Screening for Substance Abuse & Opioid Use Disorder Diagnosis and Treatment Options

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Changing What's Possible | MUSC.edu

Objectives

Participants will:

- Understand screening tools available for substance use disorders
- Discuss diagnostic criteria for opioid use disorder
- Discuss treatment options for opioid use disorder

Substance Abuse:

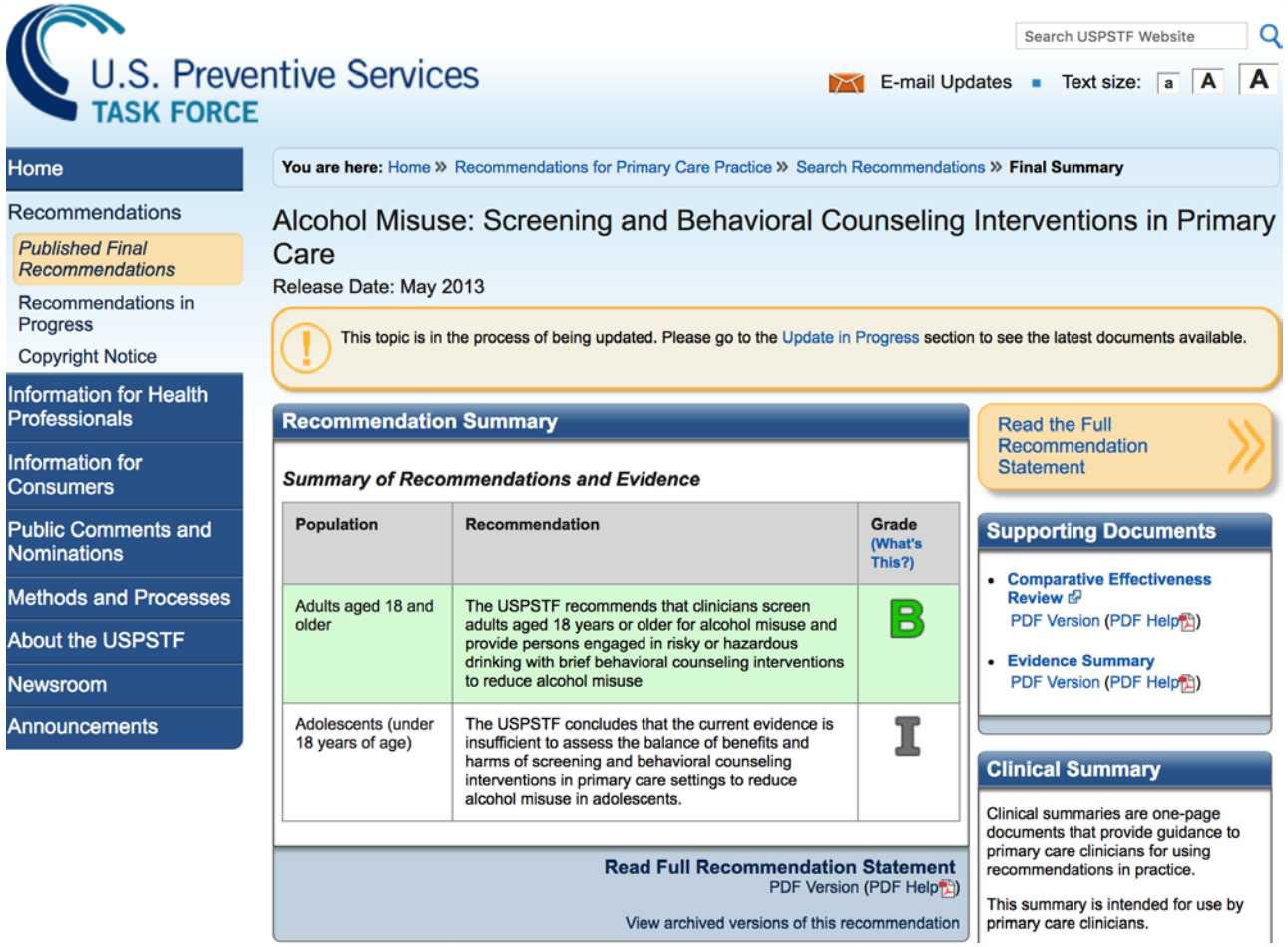
Screening Overview

The Need to Screen

- In 2009, at least 22.5 million were classified with substance dependence or abuse.
  - Increased morbidity and mortality, loss of productivity, increased healthcare costs
- ED visits involving misuse/abuse of prescription meds increased 98.4% between 2004-2009.
- Less than 20% of primary care physicians “described themselves as very prepared to identify alcoholism or illegal drug use.”
  - Over 50% of patients with substance use disorders said their primary care physician did nothing to address their abuse.
- Identifying substance use disorders early can result in less complications and greater success of treatment.

http://oas.samhsa.gov/nsduh/2k9nsduh/2k9resultsp.pdf
http://www.samhsa.gov/data/2k10/DAWNSR034EDHighlights/EDHighlightsHTML.pdf
http://www.casacolumbia.org/templates/publications_reports.aspx
https://www.aafp.org/afp/2013/0715/p113.html#afp20130715p113-b11

USPSTF: Alcohol Misuse and Behavioral Counseling Interventions in Primary Care



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Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care

Release Date: May 2013

This topic is in the process of being updated. Please go to the Update in Progress section to see the latest documents available.

Recommendation Summary

Summary of Recommendations and Evidence

Population	Recommendation	Grade (What's This?)
Adults aged 18 and older	The USPSTF recommends that clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse	B
Adolescents (under 18 years of age)	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening and behavioral counseling interventions in primary care settings to reduce alcohol misuse in adolescents.	I

Read Full Recommendation Statement
PDF Version (PDF Help)

View archived versions of this recommendation

Read the Full Recommendation Statement

Supporting Documents

- **Comparative Effectiveness Review**
  PDF Version (PDF Help)
- **Evidence Summary**
  PDF Version (PDF Help)

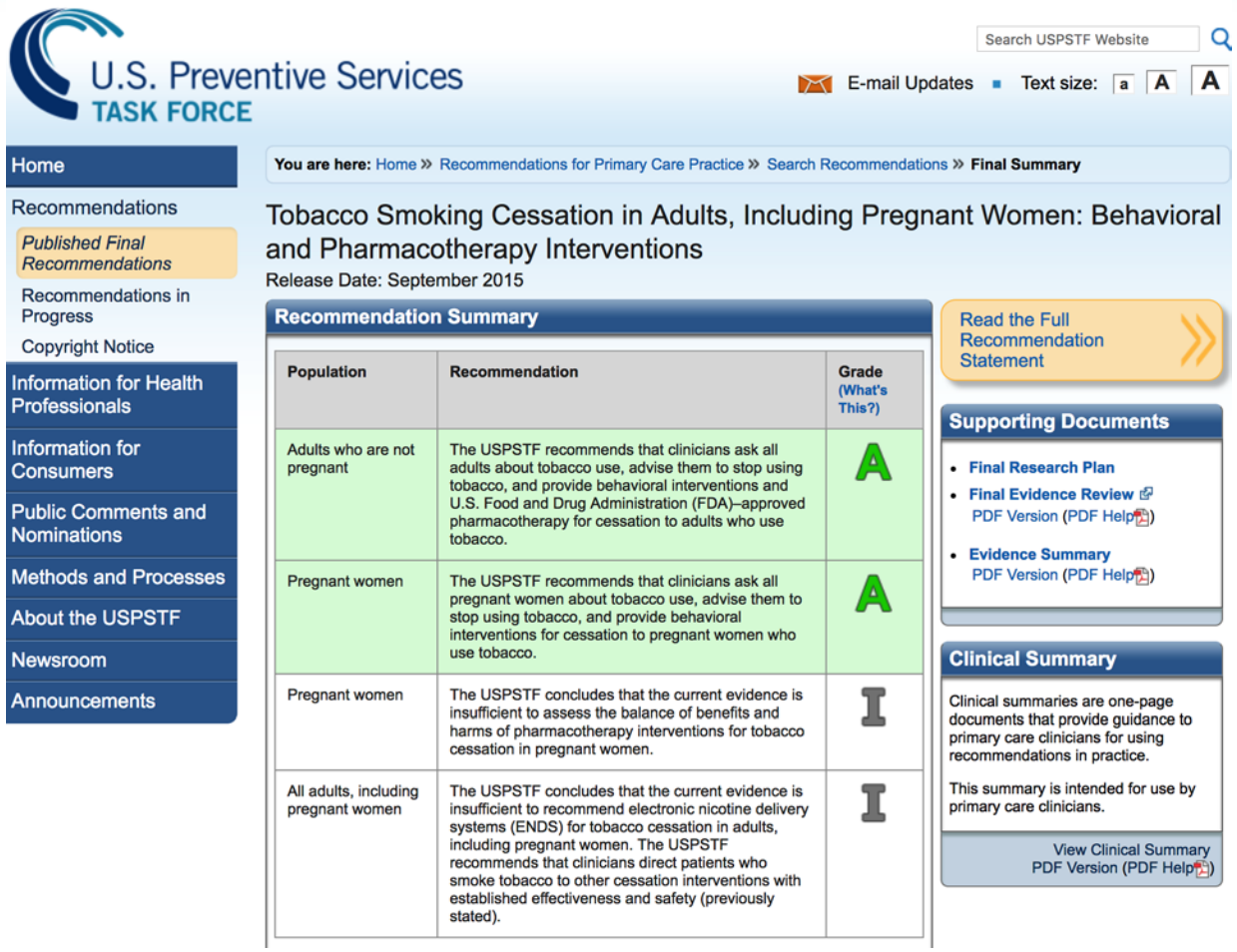
Clinical Summary

Clinical summaries are one-page documents that provide guidance to primary care clinicians for using recommendations in practice.

