Substance Use Disorders Identification Tip Sheet

Screening

The best clinical settings for early screening, detection and intervention of substance use disorders are primary care offices, trauma centers, and emergency rooms. Members with positive screens obtained through any of the methods discussed below require further evaluation. For the initial screening, the primary care or other clinician can utilize tools and techniques discussed below.

- **Administer a substance use screening tool**, such as the Alcohol Use Disorders Identification Test (AUDIT),[1] AUDIT-C (Consumption) 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 Audit-C, a three-item modified version of the AUDIT instrument, screens for frequency of alcohol consumption, quantity of alcohol consumption, and the quantity of alcohol consumption on a single occurrence. The four-item CAGE alcohol use questionnaire is the most popular screening test used in primary care.[3] The CAGE-AID expands the focus of each item of the CAGE to include both alcohol and other drugs and identifies severe alcohol and drug use problems, including dependence. (AUDIT and CAGE are available at http://pubs.niaaa.nih.gov/publications/aa65/AA65.htm.)
- **Administer a single-question screen**: *"How many times in the past year have you consumed five or more drinks in a day (for men) and four or more drinks in a day (for women)?"* or "*How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?"*
  Single-screening questions, as well as longer screening tools, can identify substance dependence and are useful in primary care settings. A recent study found that 88 percent of those with alcohol dependence and 97 percent of those with drug dependence were identified by the single-screening question.[4]
- **Look for warning signs suggesting substance use disorders**, including repeated complaints of physical discomfort, elevated vital signs, frequent accidents, sleep disturbances, fatigue, memory impairment 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, diminished interests in hobbies or sports, irritability, lying, carelessness about appearance, family conflict, injuries requiring emergency room visits, etc. When alcohol use is a problem in adolescents, illegal drug use is more likely also to be a problem. The CRAFFT test was developed specifically for screening adolescents.[5]
- **Assessing older adults**: Substance use disorders in older adults are under-diagnosed. Approximately one in three older adults who abuse alcohol developed the problem after age 60. Older adults require less alcohol to become intoxicated, and hide problematic alcohol use due to lower demands for social and occupational functioning.

Treatment

- A systematic review and meta-analysis for the U.S. Preventive Services Task Force found that behavioral counseling interventions improve alcohol consumption with brief multicontact interventions (i.e., 10-15 minute per contact) delivered by a primary care provider, a nurse or health educator.[6] In another 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.[7,8]
- Pharmacotherapy interventions can be helpful during all phases of treatment (see Table). Medications are best used in combination with psychotherapy or counseling interventions.[9,10] Medication-Assisted Treatment (MAT) has been shown to be effective in the treatment of alcohol dependence with Food and Drug Administration (FDA)-approved drugs (e.g., disulfiram, naltrexone, acamprosate) and treatment of opioid dependence with methadone, naltrexone, buprenorphine-naloxone, and naloxone hydrochloride injection (for emergency treatment of overdose).[11]
- For adolescents and adult 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) and 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. Davies DA, Winter MR, Smith PC. The ability of single screening questions for unhealthy alcohol and other drug use to identify substance dependence in primary care. J Stud Alcohol Drugs 2014, 75(1): 153-7.
5. Knight JR, Sherritt L, Shrier LA, Harris SK, Chang G. (2002). Validity of the CRAFFT Substance Abuse Screening Test Among Adolescent Clinic Patients. *Arch Pediatr Adoles Med 1*56: 607-614.
6. Jonas DE, Garbutt JC, Amick HR, Brown Jm, Brownley KA, Council CL, Viera AJ, Wilkins TM, Schwart CJ, Richmond EM, Yeatts J, Evans TS, Wood SD, Harris RP. Behavioral counseling after screening for alcohol misuse in primary care: a systematic review and meta-analysis for the U.S. Preventive Services Task Force. Ann Intern Med 2012; accessed online at http://annals.org/article.aspx?articleid=1361859.
7. 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.
8. 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.
9. National Institute on Alcohol Abuse and Alcoholism. (2007) *Helping Patients Who Drink Too Much: A Clinician's Guide*. October 2008 Update http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/guide.pdf.
10. Magellan Healthcare. (2012) *Clinical Practice Guideline for the Treatment of Patients with Substance Use Disorders.* www.MagellanHealth.com/provider.
11. U.S. Department of Health and Human Services. SAMHSA. Medication-assisted treatment for substance use disorders. Accessed online November 15, 2012 at http://dpt.samhsa.gov/medications/medsindex.aspx.
12. Johnson BA, Rosenthal N, Capece JA, Wiegand F, Mao L, Beyers K, McKay A, Ait-Daoud N, Anton RF, Ciraulo DA, Kranzler HR, Mann K, O'Malley SS, Swift RM for the Topiramate for Alcoholism Advisory Board and the Topiramate for Alcoholism Study Group. Topiramate for Treating Alcohol Dependence. *Journal of the American Medical Association*, October 10, 2007. Vol. 298, No. 14.
13. Johnson BA. Medication Treatment of Different Types of Alcoholism. Am J Psychiatry 2010; 167:630-639. Vivitrol™ (naltrexone for extended-release injectable suspension) for the treatment of Opioid Addiction and Alcohol Dependence. Magellan Technology Assessment Report (Revised May 2011).

