge how difficult it is

**Practice Tip**

Written screening questions tend to be more effective when screening for tobacco/alcohol than illicit drug or prescription drug misuse because many people admit to the use of illicit drugs less readily. Asking about different specific drugs of abuse in-person may yield more honest responses.

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**Physical Signs & Symptoms of Opioid Misuse**

Some patients who misuse opioids may appear mostly normal physically. A number of signs and symptoms that suggest a patient’s prolonged use of opioids can be detected through a physical exam.

**Physical Signs of Opioid Misuse**

- Gastrointestinal upset (constipation or nausea)
- Low blood pressure
- Decreased respiration rate
- Confusion
- Constipation
- Pupillary constriction
- Suppression of cough reflex
- Dry mouth and nose
- Decreased libido and/or sexual dysfunction
- Irregular menses
- Irritation of nose lining
- Perforated nasal septum
- Abscesses, cellulitis, or dermatitis present at injection sites
- Skin necrosis
- Tourniquet pigmentation

Other patients seeking opioids may present in active withdrawal and present instead with elevated vital signs and other withdrawal symptoms, which are covered later in this module, such as cough or diarrhea.
Physical Signs of Injection and Other Illicit Drug Use

Look for changes in patient affect and behavior as well as physical evidence of injection. For example, marijuana or stimulant use may sometimes produce paranoia.

In addition to all the signs listed above for prescription opioid use, needle marks are a common sign of IV heroin use. A thorough exam may be required to find the marks, as they may appear on overlooked areas of the body, such as the feet or the groin area. The photo below provides an example of recent needle-punctate lesions on a heroin user’s arm.

To detect other signs of opioid use, the physical exam should focus on evaluating neurocognitive function and identifying the sequelae of opioid misuse or severe hepatic dysfunction.

Practice Tip

Physical Exam for Teens

The adolescent’s history may yield more information than the physical examination because a relatively short history of use typically does not cause drug-associated health problems, physical dependence, or withdrawal. Still, signs and symptoms of substance use may be seen, similar to those found in adults.

Indications of Substance Use

Patient complaints that can indicate alcohol or other drug problems, including the following:

- Frequent absences from work or school
- Depression
- Anxiety
- Labile hypertension
- Gastrointestinal symptoms
- History of frequent trauma or accidental injuries
- Sexual dysfunction
- Sleep disorders

Especially in the presence of physical signs of opioid use, these complaints may be associated with drug abuse.

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**Elicit the Patient’s History of Drug Use**

After substance abuse is detected, fully evaluate the patient to determine a correct diagnosis before initiating treatment planning. Issues to cover during evaluation should include the following\(^4,7,28,29\).

**Include all possible drugs:**

- Illicit drugs
- Prescription drugs
- Alcohol, tobacco, and caffeine

**Time factors to include:**

- Initiation of drug use
- Change in use over time
- Current use patterns
- Time of last use

**Tolerance, Intoxication, and Withdrawal**

If necessary, define these concepts for the patient. Determine patterns of tolerance and withdrawal and include questions about injuries sustained while intoxicated.

**Abstinence and Relapse**

Ask if, when, and how long the patient has attempted to abstain from drugs. Also, explore what factors contributed to relapse, if applicable.

**Consequences of Use**

What have been the outcomes of drug use? Identifying losses and/or problems in their lives that may increase patients’ motivation to change. Ask about consequences by category, such as medical, family, employment, and legal.
Craving and Control

Assess if and to what extent the patient feels a craving for the drug. Does the patient have a sense of control over drug use?

Treatment History

Ask about prior treatment episodes, e.g., therapy, medication, self-help, etc., and how the patient responded to treatment. Self-help groups might include 12-step Narcotics Anonymous or Alcoholics Anonymous.

Psychiatric History

Questions about previous psychiatric treatments should include where, the provider’s name, and psychotherapeutics prescribed if any.

Medical History

What past illnesses, hospitalizations, or operations has the patient had? Does the patient currently take any prescription or over-the-counter medications? Have drug allergies?

Family History

Ask about the prevalence of substance use disorders and psychiatric and medical conditions within the patient’s family.

