Detection and Diagnosis

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DETECTION AND DIAGNOSIS OF OPIOID USE DISORDER

Goal:
To prepare providers to screen for and diagnose opioid use disorder and motivate patients to change.

After completing this module participants will be able to:
- Use motivational interviewing skills to optimize patient communication in a buprenorphine practice
- Screen for opioid use disorder through patient interviews and use of standardized screening instruments
- Assess patients for signs and symptoms of opioid use disorder
- Diagnose patients with opioid use disorder using current DSM criteria

Professional Practice Gaps
The Substance Abuse and Mental Health Services Administration (SAMHSA), based on National Survey on the 2013 Drug Use and Health survey, found the following evidence of a continuing opioid epidemic and need for additional treatment among Americans age 12 and over\(^1\):

- Current use:
  - 289,000 or 0.1 percent current users of heroin (similar to 2008 to 2012)
  - 4.5 million or 1.7% current users of non-medical use of pain relievers (similar to 2011 and 2012).
- Rate of starting misuse:
  - 169,000 new initiates to heroin (similar to estimates from 2007 to 2012)
  - 1.5 million new initiates to nonmedical use of pain relievers (lower than 2002 to 2012, which was 1.9 million to 2.5 million).
- Receiving treatment: Only a small fraction of users needing treatment for an opioid use disorder receive it, especially for prescription pain relievers, but the numbers increased in 2013:
  - Past year receipt of treatment for heroin users rose from 277,000 persons in 2002 to 526,000 persons in 2013
  - Past year receipt of treatment for nonmedical users of prescription pain relievers increased from 360,000 in 2002 to 746,000 in 2013.

Buprenorphine is a safe and effective treatment for opioid use disorder that offers patients a more widely available, accessible, convenient treatment option as compared to traditional opioid treatment programs (OTP)\(^2-4\). The Drug Addiction Treatment Act (DATA) of 2000—an amendment to the Controlled Substances Act — allowed physicians who are not part of an OTP to prescribe buprenorphine with additional training and a waiver to the Controlled Substances Act. The Comprehensive Addiction and Recovery Act of 2016 (CARA) added nurse practitioners and physician assistants to the list of providers who can train to prescribe buprenorphine and become waivered.

The law requires physicians to complete an 8-hour buprenorphine training conducted by an approved organization in order to prescribe it; the required training for nurse practitioners and physician
assistants is 24 hours. While buprenorphine is relatively safe, there are risks of overdose and death due to buprenorphine and there is a risk of diversion, which, in addition to skills needed to prescribe the medication effectively for each individual, are among the reasons for the mandatory training.

This buprenorphine training activity prepares providers to prescribe buprenorphine safely and effectively to address needs of the millions of Americans with opioid use problems. The activity has been developed to meet the DATA 2000 training guidelines as defined in Public Law 106-310-106th Congress as well as the Comprehensive Addiction and Recovery Act of 2016 (S 524, Title III, Section 303-114th Congress) and is endorsed by the American Society of Addiction Medicine, one of the approved training organizations named in DATA 2000. The activity content was initially based upon SAMHSA's 2004 publication Treatment Improvement Protocol (TIP) #40: Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction and follow the Model Policy on DATA 2000 and Treatment of Opioid Addiction in the Medical Office. It has been edited to SAMHSA's Sublingual and Transmucosal Buprenorphine for Opioid Use Disorder - Review and Update (2016), ASAM's National Practice Guideline For the Use of Medication in the Treatment of Addiction Involving Opioid Use (2015), and the CDC's guidelines on opioid treatment as well as CARA 2016. The courses are regularly reviewed and updated by ASAM members who are experts in the field of addiction medicine and buprenorphine treatment.

Specific Gap in Training:

Providers need to learn how to screen patients for opioid use disorder and risk and to make the diagnosis. An entire chapter of TIP 40, Chapter 3, is on Patient Assessment, which underscores the importance of providers who prescribe buprenorphine being familiar with screening, assessment, and diagnosis of opioid use disorder. The FSMB Model policy also describes 6 critical aspects of patient assessment.

MODULE INTRODUCTION

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

Building rapport and motivating patients is an important skill when treating addiction, especially in the early phases of treatment, so this module also discusses counseling skills that can be effective for that purpose.
Case Illustrations
The following cases will be used to illustrate the screening and assessment of patients for opioid use disorder. These case scenarios will also illustrate the use of motivational interviewing to facilitate patient communications in this process.

MR. HUGHES
Mr. Hughes is having an annual physical and vaguely describes using opioids "sometimes."

How can you establish rapport and discuss his possible misuse of opioids?

MRS. THOMAS
Mrs. Thomas is in the area temporarily and requests oxycodone for chronic low back pain.

How can you determine if Mrs. Thomas has opioid use disorder? What are the criteria?

MR. LOPEZ
Mr. Lopez has been self-medicating with buprenorphine to reduce his use of hydrocodone and oxycodone.

Does he meet the DSM 5 criteria for opioid use disorder?

Source
This content was originally adapted from the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction (TIP 40) (2004). Because it is the basis for the content, we do not cite the TIP 40 source in the text.

The content has been updated, as noted by citations, according to SAMHSA's (2016) Sublingual and Transmucosal Buprenorphine for Opioid Use Disorder - Review and Update, expert review, and other subsequent literature including The ASAM National Practice Guideline For the Use of Medication in the Treatment of Addiction Involving Opioid Use (2015).

BupPractice was created using NO pharmaceutical or other industry support.
MOTIVATIONAL INTERVIEWING

Why Use Motivational Interviewing In Office-Based Opioid Treatment
To establish the need for buprenorphine treatment, patients must be screened and further assessed for opioid use disorder. Skills from motivational interviewing can facilitate connecting with patients for effective screening and diagnosis, as well as motivating patients to obtain treatment.

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

Motivational interviewing differs from an advice-giving approach by:
- Recognizing the expertise of the patient on his or her own motivations
- Guiding the patient to examine and resolve his/her ambivalence about the problem

The process of motivational interviewing moves through four basic steps:
1. Building rapport with the patient
2. Focusing on the topic
3. Evoking or eliciting the patient's thoughts emotions about the topic
4. Planning for change

KEY POINTS
Eliciting insights from the patient can increase the effectiveness of substance abuse interventions.

STEP 1: BUILDING RAPPORT
In motivational interviewing, the patient's readiness for change is increased through the following basic steps. The first step is building rapport and engaging the patient:

1. Engage
Introduce the topic with openness, concern, and lack of judgment and establish rapport. Establishing rapport helps decrease the patient's defensiveness and increase openness to the possibility of change, including treatment. Expressing acceptance and affirmation are important. Try opening the conversation without giving the option of a "no" response. For instance, say:

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

How to Build Rapport
You walk a fine line when dealing with substance-abusing patients; you must respect their autonomy while also confronting them about drug use for the sake of their health.
When discussing the seriousness of substance misuse with patients:

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

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

- Remain nonjudgmental, be sensitive to the patient's perspective, listen carefully, and convey empathy when discussing substance use.

**Ask open-ended questions**

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

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

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

**Listen effectively**

*Provider: It sounds like your oxycodone and heroin use makes you feel isolated. How do you think this affects your ability to talk about drug use?*

**Convey a non-judgmental attitude**

*Provider: I am not here to decide if you are drinking too much. Instead, I want to help you make the best possible decisions about your use of alcohol.*

**Empathize with the patient**

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

**PRACTICE TIPS**
Motivational interviewing techniques establish rapport and put your patients at ease.

- Remain nonjudgmental.
- Be sensitive to the patient's perspective.
- Listen carefully.
- Convey empathy when discussing substance abuse.

