Palmetto Health Quality Collaborative

Care Map

Management of Substance-Related Disorders in Primary Care

IMPORTANCE OF FOCUS

Substance-related disorders (SRDs) are ubiquitous, costly, disabling and potentially lethal. About 10% of Americans will abuse or become dependent on illicit substances during their lifetime. By 2050, SRD's in persons over the age of 65 are expected to double, while 44% of adolescents will have used illicit drugs by age 18. Primary care SRD prevalence is estimated to be between 10% and 20%.

GOALS

The overall goal of this Care map is to improve the care of adults entering the primary care setting with a SRD by increasing compliance with evidence-based practice guidelines.

The ultimate treatment goal for the patient is to achieve total cessation of non-medically supervised substance use. A primary care oriented conceptualization of treatment goals in on a continuum, flanked on one end by initial engagement in treatment and on the other by long-term abstinence. Along this continuum lie intermediate goals that focus on decreasing risky behaviors: reducing the frequency or quantity of use, the number of substances used, high-risk delivery methods, or high-risk behaviors while under the influence. The clinician may continue to encourage abstinence as a long-term goal, while all along the way promoting behaviors that lessen the psychological, medical and social consequences.

KEY RECOMMENDATIONS

FRAMES Guideline to Motivation Interviewing

Feedback **is given regarding the negative consequences of substance use behaviors, including future risk.**
Responsibility **for change emphasizes personal choice.**
Advice **is given about behavioral change, from reduction to abstinence.**
Menu **of treatment options reinforces personal responsibility and choice.**
Empathic **and non-judgmental counseling style.**
Self-efficacy **encourages a sense of optimistic empowerment and positive change.**

Adapted from Miller WR, Sanchez, VC. Motivating young adults for treatment and lifestyle change. In Howard G, ed. *Issues in Alcohol Use and Misuse by Young Adults*. Notre Dame, IN: University of Notre Dame Presee, 1994: 55-82.

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CARE PATHWAY COMPONENTS

Initial Visit

- Use of a screening tool, such as the Drug Abuse Screening Test-10 (DAST-10) or clinical concern
- Establish diagnosis, review DSM5 criteria
  - Distinguish between hazardous use, mild use disorder and moderate/severe use disorder
- Possible additional sources for information:
  - Check prescription monitoring program
  - Urine drug screen
  - Collateral information
- Screen for psychiatric comorbidities
- Suicide risk assessment

Initial Treatment Plan for hazardous use or mild use disorders

- Harm reduction is a viable option and is appropriate in some cases and for some substances.
- Conduct a brief intervention (5-10 minutes), which includes:
  - Providing information and feedback about screening results.
    - Having some tools or information about norms and how that compares to the patient's results can be useful.
    - Provide psychoeducation on effects of substance on mental or physical health.
  - Asking the patient their reasons for use (ie: pros and cons).
    - Encourage the patient to discuss their views on use and why they may choose change (ie: interaction with medication, interference with personal responsibility or cause/exacerbation of health or mental health problems).
  - Teaching behavior change skills, such as goal-setting, to help the patient reach their goal for abstinence or reduction in use, if applicable.
  - Following-up
    - Set a specific time to follow-up with the patient to discuss goals and progress.
- Useful in a brief intervention include:
  - Resist the "righting reflex"
  - Understand the patients' reason for motivation.
  - Take an active listening role
  - Empower your patient by allowing them to design their change plan.

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Initial Treatment Plan for moderate or severe use disorders

- Determine whether outpatient or inpatient treatment is needed. Life-threatening withdrawal syndromes occur with alcohol, benzodiazepines, and barbituates. Inpatient treatment for opioid use disorders or cannabis/stimulant use disorders is typically not indicated, unless there are multiple comorbidities, whether substance or psychiatric.
- If outpatient care is appropriate, consider initiation of medication assisted treatments (MAT) or referral to specialist.
- Consider referral to a counselor/therapist for psychosocial intervention for substance use disorders.
- For opioid use disorder:
  - Prescription opioids disorders are the second most common drug disorder in the US, with cannabis disorders the most common. Heroin use is now on the rise as access to prescription opioids becomes more limited.
  - Opioid replacement therapies (ORT), like buprenorphine or methadone, have been shown to reduce mortality.
  - ORT does create physiologic dependence but reduces the behavioral aspect of addiction, such as obtaining drugs from unreliable sources, comorbid substance use, and exposure to risky behaviors.
  - Methadone for opioid use disorders can ONLY be dispensed in federally funded opioid treatment programs also known as methadone clinics. It is illegal to prescribe methadone in an office setting for opioid use disorders. There are two methadone clinics in the Columbia area (See Resource Page).
  - Buprenorphine typically comes in a combination product with naloxone. The naloxone is poorly absorbed sublingually, but is active when given parenterally, thereby, discouraging diversion of the drug by intravenous use. Buprenorphine and buprenorphine/naloxone can be prescribed out of an office by physicians that have special certifications, or an “X-license” obtained through specialized training.
  - Provide referral for ORT to patient. Most methadone clinics can work a patient in within a one-week period for either methadone or buprenorphine treatment. There are several physician offices in the area with the ability to provide ORT services, specifically buprenorphine, to patients. Often the patient’s insurance company can tell them who in their network is available for those services.
- For benzodiazepine use disorder:
  - Abrupt discontinuation of benzodiazepines can lead to seizures and delirium.
  - In patients from whom a reliable history can be obtained, are adherent, have no history of complicated withdrawal and minimal medical comorbidities, a slow taper can be attempted. Otherwise, referral to a specialist is indicated.
  - Typically, benzodiazepines with longer half-lives (IE: clonazepam) are preferable and taper can last months.

