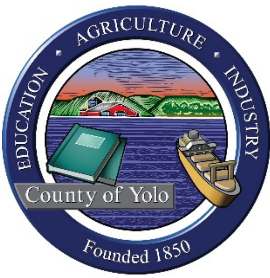

COUNTY OF YOLO

HEALTH AND HUMAN SERVICES AGENCY

POLICIES AND PROCEDURES

SECTION 5, CHAPTER 11, POLICY 002-G

ATTACHMENT G – PARAMETERS FOR THE USE OF PSYCHOACTIVE MEDICATIONS IN INDIVIDUALS WITH CO-OCCURRING SUBSTANCE ABUSE

A. Introduction

1. The appropriate use of psychoactive medications in individuals with co-occurring substance abuse requires specific training, including a specialized knowledge of substance-related disorders and commonly associated comorbid general medical conditions and particular risks/benefits ratios for use of these medications in individuals with substance abuse, withdrawal, and/or intoxication.

B. Purpose

1. The purpose of these parameters is to clarify specific Yolo County Health and Human Services Agency (HHSA) clinical policies and procedures and provide a foundation for quality management relating to the use of major classes of psychoactive medications in individuals with comorbid substance abuse disorder, to include:

   a. Antipsychotic medications,

   b. Mood Stabilizing medications,

   c. Antidepressant medications, and

   d. Anxiolytic medications.

2. These parameters are not comprehensive treatment guidelines for the use of psychopharmacologic medications, nor are they guidelines for the psychopharmacologic treatment of substance abuse. Such guidelines exist and should be familiar to prescribers:

   a. Expert Consensus Practice Guideline for Treatment of Schizophrenia;

   b. APA Guidelines for Treatment of Schizophrenia and Mood Disorders;

   c. PORT Schizophrenia Guidelines;

   d. Texas Medication Algorithm Project;

   e. International Psychopharmacological Algorithm Project Report;

   f. AHCPR Guidelines for Depression in Primary Care;

g. ASAM Guidelines for Treatment of Substance Abuse; and

h. CSAT Guidelines for Treatment of Substance Abuse.

3. Physicians prescribing psychopharmacologic treatment to HHSA consumers with comorbid substance abuse should be familiar with all applicable HHSA parameters. These include all Attachments A-J in this Policy.

4. Treatment non-adherence in individuals with substance abuse disorders is a special situation that must be addressed by the prescriber. The physiologic dangers inherent in this situation must be considered and the nature and outcome of such deliberations must be clearly documented in the medical record. Specific psychosocial interventions to improve treatment compliance, including motivational and educational techniques, should be available.

C. General Parameters

1. Assessment of individuals with comorbid substance abuse should take into account the potential contribution of substance-induced psychiatric disorders to presenting symptoms. Re-assessment of diagnosis and treatment should occur between two and four weeks of abstinence from the abused substance(s).

2. Psychoactive medications being taken on an ongoing basis for treatment of a psychiatric disorder should be continued during detoxification from abused substances, unless specific contraindications to the use of these medications exist.

3. Assessment for possible pharmacologic treatment of individuals with an exacerbation of psychiatric symptoms during detoxification from abused substances should explicitly consider adjustment of the dose of withdrawal medications prior to addition of other psychoactive medications.

4. Assessment for prescription of additional medications for psychiatric symptoms during detoxification should explicitly consider the potential interactions with the withdrawal medications, with the abused substance, and with any associated physiologic complications.

5. Psychoactive medications with a low potential for abuse should be preferentially prescribed in individuals with comorbid substance abuse disorders.

6. Medications for the treatment of psychiatric disorders should not be withheld from individuals with substance abuse disorders solely because they continue to abuse substances. Rather, the medication treatment regimen should be one that best manages they psychiatric disorder while minimizing the potential for interactions among the prescribed medications, the abused substance, and associated mental and physiologic effects.

7. Medications for the treatment of psychiatric disorders should not be withheld from individuals with substance abuse disorders solely because they are taking medications for relapse prevention. Rather, the medication treatment regimen should be one that best

manages the psychiatric disorder while minimizing the potential for pharmacologic interactions between the prescribed medications.

8. Laboratory studies for assessment of physiologic processes that may be affected by abused substances and are relevant to the metabolism of prescribed psychoactive medications should be obtained, monitored, and documented.

9. Individuals with substance abuse disorders should be regularly queried about their degree of adherence to medication regimens, and motivational enhancement techniques should be employed to encourage the appropriate use of medication.

D. Medication Uses in Individuals with Comorbid Substance Abuse

1. Antipsychotic Medications

- **a.** Newer (second generation) antipsychotic medications should be preferentially prescribed to individuals with comorbid substance abuse.
- **b.** Sedating antipsychotic medications should be avoided in individuals who persist in the abuse of alcohol, opioids, and sedative-hypnotics.
- **c.** Antipsychotic medications should be administered concurrently with any withdrawal medications during detoxification of individuals with schizophrenia who are experiencing an exacerbation of psychosis.
- **d.** Depot antipsychotic medication should be preferentially considered in individuals with substance abuse who have a high probability of non-adherence with oral medication regimens.
- **e.** Antipsychotic medication regimens prescribed for the emergence of psychotic symptoms or agitation during withdrawal should be re-evaluated after detoxification is completed.