**STEP 2: FOCUSING**
In the next step of Motivational Interviewing, you bring the conversation around to the topic at hand for this counseling session. This could be bringing up the subject of drug use or treatment, or continuing counseling that started in a previous patient encounter.

**2. Focus**
Focus on a particular behavior to discuss in this particular session.
One method of focusing is to assess motivation. This will help you focus interventions on their current stage of change. One method of assessing motivation is to ask how important the change is for the patient on a scale of 1 to 10, and then asking:

**Provider:** On a scale of 1 to 10, how ready are you to quit?

**Patient:** Uh... I'd say a 4.

**Provider:** Why not lower?

**Patient:** Lower? Why not lower? Um, well, there's my job that's important to me.

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

**STEP 3: ELICITING/EVOKING**

3. Elicit/Evoke Thoughts & Feelings

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

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

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

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

Resolving the ambivalence might go like this:

**Provider:** On the one hand you say drinking helps you relax and on the other hand you are concerned about your DWIs. Can we talk about the importance of each of these pros and cons for drinking?

Once rapport has been established, ask permission to provide patient education. Patients may not understand the brain disease of addiction, what it entails, and what it means to stop using. Such education may also affect levels of readiness.
STEP 4: PLANNING

4. Plan
Help patients make a plan for change. In motivational interviewing, the client comes up with his or her own plan for change. Elicit a plan from the patient for the next 30 to 90 days that uses affirming "change talk", for example, "I will" rather than "I could." The plan is based on the patient's current stage of change and does not need to include quitting if the patient isn't ready. For example, you could ask:

Provider: What step, if any can you do in the next month to move in the direction of thinking about quitting?

If they cannot think of any, ask if they can commit to a follow-up appointment to further discuss treatment.

An acronym for effective goals is SMART: Help patients develop goals that are specific, measurable, appropriate, reasonable, and time based.

POLL: I ALREADY USE MOTIVATIONAL INTERVIEWING TECHNIQUES WITH PATIENTS HAVING SUBSTANCE USE PROBLEMS.

1. Infrequently 0-10% of the time
   • 18% (839 votes)
2. A Little 11-25% of the time
   • 22% (1031 votes)
3. Some 26-50% of the time
   • 25% (1176 votes)
4. Often 51-75% of the time
   • 21% (1004 votes)
5. Most 76-100% of the time
   • 15% (711 votes)

Total votes: 4761

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

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

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

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

**PRACTICE TIPS**
Motivational interviewing interventions can be brief.

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

**VIDEO: MOTIVATIONAL INTERVIEWING**
A video that illustrates the use of motivational interviewing in a patient interview regarding substance use can be found here: [https://youtu.be/cOlb7ADwsMw](https://youtu.be/cOlb7ADwsMw).²

If you watch the video, notice how the provider uses various techniques from motivational interviewing (MI), such as empathy, reflective listening, and open-ended questions, to achieve the four steps of MI:

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

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

**SCREENING**
Substance abuse screening as a standard part of *every adolescent and adult patient interview* is supported by several professional organizations (AMA, ASAM, CSAT, AAP, NIAAA). In their resource for general medical settings, the National Institute for Drug Abuse encourages the incorporation of drug use screening and brief intervention in practices.¹³ However, note that in 2008, the US Preventive Services Task Force found insufficient evidence to assess the balance of benefits and harms of screening for illicit drug use, but did recommend screening for tobacco and alcohol use.¹⁴

Screening can be conducted:
- As part of routine history taking
• For example, on a self-administered intake questionnaire at the start of every appointment
  • Or when the patient's presenting complaint could be a direct or indirect result of a substance use problem

**BRINGING UP THE TOPIC**

Effective screening for opioid use disorder, and other substance use problems, requires that you bring up the topic with all patients. Any of your patients may have a substance use problem, not just the ones that come in seeking treatment.

**Reflection:**
• How willing are you to bring up sensitive subjects with your patients?
• How careful are you to not make assumptions about your patients?

**PRACTICE TIP**
Routinely screening all patients for substance abuse or misuse along with other questions related to behavior and lifestyle, as part of the questions about comprehensive health, helps reduce the stigma and reduce patient anxiety.

**FYI**
Screen patients who are on chronic opioid therapy for opioid use disorder. A number of studies have found high rates, as high as 50%, of aberrant drug-related behaviors, drug abuse, or misuse in patients on opioids for chronic non-cancer pain\(^{15}\).

**TIPS FOR BRINGING UP THE SENSITIVE SUBJECT OF OPIOID USE DISORDER**

Some patients will volunteer their substance use, and others will not. If you suspect substance abuse, you will need to ask about it.

**Try these sensitive interviewing techniques when asking patients about their drug use:**
• Remember your role as a health provider – Explain to patients that you need to discuss drug use because you care about their health.
• Remain nonjudgmental this will build patients' self-esteem and prevent them from just telling you what they think you want to hear.
• Convey empathy – Let patients know that you understand that it is difficult to stop using drugs and that you want to help.
• Speak with confidence and knowledge about substance abuse patients often respond more positively to clinicians they deem to be competent and interested.
• Maintain the patient's privacy and assure them of confidentiality – conduct the interview in private and do not bring up the substance abuse around other staff members without the patient's permission.
• Ask simple, open-ended questions, which will elicit the most honest responses.
APPLYING MOTIVATIONAL INTERVIEWING IN SCREENING
In approaching your patients to screen for substance use it is important to:

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

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

QUIZ:
True or False: Although the USPSTF has not found sufficient evidence to weigh the balance of benefits and harms, NIDA encourages the incorporation of drug screening and brief interventions into practices in their general medical resource.

Choose one

1. True
   - Feedback:
   - Correct. The National Institute on Drug Abuse encourages providers to incorporate screening for drug use (including tobacco, alcohol, illicit [i.e., illegal] drugs, and nonmedical use of prescription drugs) in their practices.

2. False
   - Feedback:
   - Incorrect. The National Institute on Drug Abuse does encourage providers to incorporate screening for drug use (including tobacco, alcohol, illicit [i.e., illegal] drugs, and nonmedical use of prescription drugs) in their practices.

VIDEO: SCREENING DURING THE PATIENT INTERVIEW
First Step: Simply Ask
An easy, straightforward, direct approach requires only a single question asked during the patient interview, such as the following:

"How many times in the past year have you used an illegal drug or misused a prescription medication?"
Questions About Prescription Drug Use
There are a variety of approaches to screen for prescription drug misuse. SAMHSA (2008) suggests asking your patients the following questions:

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

Example
A video that illustrates a primary care physician conducting a health risk screening for substance use can be found here: https://youtu.be/5LjhAJMTwmI

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

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

Drug Type
Never Once or Twice Monthly Weekly Daily or almost Daily

Alcohol:
Men: > 5 drinks/day
Women: > 4 drinks/day

Tobacco products

Misused prescription drugs

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

QUIZ: CHALLENGE
Question: Patients who are asked assumptive questions about their drug use often provide accurate and complete responses, while others find them offensive. Which of the following do you think is an assumptive question?

Choose one
1. "Have you been using heroin?"
   - Feedback: Incorrect. This is not assumptive and gives patients an opportunity to deny using drugs. If they say, "No," it is a dead end in the patient interview.
2. "When was the last time you used heroin?"
• Feedback: Correct. When was the last time you used heroin? is the only assumptive question of the three options. By asking ‘When was the last time you used heroin?’ you are assuming that the patient has been using drugs.

• Regarding assumptive questions, some providers feel that there should be no doubt about the situation before such a question is asked. Otherwise, you may offend the patient by making the assumption and immediately destroy the provider-patient relationship.