This summary is intended for use by primary care clinicians.

https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/alcohol-misuse-screening-and-behavioral-counseling-interventions-in-primary-care?ds=1&s=substance%20abuse

USPSTF: Tobacco Smoking Cessation in Adults



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Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions

Release Date: September 2015

Recommendation Summary

Population	Recommendation	Grade (What's This?)
Adults who are not pregnant	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to adults who use tobacco.	A
Pregnant women	The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.	A
Pregnant women	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of pharmacotherapy interventions for tobacco cessation in pregnant women.	I
All adults, including pregnant women	The USPSTF concludes that the current evidence is insufficient to recommend electronic nicotine delivery systems (ENDS) for tobacco cessation in adults, including pregnant women. The USPSTF recommends that clinicians direct patients who smoke tobacco to other cessation interventions with established effectiveness and safety (previously stated).	I

Read the Full Recommendation Statement

Supporting Documents

- Final Research Plan
- Final Evidence Review
  PDF Version (PDF Help)
- Evidence Summary
  PDF Version (PDF Help)

Clinical Summary

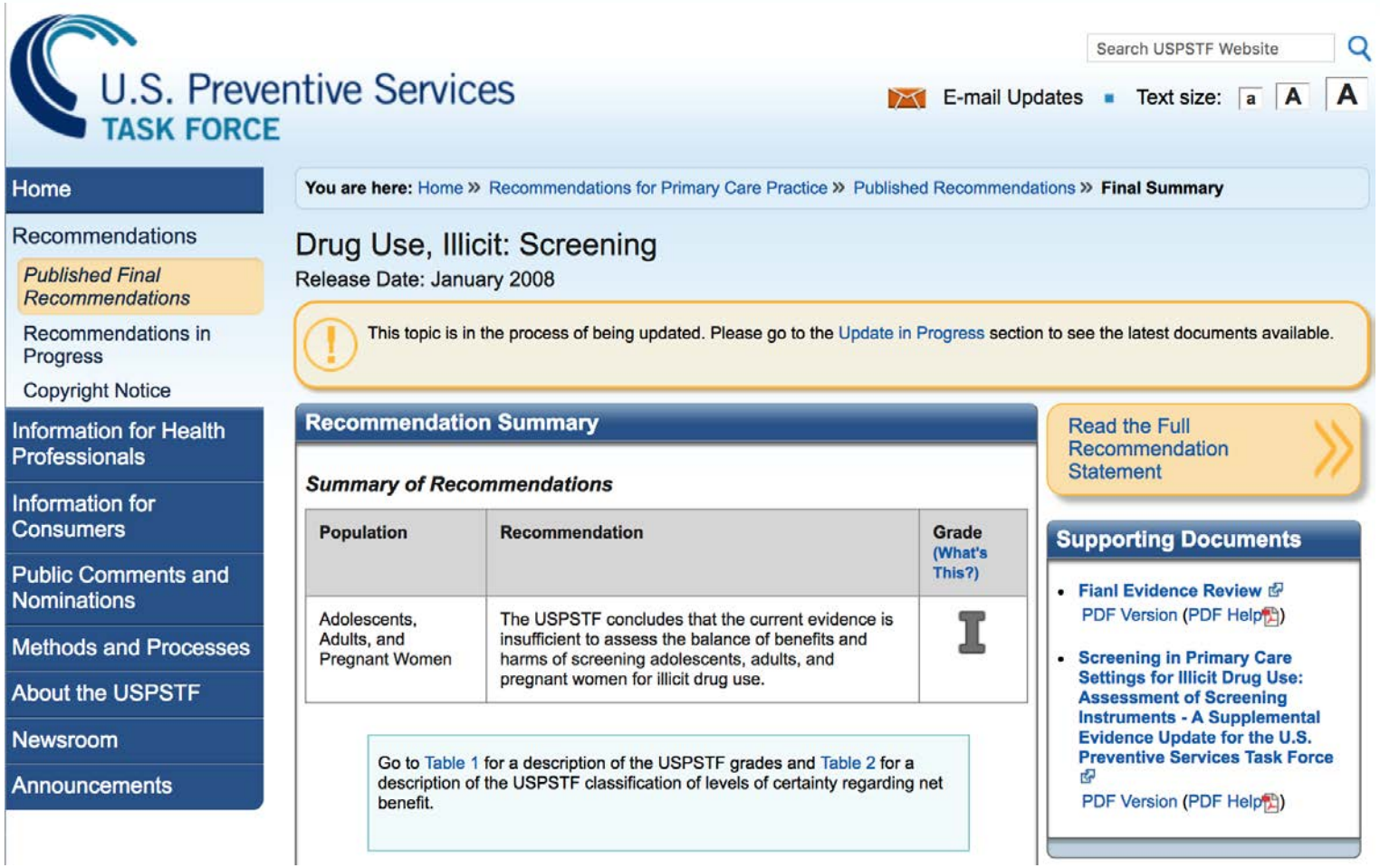
Clinical summaries are one-page documents that provide guidance to primary care clinicians for using recommendations in practice.

This summary is intended for use by primary care clinicians.

View Clinical Summary
PDF Version (PDF Help)

https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions1?ds=1&s=tobacco

USPSTF: Illicit Drug Screening



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Drug Use, Illicit: Screening

Release Date: January 2008

This topic is in the process of being updated. Please go to the Update in Progress section to see the latest documents available.

Recommendation Summary

Summary of Recommendations

Population	Recommendation	Grade (What's This?)
Adolescents, Adults, and Pregnant Women	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening adolescents, adults, and pregnant women for illicit drug use.	I

Go to Table 1 for a description of the USPSTF grades and Table 2 for a description of the USPSTF classification of levels of certainty regarding net benefit.

Read the Full Recommendation Statement

Supporting Documents

- Fianl Evidence Review
  PDF Version (PDF Help)
- Screening in Primary Care Settings for Illicit Drug Use: Assessment of Screening Instruments - A Supplemental Evidence Update for the U.S. Preventive Services Task Force
  PDF Version (PDF Help)

https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/drug-use-illicit-screening

SAMHSA/CSAT Treatment Improvement Protocols No. 24

"…Recommend that primary care clinicians periodically and routinely screen all patients for substance use disorders. Deciding to screen some patients and not others opens the door for cultural, racial, gender, and age biases that result in missed opportunities to intervene with or prevent the development of alcohol- or drug-related problems. Visual examination alone cannot detect intoxication, much less more subtle signs of alcohol- and drug-affected behavior."

https://www.ncbi.nlm.nih.gov/books/NBK64820/

Before Screening

- Determine staffing roles: who will administer? who will discuss results with patients?
- Train staff to conduct screening, intervene and refer
- Decide how results will be used and procedure for handling positive results
  - Screenings are not full assessments, positive screens will likely warrant additional assessment
- Consider existing office procedures when determining documentation of screening, consent, confidentiality/HIPAA and patient flow
- Consider patient population
- Determine if it is a billable service
- Establish or identify relationships with external or internal providers (if necessary) who can accept referrals for additional assessment or treatment.

https://www.drugabuse.gov/publications/resource-guide-screening-drug-use-in-general-medical-settings/before-you-begin-screening-patients

Substance Use:

Screening Tools

Chart of Evidence-Based Screening Tools for Adults and Adolescents

National Institute on Drug Abuse
Advancing Addiction Science

Screening Tool	Substance type		Patient age		How tool is administered	
	Alcohol	Drugs	Adults	Adolescents	Self-administered	Clinician-administered
Prescreen						
NIDA Drug Use Screening Tool: Quick Screen	X	X	X	See APA Adapted NM ASSIST tools	See APA Adapted NM ASSIST tools	X
CRAFFT (Part A)	X	X		X	X	X
Alcohol Use Disorders Identification Test-C (AUDIT-C (PDF, 41KB))	X		X		X	X
Opioid Risk Tool (PDF, 168KB)		X	X		X	
Brief Screener for Alcohol, Tobacco, and other Drugs (BSTAD)	X	X		X	X	X
Screening to Brief Intervention (S2BI)	X	X		X	X	X

https://www.drugabuse.gov/nidamed-medical-health-professionals/tool-resources-your-practice/screening-assessment-drug-testing-resources/chart-evidence-based-screening-tools-adults

NIDA Drug Use Screening Tool: Quick Screen

NIDA Drug Screening Tool

NIDA-Modified ASSIST (NM ASSIST)

Clinician's Screening Tool for Drug Use in General Medical Settings*

In the past year, how often have you used the following?

Alcohol (For men, 5 or more drinks a day. For women, 4 or more drinks a day)

Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily

Tobacco Products

Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily

Prescription Drugs for Non-Medical Reasons

Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily

Illegal Drugs

Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily

https://www.drugabuse.gov/nmassist/step/0

ASSIST V3.1: Alcohol, Smoking and Substance Involvement Screening Test

QUESTION 1 | In your life, which of the following substances have you *ever used* (non-medical use only)?		
a Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	No	Yes
b Alcoholic beverages (beer, wine, spirits, etc.)	No	Yes
c Cannabis (marijuana, pot, grass, hash, etc.)	No	Yes
d Cocaine (coke, crack, etc.)	No	Yes
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)	No	Yes
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)	No	Yes
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)	No	Yes
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	No	Yes
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)	No	Yes
j Other – specify: _____	No	Yes

Probe if all answers are negative:
"Not even when you were in school?"

If "No" to all items, stop interview.

If "Yes" to any of these items, ask Q2 for each substance ever used

QUESTION 2 | In the *past three months*, how often have you used the substances you mentioned (first drug, second drug, etc)?	Never	Once or twice	Monthly	Weekly	Daily or almost daily
a Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	2	3	4	6
b Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
c Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
d Cocaine (coke, crack, etc.)	0	2	3	4	6
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)	0	2	3	4	6
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	2	3	4	6
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)	0	2	3	4	6
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	0	2	3	4	6
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)	0	2	3	4	6
j Other – specify: _____	0	2	3	4	6

If "Never" to all items in Q2, skip to Q6.

