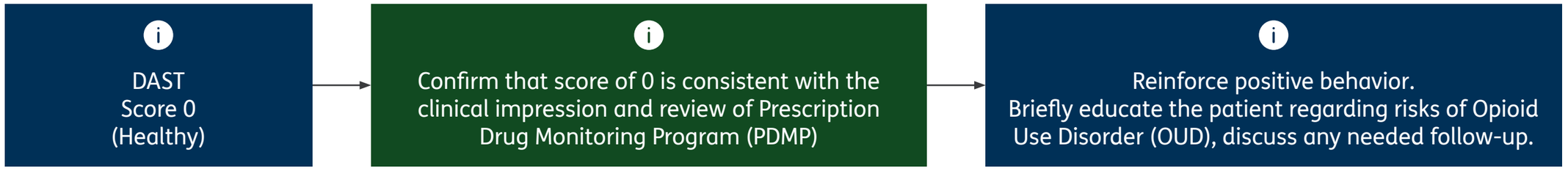
Clinical Practice Guidelines (CPG): Drug Abuse Screening Test (DAST)



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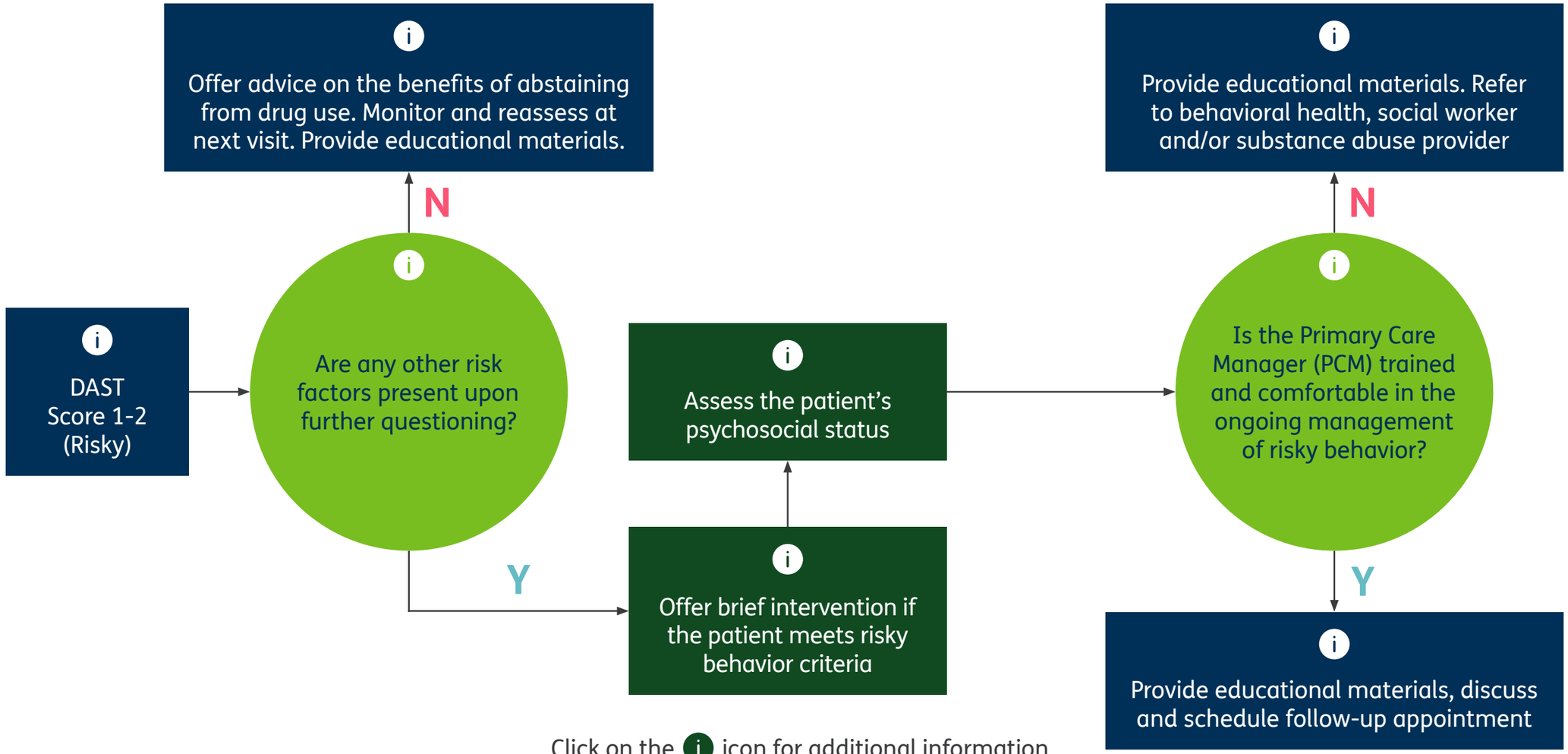

