Magellan Substance Use Disorders Identification Tip Sheet

Screening

Among the best clinical settings for early screening, detection and intervention of substance abuse disorders are primary care offices, trauma centers, and emergency rooms. Members with positive screens through any of the following methods should be further evaluated. For the initial screening, the primary care or other clinician can:

- **Administer a substance use screening tool**, such as the Alcohol Use Disorders Identification Test (AUDIT)[1] or the CAGE-AID.[2] The first three questions of the AUDIT can be used alone to detect up to 80 percent of patients with mild to moderate alcohol use problems. The CAGE-AID is more appropriate to identify severe alcohol and drug use problems, including dependence. The four-item CAGE is the most popular screening test used in primary care.[3] (AUDIT and CAGE can be accessed at http://pubs.niaaa.nih.gov/publications/aa65/AA65.htm.)
- **Administer a single-question screen**:
  "When was the last time you had more than four drinks (women) or five drinks (men) in one day?"
  Up to 86 percent of those with alcohol-use problems can be identified with this question. A positive result is "one or more times in the past three months."[4]
- **Look for warning signs suggesting substance use disorders**, including repeated complaints of physical discomfort, elevated vital signs, frequent accidents, sleep disturbances, fatigue, and unintentional weight loss.
- **Assessing Adolescents:** Signs of substance use disorders in adolescents may include involvement in the juvenile justice system, truancy or poor grades, family conflict, and injuries requiring emergency room visits. If alcohol use is a problem in adolescents, illegal drug use is 11 times more likely to also be a problem. The CRAFFT test was developed specifically for screening adolescents.[5] (Access at http://www.netwellness.org/healthtopics/substanceabuse/crafft.cfm).
- **Assessing Older Adults:** Substance use disorders in older adults are under-diagnosed. One in three older adults who abuse alcohol develops the problem after age 60. Older adults require less alcohol to become intoxicated, and can easily hide problematic alcohol use due to lower demands for social and occupational functioning.

Treatment

- Even a 15-minute counseling intervention by a primary care physician or other clinician can be helpful in reducing problem drinking. In one study, a single discussion on the risks of alcohol abuse, goal setting for cutting back, and one follow-up discussion reduced alcohol consumption by 30 percent and occasions of binge-drinking over a 12 month period.[6,7]
- Pharmacotherapy interventions can be helpful during all phases of treatment (see Table). Medications are best used in combination with psychotherapy or counseling interventions.[8,9]
- For adolescents and patients on methadone maintenance, family therapy has demonstrated effectiveness.
- Psychosocial treatment emphasizing social support is effective for older adults at risk of relapse due to loneliness and social isolation.
- Self-help groups, such as Alcoholics Anonymous (www.alcoholics-anonymous.org), Narcotics Anonymous (www.na.org), or Al-anon (www.al-anon.alateen.org) can be helpful.

References

1. Babor TF, Higgins-Biddle JC, Saunders JB, Monteiro MG. (2001) *AUDIT: The Alcohol Use Disorders Identification Test: guidelines for use in primary health care.* Geneva: World Health Organization Dept. of Mental Health and Substance Dependence. Edition WM 274 2001SC, 2nd Ed., Doc # WHO/MSD/MSb/01.6a.
2. Brown RL, Rounds LA. (1995) Conjoint screening questionnaires for alcohol and other drug abuse: criterion validity in a primary care practice. *Wisconsin Medical Journal* 94:135-40.
3. U.S. Preventive Services Task Force. (2004) Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse: Recommendation Statement. *Annals of Internal Medicine* 140: 554-556.
4. Williams R, Vinson DC. (2001) Validation of a single screening question for problem drinking. *Journal of Family Practice* 50:307-312.
5. Knight JR, Sherritt L, Shrier LA, Sion KH, Chang G. (2002) Validity of the CRAFFT Substance Abuse Screening Test Among Adolescent Clinic Patients. *Arch Pediatr Adoles Med* 156: 607-614.
6. Fleming MF, Mundt MP, French MT, Manwell, LB, Stauffacher EA, Barry KL. (2002) Brief physician advice for problem drinkers: long-term efficacy and benefit-cost analysis. *Alcoholism Clinical Experience and Research* 26:36-43.
7. Whitlock EP, Polen MR, Green CA, Orleans T, Klein J. (2004) Behavioral Counseling Interventions in Primary Care to Reduce Risky/Harmful Alcohol Use by Adults. *Annals of Internal Medicine* 140:558-569.
8. National Institute on Alcohol Abuse and Alcoholism. (2007) *Helping Patients Who Drink Too Much: A Clinician's Guide.* Bethesda: http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/guide.pdf
9. Magellan Health Services. (2008) *Clinical Practice Guideline for the Treatment of Adults with Substance Use Disorders.* www.MagellanHealth.com/provider.

