ASSESSING PATIENTS FOR BUPRENORPHINE TREATMENT

Goal
To train providers to assess whether patients having opioid use disorder meet criteria for receiving office-based buprenorphine treatment and select patients who are suitable.

After completing this module, participants will be able to:
• Assess whether patients having opioid use disorder are appropriate for office-based buprenorphine treatment
• Identify patients who are not good candidates for office-based buprenorphine treatment
• Anticipate common medical and psychiatric problems in patients with opioid use disorder that may complicate its treatment
• Adjust assessment to meet needs of patient groups having specific additional requirements, including adolescents, pregnant women, and geriatric patients
• Develop an individualized buprenorphine treatment plan for patients
• Determine what referral is appropriate for the treatment of opioid use disorder when patients are not good candidates for office-based treatment

Practice Gap
Providers need to be able to assess patients with opioid use disorder for appropriateness for office-based opioid treatment. TIP 40, Chapter 3, is on Patient Assessment, focuses on patient assessment in the treatment of opioid use disorder. The FSMB Model policy also describes 6 critical aspects of patient assessment.
**QUIZ: THINK AHEAD CASE – MR. REYES**

**Name:** Mr. Reyes  
**Age:** 30 years old  
**Reason For Visit:** Mr. Reyes, a schoolteacher, is having difficulty with work because he has been calling in sick too much.

**Patient History:** Mr. Reyes injects heroin at least once daily and also regularly takes large quantities of codeine pills. He has been injecting heroin on and off since he was 16 years old. A few years ago, he was in an automobile accident that resulted in a back injury. Following the accident, he experienced back pain for which he needed codeine. The back pain has since resolved, but he still takes large quantities of codeine pills, from several providers, to stave off heroin withdrawal.

**Treatment History:** Mr. Reyes has a history of several outpatient detoxifications and three residential drug treatment stays without opioid pharmacotherapy. He remained heroin-free and codeine-free for about 6 months following the last treatment, which was about a year ago. He also has been alcohol abstinent for the past two years. His only current medical problem is that he is hepatitis C positive, and he has been so for at least 10 years. His liver function tests are currently in the acceptable range for buprenorphine treatment.

**With What You Now Know, Is Mr. Reyes A Good Candidate For Office-based Buprenorphine Treatment At This Time? (Choose The Best Answer)**
1. Yes, he may be a good candidate for office-based buprenorphine treatment at this time  
2. No, intensive outpatient counseling and groups are his best option at this time  
3. No, medically supervised withdrawal only is his best option at this time
**CASE – MR. REYES QUIZ FEEDBACK**

1. **Yes, He May Be A Good Candidate For Office-based Buprenorphine Treatment At This Time**
   
   **Correct.** Mr. Reyes may be a candidate for office-based buprenorphine treatment. Even though he failed very intensive treatment before, opioid maintenance therapy was not offered in those treatments and could be tried. Intensive outpatient treatment is likely to interfere with work obligations, and privacy is especially important in his profession. Due to several unsuccessful attempts at detoxification in the past, maintenance as part of his treatment plan will be particularly important. He will also need supportive counseling as part of his plan, which could be offered at evening or weekend appointments. Having maintenance continue for now does not preclude the possibility of attempting to taper the buprenorphine at some point in the future.

2. **No, Intensive Outpatient Counseling And Groups Are His Best Option At This Time**
   
   Saying "No" to office-based buprenorphine treatment is not the best answer. Intensive outpatient treatment is likely to interfere with work obligations, and privacy is especially important in his profession.

3. **No, Medically Supervised Withdrawal Only Is His Best Option At This Time**
   
   This is not the best answer at this time, because Mr. Reyes has had several unsuccessful attempts at detoxification in the past. Even though he failed very intensive treatment before, opioid maintenance was not offered in those programs and could be tried. Maintenance therapy is particularly important for him as part of his treatment plan because of the past failed attempts at detoxification.
GUIDELINES FOR PATIENT ASSESSMENT

The Assessment Process

This part of the training assumes that you have completed the training on screening, detection, and diagnosis of opioid use disorder. For patients that you have diagnosed opioid use disorder, evaluate their illness and comorbidities thoroughly to determine if buprenorphine treatment is the optimal treatment for them. If so, then determine how to tailor the treatment to meet their needs.

On rare occasions, patients who are not currently physically dependent on opioids are still candidates for office-based opioid treatment. Patients in this category include those with a history of opioid addiction and those who have failed with other treatment modalities.

Patients who are not physically dependent on opioids and who do not have opioids in their system can proceed directly to the induction phase on a very low dose to avoid over-medication.

The process before starting buprenorphine treatment includes:

1. Assessment of the diagnosed opioid use disorder
2. Assess for other substance abuse
3. Address tobacco use
4. Medical evaluation
5. Assess for comorbidities
6. Assess for pain
7. Assess common psychiatric comorbidities
8. Consider cultural factors
9. Consider other factors
10. Identify unlikely candidates and refer if necessary
11. Determining the patient's readiness to start and comply with treatment
12. Determine if office-based opioid treatment is appropriate and, if so, what level of treatment is needed
13. Finalize the treatment plan
ASSESSMENT OF THE DIAGNOSED OPIOID USE DISORDER

It is essential to assess the extent of other drug use before starting treatment. Patients with opioid use disorders commonly have problems with other substances as well.

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

Assessment of the patient’s opioid use disorder includes obtaining the following information:

1. Duration, pattern, and severity of opioid misuse. Assess their history of substance use as well as current use. Patients who misuse drugs, commonly use other drugs, tobacco, or alcohol. Drug misuse holds true for young adolescents as well.

2. The opioid they typically misuse, including whether it is short or long-acting

3. Level of tolerance (How effective is the dose?)

4. History of previous attempts to discontinue opioid use with or without agonist therapies and response to treatment

5. History of withdrawal episodes

6. Current opioid use or withdrawal status

Questions to Ask Patients

In Practice Guidance for Buprenorphine for the Treatment of Opioid Use Disorders, produced by expert panel process, they recommended asking patients:

- Whether they have any of the criteria for Opioid Use Disorder by DSM-5 Standards
- Their psychiatric history, paying attention to medication compliance
- Their medical history, with attention to liver and cardiac status, medications, and seizures
- Whether they are pregnant or planning to get pregnant
- The status of their psychosocial supports (Employment, family, housing, 12-step involvement)
- Their substance use history with attention to current substance use
- Their history of substance use treatment, including buprenorphine or methadone
- Obtain a witnessed urine drug screen to assess for current opioid agonist (methadone, buprenorphine) use or benzodiazepines
- Their withdrawal status
- Severity of their addiction.
- Potential treatment needs in relation to the provider’s ability to accommodate them (Intensive monitoring, legal system interactions, employers, etc.)
- Their pain status
Finding Good Candidates
Per the above guidelines patients who meet the following criteria are considered to be good candidates for treatment. The guidelines stem from a strong consensus by expert review and are not an assessment protocol.

- Currently experiencing opioid dependence
- Currently on methadone and are unwilling or unable to receive treatment from a methadone clinic
- Have adequate psychosocial support
- Do not have a co-occurring mental disorder OR the disorder is stable
- Not suicidal
- May be pregnant
- Expected to be reasonably compliant with treatment
- Not dependent on CNS depressants (benzodiazepines and alcohol included)
- Interested in treatment
ASSESS FOR OTHER SUBSTANCE ABUSE

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

Likely Substances

A National survey data conducted by SAMHSA asked respondents to identify any drugs they were dependent on or had abused during the past year of 2013. The order from most common to least common was:

1. Alcohol – most commonly used
2. Marijuana
3. Pain Relievers
4. Cocaine
5. Heroin
6. Stimulants
7. Tranquilizers – least commonly used among this list

Among opioid addicts, cocaine and alcohol are the most frequently abused substances.

The assessment should not be limited to just illicit drugs, because patients often take other prescription drugs. Even if other drugs taken do not fall into the typical classes of drugs of abuse, they can interfere with treatment by causing:

- Impairment
- Sedation
- Increasing the opioid effect

People who are addicted to heroin have high rates of other illicit drug use; around 75% reported concurrent heroin and cocaine use. Ask patients about all forms of opioids used. Screening urine drug tests typically test for morphine, opiates (means derived from opium and does not include synthetics), and oxycodone. Some opioids, such as fentanyl, may not be detected in screening tests.

Approaches For Assessing Opioid-Dependent Patients For Other Substance Abuse

Build rapport to improve the chance that they are comfortable telling you about substance use when using interviews and screening instruments to detect polysubstance use. Use motivational interviewing techniques to establish open communication and build rapport with your patients.

Otherwise, patients may downplay the use of other drugs if they think it could harm their chances of acceptance into treatment.

Clinical Assessments:

Beyond your efforts to ask patient directly, consider asking permission to ask family members as well.

A video that illustrates a provider substance-use screening during a patient interview can be found here: https://youtu.be/L-A4Wea3SaE
In the video, the provider demonstrates screening for tobacco, alcohol, and drug use during a patient interview. Specifically, he asks about:

- Current and past use of tobacco
- Frequency of alcohol use, amount she drinks per week, and number of times per year she binge drinks, i.e., drinks more than four drinks at a time
- Misuse of prescription pain medications
- Use of illicit drugs

**Physical Signs Of Possible Drug Use Include The Following:**

- Multiple traumas
- Frequent or recurring hospitalizations
- Infections – such as abscesses or cellulitis
- Confusion or disorientation

**Screening Instruments:** MAST, DAST, CAGE-AID, AUDIT

**Structured Interviews:** DSM SCID (Structured Clinical Interview For DSM- Axis I Disorders)

**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
- Screening urine drug tests that have been waived by CLIA for in-office testing commonly test for the following drugs: amphetamines, barbiturates, benzodiazepines, cocaine, ecstasy, marijuana, methadone, methamphetamine, morphine, opiates, oxycodone, phencyclidine, propoxyphene, and tricyclic antidepressants.  
  
Some people seeking buprenorphine treatment have already taken it, obtaining it illicitly. Knowing this would affect the induction process; however, some patients may hesitate to tell their providers. The screening for opiates does not detect buprenorphine. Therefore, consider including buprenorphine in urine drug tests, even before prescribing it. Several multidrug testing products include buprenorphine.

**Ask Patients About Self-Treatment**

Be sure to ask patients about any self-treatment of symptoms related to their opioid use disorder. Increasingly patients are presenting for buprenorphine treatment having already used it; obtaining it illicitly to control their withdrawal symptoms, either in an attempt to quit on their own or to control withdrawal when they cannot obtain the opioid to which they are addicted.

