



## The Michigan InterPlan Behavioral Health Work Group Guideline for *Specialists* For Substance Use Disorders

The following guidelines apply to the Diagnosis and Management of Substance Use Disorders by the Behavioral Medicine Specialist which may include Psychiatrists, Nurse Clinicians, Social Workers, Psychologists, and Counselors

Eligible Population	Key Components	Recommendation and Level of Evidence	Frequency
Adolescents and Adults who have been referred and those who have self-referred to specialty care.	Screening	<ul style="list-style-type: none"> <li>• Maintain high index of suspicion for substance use in all individuals referred to behavioral health. [C]</li> <li>• <b>Ask all patients about their past and current use of substances</b></li> </ul> <p><b>A tool should be used to screen for substance use. The following tools are recommended: Alcohol Use Disorders Identification Test (AUDIT), CAGE, TWEAK (for pregnant women), the Michigan Alcohol Screening Test (MAST), and AOD (Alcohol and Other Drugs)</b></p>	<ul style="list-style-type: none"> <li>• Initial visit</li> <li>• Signs of negative life changes</li> <li>• Indicators of limited progress or symptom reduction</li> </ul>
Adolescents and Adults who have been referred and those who have self-referred to specialty care.	Assessment/Triage	<ul style="list-style-type: none"> <li>• Identify comorbid psychiatric and medical conditions, and assess for suicidality and past attempts.</li> <li>• Identify current problems, relevant history, and life context incl. personal stressors (e.g. loss of job).</li> <li>• Review substance abuse treatment history including episodes of medical detoxification.</li> <li>• Assess family history, social support, and availability of substance in the immediate environment.</li> <li>• Complete an assessment tool, e.g. Addiction Severity Index.</li> <li>• Integrate and prioritize biopsychosocial assessment information as a basis for diagnosis and treatment recommendations.</li> <li>• Obtain urine drug screen and other lab tests as appropriate</li> </ul> <p>The patient's culture and language must be accounted for in screening and treatment to assure that patients receive services tailored to their needs.</p>	<ul style="list-style-type: none"> <li>• Initial visit</li> <li>• As needed</li> </ul>
A diagnosis of either substance dependence or abuse is made when symptoms indicate a maladaptive pattern of substance use resulting in clinically significant impairment or distress.			
Patients with Substance Use Disorders	Diagnosis	<p>Please refer to DSM-IV-TR for diagnostic criteria.</p> <p><b>The diagnosis of <u>abuse</u> is made when the distress is manifested by one (or more) of the following occurring within a 12-month period:</b></p> <ul style="list-style-type: none"> <li>• Recurrent substance use resulting in a failure to fulfill major role obligations.</li> <li>• Recurrent use in situations that are physically hazardous.</li> <li>• Substance-related legal problems.</li> <li>• Use despite having persistent or recurrent social or interpersonal problems. (Symptoms do not meet criteria of dependence.)</li> </ul>	<ul style="list-style-type: none"> <li>• Initial visit</li> <li>• No evidence of progress and/or symptom improvement</li> <li>• Significant life changes</li> </ul>

Levels of Evidence for the most significant recommendations: A= randomized controlled trails; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

*This guideline represents core management steps. Individual patient considerations and advances in medical science may supercede or modify these recommendations.*

