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Assessing Patients for Buprenorphine Treatment

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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 treatment protocols 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

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 (The years from 2008 to 2012 had a similar rate.)
  - 4.5 million or 1.7% current users of non-medical use of pain relievers (similar to 2011 and 2012).
- New use:
  - 169,000 individuals were new initiates to heroin (similar to estimates from 2007 to 2012).
  - 1.5 million individuals were 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:
  - Receipt of treatment for heroin use in the past year rose from 277,000 persons in 2002 to 526,000 persons in 2013
  - Receipt of treatment for nonmedical use of prescription pain relievers in the past year increased from 360,000 in 2002 to 746,000 in 2013.

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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 buprenorphine for treatment of opioid use disorder. The required training for nurse practitioners and physician assistants is 24 hours. While buprenorphine is relatively safe, there are associated risks of overdose and death[5]. There is also a risk of diversion. These risks, in addition to skills needed to prescribe the medication effectively for each patient's individual needs, 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). The training is endorsed by the American Society of Addiction Medicine, one of the approved training organizations named in DATA 2000 and CARA 2016, the laws which describe the requirements of this training. 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 law which permits this treatment, *DATA 2000*. It has been edited according to the following major updates to guidelines and requirements:

- *Treatment of Opioid Addiction in the Medical Office*[5]
- 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)*
- CDC's *Guidelines on Opioid Treatment*[6]
- 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 be able to assess patients with opioid use disorder for appropriateness for office-based opioid treatment. An entire chapter of TIP 40, Chapter 3, is on Patient Assessment, which includes this assessment, which underscores the importance of physicians who prescribe buprenorphine being familiar with patient assessment in the treatment of opioid use disorder[4,7,8]. The FSMB Model policy also describes 6 critical aspects of patient assessment[5].

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MODULE INTRODUCTION

Before starting buprenorphine treatment, evaluate patients thoroughly in order to assure that it is the optimal treatment for them and to determine how to tailor the treatment to meet their needs. Assess patients to determine whether they have the diagnosis of opioid use disorder or common, related comorbidities.

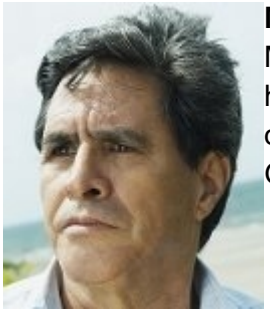
Case Illustrations

The following cases will be used to illustrate how to assess patients to determine whether buprenorphine is an appropriate treatment for them.

MS. TAYLOR

Ms. Taylor has been using heroin daily for 3 months and heard there is a "drug to take if you are addicted to heroin."

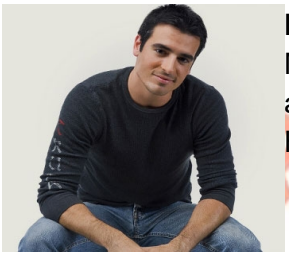
How do you determine if Ms. Taylor is a candidate for buprenorphine treatment?



MR. SANTOS

Mr. Santos wants to stop using heroin because his HIV treatment provider told him that it would interfere with that treatment. He has attempted several in-patient detoxifications for opioids previously that ultimately failed.

Given this history, is Mr. Santos a candidate for buprenorphine treatment?



MR. HARRIS

Mr. Harris has come in to "try bupe" and reports that he does drink a moderate amount of alcohol regularly.

How will his alcohol use affect buprenorphine treatment?

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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

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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.

WHAT TO ASSESS

The patient assessment before starting buprenorphine treatment includes[8]:

- Assessment of their opioid use disorder
- Determination of whether office-based opioid treatment is appropriate, and, if so, what level of treatment is needed
- Identifying unique patient medical (including chronic pain), psychosocial, and other needs requiring modifications to buprenorphine treatment
- Obtaining the patient's substance abuse history, including the use of other illicit and prescription drugs
- Determining the patient's readiness to start and comply with treatment

EVALUATING PAIN

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.

Using a Systematic Approach to Pain Assessment

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 Related Resources section at the end of this module lists several pain assessment tools.