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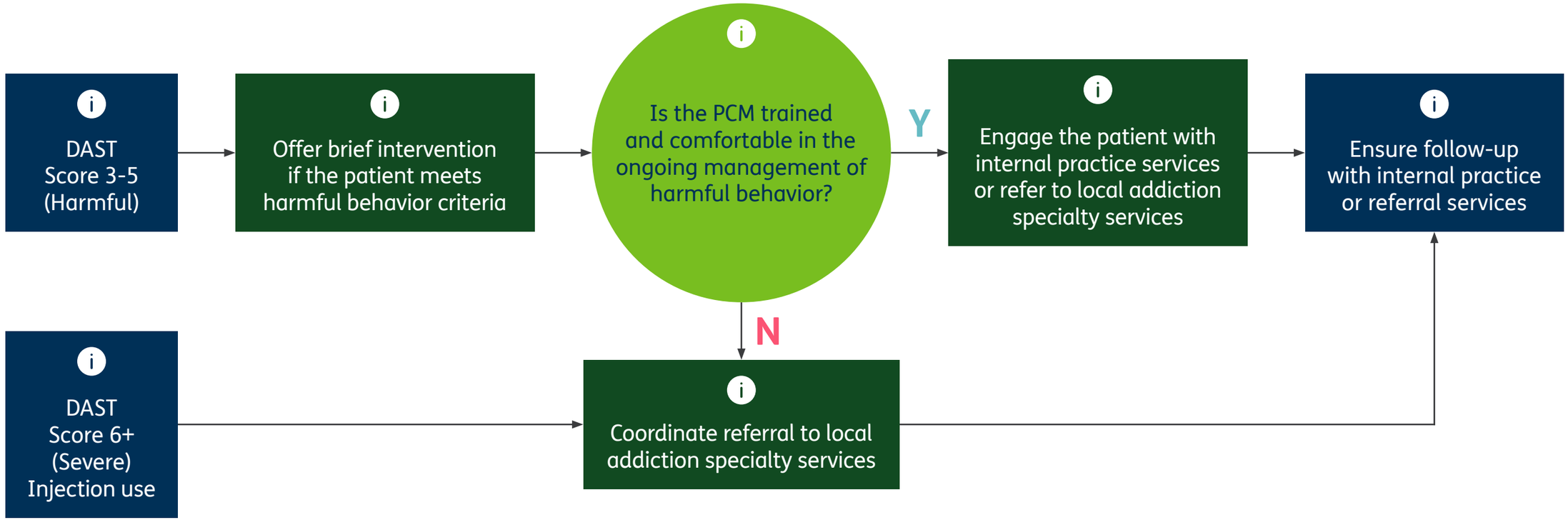

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DAST: Score 0 (Healthy)

A DAST-10 score of 0 means the individual is not at risk for opioid-related health problems.

This screening instrument has a sensitivity (true positive) of 80-85% and a specificity (true negative) of 78-88%. [6,10,13,18]

Refer to the following screening sections for **background information** and **secondary screening tools**.

Confirm that the score of 0 is consistent with the clinical impression and review of Prescription Drug Monitoring Program (PDMP).

The provider should confirm that his/her clinical impression is consistent with the patient's score of no risk.

If the score is inconsistent with the provider's clinical impression, it may be best to consider addressing this issue at a follow-up visit, as some patients may have a difficult time accepting that they may have a problem with opioids or other substances. Resistance to change is normal, and it is important to avoid arguing with a patient around these issues.

Reviewing state PDMP may further assist with confirming screening score results. State PDMPs allow practitioners to review information about patient-specific use of controlled substance prescriptions, such as opioid analgesics, benzodiazepines and stimulants. These electronic databases aid in reducing misuse, abuse, diversion and overdose by tracking prescription and dispensary behaviors. PDMPs can also be used to confirm the accuracy of screening results and to determine any inconsistencies between screening responses and PDMP data.

Each state has its own specific prescriber use mandates delineating database use frequency, prescribing restrictions, and which drugs prompt PDMP review. Since PDMP policies vary from state to state, it is recommended to review a specific state PDMP at **pdmpassist.org** or go directly to the specific state PDMP website. [22,23]

Reinforce positive behavior. Briefly educate the patient regarding risks of Opiod Use Disorder (OUD), discuss any needed follow-up.

Screening not only identifies those at risk for opioid misuse or OUD, but also identifies those engaging in healthy behaviors. Providers should reinforce healthy behaviors that are contributing to an individual's healthy status.

Providing low-risk individuals with verbal and/or written educational material may be beneficial as it may enhance general knowledge about the risks of opioid misuse and aid in identifying risky behavior in others. Additionally, such materials may act as a reminder of the dangers associated with OUD in individuals with a past medical history of OUD. [9,10]

The **National Institute on Drug Abuse** website can be accessed to obtain patient handout materials.

- **Effects of Drugs**
- **FAQs About Opioids**
- **Pain Medicine (Oxy, Vike) Facts**
- **Prescription Drug Abuse**

DAST: Score 1-2 (Risky)

A DAST-10 score of 1-2 means an individual is at risk for health problems related to drug use.

The individual's responses to the below criteria further bifurcates this risk category to determine subsequent actions.

- No daily use of any substance
- No weekly use of drugs other than cannabis
- No injection drug use in the past three months
- Not currently in treatment means the individual is not at risk for related health problems

This screening instrument has a sensitivity (true positive) of 80-85% and a specificity (true negative) of 78-88%. [6,10,13,18]

Refer to the following screening sections for **background information** and **secondary screening tools**.

Are any other risk factors present upon further questioning?

Research has identified individual risk factors associated with opioid misuse or Opioid Use Disorder (OUD).

