Management of Substance Abuse Disorders

Samantha Marks, BS, PharmD Candidate 2014
Doug Brink, PharmD, BCPP

Introduction

Drug and alcohol abuse is common in the United States, with 22.2 million people meeting the criteria for substance abuse or dependence in 2012. The burden of alcohol and substance abuse is disproportionately high in New Mexico. New Mexico ranks number one in alcohol-attributable deaths (53.8 per 100,000 vs. the national average of 28.2 per 100,000) and has the second highest drug overdose death rate in the United States (28.9 deaths per 100,000 vs. the national average of 12.3 per 100,000).

Because of the significant morbidity and mortality associated with alcohol and substance abuse, it is important for clinicians to identify at risk patients and refer them to appropriate treatment. Additionally, providers must implement practices to promote responsible opioid prescribing to help reduce widespread prescription drug abuse. This newsletter provides a brief introduction to screening and prevention of substance abuse disorders, and highlight available treatment options.

Screening Patients for Substance Abuse Disorders

The U.S. Preventive Services Task Force recommends screening for alcohol misuse and abuse for all adults ages 18 and over. While universal screening for illicit substance abuse is not recommended for all patients at this time, clinicians may consider screening patients due to their controlled substance prescription use and significant morbidity and mortality associated with substance abuse.

Several validated tools are available for assisting clinicians in identifying patients at risk of alcohol or substance abuse, including the AUDIT, and AUDIT-C screening instruments for alcohol misuse and the DAST-10 instrument for drug abuse. These instruments take 2-5 minutes to administer and have demonstrated good sensitivity and specificity for detecting a wide spectrum of substance use disorders. Single question screening tools (Table 1) have also demonstrated adequate sensitivity and may be preferred by busy clinicians as they take less than a minute to complete.

<table>
<thead>
<tr>
<th>Table 1: Single questions screening tools for alcohol and substance abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>“How many times in the past year have you had 5 [for men] or 4 [for women and all adults older than 65 years] or more drinks in a day?”</td>
</tr>
<tr>
<td>“How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?”</td>
</tr>
</tbody>
</table>
Preventing Prescription Medication Abuse

Prescribers should evaluate patient risks for prescription medication abuse prior to the initiation of treatment. Low risk patients with chronic pain who have no history of abuse and do not suffer from psychiatric co-morbidities can usually be managed in the primary care setting. Patients with additional risk factors, such as psychiatric co-morbidity or a history of substance abuse, may require consultation from a psychiatric or addiction specialist. The high risk patients, with an active substance abuse disorder, should be referred to an outside pain management clinic where they can receive care from clinicians specializing in pain management.

All patients receiving chronic opioid therapy should be routinely monitored to ensure safe and effective use of narcotics. At a minimum, pain severity, treatment compliance, substance use, and aberrant drug-related behavior should be assessed every 3 to 6 months in patients at low risk for abuse. Patients at high risk will require more frequent monitoring. One tool for improving patient monitoring and encouraging responsible opioid use is the opioid contract, also called an opioid agreement. An opioid contract is a formal, written agreement between a patient and a prescriber that outlines expectations regarding adherence and appropriate use of narcotic medication. Such agreements may require patients to commit to using only one prescriber and pharmacy for all narcotic medications, provide information regarding safe opioid use and storage, and define boundaries for prescription refills. Opioid contracts also discuss consequences for violating the terms of the agreement, such as referral to a different clinic or opioid discontinuation.

Prescription Monitoring Programs

Prescription Monitoring Programs (PMPs) are statewide electronic databases which collect information on controlled substances dispensed throughout the state. These programs document controlled prescription information, including the patient’s name, the prescriber, and the pharmacy where the prescription was filled. In New Mexico, authorized prescribers and pharmacists can request a patients prescription history from the New Mexico PMP using a secure website. Information gathered from this site can be used to identify patients receiving controlled substances from multiple prescribers or multiple pharmacies and can alert clinicians to potential opioid abuse. It is recommended that prescribers obtain a patient’s controlled substance history from the PMP prior to initiating opioid therapy.

Treatment Options

The core components of any addiction treatment program should include treatment planning, clinical and case management, behavioral therapy and counseling, support groups (12-Step Programs), substance abuse monitoring, and where indicated, pharmacotherapy. Additional supportive services, including mental health care and financial, legal, and housing support may be integrated into a comprehensive treatment program. In general, patients should be treated in the least restrictive setting that is likely to be safe and effective.

