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Opioid Use Disorders: Assessment and Diagnosis

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Presentation Outline

- Case
- Basics of DSM 5 diagnostic criteria for SUD
- Diagnostic criteria for OUD
- Assessing for OUD
- Screening and assessment tools
- The patient interview
- Conclusion and Questions

Case

- A 33 year-old male with a 10 year history of chronic back pain is prescribed 90 milligrams of oxycodone, in addition to 2 milligrams of Xanax on a daily basis.
- The medications are provided by his primary care physician.
- He has a history of depression, and possibly PTSD.
- The patient is not currently engaged in psychiatric care, and his only healthcare provider is his primary care physician.

Case (continued)

- He's frequently requesting early refills of Xanax and oxycodone.
- He reports that he runs out medications early, due to frequently vomiting of the pills. He has struggled with chronic nausea and vomiting since childhood, and reports the episodes are triggered by pill ingestion.
- You're concerned about addiction, and you discuss the patient's care with his wife, who is an RN, after you've obtained consent.
- His wife adamantly denies any history of substance use problems, and reports that her husband "hates pills."

Case (continued)

- His wife further reports: “My brother was an addict. If there was a problem with my husband, I would know it.”
- She verifies the patient’s report of vomiting the medications.
- A recent UDS showed the presence of morphine and diazepam, which the patient is not prescribed.
- He reports that he was prescribed morphine and Valium by an ER physician, after he dislocated his shoulder 4 days ago.
- His prescription monitoring report verifies the prescribed morphine and Valium, by an ER physician at a local hospital.



Case (continued)

- You do not have the ER records
- You again ask about substance use difficulty, and request that the patient be seen for an addiction specialist for a consultation, given your concerns.
- The patient, and his wife, become angry.
- They allege that you are not providing appropriate care, and are being judgmental and prejudice, due to the patient's chronic pain condition.
- They request to be transferred to another physician in the practice, and also ask to speak to "your boss."

Case (continued)

- Questions
 - How can you confirm or rule-out the presence of OUD in this patient?
 - Do you continue to prescribed both oxycodone and Xanax?
 - What are the next steps?

DSM 5 Basics

- The substance-related disorders encompass 10 separate classes of drugs:
 - Alcohol
 - Caffeine
 - Cannabis
 - Hallucinogens
 - Inhalants
 - Opioids
 - Sedatives, hypnotics, and anxiolytics
 - Stimulants (amphetamine-type substances, cocaine, and other stimulants)
 - Tobacco
 - Other (or unknown) substances

DSM 5 Basics

- These 10 classes are not fully distinct.
 - All drugs that are taken in excess have in **common direct activation of the brain reward system**.
- Gambling disorder is also in the DSM-5.
 - Gambling behaviors activate reward systems similar to those activated by drugs of abuse and produce some behavioral symptoms that appear comparable to those produced by the substance use disorders.

DSM 5 Basics

- *“Other excessive behavioral patterns, such as Internet gaming, have also been described, but the research on these and other behavioral syndromes is less clear. Thus, groups of repetitive behaviors, which some term behavioral addictions, with such subcategories as ‘sex addiction,’ ‘exercise addiction,’ or ‘shopping addiction,’ are not included because at this time there is insufficient peer-reviewed evidence to establish the diagnostic criteria and course descriptions needed to identify these behaviors as mental disorders.”*

DSM 5 Basics

- The substance-related disorders are divided into two groups:
 - substance **use** disorders
 - substance-**induced** disorders
 - Intoxication
 - Withdrawal
 - Other substance/medication-induced mental disorders (e.g. substance-induced psychotic disorder, mood disorder, etc.)

Substance Use Disorders

- *“The essential feature of a substance use disorder is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems.”*
- An important characteristic of substance use disorders is an underlying **change in brain circuits that may persist beyond detoxification**, particularly in individuals with severe disorders.
- Substance use disorder can be applied to all 10 classes included in the DSM 5 **except caffeine**.

Substance Use Disorders

- The 11 DSM 5 diagnostic criteria for SUD are divided into 4 groups:
 - **Impaired control** (criteria 1 – 4).
 - **Social impairment** (criteria 5 – 7).
 - **Risky use** (criteria 8 – 9).
 - **Pharmacological criteria** (criteria 10 – 11).

