SUBSTANCE USE HISTORY TIP SHEET

Substance Use History Table in the BSAS Enrollment Assessment



WHAT

This section of the enrollment assessment asks about the patient's history of substance use. The first question about each substance is whether the patient has ever used the substance. This refers to **any use of the substance** by the patient during their lifetime. If the patient has used the substance, the provider then asks the patient their age at first use of the substance, how recent their last use of the substance was, the frequency of their last use of the substance, and the route of administration they use/used for the substance.



WHY

The information gathered about patients' substance use history is used to understand the need for substance use treatment services in Massachusetts and to design services that align with the needs. Therefore, it is important that you record specific, complete information in this table.

INTRODUCING THIS PART OF THE ASSESSMENT

This table can be challenging because it lists many substances and there are several questions about each substance the patient reports using. Some patients find discussing details about their substance use history frustrating or triggering.

One way to introduce this section of the assessment is to say, "Now we are going to go through a list of substances you may or may not have used. I have a few questions to ask you about each substance. Please be open and honest."



HOW

Note that the first question about each substance is whether the patient has ever used the substance. You are asked to record all use of each substance, not just current use or use that the patient or you consider problematic.

When a patient reports they have used a substance, you may want to use this wording to ask the four follow-up questions:

- How old were you when you first used (insert name of substance)?
- When did you last use (insert name of substance)?
- When you last used (insert name of substance) how frequently did you use it?
- How did you use (insert name of substance)? (Route of administration)



Do's:

- Record any use of each substance over the patient's lifetime.
- Ask patients about every substance listed in the table.
- If a patient has used a substance just once or twice, record it in the table.
- If a patient uses or has used a prescribed medication for **non-medical purposes or at higher dosage** than prescribed, **record that** in the table.
- If a patient says they started using (or tried) a given substance at X age, but the substance didn't "become a problem" for them until Y age, **record the age when they first used the substance.**
- Because patients who have used heroin for a while often don't know when fentanyl first began to be mixed with it, when a patient says they have used fentanyl, **consider asking**, "When did you first *know* you were using fentanyl?" and "When did you last *knowingly* use fentanyl?"
- If a patient's response about a substance doesn't seem factual (for example, they say they haven't used a substance, but you can smell the substance on them), record what the patient tells you.

Don'ts:

- **Do not record** in the table information about the patient that you have gathered **from external sources** (e.g., from an ER assessment).
- Do not record just substance use that seems problematic to you or that the patient says they engage in regularly.
- Do not record just the patient's current or recent use of the substances in the table. Record all lifetime use.
- **Do not ask** patients whether they **"have a problem with**" any of the substances in the table. Instead, ask them which substances they have used or are using.
- **Do not record** information about **only the substances the patient says are their primary drug.** Record information about every substance they have used or are using.
- **Do not record** in the table medications prescribed for the patient (e.g., pharmaceutical opiates, benzodiazepines, marijuana) that they use or have **used for medicinal purposes at the prescribed dosage.**