Screening, Brief Intervention, and Referral to Treatment

Screening, brief intervention, and referral to treatment (SBIRT) is a well-supported method for addressing substance abuse in at-risk patients who may not meet the clinical criteria for abuse or dependence. In this approach, clinicians screen patients using a validated screening tool (discussed above), provide a physical and psychological examination, and spend 5-20 minutes providing targeting counseling using techniques, such as motivational interviewing, to encourage reduction or abstinence from illicit substance or alcohol use. Studies suggest that SBI is very effective at reducing alcohol intake and motivating patients to receive higher levels of treatment.

Detoxification

Detoxification can help to alleviate the physical symptoms of alcohol or substance withdrawal, and provide medical support for patients who may face life threatening complications from alcohol or substance withdrawal. These programs can also be useful for motivating patients to seek further treatment; however detoxification programs do not address the psycho-social problems that are associated with addiction. By itself, medical detoxification does little to change long-term drug or alcohol use, and should be viewed as a first step in a long-term treatment plan.
Hospital-based Inpatient Treatment

Hospital-based treatment is the most restrictive and expensive form of substance abuse treatment, however it may be the most appropriate option for certain high risk patients. Patients who cannot be safely treated in other environments, such as patients at risk for medically complicated withdrawal syndromes, patients with severe mental illness requiring psychiatric hospitalization, and patients who are having suicidal thoughts or ideations benefit most from inpatient hospital programs.

Residential Programs

Residential programs provide 24 hour care and a highly structured environment that may be suitable for patients who do not meet the criteria for inpatient hospital programs, but are unlikely to remain abstinent in the outpatient setting. These programs are particularly beneficial for patients whose social interactions have come to revolve around substance use and do not have the substance-free social support needed for success in outpatient programs. Individuals who lack motivation to continue treatment on their own are also candidates for residential treatment. Therapeutic approaches and length of treatment vary greatly from facility to facility, and may be adjusted to suit individual patient needs and treatment goals. Most patients will require continued support from outpatient or 12-step programs after the completion of a residential program.

Partial Hospitalization

Partial hospitalization is a viable option for patients who require intensive care due to co-occurring psychiatric conditions, lack or social support, or a history of relapse, but are likely equipped to remain abstinent without 24 hour care. In these programs, patients usually receive treatment for 6-8 hours daily, but return to their home environment each night. Partial hospitalization is often used during the transition from a residential program for patients who remain at high risk of relapse, or for patients who have been unsuccessful in intensive outpatient treatment.

Intensive Outpatient Programs

Intensive outpatient programs (IOP) provide treatment 3-5 hours a day, 3-6 times a week. This level of care is appropriate for the majority of patients requiring treatment for substance abuse, provided that they have adequate motivation and social support. One benefit to these programs is that patients are not removed from the challenges in their everyday life, so they can develop appropriate coping mechanisms with assistance and support from the treatment program.

Outpatient Programs

Outpatient treatment programs are much less restrictive than other alternatives, often requiring patients to receive treatment only once or twice weekly, thus patients referred to these programs should have sufficient resources and social support to be successful. This option is most suitable for patients in the early stages of addiction who have no other psychiatric co-morbidities.

12-Step Programs

12-Step program support groups, such as Alcholics Anonymous (AA) or Narcotics Anonymous (NA), play an integral role in supporting patients who have completed inpatient or outpatient treatment programs, and may be appropriate for some low-risk patients as a first line approach. These programs usually consist of at least weekly group meetings and continue for 6 to 12 months.

Pharmacotherapy

Pharmacotherapy can be used to augment the behavioral therapy provided in substance abuse treatment programs. Currently, a variety of FDA approved pharmacological treatment options exist for alcohol and opioid dependence. The selection of the most appropriate agent depends on the needs and circumstances of the individual and the phase of treatment they are in. The following discusses the various pharmacologic treatment options.
Benzodiazepines

Benzodiazepines are recommended for treatment of alcohol withdrawal in the inpatient and outpatient settings. A “symptom triggered” regimen is recommended for patients closely monitored in hospital or residential facilities, while a fixed dose regimen is recommended for routine use in the outpatient setting. Long-acting benzodiazepines, such as chlordiazepoxide or diazepam, are also the drugs of choice for primary and secondary prevention of alcohol withdrawal related seizures and delirium. Benzodiazepines are not indicated for long-term management of alcohol abuse.19

