Northwest Frontier ATTC
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Addiction Messenger

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Medication-Assisted Treatment

Part 1 - Alcohol Relapse Prevention

Optimal addiction treatment is holistic, addressing all dimensions – physical, psychological, social, and spiritual. This 3-part series will focus on incorporat-ing medications into recovery services as aides to alleviating physical and psychological distress, including the need to use. Part 1 will describe how specific medications can compliment recovery services for alcohol use disorders (AUD).

We know chronic heavy drinking can cause long-lasting changes in the brain, neuroadaptations linked to cognitive and behavioral changes that result in the need to drink more to ward off craving and other withdrawal symptoms. AUD medications that help balance brain chemistry, help reduce cravings, and block the pleasurable effects of alcohol, can free a person to focus on recovery. They can:

- "Lengthen periods of abstinence, which in turn can increase individual coping capacities necessary for long-term recovery;
- Prevent a lapse from becoming a full-blown relapse;
- Allow brain cells to readapt to a normal nonalcoholic state, helping patients stabilize, think more clearly, have more positive emotional responses, strengthen coping mechanisms, enhance self-esteem, and increase readiness for change;
- Relieve symptoms of protracted withdrawal, and;
- Support the effects of psychosocial treatment and sustains the gains of intervention."(CSAT TIP 49, 2009)

FDA-approved AUD medications are neither addictive nor prone to abuse and generally have mild side effects, if prescribed and monitored carefully. Since the risk in using them is low, and they can make a lifetime of difference for a patient who might otherwise relapse, they are an option well worth considering.

Counselor Roles

Any pharmacologic treatment for AUD should be provided as an adjunct to behavioral support or specialized psychosocial treatment. While oversight is the purview of prescribers, counselors are necessary partners whose roles include counseling interventions; education and positive support (particularly around adherence); being knowledgeable about issues requiring consultation or referral; and, with experience, recognizing potential candidates for medication-assisted treatment (MAT).

Side effects, drug interactions, and contraindications exist to varying degrees for all medications; and it is the responsibility of prescribers to educate and monitor patients. Counselors can, however, watch for symptoms and other signs meriting consultation. Quick access to information is readily available in CSAT TIP 49 (2009), and through reputable websites such as www.safemedication.com from the

"There is a principle which is a bar against all information... proof against all arguments... that principle is contempt prior to investigation."

~ AA Big Book, attributed to Herbert Spencer ~

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Next Issue:

MAT for Opioid Addiction

Funded by Substance Abuse and Mental Health Services Administration

American Society of Health-Systems Pharmacists.

Your capacity to team with prescribers is key. If your agency lacks medical staff you may need to collaborate with other local treatment providers and hospitals. Also, as an aide to effective communications with prescribers, Mid-America ATTC (2004) and NAADAC (2008) have developed forms for counselors to use in providing treatment updates.

AUD Medications

There are three FDA-approved medications for individuals having an AUD: acamprosate, naltrexone, and disulfiram. Optimal treatment durations have not been established. The NIH (2008), however, citing high risk for relapse in the first 6–12 months of abstinence recommends an initial period of 3 months of AUD pharmacotherapy, with continuation up to a year (or longer) if a patient responds. FDA approval is time-limited for acamprosate (for use up to a year); and for oral naltrexone (up to 3 months, though many studies featured treatment of 6-9 months with favorable outcomes). Also, medications can also be used temporarily for patients in stable recovery who face risky situations, such as social situations involving alcohol.

Acamprosate Calcium (Campral®

Mechanism: Used and studied extensively since 1989 in Europe for alcohol dependency treatment, acamprosate was FDA-approved in 2004. Research indicates it interacts with the brain's glutamate neurotransmitter system to help restore an alcohol-related imbalance of inhibitory and excitatory signals; and that this helps reduce protracted withdrawal symptoms – such as insomnia, anxiety, and restlessness – that can contribute to negative emotional states and lead to relapse.

Who May benefit: Campral is recommended for dependent individuals moderately to highly motivated for abstinence; compliance – linked to positive outcomes – can be a challenge due to frequent dosing requirements. Counselors can help set up patient monitoring (e.g., contracts with friends or spouse), provide incentives, or develop reminders (e.g., setting watch alarms). Campral is not contraindicated with opioids, so may be particularly appropriate for patients using opioid analgesics, on opioid maintenance therapy, or at risk of relapsing to opioids. Multiple studies indicate it improves abstinence rates; better results for European studies may relate to participants having more severe dependencies, longer abstinence prior to treatment, and/or receiving inpatient/longer treatment.

Dosage: Two tablets 3x/day; taken with or without food, but pills *must be swallowed whole* to preserve the timed-release coating. Patient must be abstinent and detoxified from alcohol, though medication can be continued if a brief lapse back to use occurs.

Side effects: Most are mild and transient; including diarrhea (which may persist), pain, dizziness, dry mouth, itching, appetite loss, weakness, accidental injury, anxiety, depression, insomnia, sweating, nausea, dry mouth, and flatulence. Risk of overdose is remote and Campral hasn't been shown to cause adverse drug reactions; monitoring for depression or suicidal thinking is recommended.

Naltrexone Hydrochloride (Depade®, ReVia®, Extended-Release Vivitrol ®)

Mechanism: Approved by the FDA for AUD in 1994 (tablets) and 2006 (extended release), naltrexone binds to opioid receptors, blocking the ability of endogenous opioids released with alcohol consumption to bind and activate the release of dopamine. This reduces the pleasurable effects of alcohol, which concurrently can help reduce cravings.