2. Mood Stabilizing Medications

- **a.** Because of data that suggest a higher prevalence of rapid cycling bipolar disorder in individuals with comorbid substance abuse, divalproex should be used preferentially over lithium for this indication, recognizing that special attention must be directed toward ensuring normal liver function.
- **b.** In individuals with alcohol abuse, divalproex should be used only when liver transaminases are less than twice the upper limit of normal, and this value should be monitored on a regular basis.
- **c.** Mood stabilizing medication regimens prescribed for emergence of manic symptoms during withdrawal should be re-evaluated after detoxification is complete.

3. Antidepressant Medications

a. Because of data that suggest newer antidepressants (SSRIs, SNRIs) may decrease alcohol craving and because they are associated with fewer serious adverse effects, these medications should be preferentially used for treatment of primary mood disorders in individuals with alcohol abuse.

b. Use of sedating tricyclic antidepressants (TCAs) in opioid-dependent individuals should generally be avoided because of data suggesting a potential for abuse.

c. Because of the potential for increased cardiotoxicity in individuals with cocaine abuse, TCAs should generally be avoided in such cases.

d. For individuals who have not been taking antidepressant medication on an ongoing basis, initiation of antidepressant medication should generally be withheld until detoxification is completed and abstinence has been established for two to four weeks. Exceptions may include individuals who are very severely depressed or suicidal.

e. Because of induction of hepatic microsomal activity by alcohol, higher doses of both SSRIs and TCAs should be considered in individuals with alcohol dependence and major depressive disorders that do not respond to standard doses.

4. Anxiolytic Medications

a. The assessment and pharmacologic treatment of anxiety in individuals with comorbid substance abuse must take into account special considerations, including:

b. Because of data that suggests a reduction in craving and because of fewer untoward effects relative to TCAs and MAOIs, newer antidepressants should be preferentially used for pharmacological treatment of anxiety disorders in individuals with comorbid substance abuse.

c. When newer antidepressants (SSRIs, SNRIs) are contraindicated for treatment of primary anxiety disorders in an individual with comorbid substance abuse, buspirone should be preferentially considered over other anxiolytic agents because of its relative safety.

d. For pharmacologic treatment of insomnia due to an anxiety disorder in individuals with comorbid substance abuse, sedating non-TCA antidepressants (e.g., trazodone, nefazodone, and mirtazapine) should be used preferentially over sedating TCAs due to their relative safety.

5. Benzodiazepines

a. Benzodiazepines prescribed as withdrawal medications during detoxification from abused substances should almost always be discontinued after detoxification is completed.

b. The continued presence of overriding reasons for continuation of these medications past the detoxification period must be repeatedly and frequently documented in the medical record.

c. Because of their increased potential for abuse, use of benzodiazepines for treatment of primary anxiety disorders or adjustment disorders should almost always be avoided in individuals with comorbid substance abuse.

d. In cases when benzodiazepines are the only effective treatment for otherwise unmanageable anxiety, those with especially rapid onset (e.g., alprazolam and diazepam) should be avoided in order to minimize the potential for abuse.

e. Benzodiazepines and clozapine should not be used in combination because significant adverse reactions have been reported in administration of benzodiazepines to clients receiving clozapine.

f. Agitation and/or delirium stemming from alcohol withdrawal should be treated with parenteral rapid-acting benzodiazepines because they are more effective than neuroleptic agents in reducing duration of alcohol withdrawal delirium and mortality.

6. Anti-craving Medications

a. Individuals with comorbid psychotic disorders and alcohol abuse should be subsequently evaluated for disulfiram-induced exacerbation of psychotic symptoms when disulfiram is initiated.

b. Disulfiram may be used to decrease craving in individuals with comorbid alcohol abuse or comorbid cocaine abuse.

c. Naltrexone should be considered for individuals with comorbid alcohol and/or opioid and/or cocaine abuse.

d. Acamprosate should be considered in individuals with alcohol abuse for whom naltrexone is not tolerated or in combination with naltrexone when naltrexone alone is not effective. A medication Treatment Authorization Request (TAR) is required.

e. Methadone should not be initiated by HHSA psychiatrists, as HHSA does not meet the FDA-mandated special institutional requirements for such treatment. Clients requiring such treatment should be referred to a contracted Methadone clinic, such as CommuniCare Health Centers Medication Assisted Treatment (MAT) program in Woodland, CA or CORE Medical Clinic in Sacramento, CA.

f. Buprenorphine use must be approved on a case-by-case basis by the Medical Director.