3. "I see that you have needle tracks on your arm – have you been injecting heroin?"
• Feedback: Incorrect. This is not assumptive and gives patients an opportunity to deny using drugs. If they say, "No," it is a dead end in the patient interview.

SCREENING INSTRUMENTS

Several standardized substance use screening instruments exist, with a varied range of:

• Sensitivity and specificity
• Cost
• Ease of administration

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

CAGE-AID
One of the most commonly used standardized screening tools for detecting drug use problems is the CAGE-AID. It is a variation on the CAGE instrument that was originally created to screen for alcohol use. The CAGE questionnaire was modified to add screening for drug use. "AID" stands for "adapted to include drugs." The authors were able to obtain 70.9% sensitivity and 75.7% specificity with this modified scale.

Each letter in the acronym CAGE represents one question in the 4-item scale:

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

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

OTHER SCREENING INSTRUMENTS

• Two-Item Conjoint Screening (TICS): Brown et al. also created the TICS instrument to screen for substance use disorder in a primary care population. Unlike some other scales,
TICS screens for both alcohol and drug use and is designed to detect current substance use, NOT a history of use. The questions can be integrated into a standard clinical interview.

- **NIDA-Modified Alcohol, Smoking, and Substance Involvement Screening Test (NMASSIST):** Is used to further assess drug use after a positive NIDA Quick Screen.
- **Drug Abuse Screening Test-10 (DAST-10):** A short version of the Drug Abuse Screening Test often used as a screening and diagnostic tool in primary care.
- **AUDIT:** For alcohol, the Alcohol Use Disorders Identification Test, (AUDIT), is often used in primary care for brief screening.

### SCREENING ADOLESCENTS

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

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

#### The Importance of the Interview

Establishing rapport and trust in relationships with young patients can be challenging, but important. Following a patient-centered approach, including an emphasis on building rapport with the adolescent patient can help.

#### Effective Approaches to Establishing Rapport

1. Find something of interest to the adolescent patient and meet them where they are in that area of interest.
2. Adolescents are less likely to talk, make sure to ask open-ended questions.
3. Phrase questions so that your concern is clear.
   - For example, you might lead up to a question with, "In order to provide you with the best care, I am going to ask for information in some sensitive health areas."[^21]
4. Structure the interview to start with questions that the patient could perceive as least threatening.[^21]
5. Once you reach illicit drug use questions, ask about marijuana first, as it is most often the first illicit drug to be used by adolescents.
6. If the patient affirms that he or she uses drugs, ask about patterns of use.

Remember, sensitive issues, such as drug use, should be raised with the patient only, not in the presence of his or her parents. Explaining confidentiality and the patient's right to privacy is especially important with adolescent patients[^22].

Behavioral changes—including psychosocial and academic problems—are likely to accompany problematic drug use; therefore, ask specifically about:

- School attendance, suspensions, or expulsions
- Whether he or she ever has been stopped by the police or arrested[^23]
• Sexual activity and sexual orientation (this can be a source of pain and confusion for some adolescents)

PRACTICE TIP
Be attentive to the adolescent's nonverbal behavior; if you follow-up on nonverbal cues, your patient is likely to divulge more information\textsuperscript{21}. This kind of perceptiveness can strengthen the physician-patient relationship.

TOOLS FOR ADOLESCENTS

Screening
Several standardized screening tools have been validated for use with adolescents, including the commonly used CRAFFT\textsuperscript{24} scale.

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

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

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PRACTICE TIPS
• Try making gentle assumptions ("How often do you drink alcohol?")
• Address positive responses immediately, with further assessment, intervention, and discussion of possible referral or treatment, if indicated, rather than postponing to later in the appointment.

ADOLESCENT RISK FACTORS
Factors conferring greater risk of substance use disorder include childhood ADHD\textsuperscript{25}; conduct disorder\textsuperscript{23}; and sensation-seeking behavior. Homelessness in youth and running away are associated with greater risk of injected opioid use\textsuperscript{26}.

The following are additional red flags for adolescent substance use problems:\textsuperscript{27}
• Marked change in physical health
• Deteriorating performance in school or job
• Dramatic change in personality, dress, or friends
• Involvement in serious delinquency or crimes
• HIV high-risk activities
• Serious psychological problems

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

ADHD is associated with poorer substance use treatment outcomes\(^\text{28}\). Adolescents with ADHD and substance use problems have more severe substance use disorders if they also have major depression and so may warrant more intensive treatment\(^\text{29}\).

**VIDEO: ADOLESCENT INTERVIEW EXAMPLE**

A video that illustrates the following skills being used with an adolescent who, during the interview, reveals illicit opioid use, can be found here: \(\text{https://youtu.be/OAKRz9TJUE}\)\(^\text{30}\)

**Motivational Interviewing Skills**
- Establishing rapport, being non-judgmental, but firm, asking permission to discuss drug use
- Summarizing
- Affirming the patient's strengths
- Establishing the patient's stage of change
- Developing a plan

**Other Counseling Skills**
- Respecting and clarifying confidentiality
- Screening for opioid use disorder
- Patient education

**CASE: MR. HUGHES**

*This is the first of a series of clinical case studies within the module.*

**Meet Your Patient**

Name: Mr. Hughes

Age: 22 years old

Reason for visit: He is in your office today for an annual exam.

Patient History: Mr. Hughes has been a patient of yours for the last 3 years. He has no significant history of medical problems and routinely presents for his annual history and physical, which is required by his college. When completing the routine screening questionnaire for his present visit, he scribbled "sometimes" next to the question about use of drugs.
Think Ahead Question

Question: What are some of the primary physical signs and symptoms of opioid use disorder you should look for during the exam? Please check all that you think apply. We will discuss these symptoms later in the module.

Choose all that apply

1. Pupillary constriction
   - Feedback: Correct. This is a possible physical sign of opioid use disorder. From the list presented, physical signs of opioid misuse include pupillary constriction, needle track marks, skin abscesses, nausea or vomiting, and low blood pressure. Additionally, there may be constipation, decreased respiration rate, confusion, suppression of cough reflex, dry mouth and nose, decreased libido and/or sexual dysfunction, irregular menses, irritation of nose lining, perforated nasal septum, cellulitis or dermatitis present at injection sites, skin necrosis, and tourniquet pigmentation. Additionally, if Mr. Hughes is in withdrawal, he would experience withdrawal symptoms such as sweating, restlessness and pupil dilation.

2. Hair loss
   - Feedback: Incorrect. This is not a physical sign of opioid use disorder.

3. Track marks
   - Feedback: Correct. This is a possible physical sign of opioid use disorder. From the list presented, physical signs of opioid misuse include pupillary constriction, needle track marks, skin abscesses, nausea or vomiting, and low blood pressure. Additionally, there may be constipation, decreased respiration rate, confusion, suppression of cough reflex, dry mouth and nose, decreased libido and/or sexual dysfunction, irregular menses, irritation of nose lining, perforated nasal septum, cellulitis or dermatitis present at injection sites, skin necrosis, and tourniquet pigmentation. Additionally, if Mr. Hughes is in withdrawal, he would experience withdrawal symptoms such as sweating, restlessness and pupil dilation. Diarrhea may also be a sign of withdrawal.

4. Skin abscesses
   - Feedback: Correct. This is a possible physical sign of opioid use disorder. From the list presented, physical signs of opioid misuse include pupillary constriction, needle track marks, skin abscesses, nausea or vomiting, and low blood pressure. Additionally, there may be constipation, decreased respiration rate, confusion, suppression of cough reflex, dry mouth and nose, decreased libido and/or sexual dysfunction, irregular menses, irritation of nose lining, perforated nasal septum, cellulitis or dermatitis present at injection sites, skin necrosis, and tourniquet pigmentation. Additionally, if Mr. Hughes is in withdrawal, he would experience withdrawal symptoms such as sweating, restlessness and pupil dilation. Diarrhea may also be a sign of withdrawal.

