

Patient Assessment & Selection

**2010 CA Area Indian Health Conf
and the AOAAM OBOT**

Office-based Buprenorphine and Patient Assessment/Selection

The purpose of this section is to provide information on how to assess and select appropriate patients for office-based treatment with buprenorphine. Not all patients who are opioid dependent are good candidates for office-based buprenorphine treatment, and success for both the patient and the practitioner will depend in part on these initial steps of assessment and selection.

Outline for This Talk

- I. Identify opioid use/abuse**
- II. Establish the diagnosis of opioid dependence**
- III. Assess for other conditions**
- IV. Determine appropriateness for office-based buprenorphine**
- V. Match the treatment plan and treatment resources**
- VI. Summary**

Commonly Abused Opioids

Diacetylmorphine (Heroin)

Hydromorphone (Dilaudid)

Oxycodone (OxyContin, Percodan, Percocet, Tylox)

Meperidine (Demerol)

Hydrocodone (Lortab, Vicodin)

Commonly Abused Opioids (continued)

Morphine (MS Contin, Oramorph)

Fentanyl (Sublimaze)

Propoxyphene (Darvon)

Methadone (Dolophine)

Codeine

Opium

Commonly Abused Opioids

Opioids are abused by all routes of administration including oral, inhalation, smoking, and injection.

Heroin is most commonly used intravenously, but can be inhaled, smoked, or injected intramuscularly or subcutaneously.

Opium is usually smoked.

The pharmaceutical opioids are usually taken orally (but may also be injected).

Evaluation of the Patient

Attitude of the interviewer:

Matter-of-fact, non-judgmental, curious, respectful, interested, professional, focused on taking a good medical history

Approaches that facilitate effective treatment:

Acknowledge that some information is difficult to talk about

Assure the patient that you are asking because of concern for his/her health

Try to avoid using labels or diagnoses

Evaluation of the Patient

History of drug use:

Start with first substance used

Ask about all substances (including licit and illicit)

Determine changes in use over time (frequency, amount, route)

Assess recent use (past several weeks)

Evaluating the Patient

Approaches of the interviewer:

Assure confidentiality (as long as no one is at risk of being harmed)

Begin with open-ended questions initially and move to more directed questions

Evaluating the Patient

Approaches of the interviewer (*continued*):

Pay attention to the manner in which the patient responds as well as the content

Acknowledge discomfort (e.g., “You seemed to get quiet when I asked that.”)

Be persistent

Always follow-up on “qualified answers”

Evaluating the Patient

Approaches of the interviewer (*continued*):

Be careful using “slang” because of regional variation

Always ask about each specific class of drug

Ask about prescription and OTC drugs

If there is any hint of substance abuse, get collateral information

Evaluation of the Patient

Tolerance, intoxication, withdrawal:

Explain what is meant by tolerance

Determine the patient's tolerance and withdrawal history

Ask about complications associated with intoxication and withdrawal

Evaluation of the Patient

Relapse/attempts to abstain:

Determine if the patient has tried to abstain, and what happened

Ask what was the longest period of abstinence

Identify triggers to relapse

Evaluation of the Patient

Consequences of use:

Determine current and past levels of functioning

Identify consequences to drug/alcohol use (such as):

Medical

Family

Employment

Legal

Other

Evaluation of the Patient

Craving and control:

Ask if the patient experiences craving to use
and/or a compulsive need to use

Determine if patient sees loss of control over
use

Evaluation of the Patient

Substance use disorder treatment history:

Treatment episodes (detoxifications – medically and non-medically supervised; maintenance; counseling)

Response following each treatment intervention

Attendance at 12 step (or other self-help) meetings

Evaluation of the Patient

Psychiatric history:

Inpatient and/or outpatient treatment episodes

Untreated episodes of psychiatric illness

Treatment with psychiatric medications

Ask about treatment delivered by non-psychiatrists
(e.g., an antidepressant prescribed by a family
physician, psychotherapy provided by a
psychologist)