A Quick Assessment of Pain and Functioning: PEG Scale

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

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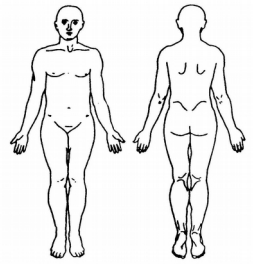
adverse effects?
    - What dosages of medications have other providers or the patient tried?
- **Past:** The same questions applied to the past. Also, what is the past history of this problem?

Quality of Pain. For example, is the pain sharp or dull, throbbing? The McGill Pain Questionnaire includes a comprehensive list of pain descriptions[9].

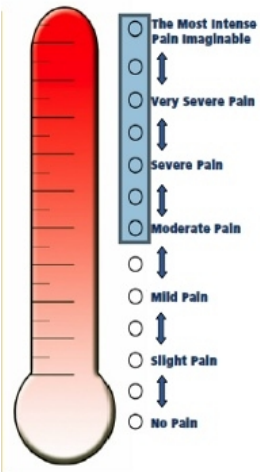
Region of Pain/Radiation.

- **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[10].



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:

1. 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[11].
2. 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[11]. Support adequate sleep through patient education regarding sleep hygiene

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rather than by using benzodiazepines, due to the risk of overdose.

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

PRACTICE TIP

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

SYSTEMATIC PAIN EVALUATION (CONT)

Pain Assessment Acronym: Steps T and U

Timing.	Questions about time and pain including the following: • **Onset:** When did the pain start? Is the pain immediate or delayed? How long after precipitating factors does it start? • **Time of day:** When does the pain occur? • **Pattern:** Is it intermittent or constant pain? • **Duration:** How long does the pain last?
U (How Pain Affects You).	Assessment of **functioning** is critical in determining the extent of treatment needed. • Patients' mood, work/activities, relationships, etc., may be affected by pain • Start with Activities of Daily Living assessment • Supplement with open-ended questions regarding pain effects on functioning, for example: "Please tell me how the pain affects your daily life?"

After listening and providing empathy for this significant part of the chronic pain experience, ask the patient for any further information needed about the following three basic areas of functioning[12]:

- **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 Related Resources section of this page is an example of pain assessment questionnaire that is reliable, valid, and may even be able to detect the origin of pain[13].

PRACTICE TIP

Consider carefully whether the patient with chronic pain has an unnecessarily high dose 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):

- ≥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.

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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.[15]

QUIZ: PAIN INQUIRY

You have asked your patient: "Where is the pain located? What causes pain or makes it worse? What is the pain intensity on a scale of 0-10? When did the pain start? How does the pain affect your life?"

Question: To 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 this patient?

Choose one

1. "Where is the pain located?"
    - Feedback: Incorrect. This exact question was asked already.
2. "Does it hurt?"
    - Feedback: Incorrect. The answer to this question is already clearly yes.
3. "Is the pain dull, sharp, or throbbing?"
    - Feedback: 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?"
    - Feedback: Incorrect. This question assesses the severity of the pain which was already asked by asking about pain intensity.

ASSESSING PATIENTS WITH OPIOID USE DISORDER

Assessment of the patient's opioid use disorder includes obtaining the following information[8]:

1. Duration, pattern, and severity of opioid misuse
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

PRACTICE TIP

For #4, "History of previous attempts to discontinue opioid use with or without agonist therapies and response to treatment", be sure to ask about self-treatment:

1. 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.
2. Loperamide (Immodium®), the over-the-counter antidiarrheal medication, which is a μ receptor agonist, is sometimes taken at doses far beyond therapeutic doses, to control

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withdrawal symptoms from opioids[16]. 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[16].

CULTURAL CONSIDERATIONS

Overview

Different populations may need their interventions for substance abuse and treatment individualized. Base the customization on their individula 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[17].

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[17]. Another difference encounterd 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[17]. 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[17]. 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[17].

Veterans

Substance use disorder affects a high percentage of veterans; 7.1% meet the criteria[17]. 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[17].

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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[17]. Compounding the issue is that 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[17]. 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.

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:

Questions	***Considerations***
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 understands 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

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resources.

PRACTICE TIP
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[18]

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[19]. 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[19]. 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.

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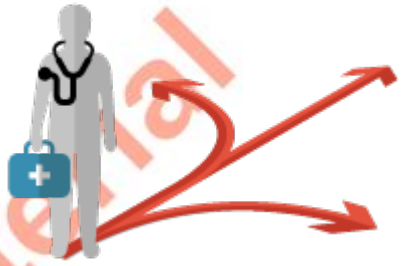
VA/DoD Guidelines

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 Related Resources section on this page.