- A personal history of Substance Use Disorder (SUD), behavioral illness and/or overdose
- Younger age, psychotropic medication use, long-term or high-dose opioid use and a family history of SUD
- Aberrant behaviors include calls after office hours, frequent early refill requests, doctor and/or pharmacy shopping, insistence that non-opioid medications are ineffective, and the need for opioid-only therapy [12]

The DAST-10 created by SBIRT Oregon (**sbirtoregon.org**) categorizes risky as:

- Daily use of any substance
- Weekly use of drug other than cannabis
- Injection drug use in the past three months
- Currently in treatment

Offer brief intervention if the patient meets risky behavior criteria.

Individuals responding “yes” to any of the below criteria places them in the risky category requiring brief intervention.

- Daily use of any substance
- Weekly use of drugs other than cannabis
- Injection drug use in the past three months
- Currently in treatment means the individual is not at risk for related health problems

If screening indicates the presence of injection drug use:

- Perform a brief intervention and provide the individual with educational materials on the risks of injecting drugs
- Inform the individual that injecting drugs is associated with an increased risk of blood borne illnesses (HIV/AIDS and hepatitis B and C) and recommend testing for these infections [6]
- Refer to specialty treatment and conduct further biopsychosocial assessment

During brief intervention sessions, the healthcare professional provides information to increase the individual’s awareness and understanding about his/her inappropriate opioid use. The healthcare professional also assesses the individual’s motivation toward behavioral change and provides advice on how to influence positive change. The healthcare professional and the individual engage in a collaborative effort to establish realistic goals and next steps. [9,10]

The clinician can initiate the conversation by asking:

“Are you interested in seeing how you scored on the questionnaire you just completed?” [9]

If the patient replies “yes,” proceed with:

“These are all the substances I asked you about and these are your scores for each of the substances (point to scores). As you can see your score for opioids was…” [9]

The number and duration of brief intervention sessions vary, typically involving one to five sessions lasting five minutes to an hour. The success of a brief intervention relies on a personalized and non-judgmental approach. [9,10]

The healthcare professional can choose from a variety of brief intervention approaches including motivational interviewing, FRAMES approach, OARS model and model of behavior change. [9,16,20]

Refer to **brief intervention** section and **Appendix D** for further details.

Assess the patient's psychosocial status.

Opioid Use Disorder (OUD) is a biopsychosocial condition and warrants obtaining a psychosocial history for all individuals.

The Primary Care Manager (PCM) should interview the patient about current alcohol, drug and tobacco use, as well as the presence or history of behavioral health and psychiatric disorders.

Relevant social and environmental factors should also be queried as well as screening for general well-being and life events. [2]

A few pertinent screening tools are listed below:

- **Healthy Living Questionnaire**
- **Life Events Checklist**
- **Patient Health Questionnaire 2 (PHQ-2)**
- **My Mood Monitor (M-3)**

This assessment may occur over numerous visits. Refer to **psychosocial history** section for further details.

Screening not only identifies those at risk for opioid misuse or Opioid Use Disorder (OUD), but also identifies those engaging in healthy behaviors. Providers should reinforce healthy behaviors that are contributing to an individual's healthy, low-risk or risky status.

Providing low-risk individuals with verbal and/or written educational material may be beneficial as it may enhance general knowledge about the risks of opioid misuse and aid in identifying risky behavior in others. Additionally, such materials may act as a reminder of the dangers associated with OUD in individuals with a past medical history of OUD. [9,10]

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Is the Primary Care Manager (PCM) trained and comfortable in the ongoing management of risky behavior?

Developing an SBIRT implementation plan involves considering the office's resources, patient population, and community resources and may enable the provider's adoption of the program. Such strategizing identifies facilitators and potential obstacles which will help guide the implementation process and tailor the program to the office's specific needs. [9,20]

Refer to **SBIRT in the primary care setting** and **Appendix E** for further details.

Provide educational materials, discuss and schedule follow-up appointment.

Individuals responding “yes” to any of the below criteria places them in the risky category requiring brief intervention and need for educational materials.

- Daily use of any substance
- Weekly use of drugs other than cannabis
- Injection drug use in the past three months
- Currently in treatment means the individual is not at risk for related health problems

Patients at with risky behaviors (such as injection drug use) may need referral to a trained behavioral provider or a specialty care facility.

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- **Effects of Drugs**
- **FAQs About Opioids**
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Provide educational materials. Refer to behavioral health, social worker and/or substance abuse provider.

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A referral aims to ensure the individual receives specialized assessment and appropriate treatment as well as promotes patient engagement in treatment. Referral would be particularly important for patients who document any history of injecting drugs.

The complexity of referral to treatment varies and may involve additional services, such as behavioral health services, case management and transportation needs.

It is vital to establish a communication feedback loop between the Primary Care Manger (PCM) and specialists to ensure proper patient engagement and overall medical care.

The PCM should schedule a follow-up appointment after the initial specialty appointment to confirm participation in treatment. [10]

Information on publicly funded substance use disorder treatment facilities may be found on SAMHSA's **Behavioral Health Treatment Services Locater** website.

DAST: Score 3-5 (Harmful)

A DAST-10 score of 3-5 means the individual is at risk for health problems related to drug use and a possible mild or moderate Substance Use Disorder (SUD).