Evaluation of the Patient

Medical history:

Past and/or present:

Significant medical illnesses

Hospitalizations

Operations

Accidents/injuries

Drug allergies

Current medications: Prescription and OTC

Evaluating the Patient

Physical examination:

Needle marks

Sclerosed veins (track marks)

Cellulitis/Abscess

Evidence of hepatitis or HIV

Evaluation of the Patient

Family history:

Substance use disorders

Other psychiatric conditions

Other medical disorders

Evaluation of the Patient

Personal (or social) history:

Birth and early development

Education

Employment and occupations

Marital status and children

Living situation

Legal status

Evaluating the Patient

Substance abuse history:

TRAPPED:

Treatment History (inpt, outpt, methadone)

Route of Administration (IV, IN, IM, smoked)

Amount (\$, “bags”, “caps”, “dimes”, mgs, grams)

Pattern of Use (with changes over time)

Prior Abstinence (in & out of institution)

Effects (including overdoses & withdrawal)

Duration of Use (including most recent use)

DSM-IV Criteria for Opioid Dependence

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

- 1. Tolerance, as defined by either of the following:**
 - a) a need for markedly increased amounts of the substance to achieve intoxication or the desired effect, or**
 - b) markedly diminished effect with continued use of the same amount of the substance**

- 2. Withdrawal, as manifested by either of the following:**
 - a) the characteristic withdrawal syndrome for the substance, or**
 - b) the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms**

DSM-IV Criteria for Opioid Dependence

- 3. The substance is often taken in larger amounts or over a longer period than was intended**
- 4. There is a persistent desire or unsuccessful efforts to cut down or control substance use**
- 5. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects**
- 6. Important social, occupational, or recreational activities are given up or reduced because of substance use**
- 7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance**

DSM-IV Criteria for Opioid Dependence

Diagnosis can include modifiers indicating if the patient is physiologically (or physically) dependent on the substance (i.e., has evidence of tolerance or withdrawal), is in various stages of remission, is on agonist treatment, or is in a controlled environment

DSM-IV Criteria for Opioid Abuse

- 1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:**
 - a) recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home**
 - b) recurrent substance use in situations in which it is physically hazardous**
 - c) recurrent substance-related legal problems**
 - d) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance**
- 2. The symptoms have never met the criteria for Substance Dependence for this class of substance.**

Opioid Physical Dependence

Important Clinical Features of Opioid Physical Dependence

Physical dependence can occur after relatively short periods of daily use (e.g., 2 weeks)

Opioid physical dependence is characterized by regular administration to avoid withdrawal

Characteristics of Addiction: The 4 “Cs”

Control (loss of)

Compulsion to use

Consequences (continued use despite negative consequences – family, occupational/educational, legal, psychological, medical)

Craving

Assess for Other Conditions

- A. Other substance use, abuse, dependence**
- B. Medical co-morbidity (SEPARATE SECTION)**
- C. Psychiatric co-morbidity (SEPARATE SECTION)**

Other Substance Use, Abuse, Dependence

Reason to assess for other substance use

Co-morbid substance use disorders are common in patients with opioid dependence

Important to assess when initially evaluating the patient, as their presence/absence can guide whether or not office-based treatment is appropriate

Types of Other Substance Use

Alcohol

Sedative-hypnotics

Cocaine

Methamphetamine

Cannabis

PCP

Nicotine

“Club Drugs” (Ecstasy, Ketamine, GHB)

Non-controlled (clonidine, etc.)