Patients with Substance Use Disorders	Diagnosis Con't	<p><b>The diagnosis of <u>dependence</u> is made when the distress is manifested by three (or more) of the following occurring within a 12-month period:</b></p> <ul style="list-style-type: none"> <li>• Tolerance.</li> <li>• Withdrawal.</li> <li>• Substance use in larger amounts or over a longer period than was intended.</li> <li>• Persistent desire or unsuccessful efforts to cut down.</li> <li>• Great deal of time is spent in activities necessary to obtain the substance.</li> <li>• Reduction in social, occupational or recreational activities because of use.</li> <li>• Use continues despite knowledge of problems.</li> </ul>	<ul style="list-style-type: none"> <li>• Evaluate for dependence at initial visit</li> <li>• At subsequent visits if a diagnosis of abuse was made at initial or prior follow-up visits</li> </ul>
	<ul style="list-style-type: none"> <li>• Treatment</li> </ul>	<ul style="list-style-type: none"> <li>• The appropriate specialist should</li> <li>• Provide a brief intervention <b>[A]</b> that focuses on: (1) Providing feedback about normative use the role of substances in current medical, psychiatric, or psychosocial problems; (2) Assessing &amp; enhancing motivation for change; (3) Negotiating goals &amp; strategies for reducing consumption/abstaining, while also providing direct advice; (4) Emphasizing personal responsibility &amp; self-efficacy; (5) Involving family members as appropriate; (6) Scheduling a follow-up appointment to monitor status &amp; changes.</li> <li>• If brief intervention does not achieve negotiated goals, then initiate or refer to addiction-focused treatment.</li> <li>• Identify the least restrictive level of initial treatment intensity that will safely help patient achieve remission, considering outpatient, intensive outpatient, partial hospitalization, or residential care.</li> <li>• Involve patient and significant others in developing a treatment plan and selecting the most appropriate treatment approach.</li> <li>• Encourage attendance at mutual self-help group meetings, e.g., Twelve-Step Meetings. <b>[D]</b></li> <li>• Ensure that member receives the appropriate number of substance abuse treatments following initial diagnosis.</li> </ul>	<ul style="list-style-type: none"> <li>• Schedule follow-up appointments to monitor patient response to treatment.</li> <li>• If a patient is newly diagnosed &amp; admitted for inpatient treatment, then upon discharge the patient should be seen within 7 days &amp; receive <u>at least</u> 2 additional substance use services/visits within 30 days of discharge <b>[D]</b></li> <li>• If the patient is newly diagnosed at an outpatient visit, a follow-up substance abuse service/visit should occur within 7-14 days &amp; 2 additional services/visits should occur within 30 days of the first follow-up visit <b>[D]</b></li> <li>• Continue regular visits for at least 3 to 6 months when risk of relapse is highest <b>[D]</b></li> </ul>
	Pharmacological Management	<ul style="list-style-type: none"> <li>• Medical detoxification should be followed by referral for intensive after-care treatment services. Pharmacotherapy to prevent relapse is adjunctive to psychosocial therapy &amp; should be conducted by or in collaboration with addiction-specialized physicians. <b>[D]</b></li> </ul>	<ul style="list-style-type: none"> <li>• Evaluate for duration of recovery.</li> </ul>

*This guideline represents core management steps. Individual patient considerations and advances in medical science may supercede or modify these recommendations.*

Patient Education/ Follow-up	<ul style="list-style-type: none"> <li>Promote abstinence or reduced use; monitor for urges and relapse</li> <li>Reinforce use of community based programs (e.g., Alcoholics Anonymous) or Employee Assistance Program, or (especially if substance dependent) a substance abuse or behavioral health specialist. <b>[D]</b></li> </ul>	<ul style="list-style-type: none"> <li>Periodic assessment for duration of treatment should be tailored to patient's individual needs.</li> </ul>
Coordination of Care	<ul style="list-style-type: none"> <li>Identify patients who either do not or no longer require specialty care and coordinate with PCP</li> <li>Refer possible comorbid med consult to PCP (diabetes, asthma, CHF) or Addictionologist. <b>[D]</b></li> <li>Provide continuity of care with PCP, including continued prescription of medications (see below)</li> <li>At discharge provider information to ensure continuation of care coordination</li> </ul>	<ul style="list-style-type: none"> <li>Alert PCP to possible comorbid medical conditions</li> </ul>

Levels of Evidence for the most significant recommendations: A= randomized controlled trails; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

**References:** (1) VA/DOD Clinical Practice Guideline for Management of Substance Use Disorders, August 2001.  
(2) "Cultural Issues in Substance Abuse". Publication of the Substance Abuse and Mental Health Services Administration.  
(3) "Diagnostic and Statistical Manual for Mental Disorders – IV-TR "Publication of the American Psychiatric Association for Mental Disorders"

### Medical Data Disclaimer

Clinical Practice Guidelines have been designed to provide information to patients, healthcare professionals, support networks, and other interested audiences. We have made great effort to provide accurate and current information. These pages are not intended to provide individual medical advice. For such advice, patients or specialists should contact a physician.