This screening instrument has a sensitivity (true positive) of 80-85% and a specificity (true negative) of 78-88%. [6,10,13,18]

Refer to the following screening sections for **background information** and **secondary screening tools**.

Offer brief intervention if the patient meets harmful behavior criteria.

During brief intervention sessions, the healthcare professional provides information to increase the individual's awareness and understanding about his/her inappropriate opioid use. The healthcare professional also assesses the individual's motivation toward behavioral change and provides advice on how to influence positive change. The healthcare professional and the individual engage in a collaborative effort to establish realistic goals and next steps. [9,10]

The clinician can initiate the conversation by asking:

"Are you interested in seeing how you scored on the questionnaire you just completed?" [9]

If the patient replies "yes," proceed with:

"These are all the substances I asked you about and these are your scores for each of the substances (point to scores). As you can see your score for opioids was..." [9]

The number and duration of brief intervention sessions vary, typically involving one to five sessions lasting five minutes to an hour. The success of a brief intervention relies on a personalized and non-judgmental approach. [9,10]

The healthcare professional can choose from a variety of brief intervention approaches including motivational interviewing, FRAMES approach, OARS model and model of behavior change. [9,16,20]

Refer to **brief intervention** section and **Appendix D** for further details.

Is the Primary Care Manager (PCM) trained and comfortable in the ongoing management of harmful behavior?

Developing an SBIRT implementation plan considering the office's resources, patient population, and community resources and may enhance the PCM's usage of the program. Such strategizing identifies facilitators and potential obstacles which will help guide the implementation process and tailor the program to the office's specific needs. [9,20]

Refer to **SBIRT in the primary care setting** and **Appendix E** for further details.

Engage the patient with internal practice services or refer to local addiction specialty services.

The patient will require ongoing care, either within the internal practice or a local addition specialty facility.

The patient may also need referrals to additional services, such as behavioral health services and case management.

Ensure follow-up with internal practice or referral services.

Reference Humana Military referral network and criteria prior to referring a patient for specialty care.

DAST: 6+ (Severe) or injection use

A DAST-10 score of 6 or greater means the individual is at risk for health problems related to drug use and a possible mild or moderate substance use disorder.

This screening instrument has a sensitivity (true positive) of 80-85% and a specificity (true negative) of 78-88%. [6,10,13,18]

Refer to the following screening sections for **background information** and **secondary screening tools**.

If screening indicates the presence of injection drug use, perform a brief intervention and provide the individual with educational materials on the risks of injecting drugs.

Inform the individual that injecting drugs is associated with an increased risk of blood borne viruses (HIV/AIDS and hepatitis B and C) and recommend testing for these infections. [6]

Individuals identified as injection drug users should be referred to specialty treatment and undergo further biopsychosocial assessment.

Coordinate referral to local addiction specialty services.

A referral aims to ensure the individual receives specialized assessment and appropriate treatment as well as promotes patient engagement in treatment. [10]

Opioid treatment programs may occur in inpatient hospitals, residential addiction facilities, licensed intensive outpatient clinics and outpatient care settings. [2,22]

Quality treatment programs have the following features:

- State licensed or certified
- Prescribes FDA-approved medications to aid in recovery and prevent relapse
- Offers evidence-based therapies such as motivational intervention, cognitive behavioral therapy, counseling, and peer support
- Allows family members to participate in the treatment process
- Provides long-term treatments such as ongoing counseling, coaching and support, sober housing, employment supports

The complexity of referral to treatment varies and may involve additional services, such as behavioral health services, case management and transportation needs.

It is vital to establish a communication feedback loop between the Primary Care Manager (PCM) and specialists to ensure proper patient engagement and overall medical care.

The PCM should schedule a follow-up appointment after the initial specialty appointment to confirm participation in treatment. [10]

Information on publicly funded substance use disorder treatment facilities may be found on SAMHSA's **Behavioral Health Treatment Services Locater** website.

Screening

The SBIRT model utilizes screening as a preliminary and vital step in identifying individuals with opioid misuse or potential OUD. It is important to note that the screening process is not intended to be a diagnostic measure. Screening allows the healthcare professional to quickly assess for risky patterns associated with opioid misuse or OUD.10 Furthermore, screening alone is unlikely to evoke change in an individual's risky opioid behaviors and, therefore, should be used in conjunction with intervention and referral. [9]

Successful implementation of an SBIRT program requires the office to assess their patients' needs and facility resources. Such assessment will allow the SBIRT program to be specifically tailored to the office's needs, thus maximizing its benefit. Given each facility's resources, the facility must determine which population to screen, how frequently to screen, which screening instruments to use, and method of instrument administration. [10]

Choosing a screening population

The population undergoing screening is to be determined by each facility. This determination can be revised based on evolving needs. Universal screening is entirely consistent with the SBIRT paradigm. Office constraints (i.e., time, staff availability, cost, etc.) may preclude a broad approach and require a more narrow focus towards at-risk individuals. Research has identified individual risk factors associated with opioid misuse or OUD. These risk factors include a personal history of SUD, mental illness, and/or overdose. Other distinctive risk factors include younger age, psychotropic medication use, long-term or high-dose opioid use, and a family history of SUD. [11] Additional aberrant behaviors that should prompt screening include calls after office hours, frequent early refill requests, doctor and/or pharmacy shopping, insistence that non-opioid medications are ineffective, and the need for opioid-only therapy. [12]