If any substances in Q2 were used in the previous three months, continue with Questions 3, 4 & 5 for each substance used.

http://apps.who.int/iris/bitstream/10665/44320/1/9789241599382_eng.pdf

ASSIST V3.1: Alcohol, Smoking and Substance Involvement Screening Test

The type of intervention is determined by the patient's specific substance involvement score				
	Record specific substance score	**No intervention**	**Receive brief intervention**	**More intensive treatment**
a Tobacco		0 – 3	4 – 26	27+
b Alcohol		0 – 10	11 – 26	27+
c Cannabis		0 – 3	4 – 26	27+
d Cocaine		0 – 3	4 – 26	27+
e ATS		0 – 3	4 – 26	27+
f Inhalants		0 – 3	4 – 26	27+
g Sedatives		0 – 3	4 – 26	27+
h Hallucinogens		0 – 3	4 – 26	27+
i Opioids		0 – 3	4 – 26	27+
j Other drugs		0 – 3	4 – 26	27+
Now use ASSIST feedback report card to give client brief intervention.				

Specific substance involvement scores	Score	Risk Level	
a Tobacco products		0 – 3 4 – 26 27+	Lower Moderate High
b Alcoholic beverages		0 – 10 11 – 26 27+	Lower Moderate High
c Cannabis		0 – 3 4 – 26 27+	Lower Moderate High
d Cocaine		0 – 3 4 – 26 27+	Lower Moderate High
e Amphetamine-type stimulants		0 – 3 4 – 26 27+	Lower Moderate High
f Inhalants		0 – 3 4 – 26 27+	Lower Moderate High
g Sedatives or sleeping pills		0 – 3 4 – 26 27+	Lower Moderate High
h Hallucinogens		0 – 3 4 – 26 27+	Lower Moderate High
i Opioids		0 – 3 4 – 26 27+	Lower Moderate High
j Other – specify: _____		0 – 3 4 – 26 27+	Lower Moderate High

What do your scores mean?

Lower: You are at lower risk of health and other problems from your current pattern of use.

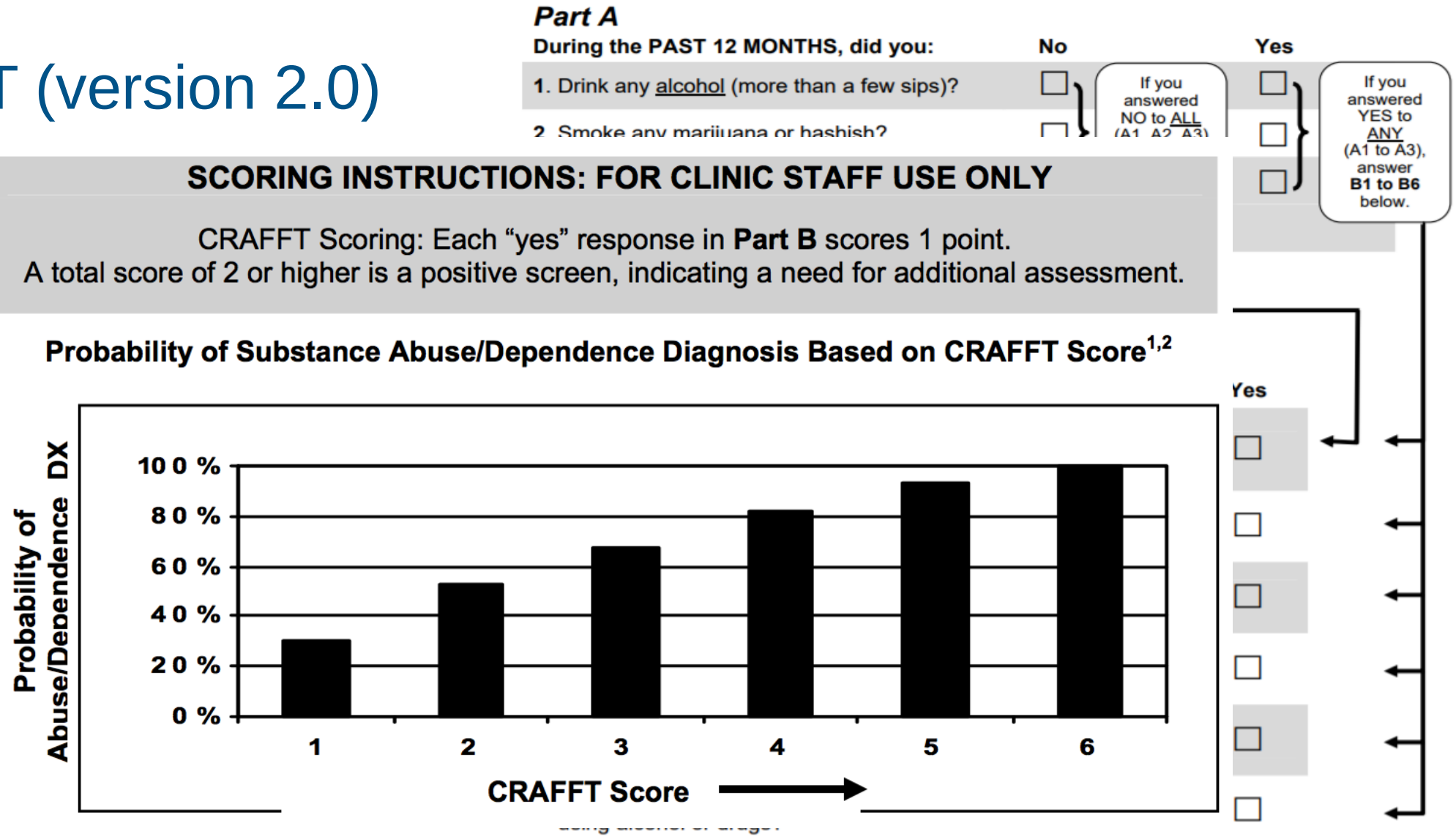
Moderate: You are at moderate risk of health and other problems from your current pattern of substance use.

High: You are at high risk of experiencing severe problems (health, social, financial, legal, relationship) as a result of your current pattern of use and are likely to be dependent.

http://apps.who.int/iris/bitstream/10665/44320/1/9789241599382_eng.pdf

CRAFFT (version 2.0)

- CRAFF
  acronyn
  words ir
  questior
  be aske



DAST-10 Questionnaire

DAST-10 Questionnaire

I'm going to read you a list of questions concerning information about your potential involvement with drugs, excluding alcohol and tobacco, during the past 12 months.

When the words "drug abuse" are used, they mean the use of prescribed or over-the-counter

Interpretation of Score:

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	None at this time
1-2	Low level	Monitor, reassess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment

choose "No."		
6. Does your spouse (or parents) ever complain about your involvement with drugs?	0	1
7. Have you neglected your family because of your use of drugs?	0	1
8. Have you engaged in illegal activities in order to obtain drugs?	0	1
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	0	1
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	0	1

Skinner HA (1982). The Drug Abuse Screening Test. Addict Behav 7(4):363-371. Yudko E, Lozhkina O, Fouts A (2007). A comprehensive review of the psychometric properties of the Drug Abuse Screening Test. J Subst Abuse Treatment 32:189-198.

AUDIT/AUDIT-C: Alcohol Use Disorders Identification Test

Box 6

Risk Level	Intervention	AUDIT score*
Zone I	Alcohol Education	0-7
Zone II	Simple Advice	8-15
Zone III	Simple Advice plus Brief Counseling and Continued Monitoring	16-19
Zone IV	Referral to Specialist for Diagnostic Evaluation and Treatment	20-40

*The AUDIT cut-off score may vary slightly depending on the country's drinking patterns, the alcohol content of standard drinks, and the nature of the screening program. Clinical judgment should be exercised in cases where the patient's score is not consistent with other evidence, or if the patient has a prior history of alcohol dependence. It may also be instructive to review the patient's responses to individual questions dealing with dependence symptoms (Questions 4, 5 and 6) and alcohol-related problems (Questions 9 and 10). Provide the next highest level of intervention to patients who score 2 or more on Questions 4, 5 and 6, or 4 on Questions 9 or 10.

g system			Your score
2	3	4	
2-4 mes per onth	2-3 times per week	4+ times per week	
5-6	7-9	10+	
nthly	Weekly	Daily or almost daily	
		TOTAL :	

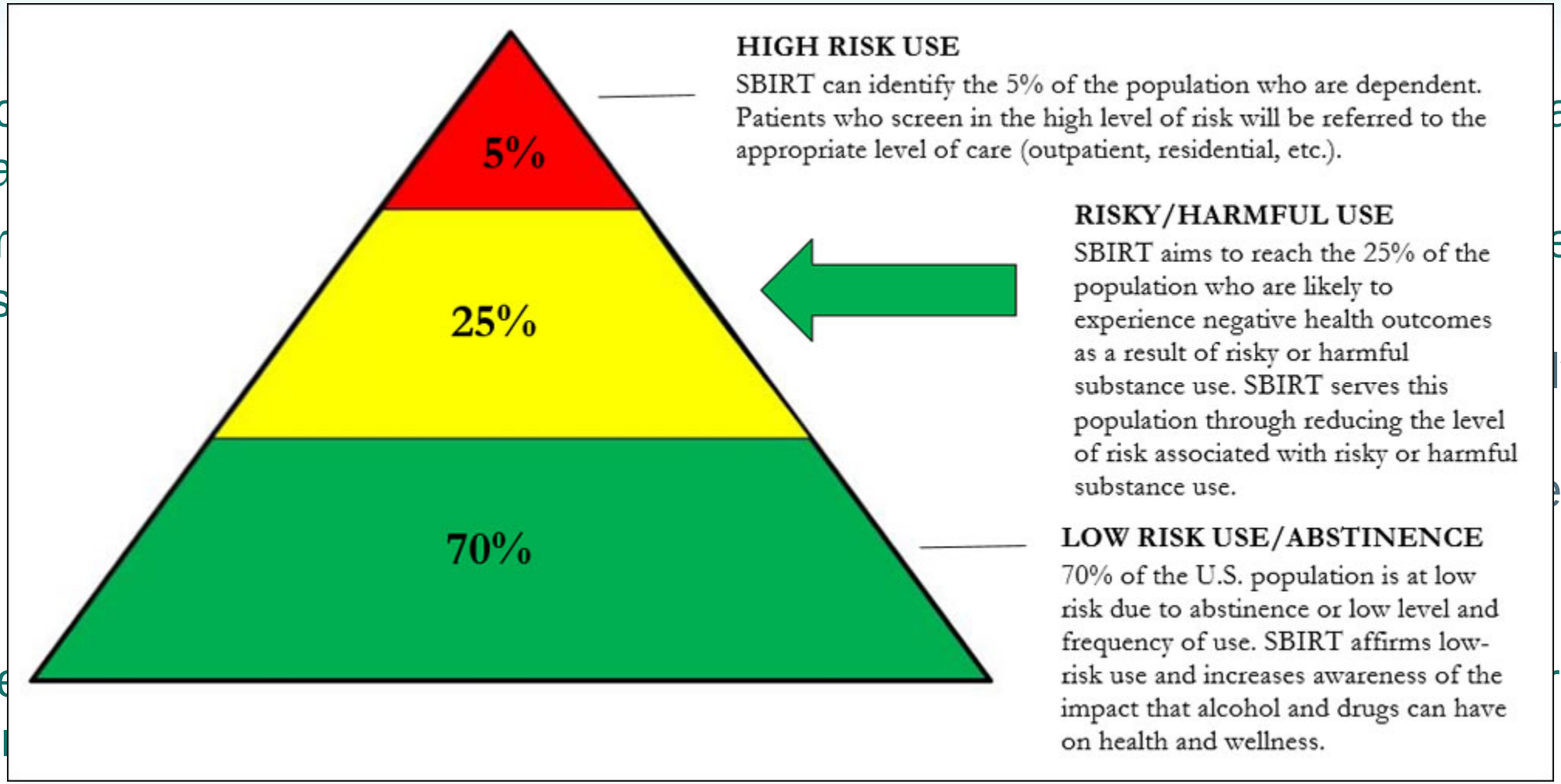
http://apps.who.int/iris/bitstream/10665/67205/1/WHO_MSD_MSB_01.6a.pdf
https://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/what-standard-drink

