

Assessment for Entry into the Opioid Pharmacotherapy Program

In this section you will...

- *Develop a comprehensive understanding of the assessment requirements for entry into the Opioid Pharmacotherapy Program.*

Section Contents

5	Assessment for Entry into the Opioid Pharmacotherapy Program	67
5.1	Assessment.....	67
5.2	Initial Assessment	67
5.2.1	Risk and Protective Factors	68
5.2.2	Contraindications	69
5.3	Substance Use History	69
5.3.1	Opioid Use History.....	69
5.3.2	Other Drug Use History	70
5.3.3	Risk Factors	70
5.3.4	Protective Factors	71
5.3.5	Prescribed Medication History	71
5.4	Past Medical History	71
5.4.1	Risk Factors	72
5.4.2	Protective Factors	72
5.5	Psychological and Psychiatric History	72
5.5.1	Risk Factors	72
5.5.2	Protective Factors	73
5.6	Social History.....	73
5.6.1	Risk Factors	74
5.7	Family History.....	74
5.7.1	Risk Factors	75
5.7.2	Protective Factors	75
5.8	Pregnancy and Breastfeeding.....	75
5.8.1	Risk Factors	75
5.8.2	Protective Factors	76
5.9	Allergies.....	76
5.10	Clinical Examination.....	76
5.10.1	Additional Consideration	77
5.11	Investigations.....	77
5.12	Urine drug screening (UDS) during assessment.....	77
5.13	Collateral Information.....	78
5.14	Summary and Formulation	79
5.15	Additional Consideration - Harm Reduction Advice	79

SECTION: 5

5 Assessment for Entry into the Opioid Pharmacotherapy Program

5.1 Assessment

The foundation of every treatment plan and intervention is a comprehensive assessment. It determines the clinical pathway for access to specialist programs and interventions, as well as informing the treatment plan.

Assessment of alcohol and other drug use is a complex and continuous process that occurs both at the commencement of, and throughout treatment (Sobell, 1988). Continuous assessment allows the clinician to identify changes that occur in the patient's life, and determine how these changes may impact on their risk status and treatment planning (Addy et al., 2000).

A carefully conducted alcohol and drug assessment should also be patient focussed and fulfil the following functions:

- to support the development of a therapeutic and trusting relationship;
- to assist patients to evaluate and consider their own drug use and motivation for change;
- to assist patients to make linkages between their drug use and current difficulties that they may be experiencing in their lives;
- to assist the patient to review their past and current circumstances and to make linkages between these and current drug use; and,
- to assist the patient to review the choices that they have made and the consequences of their drug use behaviour.

(Helfgott, 1997)

The Alcohol and Drug Service (Department of Health and Human Services, Tasmania) has developed a suite of standardised assessment tools and guidelines to inform service delivery. These include The Clinical Assessment Tool (CAT) and the Medical Examination. These tools are routinely used by ADS staff involved in the delivery of clinical services and can be accessed by contacting XXXXXX.

5.2 Initial Assessment

The aim of the initial assessment is to establish the patient's suitability for opioid pharmacotherapy with either methadone or buprenorphine. Suitability is established when there is clear evidence that the patient:

- is opioid dependent;
- meets the DSM-IV-TR criteria for opioid dependence; and,
- has been using opioids for an extended period of time.

SECTION: 5

Assessment for Entry into the Opioid Pharmacotherapy Program

If the patient has been using opioids for less than 6 months, treatment other than opioid pharmacotherapy should be considered. This can include inpatient detoxification followed by intensive psychosocial intervention or residential rehabilitation. Inpatient detoxification without follow-up is not recommended due to the risk of overdose or death if opioid use is recommenced after treatment.

Furthermore, the clinician must ensure that there is objective information to support the patient's opioid use, since commencing a non-opioid dependent patient on opioid pharmacotherapy can place the patient at risk of overdose or death.

The initial assessment should also provide opportunity for:

- establishing a therapeutic relationship with the patient;
- the patient to make an informed decision about treatment;
- documenting an initial treatment plan; and
- meeting legislative requirements (e.g. gaining authority to prescribe for the patient).

In some settings the initial assessment may be conducted by practitioners from different professional backgrounds. However, all initial assessments must include a medical examination conducted by the prescribing doctor.

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The process of the initial assessment includes history taking, examination and investigations. Specific content areas required for the initial assessment include:

- substance Use History;
- social History;
- family History;
- prescribed Medication History;
- past Medical History ;
- psychological and Psychiatric History;
- allergies; and
- clinical examination and investigations.