TREATMENT OPTIONS

What are the treatment options?

Risks and benefits of office-based treatment and of buprenorphine treatment should be balanced against those of no treatment or treatment without medication. The options include[5]:



- 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[20]. 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

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PATIENT PLACEMENT CRITERIA

According to the **ASAM Patient Placement Criteria**, the following 6 patient dimensions should be considered when formulating a treatment plan[21]:

Dimension	*Things to Consider*
Acute Intoxication and Withdrawal Potential	Assess whether the patient is currently intoxicated, is at risk of precipitated withdrawal, or is currently in withdrawal.
Biomedical Conditions and Complications	Consider the patient's existing medical conditions and how they might affect treatment.
Emotional, Behavioral, or	Note the patient's psychiatric illnesses and psychological,

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Cognitive Conditions and Complications	behavioral, emotional, or cognitive problems, and determine if they are related to or are independent of the substance use disorder.
Readiness to Change	Assess the patient's readiness to change, and determine how willing he/she is to begin treatment.
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.
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[19]:

Criteria	*OBOT*	*OTP*
Can OBOT provide the resources the patient needs?	Yes	No
Psychosocial supports	Good	Poor
Failed treatments with medication-assisted treatment	None/few	Many
Access	Yes	No
Chronic pain requiring short-acting opioids	No	Yes

POSITIVE RESPONSE TO TREATMENT

The following are among the factors associated with a positive response to buprenorphine treatment[22,23]:

- 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.

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ASSESS FOR MEDICAL CONDITIONS

Guidelines

GUIDELINES FOR BUPRENORPHINE TREATMENT

Practice Guidance for Buprenorphine for the Treatment of Opioid Use Disorders, produced by expert panel process recommend the following[24]:

Assess medical history with attention paid to liver and cardiac status, medications, and seizures (Median strength of recommendation, out of 10 (range): 8.0 (7-9))

Pregnancy status and plans (range): 9.0 (3-9))

Chronic pain (range): 8.0 (6-9))

- **Liver:** 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.
- **Medication:** Other buprenorphine drug interactions were described in detail in the pharmacotherapy module, and include: Benzodiazepines, gabapentin, other opioids, and drugs metabolized by the CYP 3A4 System.
- **Pregnancy:** Patients may be pregnant and be treated with buprenorphine, with special precautions observed[24]. Use of buprenorphine during pregnancy is covered in detail later in the activity.
- **Chronic 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[25]. 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[18]. This topic is addressed in greater detail later in the activity.[4]

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

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- 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[24]
- Whether the office has the necessary and supporting resources to be accessible to all populations [26]

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

Mild or Borderline Opioid Use Disorder

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. Start dosing low (2 mg buprenorphine*) and increase slowly to avoid over medicating.

(*Doses described were established with the original buprenorphine/naloxone sublingual tablet formulation. Adjust doses for the formulation you are using.)

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

Note that the mere presence of 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.

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PRACTICE TIP

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.[25]

CASE STUDY – MS. TAYLOR

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Meet Your Patient

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.

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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.

Question: 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.
    - Feedback: 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. However, doing poorly at a higher level of care (residential) is a red flag for potential problems. Also, note that some patients who don't tolerate methadone well feel 'normal' when taking buprenorphine and are entirely compliant.
2. Yes, only if she agrees to residential treatment.
    - Feedback: Incorrect. 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 somewhat worked in the past.
    - Feedback: Incorrect. 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.
    - Feedback: Incorrect. 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.

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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.

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ASSESSING FOR COMORBIDITIES

Comorbidities to Assess

In addition to assessing opioid use disorder, other dimensions of patient health affect the module 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[27]:

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

A physical exam can focus on evaluating[5]:

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

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

System	*Possible Complications*
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

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System	*Possible Complications*
Hematological	Anemia, thrombocytopenia
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

COMMON PSYCHIATRIC COMORBIDITIES

Psychiatric comorbidities, which frequently occur in individuals with opioid use disorder, may affect your decision to treat a patient with buprenorphine in the office. The psychiatric problems that most commonly co-occur with substance use disorders include the following[17]:

- 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[28].

