3.6 PARAMETERS FOR THE USE OF PSYCHOACTIVE MEDICATIONS IN INDIVIDUALS WITH CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH CONDITIONS

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I. INTRODUCTION

The appropriate use of psychoactive medications in individuals with co- occurring substance use and mental health conditions requires a specialized knowledge of substance- related addiction and commonly associated comorbid general medical conditions.

II. PURPOSE

A. The purpose of these parameters is to clarify specific DMH 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 use and mental health conditions, including:
   1. Antipsychotic Medications
   2. Mood Stabilizing Medications
   3. Antidepressant Medications
   4. Anxiolytic Medications

B. These parameters are not comprehensive treatment guidelines for the use of psychopharmacologic medications, nor are they guidelines for the psychopharmacologic treatment of substance use and addiction. Such guidelines exist, and should be familiar to clinicians.

C. These parameters are consistent with, but do not substitute for, other LACDMH parameters for the use of specific classes of psychoactive medications.

D. Clinicians prescribing psychopharmacologic treatment to DMH consumers with comorbid substance use should be familiar with all applicable LACDMH parameters.

E. Treatment non-adherence in individuals with substance use is a special situation that must be addressed by the prescribing physician. 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.

III. GENERAL PARAMETERS

A. Assessment of individuals with comorbid substance use should take into account the potential contribution of substance-induced presenting symptoms. Re-assessment of diagnosis and treatment should occur between 2 and 4 weeks of abstinence from substance use.

B. Psychoactive medications being taken on an ongoing basis for treatment of a psychiatric condition should be continued during discontinuation of substance use, unless specific contraindications to the use of these medications exist.
C. Assessment for possible pharmacologic treatment of individuals with an exacerbation of psychiatric symptoms during discontinuation of substance use should explicitly consider adjustment of any medications being used to manage discontinuation symptoms, prior to addition of other psychoactive medications.
D. Assessment for prescription of additional medications for psychiatric symptoms during discontinuation should explicitly consider the potential interactions with any medications being used to manage withdrawal with any associated physiologic complications.
E. Psychoactive medications with a low potential for misuse should be preferentially prescribed in individuals with comorbid substance use.
F. Medications for the treatment of psychiatric conditions should not be withheld from individuals with substance use solely because they continue to use substances. Rather, the medication treatment regimen should be one that best manages the psychiatric condition while minimizing the potential for interactions among the prescribed medication, the misused substance, and associated mental and physiologic effects.
G. Medications for the treatment of psychiatric conditions should not be withheld from individuals with substance use solely because they are taking medications for relapse prevention. Rather, the medication treatment regimen should be one that best manages the psychiatric condition while minimizing the potential for pharmacologic interactions among the prescribed medications.
H. Laboratory studies for assessment of physiologic processes that may be affected by substance use and are relevant to the metabolism of prescribed psychoactive medications should be obtained, monitored, and documented.
I. Individuals with substance use 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.

IV. USE OF ANTIPSYCHOTIC MEDICATIONS

A. Sedating antipsychotic medications should be avoided in individuals who persist in the misuse of alcohol, opioids, and sedative-hypnotics.
B. Antipsychotic medications should be administered concurrently with any medications being used to manage symptoms associated with withdrawal in individuals with schizophrenia who are experiencing an exacerbation of psychosis.
C. Depot antipsychotic medication should be preferentially considered in individuals with substance use who have a high probability of non-adherence with oral medication regimens.
D. Antipsychotic medication regimens prescribed for the emergence of psychotic symptoms or agitation during withdrawal should be re-evaluated after discontinuation period is completed.

V. USE OF MOOD STABILIZING MEDICATIONS

A. In individuals with alcohol use, divalproex should be used only when liver transaminases are less than 2x the upper limit of normal, and this value should be monitored more frequently than would otherwise be the case.

B. Mood stabilizing medication regimens prescribed for emergence of manic symptoms during the discontinuation period should be re-evaluated after that period is over.

VI. USE OF ANTIDEPRESSANT MEDICATIONS

A. Because antidepressants are associated with reduced alcohol use in individuals with comorbid depression and alcohol use, SSRIs and SNRIs should be preferentially used for treatment of primary depression in individuals with alcohol use.
B. Use of sedating TCAs in opioid-dependent individuals should generally be avoided because data suggests a potential for misuse.
C. Because of the potential for increased cardiotoxicity in individuals with cocaine use, 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 not be withheld solely due to presence of substance use.
E. Because of induction of hepatic microsomal activity by alcohol, higher doses of both SSRIs and TCAs should be considered in individuals with co-morbid alcohol use and depression that do not respond to standard dose.

VII. USE OF ANXIOLYTIC MEDICATIONS

A. The assessment and pharmacologic treatment of anxiety in individuals with comorbid substance use must take into account special considerations, including:
    1. The effect of the substance use on the presentation and self-regulation of anxiety symptoms;
    2. The contribution of the substance use to the anxiety symptoms through intoxication and discontinuation;
    3. The increased possibility that a prescribed anxiolytic medication may be misused or abused, and
    4. The interactions among the substance use, the metabolic changes resulting from the substance use, and the prescribed anxiolytic medication.
B. Because of data that suggests a reduction in craving and because of fewer untoward effects relative to TCAs and MAOIs, SSRIs and SNRIs should be preferentially used for pharmacological treatment of anxiety in individuals with comorbid substance use.
C. When SSRIs and SNRIs are contraindicated for treatment of primary anxiety in an individual with comorbid substance use, buspirone should be preferentially considered over other anxiolytic agents because of its relative safety.
D. For pharmacologic treatment of insomnia due to anxiety in individuals with comorbid substance use, sedating non-TCA antidepressants (e.g., trazodone and mirtazapine) should be used preferentially over sedating TCAs due to their relative safety.

VIII. USE OF BENZODIAZEPINES

A. Benzodiazepines prescribed during alcohol and/or benzodiazepine withdrawal management should almost always be stopped after the expected period of alcohol and/or benzodiazepine withdrawal symptoms is over.
B. The reasons for continuation of benzodiazepines past the expected period of alcohol and/or benzodiazepine withdrawal symptoms must be documented whenever they are re-prescribed.
C. Because of their increased potential for misuse, use of benzodiazepines for treatment of primary anxiety or adjustment conditions should almost always be avoided in individuals with comorbid substance use.
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 overuse.
E. Benzodiazepines and clozapine should not be used in combination because significant adverse reactions have been reported.
F. When emergent intervention is necessary, agitation and/or delirium stemming from alcohol discontinuation should be treated with parenteral rapid-acting benzodiazepines because they are more effective than other agents in reducing duration of alcohol withdrawal delirium and mortality.