Assessment, Diagnosis, and Treatment Planning

in Patients with OUD

BY:

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Aims:

Increasing knowledge and clinical skills development in

- **Assessment of patients with opioids use disorder**
- **Diagnostic criteria for opioids use disorder**
- **Treatment planning**

Assessment is the process of obtaining information about the patient's drug use and how it is affecting his or her life. It is an essential part of treatment and care for people who use drugs.

before commencing the assessment, it is important to do three things :

Is the patient able to complete the assessment?

Acute conditions

- **Some patients might present in acute distress in the emergency room**

- **Usually difficult to take a good medical history, so get a prompt physical and psychiatric assessment and diagnosis.**

- **Symptom oriented treatment with continuing monitoring until Symptoms resolve. Usually, most symptoms will resolve within few hours in the emergency room setting.**

Establish rapport with the patient

- **spend a few minutes on ‘small talk’.**

(Introduce yourself, and ask the patient for his or her name.)

- **open-ended question**
- **show the patient empathy**

Explain the assessment process to the patient.

Assurance the patient that the assessment is confidential.

Before you begin the assessment, ask the patient if he or she has any questions for you.

Principles of Patient’ s Assessment

- Privacy
- Confidentiality
- Empathy
- Multidimensionality And comprehensiveness

AREAS OF ASSESSMENT

- Demographic characteristics
- Drug use history
- History of drug treatments
- High risk behaviors
- Physical health status
- Psychiatric health status
- Legal problems
- Employment
- Family problems

Demographic characteristics

- Age
- Gender
- Education level
- Marital status

- **Female patients** should be asked if they are pregnant and offered the opportunity to take a pregnancy test.

Substance Use History

General instructions

- To list common substances of use
- Age of initiation
- Years of regular substance use
- Days of use during last month
- Route of administration
- Amount of use in a typical day of use

- Last episode of drug use
- Have you ever overdosed?
- Have you ever experienced withdrawal symptoms in the past?

