UniCare Health Plan of West Virginia, Inc.
Medicaid Managed Care

Preferred Practice Guidelines for the Identification and Treatment of Substance Use Disorders

These Guidelines were based in part on the following:

"Treatment of Patients with Substance Use Disorders" from the American Psychiatric Association (APA), May 2006.

http://psychiatryonline.org/guidelines.aspx

The APA guideline Treatment of Patients with Substance Use Disorders was amended by the following Guideline Watch from the American Psychiatric Association (APA), April 2007.

http://www.psychiatryonline.com/content.aspx?aid=149073

The practice guidelines included in this document are not intended to be required treatment protocols. Physicians and other health professionals must rely on their own expertise in evaluating and treating patients. Practice guidelines are not a substitute for the best professional judgment of physicians and other health professionals. Behavioral health guidelines may include commentary developed by the Company's behavioral health committees. Further, while authoritative sources are consulted in the development of these guidelines, the practice guideline may differ in some respects from the sources cited. With respect to the issue of coverage, each patient should review his/her Policy or Certificate and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment. The practice guidelines do not supersede the Policy or Certificate and Schedule of Benefits.

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Identification and Treatment of Substance Use Disorders (SUD)

Rationale:

Substance use disorders are highly prevalent illnesses. Alcohol misuse is strongly associated with health problems, disability, death, accident, injury, social disruption, and violence. [1] Each year, drug and alcohol abuse contributes to the death of more than 120,000 Americans. Drugs and alcohol cost U.S. taxpayers nearly $276 billion annually in preventable health care costs, extra law enforcement, auto crashes, crime and lost productivity. [2] The U.S. Preventive Services Task Force (USPSTF) recommends screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women in primary care settings. [3] Data specific to adolescents are limited, but there is growing evidence that successful early intervention and treatment carries significant benefit for the individual and society. [4]

Identification and intervention by the physician is especially important, because even a brief physician intervention has been shown to be helpful in stimulating patients to examine and decrease their substance use. Early physician diagnosis and intervention reduces subsequent direct and indirect costs, motor vehicle accidents, emergency department visits, morbidity, and mortality.

Identification:

Screening for Substance Use Disorders (SUD) can take place as part of a complete history, or even in the more restrictive setting of a brief office visit. All health care providers should have a high index of suspicion regarding SUD in those patients who present with the following:

- Laboratory findings suggestive of SUD, such as elevated MCV or otherwise unexplained abnormalities of liver function (e.g. GGT > 50 U/L, AST >40 U/L, ALT > 35, or AST/ALT > 1).
- Requests for prescription of specific controlled substances by name, requests for early refills, and "lost" supplies of controlled substances.
- Otherwise unexplained changes in behavior.
- Stigmata of needle injection.
- Patients with psychiatric disorders who fail to respond to standard treatments for the disorders being treated.

Particular attention should be paid to the following groups of patients:

- Patients with co-existing significant psychiatric disorder (e.g. depressive disorders, bipolar disorder, anxiety disorders including post traumatic stress disorder, personality disorders, ADHD, conduct disorder, schizophrenia and others).

- Patients with medical disorders likely to be compromised or complicated by substance abuse or dependence (e.g. hepatic disease, diabetes, obstructive sleep apnea, heart disease and hypertension).
- Patients for which substance abuse has resulted in legal problems or consequences.
- Adolescents with marked changes in behavior or academic performance.
- Patients with a family history of substance abuse.

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- Patients with nicotine dependence.

Screening:

The American Medical Association has recommended that primary care physicians should establish routine alcohol screening procedures for all patients, including children and adolescents as appropriate and that primary care physicians should learn how to conduct brief intervention counseling and motivational interviewing. [5] The USPSTF has recommended screening of all adults, [3] and the American Academy of Pediatrics (AAP) Committees on Child Health Financing and Substance Abuse [4] has recommended screening of adolescents for substance abuse. Other physicians, especially psychiatrists and physicians treating traumatic injuries, also have the opportunity to identify patients with substance abuse and to intervene in a way that decreases the likelihood of later sequellae.

Substance Abuse and Dependence Instruments:

There are a number of screening instruments available to providers. Instruments suitable for primary care settings have been emphasized, but these instruments can be helpful in any clinical setting.

The easiest and quickest is the Two-Item Conjoint Screen.

