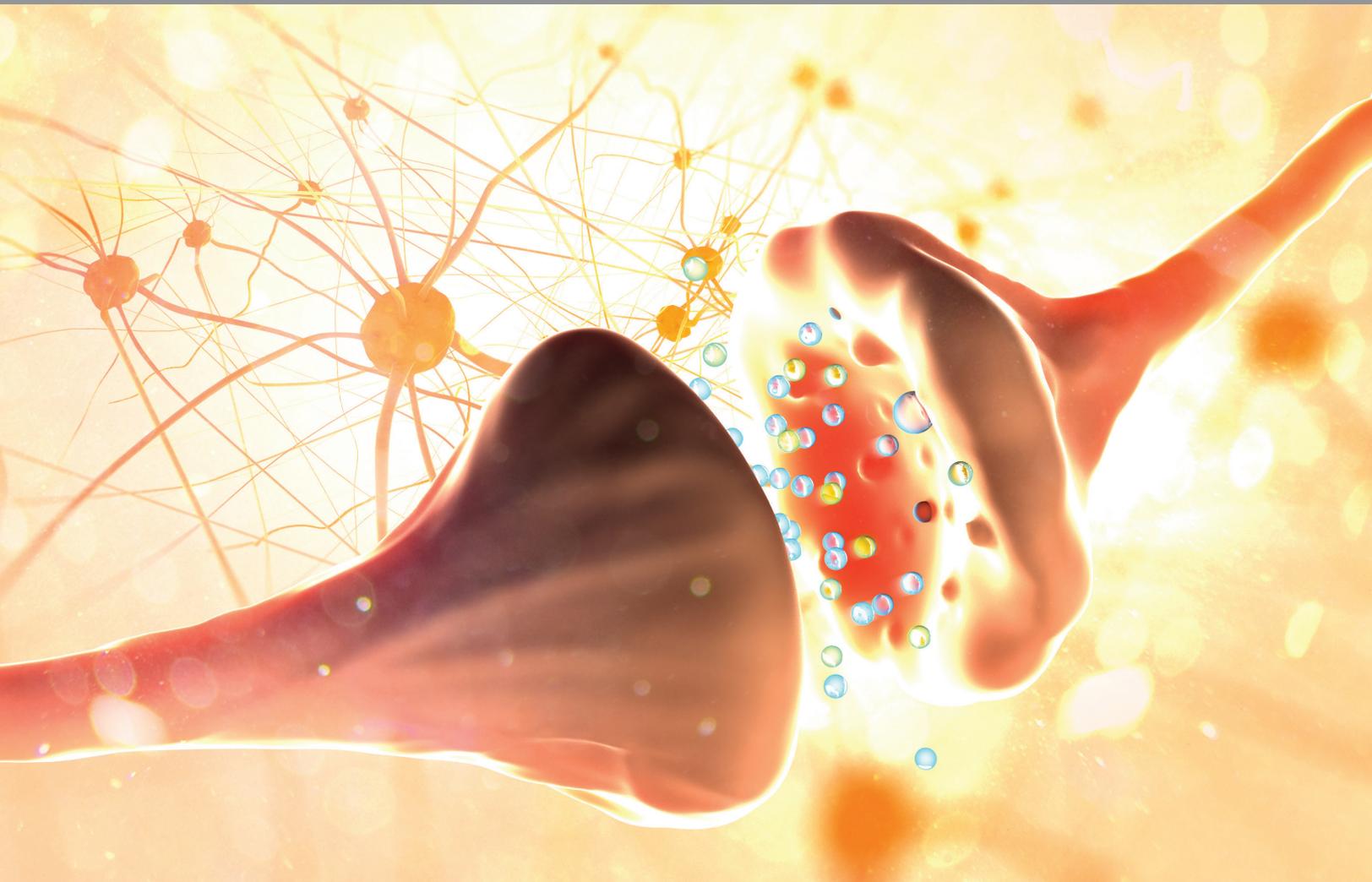




Helping patients manage substance use disorder: Tobacco, alcohol, and other drugs



Substance use disorder (SUD) is a chronic, relapsing, treatable medical condition

Repeated use of substances, whether prescribed, legal, or illegal, can cause neurochemical changes in the brain that often require treatment to overcome.¹

DSM-5 criteria for substance use disorders

SUD is problematic substance (tobacco, alcohol, and/or drug such as an opioid) use that leads to clinically significant impairment or distress.