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- For cannabis or stimulant use disorders (cocaine, methamphetamine, prescription stimulant medications):
  - There are no FDA approved medications for stimulant or cannabis use disorders.
  - Cannabis use is problematic and can cause psychosis, anxiety with long term use, and appears to be particularly detrimental to adolescents. Despite the legalization of cannabis, there is not an extensive literature on its effects.
  - Conduct a brief intervention, provide psychoeducation on effects of cannabis on mental health and aid the patient in formulating goals for future use, whether cutting back or abstinence.
  - Withdrawal syndrome from stimulants and cannabis exists, but is not life-threatening.
  - Behavioral therapies are considered the mainstay of treatment for these disorders. Consider referral to a counselor or therapist.

Follow-Up Visits #1 & #2:

- Hazardous or Mild Use Disorders
  - Check in with the patient about their substance use and goal-setting
  - Reconsider or change goals if necessary
  - If applicable, consider obtaining a urine drug screen or check prescription monitoring program.
- For Moderate/Severe Use Disorders
  - For opioid use disorder:
    - If you are managing buprenorphine, provide treatment based on patient.
    - If another facility/provider is managing opioid use disorder, discuss treatment with the patient and consider obtaining a release of information with the facility/provider for continuity of care.
  - For benzodiazepine use disorder:
    - Obtain vital signs and use a standardized withdrawal scale to obtain objective data about withdrawal symptoms.
    - If able, continue slow taper of benzodiazepine with decreasing amount of medication at one dosing interval.
    - Continue to discuss the taper with the patient and provide reassurance.
    - If applicable, consider obtaining a urine drug screen, check prescription monitoring program, or check in to see if the patient has engaged in psychosocial intervention.
  - For cannabis or stimulant use disorder:
    - Check in with the patient about their substance use and goal-setting
    - Reconsider or change goals if necessary
    - If applicable, consider obtaining urine drug screen or check prescription monitoring program.

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- If patient continues to have difficulty with controlling use, this may be indicative of more severe disorder and referral to specialty services may be indicated.

Subsequent Follow-Up Visits:

- Hazardous or Mild Use Disorders
  - Check in with the patient about their substance use and goal-setting
  - Reconsider or change goals if necessary
  - If applicable, consider obtaining urine drug screen or check prescription monitoring program.
  - If patient continues to have difficulty with controlling use, this may be indicative of more severe disorder and referral to specialty services may be indicated.
- For Moderate/Severe Use Disorders
  - For opioid use disorder:
    - If you are managing buprenorphine, provide treatment based on patient.
    - If another facility/provider is managing opioid use disorder, discuss treatment with the patient and status.
  - For benzodiazepine use disorder:
    - Obtain vital signs, assess clinical signs of withdrawal, and use a standardized withdrawal scale to obtain objective data about withdrawal symptoms.
    - If able, continue slow taper of benzodiazepine with decreasing amount of medication. If in doubt, err on the side of a slower taper.
    - Continue to discuss with the patient the taper and provide reassurance.
    - If applicable, consider obtaining a urine drug screen, check prescription monitoring program, or check in to see if the patient has engaged in psychosocial intervention.
    - A slow taper can take months. Schedule the patient at regular intervals, such as every two weeks or monthly, to check in and advance the taper.
  - For cannabis or stimulant use disorder:
    - Check in with the patient about their substance use and goal-setting
    - Reconsider or change goals if necessary
    - If applicable, consider obtaining urine drug screen or check prescription monitoring program.
    - If patient continues to have difficulty with controlling use, this may be indicative of more severe disorder and referral to specialty services may be indicated.

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WHEN TO REFER

Emergency Referral (Either direct admission or ED referral):

1. Pronounced withdrawl sypmtoms
2. Suicidal intention

Routine Referral:

1. Maintenance pharmacotherapy for buprenorphine or methadone
2. Need for psychosocial treatments (Narcotics Anonymous, counseling, behavioral treatment programs, vocational rehab)
3. Repeated failed treatment in primary care or outpatient treatment

RESOURCES

DSM-V, American Psychiatric Association

DAST-10

For Additional Information

Palmetto Health Assessment and Referral 434-4813

LRADAC (inpatient and outpatient treatment options): 726-9300 (Richland); 726-9400 (Lexington)

Columbia Metro Treatment Center: 791-9422

Crossroads Treatment Center: 791-9422

American Psychiatric Association: www.psychiatry.org

Reviewed/Updated 03/18/16

This Care Map presents a model of best care based on the best evidence available at the time of publication. It is not a prescription for every patient, and it is not meant to replace clinical judgment. Although physicians are encouraged to follow the Care Map to help focus on and measure quality, variation from the pathway may occur as clinical freedom is exercised to meet the needs of the individual patient. Send feedback to Elizabeth Sheridan, Manager of Clinical Integration for the Palmetto Health Quality Collaborative (PHQC) at Elizabeth.sheridan@palmettohealth.org or 803 296-2384