

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

OFFICE OF THE MEDICAL DIRECTOR

**3.6 PARAMETERS FOR THE USE OF PSYCHOACTIVE MEDICATIONS IN
INDIVIDUALS WITH CO-OCCURRING SUBSTANCE ABUSE**

October 2014

I. INTRODUCTION: The appropriate use of psychoactive medications in individuals with co-occurring substance abuse requires a specialized knowledge of substance-related disorders 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 abuse disorder, 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 abuse. 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 abuse should be familiar with all applicable LACDMH parameters. These include the following DMH Parameters:

[1.0 Introduction to Clinical Parameters](#)

[3.2 Parameters for the Use of Antidepressant Medications](#)

[3.3 Parameters for the Use of Antipsychotic Medications](#)

[3.4 Parameters for the Use of Anxiolytic Medications](#)

[3.5 Parameters for the Use of Mood Stabilizing Medications](#)

[3.7 Parameters of General Health-Related Monitoring and Interventions
in Adults](#)

[3.10 Parameters for the Use of Medication Assisted Treatment](#)

[4.3 Parameters for Treatment Non-Compliance in OP Settings](#)

[4.5 Parameters for Clinical Treatment of Individuals with Co-occurring
Substance Abuse](#)

- E. Treatment non-adherence in individuals with substance abuse disorders 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 FOR THE USE OF PSYCHOACTIVE MEDICATIONS IN INDIVIDUALS WITH COMORBID SUBSTANCE ABUSE

- A. Assessment of individuals with comorbid substance use should take into account the potential contribution of substance-induced psychiatric disorders to presenting symptoms. Re-assessment of diagnosis and treatment should occur between 2 and 4 weeks of abstinence from the abused substance(s).
- B. Psychoactive medications being taken on an ongoing basis for treatment of a psychiatric disorder should be continued during discontinuation of abused substances, 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 abused substances 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 discontinuation symptoms, with the abused substance, and with any associated physiologic complications.
- E. Psychoactive medications with a low potential for abuse should be preferentially prescribed in individuals with comorbid substance use disorders.
- F. Medications for the treatment of psychiatric disorders should not be withheld from individuals with substance use disorders solely because they continue to use substances. Rather, the medication treatment regimen should be one that best manages the psychiatric disorder while minimizing the potential for interactions among the prescribed medication, the abused substance, and associated mental and physiologic effects.
- G. Medications for the treatment of psychiatric disorders should not be withheld from individuals with substance use 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 among the prescribed medications.

- H. 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.
- I. Individuals with substance use 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.

IV. USE OF ANTIPSYCHOTIC MEDICATIONS

- A. Sedating antipsychotic medications should be avoided in individuals who persist in the abuse of alcohol, opioids, and sedative-hypnotics.
- B. Antipsychotic medications should be administered concurrently with any medications being used to manage symptoms associated with discontinuation of abused substances in individuals with schizophrenia who are experiencing an exacerbation of psychosis.
- C. Depot antipsychotic medication should be preferentially considered in individuals with substance use disorders 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 discontinuation of abused substances should be re-evaluated after discontinuation period is completed.

V. USE OF MOOD STABILIZING MEDICATIONS IN INDIVIDUALS WITH COMORBID SUBSTANCE ABUSE

- A. Because of data that suggest a higher prevalence of rapid-cycling bipolar disorder in individuals with comorbid substance use disorders, 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 use disorder, 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.
- C. 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 IN INDIVIDUALS WITH COMORBID SUBSTANCE ABUSE

- A. Because of data that suggest newer antidepressants may decrease alcohol craving and because they are associated with fewer serious adverse effects, these medications should be preferentially used for treatment of primary depressive disorders in individuals with alcohol abuse.
- B. Use of sedating TCAs in opioid-dependent individuals should generally be avoided because data suggests 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 not be withheld solely due to presence of substance abuse.
- 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 disorders and depressive disorders that do not respond to standard doses.

VII. USE OF ANXIOLYTIC MEDICATIONS IN INDIVIDUALS WITH COMORBID SUBSTANCE ABUSE

- A. The assessment and pharmacologic treatment of anxiety in individuals with comorbid substance abuse must take into account special considerations, including:
 - 1. The effect of the substance use disorder on the presentation and self-regulation of anxiety symptoms;
 - 2. The contribution of the abused substance 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 abused substance, the metabolic changes resulting from the abused substance, 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, newer antidepressants should be preferentially used for pharmacological treatment of anxiety disorders in individuals with comorbid substance abuse.

- C. When newer antidepressants 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, and mirtazapine) should be used preferentially over sedating TCAs due to their relative safety.

VIII. USE OF BENZODIAZEPINES IN INDIVIDUALS WITH COMORBID SUBSTANCE ABUSE

- A. Benzodiazepines prescribed during discontinuation of abused substances should almost always be stopped after the expected period of withdrawal symptoms is over.
- B. The reasons for continuation of benzodiazepines past the expected period of substance withdrawal symptoms must be documented whenever they are re-prescribed.
- 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 use disorders.
- 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.
- 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 discontinuation delirium and mortality.