SUD is marked by at least <u>two</u> of these criteria over the past 12 months:²	<input type="checkbox"/> Use at higher doses or longer than intended or prescribed
	<input type="checkbox"/> Unsuccessful attempts to control or reduce use
	<input type="checkbox"/> Significant time lost obtaining, consuming, or recovering from use
	<input type="checkbox"/> Craving for the substance
	<input type="checkbox"/> Failure to fulfill obligations because of substance use
	<input type="checkbox"/> Use causes persistent social or interpersonal problems
	<input type="checkbox"/> Use displaces social, work, or recreational activities
	<input type="checkbox"/> Use creates hazardous situations (e.g., while driving)
	<input type="checkbox"/> Use continues despite physical or psychological problems caused or worsened by the substance
	<input type="checkbox"/> Tolerance: a reduced effect of the substance despite increasing dosages (in patients taking the substance other than as prescribed)
	<input type="checkbox"/> Withdrawal (in patients taking the substance other than as prescribed)

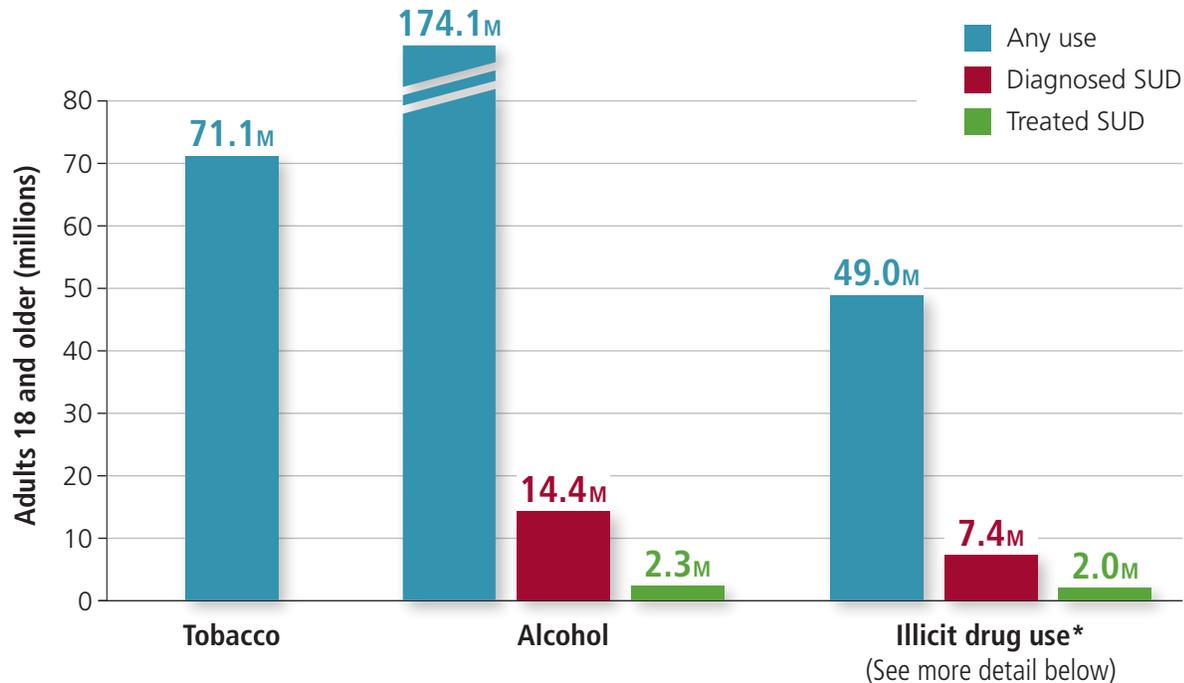
The severity of SUD is defined by the number of criteria that are present:



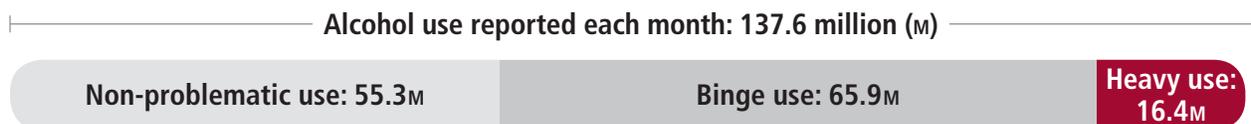
SUDs can be managed with effective treatments.