Pharmacotherapy for Substance Use Disorders

Name	*Indications*	*Prescribing (Starting dose, range, baseline labs)*	*Advantages*	*Risks*
Disulfiram (Antabuse)	Helps prevent relapse of alcohol abuse. Administer only after abstained from alcohol for 12 hours. 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 125-500mg daily. **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, seizures, 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 up to 12 weeks.	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)	Treatment of alcohol dependence in patients who are able to abstain from alcohol in an outpatient setting prior to initiation of treatment with Vivitrol. Prevention of relapse following opioid detoxification.	**380 mg delivered as an intramuscular gluteal injection every 4 weeks; alternating buttocks for each subsequent injection. Product has to be refrigerated.** **Alcohol Dependence:** Be sure patient is alcohol-free for at least a week. **Opioid Dependence**: Be sure patient is opioid-free for 7-10 days prior to administering. **Labs:** UDS, LFTs prior to induction and every six months thereafter.	Vivitrol™ may be easier for patients recovering from alcohol dependence to use consistently. The once-monthly formulation addresses the critical problem of adherence in the opioid addicted population. Also addresses problems encountered with substitution therapy – i.e., access, acceptability, diversion, illicit use and overdose deaths.	Vivitrol™ should not be used by a patient who is using opioids such as heroin or opioid analgesics to avoid precipitation of opioid withdrawal that may be severe enough to require hospitalization. Patients may experience injection site reactions. Cases of hepatotoxicty and clinically significant liver dysfunction were observed in patients taking Vivitrol.
Naloxone hydrochloride injection (Evzio)	To reverse opioid overdose; an emergency treatment.	Pre-filled auto-injector with 0.4 mg/0.4 ml naloxone hydrochloride solution; administer into the anterolateral aspect of the thigh, through clothing if necessary (intra- muscular or subcutaneous use only); call 911 - emergency medical services (EMS) prior to or at time of injection as emergency medical care is needed immediately after use; additional doses every 2-3 minutes while awaiting medical assistance.	For emergency treatment of opioid overdose; it rapidly delivers a dose for treatment of manifestations of overdose: respiratory and/or central nervous system depression.	Acute withdrawal syndrome may result when abrupt /complete reversal of opioid effects, especially in newborns of mothers physically dependent on opioids.