Choosing a screening tool

Each facility should select a screening tool that best meets their practice's needs. An overall pragmatic screening strategy involves the use of a pre-screening tool followed by a secondary instrument to stratify risk, when indicated. Pre-screening tools provide the means to quickly evaluate risky opioid behaviors. A positive response obtained during the pre-screen requires advancing to a comprehensive secondary screening instrument. Numerous multi-question secondary screening tools have been designed for use in the primary care setting to identify the individual's level of risk. [9,10]

Screening tools may be administered by face-to-face interview, written self-report on a form, or use of a computerized program. Some screening questionnaires for opioid use are embedded in other health and lifestyle behaviors questions (such as cocaine, alcohol consumption, depression, and tobacco use). [10]

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Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)

The **ASSIST** (version 3.0) is an eight-item screening tool developed by the World Health Organization. Items cover use of alcohol, tobacco, and various prescription drugs as well as illicit substances, including opioids. It has been internationally tested and validated for use in adults in the primary care setting. It takes less than 10 minutes for the healthcare professional to administer the questionnaire to the individual. A risk score for each substance is assigned to one of three categories: low risk (0-3), moderate risk (4-26), and high risk (>27). Individuals categorized as moderate risk should receive brief intervention, whereas individuals categorized as high risk should undergo further assessment and be referred for more intensive treatment. When discriminating between opioid use and abuse, this instrument is sensitive (94%) and specific (96%). This tool is available in multiple languages.[6,10,13,17]

Drug Abuse Screening Test (DAST-10)

The **DAST-10** consists of 10 yes/no questions assessing use of various classes of drugs in adults over the past 12 months. This brief tool is both reliable and valid for use in different healthcare settings. The tool can be administered as a self-report instrument (available in paper format and electronically) or in interview format and takes approximately five minutes to complete. The risk score categories are healthy (0), risky (1-2), harmful (3-5), and severe (6+). The severe category is suggestive of substance use problems and these individuals should undergo further assessment and be referred to specialized treatment. The DAST-10 correlated very high with the DAST-20. This screening instrument has a sensitivity of 80-85% and a specificity of 78-88%. This tool is available in several languages and may require a fee associated with its electronic use.[6,10,13,18]

Tobacco, Alcohol, Prescription medications, and other Substance (TAPS-2)

The **TAPS-2** tool is the secondary screening tool to the pre-screen TAPS-1 tool and assesses more detailed use-related behaviors. Risk categories include no use in past three months (0), problem use (1), and higher risk (2+).[15] With respect to substances other than tobacco, alcohol, and marijuana, individuals scoring 1+ should receive further assessment. Despite TAPS having acceptable sensitivity and specificity for tobacco, alcohol, and marijuana, it is not yet suitable for detecting opioid misuse or OUD. Therefore, no further discussion of TAPS will occur within this guideline.[19]

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The **DAST-10** consists of 10 yes/no questions assessing use of various classes of drugs in adults over the past 12 months. This brief tool is both reliable and valid for use in different healthcare settings. The tool can be administered as a self-report instrument (available in paper format and electronically) or in interview format and takes approximately five minutes to complete. The risk score categories are healthy (0), risky (1-2), harmful (3-5), and severe (6+). The severe category is suggestive of substance use problems and these individuals should undergo further assessment and be referred to specialized treatment. The DAST-10 correlated very high with the DAST-20. This screening instrument has a sensitivity of 80-85% and a specificity of 78-88%. This tool is available in several languages and may require a fee associated with its electronic use.[6,10,13,18]

Tobacco, Alcohol, Prescription medications, and other Substance (TAPS-2)

The **TAPS-2** tool is the secondary screening tool to the pre-screen TAPS-1 tool and assesses more detailed use-related behaviors. Risk categories include no use in past three months (0), problem use (1), and higher risk (2+).[15] With respect to substances other than tobacco, alcohol, and marijuana, individuals scoring 1+ should receive further assessment. Despite TAPS having acceptable sensitivity and specificity for tobacco, alcohol, and marijuana, it is not yet suitable for detecting opioid misuse or OUD. Therefore, no further discussion of TAPS will occur within this guideline.[19]

The healthcare professional initiates the screening process by using either a valid pre-screening or secondary screening tool to assess the presence of opioid misuse or OUD. Based on screening results, the healthcare professional can then identify an individual's risk level and determine the appropriate next step based on this information (see **Appendix C**). If screening determines that an individual's opioid use patterns fall in the moderate, risky, or harmful risk categories, a brief intervention follows.[9,10]

Provider response to healthy or low-risk categories

Screening not only identifies those at risk for opioid misuse or OUD, but also identifies those engaging in healthy behaviors. Providers should reinforce healthy behaviors that are contributing to an individual's healthy, low-risk, or risky status. Providing low-risk individuals with verbal and/or written educational material may be beneficial as it may enhance general knowledge about the risks of opioid misuse and aid in identifying risky behavior in others. Additionally, such materials may act as a reminder of the dangers associated with OUD in individuals with a past medical history of OUD.[9,10] The National Institute on Drug Abuse website can be accessed to obtain patient handout materials.