Personal (Social) History

Chronicle the patient’s life from birth and childhood to present circumstances.

Psychosocial Indicators of Opioid Misuse

Individuals who are abusing/misusing opioids often exhibit an array of psychosocial problems that may be easier to detect than physical signs.

- **Cravings:** Cravings are an added criterion in the DSM 5 diagnosis of opioid use disorder. When asking about craving, ask whether they think a lot about using the drug or have dreams about using.
- **Behavioral:** Agitation, anxiety, anger, irritability, depression, insomnia, mood swings, weight changes
- **Family:** Marital problems (including separation and divorce), abuse or violence, children’s behavioral problems, family members’ anxiety and depression
- **Social:** Loss of long-standing friendships, spending time with other drug abusers, social isolation, loss of interest in regular activities
- **Work or School:** Missing work or school, poor performance, frequent job changes or relocations
• **Legal**: Arrests, DUIs, theft, drug dealing (legal problems are no longer a diagnostic criterion)
• **Financial**: Recent large debt, borrowing money from friends/relatives, selling possessions

**FYI:**

Keep in mind that people may have some of these psychosocial indications for reasons not related to drug abuse and may have never misused or abused opioids.

### Screening Adolescents

**Routine Screening of Adolescent Patients for Opioid Use**

Adolescents pose unique issues related to screening and detection of opioid abuse. Despite these issues, primary care physicians should routinely screen all adolescent patients for substance use disorders.

Establishing rapport and trust in relationships with young patients can be challenging, but important. Following a patient-centered approach can help.

**Effective Approaches to Establishing Rapport**

1. Find something of interest to the adolescent patient and meet them where they are in that area of interest.
2. Adolescents are less likely to talk, so make sure to ask open-ended questions.
3. Phrase questions so that your concern is clear.

For example, you might lead up to a question with, “In order to provide you with the best care, I am going to ask for information in some sensitive health areas.”

4. Structure the interview to start with questions that the patient could perceive as least threatening.
5. Once you reach illicit drug use questions, ask about marijuana first, as it is most often the first illicit drug to be used by adolescents.
6. If the patient affirms that he or she uses drugs, ask about patterns of use.

Remember, sensitive issues such as drug use should be raised with the adolescent patient only, not in the presence of his or her parents. Explaining confidentiality and the patient’s right to privacy is especially important with adolescent patients.
Behavioral changes—including psychosocial and academic problems—are likely to accompany problematic drug use; therefore, ask specifically about:

- School attendance, suspensions, or expulsions
- Whether he or she ever has been stopped by the police or arrested
- Sexual activity and sexual orientation (this can be a source of pain and confusion for some adolescents)

**PRACTICE ACTIONS**

Be attentive to the adolescent’s nonverbal behavior and follow up on nonverbal cues. This kind of perceptiveness can strengthen the physician-patient relationship.

**Tools for Adolescents**

**Screening**

Several standardized screening tools have been validated for use with adolescents, including the commonly used CRAFFT scale.

**CRAFFT**

- **C:** Car—Have you ever ridden in a car driven by someone (including yourself) who was “high” or had been using alcohol or drugs?
- **R:** Relax—Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?
- **A:** Alone—Do you ever use alcohol or drugs while you are by yourself or alone?
- **F:** Forget—Do you ever forget things you did while using alcohol or drugs?
- **F:** Family/Friend—Do your family or friends ever tell you that you should cut down on your drinking or drug use?
- **T:** Trouble—Have you ever gotten into trouble while you were using alcohol or drugs?

**Interpretation:** Two or more positive items indicate the need for further assessment.

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- Depending upon the extent of the rapport you have established with the patient, you may be able to make gentle assumptions (“How often do you drink alcohol?”) that help the patient be honest with themselves.
- Respond immediately to things the adolescent patient says to capitalize on teachable moments.

**Adolescent Risk Factors**

Factors conferring greater risk of substance use disorder in adolescents include childhood ADHD\(^ {34}\); conduct disorder\(^ {32}\); and sensation-seeking behavior. Homelessness in youth and running away are associated with greater risk of injected opioid use\(^ {35}\).