## Substance Abuse Disorder Medications

<u>DRUG</u>	<u>DOSE</u>	<u>USE/INDICATIONS</u>	<u>SPECIAL CONSIDERATIONS</u>
Naltrexone (Revia) Evidence: A	<ul style="list-style-type: none"> <li>Single dose of 50mg/day up to 100 mg/day for 3 months minimum, but effect decreases after 1 month of stopping <b>[A]</b></li> </ul>	<ul style="list-style-type: none"> <li>Antagonist therapy</li> <li>Attenuates the reinforcing effects of alcohol</li> <li>Reduces craving, helps patients remain abstinent</li> </ul>	<ul style="list-style-type: none"> <li>Do not use during pregnancy</li> <li>Do not use if severe liver or kidney disease</li> <li>May cause nausea</li> <li>Obtain signed consent to use medication</li> <li>Adjunct to addiction-focused psychosocial therapy <b>[D]</b></li> </ul>
Disulfiram (Antabuse) Evidence: D	<ul style="list-style-type: none"> <li>Single dose of 250 - 500 mg/day for 1-2 weeks</li> <li>Maintenance dose of 125-500 mg/day depending on individual need (up to 2 years with quarterly assessment)</li> </ul>	<ul style="list-style-type: none"> <li>Aversion therapy</li> <li>Effective adjunct to a comprehensive treatment program for chronic alcoholism</li> <li>Effectiveness increased by supervised administration or use of positive contingencies <b>[D]</b></li> </ul>	<ul style="list-style-type: none"> <li>Begin no less than 12 hours after last ingestion of alcohol, but only when blood or breath alcohol level = 0.</li> <li>Use caution in prescribing to patients who may ingest alcohol or pose a suicide risk: risk of dangerous reactions with alcohol ingestion</li> <li>Do not use if patient has psychotic symptoms</li> <li>Obtain signed consent to use medication</li> </ul>

This guideline represents core management steps. Individual patient considerations and advances in medical science may supercede or modify these recommendations.

			<ul style="list-style-type: none"> <li>• Baseline and follow-up transaminase tests to monitor hepatic function (hold if LFTs &gt;3X NL)</li> <li>• Verify that patient is not taking other medications including oral and topical that may interact adversely</li> </ul>
<p>Buprenorphine (Suboxone)</p> <p>Evidence: A</p>	<ul style="list-style-type: none"> <li>• Physician must have approval from the Drug Enforcement Administration to prescribe this medication.</li> <li>• Up to 16-32mg/day &amp; tapered to 0mg for detox or lowest effective dose for maintenance.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Opioid partial agonist</li> <li>▪ Opioid detoxification</li> <li>▪ Opioid maintenance therapy</li> <li>▪ Displays both agonist and antagonist activity</li> </ul>	<ul style="list-style-type: none"> <li>▪ Patient should not be taking sedative medications.</li> <li>▪ Obtain signed consent to use medication</li> <li>▪ May cause CNS Depression</li> <li>▪ CNS Depressants may enhance the CNS depressant effect of Ethyl Alcohol</li> <li>▪ May cause headaches and nausea</li> </ul>
<p>Acamprosate (Campral)</p> <p>Evidence: A</p>	<ul style="list-style-type: none"> <li>• 666 mg po TID</li> <li>• May reduce dose by one-third to one-half if not tolerated.</li> <li>• Supplied as 333 mg pills</li> </ul>	<ul style="list-style-type: none"> <li>▪ glutamate antagonist</li> <li>▪ GABA modulator</li> <li>▪ Helps patients remain abstinent</li> </ul>	<ul style="list-style-type: none"> <li>▪ Adjunct to addiction-focused psychosocial therapy <b>[D]</b></li> <li>▪ Obtain signed consent to use medication</li> <li>▪ Do not use if severe kidney disease</li> <li>▪ May cause nausea or diarrhea</li> <li>▪ Requires a period of alcohol withdrawal</li> <li>▪ Use with caution in suicidal ideation</li> <li>▪ Monitor for depression and or suicidal thinking</li> <li>▪ Not studied for safety and efficiency in children</li> </ul>
<p>Methadone</p>	<ul style="list-style-type: none"> <li>• Titrated to replace the amount of the opioid</li> <li>• Once stabilized may gradually reduce the dose by 10% per day every 10 to 14 days</li> <li>• Dose should not exceed 40 mg of methadone the 1<sup>st</sup> day.</li> <li>• Must be dispensed according to guidelines established by SAMHSA CSAT</li> </ul>	<ul style="list-style-type: none"> <li>• Detoxification and maintenance treatment of opioid addiction</li> <li>• Binds to opiate receptors in the CNS</li> <li>▪ Must be part of an FDA approved program</li> <li>▪ <a href="http://dpt2.samhsa.gov/treatment/">http://dpt2.samhsa.gov/treatment/</a></li> </ul>	<ul style="list-style-type: none"> <li>• Obtain signed consent to use medication</li> <li>• May cause nausea and sweating</li> <li>• May potentiate sedative of other medications</li> <li>• Interacts with CYP3A4 Inhibitors</li> <li>▪ Oral dose for detox/maintenance is dissolved in and administered in juice or water.</li> </ul>