Detecting Other Substance Use

Screening instruments – e.g., DAST-10

Self-report of use, reason

Multiple trauma

Hospitalization

Infections

Body fluid testing (e.g., urine)

Detecting Other Substance Use

Drug Abuse Screening Test (DAST-10)

**Ten yes/no questions to assess
involvement with drugs not including
alcohol**

Available online at

**[http://www.drugabuse.gov/Diagnosis-
Treatment/DAST10.html](http://www.drugabuse.gov/Diagnosis-Treatment/DAST10.html)**

Detecting Other Substance Use

Laboratory methods:

Blood

liver function test abnormalities

elevated mean corpuscular volume on CBC

Urine testing for presence of drugs of abuse

**Hair, saliva, sweat – limited and primarily
experimental**

Co-morbid Medical Disorders

Important to assess for such, since (like other co-morbid disorders), their presence can influence the decision to provide office-based treatment of opioid dependence

Advantage: One-stop treatment for opioid dependence and other medical needs

Disadvantage: Management of co-morbidity can be complicated and require specialized services

Appropriateness for Office-based Buprenorphine

Factors to keep in mind when considering a patient for office-based buprenorphine treatment

Factors indicating the patient is less likely to be an appropriate candidate for office-based buprenorphine treatment

Appropriateness for Office-based Buprenorphine

Consider these factors

- 1. Does the patient have a diagnosis of opioid dependence?**
- 2. Is the patient interested in office-based buprenorphine treatment?**
- 3. Does the patient understand the risks/benefits of buprenorphine treatment?**

Appropriateness for Office-based Buprenorphine

Consider these factors (continued)

- 4. Is he/she expected to be reasonably compliant?**
- 5. Is he/she expected to follow safety procedures?**
- 6. Is the patient psychiatrically stable?**

Appropriateness for Office-based Buprenorphine

Consider these factors (continued)

- 7. Are the psychosocial circumstances of the patient stable and supportive?**
- 8. Can the office provide the needed resources for the patient (either on or off site)?**
- 9. Is the patient taking other medications that may interact with buprenorphine (naltrexone, benzodiazepines, other sedative-hypnotics)?**

Appropriateness for Office-based Buprenorphine

Factors to keep in mind when considering a patient for office-based buprenorphine treatment

Factors indicating the patient is less likely to be an appropriate candidate for office-based buprenorphine treatment and should be referred elsewhere

Appropriateness for Office-based Buprenorphine

Patient is less likely to be an appropriate candidate for office-based buprenorphine treatment

- 1. Dependence on high doses of benzodiazepines, alcohol, or other CNS depressants**
- 2. Significant psychiatric co-morbidity**
- 3. Active or chronic suicidal or homicidal ideation or attempts**

Appropriateness for Office-based Buprenorphine

Patient is less likely to be an appropriate candidate for office-based buprenorphine treatment (continued)

- 4. Multiple previous treatments and relapses**
- 5. Non-response to buprenorphine in the past**
- 6. High level of physical dependence (risk for severe withdrawal)**
- 7. Patient needs cannot be addressed with existing office-based resources**

Appropriateness for Office-based Buprenorphine

Patient is less likely to be an appropriate candidate for office-based buprenorphine treatment (continued)

8. High risk for relapse

9. Pregnancy

10. Current medical condition(s) that could complicate treatment

11. Poor support systems

Matching the Treatment Plan and Resources

Determine appropriateness of patient for office based buprenorphine treatment:

consider the needs of the patient

consider the available resources

Can the needs of the patient be addressed by available resources?

Matching the Treatment Plan and Resources

The six ASAM patient placement criteria can help guide this decision making; they are:

- 1. Acute intoxication/withdrawal potential**
- 2. Biomedical conditions, complications**
- 3. Emotional/behavioral/cognitive conditions and complications**
- 4. Readiness to change**
- 5. Continued use or continued problem potential**
- 6. Recovery environment**

Matching the Treatment Plan and Resources

The decision to provide treatment from the office should be based upon the suitability of the patient for this level of service and the availability of other resources in case complications in the office-based treatment arise.

Summary

Determination of suitability for office-based buprenorphine treatment begins with the presence of a diagnosis of opioid dependence

In addition, many patient factors (such as co-morbid conditions) will guide the decision of whether or not to treat in the office with buprenorphine

Final decision is whether the patient's needs can be addressed by the resources available through the office