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GUIDELINES FOR PATIENTS WITH PSYCHIATRIC COMORBIDITIES

Guidelines for Individuals with Psychiatric Problems

GUIDELINES FOR BUPRENORPHINE TREATMENT

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[29]:

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

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- 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.

Note that these are the guidelines for which there was a strong consensus by expert review and do not represent a complete protocol.

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[18]:

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

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Depression Screening Guidelines

The AHRQ guidelines for depression recommend screening all adult patients based on Grade B evidence[28]. The recommendation is to implement screening as long as there are adequate systems in place for "accurate diagnosis, effective treatment, and appropriate follow-up"[28]. 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.

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?

1. Yes, I will recommend that my patients look for patient websites on buprenorphine.
    - 16% (712 votes)
2. Yes, I will recommend specific patient website(s) on buprenorphine to my patients.
    - 72% (3194 votes)
3. No, I plan to provide all the information the patient needs via my own website.
    - 2% (71 votes)
4. No, I plan to use only paper to provide patient education on buprenorphine.
    - 6% (276 votes)
5. Does not apply to me or none of the above
    - 4% (160 votes)

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Total votes: 4413

QUIZ: QUICK CASE – MRS. DAWSON

Name: Mrs. Dawson

Age: 46 years old

Reason for visit: Followup for a shoulder injury

Patient History: Mrs. Dawson has abused prescription opioids sporadically for several years. She recently injured her shoulder and had been using opioids more frequently to manage her pain; she currently meets the criteria for opioid use disorder, according to your present assessment. She also takes paroxetine (Paxil®) for depression and anxiety.

Question: With what you now know, is Mrs. Dawson a good candidate for office-based buprenorphine treatment at this time? (Please choose the best answer.)

Choose one

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.
    - Feedback:
    - 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.
    - Feedback:
    - Mrs. Dawson's 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.
    - Feedback:
    - There is no need to taper Mrs. Dawson 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.
    - Feedback:
    - Patients who are psychiatrically stable can take SSRIs and buprenorphine simultaneously, monitoring for possible additive sedative effects, especially at first.

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However, you will need to further evaluate her suitability as a candidate and explore all options before making a final decision.

IDENTIFYING AND ASSESSING SUBSTANCE USE

Prevalence and the Importance of Assessment

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[17].

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

What Drugs to Assess

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. 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

Assess their history of substance use as well as current use[24]. Patients who misuse drugs, commonly use other drugs, tobacco, or alcohol[30]. This holds true for young adolescents as well[31].

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[32]. Regarding some specific substances:

- People who are addicted to heroin have high rates of other illicit drug use; around 75% reported concurrent heroin and cocaine use[33]. 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.
- Among opioid addicts, cocaine and alcohol are the most frequently abused substances[34].
- 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[35].
- Some people seeking buprenorphine treatment have already taken it, obtaining it illicitly[36]. Knowing this would affect the induction process; however, some patients may hesitate to tell

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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.

ASSESS FOR OTHER SUBSTANCE ABUSE

Patients may downplay the use of other drugs if they think it could harm their chances of acceptance into treatment. Keep this in mind when using interviews and screening instruments to detect polysubstance use. Use motivational interviewing techniques to establish open communication and build rapport with your patients.

Physical signs of possible drug use include the following:

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

Try these four main approaches for assessing opioid dependent patients for other substance abuse:

- Screening instruments: MAST, DAST, CAGE-AID, AUDIT
- Clinical assessments: Ask patient directly, ask family members
- 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

A video that illustrates a provider substance-use screening during a patient interview can be found here: https://youtu.be/L-A4Wea3SaE[37]

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, ie., drinks more than four drinks at a time
- Misuse of prescription pain medications
- Use of illicit drugs

QUIZ: COMMON MISUSED DRUGS

The following question is based on national survey data conducted by SAMHSA in which people were asked to respond to a question on any drugs they were dependent on or had abused during the past year of 2013[30].

See how your idea of which drugs are most commonly involved in abuse or dependence compares to the survey results. The

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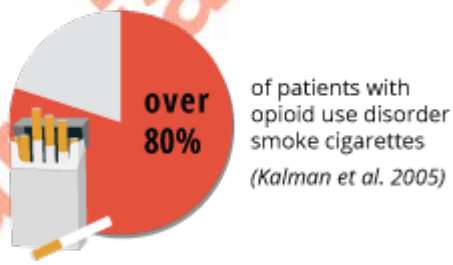
correct order is presented below in order from most common to least common, with #1 being the most and #7 the least common.