SUDs are common, though underrecognized

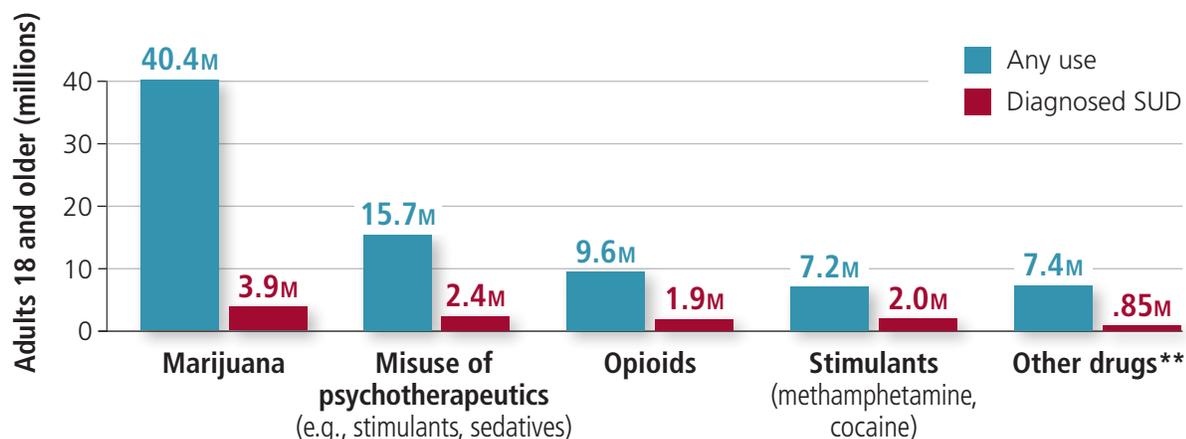
Figure 1. Results from the 2018 National Survey on Drug Use and Health for adults age 18 and over identified substance use is common, but treatment is not.^{3,4}



Each month many people 18 and older use alcohol, but not all use is problematic.^{3,4}



Illicit drug use,* by type, 2018 National Survey on Drug Use and Health^{3,4}

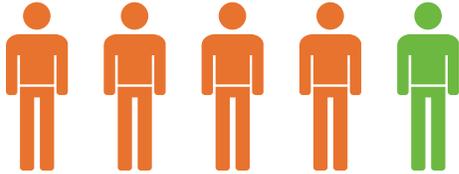


*Drug use numbers do not sum to annual total as multi-substance use is reported.

**Other drugs: heroin, hallucinogens, and inhalants.

Encourage treatment engagement

Nearly 2 million Americans have opioid use disorder (OUD).^{5,6}



Even though medical treatment greatly improves outcomes, only about one in five people with OUD receives it.⁷

Engaging and retaining patients in medication-based treatment can help to successfully manage SUD, improve quit rates, and reduce the risk of harm and death.⁸⁻¹¹

Create a supportive and compassionate dialog with patients in substance use discussions.



Ask open-ended questions to elicit conversation about substance use.
e.g., *"How do you feel about (substance)?"*



Include statements of appreciation and understanding.
e.g., *"It's hard to talk about.... , I really appreciate your keeping on with this."*