**Case Study – Mr. Harris**

**Meet Your Patient**

**Name:** Mr. Harris  
**Age:** 28 years old  
**Reason For Visit:** He wants “to try bup”.

**Patient History:** Mr. Harris says he has been seeing physicians at the VA, but they are “upset with me because I crushed my pain pills and snorted them, but I didn't use any more in a day than they told me I could. They don't like it, but it's the only way to stop the pain. Even then it's only for about 3 hours.”
Mr. Harris has undergone seven reconstructive surgeries. He has a history of shrapnel injuries to legs, arms, and face during military service 9 years ago. He says that he has a prescription for 80 mg oxycodone tablets, eight per day, for pain control. He reports drinking no more than three drinks per day, but he does drink at least five times a week at that rate.

**Mr. Harris – Conversation**

**Determining If Mr. Harris Is An Appropriate Candidate For Buprenorphine Treatment**

Mr. Harris is a patient with legitimate pain who also may have opioid use disorder. He has some concerning symptoms that suggest the diagnosis, but it is not yet clear if he is appropriate for buprenorphine treatment. For instance, he admitted to crushing and snorting his pain medication. Inappropriate administration of chronic pain medication (crushing/inhaling, or dissolving/injecting) does not in itself mean he has opioid use disorder, but it is a red flag. Patients with chronic pain may inappropriately change the method of administering a drug in order to achieve better pain control. Rather than addiction, his snorting misuse could also be to experience euphoria from opioids. Usually snorting crushed tablets would result in faster effect and shorter duration of action, making the medication more “abusable” and increasing the likelihood of addiction.

Some questions you should ask to determine whether Mr. Harris is an appropriate candidate for buprenorphine treatment include whether his opioid use is affecting his psychosocial circumstances and why he wants to try buprenorphine now.

**Provider:** I see from your chart that you are taking oxycodone. Who is prescribing it for you?

**Mr. Harris:** The doctor down at the VA gives it to me. He knows how much I hurt and that it helps ease my pain.

**Provider:** What happens when you don't take your prescription?

**Mr. Harris:** I hurt too much. Start getting the shakes and headaches.

**Provider:** How about lessening your dosage? Have you ever tried that?

**Mr. Harris:** Not if I can help it. Sometimes I have to stretch it before I can get back and get a refill, but I can't sleep well when I do that.

**Provider:** Have you ever tried other medications for your pain?

**Mr. Harris:** They don't do any good. The oxycodone seems to work the best for me.

**Provider:** But now you want to try buprenorphine treatment? Tell me, what's making you consider buprenorphine?

**Mr. Harris:** I know I'm not getting any better. And I'm relying on the oxycodone too much. I need to try something else.
ADAPTATIONS FOR POLYSUBSTANCE USE

Which Substances
Patients in the following populations may benefit from altered treatment. These include:

- Illicit buprenorphine users
- Heroin users
- Patients with other drug use disorders
- Patients with alcohol use disorder

Adaptations for Polysubstance Use
Patients who abuse more than one substance may or may not be dependent upon all of them, so with multiple substances being used, be sure to assess the patient's entire range of substance use before starting treatment.

Follow These Steps When Treating An Opioid-Dependent Patient Who Also Has Another Substance Use Disorder:
1. Stabilize the patient's opioid use problem first, which may include starting buprenorphine treatment.
2. Gradually withdraw them from the other substance(s)
3. Emphasize that formal counseling and recovery group meetings are mandatory because buprenorphine will not treat other drug problems
4. Make it clear that ongoing use of other substances will not be tolerated during buprenorphine treatment

These steps are just one approach – some clinicians require their patients to address their other substance abuse first (stopping on their own or going through detoxification) before starting buprenorphine treatment. For instance, alcohol or benzodiazepine dependence can be life-threatening and should not be overlooked in favor of treating opioid dependence.

The VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders recommends that patients with multiple substance use disorders be managed according to guidelines for each disorder.

Additional Considerations
- Some patients with polysubstance abuse will require the greater structure and support of a methadone or residential treatment program, so proceed with caution before starting office-based buprenorphine.
- Be aware of prescribing buprenorphine in patients who abuse alcohol and in those who abuse sedatives, especially benzodiazepines, because of possible fatal drug interactions between the two drugs.
- Abrupt elimination of all substance abuse problems simultaneously is often not successful.
QUIZ: MR. HARRIS – DIAGNOSIS AND PLAN

Preliminary Diagnosis
- History of pain syndrome, r/o chronic pain
- Misuse of prescription opioids, r/o opioid use disorder
- Alcohol use, r/o alcohol use disorder

Based On What You Know And His Preliminary Diagnoses, Is Mr. Harris A Good Candidate For Buprenorphine Treatment? (Choose One)
1. Yes, he fits the criteria for being a good candidate for treatment now.
2. No, he is not a good candidate for treatment and further evaluation is not needed.
3. Further evaluation is needed to determine whether office-based opioid treatment with buprenorphine is a good choice for him.
**Mr. Harris – Diagnosis and Plan Quiz Feedback**

**1) Yes, He Fits The Criteria For Being A Good Candidate For Treatment Now**

**2) No, He Is Not A Good Candidate For Treatment And Further Evaluation Is Not Needed.**

It appears that Mr. Harris is **not** a good candidate for buprenorphine maintenance at this time; he requires further evaluation. A complete evaluation for opioid use disorder and more about his history and current drug use is warranted in order to determine his candidacy. Recommended next steps are as follows:

- Determine the basis of his behavior in crushing his medication
- Provide appropriate pain management and dose control for indicated pain medications
- Give information about opioid use disorder, and risk of misusing and borrowing medications to "get high"
- Coordinate care with all prescribers and other providers to better monitor this patient
- Conduct ongoing evaluation to aid in full diagnosis

**3) Further Evaluation Is Needed To Determine Whether Office-based Opioid Treatment With Buprenorphine Is A Good Choice For Him.**

**Correct.** It appears that Mr. Harris is not a good candidate for buprenorphine maintenance at this time; he requires further evaluation. To determine his candidacy, complete an evaluation for opioid use disorder and learn more about his history and current drug use. Recommended next steps are as follows:

- Determine the basis of his behavior in crushing his medication
- Provide appropriate pain management and dose control for indicated pain medications
- Give information about opioid use disorder, and risk of misusing and borrowing medications to "get high"
- Coordinate care with all prescribers and other providers to better monitor this patient
- Conduct ongoing evaluation to aid in full diagnosis
TOBACCO USE

The prevalence of tobacco use is extremely high in patients with opioid use disorder – about three times more prevalent than tobacco use in the general population\textsuperscript{16}.

The rate of comorbid cigarette smoking with opioid addiction is high, and the rate of smoking cessation is low. More than 80\% of patients with opioid use disorder smoke cigarettes\textsuperscript{17}.

Quitting In The Context Of Substance Use Disorder Treatment

Despite well-established health effects from tobacco use, few substance abuse treatment programs address smoking\textsuperscript{18}. Aside from harm from smoking itself, smoking a cigarette functions as a cue for drug and alcohol craving\textsuperscript{19,20}. Within buprenorphine treatment, quitting smoking is rarely encouraged, in part from an assumption that patients do not want to quit\textsuperscript{21}. Several studies found that smokers in substance abuse treatment are aware of the harmful health effects of smoking and wish to quit\textsuperscript{22}.

Other incorrect assumptions include that quitting may worsen psychiatric symptoms\textsuperscript{21} or quitting attempts may negatively affect opioid abstinence\textsuperscript{23}. Studies have found that quit attempts during substance abuse treatment do not, for the most part, have the feared adverse effects on psychiatric symptoms or abstinence:

- Significant smoking cessation rates are possible while in opioid treatment\textsuperscript{24}. Integrating smoking cessation into substance abuse treatment can be done without threatening recovery goals\textsuperscript{22}.
- Other studies found that patients who are smoke-free during treatment and at follow-up are almost twice as likely to have drug-free urine specimens compared to patients who continue to smoke\textsuperscript{25,26}.
- However, concurrent smoking cessation treatment for patients with alcohol use disorder demonstrated a higher relapse rate when compared to patients whose smoking cessation treatment was delayed\textsuperscript{27}.

The effectiveness of smoking cessation with buprenorphine treatment needs further research.

Use A Routine Approach To Tobacco Cessation

Treatment for tobacco use disorder requires the following:

1. Screening: Ask all patients if they use tobacco or have used it in the past. Also, ask if they are exposed to second-hand smoke.
2. Advise current tobacco users to quit
3. Assess for readiness to quit
4. Provide a combination of counseling and pharmacological support, which is more effective than either approach alone\textsuperscript{28}.
   - Telephone quit-lines (most states have their own or use a national quit-line 1 800 QUITNOW) and online counseling have proven effective for many patients\textsuperscript{28}. Counseling can also be in person using a motivational interviewing approach, such as has been recommended in this program for opioid use disorder.
   - Effective pharmacological supports include varenicline (Chantix\textsuperscript{®}), bupropion (Zyban\textsuperscript{®}), and nicotine replacement, keeping in mind the precautions that are well-described on current package inserts.
5. Referral to tobacco cessation specialists may be indicated when routine treatment is not sufficient\textsuperscript{18}.
**Poll: Among your patients who are opioid-addicted and use tobacco, would you recommend tobacco cessation?**

- Yes, I would treat both the tobacco addiction and the opioid addiction
- Yes, but I would focus on the opioid addiction first
- No, tobacco use isn't necessary in this situation

What do you think? Take the poll yourself!

[https://bup.clinicalencounters.com/assessing-patients-poll/](https://bup.clinicalencounters.com/assessing-patients-poll/)
ALCOHOL USE

Co-Occurring Alcohol Use Disorder And Opioid Use Disorder
Co-occurring alcohol use disorder and opioid use disorder is common: Clinical trials show that around 38% of patients seeking treatment for problematic opioid use have concurrent alcohol use disorder.[29,30]

Screening For Alcohol Use Disorder
Patients who screen positively for alcohol use should be thoroughly assessed for alcohol use disorder, including severity, before starting buprenorphine treatment. The AUDIT is widely used in primary care to screen for alcohol use disorder. Patients will generally underestimate their alcohol use, so getting an accurate report may be difficult. However, patients with alcohol use disorder can usually be identified during the clinical exam at the office visits that are required prior to buprenorphine induction.

