Assessing and Diagnosing OUD

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Objectives

- Define Opioid Use Disorder
- Pain and Opioid Use Disorder
- State Law regarding documentation / treatment
- Assessing overdose risk
- Addressing the stigma of addiction

What is the Definition of Opioid Use Disorder?

(also know as opioid "addiction")

According to the American Society of Addiction Medicine's definition:

Addiction is a primary, chronic and relapsing brain disease characterized by an individual pathologically pursuing reward and/or relief by substance use and other behaviors

How do You Diagnose Opioid Use Disorder (OUD)?

2 or more criteria = OUD:

- Using larger amounts/longer than intended
- Much time spent using
- Activities given up in order to use
- Physical/psychological problems associated with use
- Social/interpersonal problems related to use
- Neglected major role in order to use
- Hazardous use
- Repeated attempts to quit/control use
- Withdrawal *
- Tolerance *
- Craving

*Does not count if taken only as prescribed and constitutes the sole criteria

DSM 5, American Psychiatric Association

Physical dependence
on opioids

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Opioid use disorder
(opioid addiction)

DIAGNOSIS OF OPIOID USE DISORDER

- patient on opioids who does not have opioid use disorder (patient on 30 hydrocodone a month who takes them prn without any negative consequences)
- patient who clearly has opioid use disorder (patient who converted to heroin with multiple negative consequences as a result)
- patient on high dose prescription pain meds who denies any negative consequences as long as they get their medication

Is this pain or is this addiction?

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WRONG QUESTION

Is this pain or is this addiction?

- Far more complex,
- Large proportion of patients with SUD have pain, much smaller proportion of chronic pain patients have SUD
- Rates of pain are even higher in those receiving SUD treatment (up to 75%)
- Pain in SUD more disabling (38% vs 19% without SUD)
- Reciprocal relationship between pain and addiction

The Spectrum of Opioid Use Disorder

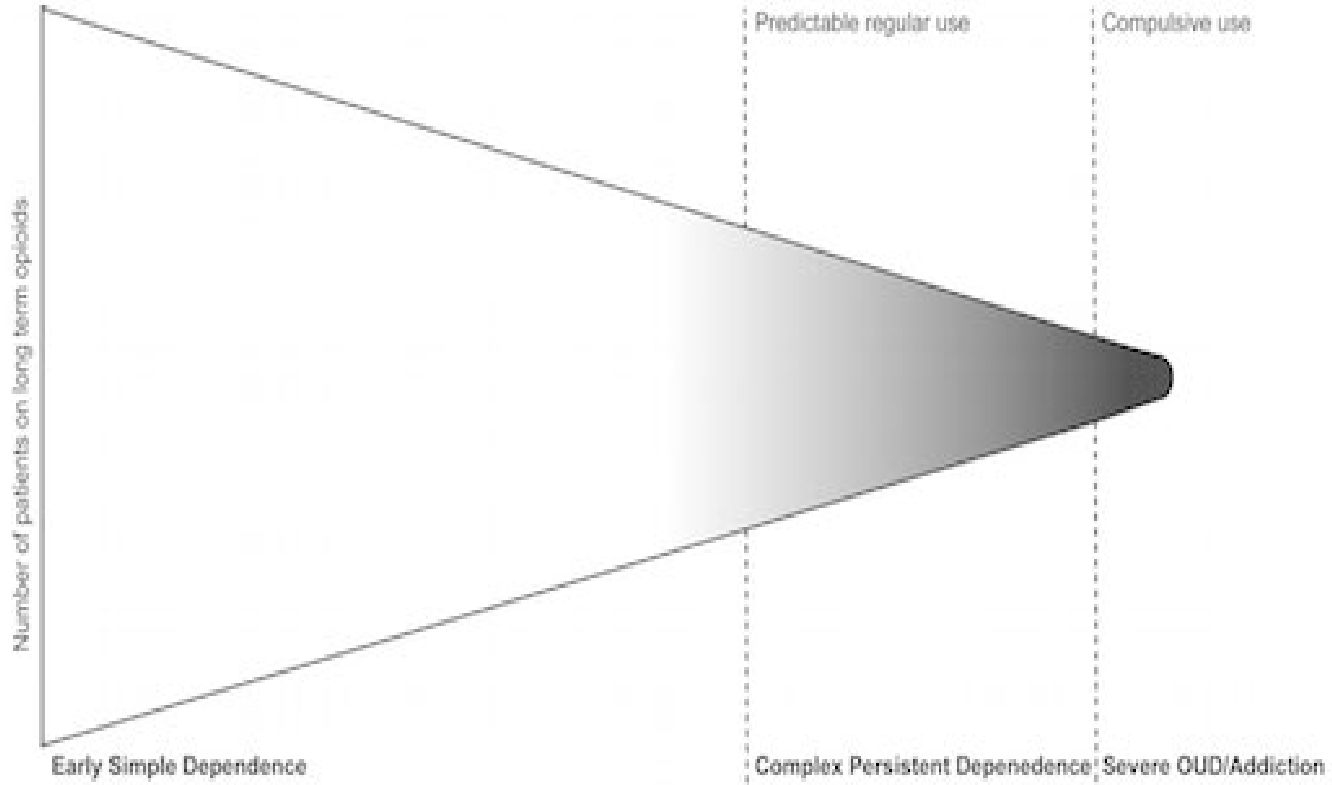

Fig. 2. A pictorial representation of the continuum of opioid dependence among LTOT patients.