Route of administration

1.oral ingestion

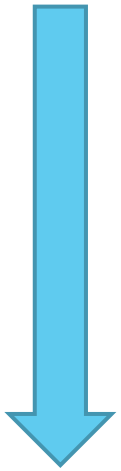
2.Sniffing/snorting

3.Smoking/inhalation

4.Non IV injection

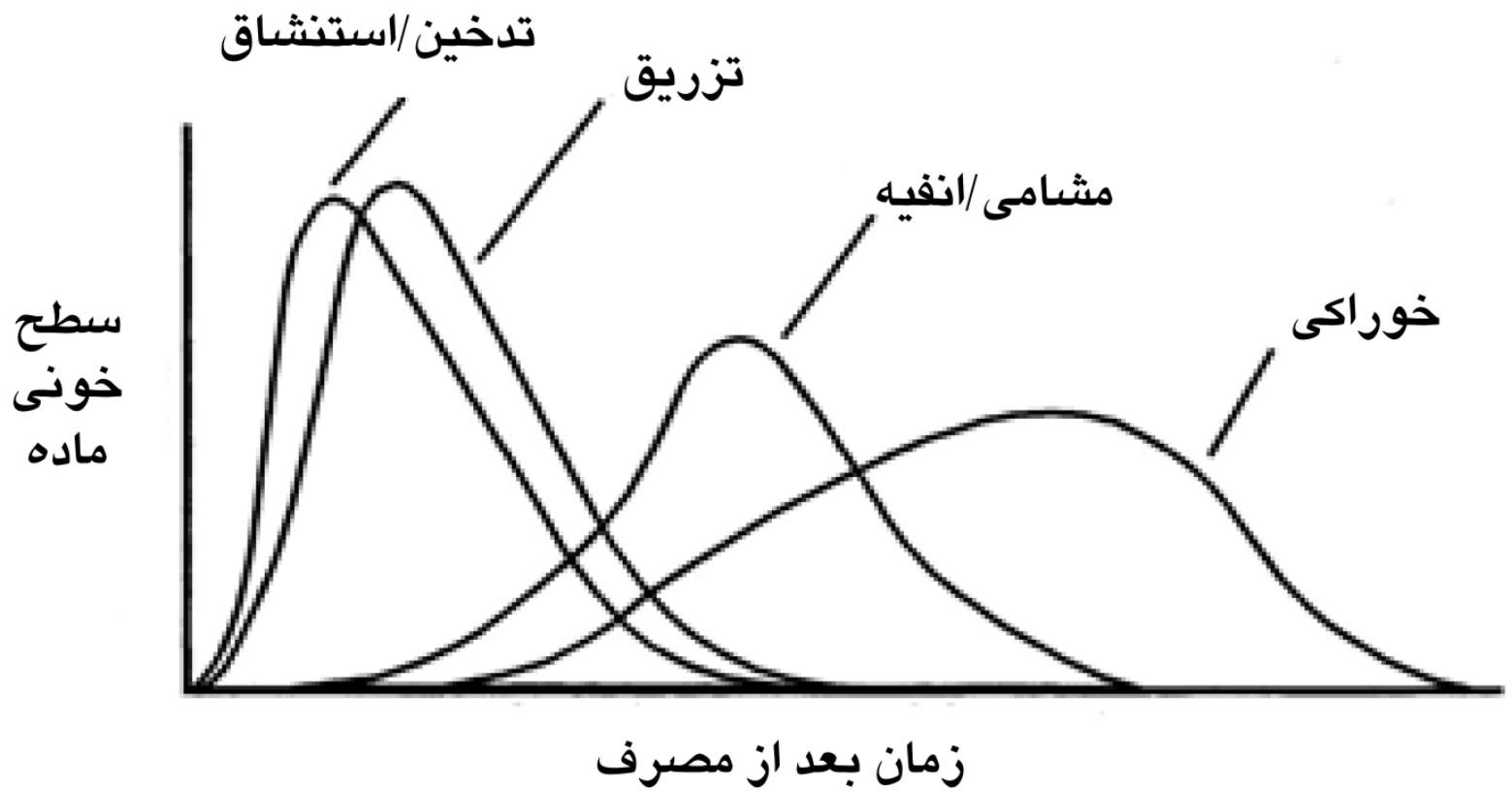
5.IV injection

Lower risk



Higher risk

Time to peak serum levels by route of administration



If patient reports using a drug via ***more than one route***

write ***the route with highest risk*** and bring other routes in the

comment column.

- **Amount of use in a typical day of use**
  - **Main problematic drug of use**
  - **Could be more than one drug**

Risk Behaviors :

- High risk drug use
- High risk sexual behavior

➢ High risk drug use

- **Injecting drug use**
- **Reuse of own syringe**
- **Sharing syringes:**
  - **Borrowing a syringe used by other people**
  - **Lending your own syringe to others**

if the patient inject a drug, ask about injecting behaviours:

- **Have you ever used a needle or syringe after some one else has used it?**
- **Do you have any infections or sores around where you inject?**
- **Have you been tested for HIV, hepatitis C or hepatitis B?**

High risk sexual behavior

- Unprotected sexual behavior
- Having multiple partners
- Sex after using methamphetamine or other drugs

  (Sex drug link)
- Sex exchange drug or money

Treatment History

If the patient indicates they have previously *experienced withdrawal symptoms*,

ask:

- ***What symptoms*** **did you experience?**
- **What did you do or *what medications* did you take to relieve these symptoms?**
- **Did you experience any *serious complications* such as seizures or hallucinations?**
- **Do you have *any concerns* about your withdrawal?**

Physical Health

History of medical diseases

- **Attend to *any physical complaint***
- **Check history of *medical disease***
- **Common medical disease according to demographic characteristics**
- **Common *medical disease among people who use/inject* drugs**

HIV/HCV/HBS testing/TSI

Ask the patient if they have any history of, or currently have:

- ***Seizures*** **or epilepsy**
- **Diabetes**
- **Heart disease**
- **Liver disease**
- **Viral hepatitis**
- **Tuberculosis**
- **Head injury**
- **Physical or intellectual disability (note type of disability)**
- ***Allergies to any medications***
- **Any prescribed or over-the-counter *medications they are currently taking***

Psychiatric Health

Many people who use drugs have poor mental health. Ask the patient:

- **Have you ever been diagnosed with schizophrenia?**
- **Have you ever been diagnosed with depression or bipolar disorder?**
- **Have you ever been diagnosed with post-traumatic stress disorder?**
- **Have you ever been diagnosed with any other mental health problem?**
- **Have you ever been given medication for a mental illness?**
- **Have you ever deliberately hurt yourself or tried to kill yourself? Do you feel like you may try to hurt or kill yourself?**

Schizophernia	Drug Induced psychosis
Symptoms appear before heavy substance use.	Symptoms appear only during periods of heavy substance use/sudden increase in potency.
Symptoms persist despite drug abstinence.	Symptoms abate or are reduced with drug abstinence.
More likely to have a family history of psychotic disorders.	Less likely to have a family history of psychotic disorders.
Antipsychotics markedly improve symptoms.	Antipsychotics typically do not improve symptoms.
Often present with bizarre delusions, auditory hallucinations and/or thought disorder.	Often present with non-bizarre delusions and/or visual hallucinations.
Poorer insight into their psychosis.	Better insight into their psychosis.

- **If there are only some symptoms rather than the full criteria, then a substance-induced etiology may be more likely.**

- **in 35 to 40 per cent of cases, it may be impossible to determine if a mood disorder is primary or substance-induced.**

- Co-morbid psychiatric disorders generally have greater severity of symptoms, are more resistant to treatment and have an increased relapse rate.

Men use substances more often than women, making them more likely to have substance-induced psychiatric symptoms. Women using substances are more prone to an accelerated progression, or telescoping, to the development of SUD and admission to treatment with higher rates of comorbid primary psychiatric disorders, especially mood, anxiety and eating disorders.

Psychologic and psychiatric treatments

- **History of receiving psychosocial treatments/counselling**
- **History of psychiatric visit**
- **History of admission in psychiatric ward**
- **Psychiatric medications**

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Lifetime

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Last month

The clinical assessment of persons with SUD also requires screening for non-suicidal self-injurious behavior, suicidal behavior and potential for violence/aggression.

Legal, Employment and Familial Functions

Diagnostic criteria for opioids use disorder

From Use to Use Disorder

- Opioids use is commonly initiates with opium or prescription opioids (e.g., tramadol) recreationally.
- Recreational use escalates over time, with more frequent episodes of use, increasing amounts per episode, and changes in the route of administration to deliver faster effects (iv)
- Inability to control use
- Impairment in many areas of functioning (relationships, social function, and may develop work, housing, and legal problems

DSM 5 opioids Related Disorders

- Opioids Use Disorder
- Opioids Intoxication
- Opioids Withdrawal
- Other Opioids Induced Disorders (included in the classification of that disorder class)
- Depressive
- Anxiety
- Sexual dysfunction

Delirium

Loss of Control

- taken in larger amounts or over longer period
- persistent desire or unsuccessful efforts to cut down or control use
- much time spend in activities to obtain, use, or recover from use
- craving, strong desire, or urge to use

Social Problems

- failure to fulfil major obligations at work, school, or home
- continuing use despite persistent/recurrent social or interpersonal problems
- Important social, occupational, or recreational activities are given up or reduced

Risky Use

- use in situations in which it is physically hazardous
- use continues despite persistent/recurrent physical or psychological problems

Physiological effects

tolerance

withdrawal

Criteria count as severity indicator

- Mild (2-3)
- Moderate (4-5)
- Severe (6-11)

Treatment Planning

- Patient’s motivation and readiness for treatment
- Patient's experience with different treatment methods
- Patient’s understanding and expectation from treatment

Developing a treatment plan ***involves reviewing the patient's assessment*** and ***consulting with the patient*** as necessary.