Patients who benefit: Good candidates for oral dosing may be patients highly motivated for abstinence; in cases of lower motivation, dose monitoring or time-released Vivitrol may help. Research indicates patients with intense cravings and/or a family history of alcohol dependence may benefit. Analysis of multiple clinical trials concluded naltrexone (used 12 weeks or less) improved relapse rates during treatment and follow-up, lengthened abstinence, and decreased drinking during relapse. It may be a particularly good option for those in recovery from opioids who now seek AUD treatment, since it also reduces reinforcing effects of and curbs cravings for opioids (TIP 49, 2009). Since it is an opioid antagonist, patients using opioids or those who may need opioid analgesics are not candidates.

Dosage: Must be abstinent from opioids 7-10 days. Oral, once-daily; can be taken with food and crushed/diluted. Injectable, monthly intra-muscular by a medical provider.

Side effects: Most are mild and time-limited, though serious reactions can occur. They may include nausea (more commonly), vomiting, headache, dizziness, and fatigue. Symptoms also listed for oral: nervousness, anxiety, and drowsiness; for injectable: injection site reactions, back pain, upper abdominal pain, decreased appetite; and precaution to monitor for depression. Some risk of overdose exists, though it's greatly reduced with physician-injected Vivitrol. Patients should carry a medical alert card.

Disulfiram (Antabuse®)

Mechanism: Approved by the FDA in 1951, disulfiram is an aversion therapy that blocks the breakdown of alcohol in the liver resulting in a buildup of acetaldehyde and a toxic reaction 5–30 minutes after drinking alcohol. The "disulfiram-alcohol reaction" includes nausea, vomiting, facial flushing, headache, dizziness, sweating, heart palpitations, and blurred vision; it lasts 30 minutes to a few hours after alcohol use stops. Severity is usually proportional to ingested amounts of disulfiram and alcohol; also, the longer disulfiram is taken the stronger the effects. Alcohol and alcohol-containing products should be avoided (e.g., mouthwash, cologne/aftershave, cold medications, rubbing alcohol, paint fumes/thinner, varnish/shellac) while taking and two weeks after stopping disulfiram. Patients should be thoroughly educated and carry a medical alert card.

Dosage: Tablet 1x/day; may be crushed and diluted; must be abstinent at least 12 hours from alcohol and alcohol-containing products to begin medication.

Who may benefit: A good candidate might be a highly motivated alcoholic with poor impulse control who uses despite multiple treatment episodes. Research findings are mixed, but compliance to medication appears key to achieving positive outcomes. Since disulfiram also alters the metabolism of dopamine in the reward circuitry of the brain, it's being studied as a treatment for cocaine dependence and may help with cocaine-alcohol cross-addiction.

Side effects: Usually minor and transient, but may include drowsiness, fatigue, metallic or garlic aftertaste, skin rash or acne, headaches, and impotence. Very rarely can cause serious liver injury; liver function should be tested prior to and regularly during treatment. Overdose is possible; if suspected contact Poison Control Center.

Medication Costs/Coverage

Estimates only, based on a 30-day supply of a typical dose; averaged from costs obtained January 28, 2010 from DestinationRx.com, Drugstore.com, and Pharmacychecker.com:

- Acamprosate (333 mg, 6 tablets/day): Campral – $158/month, 5.28/day; qualifies for Forest Laboratories' Patient Assistance Program.
- Naltrexone Oral (50 mg tablet/day): Generic – $92/month, 3.07/day; ReVia – $227/mo., 7.57/day.
- Naltrexone Extended-Release (380 mg injection 1x/month): Vivitrol – $948/mo, 31.60/day. For information about insurance and a free dose: 1-800-VIVITROL.
- ***Disulfiram*** (250 mg, 1 tablet/day): Antabuse – $114/month, 3.80/day.

Medications are covered by most major insurance carriers, and Medicare, Medicaid; for Vivitrol approximately 90% of clients received insurance coverage without restrictions and there's now a "J code" for payers (NAADAC, 2008). The VA (per national policy) covers both disulfiram and oral naltrexone; Campral (if the former two medications are contraindicated); and Vivitrol for patients who exhibit evidence of likely non-adherence to, or fail, oral medications.

Case Studies

Interesting and encouraging case studies of alcoholics helped by disulfiram, acamprosate, and naltrexone (DiClemente C., 2007) are included in an excellent series in *Addiction Professional,* January – November 2007; the six articles cover numerous aspects of AUD medications, are well worth reading, and are readily available on-line.

Conclusion

Increasingly, clinical trials of AUD medications are expanding and improving medical options. By now pharmacotherapy should be considered a potential component of alcoholism recovery services, one that is expanding and strengthening aides in bio-psycho domains. What works for some may not work for others, but patients deserve to have all options considered in their journey of recovery. Our next issue will focus on MAT for opioid addiction. Stay tuned!

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February 18-19, 2010 - Mt. Vernon, WA
February 25-26, 2010 – Grants Pass, OR
1.5 -day Course (10 CE Hours) – focuses on building skills in the use of cognitive behavioral therapy for counseling interventions. Participants will have the opportunity to develop or improve skills in the use of CBT appropriate for those clients with substance use disorders and mental health issues.

Supervisory Tools for Enhancing Counselor Motivational Interviewing Skills ("MIA:STEP")
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2-day Course (12 CE Hours) ~ designed for clinical supervisors who want to maintain and build the MI skills of counselors and other direct service providers. Tools presented fortify a supervisor's ability to provide structured, focused, and effective clinical supervision. Participants are introduced to an effective strategy for observation-based MI-oriented clinical supervision.

Developing Effective Treatment Plans ("Treatment Planning MATRS")
February 17, 2010 – Tacoma, WA
March 24, 2010 – Spokane, WA
March 31, 2010 – Pendleton, OR
1-day Course (7 CE Hours) - designed to help counselors develop treatment plans that are individualized, strength-based, and oriented toward specific client needs. Course is focused on using assessment information effectively in treatment planning and ongoing case management.

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