Substance Use Screening:

Discussing the Results

“SBIRT” & Motivational Interviewing

- So… a pa…
- Br… e us…
  - …lve
- …erm
- Re… …red fo…



Why “SBIRT”?

- “SBIRT” is an opportunity to begin to **normalize** the conversation around alcohol and drug use as a health issue.
- Brief interventions are proven to **reduce or eliminate substance use** and help individuals get into needed treatment.
- Opportunity to build on already existing trusted relationships in a safe, confidential and accessible environment.
- Through doors already open to patients, quick and easy screening can uncover a need for further counseling.

The 5 A’s

- Ask, Advise, Assess, Assist and Arrange
- Ask the question(s), review results
- Advise: Provide medical advice about drug use, recommend quitting before problems develop, educate on risks
- Assess readiness to quit: "Given what we've talked about, do you want to change your drug use?“ If not ready, reiterate drugs being a health problem and that we will revisit on future visits.
- Assist in making a change: Set concrete, reasonable goals
- Arrange specialty assessment, drug treatment and/or follow-up visit as necessary.

https://www.drugabuse.gov/publications/resource-guide-screening-drug-use-in-general-medical-settings/screen-then-intervene-conducting-brief-intervention

https://www.youtube.com/watch?v=b-ilxvHZJDc

Ways to Start the Conversation

- High Risk:
  - "Based on the screening results, you are at high risk of having or developing a substance use disorder. It is medically in your best interest to stop your use of [insert specific drugs here]. I am concerned that if you do not make a change quickly, the consequences to your health and well-being may be serious.“
- Moderate Risk:
  - "Based on the screening results, you are at moderate risk of having or developing a substance use disorder. It is medically in your best interest to change your use of [insert specific drugs here].“
- Lower Risk:
  - "Your screening results show you are unlikely to have a substance use disorder. However, people with any history of substance use can be at some risk of adverse consequences and developing a disorder especially in times of stress or if they have just started to use recently. It is impossible to know in advance whether or not a person will become addicted. As your physician I encourage you to only use alcohol moderately and responsibly and to avoid using other substances."

https://www.drugabuse.gov/publications/resource-guide-screening-drug-use-in-general-medical-settings/screen-then-intervene-conducting-brief-intervention

Coding for Screening and Brief Intervention Reimbursement

Reimbursement for SBIRT

Payer	Code	Description	Fee Schedule
Commercial Insurance	CPT 99408	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes	$33.41
	CPT 99409	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes	$65.51
Medicare	G0396	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes	$29.42
	G0397	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes	$57.69
Medicaid	H0049	Alcohol and/or drug screening	$24.00
	H0050	Alcohol and/or drug screening, brief intervention, per 15 minutes	$48.00

https://www.samhsa.gov/sbirt/coding-reimbursement

Opioid Prescribing:

Screening Tools

Opioid Risk Tool

Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

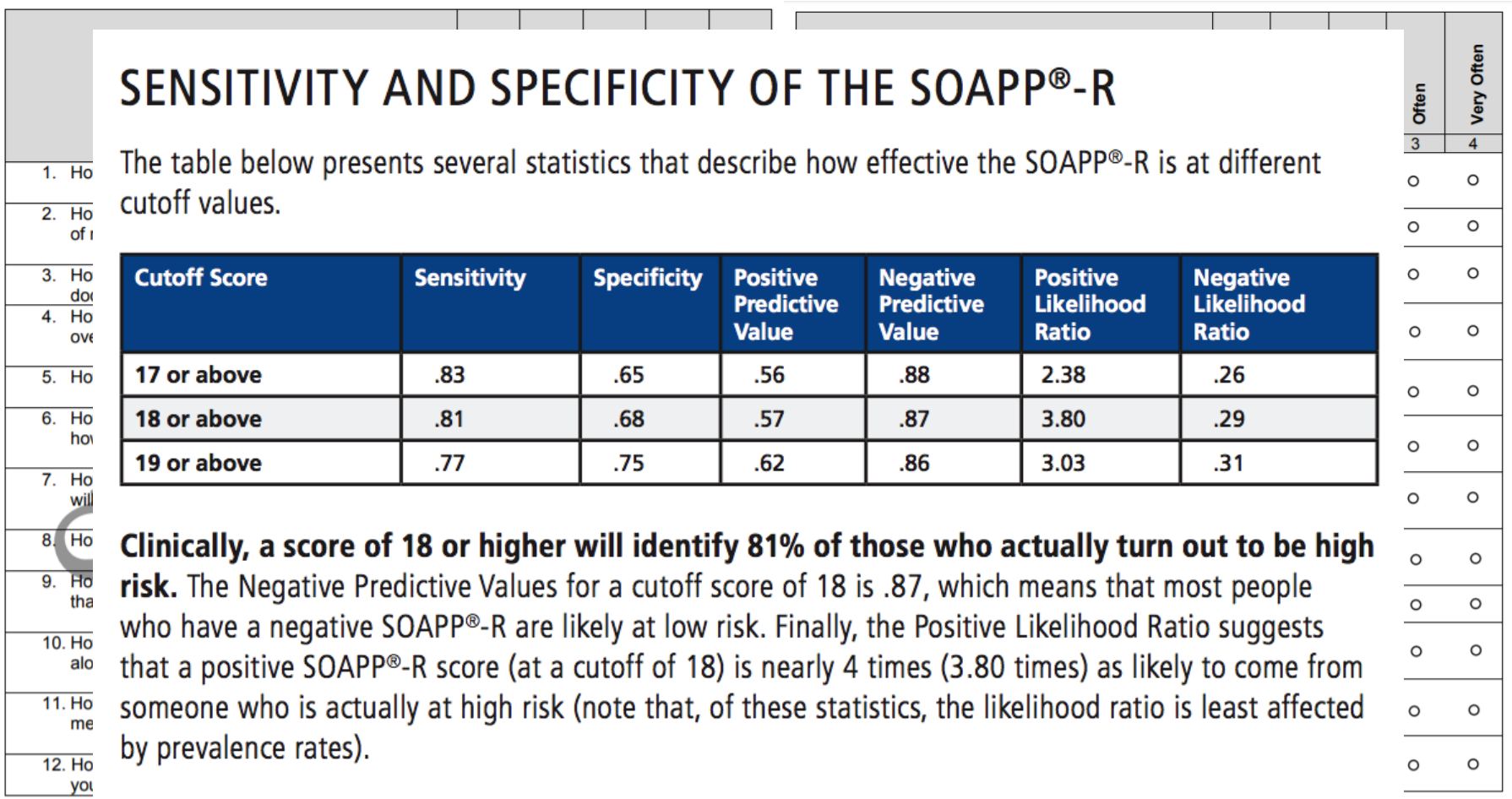
Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk too. Pain Med. 2005; 6 (6) : 432

Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R)

- **Purpose:** The Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R) predicts possible opioid abuse in chronic pain patients
- **Evidence:**
  - Provides excellent discrimination between high risk and low risk patients (Passik et al. 2008)
  - High-risk score on the SOAPP-R correlates with an increased likelihood of drug abuse (Chou et al. 2009)
  - Study suggests that the SOAPP-R is an improvement over the original version in screening risk potential for deviant medication-related behavior among chronic pain patients (Butler et al. 2008).

https://www.opioidrisk.com/node/1209

SOAPP-R



SENSITIVITY AND SPECIFICITY OF THE SOAPP®-R

The table below presents several statistics that describe how effective the SOAPP®-R is at different cutoff values.

Cutoff Score	Sensitivity	Specificity	Positive Predictive Value	Negative Predictive Value	Positive Likelihood Ratio	Negative Likelihood Ratio
17 or above	.83	.65	.56	.88	2.38	.26
18 or above	.81	.68	.57	.87	3.80	.29
19 or above	.77	.75	.62	.86	3.03	.31

Clinically, a score of 18 or higher will identify 81% of those who actually turn out to be high risk. The Negative Predictive Values for a cutoff score of 18 is .87, which means that most people who have a negative SOAPP®-R are likely at low risk. Finally, the Positive Likelihood Ratio suggests that a positive SOAPP®-R score (at a cutoff of 18) is nearly 4 times (3.80 times) as likely to come from someone who is actually at high risk (note that, of these statistics, the likelihood ratio is least affected by prevalence rates).

