HIV CLINICAL RESOURCE ¼-FOLDED GUIDE

VISIT HIVGUIDELINES.ORG TO LEARN MORE OR VIEW COMPLETE GUIDE

SUBSTANCE USE SCREENING AND RISK ASSESSMENT IN ADULTS

NYSDOH AIDS INSTITUTE HIV CLINICAL GUIDELINE NOVEMBER 2023

ALL RECOMMENDATIONS: SUBSTANCE USE SCREENING AND RISK ASSESSMENT P.1

Substance Use Screening for All Adults in the Primary Care Setting

- During the initial visit and during annual follow-up visits, primary care clinicians should screen for the following in adults ≥18 years old:
  - Alcohol use, and when unhealthy use is identified, assess the level of risk to the patient. (A1)
  - Tobacco use, and when it is identified, provide assessment and counseling. (A1)
  - Drug use (B3), and when unhealthy use is identified, assess the level of risk to the patient. (A3)
  - See the guideline section Risk Assessment.
- Before screening for drug use, clinicians should explain the risks and benefits of screening to all patients, especially those who are pregnant or planning to conceive; the discussion should include state reporting requirements and the potential for involvement of child protective services. (A3)
  - For information on the Child Abuse Prevention and Treatment Act (CAPTA) in New York State, see Plans of Safe Care for Infants and their Caregivers.
- Clinicians should repeat substance use screening to inform clinical care when:
  - Prescribing medication(s) that have adverse interactions with alcohol or drugs. (A2)
  - A patient has symptoms or medical conditions that could be caused or exacerbated by substance use. (A3)

Screening Tools

- Healthcare providers should use standardized and validated questionnaires for substance use screening (see Table 1: Recommended Validated Tools for Use in Medical Settings to Screen for Alcohol and Drug Use in Adults in full guideline). (A3)

Risk Assessment

- Clinicians should assess the level of substance use risk in individuals who have a positive substance use screening result or a history of substance use disorder (SUD) or overdose. (A3)
- Clinicians should use standardized and validated tools to assess the level of risk associated with substance use (see Table 2: Brief, Validated Risk Assessment Tools for Use in Medical Settings With Adults ≥18 Years Old in full guideline). (A3)

ALL RECOMMENDATIONS: SUBSTANCE USE SCREENING AND RISK ASSESSMENT P.2

Diagnosis of Substance Use Disorder

- For accurate diagnosis of an SUD and its severity, clinicians should perform or refer patients for a full assessment based on Diagnostic and Statistical Manual of Mental Disorders−5 (DSM−5) criteria. (A3)
- Clinicians should assess patients' perceptions of their substance use and readiness to change substance use behaviors. (A3)
- If individuals present with symptoms consistent with both an SUD and a mental health disorder, clinicians should assess for both types of disorder before making a diagnosis and should refer for specialty behavioral healthcare when indicated. (A3)

KEY POINTS

- Urine toxicology, measures of blood alcohol level, and other laboratory tests should not be relied on for identifying unhealthy drug use.
- It is important to ask patients about substance use during an initial visit and during follow-up visits because patterns of use may change over time. Annual screening may be most appropriate, and most validated alcohol and drug screening questionnaires ask about use in the past year.
- It is important to inform patients that information about their substance use is protected by the same privacy laws that apply to all other information in their medical records.

ALL RECOMMENDATIONS: SUBSTANCE USE HARM REDUCTION IN MEDICAL CARE P.1

Implementing Substance Use Harm Reduction

- For patients who use substances, whether or not they are engaged in SUD treatment, clinicians should continue to offer medical care, including HCV and HIV screening and treatment, HIV PrEP, and HIV PEP, as indicated. (A3)
- Clinicians should offer or refer for harm reduction counseling and services, including counseling on safer substance use. (A3)
- To assist in harm reduction and treatment planning, clinicians should ask patients about all of the substances they use, methods of use, use networks, and the role and effects of substance use in their daily lives. (A3)
- Clinicians should collaborate with patients to set specific harm reduction/treatment goals, recognizing that goals other than full abstinence, such as reduced or safer use, are acceptable. (A3)

