

# **Patient Assessment & Selection**

**2009 AOAAM OBOT**

## **Office-based Buprenorphine and Patient Assessment/Selection**

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

## Outline for This Talk

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

## **Commonly Abused Opioids**

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**Diacetylmorphine (Heroin)**

**Hydromorphone (Dilaudid)**

**Oxycodone (OxyContin, Percodan, Percocet, Tylox)**

**Meperidine (Demerol)**

**Hydrocodone (Lortab, Vicodin)**

## **Commonly Abused Opioids (continued)**

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**Morphine (MS Contin, Oramorph)**

**Fentanyl (Sublimaze)**

**Propoxyphene (Darvon)**

**Methadone (Dolophine)**

**Codeine**

**Opium**

## **Commonly Abused Opioids**

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

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

**Opium is usually smoked.**

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

## Evaluation of the Patient

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### Attitude of the interviewer:

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

### Approaches that facilitate effective treatment:

Acknowledge that some information is difficult to talk about

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

Try to avoid using labels or diagnoses

## Evaluation of the Patient

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### History of drug use:

**Start with first substance used**

**Ask about all substances (including licit and illicit)**

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

**Assess recent use (past several weeks)**

## Evaluating the Patient

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### Approaches of the interviewer:

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

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

## Evaluating the Patient

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### Approaches of the interviewer (*continued*):

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

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

Be persistent

Always follow-up on “qualified answers”

## Evaluating the Patient

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### Approaches of the interviewer (*continued*):

Be careful using “slang” because of regional variation

Always ask about each specific class of drug

Ask about prescription and OTC drugs

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

## Evaluation of the Patient

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### Tolerance, intoxication, withdrawal:

**Explain what is meant by tolerance**

**Determine the patient's tolerance and withdrawal history**

**Ask about complications associated with intoxication and withdrawal**

## Evaluation of the Patient

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### Relapse/attempts to abstain:

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

Ask what was the longest period of abstinence

Identify triggers to relapse

## Evaluation of the Patient

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### Consequences of use:

Determine current and past levels of functioning

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

Medical

Family

Employment

Legal

Other

## Evaluation of the Patient

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### Craving and control:

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

Determine if patient sees loss of control over  
use

## **Evaluation of the Patient**

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### **Substance use disorder treatment history:**

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

**Response following each treatment intervention**

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

## Evaluation of the Patient

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### Psychiatric history:

Inpatient and/or outpatient treatment episodes

Untreated episodes of psychiatric illness

Treatment with psychiatric medications

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

## Evaluation of the Patient

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### Medical history:

Past and/or present:

Significant medical illnesses

Hospitalizations

Operations

Accidents/injuries

Drug allergies

Current medications: Prescription and OTC

## **Evaluating the Patient**

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### **Physical examination:**

**Needle marks**

**Sclerosed veins (track marks)**

**Cellulitis/Abscess**

**Evidence of hepatitis or HIV**

## Evaluation of the Patient

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### Family history:

Substance use disorders

Other psychiatric conditions

Other medical disorders

## Evaluation of the Patient

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### Personal (or social) history:

Birth and early development

Education

Employment and occupations

Marital status and children

Living situation

Legal status

## Evaluating the Patient

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### Substance abuse history:

#### TRAPPED:

Treatment History (inpt, outpt, methadone)

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

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

Pattern of Use (with changes over time)

Prior Abstinence (in & out of institution)

Effects (including overdoses & withdrawal)

Duration of Use (including most recent use)

## **DSM-IV Criteria for Opioid Dependence**

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

- 1. Tolerance, as defined by either of the following:**
  - a) a need for markedly increased amounts of the substance to achieve intoxication or the desired effect, or**
  - b) markedly diminished effect with continued use of the same amount of the substance**
  
- 2. Withdrawal, as manifested by either of the following:**
  - a) the characteristic withdrawal syndrome for the substance, or**
  - b) the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms**

## **DSM-IV Criteria for Opioid Dependence**

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

## **DSM-IV Criteria for Opioid Dependence**

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

## **DSM-IV Criteria for Opioid Abuse**

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

## **Opioid Physical Dependence**

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### **Important Clinical Features of Opioid Physical Dependence**

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

**Opioid physical dependence is characterized by regular administration to avoid withdrawal**

## **Characteristics of Addiction: The 4 “Cs”**

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**Control (loss of)**

**Compulsion to use**

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

**Craving**

## **Assess for Other Conditions**

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

## **Other Substance Use, Abuse, Dependence**

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### **Reason to assess for other substance use**

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

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

## **Types of Other Substance Use**

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**Alcohol**

**Sedative-hypnotics**

**Cocaine**

**Methamphetamine**

**Cannabis**

**PCP**

**Nicotine**

**“Club Drugs” (Ecstasy, Ketamine, GHB)**

**Non-controlled (clonidine, etc.)**

## **Detecting Other Substance Use**

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**Screening instruments – e.g., DAST-10**

**Self-report of use, reason**

**Multiple trauma**

**Hospitalization**

**Infections**

**Body fluid testing (e.g., urine)**

## **Detecting Other Substance Use**

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### **Drug Abuse Screening Test ( DAST-10)**

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

**Available online at**

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

## **Detecting Other Substance Use**

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### **Laboratory methods:**

#### **Blood**

**liver function test abnormalities**

**elevated mean corpuscular volume on CBC**

**Urine testing for presence of drugs of abuse**

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

## Co-morbid Medical Disorders

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

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

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

## **Appropriateness for Office-based Buprenorphine**

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

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

## **Appropriateness for Office-based Buprenorphine**

### **Consider these factors**

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

## **Appropriateness for Office-based Buprenorphine**

### **Consider these factors (continued)**

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

## **Appropriateness for Office-based Buprenorphine**

### **Consider these factors (continued)**

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

## **Appropriateness for Office-based Buprenorphine**

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

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

## **Appropriateness for Office-based Buprenorphine**

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

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

## **Appropriateness for Office-based Buprenorphine**

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

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

## **Appropriateness for Office-based Buprenorphine**

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

**8. High risk for relapse**

**9. Pregnancy**

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

**11. Poor support systems**

## **Matching the Treatment Plan and Resources**

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**Determine appropriateness of patient for office based buprenorphine treatment:**

**consider the needs of the patient**

**consider the available resources**

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

## **Matching the Treatment Plan and Resources**

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

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

## **Matching the Treatment Plan and Resources**

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

## Summary

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

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

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