The following are additional red flags for adolescent substance use problems:\(^ {36}\)

- Marked change in physical health
- Deteriorating performance in school or job
- Dramatic change in personality, dress, or friends
- Involvement in serious delinquency or crimes
- HIV high-risk activities
- Serious psychological problems

SAMHSA recommends referring any adolescent showing any of these signs to a treatment specialist who has experience with adolescents.

ADHD is associated with poorer substance use treatment outcomes\(^ {37}\). Adolescents with ADHD and substance use problems have more severe substance use disorders if they also have major depression and may warrant more intensive treatment\(^ {38}\).

**Video: Adolescent Interview Example**

A video that illustrates the following skills being used with an adolescent who, during the interview, reveals illicit opioid use, can be found here: [https://youtu.be/OAKRz9TjJUE](https://youtu.be/OAKRz9TjJUE)\(^ {39}\)
These Motivational Interviewing and Counseling Skills Work Well with Adolescents

- Respecting and clarifying confidentiality
- Establishing rapport, being non-judgmental, but firm, asking permission to discuss drug use
- Summarizing what they say
- Affirming the patient’s strengths
- Establishing the patient’s stage of change
- Developing a plan
- Patient education

Diagnosis of Opioid Use Disorder

Substance Use Disorder Characteristics

To recognize all patients who may have opioid use disorder, it is important to be familiar with the diagnostic criteria. The diagnostic features of opioid-use disorder, according to the DSM 5 include the following:\(^9\):

- Prolonged misuse
- For pain management, prolonged use, or use in excess of what is needed to treat the pain and used not just for the pain
- Compulsive use
- Obtaining it illegally or fraudulently (including exaggerations) from a medical practitioner
- Tolerance and withdrawal
- Conditioned response to drug-related stimuli or cues. This conditioning may continue well into buprenorphine maintenance.

**Case: Mrs. Thomas**

Mrs. Thomas reports that she visits 2 providers regularly to get her prescriptions filled. She says that she needs a higher dose of oxycodone than either of her providers will prescribe to make sure she always has a prescription and enough pills to hold her over. She also reports that she sees several specialists that deal with different areas of pain and stress management. A prescription monitoring report obtained for Mrs. Thomas reveals that they sometimes write her prescriptions for opioids as well.

**Multiple Medications and Pharmacies**

**Provider:** Are you taking any other prescriptions currently?

**Mrs. Thomas:** I’ve also been taking meperidine “off and on for years,” prescribed by another doctor for pain after my surgery. I travel a lot and get my prescriptions filled wherever I can, so I don’t always use the same pharmacy.

**Signs and Symptoms**

**Provider:** How’s your sleep?

**Mrs. Thomas:** I’m pretty sleepy even during the day sometimes and feel nauseated.

Mrs. Thomas daytime sleepiness and nausea could be from intoxication. GI symptoms, including nausea, may also be related to withdrawal symptoms. Insomnia from withdrawal might also produce subsequent
sleepiness. Later, during the physical exam you observe pupillary constriction, suggesting current intoxication.

**Family Issues**

**Provider:** Has anyone in your family expressed concerns about your opioid use or symptoms?

**Mrs. Thomas:** Well, actually, my 5 children have confronted me about my oxycodone use. In fact, I haven’t spoken to my youngest son in over a month since he accused me of being “hooked” on the pills. Sometimes I feel a bit ashamed because I need so much pain medication. Every day I think about quitting the pain pills, but I’m afraid that the severe pain will return.

**Supporting Mrs. Thomas**

Acknowledge her medical issues, explain what happened with her pain and that slowly tapering from a high dose to a lower dose is often possible without experiencing pain. Explain, too, how in some people, narcotics can lead to substance use disorder. Additionally, remember to acknowledge it as a disease.