Guidelines For Buprenorphine Treatment Regarding Alcohol Use
A number of considerations are important regarding treating co-occurring alcohol use and opioid use disorders:

- It is essential to optimal patient outcomes to treat all substance use disorders when treating one.[31]
- Patients with alcohol use disorder are rarely good candidates for office-based buprenorphine treatment, especially if it is severe. However, a person with severe alcohol use disorder may do well on buprenorphine in an Opioid Treatment Program (OTP). At an OTP, buprenorphine dosing can be observed at a dispensing window, with daily breath tests for alcohol, which is what is often done with methadone treatment.
- Patients may present at induction experiencing withdrawal from both alcohol and opioids. Buprenorphine does not control seizures caused by withdrawal from alcohol.
- Patients should be advised to abstain from alcohol use while taking buprenorphine.
- Treating a patient with co-occurring alcohol and opioid use disorders depends on your comfort level and resources available to you. These patients tend to present unique problems and may benefit from referral to more intensive treatment.
- Some clinicians require these patients to undergo inpatient alcohol detoxification before starting them on buprenorphine. Benzodiazepines are often used to ease withdrawal symptoms during alcohol detoxification, so it is best if patients are not on buprenorphine at the same time.
- After detoxification, patients who are then inducted onto buprenorphine should be closely monitored for resumed alcohol use. Patients with a history of alcohol use disorder may be more likely to return to drinking once they are abstinent from opioids.

CAUTION TIP
Alcohol is a depressant and when taken with buprenorphine can cause overdose, respiratory depression, and death.[32]

Patients who have substance use disorder involving sedative-hypnotics, including alcohol, are rarely appropriate for buprenorphine treatment.[33]
HEROIN USE

Heroin users and prescription opioid misusers, on the average, differ in a number of ways affecting buprenorphine treatment. For example, comorbidities associated with heroin use may reduce success rates with buprenorphine. Similarly, IV drug use decreases the chances of successful treatment in an office-based opioid treatment setting, but this does not mean it is not possible. This information suggests that patients addicted to heroin and especially with comorbidities and IV drug use would be likely to benefit from additional treatment structure. A signed, written patient-provider treatment agreement can help reinforce the enhanced structure.

Differences that have been demonstrated include the following:

- Prescription opioid-addicted patients were typically older and with higher levels of employment. They were more likely to be involved in his or her psychiatric treatment and report pain than heroin using patients according to one study.34
- Prescription opioid-addicted patients had higher retention rate in treatment, fewer positive opioid urine tests, and more weeks of continuous abstinence according to another study.35
- The prescription opioid group had higher mean incomes, used opioids for a shorter amount of time, and were less likely to have participated in drug treatment before in another study.35
- Although it is not recommended treatment, when patients do taper off buprenorphine, those who were dependent on prescription opioids are more successful than those who were dependent on heroin. More prescription opioid patients provided an opioid-free urine sample 3 months post-taper than their heroin counterparts in another study.36

Results from one large study (START) suggest that some of these differences may be related to severity of addiction rather than type of opioid of abuse.37

FYI: The Prevalence Of Heroin Use

SAMHSA national survey data has shown an almost 50% increase of heroin use in the 2002-2013 period.38 The prevalence of heroin use remained fairly stable during 2002-2007 with fewer than 400,000 users but then increased significantly up to 681,000 during the 2007-2013 period.38,39

Evaluating and Treating Heroin Users

Assessment

Screen and/or examine heroin-dependent patients for these conditions:

- HIV/AIDS
- Hepatitis B and C
- Other infectious diseases, e.g., tuberculosis and STDs
- Other drug use and/or alcohol abuse
- Tobacco dependence
- Gingivitis and periodontal disease
- Bacterial infections
• Skin abscesses
• Other skin/tissue infections – ulceration, cellulitis, abscesses, endocarditis, and tetanus
• Respiratory complications – non-cardiac pulmonary edema and narcotic lung (a combination of edema and congestion that results from heroin overdose).
• Comorbid psychiatric disorders

**Treatment**
Heroin is a short-acting opioid. Patients who are dependent on heroin should abstain from use for 4-24 hours before the first dose of buprenorphine in order to prevent precipitated withdrawal.

Patients who are dependent on heroin (especially intravenous heroin users) often have other associated health issues.

**Poll: How comfortable are you with providing office-based opioid treatment to patients who report other substance use?**
• Very comfortable
• Somewhat comfortable
• Somewhat uncomfortable
• Very uncomfortable

Let us know what you think!

https://bup.clinicalencounters.com/methadone-poll/
MEDICAL EVALUATION

Practice Guidance for Buprenorphine for the Treatment of Opioid Use Disorders, produced by expert panel process, recommends the following be assessed:

**Medical History And Physical**
Pay attention paid to liver and cardiac status, medications, and seizures. Ask women of childbearing age if they anticipate pregnancy or are currently pregnant.

**Medications:**
Verification of patient list of medications and cross check with buprenorphine including benzodiazepines, gabapentin, other opioids, and drugs metabolized by the CYP 3A4 System.

**Laboratory Tests:**
- Screening for use of illicit drugs, misuse of prescription drugs, and alcohol use
- Liver function tests – patients with elevated liver function 3 to 5 times above normal should not be considered for buprenorphine
- Urine toxicology – Screen for naturally occurring opioids (heroin is detected as morphine), synthetic and semisynthetic opioids (methadone, oxycodone), and other commonly abused drugs such as cocaine, amphetamines, and benzodiazepines
- Pregnancy test
- HIV and viral hepatitis serologies

**Liver Function:** Elevated liver enzymes are not a contraindication to treatment, but they should be assessed and monitored frequently especially with a history of injection of opioids, because of the associated risk of viral hepatitis.

**Cardiac status:** Similarly, assess and monitor cardiac status due to a higher risk of arrhythmia, cardiomyopathy, heart murmur, endocarditis, pericarditis, thrombophlebitis, mycotic aneurysm with opioid use disorder, especially illicit, injection use.

**Seizures:** Use buprenorphine with caution in patients with seizures due to drug interactions with antiseizure medications. Interactions with sedative-hypnotics, such as phenobarbital and clonazepam, should also be considered.

**Self Treatment Of Opioid-Induced Constipation**
Patients sometimes take loperamide (Imodium®), the over-the-counter antidiarrheal medication, which is a μ receptor agonist, at doses far beyond therapeutic doses, to control withdrawal symptoms from opioids. Self-administered, dangerously high doses of 30 to 200 mg, sometimes augmented by taking a P-glycoprotein inhibitor (e.g., verapamil), have clinical manifestations of opioid toxicity, including miosis, CNS depression, and respiratory depression as well as cardiac dysrhythmias. Overdoses can result in death. Ask patients presenting with unexplained syncope or unexplained prolongation of the QRS or QTc intervals about whether they have taken loperamide. In two reported cases of death associated with taking loperamide, the patients were concurrently on buprenorphine and previously on buprenorphine respectively.
ASSESSING FOR COMORBIDITIES

Comorbidities To Assess
In addition to assessing opioid use disorder, other dimensions of patient health affect the course and setting of treatment:

- Medical comorbidities including chronic pain
- Psychiatric comorbidities
- Other substance use

Although it would benefit the patient to integrate treatment for comorbidities in one setting, this might prove too complicated for primary care. A more intensive treatment setting may be appropriate.

THINK AHEAD
Keeping in mind that up to 60% of patients with opioid use disorder also have other substance use disorders, what special considerations does this population need?

Common Medical Comorbidities of Opioid Use
Infectious and sexually transmitted diseases, as well as liver and nutritional problems, are all common among patients with opioid use disorder, but any body system can be affected.

Medical comorbidities often associated with opioid use disorder, especially from illicit drug use include:

- Hepatitis B and C
- HIV or AIDS
- Sexually transmitted diseases
- Liver diseases
- Nutritional problems
- Chronic pain

A physical exam can focus on evaluating:

- Neurocognitive function
- Effects of chronic opioid misuse
- Hepatic function

Organized by system, the following complications are common among opioid abusers:

**Skin:** Track marks, cellulitis

**Infectious Diseases:** Tuberculosis, HIV, hepatitis (A, B, C, D), syphilis, pelvic inflammatory disease, other sexually transmitted diseases

**Obstetric-Gynecological:** Amenorrhea, pregnancy, birth complications, spontaneous abortion

**Cardiovascular:** Arrhythmia, cardiomyopathy, heart murmur, endocarditis, pericarditis, thrombophlebitis, mycotic aneurysm

**Gastrointestinal:** Hepatitis, cirrhosis

**Hematological:** Anemia, thrombocytopenia
Assessing Patients for Buprenorphine Treatment

Pulmonary: Pulmonary edema, chronic obstructive pulmonary disease, chronic cough, pneumonia

Immune Function: Lymphadenopathy, lymphocytosis

Musculoskeletal: Fractures, osteomyelitis, septic arthritis, aseptic necrosis

Neurological: Brain, epidural, or subdural abscess; fungal meningitis; stroke; neuropathy; head injury

Nutritional: Vitamin/mineral deficiency, malnutrition

Trauma: Motor vehicle accident, pedestrian accident, falls, head injury

Quiz: Case Study – Mr. Santos

Name: Mr. Santos
Age: 58 years old

Reason For Visit: Mr. Santos came to your office with his wife to request buprenorphine treatment.

Patient History: He recently started using heroin again at present, he uses about "three to four grams a day." He is also being treated for HIV. He says that his "inpatient detox worked with buprenorphine, but now I started using heroin again, and I'm afraid it will mess up my HIV treatment." Mr. Santos has been using heroin since age 25. He was diagnosed as having PTSD after witnessing the death of his parents as a young adult but received extensive treatment for this. His wife, Linda, says he still has occasional nightmares. She keeps track of his HIV medications and makes him take them every day, but now that he has relapsed she is threatening to leave. She says, "I just can't be around him when he's using drugs every day."

Treatment History: Mr. Santos mentions that he has previously used buprenorphine during an inpatient detox.

With What You Now Know, Is Mr. Santos A Good Candidate For Buprenorphine Treatment In Primary Care? (Choose One)

1. Yes, because it is likely he has opioid use disorder and seems to be interested in treatment.
2. Yes, because he has had success in the past with detoxification using buprenorphine.
3. No, because his HIV will complicate treatment too much.
4. No, because PTSD complicates treatment too much.
CASE STUDY – MR. SANTOS QUIZ FEEDBACK

(1) Yes, Because It Is Likely He Has Opioid Use Disorder And Seems To Be Interested In Treatment.
Possibly. With the facts that you have so far, Mr. Santos seems like he may be an appropriate candidate for buprenorphine treatment. You will have to explore his history of use and treatment attempts further and learn more about his medical and psychiatric problems before proceeding, however. Given the known history regarding past PTSD and current relationship problems, concurrent counseling is indicated.

(2) Yes, Because He Has Had Success In The Past With Detoxification Using Buprenorphine.
That is not the best answer. Taking buprenorphine in the past for detoxification should not factor into your current evaluation. You will have to explore further his history of use and treatment attempts and learn more about his medical and psychiatric problems before proceeding. If there are no major problems, Mr. Santos would be an appropriate candidate for buprenorphine treatment. Given the known history regarding past PTSD and current relationship problems, concurrent counseling is indicated.