5.2.1 Risk and Protective Factors

Consideration of risk should be an integral component of every assessment and ongoing management of the patient (Reith, 1998). Patients accessing alcohol and other drug treatments often have comorbid mental health disorders, chaotic and unstable lives and are frequently at greater risk of suicide (Maloney et al 2007).

However, patients may also have protective factors that mitigate risks and facilitate or support treatment interventions (Reith, 1998). When reviewing each of the initial assessment content areas (listed above), clinicians should consider both risk and protective factors. The key risk and protective factors will be highlighted throughout this section.

It is important to note that risk factors do not necessarily preclude the patient from accessing opioid pharmacotherapy, but may indicate the need for closer monitoring, second opinions, risk management strategies or caution around dosing practices (e.g. precluding them from take-away doses). Risk factors may also have implications on longer-term treatment planning and referral, consultation or communication with other treatment services. Risk factors for specific issues, such as drug use, medical and psychiatric histories, are discussed in the following subsections.

Considering risk and protective factors when assessing patients and developing treatment plans is a strengths based approach. Such models are commonly used in other health areas, such as mental health. In adopting and applying this framework to Tasmanian ADS patients, it is expected that clinical safety will be enhanced. For further information about the model and its application in Tasmania, please contact XXXXX.

5.2.2 Contraindications

Clinicians are referred to Section 4 which contains a list of treatment contraindications and circumstances under which a second opinion is either recommended or required.

5.3 Substance Use History

It is essential that a comprehensive substance use history is carried out for new patients. This assessment should focus on all current and lifetime drug use - both prescribed and illicit.

5.3.1 Opioid Use History

Obtaining a thorough assessment of a patient's opioid use history is essential at the commencement of treatment. This includes assessing opioid dependence, withdrawal and neuroadaptation. Assessment for opioid dependence and withdrawal are discussed in Section 2. Critical information in establishing evidence of neuroadaptation includes:

- age when first used opioids and relevant circumstances;
- age when first dependent on opioids;
- duration, route, frequency and pattern of use;
- duration of current episode of dependence on opioids;
- cues for drug use;
- type of drug used (i.e. heroin; oxycodone);
- date and time of last use of opioids;
- needle sharing and equipment cleaning practices;

SECTION: 5

Assessment for Entry into the Opioid Pharmacotherapy Program

- previous treatment history, particularly opioid pharmacotherapy or opioid withdrawal;
- history of overdose and severity;
- any other previous complications of injecting drug use; and
- longest opioid free period and how this was achieved.

5.3.2 Other Drug Use History

Critical in establishing the patient's safety on the program will be accurate knowledge about the patient's non-opioid drug use history. Key information includes:

- age when first used drugs and relevant circumstances;
- all current drug use, including alcohol, tobacco and cannabis;
- duration, route, frequency and pattern of use;
- duration of current episode of dependence on other drug/s;
- type of drug used;
- date and time of last use of other drugs;
- number of drug free periods and how these were achieved;
- cues for drug use;
- previous treatment history, particularly detoxification or rehabilitation;
- history of overdose and severity; and
- any other previous/current complications of substance use.

5.3.3 Risk Factors

When assessing for the above factors, it is important to consider the behaviours associated with the opioid and other substance use. Some behaviours that might indicate increased risk on the program include:

- doctor shopping';
- accessing substances from multiple sources;
- over-the-counter drug seeking from pharmacies;
- concurrent use of multiple opioids;
- reporting of lost, stolen, or misplaced medications and/or prescriptions within the last 12 months;
- history of drug overdose;
- unsafe injecting practices;
- history of diversion;
- polysubstance use that increases the risk of multiple drug toxicity;
- using up prescription medication ahead of time;

- poor compliance or removal from previous treatment programs;
- benzodiazepine dependence and concurrent use with opioids;
- frequent alcohol use or binge drinking; and
- complications associated with withdrawal.

5.3.4 Protective Factors

Protective factors in this category are those behaviours that mitigate the risks involved with unsanctioned opioid and/or other drug use, for example:

- use of harm reduction strategies around drug use;
- previous attempts to cease substance use;
- positive engagement with previous treatment services;
- compliance with previous treatment programs;
- adherence with recommendations regarding prescription medications;
- absence of risky polysubstance use;
- successful periods of abstinence; and
- a pattern of regular and stable opioid or other drug use as opposed to chaotic and binging behaviours.