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

PATIENTS WITH TOBACCO USE DISORDER

Prevalence

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[38].



Quitting in the Context of Substance Use Disorder Treatment

Despite well-established health effects from tobacco use, few substance abuse treatment programs address smoking[39]. Aside from harm from smoking itself, smoking a cigarette functions as a cue for drug and alcohol craving[40,41]. Within buprenorphine treatment, quitting smoking is rarely encouraged, in part from an assumption that patients do not want to quit[42]. Yet, several studies found that smokers in substance abuse treatment are aware of the harmful health effects of smoking and wish to quit[43].

Other incorrect assumptions include that quitting may worsen psychiatric symptoms[42] or quitting attempts may negatively affect opioid abstinence[44]. 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[45]. Integrating smoking cessation into substance abuse treatment can be done without threatening recovery goals[43].
- 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[46,47].
- 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[48].

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:

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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[49]
    - 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[49]. 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®), bupropion (Zyban®), 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[39]

POLL: AMONG YOUR PATIENTS WHO ARE OPIOID-ADDICTED AND USE TOBACCO, WOULD YOU RECOMMEND TOBACCO CESSATION?

1. Yes, I would treat both the tobacco addiction and the opioid addiction
    - 55% (2379 votes)
2. Yes, but I would focus on the opioid addiction first
    - 44% (1925 votes)
3. No, tobacco use isn't necessary in this situation
    - 1% (43 votes)

Total votes: 4347

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[50]. 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

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QUIZ: CASE STUDY – MR. SANTOS

MEET YOUR PATIENT

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.

Question: 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.
    - Feedback: 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.
    - Feedback: 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.
    - Feedback: 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 futher and learn more about his medical and psychiatric problems before proceeding, however. If there are no major problems, Mr. Santos would be an

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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.
    - Feedback: 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.

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

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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. Induction guidelines and protocols are covered in much greater detail later in this activity.

POLL: BASED ON THE INFORMATION PROVIDED, ARE YOU INCLINED TO PRESCRIBE BUPRENORPHINE TO MR. SANTOS?

Poll Responses:

1. Yes
    - 94% (3940 votes)
2. No
    - 6% (242 votes)

Total votes: 4182

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

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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.

RISK FOR OPIOID USE DISORDER

Risk for Physical Dependence vs. Opioid Use Disorder

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[51].

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. This is discussed in more detail later in the activity.

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 Features	*Patients With Pain*	*Patients Who Are Addicted to Opioids*
Compulsive drug use	Rare	Common
Crave drug (when not in pain)	Less likely if they take their medication on schedule, but physical dependence does typically develop in chronic opioid therapy	Common
Obtain or purchase drugs from non-medical sources	Rare	Common
Procure drugs through illegal activities	Absent	Common
Escalate opioid dose without medical instruction	Rare, but may occur with an episode of breakthrough pain, despite warnings	Common

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Clinical Features	*Patients With Pain*	*Patients Who Are Addicted to Opioids*
Supplement with other opioid drugs	Unusual, if pain is adequately managed	Frequent
Demand specific opioid agent	Not as common	Common
Can stop use when effective alternative treatments are available	Usually, with appropriate discontinuation protocol that considers any physical dependency that developed	Usually not
Prefer specific routes of administration	No	Yes
Can regulate use according to supply	Yes, if pain is adequately managed	No

ASSESSING 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 Buprenorphine Protocols: 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

Buprenorphine is sometimes used to treat women who are pregnant. 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[52]. Both are category C, however, and there is more experience with methadone.

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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[53]. A less intensive treatment, such as drug counseling, is appropriate for these users[54].

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, for example of their life partner, may be needed. SAMHSA's Tip 26 on Substance Abuse Among Older Adults describes screening tools designed for the geriatric population.

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QUIZ: QUICK 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

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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.

Question: With what you now know, is Mr. Reyes a good candidate for office-based buprenorphine treatment at this time? (Please choose the best answer.)