DSM 5 SUD Diagnostic Criteria

- Impaired Control (Criteria 1 – 4)
 - **Criterion 1:** The individual may take the substance in larger amounts or over a longer period than was originally intended
 - **Criterion 2:** The individual may express a persistent desire to cut down or regulate substance use and may report multiple unsuccessful efforts to decrease or discontinue use.
 - **Criterion 3:** The individual may spend a great deal of time obtaining the substance, using the substance, or recovering from its effects
 - **Criterion 4:** Craving
 - Is manifested by an intense desire or urge for the drug that may occur at any time but is more likely when in an environment where the drug previously was obtained or used.

DSM 5 SUD Diagnostic Criteria

- Social impairment (criteria 5 – 7):
 - **Criterion 5:** Recurrent substance use may result in a failure to fulfill major role obligations at work, school, or home
 - **Criterion 6:** The individual may continue substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance
 - **Criterion 7:** Important social, occupational, or recreational activities may be given up or reduced because of substance use.

DSM 5 SUD Diagnostic Criteria

- Risky use (Criteria 8 - 9);
 - **Criterion 8:** This may take the form of recurrent substance use in situations in which it is physically hazardous
 - **Criterion 9:** The individual may continue substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
 - *The key issue in evaluating this criterion is not the existence of the problem, but rather the individual's failure to abstain from using the substance despite the difficulty it is causing.*

DSM 5 SUD Diagnostic Criteria

- Pharmacological criteria (Criteria 10 -11):
 - **Criterion 10:** Tolerance.
 - The requirement of an increased dose of the substance to achieve the desired effect or a markedly reduced effect when the usual dose is consumed.
 - **Criterion 11:** Withdrawal
 - Significant withdrawal has *not* been documented in humans after repeated use of phencyclidine, other hallucinogens, and inhalants.

DSM 5 SUD Diagnostic Criteria

- The appearance of normal, expected pharmacological tolerance and withdrawal during the course of medical treatment has been known to lead to an erroneous diagnosis of “addiction.”
- **Individuals whose *only* symptoms are tolerance and withdrawal that occur as a result of appropriate medical treatment should not receive a diagnosis solely on the basis of these symptoms.**

DSM 5 SUD Diagnostic Criteria

- Severity specifier:
 - **Mild:** 2-3 criteria
 - **Moderate:** 4-5 criteria
 - **Severe:** 6 or more criteria
- Other specifiers:
 - In early remission
 - In sustained remission
 - On maintenance therapy
 - In a controlled environment

Opioid Use Disorders

- **In early remission:** After full criteria for opioid use disorder were previously met, none of the criteria for opioid use disorder have been met for at least 3 months but for less than 12 months (with the exception that Criterion A4, “Craving, or a strong desire or urge to use opioids,” may be met).
- **In sustained remission:** After full criteria for opioid use disorder were previously met, none of the criteria for opioid use disorder have been met at any time during a period of 12 months or longer (with the exception that Criterion A4, “Craving, or a strong desire or urge to use opioids,” may be met).

Opioid Use Disorders

- **On maintenance therapy:**
 - This additional specifier is used if the individual is taking a prescribed agonist medication such as methadone or buprenorphine.
 - None of the criteria for opioid use disorder have been met for that class of medication (except tolerance to, or withdrawal from, the agonist).
 - This category also applies to those individuals being maintained on a partial agonist, an agonist/antagonist, or a full antagonist such as oral naltrexone or depot naltrexone.
- **In a controlled environment:** This additional specifier is used if the individual is in an environment where access to opioids is restricted.

Diagnosing OUD

- Key clinical points:
 - Diagnosis of OUD can be challenging and time consuming.
 - Some cases may take weeks or months to confirm or rule-out a diagnose.
 - Patients can conceal addiction for prolonged periods of time.
 - Do not feel you have to make a diagnosis after one visit.
 - Do **NOT** document OUD in the patient's medical record unless you are 100% certain of the diagnosis.

