

# HOW TO SCREEN AND ASSESS

## Clinical tips and advice about:

- Conducting substance abuse screening
- Assessing patients for the DSM criteria for Substance Use Disorder
- Assessing patients for Withdrawal

## *Plus resources on each page with additional tips and tools!*

Written by [Clinical Tools, Inc.](#)

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## SUBSTANCE ABUSE SCREENING GUIDELINES



The NIH and SAMHSA recommend that physicians screen all patients over the age of 12 for potential substance abuse problems. Patients should be screened at every visit since substance use may change over time.

### How To Do Substance Abuse Screening

- Conduct a simple initial screening by asking about tobacco, alcohol, and drug use during the patient interview. Use a routine and non-judgemental approach when asking these questions.
- Start with open-ended questions, "Tell me about your alcohol use?" instead of "Do you drink alcohol?" -- assuming that all patients consume some alcohol may yield more forthright answers. Probe responses by asking about frequency (how many days per week on average) and quantity (how many drinks on a typical day).
- Alternatively, incorporate a short substance abuse screening instrument, like the 4-item CAGE or CAGE-AID (adapted version that also includes drug abuse), into a health status questionnaire that all patients complete before their appointment. When substance abuse is indicated, follow-up with additional interview questions to learn more.
- Patients may be less honest about drug use, but many signs and symptoms of drug use can be identified through the physical exam, laboratory, or toxicological testing.

### Related Resources:

- [Assessment and Screening Instruments](#)  
**Description:** This document provides links to several substance use screening instruments.  
**Source:** American Society of Addiction Medicine (ASAM)

## DSM 5 CRITERIA FOR SUBSTANCE USE DISORDER

**Opioid Use Disorder Description:** A pattern of using opioids that causes "clinically significant impairment or distress" and meets at least 2 of the following criteria:

**Opioid Use Disorder Criteria:**

A minimum of 2-3 criteria is required for a mild substance use disorder diagnosis, while 4-5 is moderate, and 6-7 is severe (APA, 2013). Opioid Use Disorder is specified instead of Substance Use Disorder, if opioids are the drug of abuse. Note: A printable checklist version is linked below

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 unable to carry out major obligations at work, school, or home due to opioid use
6. Continued 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. Recurrent use of opioids in physically hazardous situations
9. Consistent use of opioids despite acknowledgment of persistent or recurrent physical or psychological difficulties from using opioids
- 10.\*Tolerance 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)

\*This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision.

## RECOGNIZING OPIOID WITHDRAWAL

In many patients, you will be able to identify opioid withdrawal by observing the patient and through physical exam.

### Look For The Following Signs And Symptoms Of Withdrawal:

- drug craving
- anxiety
- drug-seeking behavior
- yawning
- sweating
- lacrimation
- rhinorrhea
- mydriasis
- gooseflesh
- muscle twitching
- anorexia
- insomnia
- increased pulse, respiratory rate, and blood pressure
- abdominal cramps
- vomiting
- diarrhea
- weakness

You may wish to use the Clinical Opioid Withdrawal Scale (COWS), or one of the other opioid withdrawal scales listed below, to assess a patient's level of withdrawal. Many clinicians use this assessment tool with patients during the first stages of buprenorphine induction.

### Buprenorphine Withdrawal

Buprenorphine's high affinity and low dissociation contribute to its long therapeutic half-life and relatively mild withdrawal syndrome.

### [Related Resources:](#)

#### DSM-5 Criteria For Opioid Withdrawal

Description:

Lists DSM-5 Criteria for Opioid Withdrawal

Opioid withdrawal occurs in opioid-dependent individuals who reduce or stop their opioid use or who take an opioid antagonist (precipitated withdrawal). Because of its high affinity but low activity at opioid receptors, buprenorphine can act as an antagonist in some patients.

## DSM-5 Criteria for Opioid Withdrawal

A. Either of the following:

- cessation of (or reduction in) opioid use that has been heavy and prolonged (several weeks or longer)
- administration of an opioid antagonist after a period of opioid use

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

- dysphoric moods
- nausea or vomiting
- muscle aches
- lacrimation or rhinorrhea
- pupillary dilation, piloerection, or sweating
- diarrhea
- yawning
- fever
- insomnia

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

D. The signs or symptoms are not due to another medical condition and are not better accounted for by another mental disorder, including intoxication or withdrawal from another substance.

The ICD-10-CM code with moderate or severe opioid use disorder is F11.23. (Do not use withdrawal code with mild opioid use disorder.) The ICD-9 CM code was 292.0.

(Reprinted with permission from Diagnostic and Statistical Manual of Mental Disorders, 4th ed, Text Revision. Copyright © 2000 American Psychiatric Association.). Updated to: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing.

- [Clinical Opioid Withdrawal Scale \(COWS\)](#)

**Description:** This PDF Document contains the Clinical Opioid Withdrawal Scale (COWS), a common instrument used to assess a patient's opioid withdrawal severity.