ALL RECOMMENDATIONS: SUBSTANCE USE HARM REDUCTION IN MEDICAL CARE P.2

Implementing Substance Use Harm Reduction, *continued*

- To reduce harms associated with drug injection, clinicians should refer patients to an NYS Authorized Syringe Exchange Site and advise patients against sharing and reusing equipment given the associated risks. (A2)

Overdose Prevention

- Clinicians should educate patients on the risks of drug overdose, especially fentanyl overdose, discuss risk reduction strategies, and counsel patients to:
  - Assume that all illicitly manufactured opioids contain fentanyl or other high-potency synthetic opioids and that stimulants and counterfeit pills may contain these agents. (A3)
  - When possible, test drugs with fentanyl and xylazine test strips or other drug-checking systems. (A3)
  - Avoid using drugs alone. (A3)
  - Start with a small amount when using any drug. (A3)
  - Carry naloxone, learn how to use it to reverse an opioid overdose, and encourage friends and contacts to do the same. (A2)
- Clinicians should offer or refer patients to a local or online resource for fentanyl and xylazine test strips and instructions on their use. (B3)
- Clinicians should ensure that patients have access to NLX: prescribe the 4 mg NLX nasal spray formulation with refills or refer the patient to a local or online resource. (A2)

Pharmacologic Treatment

- When indicated, clinicians should offer pharmacologic treatment for patients with an SUD. (A3)
  - See NYSDOH AI guidelines Treatment of Opioid Use Disorder and Treatment of Alcohol Use Disorder.
- Clinicians should continue to prescribe SUD treatment for patients who continue or resume use. (A3)

Avoiding Substance Use-Associated Discrimination

- Clinicians should examine their assumptions and decisions for any personal biases that may affect their ability to provide effective care for individuals who use substances. (A3)
- Clinicians and other staff interacting with patients should use neutral terms to describe all aspects of substance use and avoid language that perpetuates stigma. (A2)

DSM-5 Diagnostic Criteria for Diagnosing and Classifying Substance Use Disorders [a,b,c]

Criteria Type	Description
Impaired control over substance use (DSM-5 criteria 1 to 4)	• Consuming the substance in larger amounts and for a longer amount of time than intended. • Persistent desire to cut down or regulate use. The individual may have unsuccessfully attempted to stop in the past. • Spending a great deal of time obtaining, using, or recovering from the effects of substance use. • Experiencing craving, a pressing desire to use the substance.
Social impairment (DSM-5 criteria 5 to 7)	• Substance use impairs ability to fulfill major obligations at work, school, or home. • Continued use of the substance despite it causing significant social or interpersonal problems. • Reduction or discontinuation of recreational, social, or occupational activities because of substance use.
Risky use (DSM-5 criteria 8 and 9)	• Recurrent substance use in physically unsafe environments. • Persistent substance use despite knowledge that it may cause or exacerbate physical or psychological problems
Pharmacologic (DSM-5 criteria 10 and 11)	• **Tolerance:** Individual requires increasingly higher doses of the substance to achieve the desired effect, or the usual dose has a reduced effect; individuals may build tolerance to specific symptoms at different rates. • **Withdrawal:** A collection of signs and symptoms that occurs when blood and tissue levels of the substance decrease. Individuals are likely to seek the substance to relieve symptoms. No documented withdrawal symptoms from hallucinogens, PCP, or inhalants. • **Note:** Individuals can have an SUD with prescription medications, so tolerance and withdrawal (criteria 10 and 11) in the context of appropriate medical treatment do *not* count as criteria for an SUD.

Abbreviations: DSM-5; Diagnostic and Statistical Manual of Mental Disorders−5; PCP, phencyclidine; SUD, substance use disorder.

Abbreviations

a. Adapted from [APA 2013]; see the full guideline for citations.

b. SUDs are classified as mild, moderate, or severe based on how many of the 11 criteria are fulfilled: mild, any 2 or 3 criteria; moderate, any 4 or 5 criteria; severe, any 6 or more criteria.

c. Please consult the DSM-5 for substance-specific diagnostic information.