(3) No, Because His HIV Will Complicate Treatment Too Much.
That is not the best answer. His HIV is well-controlled and can be treated concurrently with opioid dependence. You will have to explore his history of use and treatment attempts further and learn more about his medical and psychiatric problems before proceeding, however. If there are no major problems, Mr. Santos would be an appropriate candidate for buprenorphine treatment. Given the known history regarding past PTSD and current relationship problems, concurrent counseling is indicated.

(4) No, Because PTSD Complicates Treatment Too Much.
Possibly incorrect. Severe psychiatric problems are a contraindication to buprenorphine treatment in the office. However, it is not clear that his PTSD is currently a severe problem. Evaluating this will be important. His HIV is well-controlled and can be treated concurrently with opioid dependence. You will have to explore his history of use and treatment attempts further and learn more about his medical and psychiatric problems before proceeding. Mr. Santos may be an appropriate candidate for buprenorphine treatment. Given the known history regarding past PTSD and current relationship problems, concurrent counseling is indicated.
EVALUATING PAIN

Many patients with opioid use disorder have chronic pain which complicates treatment. An ASAM Consensus Panel on buprenorphine treatment determined that there is insufficient data to recommend the use of buprenorphine for the treatment of acute or chronic pain in patients with a history of opioid use disorder\(^\text{33}\). A panel of experienced prescribers noted that patients having both chronic pain and opioid use disorder can be more challenging to treat in office-based opioid treatment\(^\text{42}\).

Assessment Tools

Screen buprenorphine treatment candidates for chronic pain as it could complicate treatment. Assess patients who have chronic pain further to understand and meet their need for pain management, especially if they have had opioids prescribed for pain management.

Pain assessment tools allow the patient a medium in which to express critical facts about the pain intensity, part of the body where it originates, type of pain, and how it impacts the quality of life. The Resources section at the end of this module lists several pain assessment tools.

PEG Scale:

A simple, 3 point questionnaire that can be used to evaluate chronic pain severity (P), interference with enjoyment of life (E), and interference with general activity or functioning (G). With only 3 questions, it is well-suited for a quick assessment.

Pain Assessment PQRSTU Acronym: Part 1: P, Q, R, And S Steps

The acronym PQRSTU can help clinicians remember all the factors to assess regarding pain:

**Provocation/Palliation/Past:**

- **Provocation:** What elicits pain or aggravates it/makes it worse?
- **Palliation:**
  - What makes it better? What has the patient tried? Include both pharmacological (over the counter and prescription) and non-pharmacological (e.g., ice/heat, massage, acupuncture, guided imagery, physical therapy, meditation)?
  - Response to treatment: How well did each treatment work? Any adverse effects?
  - What dosages of medications have other providers or the patient tried?
- **Past:** The same questions applied to the past. Also, what is the past history of this problem?

**Quality of Pain**

- For example, is the pain sharp or dull, throbbing? The McGill Pain Questionnaire includes a comprehensive list of pain descriptions\(^\text{9}\).

**Region of Pain/Radiation**

- **Region/Location of pain**
- **Radiation** of pain, whether it moves to other areas, for example, the visceral pain of a myocardial infarction may radiate to an arm or the jaw; sciatic nerve pain may radiate down the leg.
- Draw both "Rs," on a diagram (McGill Pain Questionnaire)

**Severity of Pain**
• Patients may have difficulty expressing the nature and intensity of their pain. Because pain is subjective, there is no completely objective way to detect it. Scales can help patients rate their pain severity, for example
  
  - **Numeric pain intensity scale**: Asks the patient to rate their pain intensity on a scale of 0 to 10 with 0 equaling no pain and 10 equaling the worst pain possible
  
  - **Visual analog rating scales**: Example – the Pain Thermometer, in which higher temperatures correspond to higher pain intensity. For children and those with cognitive impairment, the Faces Pain Rating Scale is a valid measurement that depicts a range from a very happy face to a very sad face\(^\text{10}\).  

**Pain Assessment Acronym: Steps T And U**

Pain thermometer used with permission of Keela Herr, Ph.D., R.N., The University of Iowa

**PRACTICE TIP**

The patient self-report is often the most reliable indicator of pain.

Sleep is another factor affecting and affected by chronic pain. Ask patients how well they are sleeping and ask about daytime sleepiness for two reasons:

Evaluate patients for sleep apnea before prescribing opioids because of the increased risk for potentially life-threatening respiratory depression. Also evaluate patients, who are already on chronic opioids, for sleep apnea because chronic opioids can induce this and other sleep irregularities\(^\text{43}\).

Supporting adequate sleep is an essential part of pain management. Chronic pain disrupts sleep both from the pain itself and from sleep irregularities caused by chronic opioids\(^\text{43}\). Support adequate sleep through patient education regarding sleep hygiene rather than by using benzodiazepines, due to the risk of overdose.

**Follow-up With Further Pain History Questions After the PQRSTU**

After listening and providing empathy for patient responses to the above questions, which cover a significant part of the chronic pain history, ask the patient for any further information needed about the following three basic areas of functioning\(^\text{44}\):

- **Psychological Functioning/Mood**: Does the pain affect your mood?
- **Daily Activities**: Does your pain keep you from doing daily activities, such as sleeping, walking, cleaning, shopping, work, play, or hobbies.
- **Social Functioning**: Does the pain affect your relationships?

The *Brief Pain Inventory* in the Resources section of this module is an example of pain assessment questionnaire that is reliable, valid, and may even be able to detect the origin of pain\(^\text{45}\).

**Physical Dependence in Pain Treatment**

Patients treated for pain with chronic opioid therapy often become physically dependent on their prescribed opioid analgesics. While they may be physically dependent, only a small percentage of these patients develop opioid use disorder. Only around 1.5% experience abuse, addiction, or aberrant drug-related behavior if they have no history of substance abuse\(^\text{46}\).

Those who do show signs of opioid use disorder will require treatment.
For patients whose pain is not well-managed on continuous short-acting opioids, consider referral to a provider who has training in treating pain and addiction. Patients who experience cravings while maintained on continuous short-acting opioids might also be considered for such referral. The complex nature of treating a patient for addiction who continues to need opioids for chronic pain makes referral to a pain treatment center the ideal treatment. An addiction specialist who also specializes in pain treatment is another possibility for referral.

Note: Buprenorphine has also been approved as a treatment for chronic pain in a different formulation, a skin patch.

FYI
Treating both addiction and pain simultaneously and effectively is challenging. Non-opioids should be the first course of treatment for pain among patients already maintained on buprenorphine.

Physical Dependence vs. Opioid Use Disorder
Patients on chronic opioid pain therapy often present differently when they are addicted to opioids than when they are not. It is essential to distinguish between the needs of these two patient types:

**Clinical Feature:** Compulsive drug use
- Patients With Pain: Rare
- Patients Who Are Addicted to Opioids: Common

**Clinical Feature:** Crave drug (when not in pain)
- Patients With Pain: Less likely if they take their medication on schedule, but physical dependence does typically develop in chronic opioid therapy
- Patients Who Are Addicted to Opioids: Common

**Clinical Feature:** Obtain or purchase drugs from non-medical sources
- Patients With Pain: Rare
- Patients Who Are Addicted to Opioids: Common

**Clinical Feature:** Procure drugs through illegal activities
- Patients With Pain: Absent
- Patients Who Are Addicted to Opioids: Common

**Clinical Feature:** Escalate opioid dose without medical instruction
- Patients With Pain: Rare, but may occur with an episode of breakthrough pain, despite warnings
- Patients Who Are Addicted to Opioids: Common

**Clinical Feature:** Supplement with other opioid drugs
- Patients With Pain: Unusual, if pain is adequately managed
- Patients Who Are Addicted to Opioids: Frequent

**Clinical Feature:** Demand specific opioid agent
- Patients With Pain: Not as common
- Patients Who Are Addicted to Opioids: Common

**Clinical Feature:** Can stop use when effective alternative treatments are available
• Patients With Pain: Usually, with appropriate discontinuation protocol that considers any physical dependency that developed
• Patients Who Are Addicted to Opioids: Usually not

Clinical Feature: Prefer specific routes of administration
• Patients With Pain: No
• Patients Who Are Addicted to Opioids: Yes

Clinical Feature: Can regulate use according to supply
• Patients With Pain: Yes, if pain is adequately managed
• Patients Who Are Addicted to Opioids: No

Quiz: Pain Inquiry – Mrs. Davis

Name: Mrs. Davis
Age: 46 years old
Reason For Visit: Followup for a shoulder injury

Patient History: Mrs. Davis has abused prescription opioids sporadically for several years. She recently injured her shoulder and had been using opioids more frequently to manage her pain.

Review the following dialogue and determine whether it is a complete pain history:

Provider: How long have you had this pain?

Mrs. Davis: Around a week. It seems to be getting worse instead of better.

Provider: I'm sorry to hear that. Is it limiting what you can do or affecting your sleep?

Mrs. Davis: Getting dressed is difficult. Sometimes I roll on it in my sleep, and it wakes me up.

Provider: Can you use your other arm and show me where the pain is located?

Mrs. Davis: Here. [Points to the back of her right shoulder].

Provider: I see. What seems to trigger the pain or make it worse?

Mrs. Davis: Reaching behind me is the worst.

Provider: What is the pain intensity on a scale of 0-10?

Mrs. Davis: It’s a 10 for a second and lingers at an 8 for a while. I take an opioid and it settles down.

Of course, the provider would follow-up on Mrs. Davis’ self-medication with opioids. But focusing on just the pain history, try using the acronym PQRSTU to help you remember all the questions to ask in a complete pain history, answer the following question:

Of The Choices Below, Which Question Category Has NOT Yet Been Asked Of Mrs. Davis? (Choose One)

1. "Where is the pain located?"
2. "Does it hurt?"
3. "Is the pain dull, sharp, or throbbing?"
4. "How badly does it hurt?"
Case Pain Inquiry Quiz Feedback

(1) "Where Is The Pain Located?"
This exact question was asked already.

(2) "Does It Hurt?"
The answer to this question is already clearly yes.

(3) "Is The Pain Dull, Sharp, Or Throbbing?"
Correct. This question assesses the Q of the PQRSTU acronym and stands for pain quality, which is a question that has not been asked yet.

(4) "How Badly Does It Hurt?"
This question assesses the severity of the pain which was already asked by asking about pain intensity.
Quiz: Mrs. Davis Treatment Selection

Name: Mrs. Davis
Age: 46 years old
Reason For Visit: Followup for a shoulder injury
Review History: Mrs. Davis has been assessed to have opioid use disorder. She has been using opioids more frequently to manage her pain and takes paroxetine (Paxil®) for depression and anxiety.