The patient has the right to be involved in making decisions about what treatment he or she receives, and involving the patient can help to improve patient cooperation with treatment.

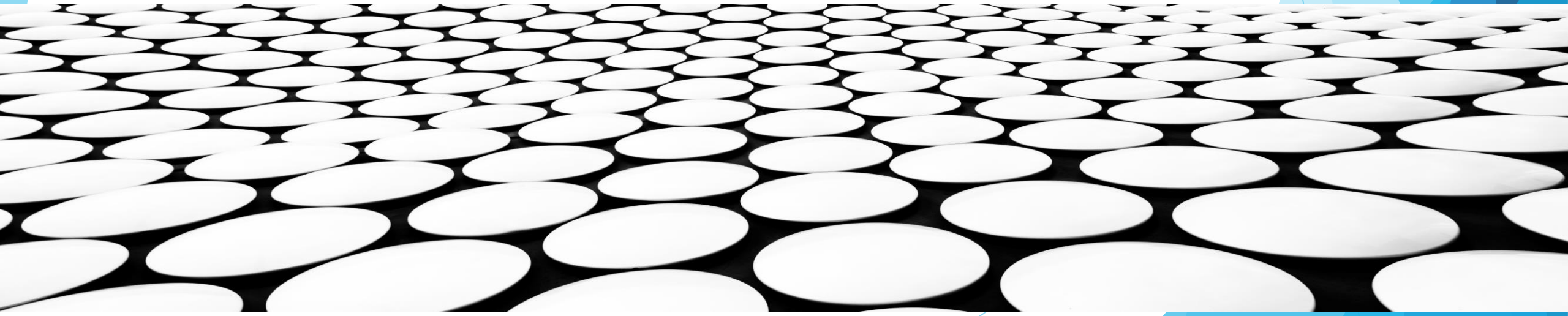
The treatment plan should be developed using the ***stepped care approach*.**

Stepped care involves matching treatment to patients based on the **least intensive intervention that is expected to be effective**. Based on how the patient responds to the chosen intervention, the healthcare worker *can increase (‘step up’)* or *reduce (‘step down’)* the intensity of treatment.

Once a treatment plan has been commenced, it is important to regularly evaluate the patient's progress and determine if the interventions that were used have been useful to the patient.

Stages of change

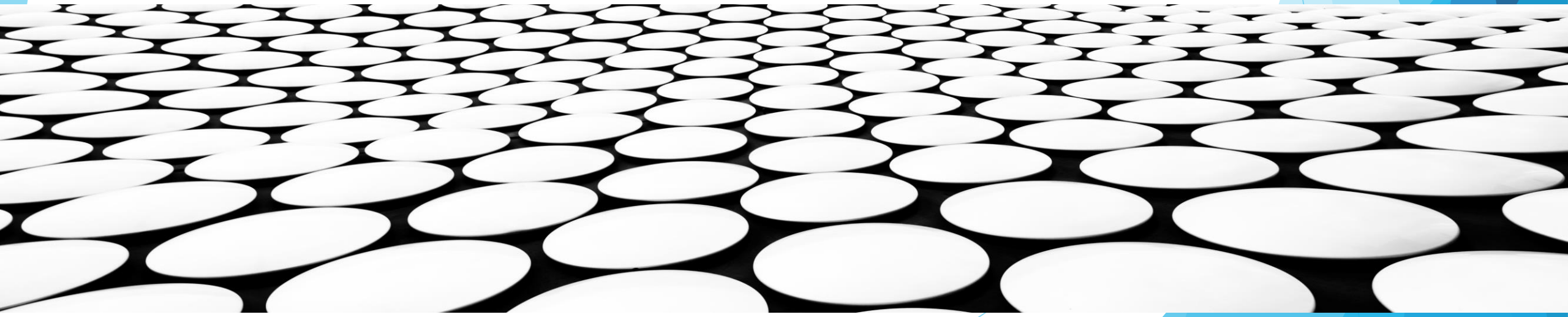
- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance
- Relapse