5. Diarrhea
   - Feedback: Not a sign of opioid use disorder per se, but is a sign of withdrawal. While diarrhea is not a primary physical sign of opioid use disorder, it is, along with other
symptoms, such as dilated pupils, elevated blood pressure, yawning, sweating, watery eyes, runny nose, restlessness, and more, a symptom of opioid withdrawal. Opioid withdrawal, in turn, is a criterion for opioid use disorder. Opioid withdrawal is discussed in more detail later in this course. Diarrhea would also be more common in an IV drug user, as a result of their increased risk for various infectious diseases.

6. Nausea or vomiting
   - Feedback: Correct. This is a possible physical sign of opioid use disorder. From the list presented, physical signs of opioid misuse include pupillary constriction, needle track marks, skin abscesses, nausea or vomiting, and low blood pressure. Additionally, there may be constipation, decreased respiration rate, confusion, suppression of cough reflex, dry mouth and nose, decreased libido and/or sexual dysfunction, irregular menses, irritation of nose lining, perforated nasal septum, cellulitis or dermatitis present at injection sites, skin necrosis, and tourniquet pigmentation. Additionally, if Mr. Hughes is in withdrawal, he would experience withdrawal symptoms such as sweating, restlessness and pupil dilation. Diarrhea may also be a sign of withdrawal.

7. Coughing
   - Feedback: Incorrect. This is not a primary physical sign of opioid use disorder. In fact, the cough reflex may be suppressed. However coughing might be more common in an IV drug user, as a result of their increased risk for various infectious diseases.

8. Low blood pressure
   - Feedback: Correct. This is a possible physical sign of opioid use disorder. From the list presented, physical signs of opioid misuse include pupillary constriction, needle track marks, skin abscesses, nausea or vomiting, and low blood pressure. Additionally, there may be constipation, decreased respiration rate, confusion, suppression of cough reflex, dry mouth and nose, decreased libido and/or sexual dysfunction, irregular menses, irritation of nose lining, perforated nasal septum, cellulitis or dermatitis present at injection sites, skin necrosis, and tourniquet pigmentation. Additionally, if Mr. Hughes is in withdrawal, he would experience withdrawal symptoms such as sweating, restlessness and pupil dilation. Diarrhea may also be a sign of withdrawal.

**PHYSICAL SIGNS & SYMPTOMS**

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

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

Physical Signs of Injection and Other Illicit Drug Use
(Image courtesy of NIDA)

Look for changes in patient affect and behavior. For example, paranoia can be seen with marijuana or stimulant use.

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

PRACTICE TIP
Physical Exam for Teens

The adolescent's history will yield more information than the physical examination\(^23\), because a relatively short history of use typically does not cause drug-associated health problems, physical dependence, or withdrawal. Still, signs and symptoms of substance use may be seen, similar to those found in adults.

OTHER SIGNS OF OPIOID USE

Appearance of Patients
Some patients who misuse opioids may appear normal physically, especially patients who misuse prescription opioids or who take heroin intranasally. A number of signs and symptoms that suggest a patient's prolonged use of opioids can be detected through a physical exam.

The physical exam should focus on evaluating neurocognitive function and identification of sequelae of opioid misuse or severe hepatic dysfunction\(^31\).

Indications of Substance Use
Patient complaints that can indicate alcohol or other drug problems, including the following\(^32\):

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

Especially in the presence of physical signs of opioid use, these complaints should be considered red flags for drug abuse.

MR. HUGHES – PHYSICAL EXAM

Back to the case study...

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

However, there are no physical signs of injection drug use.

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

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

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

Provider: Heroin?

Mr. Hughes: Uh, actually, yeah.

Provider: Prescription narcotics?

Mr. Hughes: Some.

Provider: Some are more of a concern than others, benzodiazepines for example. Which ones do you use?

DID YOU KNOW?

When conducting a patient evaluation:

• Be nonjudgmental and convey empathy
• Use motivational interviewing and brief interventions to increase patient motivation
• Use open-ended questions to elicit more thorough information from patients
PSYCHOSOCIAL INDICATORS

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

Cravings
Cravings are an added criterion in the DSM 5 diagnosis of opioid use disorder. In asking about craving, include thinking a lot about using, dreams about using, having using opioids on your mind a lot.

Behavioral
Agitation, anxiety, anger, irritability, depression, insomnia, mood swings, weight changes

Family
Marital problems (including separation and divorce), abuse or violence, children’s behavioral problems, family members’ anxiety and depression

Social
Loss of long-standing friendships, spending time with other drug abusers, social isolation, loss of interest in regular activities

Work or School
Missing work or school, poor performance, frequent job changes or relocations

Legal
Arrests, DUIs, theft, drug dealing (legal problems are no longer a diagnostic criterion)

Financial
Recent large debt, borrowing money from friends/relatives, selling possessions

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

PATIENT INTERVIEW DETAILS

Evaluate
After substance abuse is detected, fully evaluate the patient to determine a correct diagnosis before initiating treatment planning.

Issues to cover during evaluation should include the following:

Include all possible drugs:
- Illicit drugs
- Prescription drugs
- Alcohol, tobacco, and caffeine

Time factors to include:
- Initiation of drug use
- Change in use over time
- Current use patterns
- Time of last use

For prescription drug use, ask pointed questions to determine if medications were used as prescribed.
Tolerance, Intoxication, and Withdrawal
If necessary, define these concepts for the patient. Determine patterns of tolerance and withdrawal and include questions about injuries sustained while intoxicated.

Abstinence and Relapse
Ask if, when, and how long the patient has attempted to abstain from drugs. Also explore what factors contributed to relapse, if applicable. What have been the outcomes of drug use? Identifying losses and/or problems in their lives that may increase patients' motivation to change.

Consequences of Use
Ask about consequences by category, such as medical, family, employment, and legal.

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

Treatment History
Self-help groups might include 12-step Narcotics Anonymous or Alcoholics Anonymous.

Psychiatric History
Questions pertaining to previous psychiatric treatments should include where and from whom treatment was received, and which psychotherapeutics were prescribed if any.

Medical History
Does the patient currently take any prescription or over-the-counter medications? Have drug allergies?

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

Personal (Social) History
Chronicle the patient's life from birth and childhood to present circumstances.

QUIZ: MR. HUGHES - HISTORY & EVALUATION

History (Continued): With prompting, Mr. Hughes admits to using both heroin and prescription opioids, including Percocet® and OxyContin®. He snorts the heroin instead of injecting because, in his words, "it's a lot safer." He uses opioids on a daily basis and also abuses other drugs when they are available, including alcohol, marijuana, and Ritalin®.

He started using drugs last year when he was having problems at school. He explains that he had a really demanding semester and that he liked to relax with his friends on the weekends. Previously, Mr. Hughes drank a lot but found that alcohol was not providing the "release" that he was seeking. Several of his friends introduced him to pills and eventually to heroin when he needed something stronger.

Clinical Choice
You have covered several key areas in your evaluation of Mr. Hughes, such as his medical history, drug use history, patterns of drug use, and tolerance.
**Question:** Which of the following topics is **ARE** essential part of the thorough patient evaluation that must be done prior to diagnosing and treating Mr. Hughes?