With What You Now Know, Is Mrs. Davis A Good Candidate For Office-based Buprenorphine Treatment At This Time? (Choose The Best Answer)

1. No, she has been abusing prescription opioids on and off for several years and seems to have some control of her use; therefore, she does not need maintenance treatment.
2. No, because she has a psychiatric disorder.
3. Yes, because you can safely taper her off of the paroxetine and then start buprenorphine treatment.
4. Yes, because stabilized patients can typically take selective serotonin reuptake inhibitors (SSRIs) and buprenorphine simultaneously.
Quick Case – Mrs. Davis Quiz Feedback

(1) No, She Has Been Abusing Prescription Opioids Off And On For Several Years And Seems To Have Some Control Of Her Use; Therefore, She Does Not Need Maintenance Treatment.
Not the best choice. Although her history of use is also significant, you should not assume that she has control over her use and can stop abusing prescription opioids if she chooses to do so. Because she meets the DSM criteria for opioid use disorder, she may be an appropriate candidate for buprenorphine treatment. However, you will need to further evaluate her suitability as a candidate and explore all options before making a final decision.

(2) No, Because She Has A Psychiatric Disorder.
Incorrect. Mrs. Davis’ psychiatric disorders (depression and generalized anxiety disorder) appear to be well controlled. She appears to be psychiatrically stable.

(3) Yes, Because You Can Safely Taper Her Off Of The Paroxetine And Then Start Buprenorphine Treatment.
Not the best choice. There is no need to taper Mrs. Davis off of paroxetine before starting buprenorphine. Patients who are psychiatrically stable can take SSRIs and buprenorphine simultaneously, monitoring for possible additive sedative effects, especially at first. However, you will need to further evaluate her suitability as a candidate and explore all options before making a final decision.

(4) Yes, Because Stabilized Patients Can Typically Take Selective Serotonin Reuptake Inhibitors (SSRIs) And Buprenorphine Simultaneously.
Possibly. Patients who are psychiatrically stable can take SSRIs and buprenorphine simultaneously, monitoring for possible additive sedative effects, especially at first. However, you will need to further evaluate her suitability as a candidate and explore all options before making a final decision.
COMMON PSYCHIATRIC COMORBIDITIES

Patients who have psychiatric comorbidities can usually be treated safely and effectively with buprenorphine. Psychiatric comorbidities occur in individuals with opioid use disorder and may affect your decision to treat a patient with buprenorphine in the office. Patients with psychiatric comorbidities are at greater risk to relapse back to substance use, so additional monitoring is required. More frequent clinic appointments should be required, especially during the first few months of buprenorphine maintenance.

The psychiatric problems that most commonly co-occur with substance use disorders include the following:

- Depression
- Anxiety disorders
- Bipolar
- Personality disorders

Patient stability is a consideration in determining whether to treat a patient in a primary care or more structured setting. Some psychiatric comorbidities, such as active psychosis, suicidal or homicidal ideation, are contraindications to treatment with buprenorphine in a primary care setting. Asking about the patient's compliance with their medications is one potential indicator of stability to check.

It is also important to screen for suicidal ideation. Refer for counseling and limit supplies of medications, if positive.

In support of screening all buprenorphine patients for depression, the USPSTF guidelines recommend screening all adults for depression. This recommendation emphasizes that pregnant and postpartum women, as well as those who do not indicate, even without prior evidence of depression.

Guidelines for Patients with Psychiatric Comorbidities

In Practice Guidance for Buprenorphine for the Treatment of Opioid Use Disorders, produced by expert panel process, the guidelines recommended most often on providing proper assessment and treatment for psychiatric comorbidities are the following:

Provide proper assessment and treatment for patients with comorbid depression or anxiety.

- Perform screening for depression and anxiety.
- Collect history of mental disorders and treatments, focus on the relationship of symptoms to substance use and responses to past treatments.
- Gather information about the type, quantity, frequency, and time of last illicit substance use or last use of prescribed psychotropic medication.
- Ask about family history of mental disorders.
- Assess the severity of the patient's depression or anxiety.
- Regularly reassess symptoms of depression and anxiety.
- The use of benzodiazepines for self-medication or prescribed should be discouraged. If a patient is on benzodiazepines at the outset of treatment, they should be tapered off slowly.
A group of providers based on over 10 years of prescribing buprenorphine caution that, in their experience, individuals with the following conditions are high risk if treated in an office-based opioid treatment setting:

- Personality disorders, such as antisocial and borderline
- Bipolar disorder
- Actively psychotic
- Actively addicted to cocaine or alcohol

**Depression Screening Guidelines**

Psychiatric problems, in particular depression, are common among patients with opioid use disorders. The AHRQ guidelines for depression recommend screening all adult patients based on Grade B evidence. The recommendation is to implement screening as long as there are adequate systems in place for "accurate diagnosis, effective treatment, and appropriate follow-up." Screening tools mentioned in this recommendation include "Patient Health Questionnaire," the "Hospital Anxiety and Depression Scales" in adults, the "Geriatric Depression Scale" in older adults, and the "Edinburgh Postnatal Depression Scale" in postpartum and pregnant women.

**Opioid-Induced vs. Opioid-Independent Psychiatric Disorders**

Distinguishing between opioid-induced and opioid-independent psychiatric disorders can be important, because different treatment may be indicated for each situation. However, it is often difficult to determine which came first; in most cases, patients benefit from having both addressed.

**Opioid-Induced Psychiatric Disorders**

With opioid-induced mental disorders (particularly depression), psychiatric symptoms often resolve once opioid use stops. In these cases, addiction treatment stability is the first therapeutic step. Psychiatric treatment for the disorder is necessary only in severely affected patients, such as those who are suicidal.

**Opioid-Independent Psychiatric Disorders**

Patients whose psychiatric disorders are contributing to opioid use disorder or in whom the connection is less clear may benefit more from the reverse treatment sequence. In these patients, stabilization of the psychiatric illness should be considered prior to buprenorphine treatment.

**Psychoactive Substance Metabolism**

Buprenorphine is metabolized by the CYP 3A4 pathway, as are many common medications including some antidepressants. This may have an impact on the buprenorphine maintenance dose (the dose may be slightly higher or lower than expected) for patients who are also taking these medications. Otherwise, buprenorphine is safe to use with most psychiatric medications.

**Illicit or Prescribed Benzodiazepines**

Benzodiazepines Should Be Avoided During Opioid Treatment. If benzodiazepines and buprenorphine are prescribed simultaneously, it should be with caution and close monitoring, due to reports of adverse effects in extreme situations (i.e. overdose deaths among patients injecting high doses of buprenorphine while taking high-dose benzodiazepines). In almost all cases patients should not be simultaneously treated with benzodiazepines and opioid medications.
Poll: Studies show that almost 70% of patients will use the internet to gain further insight into conditions if told to by their provider. Will you suggest websites about buprenorphine to your patients?

- Yes, I will recommend that my patients look for patient websites on buprenorphine.
- Yes, I will recommend specific patient website(s) on buprenorphine to my patients.
- No, I plan to provide all the information the patient needs via my own website.
- No, I plan to use only paper to provide patient education on buprenorphine.
- Does not apply to me or none of the above

How about you? If you haven't taken the polls yet, follow the link below:

https://bup.clinicalencounters.com/assessing-patients-poll/
CONSIDER CULTURAL FACTORS

Overview
Different populations may need their interventions for substance abuse and treatment individualized. Base the customization on their individual needs and experiences, for example, mistrust, acculturation, discrimination, and family structure. Applying standard approaches in such circumstances can make diagnosis and treatment more difficult, and conversely, accommodating such circumstances can improve outcomes.

Racial And Ethnic Groups
Members of certain racial and ethnic groups have a relatively higher proportion of individuals who benefit from a particular form of therapy. For example, in comparison to standard therapy, Alaskan Native and American Indian populations, on average, responded well to Dialectical Behavior Therapy (DBT) in combination with mindfulness and tribal and spiritual practices from their culture. Another difference encountered more frequently in a number of cultures is a preference for an authoritarian provider. For example, some Asians may prefer less participation in decision-making.

LGBT Populations
LGBT populations (lesbian, gay, bisexual, and transgender) may be at higher risk for substance use problems and may delay entering treatment until their issues are severe. Experiences with social isolation, homophobia/transphobia, family dynamics, or violence may make LGBT populations more susceptible to substance use and more hesitant to seek out help when needed. Treatment approaches should acknowledge these factors and tailor the treatment toward dealing with them alongside the substance use. CBT, social support therapy, contingency management, and motivational interviewing have all shown positive benefits when initiating addiction treatment with some LGBT populations.

Veterans
Substance use disorder affects a high percentage of veterans; 7.1% meet the criteria. Veterans have a high rate of PTSD, which is a risk factor for substance misuse. PTSD and substance misuse contribute to each other and both need to be addressed for successful treatment. Acknowledging and treating both substance misuse and PTSD within treatment results in patient improvement in both areas.

In Custody
Individuals within the criminal justice system are at increased risk for substance use issues. About half of the prison population in the United States has a substance use disorder. Compounding the issue is the fact that these populations undergo enforced abstinence while in prison, which often leads to untreated withdrawal. Being in custody also lowers tolerance for addictive substances and thus increases the risk of overdose when released. In summary, this at-risk group needs specialized care to ensure they receive appropriate treatment while incarcerated as well as have a good base of recovery when released.
Case Study – Ms. Taylor

Name: Ms. Taylor
Age: 29 years old
Reason For Visit: She heard, "There is a drug to take if you are addicted to heroin."
Present History: She has been without treatment for three months, using heroin daily during this time.

Treatment History: A year ago, Ms. Taylor spent a month in jail after being arrested on drug possession charges. She was arrested when she was 6 months pregnant.

Ms. Taylor was started on methadone in jail and was maintained on a dose of 40 mg when she transferred to a residential facility affiliated with a local methadone clinic. She requested to come off of methadone because she "didn't want the baby to be born addicted." The taper was unsuccessful, and so she continued maintenance therapy, taking 40 mg throughout her pregnancy.

Quiz: Ms. Taylor – History

Medical: She requested a methadone dose reduction for her baby.

She stated that methadone was harming her and made her feel sick, that she "did not really need it anyway." She claimed that she was constantly exhausted, although staff observed that she was quite active.

Psychosocial: She seemed well-adjusted and was compliant when she left the facility for other appointments, however, she did not tolerate the structure of residential treatment well. She had some interpersonal problems, was very dramatic, and was disruptive within the treatment facility:

- She often complained to the other patients and staff.
- She told others that the providers were putting her baby at risk.
- She interrupted groups with these issues and avoided participation in-house activities.

Follow-up: Ms. Taylor had a baby girl while in treatment and elected to have her tubes tied to avoid the potential of putting another baby through withdrawal. After her baby was born, Ms. Taylor left the program and dropped out of both methadone and residential treatment. Soon after that, she relapsed back to heroin injection. Ms. Taylor stopped breastfeeding, and her mother took over care of the baby. That was three months ago. Ms. Taylor now has come to your practice seeking treatment. She says she is highly motivated to get her baby back.