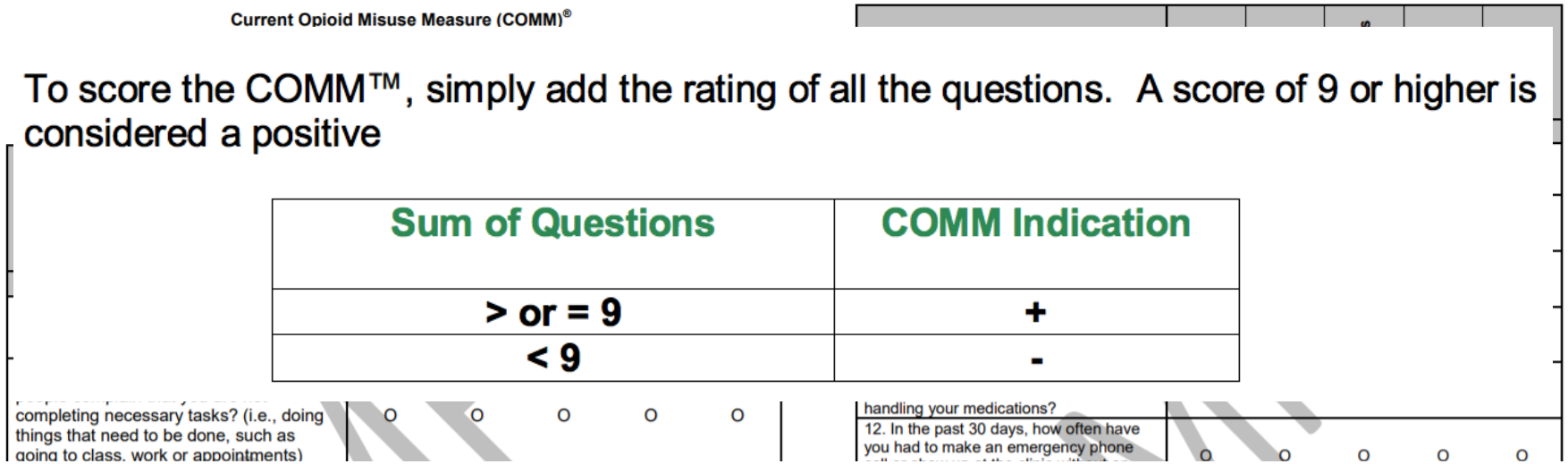
http://interactive.nejm.org/imc/NEJMdo004938/modules/management_of_chronic_pain/media/pdfs/LE3_ScreenerAndOpioidAssessment.pdf

Current Opioid Misuse Measure (COMM)™

- “The Current Opioid Misuse Measure (COMM)™ is a brief patient self-assessment to monitor chronic pain patients on opioid therapy. The COMM™ was developed with guidance from a group of pain and addiction experts and input from pain management clinicians in the field. Experts and providers identified six key issues to determine if patients already on long-term opioid treatment are exhibiting aberrant medication-related behaviors:
  - Signs & Symptoms of Intoxication
  - Emotional Volatility
  - Evidence of Poor Response to Medications
  - Addiction
  - Healthcare Use Patterns
  - Problematic Medication Behavior”

https://www.opioidprescribing.com/documents/09-comm-inflexxion.pdf

Current Opioid Misuse Measure (COMM)™



Current Opioid Misuse Measure (COMM)®

To score the COMM™, simply add the rating of all the questions. A score of 9 or higher is considered a positive

Sum of Questions	COMM Indication
> or = 9	+
< 9	-

completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)

handling your medications?

12. In the past 30 days, how often have you had to make an emergency phone

time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?

17. In the past 30 days, how often have you had to visit the Emergency Room?

COMM™ Cutoff Score	Sensitivity	Specificity	Positive Predictive Value	Negative Predictive Value	Positive Likelihood Ratio	Negative Likelihood Ration
Score 9 or above	.77	.66	.66	.95	3.48	.08

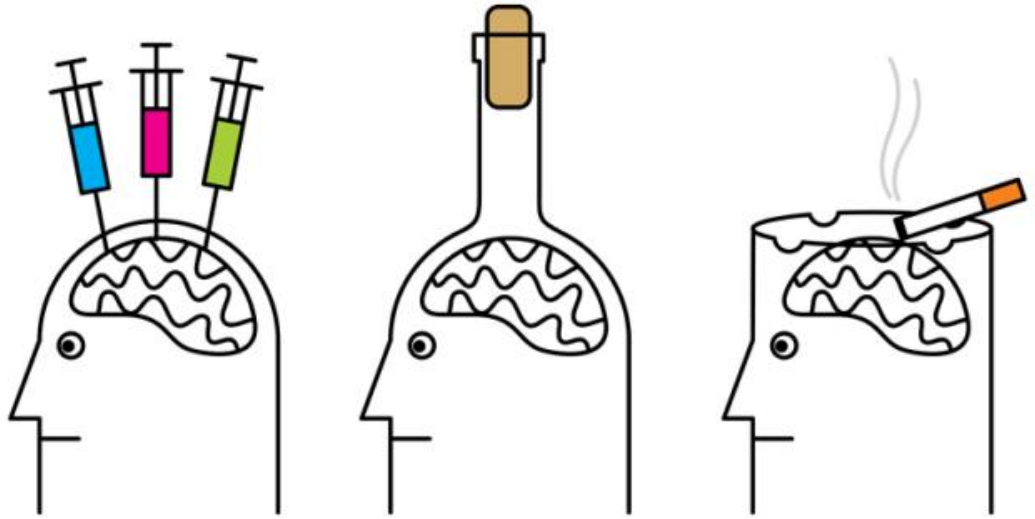
http://www.womenscollegehospital.ca/assets/pdf/TAPMI/Current%20Opioid%20Misuse%20Measures.pdf

Diagnostic Criteria:

Opioid Use Disorder

National Institute of Drug Abuse (NIDA) Definition of Addiction

Addiction is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs change the brain; they change its structure and how it works. These brain changes can be long lasting and can lead to many harmful, often self-destructive, behaviors.

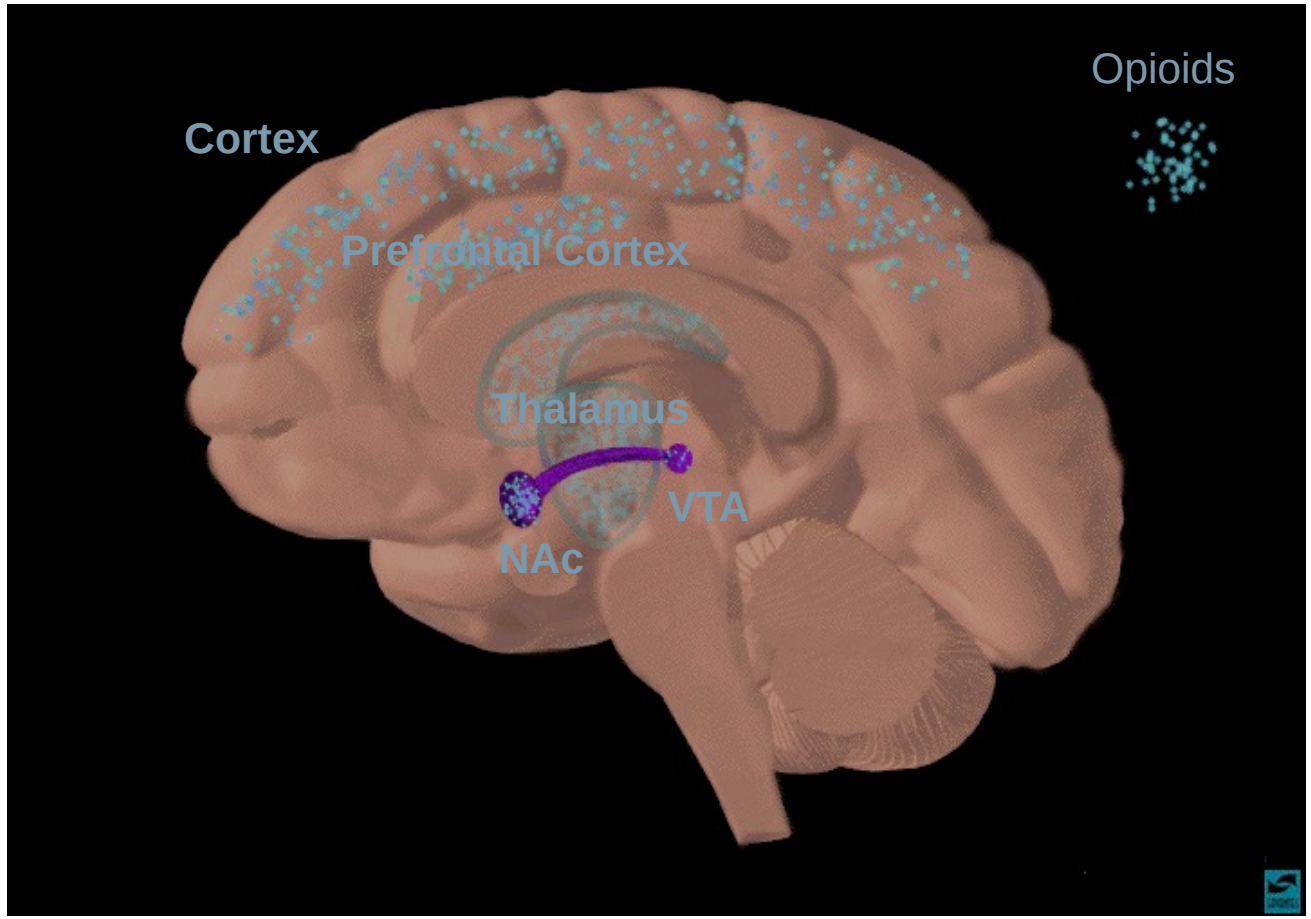


ASAM, 2011
NIDA, 2014

American Society of Addiction Medicine (ASAM) Definition of Addiction

- Addiction is a primary, **chronic disease of brain reward, motivation, memory and related circuitry**. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.
- Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, **addiction often involves cycles of relapse and remission**. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