Name	*Indications*	*Prescribing (Starting dose, range, baseline labs)*	*Advantages*	*Risks*
Naloxone hydrochloride nasal spray (Narcan nasal spray)	To temporarily stop or reverse the effects of an opioid overdose.	Administer a single spray into one nostril; administer additional doses of nasal spray using new nasal spray with each dose if no response or relapse into respiratory depression; additional doses may be administered every 2-3 minutes until arrival of emergency medical assistance.	User-friendly, needle-free; can be administered by first responders, family members, caregivers.	Sudden opioid withdrawal symptoms, e.g., body aches, diarrhea, increased heart rate, fever.
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.
Baclofen (Lioresal, Kemstro)	Baclofen has shown promise in initial clinical trials for treating severe alcohol dependence. Baclofen is administered to patients who have already become abstinent. There is also some empirical evidence that baclofen is comparable to diazepam in reducing uncomplicated alcohol withdrawal symptoms.	**Induction:** Begin 5 mg *tid* for the first three days and then to a ceiling dosage of 10 mg tid. **Maintenance:** Continue 10 mg tid. **Labs:** aspartate aminotransferase (AST), alkaline phosphatase or glucose levels for patients with liver diseases or diabetes mellitus.	Particularly well suited for patients with liver impairment as it is excreted primarily through the kidney.	Common adverse side effects: headaches, insomnia, nausea, hypotension, urinary frequency. Rare side effects include visual abnormalities and excitement.
Buprenorphine Hydrochloride (Subutex)	Can be used for office-based detoxification from opiates and maintenance treatment for opiate dependency by specially trained and registered physicians. Preferred for use ONLY during induction since it does not contain naloxone. The use of Subutex for unsupervised administration should be limited to those patients who cannot tolerate Suboxone.	**Induction:** Day 1, 8 mg sublingual tablet daily, Day 2, 16 mg sublingual tablet daily. From Day 3 onward, patients should receive either Suboxone sublingual tablet or subutex at the same buprenorphine dose as Day 2. **Maintenance:** 16 mg sublingual tablet daily. Range is 4-24 mg daily. **Labs:** UDS at induction, and monthly thereafter. LFTs on induction, every six months thereafter.	Preferred over combination buprenorphine/naloxone products for treatment of opioid dependence in pregnant women. Sublingual tablet. Buprenorphine can prevent symptoms of withdrawal in patients addicted to opiates. Alternative maintenance treatment to methadone.	Headache, nausea, vomiting, hyperhidrosis, constipation, signs and symptoms of withdrawal, insomnia, and pain.

Name	*Indications*	*Prescribing (Starting dose, range, baseline labs)*	*Advantages*	*Risks*
Buprenorphine Hydrochloride and **Naloxone Hydrochloride** (Suboxone)	Treatment of opioid dependence.	**Induction:** Day 1, administer up to 8 mg/ 2 mg Suboxone (in divided doses). On day 2, administer up to 16 mg / 4 mg of Suboxone as a single dose. **Maintenance:** Recommended target dose is 16 mg/ 4 mg in single dose. Range can be between 4 mg/ 1 mg and 24 mg/ 6 mg daily. Doses over 24 mg/ 6 mg have not been demonstrated to provide a clinical advantage. **Labs:** UDS at induction, and monthly thereafter. LFTs on induction, every six months thereafter. **Buccal or Sublingual Administration:** Place one film under the tongue, close to the base on the left or right side, and allow to completely dissolve OR place on film on the inside of the left or right cheek and allow to completely dissolve. Can only be prescribed by prescribers who are certified under the Drug Addiction Treatment Act of 2000 and who have been assigned a unique identification number ("X" number).	Sublingual film. Alternative maintenance treatment to methadone. Allows home based treatment.	Oral hypoesthesia, glossodynia, oral mucosal erythema, headache, nausea, vomiting, hyperhidrosis, constipation, signs and symptoms of withdrawal, insomnia, pain, and peripheral edema.
Buprenorphine Hydrochloride and **Naloxone Hydrochloride** (Bunavail)	Maintenance treatment of opioid dependence.	**Maintenance**: Recommended target dose of 8.4 mg/ 1.4 mg as a single daily dose. Range of 2.1 mg/ 0.2 mg to 12.6 mg/ 2.1 mg per day. Dosages higher than this have not been demonstrated to provide any clinical advantage. Bunavail 4.2 mg/ 0.7 mg is equal to Suboxone 8 mg/ 2 mg. Should be used in patients who have been initially inducted using buprenorphine sublingual tablets. **Labs:** UDS at induction, and monthly thereafter. LFTs on induction, every six months thereafter. **Administration:** Use the tongue to wet the inside of the cheek or rinse the mouth with	Buccal film. Alternative maintenance treatment to methadone. Allows home based treatment.	Headache, nausea, vomiting, hyperhidrosis, constipation, signs and symptoms of withdrawal, insomnia, and pain. NOT for induction.