Provider response to risky, moderate-risk or harmful categories

If a secondary screen indicates the presence of risky behaviors, moderate risk, or harmful use, the PCM or designated interventionist may proceed to the brief intervention phase. During this portion of the protocol, the healthcare professional provides information to increase the individual's awareness and understanding about his or her inappropriate opioid use. The healthcare professional also assesses the individual's motivation toward behavioral change and provides advice on how to influence positive change. The healthcare professional and the individual engage in a collaborative effort to establish realistic goals and next steps. The number and duration of brief intervention sessions vary, typically involving one to five sessions lasting five to 60 minutes. The success of a brief intervention relies on a personalized and non-judgmental approach.[9,10]

The healthcare professional can choose from a variety of brief intervention approaches aimed at patient education and motivation towards reducing risky opioid use.[10]

Motivational interviewing

One such approach is motivational interviewing, which is a method that uses client-centered counseling to prompt behavior change. This method promotes an empathetic approach to reduce resistance thus encouraging the individual to discuss his or her ambivalence towards behavior change. Such admissions may foster a greater chance of success in later therapies, if indicated.[9,16,20]

FRAMES approach

FRAMES may be used in collaboration with motivational interviewing. The elements of FRAMES are: [9,20]

- **Feedback:** The healthcare provider offers feedback on the dangers of misusing opioids.
- **Responsibility:** The individual is encouraged to accept responsibility for his or her behavior and decisions to address the opioid misuse.
- **Advice:** The healthcare provider clearly describes the harms and risk associated with opioid misuse.
- **Menu of options:** The healthcare provider communicates various strategies aimed at reducing opioid misuse.
- **Empathy:** The healthcare provider employs an empathetic, non-judgmental approach through reflective listening.
- **Self-efficacy:** The healthcare provider instills confidence in the individual that he or she is capable of change.

OARS model

The techniques of the OARS model employ an interactive approach centered on the individual with motivational interviewing. The healthcare provider uses both verbal responses and non-verbal behaviors to develop rapport and assess the individual's needs to help create a trusting environment. The OARS acronym stands for: [20]

- **Open-ended questions:** These questions encourage a more robust dialogue since it fosters engagement with the individual. These questions typically begin with "how," "what," or "tell me about."
- **Affirmations:** The healthcare provider uses encouragement and positive assertion that the individual is being heard and understood.
- **Reflective listening:** Active listening ensures that the individual's message is being understood by the healthcare provider through reciprocation.
- **Summarizing:** The healthcare provider revisits the main concerns of the discussion, which may then lead into confirmation of mutual next steps.

Model of behavior change

A widely accepted model utilized within brief intervention is the stage of change model. This framework provides an understanding and assessment of an individual's process to change. The stages consist of pre-contemplation, contemplation, preparation, action, maintenance, and relapse. Participation in each stage is not determined by any set period of time and the individual may cycle between stages. The healthcare professional may provide motivation specific to the individual's stage of change. Appropriate stage interventions may then be tailored specific to the individual's readiness to institute change pertaining to his or her risky opioid behaviors. [20]

Time constraints are ever present within the primary care setting. At a minimum, the selected brief intervention approach employed by the healthcare team should address certain distinct communication points. The process begins by providing tailored feedback based on the individual's responses to the screen. Comparing the responses to expected norms may provide perspective on the individual's aberrant behavior. Promoting open communication will allow the healthcare provider to gauge the individual's view regarding his or her opioid misuse. This will also allow opportunity to ascertain the individual's goals or empathetically provide suggestive goals according to the individual's specific circumstances. Educational materials should be provided to the individual and a follow-up appointment should be scheduled.[9]

Refer to **Appendix D** for a sample of a step-by-step brief intervention for moderate-risk individuals. For a shorter three-minute intervention, use only the first five steps.

Provider response to high-risk or severe categories

Screening scores classifying the individual as high or severe risk warrant brief intervention and a referral to specialized treatment.[6,10,13,18] While not intended to treat individuals identified with serious opioid use issues, brief intervention may be beneficial in encouraging this population to pursue intensive treatment.

Refer to the Substance Abuse and Mental Health Services Administration and US Department of Health and Human Services (SAMHSA-HHS) website for additional resources on brief intervention.

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Appendix D: Morphine Milligram Equivalent (MME) for oral opioids

Opioid (doses in mg/day except where noted)	Conversion factor
Codeine	0.15
Fentanyl transdermal (mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone 1-20 21-40 41-60 ≥61-80	 4 8 10 12
Morphine (reference)	1
Oxycodone	1.5
Oxymorphone	3
Tramadol	10

Do not use to convert one opioid to another.

Reference: Centers for Disease Control and Prevention. Calculating total daily dose of opioids for safe dosage. Agency Medical Directors' Group. Interagency guideline on prescribing opioids for pain. 2015.