Pain and Addiction, An Integrative Therapeutic Approach; Ajay Manhapra, William Becker, Med Clin N Am 102 (2018) 745-763

COMPLEX PERSISTENT DEPENDENCE

- More complex then simple dependence
- Patients unwilling to taper opioids despite medical or functional deterioration
- Classic OUD behaviors emerge as opioids are tapered
- Large percentage have ongoing mental health issues (anxiety, depression, personality disorder, PTSD)

How do You Diagnose Complex Pain Disorder

2 or more criteria

- Using larger amounts/longer than intended to control the pain
- Much time spent avoiding pain
- Activities given up in order due to pain
- Physical/psychological problems associated with pain
- Social/interpersonal problems related to pain
- Neglected major role due to pain
- Hazardous use to control pain
- Repeated attempts to quit/control use
- Withdrawal *
- Tolerance *
- Craving

Multidimensional Approach to Complex Dependent Patients

- Dependency treatment
- Comorbity treatment (psychiatric / medical)
- Polypharmacy Reduction
- Chronic pain treatment (nonpharmacological)

Legal requirements for prescribing buprenorphine

Senate Enrolled Act No. 141

Indiana Public Law 213

- Does not apply in
  - Correctional facility
  - Hospital
  - facility that is certified under IC 16-21-2
  - an opioid treatment program that has been certified or licensed by the division under IC-23-18
  - state institution
  - health facility licensed under IC 16-28
  - Indiana Veterans Home

Indiana Public Law 213

- Requirements for prescribing:
- Determine patients age
- Initial assessment and a physical exam as appropriate for the patients condition and the health care providers scope of practice and obtain a medical history of the patient before treatment begins
- Obtain substance use history and any substance use disorder diagnosis of the patient
- Perform a mental health assessment
- Obtain informed consent for treatment and establish the patient meets the requirements set forth in subsection d

Indiana Public Law 213

- Require office visits of the patient in person throughout treatment
- Evaluate the patient's progress and document the patients progress with the treatment plan
- Perform toxicology screening (stimulants, alcohol, opioids including oxycodone, methadone and buprenorphine, THC, BNZ, Cocaine)
- Review INSPECT before induction and at least 4 times per year
- If female and child bearing potential perform pregnancy test at onset of treatment , counsel patient about risks , provide or refer for prenatal care

Indiana Public Law 213

- Prescribe an overdose intervention drug and education
- Provide from an ongoing component of psychosocial supportive therapy with direction from the health care provider on the amount of therapy

Indiana Public Law 213

- During office visits
  - evaluate and document patients progress and compliance
  - whether patient is meeting treatment goals
  - discussion of risks and benefits of ongoing buprenorphine treatment
- If toxicology testing shows an absence of the prescribed drug the provider must discuss and implement a plan to optimize medication adherence and schedule an earlier follow up with the patient
- If toxicology screening shows a presence of an illegal or nonprescribed drug the provider shall assess the risk of the patient to be successfully treatment

Lethal doses comparison

EDUCATE CLIENTS ON OVERDOSE RISK

I'm on 205mg of methadone a day, and i've taken up to 700mg+ combined with clonazepam and clonidine and still whished I could have gotten higher. I'm tolerant to clonazepam also but not nearly as much so, 0.5mg a day will hold me in terms of physicall symptoms, but i'm prescribed 1.5mg a day. I can take 5mg with 400mg-600mg methadone with no problems at all, even topping it off with a small dose of clonidine (0.15mgs or under that) if I can't nodd as much as I'd like to. Honestly when I started MMT I could have died several times over from a single 200mg dose."

Predictors of overdose

- **Concurrent use of benzo (1.6)**
- **Concurrent use of antipsychotics (2.3)**
- **Chronic lung disease (1.7)**
- **Dose of opioids taken (4.0)**
- **Alcohol use (1.9)**
- **Mood disorders (1.8)**
- **History of heart disease (5.3)**
- **Prior overdose history (28.5)**

BOTTOM LINE

OPIOD USE DISORDER IS A FATAL DISEASE

EDUCATE CLIENTS ON OVERDOSE RISK

- **Ask them if they have or know someone who has overdosed, stories are more powerful then statistics**
- **Empathy, don't judge, build the relationship and trust**
- **Discuss the risks**
- **Offer Naloxone at the first visit (it may be your only chance)**

Reducing Stigma

- Individuals with substance use disorders (SUDs) are highly stigmatized
- Although addiction is a brain disease, people with SUDs are often regarded as simply needing more willpower, rather than treatment
- Language use perpetuates stigma in healthcare and in society at large
- Stigma prevents people from seeking care
- What are some situations in which you see stigmatizing behavior or language related to SUDs?
- Health care teams can send a powerful message by avoiding stigmatizing language and behavior

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