5.3.5 Prescribed Medication History

The patient's current and past medication history is required. Some medications used to treat infectious or other diseases are contraindicated, or may affect the choice of pharmacotherapy agent. The reader is referred to Section 4 on clinical pharmacology.

5.4 Past Medical History

A medical history should gather information on:

- physical symptoms;
- history of withdrawal-related problems;
- childhood illnesses;
- surgery and hospital admissions;
- accidents, including head trauma;
- infectious diseases including viral Hepatitis, HIV and tuberculosis;
- current medications;
- history/experience of pain related conditions; and
- chronic diseases.

SECTION: 5

Assessment for Entry into the Opioid Pharmacotherapy Program

5.4.1 Risk Factors

A good medical history assists in identifying contraindications (refer to Section 4) for opioid pharmacotherapy treatment as well as informing the selection of an appropriate treatment agent. Inaccurate reporting of medical history by the patient, or restrictions on sharing of information by key health professionals is a significant risk when assessing the patient's suitability for pharmacotherapy.

Diagnosis of HIV and HBV also gives patients priority access to the program (see Section 3).

Finally, persistent pain presentations or reluctance to follow through on referrals to specialist pain treatment services can be an indicator that the patient is drug seeking and not using prescription pain medications as prescribed.

5.4.2 Protective Factors

Overall good health and the absence of other medical conditions provide a good foundation for entry into opioid pharmacotherapy maintenance treatment. Active engagement and appropriate management of ongoing physical conditions by other relevant providers can also be a protective factor. Transparency, accurate reporting and information sharing about ongoing medical conditions are also likely to reduce risks associated with these conditions.

5.5 Psychological and Psychiatric History

The patient's psychological wellbeing, attitude towards pharmacotherapy and stage of change are important to assess. Further areas for assessment include:

- mental state, including self-harm, suicidal or homicidal ideation;
- past and present mental health diagnoses and interventions;
- mental health related hospital admissions;
- involvement of mental health support agencies or clinicians;
- cognitive functioning; and
- motivation for change and goals of treatment.

5.5.1 Risk Factors

Psychological and psychiatric risk factors include:

- a recent deterioration in mental state or psychiatric admission;
- untreated serious mental illness;
- poor compliance with medication for mental illness;
- poor insight into mental health problems;
- loss of volition;
- inability to understand and consent to pharmacotherapy treatment due to mental state or cognitive impairment;

- history of risk taking or impulsive behaviour;
- current self-harm, suicidal or homicidal ideation;
- history of self-harm, suicide attempts, or violence towards others, particularly in the past year; and
- high vulnerability to stressors.

Prescribed treatment with multiple psychoactive drugs such as antipsychotics, antidepressants, benzodiazepines, and mood stabilisers may increase the patient's risk on the pharmacotherapy program. Regardless of whether medications are prescribed or obtained illicitly, the risk of combining drugs with respiratory depressant activity with opioid pharmacotherapy is the same.

5.5.2 Protective Factors

Psychological and psychiatric protective factors include:

- stable mental state;
- active engagement in treatment for serious mental illness;
- high motivation for change;
- self awareness of strengths and weaknesses;
- stable affect and emotional regulation skills;
- past success in making cognitive and behavioural changes;
- ability to learn from and to make linkages to past experiences;
- realistic goals for treatment outcomes;
- positive thinking style;
- insight and awareness into problems; and
- well developed problem solving and coping skills.

5.6 Social History

This includes information about the patient's:

- employment history (including home duties);
- education history and qualifications;
- forensic history;
- personal interests and hobbies;
- peer groups and social networks;
- accommodation arrangements - location and co-habitants;
- intimate relationships;
- major life events including trauma, grief, loss, and history of abuse; and
- barriers to change.

SECTION: 5

Assessment for Entry into the Opioid Pharmacotherapy Program

5.6.1 Risk Factors

Within this category, factors that may increase risk include:

- insecure or unstable housing – which may exclude the patient from receiving take-away doses;
- engagement in criminal activities;
- forensic history involving violent or abusive behaviour, prescription pad theft or forgery;
- drug seeking partner and peers;
- relationship breakdown;
- unsafe sexual practices (increasing risk of exposure to blood borne viruses);
- ongoing exposure to threatening, aggressive and violent behaviour;
- peer pressure to use or supply drugs;
- social isolation; and
- recent release from prison.

Protective Factors

The following factors are likely to positively influence the patient's success on the program:

- stable employment;
- stable relationships;
- reliable transport and access to services;
- community ties;
- hobbies and interests;
- supportive social networks and partner;
- non drug seeking social network and partner;
- stable housing ; and
- absence of legal issues.