Figure 1. Substance Use Identification and Risk Assessment in Primary Care

Screen all adult patients in the primary care setting.

↓

If substance use screening test result is positive: Perform or refer patient for risk assessment [a].

Low-risk use

- Provide education on health consequences of use and reinforce negative consequences.
- Provide positive reinforcement of low-risk use behavior.
- Discuss harm reduction strategies [b].
- **Alcohol use:** Advise patients to restrict consumption to recommended limits [b,c].

→ (to ongoing support)

Moderate-risk use

- Provide education on health consequences of use.
- Discuss harm reduction strategies [b].
- Provide close follow-up.
- **Alcohol use:** Offer or refer for brief intervention [c].

↓

- Provide ongoing support as needed.
- Repeat screening annually or more often if indicated.

High-risk use

Perform or refer for SUD assessment based on diagnostic criteria of the *Diagnostic and Statistical Manual of Mental Disorders-5*.

No SUD diagnosis → (to moderate-risk use interventions)

↓

If SUD is diagnosed:

- Develop an individualized treatment plan, including pharmacologic treatment if indicated and available [c,d,e].
- Discuss harm reduction strategies [b].
- Offer or refer for behavioral treatment.

→ (to ongoing support)

Notes:

a. For patients with a known history of SUD or overdose, screening may not be required but assessment is recommended.

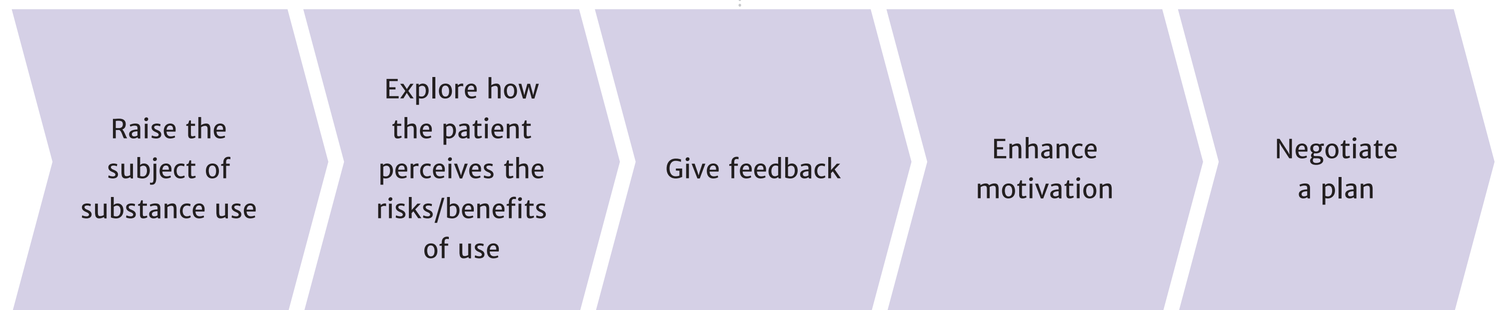
b. See NYSDOH AI guideline Substance Use Harm Reduction in Medical Care.

c. See NYSDOH AI guideline Treatment of Alcohol Use Disorder and National Institute on Alcohol Abuse and Alcoholism: Helping Patients Who Drink Too Much: A Clinician's Guide.

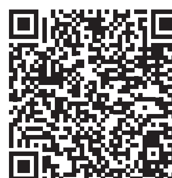
d. See NYSDOH AI guideline Treatment of Opioid Use Disorder.

e. See U.S. Public Health Service: A Clinical Practice Guideline for Treating Tobacco Use and Dependence.

Figure 2: Brief Intervention: "Can We Spend a Few Minutes Talking About Your Substance Use?"



Adapted from [Project ASSERT 2019]. See the full guideline for citations.



← Use this code with your phone's QR code reader to go directly to a mobile-friendly version of the guideline.

This ¼-Folded Guide is a companion to the New York State Department of Health AIDS Institute guideline *Substance Use Screening and Risk Assessment in Adults*
The full guideline is available at www.hivguidelines.org.