Name	Indications	Prescribing (Starting dose, range, baseline labs)	Advantages	Risks
		water to moisten the area immediately before placement of Bunavail. Open the Bunavail package immediately prior to use. Hold the Bunavail film with clean, dry fingers with the text facing up. Place the side of the Bunavail film with the text (BN2, BN4, or BN6) against the inside of the cheek. Press and hold the film in place for 5 seconds. If two films are required for one dose, the patient should place one film on the inside of one cheek and the other film on the inside of the other cheek at one time. For doses requiring multiple films, no more than two films should be applied to the inside of one cheek at a time. Can only be prescribed by prescribers who are certified under the Drug Addiction Treatment Act of 2000 and who have been assigned a unique identification number ("X" number).		
Buprenorphine Hydrochloride and **Naloxone Hydrochloride** (Zubsolv)	Treatment of opioid dependence.	**Induction:** For patients dependent on short-acting opioid products who are in moderate opioid withdrawal; on Day 1, administer up to 5.7 mg/1.4 mg of Zubsolv sublingual tablet (in divided doses). On Day 2, administer a single daily dose of up to a total dose of 11.4 mg/2.9 mg of Zubsolv sublingual tablet. **Maintenance**: Target dose is 11.4mg/2.9 mg daily. Range is between 2.9 mg/ 0.71 mg and 17.2 mg / 4.2 mg daily. Doses higher than this have not been demonstrated to provide any clinical advantage. Zubsolv 5.7 mg/ 2.4 mg is equal to Suboxone 8 mg/2 mg. **Labs:** UDS at induction, and monthly thereafter. LFTs on induction, every six months thereafter. **Administration:** Place under the tongue until it dissolves. When taking multiple tablets, place all tablets in different places under the tongue at the same time.	Sublingual tablet. Alternative maintenance treatment to methadone. Allows home based treatment. Some patients have reported this product has a better taste than Suboxone tablets.	Headache, nausea, vomiting, hyperhidrosis, constipation, signs and symptoms of withdrawal, insomnia, pain, and peripheral edema.

Name	*Indications*	*Prescribing (Starting dose, range, baseline labs)*	*Advantages*	*Risks*
		Can only be prescribed by prescribers who are certified under the Drug Addiction Treatment Act of 2000 and who have been assigned a unique identification number ("X" number).		
Buprenorphine Implant (Probuphine)	Maintenance treatment of opioid dependence in patients who have achieved and sustained prolonged clinical stability on low to moderate doses of transmucosal buprenorphine-containing products (i.e., doses of no more than 8 mg per day of Subutex or Suboxone sublingual tablet or generic equivalent).	Each dose consists of four Probuphine implants inserted subdermally in the inner side of the upper arm (74.2 mg ob buprenorphine). The implants are intended to be in place for 6 months of treatment. After the first 6 months, if continued treatment is needed, the new implant must be administered in the inner side of the upper arm that was not used previously. After one insertion in each arm, if a patient is still in need of buprenorphine maintenance, they should be transitioned back to a transmucosal buprenorphine-containing product. There is no experience with inserting additional implants into other sites outside of the upper arm, nor re-insertion into previously used administration sites. Only available through a REMS program. All healthcare providers who intend to prescribe this product must successfully complete a live training program. **Labs:** LFTs on induction	Duration – 6 months.	Insertion/removal complications. Implant site pain, itching, erythema, headache, depression, constipation, nausea, vomiting, back pain, toothache.
Buprenorphine long-term injectable (Sublocade)	Treatment of moderate to severe opioid use disorder in patients who have initiated treatment with a transmucosal buprenorphine-containng product followed by a dose adjustment period for a minimum of 7 days. Should be used as part of a complete treatment program that includes counseling and psychosocial support.	Administered monthly only by subcutaneous injection in the abdominal region. The recommended dose is two monthly initial doses of 300mg, followed by 100mg monthly maintenance doses. Increasing the maintenance dose to 300mg monthly may be considereed for patients in which the benefits outweigh the risks.	Patients do not have to remember to take oral medications. Does not require outpatient surgery. Can be administered in the office.	Injection complications. Addiction, abuse and misuse. Respiratory and CMS depression Neonatal Opioid Withdrawal Syndrome Adrenal Insufficiency Hepatitis, hepatic events Hypersensitivity reactions Orthostatic hypotension Elevation of Cerebrospinal fluid Elevation of intracholedocal pressure

For more information, please consult the NIAAA publication titled "Helping Patients Who Drink Too Much: A Clinician's Guide," October 2008 Update, Johnson BA, et al. Topiramate for Treating Alcohol Dependence, *JAMA*, October 10, 2007, Vol.298, No. 14 and 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[9] and Magellan's *Clinical Practice Guideline for the Treatment of Patients with Substance Use Disorders*.[10]

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.