**Opioid Use Disorder Criteria**

Opioid use disorder is a pattern of using opioids that causes “clinically significant impairment or distress” and meets at least 2 of the following criteria:

1. Taking the opioid in larger amounts and for longer than intended
2. Wanting to cut down or quit but not being able to do it
3. Spending a lot of time obtaining the opioid
4. Craving or a strong desire to use opioids
5. Repeatedly being unable to carry out major obligations at work, school, or home due to opioid use
6. Continuing use despite persistent or recurring social or interpersonal problems caused or made worse by opioid use
7. Stopping or reducing important social, occupational, or recreational activities due to opioid use
8. Recurrently using opioids in physically hazardous situations
9. Consistently using opioids despite acknowledgment of persistent or recurrent physical or psychological difficulties from using opioids
10. *Being tolerant for opioids as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount. (Does not apply for diminished effect when used appropriately under medical supervision)
11. *Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal (Does not apply when used appropriately under medical supervision)

*Not if taking opioids solely under appropriate medical supervision.

The above criteria are paraphrased from the APA publication; view the original wording in the Opioid Use Disorder Diagnostic Criteria resource on this page. A full description of this diagnosis is in the DSM 5.

The CDC guidelines for opioid prescribing recommend tapering patients who do not meet enough diagnostic criteria for opioid use disorder.

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**Quiz: Mrs. Thomas Diagnosis**

With the additional information provided by interviewing Mrs. Thomas, consider whether the diagnosis of opioid use disorder applies.

**Checklist of Opioid Use Disorder Criteria:**

1. The substance is often taken in larger amounts for longer than was intended.

   **Correct.** She has increased her dose and taken the medication for longer than she was originally expected to be on it.

2. There is a persistent desire or unsuccessful efforts to cut down or control substance use

   **Correct.** Near the end of the interview, she said that she thinks about quitting every day.
3. A great deal of time is spent in activities necessary to obtain the substance, use it, or recover from its effects

**Correct.** It appears that she is spending a lot of time at doctors obtaining a sufficient supply of her medication.

4. Cravings

 **Criterion not evident.**

5. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.

 **Criterion not evident.**

6. Continued substance use despite having persistent or recurrent social or interpersonal problems caused by or exacerbated by the effects of the substance.

**Correct.** Her 5 children have each confronted her about her oxycodone use. She has not spoken to her youngest son in over a month since he accused her of being “hooked” on the pills.

7. Important social, occupational, or recreational activities are given up or reduced because of substance use

**Correct.** She has not spoken to her youngest son in over a month since he accused her of being “hooked” on the pills. She was not specifically asked about her occupational or recreational activities.
8. Recurrent use of opioids in physically hazardous situations

Criterion not evident. While driving or operating machinery can be dangerous when first taking opioids, most patients are able to drive after they adjust to chronic use.

9. The substance use is continued despite the knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance

Criterion not evident

10. Tolerance, as defined by either a need for markedly increased amounts of the substance to achieve the desired effect or markedly diminished effect with continued use of the same amount of the substance.

Correct. Mrs. Thomas described needing a higher dose than she was prescribed.

11. Withdrawal, as manifested by either the characteristic withdrawal syndrome for the opioid or the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.

Possibly. It is not clear whether she is experiencing withdrawal. She only mentioned two possible symptoms of withdrawal. You would need to ask her more questions about withdrawal symptoms specifically.
Mrs. Thomas – Diagnosis and Plan

Diagnosis

Mrs. Thomas appears to meet the definition of opioid disorder of “clinically significant impairment or distress” if you consider her daily sleepiness and nausea, which may be related to her opioid use, is causing distress and alienation from family and that she thinks about quitting every day, but cannot. She currently meets more than 2 criteria for opioid use disorder, and so this diagnosis is appropriate.

As you talk to her about the problem of her misuse of prescription opioids, be sure to explain both the short-term and the long-term dangers of her disorder.

While giving your diagnosis:
- Avoid putting her on the defensive
- Use motivational interviewing techniques during discussions
- Treat her as an expert in her feelings
- Involve her in decisions
- Maintain a non-judgmental attitude
- Help her notice and resolve ambivalent feelings, etc

However, be clear and firm while discussing the gravity of her situation.

Treatment Plan

Communicating with the other physicians involved in her treatment is also important. For example, her orthopedist and/or back specialist should be involved to confirm that Mrs. Thomas does indeed have a chronic injury as recommended in the FSMB guidelines on prescribing chronic opioids\(^5\), and to obtain details of her treatment.