Acamprosate

Acamprosate is a functional glutamanergic NMDA antagonist which is moderately effective in reducing the risk of relapse in alcoholic patients after detoxification. It is recommended that acamprosate therapy begin as soon as possible after detoxification and continue for at least one year, provided the patient is benefiting and remaining abstinent. Acamprosate may be used in patients who start drinking again because evidence suggests it may help reduce alcohol consumption; however if alcohol use continues for greater than 4-6 weeks, it is unlikely that the patient will continue to benefit from acamprosate therapy.19

Naltrexone

Naltrexone is a non-selective opioid antagonist indicated for the prevention of relapse in alcoholics and highly motivated opioid abusers. Evidence supports its use in alcoholic patients as it can reduce cravings and block dopaminergic activity, thus reducing alcohol’s rewarding effects.5,19 Naltrexone is recommended for patients who have completed detoxification, however it can be safely used in patients who continue to drink.19

Naltrexone also blocks the effects of other opioid agonists, preventing the euphoria and sedation associated with opioid abuse. Naltrexone has demonstrated efficacy in patients who are highly motivated to remain abstinent (such as healthcare providers) but has not been shown to be effective for opioid addiction in other groups.5,19 Naltrexone should not be used in patients who require opioids for pain control, and can precipitate withdrawal in patients who are currently taking opioids.5,19

Disulfiram

Disulfiram blocks the conversion of acetaldehyde (a metabolite of ethanol) to acetic acid, resulting in the accumulation of acetaldehyde. Accumulated acetaldehyde causes unpleasant side-effects (flushing, nausea, heart palpitations) which can act as a deterrent to drinking. Studies demonstrate that disulfiram is generally safe for most patients, however efficacy depends highly on compliance. To optimize medication adherence and efficacy, witnessed disulfiram intake is recommended for patients who have demonstrated nonadherence. Disulfiram is recommended as a second line option for patients who have failed therapy with acamprosate or naltrexone. This medication should not be used in patients who have not completed detoxification.19

Methadone

Methadone is an opioid agonist approved for use in acute opioid withdrawal and in chronic maintenance therapy. At tapered doses, methadone is effective in reducing withdrawal symptoms; alternatively, stable doses may be used for long-term management.5 The goal of methadone maintenance therapy (MMT) is the reduction of illicit drug use, retention in a treatment program, and improved mental and physical health.19 MMT may be integrated into a long-term treatment plan where the ultimate goal is complete abstinence. Patients requiring MMT should be referred to a reputable Opioid Treatment Program (OTP) as MMT must be provided by a federally approved organization in accordance with standards developed by the Substance Abuse and Mental Health Services Administration.20-21

Buprenorphine

Buprenorphine is a partial opioid agonist indicated for long-term maintenance treatment of opioid addiction and for management of opioid withdrawal symptoms. Evidence suggests that tapered doses of buprenorphine are as effective as tapered methadone in the management of acute opioid withdrawal.19 One benefit of buprenorphine therapy is that it can be prescribed in the primary care setting.22 Because buprenorphine has a lower potential for abuse compared to methadone, the FDA permits buprenorphine to be prescribed and dispensed outside of OTP programs.22 Prescribing of
buprenorphine is restricted to prescribers who have completed training with the Center for Substance Abuse Treatment and Drug Enforcement Administration.\(^5\)

Buprenorphine is available by itself (formerly known as Subutex\(^®\)) and in combination with naloxone (Suboxone\(^®\)) to prevent diversion or abuse.\(^{5,21-22}\) Naloxone (Narcan\(^®\), Evzio\(^®\)) is also available as a single agent. Since naloxone can precipitate withdrawal, the buprenorphine/naloxone combination is not recommended for induction therapy in patients who are actively using long-acting opioids or MMT. Buprenorphine monotherapy is appropriate in these patients; however all patients should be transitioned to the buprenorphine/naloxone combination as soon as possible for maintenance therapy.\(^{21}\)

**Conclusion**

This review covers many options for the management of an individual with substance abuse issues. There is no one size fits all treatment strategy, however most experts believe that a strong 12 Step program is always beneficial. Appropriate therapies need to be tailored to individual patient situations and needs. More complicated patients may benefit from consultation or treatment by an addiction specialist.

**References**


To report medical fraud, contact the Medicaid Quality Assurance Bureau. NM Medicaid Fraud @state.nm.us or (505) 827-3100 or Fax (505) 827-3165. We appreciate your continued support of our efforts to encourage quality care for our Medicaid clients.

Questions and/or comments about this newsletter may be directed to Diana Moya, R.Ph. at (505) 827-3174 or DianaJ.Moya@state.nm.us. DUR newsletters are posted on the New Mexico Human Services Department website: http://www.hsd.state.nm.us/providers/utilization-review.aspx.