Diagnosing OUD – Work-up

- Patient interview
- Drug screen
 - Standard immunoassay
 - Gas chromatography/Mass Spectroscopy (GC/MS)
 - Special testing
 - Hair analysis – reveals 90 days of drug use.
- Review of prescription monitoring report
- Physical exam
- Collateral sources of information (if necessary)

Assessment Tools – Resource

- NIH, National Institute of Drug Abuse (NIDA):
Resource of addiction assessment and screening tools:
 - <https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools>

Screening Tools

- Screening to Brief Intervention (S2BI)
- Brief Screener for Alcohol, Tobacco, and other Drugs (BSTAD)
- Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS)
- NIDA Drug Use Screening Tool: Quick Screen (NIDA Modified ASSIST)
- Opioid Risk Tool
- CAGE-AID

Assessment Tools

- Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS)
- CRAFFT
- Drug Abuse Screen Test (DAST-10)
- NIDA Drug Use Screening Tool (NIDA Modified ASSIST)

Screening and Assessment Tools

- Advantages:
 - Evidence-based
 - Easy to administer
 - Able to identify at-risk patients
- Disadvantages
 - Rely heavily on patient self-report
 - Less likely to identify patients who are actively attempting to conceal their addiction

Assessment – Interview Techniques

- Do **NOT** start off an assessment of a new patient by asking about substance use.
- Recommended: Begin interview by asking about **social history**, including demographic information.
 - These are typically benign and non-judgmental questions, that will help relax the patient.
 - This information allows the clinician to learn a substantial amount about of the patient **before** even asking about substance use.
 - In some cases, the SUD history is attained almost entirely when asking about the patient’s social history.

Assessment – Interview Techniques

- Clinical pearls:
 - Be open-ended
 - Avoid the use of judgmental words, such as: abuse or addict.
 - Create an environment that makes the admission of use less intimidating.
 - Help the patient feel relaxed.
 - Emphasize your role as a **treating provider**
 - Avoid writing down information, or staring at a clip board.
 - Attempt to normalize the situation (Ex. “I work with many patients who struggle with this problem, and with help, they get better.”)

Assessment – Questions

- *Does the use of your pain medications ever provide you with more for you than just pain relieve?*
- *It's quite common for people who use opiates to feel some form of emotional relief from taking these medications. I know you struggle with depression and anxiety, and I was wondering if your pain meds ever help alleviate those symptoms.*
- *Have there been situations when you've taken more than you wanted to?*
- *Do these medications ever make you do things that you ordinarily would not want to do?*
- *Once a patient starts taking a higher dosage, it becomes very difficult for them to come back down to a lower dose, or stop their use. Has this ever happened to you?*

Assessment – Questions

- *Have you ever obtained opiates from anyone else, other than a doctor?*
 - *I know that can be quite expensive. Have you struggled financially because of the cost?*
- *Have the opiates ever made you feel foggy or less alert, to the point where you're not as sharp as you want to be?*
 - *Has this ever put you in a situation that you didn't want to be in?*
 - *Has the effects of the opiates ever placed you in danger?*
- *Have the opiates ever harmed you, or do you feel they have the potential to do so?*

PDMP: Prescription Drug Monitoring Programs.

- Should be viewed on every patient.
- Reports need to be reviewed **in detail**.
 - Fill date: count days between prescriptions
 - Look for multiple prescribers from **different** offices.
 - Prescriber's office address: different clinicians may work in the same office. Thus, multiple prescribers from ONE office, is not necessarily concerning.
 - Look up clinician's specialty, given that some prescribing practices may be concerning:
 - Prescribing clinicians writing for medications outside of their scope of practice. Ex: a dentist writing for regular prescriptions of Valium or other benzodiazepines.

Back to the case....

- Questions
 - How can you confirm or rule-out the presence of OUD in this patient?
 - Do you continue to prescribed both oxycodone and Xanax?
 - What are the next steps?

Conclusion

- Opioid use disorders can be challenging to diagnose, especially in cases where prescription opioids are involved.
- Evidence-based assessment and screening tools typically help identify at-risk patients, but do **NOT** confirm or rule-out an OUD diagnosis.
- In some cases, clinicians need to reach to collateral sources of information, utilize specialized drug testing, and scrutinize prescription monitoring reports.
- Establishing trust and cultivating a caring clinical environment are paramount.

Questions and Contact

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