The day before induction, complete patient education and the written, signed patient-provider treatment agreement.

Quiz: Substance Use Disorder

Which of the following are criteria for Substance Use Disorder? (Choose All That Apply)
<table>
<thead>
<tr>
<th>Continued drug use despite health problems</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Correct.</strong> Continuing to use a substance despite knowing that its use is causing health problems is one of the criteria for substance use disorder.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unsuccessful attempts to curtail drug use</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Correct.</strong> Being unable to control substance use despite one’s desires or best efforts is one of the criteria for substance use disorder.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drug tolerance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Correct.</strong> Tolerance for a substance, as defined by either the need for increasing amounts or by a diminished effectiveness, is one of the criteria for substance use disorder.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Legal problems related to substance use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorrect. Legal problems related to substance use are no longer a diagnostic criterion for substance use disorder.</td>
</tr>
</tbody>
</table>

**Refining the Diagnosis**

**Opioid Use Disorder Severity**
Most candidates for office-based buprenorphine treatment will have a diagnosis of opioid use disorder. ASAM noted that treatment “may not be appropriate for all patients along the entire opioid use disorder continuum”. Treatment is recommended for at least moderate (4 criteria) Opioid Use Disorder using the DSM 5.

**The severity** of opioid use disorder is determined by the number of diagnostic criteria a patient meets, as follows. Severity is given a different diagnostic code for mild vs. moderate or severe in both DSM 5 and ICD 10 coding:

- 0–1 No Diagnosis
- 2–3 Mild
- 4–5 Moderate
- >6 Severe

**Specifications**

The following specifications can also be added to the opioid use disorder diagnosis:

1. In early remission
2. In sustained remission
3. On maintenance therapy
4. In a controlled environment

**Case: Mr. Lopez**

**Name:** Mr. Lopez

**Age:** 50 years old

**Reason For Visit:** Mr. Lopez requests a buprenorphine prescription. He has been self-medicating with buprenorphine to reduce his use of hydrocodone and oxycodone.

**Patient History:** No present pain, but he takes Vicodin® and Percocet® at least once daily, and has done so for five years; he is unable to stop taking them. Mr. Lopez severely sprained his ankle four years ago, requiring surgical repair, and was prescribed hydrocodone. Even though his ankle pain improved, he increased the amount he takes and even started buying it on the street. He felt embarrassed and hated spending all that time on the phone trying to find his next day’s supply of pills. Money was never an issue because he has a pretty good job.

**Treatment History:** About a year ago, he was fed up and decided to stop taking hydrocodone. He tried methadone for just 2 weeks but could not make the required daily clinic visit and soon was back to using up to 15 tablets of hydrocodone a day. If he went for six hours with no pills he suffered withdrawal. So he bought 15 buprenorphine tablets from an acquaintance and switched to those for a few days. The buprenorphine helped, and he
was able to buy another two weeks’ worth from his friend, but after he ran out, he could barely function due to nausea and achiness. He held on for a few more days but soon started taking hydrocodone once again and is currently using it. He felt more clear-headed on buprenorphine, so he would like to resume taking it. This time he decided to ask to have it prescribed; hence, his visit to you.

He works as a building construction inspector, is divorced, and lives alone. The highlight of his week is taking care of his 3-year old grandson on Saturdays.

**Dialogue:**

**Provider:** Do you have any friends you can lean on?

**Mr. Lopez:** Nope, not really. I have no regular friends except the guys at the bar and at work. Most weekdays after work, he stops at the local bar and has several drinks with his friends.

**Provider:** How would you feel about decreasing or stopping drinking?

**Mr. Lopez:** I’m not sure I really want to stop drinking. My sisters have told me that I drink too much. But I’m careful to avoid alcohol when taking care of my grandson. But sometimes with the way my life is going, I just feel like drinking?