Given Her History, Should You Consider Ms. Taylor As A Potential Patient For Buprenorphine Treatment In Your Practice? (Choose One)

1. Yes, only if she agrees to psychosocial counseling.
2. Yes, only if she agrees to residential treatment.
3. No, she should be put back on methadone first since that somewhat worked in the past.
4. No, her history makes her a poor candidate for buprenorphine treatment.
Ms. Taylor – History Quiz Feedback

(1) Yes, Only If She Agrees To Psychosocial Counseling.
Correct. Office-based buprenorphine treatment may be effective because it may provide her with the comfort and support she needs to be successful and she seems motivated by her baby. Ms. Taylor may be appropriate for buprenorphine treatment, but only if she agrees to participate in psychosocial counseling. You should be aware that Ms. Taylor may be a problematic patient and plan accordingly. For instance, recall that Ms. Taylor was disruptive in a residential setting and did not like being on methadone while she was pregnant. She may be at a different 'readiness to change' phase at this point because she comes in seeking treatment and seems motivated by her baby.

Some patients who don't tolerate methadone well feel 'normal' when taking buprenorphine and are entirely compliant. However, doing poorly at a higher level of care (e.g., residential) is often a red flag for potential problems.

(2) Yes, Only If She Agrees To Residential Treatment.
Residential treatment is not the best option. Ms. Taylor is a potential candidate for buprenorphine treatment, but residential treatment may not be the best approach, because she did not tolerate the structure of residential treatment and disturbed her fellow residents at her previous treatment facility.

(3) No, She Should Be Put Back On Methadone First Since That Worked Somewhat In The Past.
Methadone is not the best option. Though methadone may have worked somewhat in the past, Ms. Taylor did not receive or react to methadone treatment well while in residential treatment, because she did not tolerate the structure of residential treatment and disturbed her fellow residents at her previous treatment facility.

(4) No, Her History Makes Her A Poor Candidate For Buprenorphine Treatment.
Buprenorphine should be considered. It is true that doing poorly at a higher level of care should be a red flag for potential problems. However, Ms. Taylor may be at a different point now regarding her willingness to change and to participate in structured treatment, because she did not tolerate the structure of residential treatment and disturbed her fellow residents at her previous treatment facility.
Ms. Taylor – Treatment Plan

The Importance Of A Structured Plan
A very structured treatment plan needs to be in place before Ms. Taylor begins buprenorphine treatment. Working together with Ms. Taylor on patient agreements and practice rules and guidelines is a must. If Ms. Taylor had not had a tubal ligation, it would also be essential to determine if Ms. Taylor plans to get pregnant again in the near future – buprenorphine is not the treatment of choice during pregnancy, as is discussed in the module on special populations.

Questions to ask Ms. Taylor include what she thinks she can handle right now regarding treatment, and if she would participate in groups, 12-step programs, or individual counseling. Because patients who have attended methadone clinics have experienced daily observed doses, she may be able to comply with structure up to a point.

Discussing Treatment With Ms. Taylor

Provider: Ms. Taylor, I think buprenorphine treatment would help you, but I am concerned because you had trouble with other treatment programs. Our program includes some components that you had trouble with before. I need you to go to counseling every week, see me every week, and attend at least one Narcotics Anonymous meeting each week. If you cannot stick to these parts of the program, then we cannot prescribe the buprenorphine treatment.

Ms. Taylor: Cool, I can do that. Hey, it's still easier than going to the methadone clinic every day.

Provider: Yes, one of the advantages of buprenorphine is that you can take it at home, instead of going to the clinic every day to get it from a nurse. It is still a big commitment, however. You still have to participate in urine drug tests and go to counseling and keep all of your appointments. Agreed?

Ms. Taylor: Yup, I can do that, doc. (signs the patient-provider treatment agreement).

Ms. Taylor – Follow Up

Following Up With Ms. Taylor
Six weeks ago, Ms. Taylor went through buprenorphine induction with no problems. The dose of generic buprenorphine/naloxone at which she was stable was 16 mg. Since then, she has attended her weekly counseling sessions and clinic visits. You have since done two urine tests, both of which were clean. She has also actively participated in Narcotics Anonymous (NA), carrying the Basic Text around with her, which is a guidebook for NA. She reports she is working on the fifth step and wants to be a better person for her daughter.
OTHER ISSUES TO CONSIDER

Literacy And Psychosocial Issues

Several other issues of importance in patient selection for buprenorphine treatment include the following:

- Patient understanding of buprenorphine educational materials and anticipated adherence to protocol
- The patient's psychiatric state and likelihood that the patient will adhere to safety procedures (including abstinence from illicit drugs and non-prescribed medications)
- The quality of the patient's psychosocial supports: employment, family, housing, 12-step involvement
- Whether the office has the necessary and supporting resources to be accessible to all populations

Assess these issues for each patient and determine whether the benefits of treatment outweigh the risks before starting office-based treatment.
IDENTIFY UNLIKELY CANDIDATES

Circumstances and issues that can make a patient a less-than-ideal candidate for office-based buprenorphine treatment, including the following:

- No response to buprenorphine during past attempts
- High level of physical dependence and the resulting risk for severe withdrawal
- Dependence on high doses of benzodiazepines or central nervous system depressants
- Dependence on alcohol
- Significant psychiatric comorbidity
- Suicidal ideation or history of past attempts
- Seizure disorder or other complicated medical conditions
- Inadequate support network
- Need for extensive additional resources

Having one or more of these factors does not mean that a patient should not receive office-based buprenorphine treatment. For example, consider how available and accessible other treatment sources are.

If the final evaluation of a patient determines that office-based buprenorphine treatment is not the best choice, consider making a referral to a more appropriate treatment source. Treatment success can be achieved even for the most complicated cases.

PRACTICE GUIDE

Patients with substance use disorders or misuse of sedative hypnotics, alcohol, or both can only be considered for buprenorphine treatment if all of the following apply:

- Clinical indication
  - Willingness to discontinue sedative hypnotics, alcohol, or both by undergoing medically supervised withdrawal
  - Success in discontinuing hypnotics, alcohol, or both

In addition, patients with liver functions tests 3 to 5 times greater than normal should not be considered for treatment with buprenorphine.
REFERRAL

Whom To Refer
In some instances, referral to a specialist or another treatment program is the best solution for the patient. Consider referring patients to an addiction specialist whenever:

- The patient has a complicated medical, psychiatric, social, or substance abuse history and requires more intensive or structured treatment than you can provide in the office setting.
- The patient has already participated in office-based buprenorphine treatment, unsuccessfully. An unsuccessful treatment episode should not equal the end of treatment attempts; substance use disorder is a chronic condition that often requires long-term (or lifetime) treatment.
- The patient requests a referral to a substance abuse treatment center or opioid treatment program.
- The patient lacks motivation or commitment needed for office-based opioid treatment to be effective.
- The patient is non-compliant with your office policies or treatment protocol.

Discussing Referral
Some patients will resist discussing their opioid abuse or misuse. However, if referral to addiction treatment is warranted, then you must discuss the issues with the patient. Explain to patients and their significant others that addiction is a treatable chronic disease and a specialist can provide the best possible care.

Other tips for discussing referral include the following:

- Skillful, empathetic interviewing is key. When discussing substance abuse with patients, use sensitive approaches that reduce resistance.
- Provide as much information as possible about the provider/clinic where you are referring the patient. If you speak with confidence and knowledge about the treatment center, patients are more likely to respond more positively.
- Maintain the patient's privacy—conduct the interview in private and do not bring up the substance abuse or referral around other staff members, family, or friends without the patient's permission.

Where To Refer
After Making The Decision To Refer
Deciding to refer a patient is merely the first step in the referral process. If you do not already have a working knowledge of area addiction specialists, treatment programs, and self-help groups, consider working to build such a knowledge base.

If, however, you do not immediately know of a place or a person to which to refer a patient, there are many ways to gather the information. A few approaches include the following:
Assessing Patients for Buprenorphine Treatment

- Tap local colleagues' knowledge or ask them for recommendations.
- Consult with a hospital or an addiction treatment professional.
- Refer to a list of substance abuse treatment programs from a local, state, or federal agency or database.

As affordability or insurance might be a problematic issue for some patients, consider familiarizing yourself with publicly funded programs.

SAMHSA has several treatment locator tools available, including a nationwide opioid treatment program (OTP) locator. Before starting office-based opioid treatment (OBOT), it is helpful to generate a list of local OTPs and addiction specialists to have on hand when needed.

What To Ask Referrers
When contacting treatment providers regarding a possible referral, it is helpful to discuss:

- What services the treatment provider offers
- The philosophy toward treatment
- Whether the provider offers methadone or buprenorphine treatment (or both) or drug-free treatment only

Including The Patient In The Referral Process
You might suggest the referral to the patient as you would when suggesting that a patient visit any other medical specialist. This will often increase the likelihood of follow-through with outside treatment.

You can make the initial call for the patient in the patient's presence. A referral letter sent to the specialist should precede the patient's first visit. If requested, communicate with the treating party after the patient's assessment or if the patient misses the appointment.

If possible, consider collaborating with the specialist in the patient's treatment. The patient must sign a consent form if he or she agrees to this sharing of information.

Patient Not Appropriate For OBOT
For the patient for whom office-based treatment is not viable or appropriate, there are several options:

- Make the patient aware of community-based treatment resources, including free, anonymous groups such as Narcotics Anonymous.
- You could also provide the patient with paper-based information and online resources about addiction and treatment. Include information on addiction and the benefits of treatment.

Patients who refuse a referral might also benefit from these resources.

FYI
Clinics and hospitals should maintain a list of local treatment providers where they can refer patients for an identified or suspected substance use problem.