Pharmacotherapy for Substance Use Disorders

Name	***Indications***	***Prescribing (Starting dose, range, baseline labs)***	***Advantages***	***Risks***
Disulfiram (Antabuse)	Helps prevent relapse of alcohol abuse. Ingested in combination with alcohol, it causes nausea, vomiting, headache and flushing.	Induction: 250-500 mg QD for 2 weeks Maintenance: 250 mg QD. Range is 125-500mg QD Labs: liver function tests (LFT)s initially, then at 10-14 days, every six months thereafter.	Useful in patients with a history of relapse, current motivation, and a witnessed ingestion program.	Metallic after-taste; dermatitis; severe reaction or death could result from alcohol ingestion.
Naltrexone (Revia)	Helps with alcohol cravings, possibly by reducing the reinforcing effects of alcohol. Also used to block the effects of opiates.	Induction for opiate dependence: Be sure patient is opioid-free for 7-10 days; confirm by urine drug screen (UDS). Start 25 mg. If no withdrawal reaction, increase by another 25 mg. Continue at 50 mg QD. Induction for alcohol dependence: Start at 50 mg QD. Continue at 50 mg QD.	Very useful in the acute recovery phase of alcohol dependence (first 12 weeks).	Nausea; abdominal pain; constipation; dizziness; headache; anxiety; fatigue.
Vivitrol (naltrexone for extended-release injectable suspension)	Vivitrol is used for alcohol abuse only and should not be used if patient has opioid dependence.	Vivitrol: Be sure patient is alcohol-free for at least a week. IM dose – 380 mg monthly Labs: UDS, LFTs prior to induction and every six months thereafter.	Vivitrol may be easier for patients recovering from alcohol dependence to use consistently.	Vivitrol should not be used by a patient who is also using opioids such as heroin.
Acamprosate (Campral)	Helps with alcohol cravings, possibly by reducing intensity of prolonged withdrawal syndrome. Benefit emerges after 30 to 90 days.	Induction: Begin two, 333 mg tablets, *tid*. Patients with renal impairment may need dosage reduction. Maintenance: 333 mg, *tid*. Labs: blood urea nitrogen (BUN), creatinine, creatinine-clearance.	Reasonably safe in patients with mild to moderate hepatic impairment (excreted via the kidneys).	Diarrhea and increased libido.
Topiramate (Topamax)	Helps patients reduce drinking, avoid relapse to heavy drinking, achieve and maintain abstinence, or gain a combination of these effects. (Note: the FDA has not approved the drug for this indication)	Induction: Initial dose 25 mg at bedtime. Increase dose by 25-50 mg daily each week, divided into morning and evening doses. Maintenance: Target dose is 200 mg per day total, but patients unable to tolerate that dose may respond to lower doses. Labs: Monitor renal function, serum electrolytes and bicarbonate.	Can be used in patients who are still drinking.	Paresthesias, taste perversion, anorexia and weight loss, somnolence, cognitive dysfunction.

Buprenorphrine Hydrochloride (Subutex) Buprenorphine Hydrochloride and Naloxone Hydrochloride (Suboxone)	Can be used for office-based detoxification from opiates and maintenance treatment for opiate dependency by specially trained and registered physicians.	Induction: Begin 8 mg SL on day one, 16 mg day two. Maintenance: Continue 16 mg SL QD thereafter. Range is 4-24 mg QD Labs: UDS at induction, and monthly thereafter. LFTs on induction, every six months thereafter.	Buprenorphine can prevent symptoms of withdrawal in patients addicted to opiates; an alternative maintenance treatment to methadone.	Dizziness; nausea; respiratory depression

For more information, please consult the NIAAA publication titled "Helping Patients Who Drink Too Much: A Clinician's Guide," December 2007 Update; Johnson BA, et al. Topiramate for Treating Alcohol Dependence, *JAMA*, October 10, 2007, Vol. 298, No. 14; Center for Substance Abuse Treatment, *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*, A Treatment Improvement Protocol (TIP) Series 40, DHHS Publication No. (SMA) 04-3939, Rockville, MD, Substance Abuse and Mental Health Services Administration, 2004; and Magellan's *Clinical Practice Guideline for the Treatment of Adults with Substance Use Disorders.*

These guidelines are not intended to replace a practitioner's clinical judgment. They are designed to provide information and to assist practitioners with decisions regarding care. The guidelines are not intended to define a standard of care or exclusive course of treatment. Health care practitioners using these guidelines are responsible for considering their patients' particular situation in evaluating the appropriateness of these guidelines.

This information is not a statement of benefits. Benefits may vary and individual coverage will need to be verified by the Plan.