Opioid Binding



NIDA, 2007

DSM-5 Criteria for SUDs

Loss of control
- more than intended
  - amount used
  - time spent
- unable to cut down
- giving up activities
- craving

Physiology
- tolerance
- withdrawal

formerly "dependence"

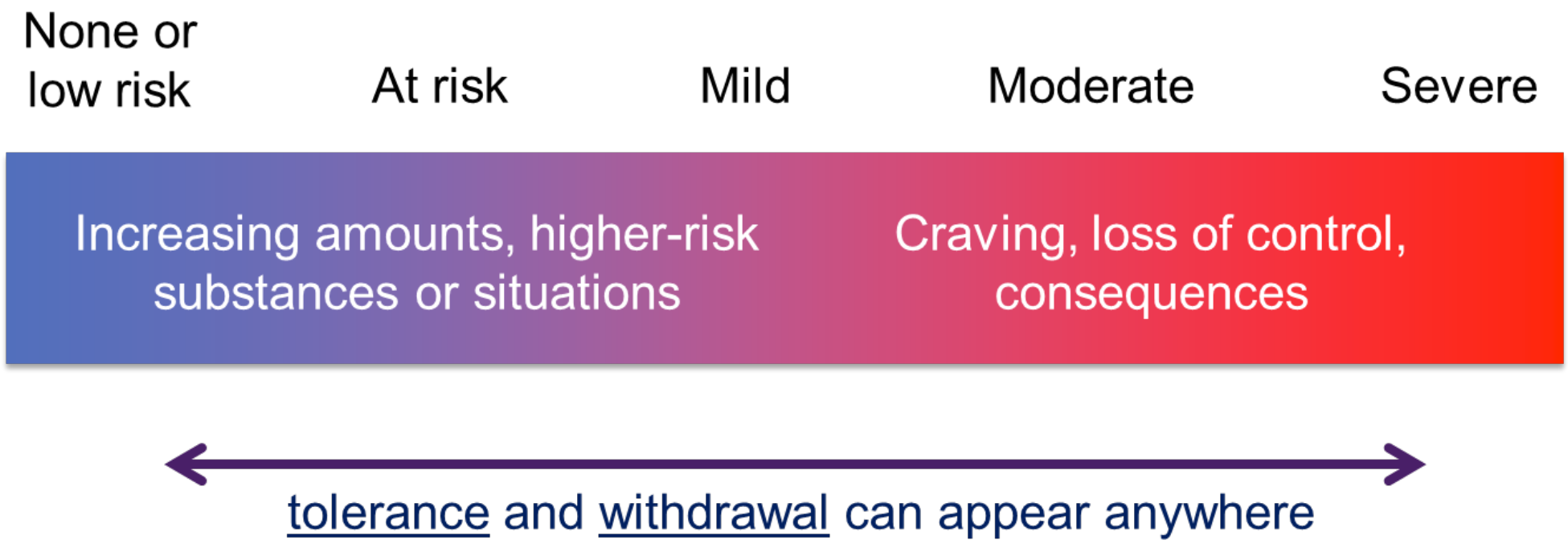
Consequences
- unfulfilled obligations
  - work
  - school
  - home
- interpersonal problems
- dangerous situations
- medical problems

formerly "abuse"

- A ***substance use disorder*** is defined by having 2 or more • in the past year resulting in distress or impairment.
- **Tolerance** and **withdrawal** alone don't necessarily imply a disorder.
- Severity is rated by the number of symptoms present:
  - 2-3 = mild
  - 4-5 = moderate
  - 6+ = severe

APA, 2013

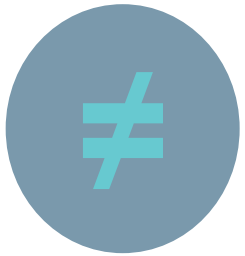
Spectrum of Substance Use



Addiction and Dependence: There is a difference

Addiction in Opioid Use Disorder

- Withdrawal
- Loss of control
- ↓ in function
- Use despite negatives
- Compulsive use
- Craving



Dependence

- Tolerance
- Withdrawal
- No loss of control
- Functioning well

Start opioid

↓Pain

Euphoria

Tolerance

Doc ↑ mg

Tolerance

Pt ↑ mg

Use for stress sleep high

Try to ↓

↑pain ↓sleep w/d

Return to drug

Run out early

Change source

Opioid Use Disorder:

Pharmacotherapy Treatment

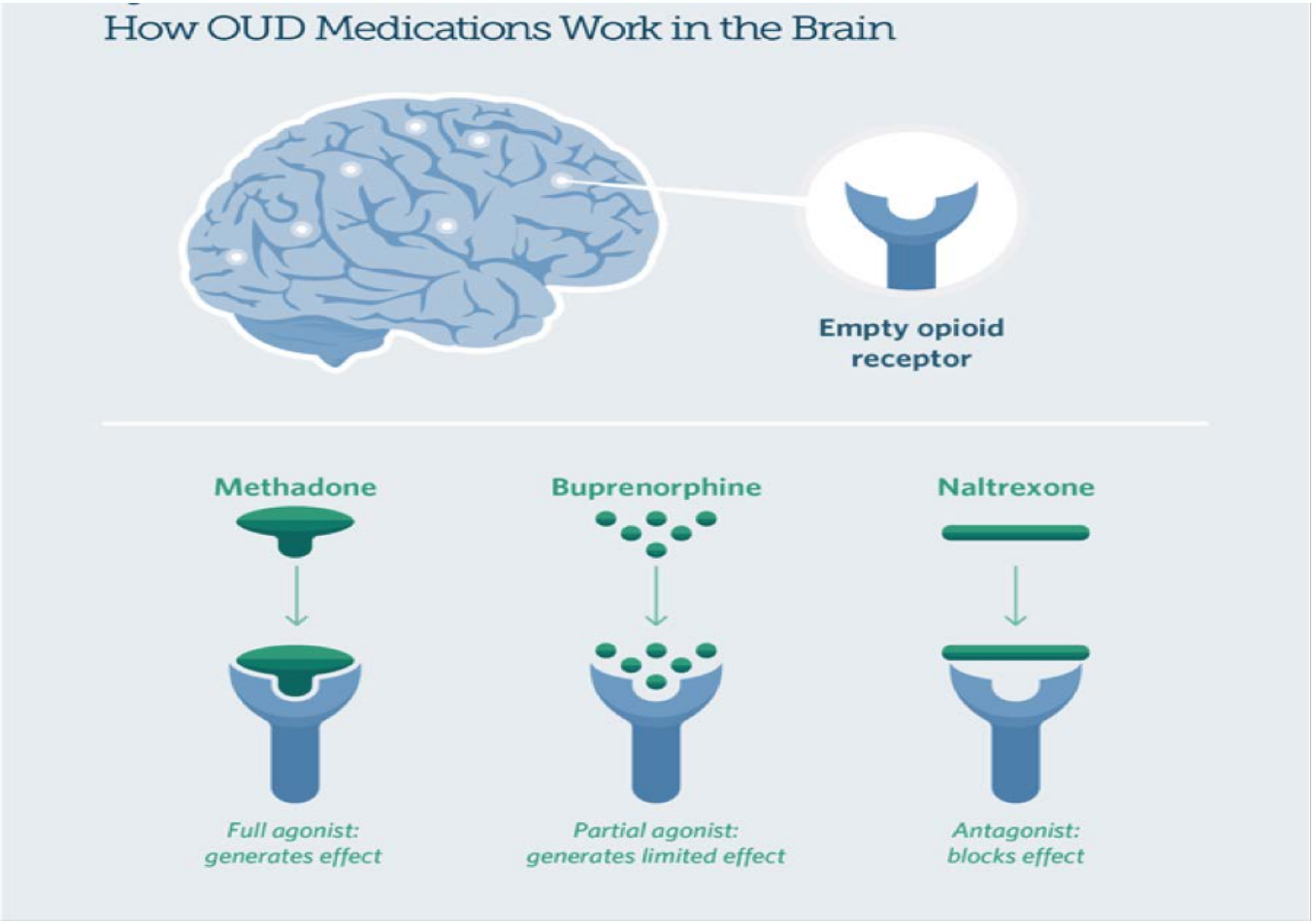
PATIENT-CENTERED CARE

- D
- B

Pharmacotherapy for Opioid Use Disorder (OUD)

- A best practice, cost-effective intervention that saves lives and money.
- Should include co-occurring psychosocial treatment.
- Methadone and buprenorphine (Subutex, Sublocade, Probuphine) or buprenorphine/naloxone (Bunavail, Suboxone, Zubsolv) are FDA approved to treat OUD
  - Opioid agonists or partial opioid agonists
  - Opioid treatment program (OTP) vs primary care availability
- Extended release injectable (Vivitrol) or oral naltrexone are FDA approved for the prevention of relapse to OUD following detoxification
  - Opioid antagonist
  - Requires complete withdrawal with 7-10 days of abstinence