5.7 Family History

Important information in this section includes:

- a genogram;
- family of origin;
- current marital status;
- quality of family relationships, family supports, and current custody and care arrangements of children; and
- substance use, medical and mental health history of the family.

5.7.1 Risk Factors

Risk factors in this section include:

- poor health and wellbeing (including special needs) of children in the patient's care, which may involve mandatory reporting or liaison with family services;
- family history of substance use and abuse;
- family history of significant mental health issues;
- family history of poor coping skills, vulnerability, and crises;
- dysfunctional or disrupted family relationships, including abuse, neglect and involvement with the child protection system; and
- family relocation.

5.7.2 Protective Factors

Protective factors in this category include:

- stable family relationships;
- secure, nurturing, and appropriate attachments;
- positive family role models;
- well developed and functional coping skills of family;
- appropriate family engagement in the patient's treatment; and
- appropriate interpersonal boundaries within the family unit.

5.8 Pregnancy and Breastfeeding

As stated in Section 3, pregnant women are a priority group for entry into opioid pharmacotherapy. Chaotic drug use and withdrawal states can place the mother and foetus at risk and may result in miscarriage.

For female patients, it is important to establish their pregnancy and breastfeeding status, as well as their plans or intention to get pregnant, as this will influence the choice of opioid pharmacotherapy treatment agent. Reported pregnancy should be confirmed with a blood test. Section 11.5 outlines the management of the pregnant patient in opioid pharmacotherapy.

Female patients often cease ovulation during periods of unsanctioned and chaotic opioid use. Commencing patients on opioid pharmacotherapy may stabilise their ovulation, hence increasing the risk of unplanned pregnancy if contraception is not used. For this reason it is important to assess and discuss with patients their current use of contraception.

5.8.1 Risk Factors

Pregnancy itself is not a risk factor that should preclude female patients from accessing opioid pharmacotherapy. However, there is a high risk of miscarriage if a pregnant patient abruptly ceases opioid maintenance treatment. Therefore, it is essential that this is clearly explained to the patient upon assessment.

SECTION: 5

Assessment for Entry into the Opioid Pharmacotherapy Program

Another risk factor to consider is reluctance to engage with antenatal services and a general practitioner or obstetrician. This may compromise the health and well being of the baby and mother, and also affect the ability to develop an integrated antenatal and postnatal care plan for the mother and baby.

5.8.2 Protective Factors

If the mother is focused on the health and wellbeing of her baby, this can be a motivating factor for positive engagement and compliance with opioid pharmacotherapy treatment. Regular and transparent communication between the treating team and antenatal services is likely to result in more positive outcomes for mother and baby.

5.9 Allergies

It is important to establish and clarify if the patient has any allergies or has had previous adverse affects associated with prescribed or non-prescribed medications. This includes clarifying allergies from drug interaction effects.

Patients may sometimes report an allergy to one of the treatment agents in order to access the alternative or their preferred treatment agent. In this instance, it is important to confirm this information through the use of, for example, discharge summaries and medical notes.

5.10 Clinical Examination

This section of the initial assessment identifies clinical signs related to drug use, including intoxication and withdrawal, injection sites, and symptoms related to any other significant medical condition.

The signs and symptoms of opioid withdrawal, intoxication and overdose (see Section 2) should form the basis of the physical examination.

The examination should also thoroughly assess for:

- injecting sites, with a particular emphasis on arms, legs, feet and the groin area;
- bruising, phlebitis and puncture marks; and
- skin disorders and cellulitis.

A general physical examination should also include a systems review, with a focus on organs that may have been damaged as a result of substance use. This should include checking for:

- heart murmurs;
- signs of liver damage or disease;
- signs of haematological disorder;
- neurological impairment; and
- skin disorders and cellulitis.

5.10.1 Additional Consideration

When conducting a physical examination of a patient who may have a history of physical or sexual abuse or trauma, or if you observe increased anxiety or agitation, it may be helpful to enquire with the patient if they would like a chaperone to be present. This would usually be another staff member of the same sex as the patient.

5.11 Investigations

A series of routine investigations should be performed to determine the general health status of the patient. Mandatory investigations include:

- full blood count and ESR;
- biochemical screen (electrolytes, hepatic and renal function);
- BBV screen;
- urine toxicology;
- breath alcohol test; and
- thyroid function.