Precontemplation

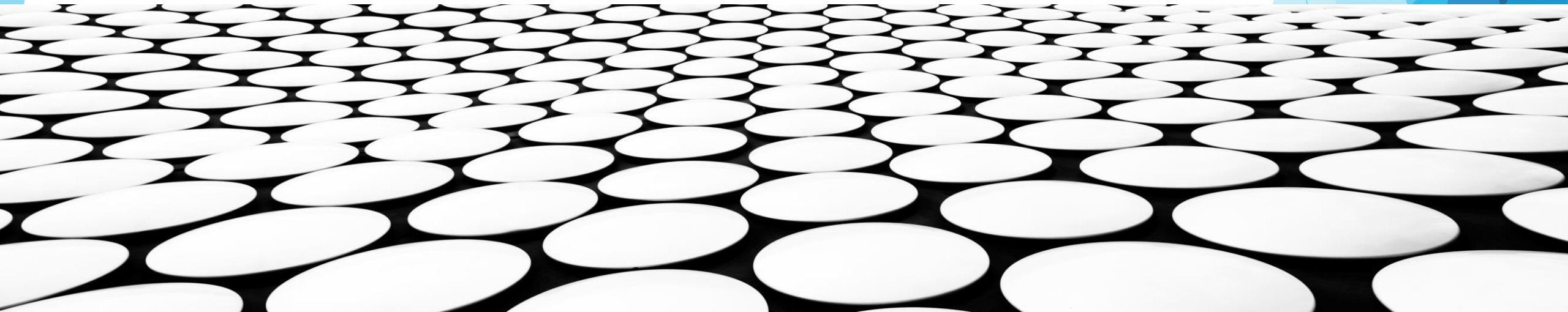
- Does not see themselves as having a problem although others might identify the problem.
- No intention of changing the problem and don't want to hear about it.
- Desire to change the people around them
- Often seen as resistant or "in denial"

I don't have a problem



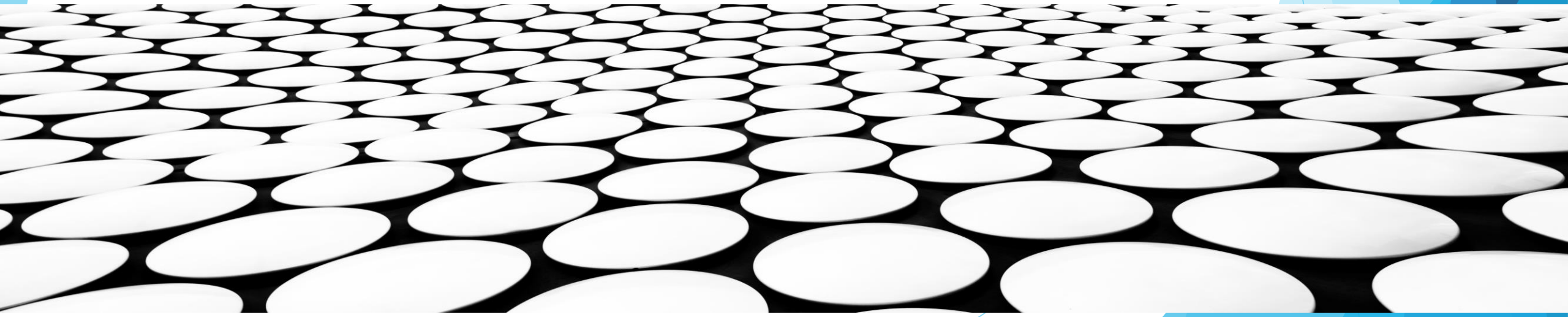
Contemplation

- Recognizes that there is ***some reason for concern***.
- Seesaws between ***reasons to change and reasons to stay the same***.
- Is best ***pictured by a scale***, you've the argument to change your position and the argument to stay at your position and they ***almost in equal balance***.

