Part C: Questions and Answers Regarding Assessing the Appropriateness and Effectiveness of Methadone Maintenance Treatment

The following are the most commonly asked questions regarding the methods for assessing patient appropriateness for methadone treatment, withdrawal from treatment, and monitoring treatment progress.

Question 1: How should patients be assessed for opioid agonist treatment?

Answer: The diagnosis of opioid dependence can be made according to diagnostic criteria as outlined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) or the *International Classification of Diseases and Related Health Problems* (ICD). The DSM and ICD criteria are presented below:

DSM-IV–TR Criteria for Substance Dependence (American Psychiatric Association, 2000)

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1. Tolerance, as defined by either of the following:
   a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect
   b. Markedly diminished effect with continued use of the same amount of the substance

2. Withdrawal, as manifested by either of the following:
   a. The characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for withdrawal from the specific substances)
   b. The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

3. The substance is often taken in larger amounts or over a longer period than was intended.

4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.

5. A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects.

6. Important social, occupational, or recreational activities are given up or reduced because of substance use.

7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

ICD-10 Clinical Description (World Health Organization, 2006)

A cluster of physiological, behavioral, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviors that once had greater value. A central descriptive characteristic of the dependence syndrome is the desire (often strong, sometimes overpowering) to take psychoactive drugs (which may or may not have been medically

prescribed), alcohol, or tobacco. There may be evidence that return to substance use after a period of abstinence leads to a more rapid reappearance of other features of the syndrome than occurs with nondependent individuals.

ICD-10 Diagnostic Guidelines (World Health Organization, 2006)

A definite diagnosis of dependence should usually be made only if three or more of the following have been present together at some time during the previous year:

- A strong desire or sense of compulsion to take the substance
- Difficulties in controlling substance-taking behavior in terms of its onset, termination, or levels of use
- A physiological withdrawal state when substance use has ceased or been reduced, as evidenced by the characteristic withdrawal syndrome for the substance or use of the same (or closely related) substance with the intention of relieving or avoiding withdrawal symptoms
- Evidence of tolerance, such that increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower doses (clear examples of this are found in alcohol- and opiate-dependent individuals who may take daily doses sufficient to incapacitate or kill nontolerant users)
- Progressive neglect of alternative pleasures or interests because of psychoactive substance use and increased amount of time necessary to obtain or take the substance or to recover from its effects
- Persisting with substance use despite clear evidence of overtly harmful consequences, such as harm to the liver through excessive drinking, depressive mood states consequent to periods of heavy substance use, or drug-related impairment of cognitive functioning; efforts should be made to determine that the user was actually, or could be expected to be, aware of the nature and extent of the harm.

ICD-10 Diagnostic Criteria for Research (World Health Organization, 2006)

Three or more of the following manifestations should have occurred together for at least 1 month or, if persisting for periods of less than 1 month, should have occurred together repeatedly within a 12-month period:

- A strong desire or sense of compulsion to take the substance
- Impaired capacity to control substance-taking behavior in terms of its onset, termination, or levels of use, as evidenced by the substance often being taken in larger amounts or over a longer period than intended, or by a persistent desire or unsuccessful efforts to reduce or control substance use
- A physiological withdrawal state when substance use is reduced or ceased, as evidenced by the characteristic withdrawal syndrome for the substance or by use of the same (or closely related) substance with the intention of relieving or avoiding withdrawal symptoms
- Evidence of tolerance to the effects of the substance, such that there is a need for significantly increased amounts of the substance to achieve intoxication or the desired effect, or a markedly diminished effect with continued use of the same amount of the substance
- Preoccupation with substance use, as manifested by important alternative pleasures or interests being given up or reduced because of substance use; or a great deal of time being spent in activities necessary to obtain, take, or recover from the effects of the substance

- Persistent substance use despite clear evidence of harmful consequences, as evidenced by continued use when the individual is actually aware, or may be expected to be aware, of the nature and extent of harm.

Dependence Syndrome

Click on the following for a description of the dependence syndrome: www.who.int/substance_abuse/terminology/definition1/en/index.html.

References

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. Text Revision (DSM-IV-TR). APA: Washington, DC, 2000.

World Health Organization. *International Statistical Classification of Diseases and Related Health Problems*. 10th Revision. 2006. Available online at: www3.who.int/icd/currentversion/fr_icd.htm.

Question 2: How is opioid withdrawal assessed?

Answer: Opioid withdrawal results from opioid abstinence in patients who are physically dependent on opioids. Assessment of opioid withdrawal can be useful in making the diagnosis of physical dependence and in making decisions regarding initiation and/or titration of medications. A number of scales have been developed for the assessment of opioid withdrawal.

These include the Objective Opioid Withdrawal Scale (OOWS), the Subjective Opioid Withdrawal Scale (SOWS) (Handelsman, Cochrane, Aronson, et al., 1987), the Short Opioid Withdrawal Scale (SOWS) (Gossop, 1990), and the Clinical Opioid Withdrawal Scale (COWS) (Wesson and Ling, 2003).

The OOWS and SOWS (Handelsman et al., 1987) are available at:
www.aodgp.gov.au/resourcekit/b4/handout6_opioids.pdf.

The COWS is available at: www.pcssmentor.org/pcss/resources_clinicaltools.php.

References

Gossop M. The development of a Short Opiate Withdrawal Scale (SOWS). *Addictive Behaviors* 1990;15(5):487-90.

Handelsman L, Cochrane KJ, Aronson M, Ness R, Rubinstein KJ, Kanof, PD. Two new rating scales for opiate withdrawal. *American Journal of Drug and Alcohol Abuse* 1987;13:293-308.

Wesson DR, Ling W. The Clinical Opiate Withdrawal Scale (COWS). *Journal of Psychoactive Drugs* 2003;35(2):253-59.

Question 3: How is patient progress in opioid agonist treatment monitored?

Answer: Patient progress should be monitored via clinical evaluation (e.g., patient self-report) and objective measures (e.g., urine toxicology testing).

The Addiction Severity Index (ASI) (McLellan, Kushner, Metzger, et al., 1992) is an instrument designed to assess the impact of a patient's addiction on his or her function. Although this instrument is typically used in research, it has been adapted for clinical use and illustrates the various aspects of a patient's life that should be assessed at each patient visit to determine the impact of active addiction or the benefits of abstinence. The ASI evaluates patient function in the areas of

- Drug use
- Alcohol use
- Psychiatric function
- Medical function
- Employment
- Social/family functioning
- Legal problems

In addition to patient self-report, urine testing can be a useful practice in monitoring patient progress in treatment. In some countries, urine testing is mandated as part of the treatment plan. A variety of substances can be detected in urine testing. Testing can occur for naturally occurring opioids (e.g., codeine, morphine) or synthetic or semi-synthetic opioids (e.g., oxycodone, methadone). Testing also can occur for benzodiazepines, cocaine, marijuana, or other drugs that are used and/or abused by the patient population. The period of detection of each of these substances varies with the laboratory technique that is used and the extent of drug use and can range from days to weeks.

References

McLellan AT, Kushner H, Metzger D, Peters R, Smith I, Grissom G, et al. The Fifth Edition of the Addiction Severity Index. *Journal of Substance Abuse Treatment* 1992;9(3):199-213.