**Choose all that apply:**

1. Assess his craving and sense of control over his drug use.
   - Feedback: Correct! It is important to assess Mr. Hughes' craving and sense of control of his drug use.
2. Gauge his understanding of the consequences of drug use.
   - Feedback: Correct! It is important to gauge Mr. Hughes' understanding of the consequences of drug use.
3. Discuss with him whether he will be able to avoid places and people where he obtained his drugs.
   - Feedback: Incorrect. Determining where/how Mr. Hughes buys his drugs is not necessary to make a diagnosis but is relevant to determining safety of the home environment in selecting a treatment setting. If his family or friends are his dealers, for example, separation from them could improve chance of successful treatment. However, all of the other options are important steps in a thorough evaluation, and you must fully evaluate his substance abuse before you can consider a diagnosis (or diagnoses) and possible treatment.
4. Gather complete medical, psychiatric, family, and social histories.
   - Feedback: Correct! It is important to gather Mr. Hughes' complete medical, psychiatric, family, and social histories.

**MR. HUGHES – SUMMARY AND PLAN**

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

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

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

The concepts of tolerance, physical dependence, and withdrawal are important to understand before discussing opioid use disorder.

Physical Dependence

PHYSICAL DEPENDENCE has been defined as the "state of biologic adaptation that is evidenced by a class-specific withdrawal syndrome when the drug is abruptly discontinued or the dose rapidly reduced, and/or by the administration of an antagonist"⁵.

**CHARACTERISTICS:**

- If withdrawal occurs after a person reduces or stops drug use, it suggests physical dependence.
- Users are not likely to experience withdrawal symptoms until they have used opioids regularly for at least two weeks.
- Physical dependence is not a diagnosis, but instead a description of a physiological state.
- Physical dependence is considered normal with chronic opioid therapy and is NOT a criterion for a diagnosis of Opioid Use Disorder³⁴.

Withdrawal

WITHDRAWAL. Briefly, opioid withdrawal, which is covered in detail in other modules, is a dysphoric and physically uncomfortable, non-fatal state that occurs when a physically dependent individual stops using opioids or markedly reduces their dose. Symptoms include:³⁴

- Dysphoric mood
- Nausea or vomiting
- Muscle aches
- Lacrimation or rhinorrhea
- Pupillary dilation, piloerection, or sweating
- Diarrhea
- Yawning
- Fever
- Insomnia

Tolerance

TOLERANCE is "a state of physiologic adaptation in which exposure to a drug induces changes that result in diminution of one or more of the drug's effects over time"⁵.

Note that opioid physical dependence and tolerance are not synonymous with opioid addiction or Opioid Use Disorder.

PRACTICE TIP

Note that patients who are taking prescription opioids for legitimate purposes and who are undermedicated can appear to meet the criteria for opioid use disorder. For example, they may exhibit diagnostic criteria, such as tolerance, withdrawal, and a lot of time spent seeking opioids. This does not necessarily mean that these patients have opioid use disorder. The appearance of a disorder will
disappear once the patient is adequately medicated. This phenomenon is sometimes called pseudo-addiction[^35].

**KEY POINTS**
- Withdrawal symptoms when a person reduces or stops opioid use suggests physical dependence, which is common with chronic opioid use.
- With tolerance, a drug user needs more of the drug to feel the same effects or feels less effect with a constant dose.

**OPIOID USE DISORDER CHARACTERISTICS**

The diagnostic features of opioid-use disorder, according to the DSM 5 include the following[^34]:
- Prolonged misuse
- For pain management, prolonged use, or use in excess of what is needed to treat the pain and used not just for the pain
- Compulsive use
- Obtaining it illegally or fraudulently (including exaggerations) from a medical practitioner
- Tolerance and withdrawal
- Conditioned response to drug-related stimuli or cues. Note that this conditioning may continue well into buprenorphine maintenance.

**OPIOID USE DISORDER CRITERIA**

The criteria for a diagnosis of Opioid Use Disorder were most recently published in the DSM 5 in May 2013[^34]. Diagnosis requires a pattern of using opioids causing "clinically significant impairment or distress" and meeting at least 2 of the following criteria:

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

11.*Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal (Does not apply when used appropriately under medical supervision)

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

The above criteria are paraphrased from the APA publication; view the original wording in the Opioid Use Disorder Diagnostic Criteria resource on this page.

OPIOID USE DISORDER SEVERITY

Severity

Severity is determined by the number of diagnostic criteria a patient meets, as follows:

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

DSM 5 diagnostic codes are:

- Opioid use disorder, Mild – 305.50
- Opioid use disorder, Moderate or Severe – 304.0

ICD 10 diagnostic codes are:

- Opioid use disorder, Mild – F11.10
- Opioid use disorder, Moderate or Severe – F11.20

Note that in ICD-10 coding, if there is opioid intoxication, opioid withdrawal, or other opioid-induced mental disorder, the codes for these conditions are used, and the comorbid opioid use disorder is only designated with an additional numeral. Details are available in the External Resource: Opioid Use Disorder Diagnostic Criteria.

Specifications

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

- In early remission: Defined as no criteria being met for ≥ 3 months, but < 12 months, except the criterion of "craving, or a strong desire or urge to use opioids."
- In sustained remission: Defined as no criteria being met for ≥ 12 months, except the criterion of "craving, or a strong desire or urge to use opioids."
- On maintenance therapy: Use when patient is on medication-assisted treatment for opioid use disorder and does not meet criteria except opioid tolerance or withdrawal. *Used with maintenance on buprenorphine, methadone, or naltrexone. Note that severity of the opioid use disorder will likely change over time with treatment.
- In a controlled environment: Patient is in an environment with restricted access to opioids, e.g., closely monitored substance-free prison, locked hospital unit

*Note that more than one specifier may apply.
Changes in DSM 5 from DSM-IV TR
The criteria for opioid use disorder in the DSM 5 are a combination of the DSM-IV TR criteria for the former diagnoses of Opioid Abuse and Opioid Dependence. Other changes include:

- Normal physiological dependence that everyone experiences if on chronic opioid therapy is not a criterion in DSM 5.\textsuperscript{34}
- The former diagnoses of Substance Abuse and Substance Dependence, found in the DSM-IV TR, are no longer in use.
- Cravings were added as a criterion
- Legal problems were removed as a criterion

QUIZ: SUBSTANCE USE DISORDER
Question: Which of the following are criteria for Substance Use Disorder?
Choose all that apply

1. Continued drug use despite health problems
   - Feedback: Correct. Continuing to use a substance despite knowing that its use is causing health problems is one of the criteria for substance use disorder.

2. Unsuccessful attempts to curtail drug use
   - Feedback: Correct. Being unable to control substance use in spite of one's desires or best efforts is one of the criteria for substance use disorder.

3. Drug tolerance
   - Feedback: Correct. Tolerance for a substance, as defined by either the need for increasing amounts or by a diminished effectiveness, is one of the criteria for substance use disorder.

4. Legal problems related to substance use
   - Feedback: Incorrect. Legal problems related to substance use is no longer a diagnostic criterion for substance use disorder.

WHEN IS TREATMENT REQUIRED?