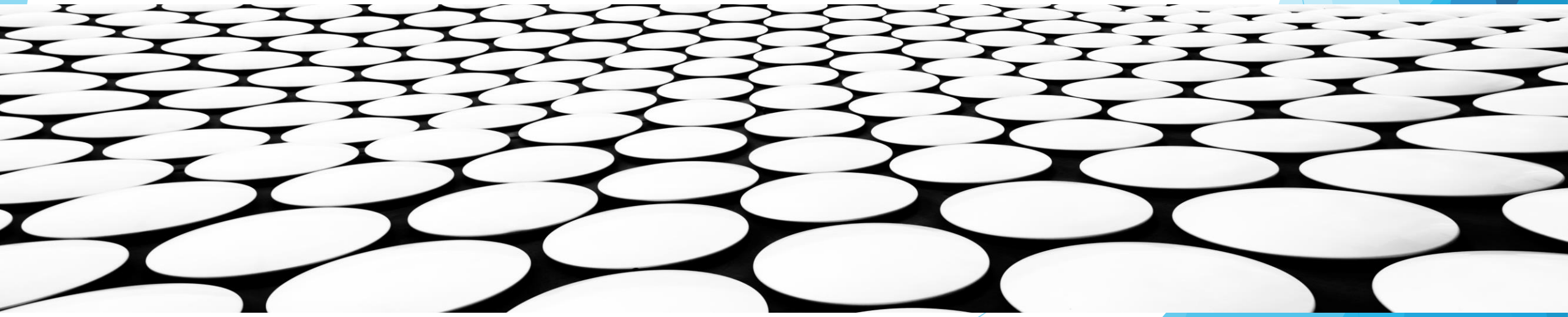


Continue…..

- Characterized ***by ambivalence*** – both considers and rejects change
- Stuck
- The **but stage**
- Indefinite plan to change in ***next 6 months***
- Can spends years here
- ***Fear*** of ***failure***



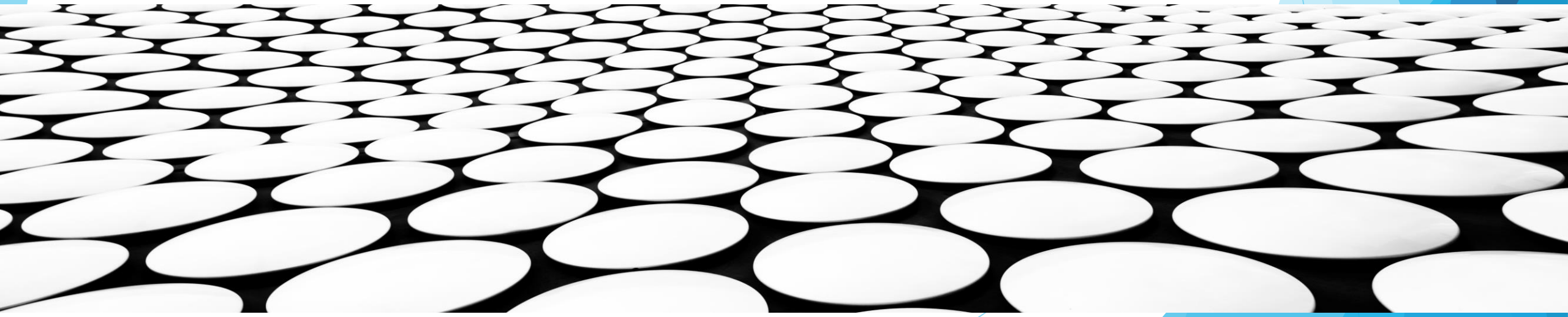
I have a problem, but ……..



Preparation

- Plan to change in the next month.
- Small changes may actually be happening here.

I’m making a plan to resolve my problem.