Medication Assisted Treatment & Opioid Receptors



https://www.confidentialrecovery.com/services/mat-medication-assisted-treatment/

Major Features of Methadone

Long acting

- half-life ~ 15-60 Hours

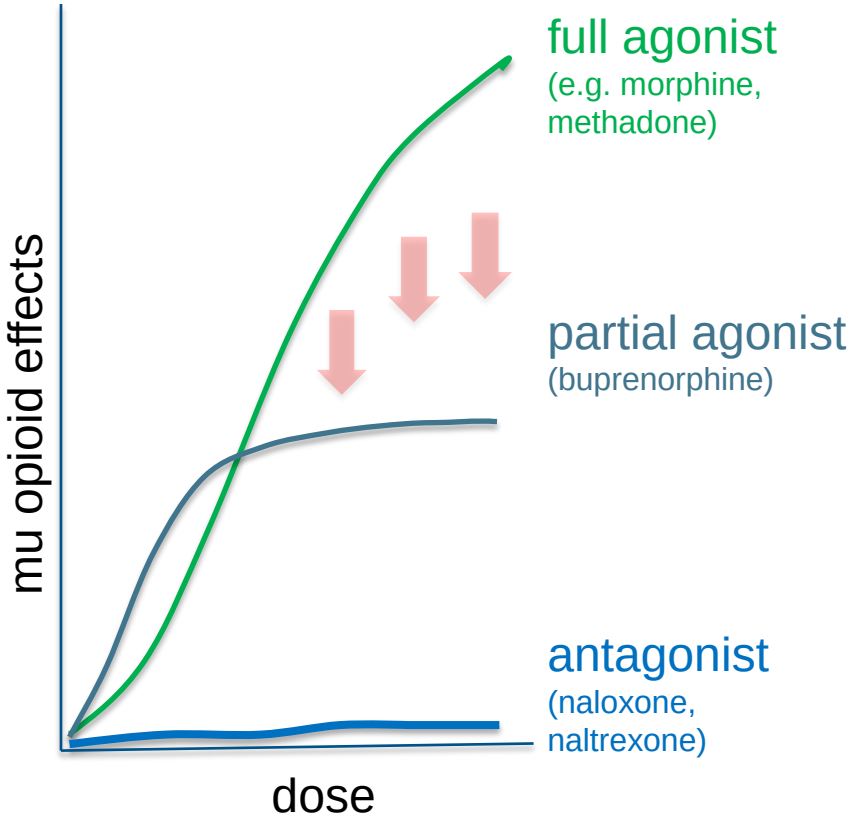
Full Agonist at mu receptor

Weak affinity for mu receptor

- *Can be displaced by partial agonists (e,g. burprenorphine) and antagonists (e.g.naloxone, naltrexone),* which can both precipitate withdrawal

Monitoring

- Significant respiratory suppression and potential respiratory arrest in overdose
- QT prolongation



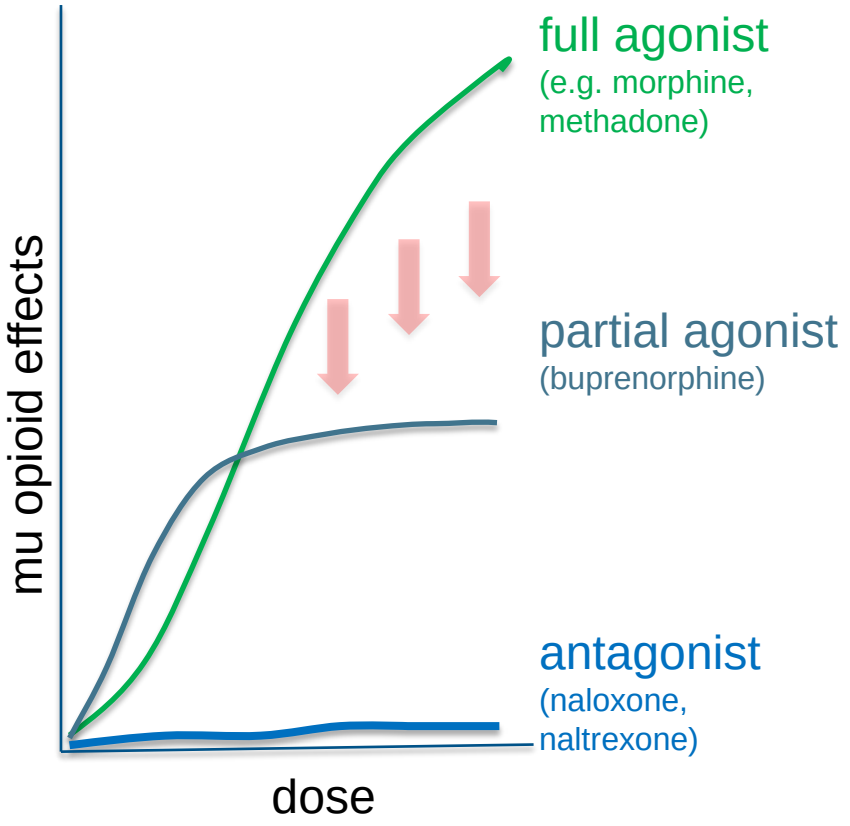
Major Features of Buprenorphine

Long acting
- half-life ~ 24-36 Hours

Partial agonist at mu receptor
- Comparatively minimal respiratory suppression and no respiratory arrest when used as prescribed

High affinity for mu receptor
- *blocks* other opioids
- *displaces* other opioids
  - can precipitate withdrawal

Slow dissociation from mu receptor
- *stays on receptor for a long time*



SAMHSA, 2018
Orman & Keating, 2009
PCSS, 2017

Rationale for the Combination of Buprenorphine with Naloxone

- When used as prescribed (sublingual or buccal administration), there is minimal bioavailability of naloxone.
- Compared to buprenorphine alone, the buprenorphine/naloxone combination:
  - was developed to decrease IV misuse
  - is more likely to precipitate withdrawal if injected
  - produces less euphoria (similar to placebo) when injected or insufflated in those who are physically dependent on opioids
  - per prescription, is less likely to be diverted

Comer et al., 2010
Jones et al., 2015
Stoller et al., 2001
PCSS, 2017

Major Features of Naltrexone

Long acting

- half-life:
  - Oral ~ 4 Hours
  - IM ~ 5-10 days

Full Antagonist at mu receptor

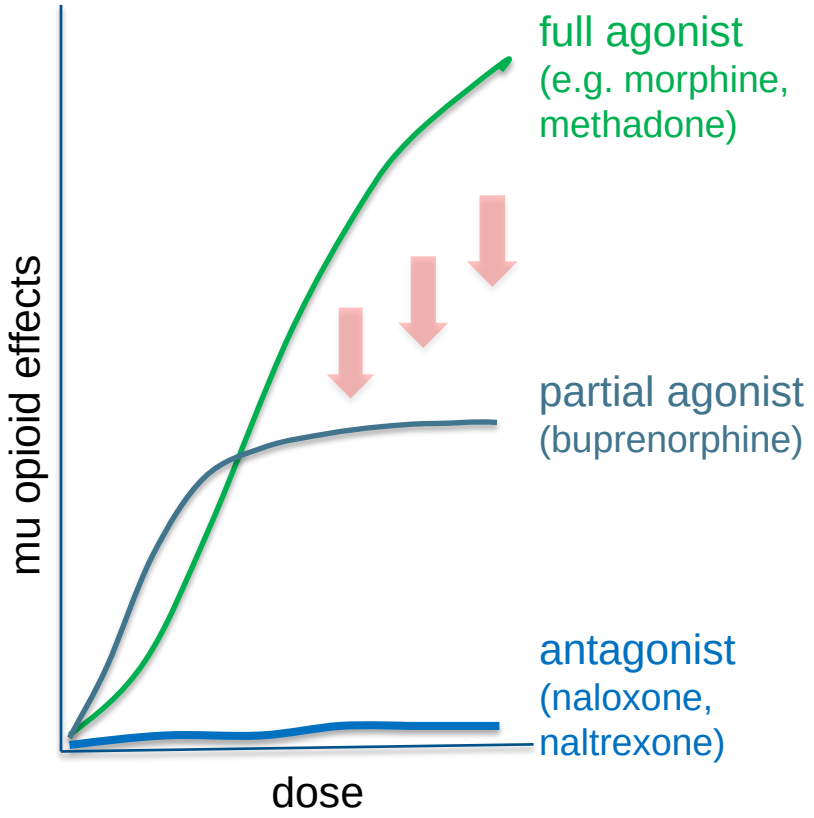
- Competitive binding at mu receptor

High affinity for mu receptor

- *blocks* other opioids
- *displaces* other opioids
  - can precipitate withdrawal