> The Two-Item Conjoint Screen (TICS) has been used in primary care to identify patients with current alcohol or other drug problems. At least one positive response to the TICS In the last year detected current substance use disorders with nearly 80% sensitivity and specificity. [6] The two questions are:
>
> 1. Have you ever drunk or used drugs more than you meant to?
> 2. Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?

The Drug Abuse/Dependence Screener (Appendix A) is a three-item screen with excellent preliminary validity in community populations.

The most commonly used instrument in primary care settings for alcohol abuse and dependence is the CAGE Questionnaire. This consists of four questions reflected in the acronym CAGE. Endorsement of two or more items is considered to be a positive screen for alcohol abuse or dependence. The wording can easily be adapted to cover other substances.

- Have you ever felt you should **C**ut down on your drinking?
- Have people **A**nnoyed you by criticizing your drinking?
- Have you ever felt bad or **G**uilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**E**ye opener)?

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The Alcohol Use Disorders Identification Test (AUDIT) has also been used extensively in the primary care setting. Scores of eight (8) or more for men (up to age 60) or four (4) or more for women, adolescents, and men over the age of 60 are considered positive screens.

The Drug Abuse Screening Test (DAST) is a 28-item (or abbreviated 10-item version) instrument to identify adverse consequences of substance abuse, but it has not been well studied in primary care settings.

Substance Withdrawal Severity Instruments:

The following instruments may prove useful to providers in assessing the severity of substance withdrawal.

- **Alcohol:** The Clinical Institute Withdrawal Assessment - Alcohol, revised (CIWA-Ar)[7] is a well-validated instrument supported by ASAM guidelines. [8,9] High scores (10 or higher) on this instrument have been shown to be predictive of withdrawal seizures and withdrawal delirium. [9]
- **Opioids:** Clinical Opiate Withdrawal Scale (COWS) is a relatively new instrument meant to be helpful during the initial evaluation. It should help the practitioner assess the severity of withdrawal. Older instruments useful for this purpose include the Subjective Opiate Withdrawal Scale (SOWS) and the Clinical Institute Narcotic Assessment Scale for Withdrawal Symptoms (CINA). [10]

It is essential to keep in mind that withdrawal from alcohol and sedative-hypnotics carries the risk of serious medical complications, including delirium and withdrawal seizures. These are potentially fatal complications. NOTE: Delirium tremens and withdrawal seizures should be treated as medical emergencies in an acute medical hospital. These could have significant life threatening issues and/or serious complications.

Specialist Referral Criteria:

Although **some** patients with substance abuse can be successfully treated within a primary care setting, it is essential that the provider consider the type, complexity and severity of the symptomology, as well their own comfort level, when determining if a referral to a specialist is required. Clinical consultation or referral to one of the following specialists should be considered in these situations:

Psychiatrists:

- Patients with significant comorbid psychiatric issues such as anxiety, depression, bipolar disorder and PTSD.

Addiction Medicine Physicians (Including physicians certified by the American Society of Addiction Medicine [ASAM] in Addiction Medicine, physicians certified by the American Board of Psychiatry a Neurology in Addiction Psychiatry, and other physicians with special training and expertise in Addiction Medicine):

- Patients who are likely to require medically-supervised withdrawal in a specialized, monitored setting to prevent complications. These include:

- A history of withdrawal seizures, delirium tremens, substance-related hallucinations, or substance-related acute psychotic symptoms.
- Sedative-hypnotic withdrawal with comorbid withdrawal from alcohol, opioids or stimulants.
- Alcohol withdrawal with a CIWA-Ar score of 10 or higher, or the equivalent on a comparable standardized scoring system.
- Moderately severe to severe opioid withdrawal (e.g. a COWS score of 25 or higher or the equivalent on a comparable standardized scoring system.
- Comorbid severe medical or psychiatric disorders likely to decompensate in the course of withdrawal.

Physicians with special training and DEA licensure for opioid maintenance therapy (OMT):

- Patients who are dependent on opioids and likely to require opioid maintenance therapy (OMT) or opioid substitution and tapering, including the use of buprenorphine. It should be noted that this treatment can usually be provided in an office-based, primary care setting. Primary care physicians whose practice includes patients dependent on prescribed or illicit opioids are strongly encouraged to seek this CME training, which is available through the American Society of Addiction Medicine (ASAM) at **www.asam.org** or the American Academy of Addiction Psychiatry at **www.aaap.org** .