If you use the same local referral resource repeatedly, you will develop a positive working relationship, enhancing communication. You can visit the treatment source, personalizing the experience. This will also improve the likelihood of your patient coming back to your practice after treatment.
REVIEW TREATMENT OPTIONS

What Are The Treatment Options?
Risks and benefits of office-based treatment and buprenorphine treatment should be balanced against those of no treatment or treatment without medication. The options include:

• Detoxification
• Detoxification followed by antagonist therapy
• Counseling alone
• Referral to outpatient, methadone, or residential treatment
• Office-based buprenorphine or buprenorphine/naloxone treatment

A Brief Overview Of ASAM Criteria For Determining The Best Treatment Option For Each Patient
ASAM Criteria can be used to help determine if office-based opioid treatment is appropriate and to complete comprehensive treatment matching and planning. Briefly, there are six dimensions of the multidimensional assessment in the ASAM Criteria:

• Acute Intoxication and Withdrawal Potential
• Biomedical Conditions and Complications
• Emotional, Behavioral, or Cognitive Conditions and Complications
• Readiness to Change
• Relapse, Continued Use, or Continued Problem Potential
• Recovery/Living Environment

Positive Response To Treatment
The following are among the factors associated with a positive response to buprenorphine treatment:

• Patient knowledge and interest
• Practice resources
• Supportive psychosocial circumstances
• Absence of interacting prescriptions
• A diagnosis of opioid use disorder
• Psychiatric stability
• Relatively mild opioid use disorder or psychiatric symptoms
• Employment, or ability to provide for oneself financially
• A high level of patient contemplation of quitting

*The Stages of Change Model can be used to assess the patient's readiness to change his or her addictive behavior and to accept treatment. Contemplation is the first change a person makes in the direction of change.
PATIENT PLACEMENT CRITERIA

According to the ASAM Patient Placement Criteria, the following 6 patient dimensions should be considered when formulating a treatment plan:

1. **Acute Intoxication and Withdrawal Potential:** Assess whether the patient is currently intoxicated, is at risk of precipitated withdrawal, or is currently in withdrawal.
2. **Biomedical Conditions and Complications:** Consider the patient's existing medical conditions and how they might affect treatment.
3. **Emotional, Behavioral, or Cognitive Conditions and Complications:** Assess the patient's psychiatric illnesses and psychological, behavioral, emotional, or cognitive problems, and determine if they are related to or are independent of the substance use disorder.
4. **Readiness to Change:** Assess the patient's readiness to change, and determine how willing he/she is to begin treatment.
5. **Relapse, Continued Use, or Continued Problem Potential:** Try to ascertain what the outcome will be if treatment is not successful, and consider if the patient can combat cravings and cues that might lead to relapse.
6. **Recovery/Living Environment:** Determine if the patient's home and work environments contribute to or detract from treatment efforts and what family and social support is available.

**Office-Based Opioid Treatment Vs. Opioid Treatment Programs**

The following criteria from the VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders provide guidance for whether office-based treatment in your clinic or a referral to the more structured treatment of an opioid treatment program is appropriate:

<table>
<thead>
<tr>
<th>Criteria</th>
<th>OBOT</th>
<th>OTP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can OBOT provide the resources the patient needs?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Psychosocial supports</td>
<td>Good</td>
<td>Poor</td>
</tr>
<tr>
<td>Failed treatments with medication-assisted treatment</td>
<td>None/few</td>
<td>Many</td>
</tr>
<tr>
<td>Access</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Chronic pain requiring short-acting opioids</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### ADJUST FOR SUBPOPULATIONS

#### Subpopulations Having Unique Challenges
Specific populations may present unique challenges when being treated with buprenorphine, requiring altered dosing protocols or the addition of specialty psychosocial treatment. Other patients may need an alternative to buprenorphine treatment. Subpopulations are covered in greater detail in the Methadone Patients and Other Subpopulations module.

#### The Homeless
Homeless patients with opioid use disorder generally have:
- Fewer social supports
- More comorbidities
- More chronic drug use

Despite these challenges, office-based buprenorphine treatment can be effective in homeless patients.

#### Assessing Pregnant Women
Patients may be pregnant and be treated with buprenorphine, with special precautions observed. Methadone maintenance treatment had traditionally been the treatment of choice for pregnant women with opioid use disorder due to existing research on its safety. However, the Maternal Opioid Treatment: Human Experimental Research (MOTHER) study concluded that buprenorphine may be as safe as methadone for this population. Both are category C, however, and there is more experience with methadone.

Patients already maintained on buprenorphine who become pregnant have been maintained successfully and safely on buprenorphine after becoming pregnant. Most guidelines recommend switching to monotherapy in these cases because of potential effects of naloxone on the fetus.

- Ideally, patients in office-based opioid treatment should not have medical or psychiatric comorbidities and should have good social support and a stable family situation.
- Determine whether there is a regular prenatal provider and obtain permission and talk with them; if there is none, make an immediate referral.

#### Older and Younger Patients

##### Assessing Adolescents
Adolescents who meet all of the following criteria may be appropriate candidates for buprenorphine treatment:
- Over age 16
- Established history of opioid use disorder (previously called opioid dependence or abuse) (>1 year)
- One or more past treatment attempt

Buprenorphine is not appropriate for patients who are experimenting with opioids or who are occasional users. A less intensive treatment, such as drug counseling, is appropriate for these users.

##### Assessing Geriatrics
Buprenorphine maintenance may not have been investigated specifically in the elderly. However, geriatric patients respond well to substance use disorder treatments designed for younger adults.
Physical and psychiatric disorders are common in the elderly and can mimic substance use disorders, complicating detection and diagnosis of addiction in geriatric patients. Also, the diagnostic criterion involving social norms is often less relevant in this age group. Cognitive problems, if present, may make screening difficult; a collateral interview, such as with their life partner, may be needed. SAMHSA's Tip 26 on Substance Abuse Among Older Adults describes screening tools designed for the geriatric population.
**APPROPRIATENESS FOR OFFICE-BASED TREATMENT**

**Issues To Consider For Office-Based Treatment With Buprenorphine**

Issues to consider to help determine whether or not a patient is an appropriate candidate for buprenorphine include the following:

- Does the patient have a diagnosis of opioid use disorder?
  - If they do, determine the severity according to DSM 5.
- Is the patient interested in office-based treatment?
  - Don't just assume that this is the case.
- Is the patient using high dose benzodiazepines, naltrexone for alcohol treatment, or CNS depressants?
  - These medications can have dangerous interactions with buprenorphine.
- Is the patient pregnant or planning to get pregnant?
  - In this case, the clinician must decide if they are comfortable treating pregnant patients before starting treatment.
- Does the patient understand the risks and benefits of buprenorphine?
  - Understanding risks and benefits is part of informed consent.
- Has the patient had past treatment attempts, including buprenorphine or methadone?
  - Many addicts have multiple treatment attempts in their lifetimes; this is not a reason to deny buprenorphine treatment. However, it is helpful to know the history and outcome of each attempt.
- Is the patient able to be reasonably compliant and follow safety procedures?
  - The clinician must make this judgment call, based on knowledge of the patient.
- Is the patient mentally stable enough to be treated in the office setting?
  - Psychiatric comorbidities can be treated simultaneously, in many cases.
- Is the patient's psychosocial situation both stable and supportive?
  - Presence of family, friends, employment, housing, or other supports, such as 12-step programs, is beneficial.
- Can your office provide needed psychosocial resources for the patient, either on or off-site?
  - No matter how well-suited for in-office buprenorphine treatment a patient might seem, the patient's treatment may not be successful without the appropriate supportive resources.

**PRACTICE ACTIONS**

For your first buprenorphine cases: Look for simple cases typically more newly addicted to prescription pain medications, although the outcomes for the success of treatment in patients with longer-term addiction are similar.

**Shared Decision Making and Engagement**

**Shared Decision Making**

Shared decision-making, recommended for all patient care, is especially crucial for patients with substance use disorder. It includes deciding what treatment patients obtain for their opioid use disorder. Patients must have all information they need to make the decision in language they understand. Shared decision making also involves learning and respecting their priorities and involving them in setting goals.
Using a patient-centered approach, review outcomes of the patient’s attempts to change their substance use previously including reasons they may have abandoned other treatments. Ask about their willingness to engage in treatment or a referral.

**Engagement Strategies**
Patients often express ambivalence or resistance to treatment at first and may continue to resist a referral. Several principles are helpful in facilitating the patient being open to engaging in treatment:

- Emphasize that treatment is effective, more effective than no treatment.
- Consider previous treatment experience.
- Motivational interviewing is often an effective approach for patients expressing the full range of readiness to engage in treatment. This approach to counseling patients includes an emphasis on:
  - Building self-efficacy that they can change
  - Develop a therapeutic alliance
  - Strengthen coping skills
  - Use reinforcement
  - Build social support
- Emphasize that participation in treatment and community support are reliable predictors of outcome.
- Promote active participation in mutual-help groups (e.g., Alcoholics Anonymous (AA), Narcotics Anonymous (NA))
- Recommend coordinated treatment of substance use problems with interventions for biopsychosocial problems. (Consider patient priorities in this.)
- Recommend the least restrictive setting possible for access, safety, and effectiveness.
- Make efforts to re-engage patients who drop out of treatment.
- Maintain use of Motivational Interviewing even if the patient is unwilling to engage in treatment, offering medical and psychiatric treatment as needed while looking for opportunities to facilitate further engagement of the patient in substance use treatment.

**VA/DoD Guidelines**
The VA/Department of Defense has created a comprehensive guideline for treating substance use disorders, from screening through treatment options. Excellent clinician pocket guides that summarize much of what has been presented here on this subject and many further details are available free-of-charge in the Provider Summary, Screening and Treatment, and Stabilization pocket guides available in the Resources section.

**Mr. Santos – Further Evaluation**

**Asking More Questions**
You must ask some more questions of Mr. Santos before you can decide about office-based opioid treatment.

**Provider:** Do you use any other drugs or alcohol?

**Mr. Santos:** Alcohol isn’t a problem now, but in the past, I drank heavily. And...well, I do smoke crack sometimes, but it’s not my main problem. I can take it or leave it. If I control my heroin problem, I’ll be fine. [He also denies use of sedatives or benzodiazepines.]
Provider: I'd like to talk about your history of addiction treatment, including your most recent detoxification experience.

Mr. Santos: I was in methadone maintenance treatment for five years, but I tapered off and was drug-free for three years before I relapsed. I was in an in-patient detox program two months ago. [He brought his records with him to show the use of monotherapy buprenorphine in treatment and a two-week taper from 32 mg down to 0 mg. He was discharged on citalopram (Celexa®) for depression.]

Provider: You said you had PTSD. Do those symptoms ever come back?

Mr. Santos: Well, I used to have a lot of nightmares about my parents' deaths. It was hard on me, but it got better with lots of therapy and with time and finding Linda.

Provider: How is your mood? Do you have depression or suicidal thoughts?

Mr. Santos: I did get down about having HIV, and that's when I started using. I'm not suicidal or anything. Plus, Linda and I have a lot to live for. The doctors say that my HIV can be controlled. If I can just stop using heroin, I'll be OK.

Provider: Yes, that is important. What kind of treatment have you had for your HIV? Do you know your t-cell count or viral load?

Mr. Santos: I've been on the HAART regimen for four months. I got checked out about six weeks ago, and I think the doctor said I was doing good. He said he couldn't detect the virus, but I can't remember what my t-cell count looked like. [His records show that his CD4 count was 375] I'm really glad my viral load isn't an issue, and I want to keep it that way. That's why I went to the detox program, and that's why I'm here today.