Does Everyone With the Diagnosis Need Treatment?
Most candidates for office-based buprenorphine treatment will have a diagnosis of opioid use disorder. In their guidelines for medication assisted treatment, which includes buprenorphine, ASAM noted that treatment "may not be appropriate for all patients along the entire opioid use disorder continuum".\textsuperscript{36} Treatment was originally recommended for the now retired DSM-IV diagnosis of opioid dependence, which, according to this source, corresponds to at least moderate (4 criteria) Opioid Use Disorder using the DSM 5. The CDC guidelines for opioid prescribing, which recommend that treatment be provided or offered to patients having opioid use disorder, suggests tapering patients who do not meet enough diagnostic criteria for opioid use disorder.\textsuperscript{37}
People Who Need Treatment Without the Opioid Use Disorder Treatment
The following groups are exceptions that may not have the diagnosis of opioid used disorder, but who still might benefit from buprenorphine treatment:

- Occasional abusers: Some high-risk, opioid-abusing patients who do not meet diagnostic criteria, may be good candidates for buprenorphine maintenance.
- Certain patients who are not currently abusing opioid may also qualify for office-based opioid treatment. For example, an inmate with a good prior treatment record with buprenorphine ("institutional abstinence") may be maintained on buprenorphine following his or her release from prison, if relapse is likely\(^2\). However, it is important that persons released from institutions with institutional abstinence be educated that their opioid tolerance is now relatively lower, in order to reduce their risk of overdose.

FYI
The FDA’s guidelines for REMS for prescribing buprenorphine, include an "Appropriate Use Checklist"\(^3\) that you can use to guide your buprenorphine practice.

ASSESS PATIENTS FOR OFFICE BASED TREATMENT
Once you identify opioid use disorder in a patient
Skills needed for patient assessment include being able to:

- Assess patient attitudes
- Motivate patients for change
- Determine appropriate interventions

The following aspects should be included in the assessment of patients with opioid use disorder, when considering them for office-based buprenorphine treatment:\(^5\):

- Duration
- Pattern and severity of opioid use disorder
- Level of tolerance
- History of previous attempts to use agonist therapy
- History of previous attempts to quit
- Current opioid use and withdrawal status
- History of withdrawal
QUIZ: CASE: MRS. THOMAS

Meet Your Patient
Name: Mrs. Thomas
Age: 52 years old
Reason for visit: Lower back pain. She is in your area for the winter and could not reach any of her regular providers. She decided that it would be best to have a provider nearby.

Patient History: Back pain started with a car accident 6 months ago. Mrs. Thomas has been seeing another provider who prescribed oxycodone telling her that she would probably need it for about a month. She has been taking the medication for almost 6 months now, by visiting multiple providers and not informing them of the others. Although Mrs. Thomas reports feeling only slight back pain now, she is taking increasingly large doses of oxycodone every day to "stay ahead of the pain."

Ms. Thomas: I still have some back pain if I don't take my meds. If I reduce my dose, I have some pain and don't feel good. I didn't intend to take oxycodone for so long, but I need it to get me through the day.

Initial Impression

Question: Which of Mrs. Thomas's behaviors suggest a possible diagnosis of opioid use disorder? (check all that apply)

Choose all that apply
1. Visiting multiple providers for prescriptions for opioids
   - Feedback: Correct. By visiting multiple doctors, Mrs. Thomas is spending significant time and effort trying to obtain opioids, which is one of the DSM-5 criteria for substance use disorder.
2. Requiring a high dose of opioids every day to help her "stay ahead" of her back pain and "get through the day"
   - Feedback: Possibly. Needing a higher dose of opioids to achieve the desired effect, known as "tolerance", is one of the DSM-5 criteria for substance use disorder. This criterion would not be met if she was "taking opioids solely under appropriate medical supervision," however, her "doctor shopping" does not qualify as "appropriate supervision." Thus she does not appear to qualify for this exclusion. However, it is possible that she is doctor shopping due to undertreated pain.

To be certain of whether to count this criteria Opioid Use Disorder, she would need to be interviewed further regarding these behaviors. Other criteria for the diagnosis and her back injury would need to be evaluated to ascertain whether this level of opioids is needed.

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

MRS. THOMAS – FURTHER EVALUATION

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

Multiple Medications and Pharmacies
You also inquire about any other prescription medications she is taking at the moment. Mrs. Thomas says that she has also been taking meperidine “off and on for years,” prescribed by another provider for pain she experienced after surgery. She reports that she travels a lot and gets her prescriptions filled wherever she can, so she does not always use the same pharmacy.

Signs and Symptoms
She self-reports daily sleepiness and nausea, which could be from intoxication. GI symptoms including nausea may also be related to withdrawal symptoms. Insomnia from withdrawal might also produce subsequent sleepiness. A physical exam reveals pupillary constriction, suggesting current intoxication.

Family Issues
After further questioning, she reports that her 5 children have each confronted her at different times about her oxycodone use, and that she has not spoken to her youngest son in over a month since he accused her of being "hooked" on the pills. She also says that sometimes she has felt a bit ashamed because she needs so much medication and that every day she considers discontinuing her use of pain pills, but she is too fearful that the severe pain will return if she stops taking the medications.

Supporting Mrs. Thomas
Acknowledge her medical issues, explain what happened with her pain and how in some people narcotics can lead to substance use disorder. Additionally, remember to acknowledge it as a disease.

QUIZ: MRS. THOMAS DIAGNOSIS

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

Question: Has Mrs. Thomas exhibited two or more of the criteria for opioid use disorder in the past 12 months? (Check all criteria that are currently present. Some, but not all, of the following criteria apply to this patient.

Choose all that apply
1. The substance is often taken in larger amounts or over a longer period of time than was intended.
   - Feedback:
   - She has increased her dose and taken the medication for longer than she was originally expected to be on it.

2. There is a persistent desire or unsuccessful efforts to cut down or control substance use
   - Feedback:
   - Near the end of the interview she said that she thinks about quitting every day.

3. A great deal of time is spent in activities necessary to obtain the substance, use it, or recover from its effects
   - Feedback:
   - It appears that she is spending a lot of time at doctors obtaining a sufficient supply of her medication.

4. Cravings
   - Feedback:
   - Criterion not evident.

5. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.
   - Feedback:
   - Criterion not evident.

6. Continued substance use despite having persistent or recurrent social or interpersonal problems caused by or exacerbated by the effects of the substance.
   - Feedback:
   - Her 5 children have each confronted her about her oxycodone use, she has not spoken to her youngest son in over a month since he accused her of being "hooked" on the pills.

7. Important social, occupational, or recreational activities are given up or reduced because of substance use
   - Feedback:
   - She has not spoken to her youngest son in over a month since he accused her of being "hooked" on the pills. She was not specifically asked about her occupational or recreational activities.

8. Recurrent use of opioids in physically hazardous situations
   - Feedback:
   - Criterion not evident. While driving or operating machinery can be dangerous when first taking opioids, most patients are able to drive after they adjust to chronic use.

9. The substance use is continued despite the knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance
   - Feedback:
   - Criterion not evident

10. Tolerance, as defined by either a need for markedly increased amounts of the substance to achieve desired effect or markedly diminished effect with continued use of the same amount of the substance.
• Feedback:  
  • Mrs. Thomas described needing a higher dose than she was prescribed. 

11. Withdrawal, as manifested by either the characteristic withdrawal syndrome for the opioid or the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.  
• Feedback:  
  • It is not clear whether she is experiencing withdrawal. She only mentioned two possible symptoms of withdrawal. You would need to specifically ask her more questions about withdrawal symptoms.

MRS. THOMAS – DIAGNOSIS AND PLAN

Diagnosis
Mrs. Thomas currently meets over 2 criteria for opioid use disorder and so this diagnosis is appropriate.

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

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

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

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

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

OPIOID WITHDRAWAL DIAGNOSIS

WITHDRAWAL, classified as a substance-induced disorder by the DSM, is a pattern of physiological, psychological, and behavioral changes precipitated by the decline in an individual's bodily levels of a substance. It generally begins between a few hours and a half a day after the last use of heroin\(^34\).