**Provider:** I’m sorry to hear that. What’s going on that triggers the drinking?

**Mr. Lopez:** I was told by one of my doctors that I was depressed, and they put me on Zoloft®. I took it as directed for six weeks, but then stopped it because it “messed up” up my sex life. Sometimes I feel dejected, not suicidal or crying a
lot, but what gets me down is this Vicodin® and Percocet® habit. If I got rid of these drugs, I wouldn’t be down at all.

**Quiz Question:**

**How does Mr. Lopez’ history affect your treatment decisions? (Choose One)**

He is still a good candidate for buprenorphine treatment, despite the alcohol use and other history.

Incorrect. At this point, Mr. Lopez needs further screening for alcohol use disorder with lab tests (liver enzymes) to discover the severity of his alcohol problem, before proceeding with buprenorphine treatment.

He is not a good candidate for buprenorphine treatment, due to the alcohol use and other history.

Incorrect. At this point, Mr. Lopez needs further screening for alcohol use disorder with lab tests (liver enzymes) to discover the severity of his alcohol problem, before proceeding with buprenorphine treatment.

Not enough information

Correct. At this point, Mr. Lopez needs further screening for alcohol use disorder with lab tests (liver enzymes) to discover the severity of his alcohol problem, before proceeding with buprenorphine treatment.
Mr. Lopez is under-aware of his potential alcohol problem.

Consider: Does he smell like alcohol? Does he have symptoms of alcohol dependence (tremors, etc.) when he doesn’t drink? Similarly, his depression evaluation needs to be updated. Depending on the severity of these problems, consider that he has two risk factors for poor buprenorphine treatment outcomes.

Your decision to treat him in an office-based opioid treatment program should consider the severity of these problems, his response to their treatment, and your level of expertise in handling cases with these complications.

Providers new to prescribing buprenorphine or treating polysubstance use might consider a referral to a more experienced provider or a higher level of care. If you do continue with OBOT, you should review with him the warning about CNS depressant use when taking buprenorphine and include additional treatment structure, such as psychosocial supports and more frequent office visits.

**Case: Mr. Lopez – Additional Treatment Concerns**

Mr. Lopez’ attempt at self-detoxification from opioids is notable and raises some concerns. He seems to be trying to keep control over his treatment. His first approach was to buy some buprenorphine outside of medical treatment and carry out his treatment alone. He is shopping as a consumer for treatment as he envisions it. On the one hand, it shows toughness, determination, and taking responsibility for his situation. On the other hand, it shows reluctance to ask for help from others. He may not want to show weakness and may have a tendency to minimize problems.

**Quiz Question: Mr. Lopez Treatment Concerns**

If Mr. Lopez explored buprenorphine treatment in an office-based opioid treatment practice, what would a tailored, optimal assessment, evaluation, and treatment plan include? (Choose All That Apply)

1. Get a more complete history

Correct.
2. Conduct a physical exam

Correct.

3. Conduct lab testing

Correct.

4. Further evaluate his social isolation and depression

Correct.

5. Further evaluate his alcohol use/abuse/addiction

Correct.

6. Involve Mr. Lopez in treatment planning and decision-making

Correct.

Case: Mr. Lopez – Summary and Plan

Summary and Treatment Plan
Given Mr. Lopez’ history, you might emphasize a patient-centered approach in which he is included in the decision-making process and is informed of all his choices. He seems to have ideas about what he wants, so it is important to understand his expectations.

For example, you could ask, “what kind of treatment do you feel would be best for you at this time?” It is also important to clearly explain your office-based opioid treatment program requirements, so he can decide early on whether he wants to participate.

You should also review how Mr. Lopez can ask for help because of his possible reluctance to ask for help. For example, explain how he can reach you if he has questions about his treatment, what to do if he feels like using opioids, etc. This can be outlined in a treatment agreement that Mr. Lopez could review and sign, along with the informed consent, which must be signed.

For patients who might hesitate to sign a treatment agreement, emphasize that the point of the agreement is to make the program clear, including what is expected to happen in terms of how they will improve, how they will be monitored, and the process for obtaining refills. The patient is often given a handbook or copy of the agreement.