Addiction Medicine Physicians AND OBGYN:

- Any patient who is pregnant and substance dependent.

Substance Abuse Specialists such as Certified Alcohol and Drug Counselors (CADAC) and licensed or certified mental health practitioners with special expertise in substance abuse:

- Patients who are likely to need psychosocial intervention beyond the skill, time, or comfort level of the PCP.
- Patients who are likely to need a structured program of substance abuse rehabilitation treatment.

Other specialties: All patients with SUD who have experienced recent significant trauma or who have evidence of any organ compromise, should receive the same level of specialty consultation and treatment that would be provided for a patient without SUD.

Behavioral Health Treatment Coordination:

The AMA recommends that primary care clinics should establish close working relationships with alcohol treatment specialists, counselors, and self-help groups in their communities, and, whenever feasible, specialized alcohol and drug treatment programs should be integrated into the routine clinical practice of medicine. [5] We strongly support efforts directed at the coordination of care between all professionals involved in providing treatment to a member. Communication between the various disciplines is essential in order to avoid conflicting treatment plans,

eliminate duplicated efforts and decrease the risk of medication errors. This type of dialogue is especially important between the primary care provider, psychiatrist, addiction medicine physician, substance abuse provider and/or other behavioral health specialist when treatment is being provided for a behavioral health issue, including substance use disorders. Toward that end, we recommend that all practitioners take an active role in coordinating behavioral health treatment by requesting an authorization to release information to the patient's primary care provider, ensuring that communication occurs and then documenting the results. Primary care providers are encouraged to communicate the rationale and any relevant medical information when a member is referred to a psychiatrist, substance abuse provider or therapist. Likewise, psychiatrists, addiction medicine physicians and other behavioral health dpecialists are encouraged to establish an ongoing dialogue with their patient's primary care providers.

References:

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10. Center for Substance Abuse Treatment. Clinical guidelines for the use of buprenorphine in the treatment of opioid addiction. Rockville (MD): Substance Abuse and Mental Health Services Administration; 2004. 171 p. (Treatment improvement protocol; no. TIP 40).

SUBSTANCE ABUSE SCREENING MATERIALS AND RESOURCES

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CAGE Questionnaire, AUDIT, are available at
http://www.mentalneurologicalprimarycare.org/page_view.asp?c=16&did=2215&fc=

The AUDIT is available as an online questionnaire at
http://pubs.niaaa.nih.gov/publications/aa65/AA65.htm

The Clinical Institute Withdrawal Assessment - Alcohol, revised (CIWA-Ar), with supporting documentation, is available at: **http://umem.org/files/uploads/1104212257_CIWA-Ar.pdf**

Articles discussing the Two-Item Conjoint Screen (TICS) and CAGE Questionnaire can be found at **http://www.medscape.com/viewarticle/405836** (Medscape site requires free registration) nd **http://www.aafp.org/afp/20030401/1529.html**

The COWS, SOWS, and CINA can all be found in PDF format starting on page number 110 in Appendix B of Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction" on the Substance Abuse and Mental Health Services Administration site at

http://www.buprenorphine.samhsa.gov/Bup_Guidelines.pdf

Substance Abuse Screening Inventory
http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.table.27990

SAMHSA/CSAT Treatment Improvement Protocols
http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.part.22441

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Appendix A

Drug Abuse/Dependence Screener

Here is a list of drugs:

- Marijuana, hashish, pot, grass
- Amphetamines, stimulants, uppers, speed
- Barbiturates, sedatives, downers, sleeping pills, Seconal, Quaaludes
- Tranquilizers, Valium, Librium
- Cocaine, coke, crack
- Heroin
- Opiates, codeine, Demerol, morphine, methadone, Darvon, opium
- Psychedelics, LSD, Mescaline, peyote, psilocybin, DMT, PCP

1. Have you ever used one of these drugs on your own more than 5 times in your life? By "on your own", I mean to get high or without a prescription or more than was prescribed.

Yes = 1; No = 0 (skip questions 2 and 3)

2. Did you ever find you needed larger amounts of these drugs to get an effect or that you could no longer get high on the amount you used to use?

Yes = 1; No = 0

3. Did you ever have emotional or psychological problems from using drugs - such as feeling crazy or paranoid or depressed or uninterested in things?

Yes = 1; No = 0

Consider screen positive for lifetime drug abuse/dependence if item 1 = Yes and either item 2 or 3 = Yes

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References:

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