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

Consideration of the diagnostic criteria for opioid withdrawal may be helpful when evaluating patients' state of withdrawal prior to buprenorphine induction.

DSM Criteria for Opioid Withdrawal
A. Either of the following:
   1. Cessation of (or reduction) opioid use that has been heavy and prolonged (several weeks or longer)
   2. After the administration of an opioid antagonist proceeding a period of opioid use

B. Three (or more) of the following, developing within minutes to several days after Criterion A:
   1. Dysphoric mood
   2. Nausea or vomiting
   3. Muscle aches
   4. Lacrimation or rhinorrhea
   5. Pupillary dilation, piloerection, or sweating
   6. Diarrhea
   7. Yawning
   8. Fever
   9. Insomnia

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

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

Note that most withdrawal scales used clinically, such as the SOWS, are broader than the DSM 5 criteria for withdrawal. For example withdrawal scales often include all vital signs, including respiration (yawning), and symptoms of withdrawal in these scales are not necessarily grouped as in the DSM list.

Significance of Opioid Withdrawal
Withdrawal from opioids generally poses no serious medical risks. It is a very uncomfortable process that often continues (sometimes for months) in a more moderate form and can entail fatigue, depression, and difficulty sleeping. This is a major reason why many former users find it problematic to remain abstinent.

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

EVALUATING WITHDRAWAL USING SCALES
Recognizing Withdrawal
Recognizing withdrawal is crucial since patients should be in moderate withdrawal immediately before their first dose of buprenorphine during induction (discussed in detail later in the activity). Note
that most patients are very familiar with their symptoms of withdrawal and will be able to tell you about it.

**Withdrawal Assessment Scales**

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

- **Grade 0** Drug craving, anxiety, and drug-seeking behavior
- **Grade 1** Yawning, sweating, watery eyes, and runny nose
- **Grade 2** Excessive or prolonged pupillary dilation, goose bumps, muscle twitching, and anorexia
- **Grade 3** Insomnia; increased pulse, respiratory rate, and blood pressure; abdominal cramps; vomiting; diarrhea; and weakness

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

**Opioid Withdrawal Scales**

Other opioid withdrawal scales include:

- Clinical Opioid Withdrawal Scale (COWS)
- Objective Opiate Withdrawal Scale (OOWS)
- Subjective Opiate Withdrawal Scale (SOWS)

**FYI**

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

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**QUIZ: CASE: MR. LOPEZ**

**Meet Your Patient**

**Name:** Mr. Lopez  
**Age:** 50 years old  
**Reason for visit:** Mr. Lopez requests a buprenorphine prescription. He has been self-medicating with buprenorphine to reduce his use of hydrocodone and oxycodone.

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

**Treatment History:** About a year ago he was fed up and decided to stop taking hydrocodone. At that point he was taking up to 15 tablets a day, and if he went for six hours with no pills he suffered withdrawal. So he bought 15 buprenorphine tablets from an acquaintance and switched to those for a few days. The buprenorphine helped and he was able to buy another two weeks' worth from his
friend, but after he ran out, he could barely function due to nausea and achiness. He was able to hold on for a few more days, but soon started taking hydrocodone once again and is currently using it. He felt more clear-headed on buprenorphine so he would like to resume taking it. This time he decided to ask to have it prescribed; hence, his visit to you.

**Initial Diagnosis**

**Question:** Based on this brief history, what is the most likely diagnosis for Mr. Lopez?

Choose one

1. Physiological opioid dependence from chronic opioid therapy
   - Feedback: Incorrect. This is not the best option. Mr. Lopez has experienced tolerance, withdrawal when stopping use, has spent a lot of time in activities related to using opioids, and had at least one unsuccessful attempt to stop. This meets a number of DSM criteria for opioid use disorder, which goes beyond simple physiological dependence from chronic opioid use.

2. Opioid use disorder
   - Feedback: Correct. Mr. Lopez does appear to meet a number of DSM criteria for opioid use disorder. He has experienced tolerance, withdrawal when stopping use, has spent a lot of time in activities related to using opioids, and had at least one unsuccessful attempt to stop.

3. No current substance use disorder
   - Feedback: Incorrect. This is not the best option. Ricardo has experienced tolerance, withdrawal when stopping use, has spent a lot of time in activities related to using opioids, and had at least one unsuccessful attempt to stop. This meets a number of DSM 5 criteria for opioid use disorder.

4. Opioid withdrawal syndrome
   - Feedback: Incorrect. This diagnosis is reserved for people who are currently in active withdrawal. Mr. Lopez is currently taking an opioid.

**QUIZ: MR. LOPEZ - MORE HISTORY**

**Patient History (continued):** Mr. Lopez works as a building construction inspector. He is divorced and lives alone. The highlight of his week is taking care of his 3-year old grandson on Saturdays.

Mr. Lopez has no regular friends except the guys at the bar and at work. Most weekdays after work, he stops at the local bar and has several drinks with his friends. When asked whether he plans to decrease or stop drinking, he says he's not sure he really wants to stop drinking. His sisters have told him that he drinks too much. He is careful to avoid alcohol when he is taking care of his grandson.

Mr. Lopez says he was told by one of his doctors that he was depressed and that the doctor put him on Zoloft®. He took it as directed for six weeks, but then stopped it because it "messed up" his sex life. Sometimes he feels dejected, but he doesn't feel suicidal and does not cry a lot. "What gets me down is this Vicodin® and Percocet® habit. If I got rid of these drugs I wouldn't be down at all."
Question: How does Mr. Lopez's history affect your treatment decisions?

Choose one

1. He is still a good candidate for buprenorphine treatment, despite the alcohol use and other history.
   - Feedback: Incorrect. At this point, Mr. Lopez needs further screening for alcohol use disorder with lab tests (liver enzymes) to discover the severity of his alcohol problem, before proceeding with buprenorphine treatment.

2. He is not a good candidate for buprenorphine treatment, due to the alcohol use and other history.
   - Feedback: Possibly Correct. At this point, Mr. Lopez needs further screening for alcohol use disorder with lab tests (liver enzymes) to discover the severity of his alcohol problem, before proceeding with buprenorphine treatment. He is under-aware of his potential alcohol problem. Consider: Does he smell like alcohol? Does he have symptoms of alcohol dependence (tremors, etc.) when he doesn't drink? Similarly, his depression evaluation needs to be updated. Depending upon the severity of these problems, consider that he has two risk factors for poor buprenorphine treatment outcomes. Your decision to treat him in an office-based opioid treatment program should consider the severity of these problems, his response to their treatment, and your level of expertise in handling cases with these complications. Providers new to prescribing buprenorphine or polysubstance use might consider a referral to a more experienced provider or a higher level of care. If you do continue with OBOT, you should review with him the warning about CNS depressant use when taking buprenorphine and include additional treatment structure, such as psychosocial supports and more frequent office visits.