**Concepts to Discuss with Patients**

It may also be useful to introduce the concept of severity of illness and let him know that additional treatment and support is needed with more severe opioid use disorder. Many patients with opioid addiction need more treatment than just medication, such as counseling or a support group. Some patients need long-term maintenance on buprenorphine and at least months of stability before attempting complete detoxification, including a taper off buprenorphine. It is important to lay the groundwork for a flexible approach depending on what he needs.

**Brief Interventions in Primary Care**

Conducting brief interventions in primary care is essential to getting substance abuse patients started down the path to treatment.

Brief intervention is effective in decreasing illicit drug use⁴¹. Here are the basic steps in a brief intervention:

1. Confirm that the patient’s screening answers indicate a concern
2. Ask about the patient’s view of the situation – Includes identifying barriers to quitting and risk factors for relapse
3. Discuss the patient’s responsibility, health effects and other consequences of substance misuse
4. Provide the patient with non-judgmental advice and describe the benefits of quitting
5. Mention treatment options and gauge patient’s reaction
6. Encourage and support the patient – Includes soliciting patient commitment to a clear goal
7. Provide patient education and resources

**Reducing the Dose of Patients on High Doses of Opioids**

A study in a chronic pain practice found that, given a choice, 40% of patients on high-dose chronic opioid therapy (for an average of 7 years) were willing to taper down or off opioids if given other means of coping with their pain. The results at 16 weeks were (n=34):

- ≥50% cut their dose by more than 50%
- 30% cut their dose by 75 to 100%
- 75% reduced their dose by at least 25%

Pain often did not increase and in some instances decreased. Anxiety about pain episodes also decreased. Results did not correlate with dose or length of time on chronic opioid therapy.

**PRACTICE ACTION**

Consider carefully whether the patient with chronic pain has an unnecessarily high dose of opioids and whether dose reduction in their treatment plan is appropriate in their case.

**FYI:**

The FDA’s guidelines for REMS for prescribing buprenorphine, include an “Appropriate Use Checklist” that you can use to guide your buprenorphine practice.

**Key Points**
Screen all patients for misuse of prescription and illicit drugs along with your screening for other substance use problems.

Build rapport with patients and adopt a non-judgmental attitude to encourage their candor in discussing their substance use.

Opioid use disorder is common, and patients may not be forthcoming about opioid use or may not be familiar with the association between their symptoms and their opioid use. Therefore, it is important to be familiar with signs and symptoms of opioid use disorder, opioid intoxication, and opioid withdrawal.

The diagnosis of Opioid Use Disorder is a pattern of using opioids that causes “clinically significant impairment or distress” and meets at least 2 of the diagnostic criteria.

Severity of opioid use disorder is determined by the number of criteria met:
- 0–1 No Diagnosis
- 2–3 Mild
- 4–5 Moderate
- >6 Severe

Summary

Substance Abuse Screening

- Remain non-judgmental, be sensitive, listen, and convey empathy.
- Routinely screen all patients for substance use disorder.
- Screening instruments can detect substance use problems more accurately than clinical judgment; e.g., CAGE-AID, can be integrated into a patient questionnaire or interview.

Motivational Interviewing

- The basic steps of motivational interviewing, which can be used to facilitate healthy behavior change in a patient, are the following:
  - Engage the patient/establish rapport
  - Focus the conversation on the topic
  - Elicit from the patient thoughts and feelings about their substance use or quitting
  - Develop a plan for change with the patient

Signs and Symptoms of Opioid Use Disorder

- Track marks are often indicative of intravenous heroin abuse as well as psychosocial indicators.
• Common signs and symptoms of prescription opioid misuse include: constipation, low blood pressure, respiratory depression, and mental status changes
• Common signs and symptoms of injection use include: pupillary constriction, sleepiness, euphoria, constipation, nausea, suppression of the cough reflex

**Further Assessment for Substance Abusers**

• Healthcare providers they see currently
• What prescription drugs they take (and why)
• History of drug of addiction use: length of, severity of, and patterns of addiction, tolerance, intoxication/withdrawal, abstinence/relapse, consequences of use, craving, and control
• Treatment: medical and psychosocial