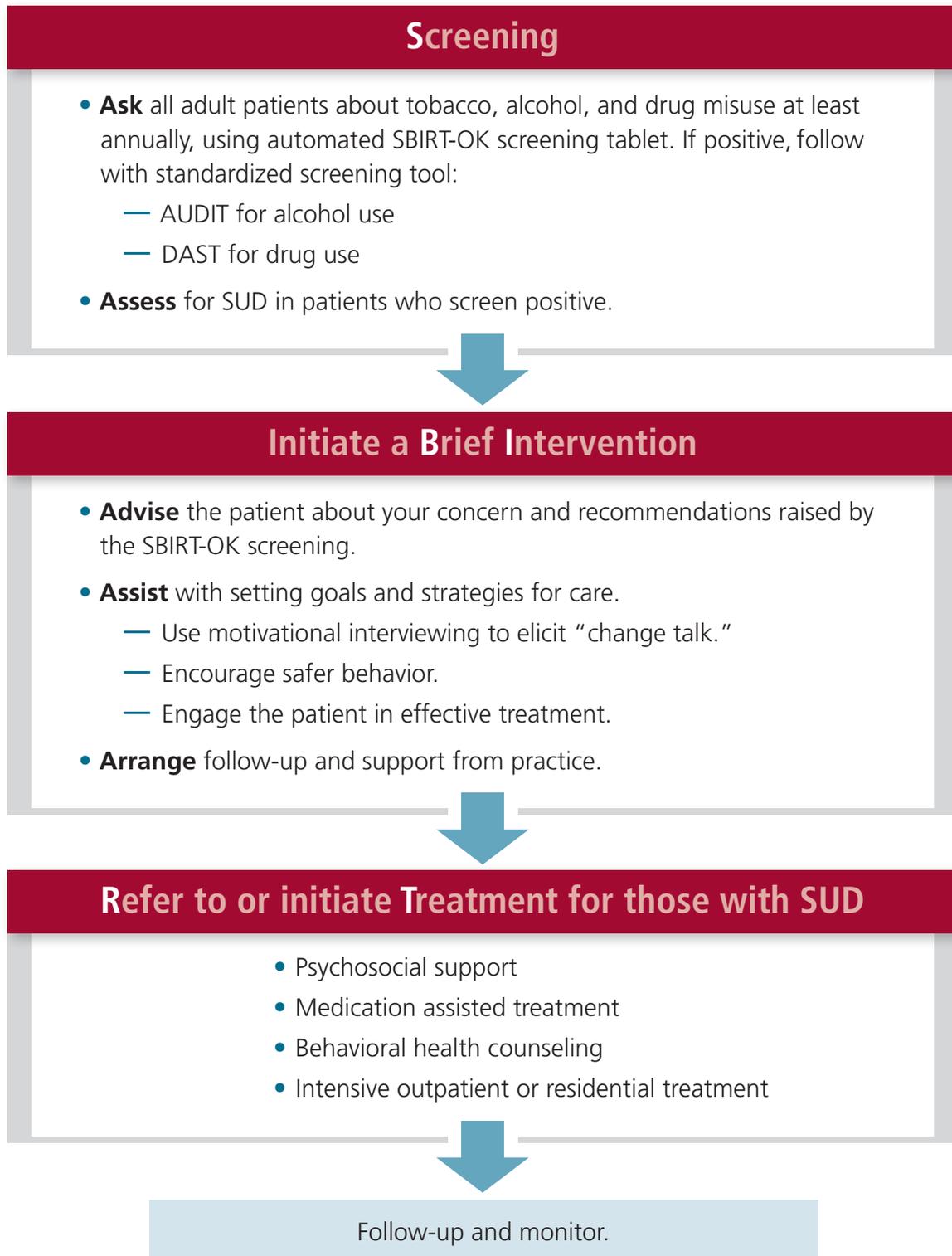
Reflect back what the patient has communicated regarding substance use. This helps the patient know you understand what they are saying.
e.g., *"I hear that you would like to cut down on your substance use at parties."*



Summarize the discussion.

Identify patients with SUD (tobacco, alcohol, drugs of abuse)

Figure 2. Begin with SBIRT (Screening, Brief Intervention, and Referral to Treatment)^{3,12}



Treat tobacco use with medications

Create a plan for patients who are ready to quit.



Select pharmacologic support based on patient preference, cost, and relevant medical and/or psychiatric conditions.

Table 1: Pharmacologic options include:

	nicotine replacement therapy (NRT)	varenicline (Chantix)	bupropion (Wellbutrin, Zyban)
Mechanism of action	 <p>full agonist of nicotine system</p>	 <p>partial agonist selective for $\alpha 4\beta 2$ nicotinic acetylcholine receptor subtypes</p>	 <p>partial agonist of 5-HT_{1A} receptors</p>
When to start	anytime	2 weeks before quit date	2 weeks before quit date
Who can treat	no prescription	any prescriber	any prescriber
Patient characteristics	anyone	caution: seizures, CVD, serious psych conditions	not if taking monoamine oxidase (MAO) inhibitors, seizures, renal disease
Dosage forms	patch, spray, gum, lozenge, inhaler	tablet	tablet

Each of these three options alone increase quit rates at one year. Nicotine replacement therapy may be combined with either bupropion or varenicline.



Provide or refer for behavioral support. Even brief, simple advice increases the likelihood of a smoker quitting. More intensive advice may result in higher rates of quitting.¹³



All drugs can be effective, though multiple attempts may be needed.¹⁴

Encourage patients to call 1-800-QUIT-NOW (1-800-784-8669) or text QUIT to 47848 to receive text message support.