3. Not enough information
   - Feedback: Correct. At this point, Mr. Lopez needs further screening for alcohol use disorder with lab tests (liver enzymes) to discover the severity of his alcohol problem, before proceeding with buprenorphine treatment. He is under-aware of his potential alcohol problem. Consider: Does he smell like alcohol? Does he have symptoms of alcohol dependence (tremors, etc.) when he doesn't drink? Similarly, his depression evaluation needs to be updated. Depending upon the severity of these problems, consider that he has two risk factors for poor buprenorphine treatment outcomes. Your decision to treat him in an office-based opioid treatment program should consider the severity of these problems, his response to their treatment, and your level of expertise in handling cases with these complications. Providers new to prescribing buprenorphine or polysubstance use might consider a referral to a more experienced provider or a higher level of care. If you do continue with OBOT, you should review with him the warning about CNS depressant use when taking buprenorphine and include additional treatment structure, such as psychosocial supports and more frequent office visits.
**QUIZ: MR. LOPEZ – ADDITIONAL TREATMENT CONCERNS**

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

**Question:** If Mr. Lopez was admitted to buprenorphine treatment in an office-based opioid treatment practice, what would a tailored, optimal assessment, evaluation, and treatment plan include? (Check all that apply)

**Choose all that apply:**
1. Get a more complete history.
   - Feedback: This and all the other steps listed are important for fully evaluating and treating Mr. Lopez.
2. Conduct a physical exam.
   - Feedback: This and all the other steps listed are important for fully evaluating and treating Mr. Lopez.
3. Conduct lab testing.
   - Feedback: This and all the other steps listed are important for fully evaluating and treating Mr. Lopez.
4. Further evaluate his social isolation and depression.
   - Feedback: This and all the other steps listed are important for fully evaluating and treating Mr. Lopez.
5. Further evaluate his alcohol use/abuse/addiction.
   - Feedback: This and all the other steps listed are important for fully evaluating and treating Mr. Lopez.
6. Involve Mr. Lopez in treatment planning and decision-making.
   - Feedback: This and all the other steps listed are important for fully evaluating and treating Mr. Lopez.

**MR. LOPEZ – SUMMARY AND PLAN**

**Summary and Treatment Plan**
Given Mr. Lopez’s history, you might emphasize a patient-centered approach in which he is included in the decision-making process and is informed of all his choices. He seems to have his own ideas about what he wants, so it is important to understand his expectations. For example, you could ask, “what kind of treatment do you feel would be best for you at this time?” It is also important to clearly explain your office-based opioid treatment program requirements so he can decide early on whether he wants to participate.
You should also review how Mr. Lopez can ask for help because of his possible reluctance to ask for help. For example, explain how he can reach you if he has questions about his treatment, what to do if he feels like using opioids, etc. This can be outlined in a treatment agreement that Mr. Lopez could review and sign, along with the informed consent, which must be signed. For patients who might hesitate to sign a treatment agreement, emphasize that the point of the agreement is to make the program clear, including what is expected to happen in terms of how they will improve, how they will be monitored, and the process for obtaining refills. The patient is often given a handbook or copy of the agreement.

**Concepts to Discuss**

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

**SUMMARY AND KEY POINTS**

**Motivational Interviewing**

The basic steps of motivational interviewing, which can be used to facilitate healthy behavior change in a patient, are the following:

- Engage the patient/establish rapport
- Focus the conversation on the topic
- Elicit from the patient thoughts and feelings about their substance use or quitting
- Develop a plan for change with the patient

**Substance Abuse Screening**

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

**Signs and Symptoms of Opioid Use Disorder**

- Track marks are often indicative of intravenous heroin abuse as well as psychosocial indicators.
- Common signs and symptoms of prescription opioid misuse include:
  - Constipation
  - Low blood pressure
  - Respiratory depression
  - Mental status changes
- Common signs and symptoms of injection use include:
- Pupillary constriction
- Sleepiness
- Euphoria
- Constipation
- Nausea
- Suppression of the cough reflex

**Further Assessment for Substance Abusers**
- Healthcare providers they are currently seeing
- What prescription drugs they take (and why)
- History of drug of addiction use:
  - Length of, severity of, and patterns of addiction
  - Tolerance, intoxication, and withdrawal
  - Abstinence and relapse
  - Consequences of use
  - Craving and control
- Treatment: medical and psychosocial

**Guidelines for Assessing Adolescent Patients**
- Adolescent patients should be routinely screened for substance abuse; standardized tools are available

**Opioid Withdrawal**
- Opioid withdrawal can begin either when opiate use ceases or is reduced or upon administration of an opiate antagonist.
- Signs and symptoms of withdrawal include:
  - Drug craving
  - Anxiety
  - Intense drug-seeking behavior
  - Yawning
  - Sweating
  - Lacrimation
  - Rhinorrhea
  - Mydriasis
  - Gooseflesh
  - Muscle twitching
  - Anorexia
  - Insomnia
  - Increased pulse, respiratory rate, and blood pressure
  - Abdominal cramps
  - Vomiting
  - Diarrhea
  - Weakness
RESOURCES AVAILABLE THROUGH THIS MODULE:

- **Assessment and Screening Instruments**
  This document provides a comprehensive collection of screening instruments and withdrawal assessments.

- **Buprenorphine-containing transmucosal products for opioid dependence (BTOD) REMS**
  REMS for buprenorphine published 2/2013 and revised 9/2013

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

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

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

- **Detecting Substance Abuse and Dependence: Red Flags, and Risk Factors**
  Lists the psychosocial and physical indications of substance abuse in general as well as the specific physical symptoms of opioid use (Source: Clinical Tools, Inc., 2004).

- **Diagnosis and Treatment of Drug Abuse in Family Practice**
  This article provides guidance on the treatment of alcohol and drug abuse, and discusses various treatment plans.

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

- **DSM-5 Criteria for Opioid Use Disorder**
  The following are the DSM-5 diagnostic criteria for Opioid Use Disorder

- **DSM 5 Criteria for Opioid Intoxication**
  The following is the DSM 5 diagnostic criteria for Opioid Intoxication.

- **DSM 5 Diagnostic Codes Related to Substance Use Disorders**
  DSM-IV and DSM 5 Diagnostic Codes Related to Substance Use Disorders (*Note: DSM 5 was released in May 2013 and includes significant changes to diagnosis. For example, it does away with separate "dependence" and "abuse" diagnoses and combines them into "substance use disorder."*)

- **DSM 5 Substance-Related and Addictive Disorders**
  The APA's breakdown on changes to substance-related addictive disorder diagnoses introduced by DSM-5. The document goes over substance use disorder, addictive disorders and briefly states the APA's position on caffeine use disorder.

- **FSMB Model Policy for the Use of Controlled Substances for the Treatment of Pain**
  This document, first published in 2004 and revised in July 2013, is a model policy for state medical boards to use in developing their guidelines for use of opioids in treating chronic pain. These Model Guidelines provide the FSMB's policy on proper treatment of pain and the use of opioids when necessary to manage pain. Source: Federal State Medical Boards (FSMB)

- **Motivational Interviewing Overview**

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Detection and Diagnosis of Opioid Use Disorder
This web page by ATTC Network is dedicated to motivational interviewing training. It contains links to a variety of articles, addressing all areas of MI from brief overviews to history, philosophy, principles, working with resistance, interaction techniques, and strategies. The site has a library, training information, and special populations information.

- **NIDA Quick Screen**
  The NIDA Quick Screen can be used in clinical practice to screen patients for substance use disorders.

- **NM ASSIST**
  The NM ASSIST is a screening tool that can be used in primary care to detect drug and alcohol abuse. The full version of the tool includes step-by-step screening algorithms.

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

- **Opioid Use Disorder Diagnostic Criteria**
  The Diagnostic criteria for opioid use disorder,

- **Risk and Protective Factors in Drug Abuse Prevention**
  This is a brief list of risk and protective factors to look for when evaluating patients for substance abuse.

- **Risk Factors: How can health professionals mitigate these risks?**
  This is a brief list of risk factors to look for when evaluating patients for substance abuse. There is also guidance on how health professionals can mitigate adolescent risk for substance abuse.

- **Self-Administered Addiction Severity Index (ASI-Self Report)**
  The ASI Self-Report Form asks questions about the following topics: your background and employment, your health and family relationships, your legal situation, and your drug and alcohol use.

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

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

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

**REFERENCES USED IN THIS MODULE:**


