

Magellan Substance-Use Disorders Identification Overview



Screening

Among the best clinical settings for early screening, detection, and intervention of substance-use disorders are primary care offices, trauma centers, and emergency rooms. Magellan Behavioral Health recommends that members with positive screens through any of the following methods should be further evaluated. For the initial screening, the primary care provider (PCP) or other clinician can use the following screening tools recommended by Magellan:

- Administer a substance-use screening tool, such as the Alcohol-Use Disorders Identification Test (AUDIT) or the CAGE-AID.^{1,2} 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. Document results in the medical record. The four-item CAGE-AID is the most popular screening test used in primary care.³ Information about the AUDIT and CAGE-AID tools is available online 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 be a problem also. The CRAFFT test was developed specifically for screening adolescents.⁵ The CRAFFT test is available at: 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.

Types of treatment

- Screening and discussion by a PCP and even a 15-minute counseling intervention by a behavioral health clinician can be helpful in reducing problem drinking. In one study, a single discussion about 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 Pharmacotherapy for substance-use disorders 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

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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. Archives of Pediatrics & Adolescent Medicine 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. www.niaaa.nih.gov/publications/EducationTrainingMaterials/guide.htm
9. Magellan Health Services. (2008) Clinical Practice Guideline for the Treatment of Adults with Substance Use Disorders. www.magellanhealth.com/provider

Adapted for use by Independence Blue Cross from the Magellan Behavioral Health Substance-Use Disorders Tip Sheet

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Pharmacotherapy for substance-use disorders

Drug 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 daily for 2 weeks. Maintenance: 250 mg daily. Range is 125 – 500 mg daily. Labs: Liver function tests (LFTs) initially, then at 10 – 14 days for every six months thereafter.	Useful in patients with a history of relapse, current motivation, and a witnessed ingestion program.	Metallic aftertaste; 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 daily. Induction for alcohol dependence: Start at 50 mg daily. Continue at 50 mg daily. Labs: UDS, LFTs prior to induction and every six months thereafter.	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 dependence <i>only</i> (should not be used if patient has opioid dependence). Be sure patient is alcohol-free for at least a week.	Induction/Maintenance: Be sure patient is alcohol-free for at least 7 days. Intramuscular dose, 380 mg monthly. Labs: UDS, LFTs prior to induction and every six months thereafter.	Vivitrol is/may be easier for people recovering from alcohol dependence to use consistently.	Vivitrol should not be used by anyone who's also using opiates, such as heroin. Injection site reactions can result from Vivitrol. Injection site reactions can include any of the following: pain, tenderness, induration (hardening of the skin), or pruritus (itching).
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, three times a day. Patients with renal impairment may need dosage reduction. Maintenance: 333 mg, three times a day. 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 change, anorexia and weight loss, somnolence, cognitive dysfunction
Buprenorphine 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 sublingual tablets on day one; 16 mg day two. Maintenance: Continue 16 mg sublingual tablets daily thereafter. Range is 4 – 24 mg daily. 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.

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