Considering Mr. Santos' Case

There are pros and cons associated with starting induction now. Considerations FOR Starting Induction Now

- He is familiar with the medication and has recently been as high as 32 mg buprenorphine. Linda could monitor his first dose at home if you chose a home induction.
- He is HIV positive and using heroin with needles, which puts him at risk for other diseases contracted from shared needles, making treatment urgent.
- He has home support and is agreeable to rekindle his group attendance.
- He has agreed to all your office structure conditions for buprenorphine treatment.

Considerations AGAINST Starting Induction Now

- You may want to talk to the previous group therapist to see what happened when he was discharged.
- You may want to observe his first dose yourself. You could give him a prescription for two, 8 mg generic combination buprenorphine/naloxone tablets for induction purposes to bring back to the office tomorrow or use at some future date.

It is important to weigh all of these options before starting Mr. Santos on buprenorphine.

Poll: Based on the information provided, are you inclined to prescribe buprenorphine to Mr. Santos?

- Yes
- No

How about you? If you haven't taken the polls yet, follow the link below:

https://bup.clinicalencounters.com/assessing-patients-poll/
**Mr. Santos – Treatment Plan**

**Deciding Mr. Santos If Is Appropriate For Office-based Opioid Treatment (OBOT)**

You are satisfied with Mr. Santos' responses and feel he is a good candidate for OBOT. You recommend that he participate in therapy to support his treatment and he agrees to this stipulation. He is pleased and ready to begin right away.

In fact, Mr. Santos MAY be ready for induction right now. You examine him and find that he has dilated pupils, a slight tremor, elevated blood pressure, and a pulse of 96, with some piloerection. He has been sniffling throughout the interview. He has some swelling on his left arm at injection sites, but no cellulitis or abscess. He has new and old 'tracks' on both arms and both legs. His liver is not enlarged or tender. His on-site dipstick urine test is positive for morphine and cocaine.
Assessing Patients for Buprenorphine Treatment

FINALIZING TREATMENT PLAN

The Buprenorphine Treatment Plan
After determining that a patient is a good candidate for office-based buprenorphine treatment, the next step is to create a treatment plan.

Complete treatment planning on a case-by-case basis. A separate appointment should be scheduled to:

- Outline treatment plan with the patient
- Establish the rules of treatment
- Begin induction

Further Treatment
Consider:

- Addressing psychiatric and medical comorbidities
- Considering psychosocial and other non-pharmacological interventions

The ability to provide psychosocial supports or make an appropriate referral is a requirement for buprenorphine prescribing.

PRACTICE TIP
Creating the treatment plan with input from the patient, empowers and engages the patient so that they may pay better attention to following instructions carefully.

Choosing A Buprenorphine Formulation
Once buprenorphine is selected as an appropriate treatment, choose whether to use:

1. Buprenorphine in combination with naloxone, which is the best form for most patients, vs.
2. Buprenorphine alone, which is rarely used except for treating pregnant women

You will also need to select the form of the medication. Currently, buprenorphine comes in the form of tablets or a film that dissolves under the tongue. Variations include cost, taste, and time it takes to dissolve.

Heeding patient preferences will improve patient adherence and retention, thus promoting treatment success.
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 use\(^{62}\). 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\(^{14}\). The results at 16 weeks were (n=34):

- \(\geq 50\%\) 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.

Video: Assessing Chronic Pain

A video that illustrates a provider assessing a patient's pain using an acronym (PQRSTU) can be found here: https://youtu.be/cKR27q9g__o.
KEY POINTS

Assess The Aspects Of The Patient’s Opioid Use:
• Duration, pattern, and severity of opioid misuse
• The opioid typically misused
• Level of tolerance
• Previous attempts to discontinue opioid use
• History of withdrawal episodes
• Current opioid use or withdrawal

Assess Patients For Conditions That Will Affect Buprenorphine Treatment:
• Chronic pain
• Certain medical conditions including liver or heart disease and seizures
• Pregnancy status and plans
• Psychiatric problems
• Polysubstance users
Assessing Patients for Buprenorphine Treatment

**SUMMARY**

**Assessing Patient Physical Health And Mental Health**
- Assess for medical and psychiatric comorbidities as they could dramatically affect the treatment plan
- Common among patients with opioid use disorder:
  - Infectious and sexually transmitted diseases, liver and nutritional problems
  - Depression, anxiety disorders, and personality disorders

Brief interventions, provided by primary care providers, can improve patient outcomes regarding substance use disorders. The basic steps include:

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

**Polysubstance Use**
- Assessing for polysubstance use before starting buprenorphine is important due to potentially harmful or even fatal interactions with some licit and illicit drugs
- Polysubstance use screening can be conducted using screening forms, patient examination and interview, and urine drug tests.

**Determining Appropriateness For Buprenorphine Treatment**
Factors associated with a positive response to buprenorphine treatment:

- Patient knowledge and interest
- Practice resources
- Supportive psychosocial circumstances
- Absence of interacting prescriptions
- Opioid use disorder
- Psychiatric stability including compliance with medications

Patients who resist quitting drug use may benefit from motivational interviewing techniques that increase the patient's readiness for change through a series of basic steps:

- Introduce the topic
- Assess motivation
• Evaluate ambivalence
• Plan for change
• Do not discount a patient as a candidate just because one of the contraindicated factors is present. Weigh these factors against positive indications.
• Create a treatment plan with input from the patient.
RESOURCES

ASAM Patient Placement Criteria: The ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised lists the 5 basic levels of care available for adult substance users. These levels of care range from Early Intervention (for at-risk individuals) to Medically Managed Intensive Inpatient Treatment (for patients with severe disorders who require around-the-clock care). The Patient Placement Criteria classifies opioid maintenance therapy as a Level I treatment since it is most often conducted in outpatient settings.

AUDIT Questionnaire: 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.

Buprenorphine: Considerations for Pain Management: This article reviews the role of buprenorphine in treating patients with pain.

CAGE-AID: Screening test for alcohol and drugs.

Drug Abuse Screening Test (DAST): 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.

DSM SCID: The Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) is a semi-structured interview for making the major DSM-IV Axis I diagnoses. The SCID-II is a semi-structured interview for making DSM-IV Axis II: Personality Disorder diagnoses. In addition to the important distinction between the SCID-I and SCID-II, there are several different versions and editions of the SCID.

FDA Approves 7-Day Buprenorphine Pain Patch (available upon free sign in): This medical news article talks about the FDA approval of Butrans and provides a summary of clinical study findings, drug administration, and warnings and adverse events.

McGill Pain Questionnaire: Printable verbal pain assessment questionnaire.

Medication Guide: Butrans™ CIII (buprenorphine) Transdermal System: This Medication Guide provides basic information about Butrans, the prescription medicine used for the management of moderate to severe chronic pain in patients requiring an around-the-clock opioid analgesic for a long period of time.

Michigan Alcohol Screening Test (MAST), Revised: Drinking too much? Test yourself and your own use or abuse of alcohol with this 22-question quiz. Focusing specifically on alcohol use, this self-test does not address the use of other drugs.

Patient Assessment Checklist: Before starting office-based buprenorphine treatment, the following Patient Assessment Questions should be answered for each patient. Topics addressed in these questions include: Diagnosis, Medications, Drugs/Alcohol, Psychiatric and Medical Comorbidities, Psychosocial Issues, Treatment, Patient Management, and Resources. If multiple issues are identified, consider whether they can be managed in your practice or if the patient requires a higher level of case, i.e., an Opioid Treatment Program or higher level.

PCSS-MAT Guidance: Treatment of Acute Pain in Patients Receiving Buprenorphine / Naloxone: This article provides guidance on the management and treatment of acute pain in patients receiving buprenorphine/naloxone.

PEG: A Three-Item Scale Assessing Pain Intensity and Interference: See title
Assessing Patients for Buprenorphine Treatment

Referral and consultation communication between primary care and specialist physicians: finding common ground: This study found that specialists and PCPs perceive the quality of their communications with each other differently regarding referral and consultations. Physicians who did not receive timely communications regarding referrals or consultation reported that it impacted their ability to provide high-quality care. This highlights the importance of effective referral as a clinical skill, and the need to improve inter-profession communication between primary care physicians and specialists.

SAMHSA's Buprenorphine Physician and Treatment Program Locator: A directory of treatment programs and physicians authorized to treat patients with buprenorphine.

Stages of Change Model: The Stages of Change Model can be used to assess the patient's readiness to change his/her addictive behavior; this should be determined before addiction treatment begins.

Substance Abuse Treatment for Persons With Co-Occurring Disorders Treatment Improvement Protocol (TIP) Series, No. 42: This TIP, Substance Abuse Treatment for Persons With Co-Occurring Disorders, revises TIP 9, Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse. The revised TIP provides information about new developments in the rapidly growing field of co-occurring substance use and mental disorders and captures the state-of-the-art in the treatment of people with co-occurring disorders. The TIP focuses on what the substance abuse treatment clinician needs to know and provides that information in an accessible manner. The TIP synthesizes knowledge and grounds it in the practical realities of clinical cases and real situations, so the reader will come away with increased knowledge, encouragement, and resourcefulness in working with clients with co-occurring disorders.

The ASAM Criteria: Described on the ASAM website as, "the most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions.

TIP 26: Substance Abuse Among Older Adults: Guideline document designed to aid treatment providers deliver better services to elderly patients with substance use disorders.

TIP 35: Enhancing Motivation for Change in Substance Abuse Treatment: Guide on using motivation to effect substance abuse treatment. Includes information on motivational interviewing, integrating motivational approaches into treatment, and measuring patient motivation.

TIP 54: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders: Practical tools and guidance for treating chronic pain in adults who have a history of substance use disorders. Topics include chronic pain management, treatment with opioids, substance abuse assessments and referrals.

Tobacco Use Assessment Form: Tobacco Use Assessment Form

Treating Tobacco Use and Dependence: A clinical guideline that explains the steps, including the 5 A's, for tobacco cessation.

VA/DoD Clinical Practice Guideline for the Management of Opioid Therapy for Chronic Pain: The guideline provides recommendations for practice interventions and evaluations when using opioid therapy to treat chronic non-cancer pain. It is entirely evidence-based and uses clinical algorithms to optimize the use of opioid therapy.


VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders Stabilization Pocket Card: A reference tool used to provide clinicians with stabilization resources for substance use disorder within active duty and veteran populations, including resources on pharmacological treatment and substance titration.
REFERENCES

5. USDHHS. Medication Assisted Treatment for Opioid Use Disorders Reporting Requirements. 2016.
7. SAMHSA. Screening, Brief Intervention, and Referral to Treatment (SBIRT). 2014.
13. FDA. CLIA - Clinical laboratory improvement amendments - currently waived analytes. 2016.


38. Substance Abuse and Mental Health Services Administration. Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings. ; 2014.