**Source:** California Society of Addiction Medicine (CSAM)

- [Objective Opiate Withdrawal Scale \(OOWS\)](#)

**Description:** 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.

**Source:** Reprinted from Handelsman, L., Cochrane, K. J., Aronson, M. J., et al. (1987) Two new rating scales for opiate withdrawal. American Journal of Drug and Alcohol Abuse, 13 (3), 293–308. By courtesy of Marcel Dekker, Inc.

- [Subjective Opiate Withdrawal Scale \(SOWS\)](#)

**Description:** Annex of opioid withdrawal scales for downloading includes the Subjective Opiate Withdrawal Scale (SOWS). The SOWS contains 16 symptoms whose intensity the patient rates on a scale of 0 (not at all) to 4 (extremely).

**Source:** Reprinted from Handelsman et al. 1987, p. 296, by courtesy of Marcel Dekker, Inc.

## SIGNS AND SYMPTOMS OF POLYSUBSTANCE ABUSE



Patients with opioid use disorders commonly have problems with other substances as well; in fact, polysubstance abuse is considered the norm rather than the exception (Patrick, 2003).

Among opioid addicts, cocaine and alcohol are the most frequently abused substances (Strain, 2002). Many also commonly misuse other prescription medications.

The signs and symptoms of polysubstance abuse include some of the same indicators for drug use in general.

Patients may or may not be dependent upon the various substances they are abusing, so it is important for you to assess the entire range of a patient's substance use.

### **Try These 4 Main Approaches For Assessing Opioid Dependent Patients For Other Substance Abuse:**

- Screening instruments: DAST, CAGE-AID, AUDIT
- Clinical assessments: ask patient directly, ask family members
- Laboratory tests: urine samples, preferably tested on-site or via a lab with a quick turn-around time so that you can address results with the patient as soon as possible

## URINE TESTING IN BUPRENORPHINE TREATMENT

**Description:**

Information on the logistics of urine testing, including the timing of testing, frequency, location, and test type.

Being able to accurately gauge the current drug use by patients enrolled in a substance abuse program is essential; self-reports, family member reports, observation of attitude alteration, and behavior changes are generally insufficient. Therefore, urine testing is an integral part of the office-based buprenorphine treatment program and should be explained as such to patients during the initial discussion of the treatment rules and expectations. Patients must understand that this, too, is an ongoing part of their treatment.

**Considerations**

Because it is an ongoing part of buprenorphine treatment, the provider must make several fundamental decisions about urine testing procedures.

<b>Timing of Testing</b>	A plan for urine testing must include a decision between random and scheduled testing. Random testing dramatically increases the probability of detecting illicit drug usage: Patients can no longer plan their drug usage around a testing schedule. A possible method of implementing random testing may require patients to call the office on scheduled days to ascertain whether that particular day will be a testing day.
<b>Frequency of Testing</b>	The provider must also consider the frequency of testing. In methadone maintenance programs, more frequent testing provides a more complete picture of drug use habits, thus helping to direct treatment (Wasserman et al., 1999). SAMHSA (2004) recommends administering monthly urine tests to patients being treated for opioid dependence. These tests should screen not only for continued opioid use but also for use of other illicit drugs (SAMHSA, 2004).
<b>Collection Methods</b>	Collection monitoring is an important consideration in urine testing -- direct observation is the most definite mechanism of observation. By requiring the patient to leave coats, purses, etc., outside the bathroom and having a same-sex observer present, the chances of obtaining a doctored sample are minimized. If direct observation is not desired or possible, thermometers or testing machines that analyze urine temperature are an appropriate substitute. If patients have a substantial commute, providers may consider testing the patient in a location outside the office, although similar monitoring considerations must be taken into account at collection times. To prevent patients from tampering with their samples using available materials, collection facilities could lack soap dispensers and cleaning agents (NIDA, 1986). If dilution of urine is a concern, consider dyeing toilet water or installing a chemical toilet (NIDA, 1986).
<b>On-Site Versus Off-Site Testing</b>	Providers must decide whether on-site or off-site urine testing is the more appropriate choice for their treatment program. Each has its advantages. Advantages of on-site testing include less handling of the specimen, which will reduce the potential for mistakes, a "greater sense of confidentiality," and quicker results (NIDA, 1986). However, in most cases, a positive result should be confirmed using a different testing technique at an off-site laboratory (NIDA, 1986). Advantages of off-site testing include immediate access to additional tests to confirm a positive initial result, which also decreases potential mistakes, and expertise of the laboratory staff (NIDA, 1986). If testing is to be done off-site, specimens should be stored in a secure (locked) location until they are shipped (NIDA, 1986). Regardless of where analysis is done, be sure to secure all sampling accoutrements,

	such as cups, lids, and labels.
<b>Test Type</b>	Urine testing for opioids can be done either by immunoassay or by laboratory-based, drug-specific identification using gas chromatography, mass spectrometry, high-phase liquid chromatography, or a similar technique. Immunoassays are fast, easy to use, and reliably detect any natural opioids (codeine, morphine, heroin) that are present. However, immunoassays often do not detect semisynthetic (oxycodone, buprenorphine) and synthetic (fentanyl) opioids (Gourlay et al., 2002). While methadone is a synthetic opioid, immunoassays have been developed specifically to detect it (SAMHSA, 2004). Drug-specific identification is more time consuming and detects only one drug per test, but it is reliable for all drugs (Gourlay et al., 2002).