Treat alcohol use disorder (AUD) with medications and support groups

- Acamprosate and disulfiram had greater durations of abstinence vs. placebo.¹⁰
- Acamprosate and naltrexone have similar effects on alcohol consumption.¹⁵
- Naltrexone reduces drinking, especially binge drinking, compared to placebo.¹⁵

Table 2. Medications for the treatment of AUD¹⁶

	acamprosate (Campral)	naltrexone (Revia, Vivitrol)	disulfiram (Antabuse)
Mechanism of action	 <p>partial agonist GABA/ glutamate system</p>	 <p>antagonist at opioid receptor</p>	 <p>enzyme inhibition leads to build up of toxic acetaldehyde with ethanol ingestion</p>
When to start	abstinent prior to starting	7-10 days abstinent prior to starting	abstinent prior to starting
Who can treat	any prescriber	any prescriber	any prescriber
Patient characteristics	not if suicidal thoughts, renal disease	frequent relapse, cravings, overlapping OUD	frequent relapse
SUD severity	moderate to severe	moderate	moderate to severe
Initiating treatment	home	in office for injection, home for tablet	home
Dosage forms	tablet	tablet or long-acting injection	tablet
Frequency	three times daily	daily for oral; monthly for injection	daily

Psychosocial treatment increases the likelihood of abstinence after one year of treatment 14-fold more than the general population.¹⁰

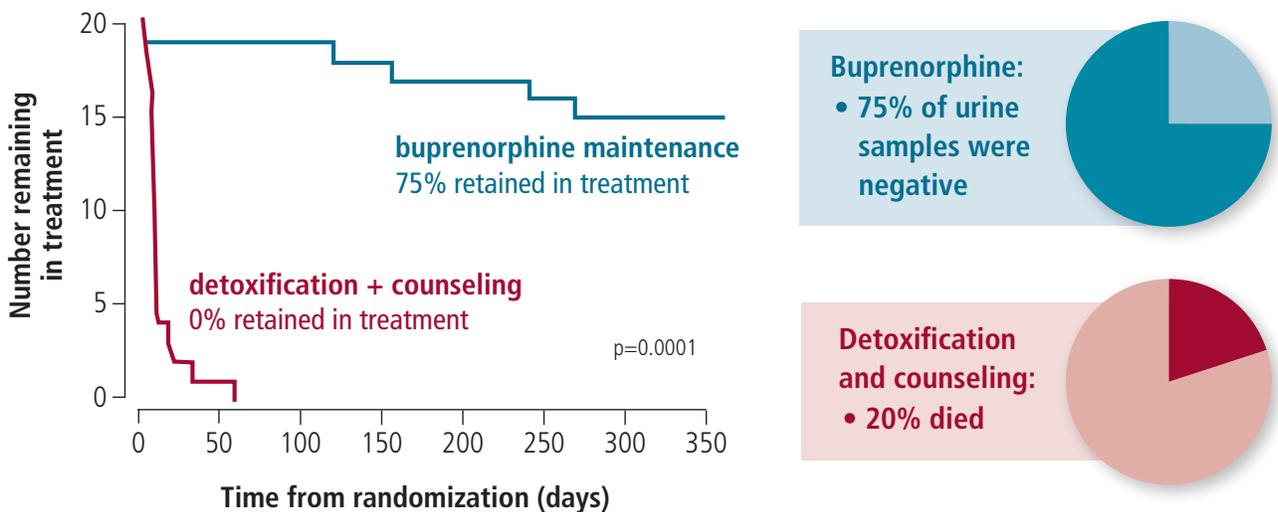
Peer-support groups like Alcoholics Anonymous are established options to encourage and support remission and recovery.

Medications for opioid use disorder (OUD) are proven to be effective

Methadone, buprenorphine, and naltrexone can all:

- Reduce the risk of death^{9,17}
- Improve retention in addiction treatment programs¹⁸
- Reduce cravings²⁰
- Decrease opioid misuse¹⁸⁻²⁰
 - Reduce urine samples that test positive for opioids
 - Increase time abstaining from opioids¹⁹

Figure 3. In a randomized trial, buprenorphine lowered the risk of death, improved retention in treatment, and reduced illicit opioid use compared to detoxification and counseling alone.⁸



Medication-based treatment is more effective than detoxification and abstinence-based therapy alone.²¹

- Medication-based treatment is so effective for opioid use disorder that it should be offered whether or not behavioral interventions are available.²²
- The choice of treatment should be a shared decision between the clinician and the patient; the setting of treatment is an important consideration as well.²³