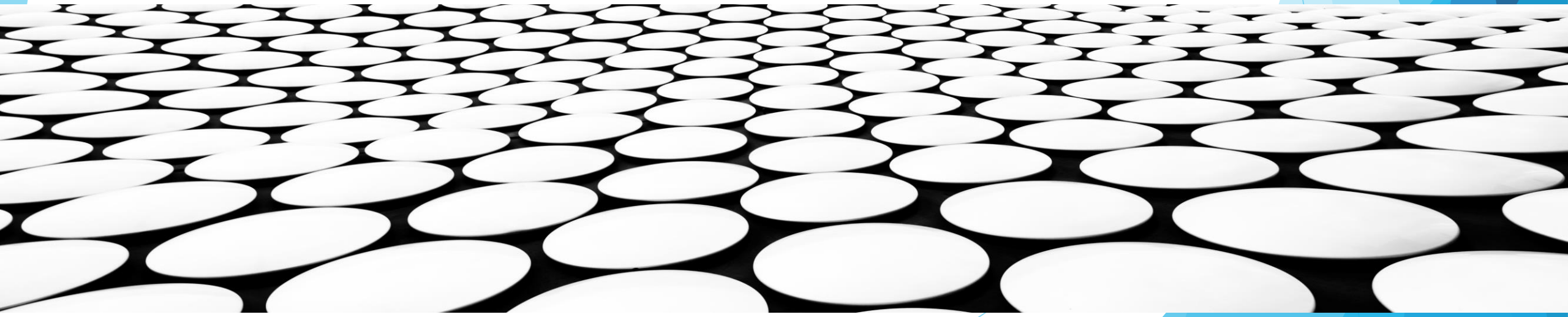


rather than diving in headfirst they usually just test the waters.

Action

- person is engaging in particular actions to bring about change.
- Visible change happens.
- It’s usually very difficult.

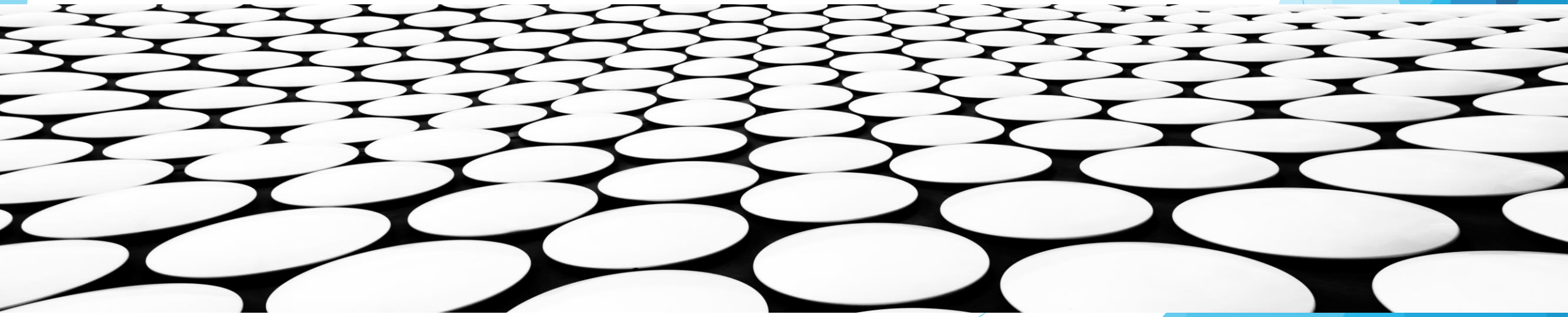
I’m working on it and it’s very difficult.



Relapse

- A reversion back to problem behavior.
- Any movement backwards through the cycle.
- Usually involves going back to contemplation.
- Not necessarily a bad thing.(reevaluate and make small changes in quit plan)
- Is to be expected(Behavior Changing take many ***tries*** to succeed)

I messed up and ……



Important points:

1. **Stage of change constantly is changing.**
2. **Pushing forward will result in resistance.**
3. **People are in different stages for different issues.**

- **Precontemplation about opium use**
- **Contemplation about Methamphetamine use**
- **Preparation about cigarette smoking**