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Appendix E: SBIRT implementation

1. Creating a team. This team should consist of a “champion” to rally support, an office manager who is tasked with plan execution, and appropriate interdisciplinary providers.
2. Organization leadership buy-in. This buy-in effort will help establish or modify resource allocations.
3. Overcoming stigma. Educating leaders and office staff about SBIRT successes may help counteract stigmas associated with OUD.
4. Choosing a screening strategy. Given each facility’s resources, the facility must determine which population to screen, how frequently to screen, which screening instruments to use, and how to administer the instrument.
5. Electronic Medical Record (EMR) facilitation. EMR allows for more efficient documentation and usage of SBIRT tools as well as communication among providers.
6. Choosing a brief intervention strategy. Identify staff members responsible for conducting brief interventions and ensuring adequate training is provided.
7. Establishing referral resources. Identifying opioid use disorder resources within the community and creating a referral strategy system.
8. Employee training. Ensure adequate training and role definition for all staff involved in the SBIRT program.
9. Reimbursement. Research reimbursement mechanisms and criteria to ensure financial sustainability.
10. Ongoing quality improvement monitoring. Quality improvement initiatives provide process feedback, thus allowing for SBIRT improvements.

Reference: Pace CA and Uebelacker LA. Addressing unhealthy substance use in primary care. Med Clin N Am (2018). 102:567-586.

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Psychosocial history

Pain assessments should include a psychosocial history. The healthcare provider should interview the patient about alcohol, drug, and tobacco use, as well as the presence or history of mental health and psychiatric comorbidities. The healthcare provider should also inquire if the pain interferes with fulfilling work, school, or home obligations.[9]

Numerous instruments assessing psychosocial history are discussed in the Clinical Practice Guideline for Opioid Use Disorder in the Primary Care Setting. Refer to this guideline for detailed information describing these instruments.

Evidence

SBIRT has a successful track record treating risky alcohol use. It is now being called into action to combat risky substance use. The clinical outcomes of using SBIRT for drug use varies among the research. Some research suggests that SBIRT purported beneficial outcomes in reducing drug use, whereas other research showed no benefit of using SBIRT to achieve abstinence or reduce medical services utilization. It is difficult to discern the effects of SBIRT specifically on opioid use since some of the studies collectively assessed various drugs. Regardless of the substance assessed, SBIRT demonstrated greater success when the PCM was directly involved in the intervention.[9]

Although the evidence surrounding SBIRT is contradictory, there are other achievable benefits from its implementation. For instance, the individual's opioid use history obtained through screening may alert the PCM to possible opioid-related complications, such as infections associated with injection drug use, sexually transmitted infections, and viral hepatitis. Such knowledge may help guide medical decisions, such as avoiding concomitant use of opioids and sedatives.[9]

Potential issues impeding implementation

Consistent screening, intervention, and treatment of individuals with risky opioid behaviors is paramount to the successful implementation of an SBIRT program in the primary care setting. Such factors contributing to a lack of engagement include time constraints, inadequate interdisciplinary staffing within the clinic, insufficient provider education regarding OUD and its subsequent management, minimal referral sources, confidentiality and compliance concerns, reimbursement and financial sustainability, stigma perceived by both providers and patients alike, and concern of disrupting provider-patient rapport when exploring unhealthy drug use.[9,20]

Implementation into clinical practice

Developing an SBIRT implementation plan considering the office's resources, patient population, and community resources may enhance the provider's adoption of the program. Such strategizing identifies facilitators and potential obstacles which will help guide the implementation process and tailor the program to the office's specific needs. SBIRT is a process that evolves according to the trials and errors experienced within each practice's workflow.[9,20] Points to consider when implementing SBIRT may be found in Appendix E.

Reimbursement

A critical component of a successful SBIRT program is sufficient funding and reimbursement. The office setting, staffing, and services rendered all factor into the costs incurred with implementing an SBIRT program. The individual's insurance coverage may dictate the use of SBIRT. Reimbursement may also guide the level of care provided. Terms of reimbursement and their corresponding codes vary among payers in both the public and private realm. SBIRT reimbursement codes for the insurance market include Current Procedural Terminology (CPT), Medicare G, and Medicaid Healthcare Common Procedure Coding System (HCPCS). Federal, state, and private sources provide potential funding to initiate SBIRT execution. Similarly, SAMHSA offers financial support for SBIRT initiatives at the state level as well as for private non-profit healthcare or behavioral healthcare systems. Facilities must be proactive in securing future monies to ensure sustainability.[10] The **SAMHSA-HRSA** website provides further detailed information on financing an SBIRT program.

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Drug	Detection timeline	Test to order	Positive test	Comments
Buprenorphine (semi-synthetic)	Three to four days	GC/MS or LC/MS/MS	Buprenorphine	Will screen negative on opiate immunoassay; Causes of false positives: Tramadol
Codeine (natural)	One to three days	Opiate immunoassay + GC/MS or LC/MS/MS opiates	Morphine, codeine, high-dose hydrocodone	Will screen positive on opiate immunoassay; Cannot differentiate various natural opiates; Causes of false positives: poppy plant/seed, quinine, quinolone antibiotics and rifampin
Fentanyl (sythetic)	One to two days	GC/MS or LC/MS/MS fentanyl	Fentanyl, norfentanyl	Will screen negative on opiate immunoassay; May not detect all fentanyl-like substances
Heroin (semi-synthetic)	One to two days	Opiate immunoassay	Morphine, codeine	Will screen positive on opiate immunoassay, as heroin is metabolized to morphine
Hydrocodone (semi-synthetic)	Two days	Opiate immunoassay GC/MS or LC/MS/MS opiates	Hydrocodone, hydromorphone	May screen negative on opiate immunoassay; Opiate assay may only detect high-dose of hydrocodone
Methadone (synthetic)	Two to 11 days	Methadone immunoassay GC/MS or LC/MS/MS methadone	Methadone	Will screen negative on opiate immunoassay; Causes of flase positives: Verapamil, quetiapine, diphenhydramine and doxylamine

Key: Gas Chromatography (GC); Mass Spectrometry (MS); Liquid Chromatography (LC)

References: Substance Abuse and Mental Health Services Administration. Part 2: addressing opioid use disorder in general medical settings; (2018). Agency Medical Directors' Group. Interagency guideline on prescribing opioids for pain. 2015; HHS Publication No. (SMA) 18-5063PT2. Keary et al. Toxicologic testing for opiates: understanding false-positive and false-negative test results. *Prim Care Companion CNS Disord*. 2012; 14(4):PCC.12f01371.