Secondary investigations (not mandatory) include:

- chest x-ray;
- sexual health screen
- mantoux test; and
- others as indicated by the history and examination.

If a patient presents with signs of alcohol intoxication or has a history of alcohol abuse, they should be breathalysed as part of a routine and thorough clinical assessment.

5.12 Urine drug screening (UDS) during assessment

Commencing a patient on opioid pharmacotherapy who is not opioid dependent presents a significant risk of overdose or death. Consequently, a supervised UDS that confirms the presence of opioid metabolites is required prior to commencing treatment. A supervised urine drug screen is compulsory for assessing suitability for treatment.

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While there are limitations in the sensitivity and specificity of each method of analysis, urine drug testing provides important objective evidence of drug use. This not only corroborates evidence of opioid use, it also establishes the test as a legitimate and integral element of opioid pharmacotherapy.

Supervised UDS

SECTION: 5

Assessment for Entry into the Opioid Pharmacotherapy Program

A supervised UDS involves monitoring and co-ordinating the process for obtaining a urine specimen, thus maximising the likelihood that the sample provided is that of the patient's. The specimen should also be warm and of normal depth and colour (not diluted).

Specifically, it involves:

- confirming the identity of the patient;
- escorting the patient to the designated area;
- providing the patient with the necessary equipment for obtaining the sample;
- receiving the specimen directly from the patient; and
- limiting or removing other items that they are allowed to take into the room (e.g. bags and coats).

In the general practice setting, the practice nurse may assist in obtaining a supervised UDS. Alternatively, a supervised UDS can be requested from the local laboratory service.

Observed UDS

An observed UDS requires the clinician to directly observe the urine leave the body into the container. This process is intrusive and, hence, should only be used where there are significant clinical risks or clear evidence that previously supplied urine samples were tampered with or not that of the patient's.

If the patient is unable to immediately provide a urine sample, provide the patient with 500ml of water to consume and repeat the UDS process again in 20-30 minutes time. If the patient is still unsuccessful in providing a specimen, they should be asked to re-present later in the day or early the next morning to repeat the procedure.

It is important to note that the UDS procedures detailed above are based on the Australian/New Zealand Standard Procedures for the Collection, Detection and Quantification of Drugs of Abuse in Urine. However, they do not meet the standards required for the provision of samples as evidence for legal proceedings.

Obtaining a specimen for a UDS is by nature an intrusive process that can be intimidating, embarrassing and distressing for patients. Ensuring that you are pleasant and professional will assist in minimising the patient's discomfort. If you are aware that a patient may have a history of abuse or trauma (or where you observe increased anxiety or agitation), it may be helpful to enquire if the patient would like a chaperone to be present. This would usually be another staff member of the same sex as the patient.

5.13 Collateral Information

Collateral information can inform a thorough assessment and aid in developing a formulation. If possible, collateral information should be collected from the following sources with the patient's consent:

- previous and current medical practitioners;
- dispensing pharmacists;
- family (with patient's consent); and

- Medicare Australia.

5.14 Summary and Formulation

A summary or formulation outlines the patient's key issues and factors that may influence treatment outcomes. In determining a patient's suitability for pharmacotherapy, the clinician should consider the identified risk and protective factors, and determine whether risk factors are manageable within the treatment program. If there are multiple or significant clinical risks that cannot be managed in the practice setting, a second opinion and clinical review should be requested from the Alcohol and Drug Service.

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5.15 Additional Consideration - Harm Reduction Advice

The initial assessment can also be an opportunity to provide harm reduction advice and information. Such information may reduce the risks associated with drug use. This advice may include:

- use of sterile injecting equipment (e.g. needles and syringes, water for injection);
- using safe injecting practices;
- not sharing injecting paraphernalia, including needles and syringes, winged-infusion sets ('butterflies'), spoons, filters, water and tourniquets;
- referring the patient to the local needle and syringe program.
- advice about mode of administration, for example, that oral administration is safer than intravenous use;
- always using in the company of others in case of overdose;
- the risk of rapidly diminishing tolerance to opioids following cessation of use and the risks of overdose on resumption of use if at levels close to those previously used;
- the heightened risks of overdose associated with use of respiratory depressant drugs, such as benzodiazepines and alcohol, in combination with methadone or buprenorphine;
- using a 'taste test', i.e. use of a small amount of a drug before using the intended amount;
- how to respond to overdose; and
- calling an ambulance in case of overdose and reassuring the patient that calling an ambulance does not involve police.

SECTION: 5

Assessment for Entry into the Opioid Pharmacotherapy Program