- [Drug Abuse Screening Test \(DAST\)](#)  
**Description:** Concerned about your use or abuse of drugs? With 20 questions, this simple self-test may help you identify aspects of your drug use which could be problematic. This test specifically does not include alcohol use.  
**Source:** Counselling Resource

## CAGE-AID

**Description:**

Screening test for alcohol and drugs.

One of the most commonly used standardized screening tools for detecting drug use problems is the CAGE-AID, a variation on the CAGE instrument that was originally created to screen for alcohol use. Brown et al., (1998) modified the CAGE questionnaire to add screening for drug use (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?

**Scoring:** A patient who answers positively to 2 or more questions is considered to be at risk.

The CAGE-AID questionnaire is reprinted with permission from <sup>1</sup> Dr. R.L. Brown.

## AUDIT SCREENING FOR ALCOHOL USE DISORDER

- [AUDIT Questionnaire](#)
- **Description:** The Alcohol Use Disorders Identification Test, or AUDIT, is comprised by ten questions that ask about the frequency and amount of alcohol consumption, the ramifications of the patient's drinking, and the concern of others for the patient's behavior. Patients are to be presented the form so that they can circle answers for each question. The AUDIT takes about 3 minutes to administer and score.
- **Source:** <https://www.sbirt.clinicalencounters.com>

## MEDICAL COMORBIDITIES WITH OPIOID DEPENDENCE

Medical complications can result from the opioid itself, as well as from the way it is administered. The main medical complications among the opioid-dependent population are related to injecting heroin.

### **Routine Testing Helps Identify These High-risk Individuals For Blood-borne And Infectious Diseases Including The Following:**

- HIV
- Hepatitis B and C
- Tuberculosis
- Syphilis

### **These Tests Also Help Identify Important Risks:**

- CBC to detect occult infection
- Genital examination for chlamydia, gonococcal disease, and human papilloma virus
- Skin examination for cellulitis

### **Related Resources:**

- [Common Comorbidities in Patients in Medication Assisted Treatment](#)  
**Description:** This webpage is part of the SAMHSA website section on Medication Assisted Treatment. The common comorbidities include viral hepatitis, HIV, and certain mental health problems.  
**Source:** Center for Substance Abuse Treatment (CSAT)
- [Psychosocial Aspects of Treatment in Patients Receiving Buprenorphine / Naloxone](#)  
**Description:** Discussing the psychosocial aspects of treatment in patients receiving Buprenorphine/Naloxone (See section on psychosocial)  
**Source:** Physician Clinical Support System (PCSS-MAT)
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## ASSESSING AND SELECTING PATIENTS FOR BUPRENORPHINE TREATMENT

Some patients are better suited than others for buprenorphine treatment. Additionally, some patients are more challenging than others, either due to complicated medical or psychiatric issues, or problematic behaviors.

When first starting your buprenorphine practice, you may want to treat "easier" patients until you feel 100% comfortable with the induction and stabilization processes. Use a checklist and/or treatment screening form to assess patients before initiating treatment.

### **Review These Conditions That Might Make A Patient A Less Optimal Candidate For Buprenorphine Treatment:**

- significant medical problems (especially for psychiatrists)
- significant psychiatric comorbidity (especially for non-psychiatrists)
- chronic suicidal or homicidal thoughts (especially for non-psychiatrists)
- polysubstance use, including alcohol dependence
- dependence on benzodiazepines or other CNS depressants
- significant pain not management with non-opioid treatment alone
- frequent relapses in prior treatment attempts
- administrative discharges from more structured treatment settings (i.e. methadone maintenance)
- pregnancy (methadone is the standard of care for opioid-dependent pregnant women)
- any other condition that you feel is outside your realm of expertise

# SUMMARY

- Screen every patient over 12 for substance abuse
- Consider using a short, validated questionnaire
- Consider the risk factors
- Look for physical and psychological signs and symptoms
- Be familiar with common medical and psychiatric comorbidities
- Be familiar with signs of withdrawal

*The End*

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<p>Brown RL, Rounds LA. <i>Conjoint Screening Questionnaires for Alcohol and Other Drug Abuse: Criterion Validity in a Primary Care Practice</i>. <i>Wis Med J</i>. 1995;94(3):135-140.</p>

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## REFERENCES

1. Brown RL, Rounds LA. Conjoint Screening Questionnaires for Alcohol and Other Drug Abuse: Criterion Validity in a Primary Care Practice. *Wis Med J*. 1995;94(3):135-140.