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Hydrocodone (semi-synthetic)	Two days	Opiate immunoassay GC/MS or LC/MS/MS opiates	Hydrocodone, hydromorphone	May screen negative on opiate immunoassay; Opiate assay may only detect high-dose of hydrocodone
Methadone (synthetic)	Two to 11 days	Methadone immunoassay GC/MS or LC/MS/MS methadone	Methadone	Will screen negative on opiate immunoassay; Causes of flase positives: Verapamil, quetiapine, diphenhydramine and doxylamine

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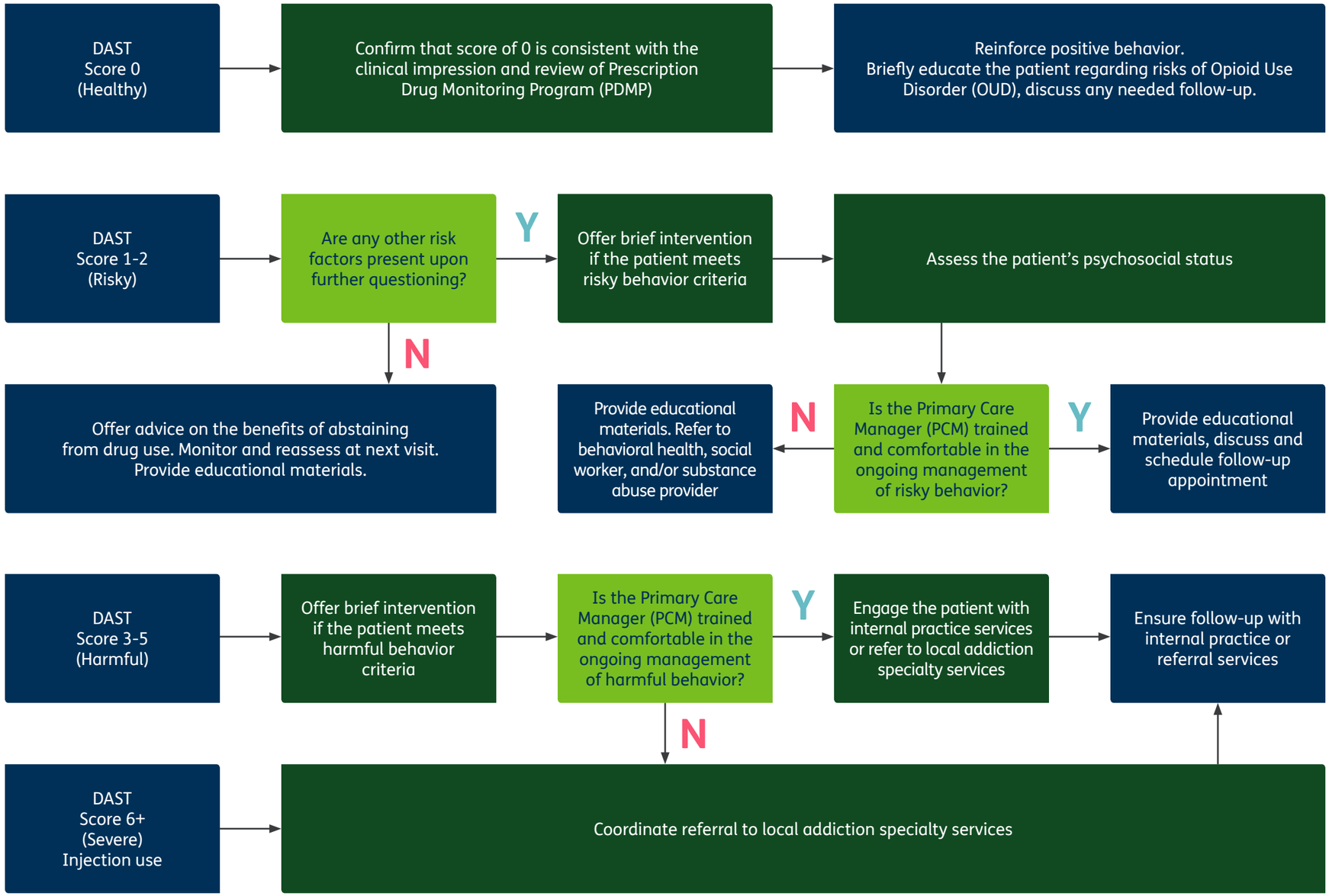
CPG: DAST

Clinical Practice Guidelines (CPG): Screening, Brief Intervention, and Referral to Treatment



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