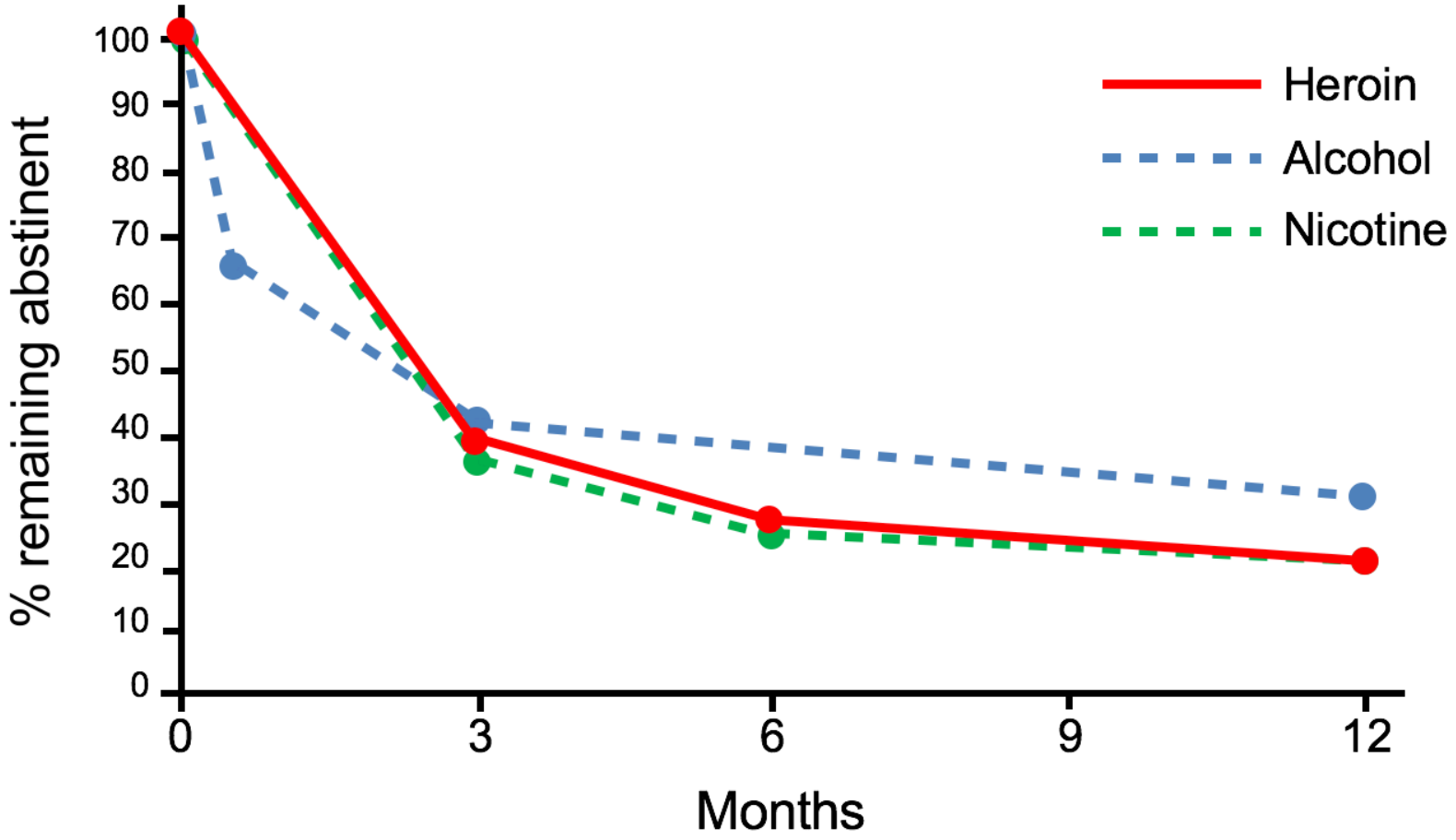
Formulations

- *Tablets: Revia®: FDA approved in 1984*
- *Extended-Release intramuscular injection: Vivitrol®: FDA approved in 2010*



SAMHSA, 2018

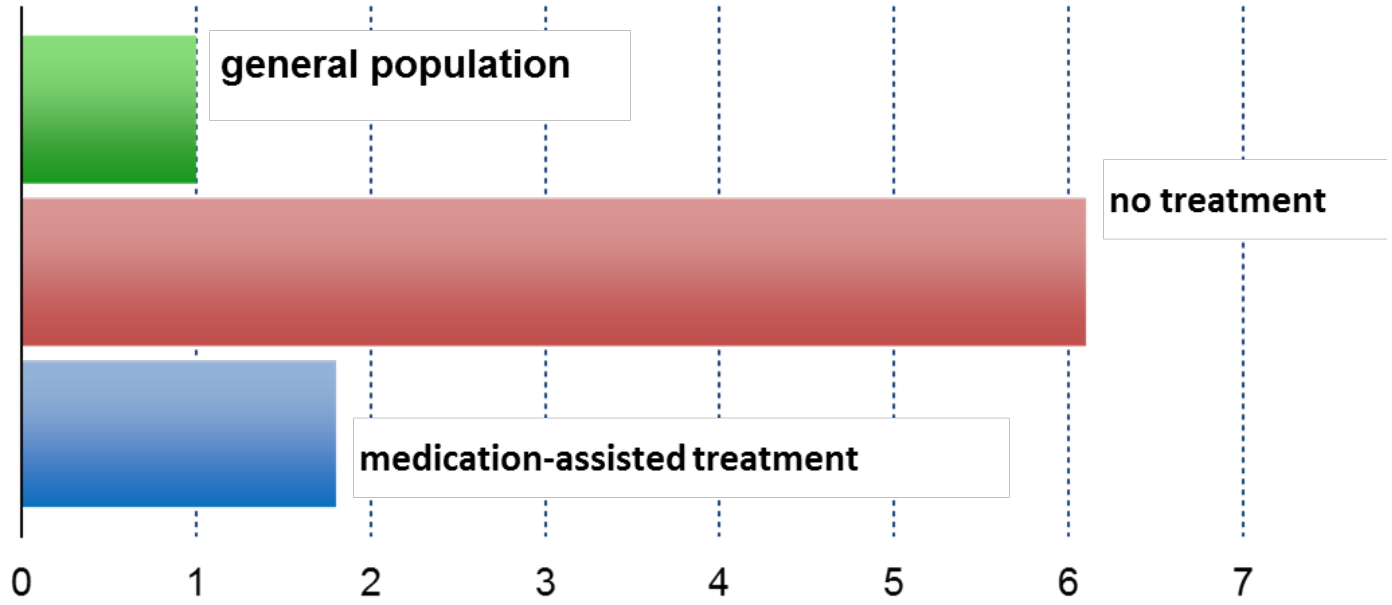
Abstinence Without MAT



Hunt et al., 1971

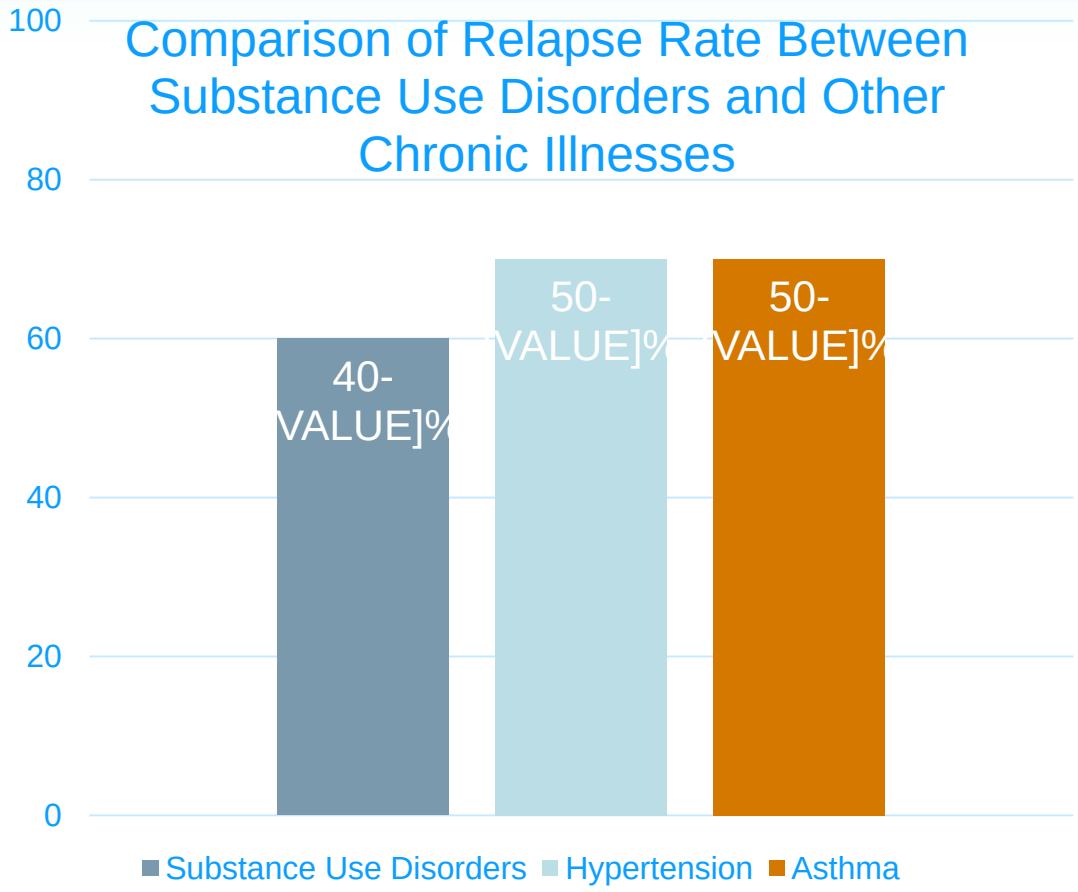
Benefits of MAT: Decreased Mortality

Death rates:



Dupouy et al., 2017
Evans et al., 2015
Sordo et al., 2017

Substance Use Disorders and Recurrence



JAMA, 284:1689-1695, 2000.

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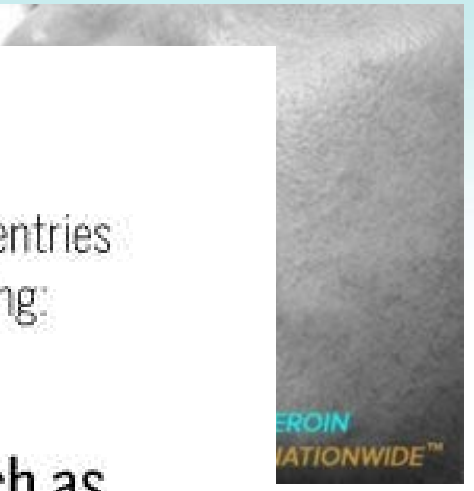

'ADDICTION-ARY' ADVICE

The Recovery Research Institute's glossary of addiction-related terms flags several entries with a "stigma alert" based on research that suggests they induce bias. A sampling:

ABUSER, ADDICT

Use "person-first" language: Rather than call someone an addict, say he or she suffers from addiction or a substance-use disorder.

DRUG

Use specific terms such as "medication" or "a non-medically used psychoactive substance" to avoid ambiguity.

CLEAN, DIRTY

Use proper medical terms for positive or negative test results for substance use.

LAPSE, RELAPSE, SLIP

Use morally neutral terms like "resumed" or experienced a "recurrence" of symptoms.

What's Next?

- Work to decrease personal and peer stigma and bias surrounding addiction.
- Commit to routine screening of all patients for substance abuse.
- Obtain DATA 2000 DEA X wavier to prescribe buprenorphine
  - Free waiver trainings offered online through AANP/SAMHSA & locally face-to-face in SC
  - Next free MUSC sponsored in person training: Lexington/Richland Alcohol and Drug Abuse Council (LRADAC) March 26th
    - *FREE,* 24 hours of CE, includes pharm hours!
- MUSC Opioid Use Disorder Project ECHO: 1st & 3rd Friday

www.scmataccess.com

Sources and Additional Information

- American Society of Addiction Medicine (ASAM)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Center for Disease Control (CDC)
- National Institute of Health (NIH) & National Institute for Drug Abuse (NIDA)
- American Association of Addiction Psychiatry
- Additional sources available upon request