Match the patient with medication treatment for OUD

Table 3. Medications available to treat OUD

	buprenorphine* (Suboxone, Bunavail, Zubsolv)	methadone	naltrexone (Vivitrol)
Mechanism of action	 partial agonist	 full agonist	 antagonist
When to start	must have mild to moderate withdrawal symptoms	anytime	7-10 days abstinent prior to starting
Who can treat	anyone with a DEA-X waiver**	certified opioid treatment program	any prescriber
Treatment delivery	no daily clinic visits required	daily clinic visits, administer with supervision	monthly injection
Patient characteristics	most prefer as first-line treatment	unsuccessful prior treatments; need daily support	mild OUD or those who cannot use agonist
SUD severity	moderate to severe	moderate to severe	mild OUD
Initiating treatment	home or in office	certified opioid treatment program	in office for injection
Dosage forms	sublingual film, tablet, buccal film, long-acting injection or implant	liquid	long-acting injection

*Buprenorphine is often combined with naloxone (e.g., Suboxone) to discourage IV injection. The naloxone precipitates withdrawal if the substance is injected.

**Anyone licensed to prescribe opioids (e.g., M.D., D.O., N.P., P.A.) can complete the training and receive an X-waiver to prescribe buprenorphine.

Promote recovery



1 Recommend or prescribe naloxone (e.g., Narcan) to prevent a potentially fatal overdose.²⁴

2 Use “person-first” language to reduce stigma.

X Language to avoid	✓ Recommended language
addict, abuser, user, junkie	a person with OUD
clean/dirty urine	urine that is positive/negative for opioids or other substances
treatment failure	return to use, recurrence, relapse

3 Support patients who return to using the substance.

- All substance use disorders may take several attempts to achieve sustained remission.
- SUD is a chronic condition, and these patients will need ongoing support as they work toward recovery.

4 Continue medications for SUD as needed.

- Patients may require medications to treat SUD for several years, and for OUD possibly indefinitely.²³
- Patients who taper buprenorphine quickly may be more likely to return to use.²⁵

Prescribing a medication to treat SUD can build on the trust and relationship a primary care clinician has already established with the patient.

- Tobacco is the most common use disorder for which clinicians use medication treatment.
- Alcohol is the next most common SUD. Using medications combined with psychotherapy, peer-support, and referral for treatment is part of primary care practice.
- Opioid Use Disorder is common and can occur in any practice that has patients treated with opioids for chronic pain.
 - Prescribing buprenorphine or naltrexone can help address these concerns and make care less stressful for both the patient and clinician.

Key points

- Substance use disorders are common. Treatment can help improve patient outcomes.
- Use SBIRT-OK to identify patients who may benefit from treatment.
- Discuss medication and behavioral health treatment options, working with the patient to select the best option.
- Foster a supportive relationship through person-first language and continued encouragement even if patients return to substance use.

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Obtaining a DEA X waiver

To prescribe or dispense buprenorphine for opioid dependency treatment:

- For physicians, DEA X waiver training is an 8-hour course. No cost training and support resources may be found at pcssnow.org/medication-assisted-treatment.
- Also see Oklahoma State Department of Health: ok.gov/health



RPR Exchange (Research to Practice to Research Exchange): A convenient way for clinicians and researchers to communicate about information relevant to clinical practice. Learn more at: rpr.lib.ok.us.



DO NO HARM is a practice improvement program helping primary care practices implement delivery system changes, technology, clinical decision support, and patient self-management to adopt guidelines for safer pain and opioid management.

Partnering organizations



The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) promotes healthy communities and access to the highest quality care to enhance the well-being of all Oklahomans. The department is responsible for comprehensive planning and implementation of prevention, treatment, and recovery services for individuals affected by mental illness or substance use disorders.



ODMHSAS coordinates Screening, Brief Intervention, and Referral to Treatment (SBIRT OK)—an evidence-based public health approach that aims to identify, reduce, and prevent symptoms of depression and problematic substance use. This integrated approach focuses on identifying risk and intervening with patients in the healthcare setting to prevent the onset of more costly disease and addiction.



Located in the Oklahoma Clinical and Translational Science Institute at The University of Oklahoma Health Sciences Center, the Oklahoma Primary Healthcare Improvement Cooperative (OPHIC) is the academic research arm of a community-engaged system with a mission to facilitate the diffusion of research innovations into community clinical delivery systems. OPHIC partners include our state's County Health Improvement Organizations and other entities critical for translational research in community settings.



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