**Guidelines for Assessing Adolescent Patients**

Adolescent patients should be routinely screened for substance abuse; standardized tools are available

**Diagnosis of Opioid Use Disorder**

• Briefly, the diagnostic criteria for opioid use disorder are:
• Taking more opioids or for longer than intended
• Not able to quit
• Spending a lot of time obtaining the opioid
• Craving
• Use negatively impacts ability to work or complete other obligations
• Use despite social or interpersonal problems
• Decreasing important life activities due to opioid use
• Use in physically hazardous situations
• Use despite physical or psychological difficulties from opioid use
• *Tolerance (*Does not apply for appropriate use)

*Withdrawal (*Does not apply for appropriate use)

**Resources & References**

Resources

Buprenorphine-containing transmucosal products for opioid dependence (BTOD) REMS: REMS for buprenorphine published 2/2013 and revised 6/2015
Clinical Opioid Withdrawal Scale (COWS): This PDF Document contains the Clinical Opioid Withdrawal Scale (COWS), a common instrument used to assess a patient’s opioid withdrawal severity.

COWS Calculator: COWS Score for Opiate Withdrawal by Dr. Donald R. Wesson.

CRAFFT: Brief Screening Tool for Adolescents: THE CRAFFT is a screening instrument used to detect alcohol and other drug abuse.

DAST-10: The Drug Abuse Screening Test, or DAST, is a self-administered test designed to provide a brief screening for drug abuse, followed by further assessment by a health care professional if necessary. A Clinical Tools Resource

Detecting Substance Abuse and Dependence: Red Flags, and Risk Factors: Lists the psychosocial and physical indications of substance abuse in general as well as the specific physical symptoms of opioid use (Source: Clinical Tools, Inc.).

Diagnostic and Statistical Manual of Mental Disorders (DSM 5): Manual for diagnosing mental health problems with diagnostic criteria and diagnostic codes.

DSM-5 Criteria for Opioid Use Disorder: A Clinical Tools Resource

DSM 5 Criteria for Opioid Intoxication: A Clinical Tools Resource

DSM 5 Diagnostic Codes Related to Substance Use Disorders: A Clinical Tools Resource.

FSMB Model Policy for the Use of Controlled Substances for the Treatment of Chronic Pain: Federal State Medical Boards (FSMB) 2013 model policy for state use in developing guidelines for use of opioids for chronic pain.

NIDA Quick Screen: To screen patients for substance use disorders with step-by-step screening algorithms.

Objective Opiate Withdrawal Scale (OOWS): The Objective Opiate Withdrawal Scale (OOWS) contains 13 physically observable signs, rated present or absent, based on a timed period of observation of the patient by a rater.

What Are Risk and Protective Factors: List of factors affecting adolescents and drug use NIDA 2011

Risk Factors: How can health professionals mitigate these risks?: A brief list of risk factors to look for when evaluating patients for substance abuse. Also, guidance on how to mitigate adolescent risk for substance abuse.
Self-Administered Addiction Severity Index (ASI-Self Report): The ASI Self-Report Form asks questions about the following topics: your background and employment, your health and family relationships, your legal situation, and your drug and alcohol use.

Subjective Opiate Withdrawal Scale (SOWS): Annex of opioid withdrawal scales for downloading includes the Subjective Opiate Withdrawal Scale (SOWS). 16 symptoms are rated from 0 (not at all) to 4 (extremely).

TAPS (Tobacco, Alcohol, Prescription medication, and other Substance Use Tool). This brief assessment quickly asks about all substance use including misuse of prescription opioids.

TICS: The Two-Item Conjoint Screening (TICS) scale is a brief screening tool. It screens for current substance use or dependence in a primary care population.

Tip 35 Enhancing Motivation for Change in Substance Abuse Treatment. SAMHSA 2019

Unhealthy Drug Use Screening. USPSTF 2020 recommendation.

References


29. SAMHSA. Talking with Your Adult Patients about Alcohol, Drug, and/or Mental Health Problems. *Publ Digit Prod*. August 2010.
36. Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT). A Guide to Substance Abuse Services for Primary Care Clinicians. Rockville, Md: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration; 2008.