Choose one

1. Yes, he may be a good candidate for office-based buprenorphine treatment at this time
    - Feedback: 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
    - Feedback: Not the best answer. 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. Even though he failed very intensive treatment before, opioid maintenance therapy was not offered in those treatments and could be tried. He will also need supportive counseling as part of his plan, which could be offered at evening or weekend appointments.
3. No, medically supervised withdrawal only is his best option at this time
    - Feedback: This is not the best answer at this time. Since Mr. Reyes has had several unsuccessful attempts at detoxification in the past, this is not the best option at this time. 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. He will also need supportive counseling as part of his plan, which could be offered at evening or weekend appointments.

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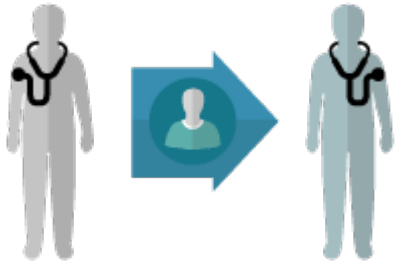
REFERRAL

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. Note that an unsuccessful treatment episode must **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.

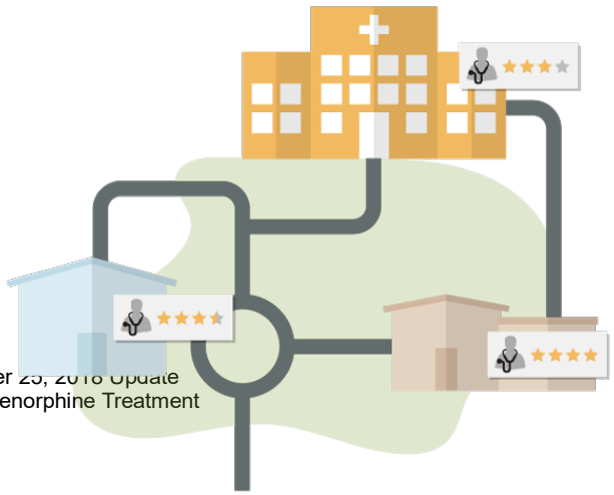
Other tips for discussing referral include the following:

- 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.



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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:

- 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 (see sidebar). 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, 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

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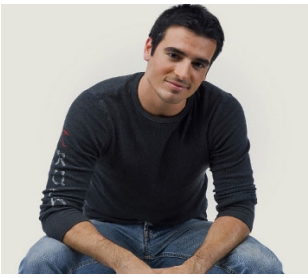
experience. This will also improve the likelihood of your patient coming back to your practice after treatment.

CASE STUDY – MR. HARRIS

Meet Your Patient



Name: Mr. Harris

Age: 28 years old

Reason for visit: He wants "to try bupe".

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?

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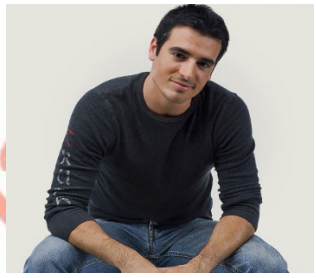
Mr. Harris: Not if I can help it. Sometimes I have to stretch it before I can get back and get a refill, but I can't sleep well when I do that.

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.



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
    - Feedback: 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
2. No, he is not a good candidate for treatment and further evaluation is not needed
    - Feedback: It appears that Mr. Harris is not a good candidate for buprenorphine maintenance at this time, but 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

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- Conduct ongoing evaluation to aid in a full diagnosis

3. Further evaluation is needed to determine whether office-based opioid treatment with buprenorphine is a good choice for him.
    - Feedback: 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

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[55]:

- 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[5,56].

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[5].

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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.

GUIDELINES FOR PATIENT ASSESSMENT

Guidelines for Buprenorphine Treatment

In *Practice Guidance for Buprenorphine for the Treatment of Opioid Use Disorders*, produced by expert panel process, the guidelines recommended most often on determining candidacy for treatment are the following[29]:

Conduct Assessments to determine candidacy for treatment.

Prior to buprenorphine treatment, ask patients about the following

- 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

Patients who meet the following criteria are considered to be good candidates for treatment:

- 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

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Note that these are the guidelines for which there was a strong consensus by expert review and not a complete protocol.

SUMMARY AND KEY POINTS

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

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  - 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 AVAILABLE THROUGH THIS MODULE:

- ASAM Patient Placement Criteria
  The ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised[20] 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

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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
- 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

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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
  2015 version. 169 pages.
- 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.

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