

TREATMENT PRACTITIONER'S RESEARCH BULLETIN

Alcohol and drug research treatment advances and best practice summary

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ADVANCING EFFECTIVE ALCOHOL AND DRUG POLICY,
PREVENTION, AND TREATMENT

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What Are the Risks of Risky Drinking?

To examine the adverse consequences of risky drinking,* researchers assessed baseline drinking among 22,122 adult national survey participants who had consumed at least 1 drink in the year preceding the baseline interview and measured the 3-year incidence of selected outcomes.

- At baseline, 60% of subjects reported no risky drinking. Seventeen percent reported risky drinking <1 time per month; 9%, 1 to 3 times per month; 8%, 1 to 2 times per week; 3%, 3 to 4 times per week; and 3%, daily or near daily.
- The risk for adverse consequences increased as the frequency of risky drinking increased. In adjusted analyses, participants who reported risky drinking 1 to 2 times per week were more likely than those who reported no risky drinking to have incident alcohol abuse (odds ratio [OR], 3.3); alcohol dependence (OR, 2.7); drug use (OR, 1.6); drug dependence (OR, 2.3); tobacco use (OR, 2.7); nicotine dependence (OR, 1.8); and any liver disease (OR, 2.8). They were also more likely to divorce or separate (OR, 1.3) and lose their driver's licenses (OR, 1.8).
- In similar analyses, the risk for adverse consequences was generally higher in subjects who reported risky drinking on a daily or near-daily basis.

*In this paper, risky drinking was defined as 5+ drinks in a day for men and 4+ drinks in a day for women.

Comments by Tom Delaney, MSW, MPA

This paper is useful for counselors in 2 ways: First, it discusses criteria for risky drinking, which can be used in current practice. Second, it alerts practitioners to the need for more precise tools to identify at-risk drinking. These findings show the advantages of measuring multiple outcomes. Although a relationship between risky drinking and health, social, and legal problems is shown, as noted by the authors, causality could be either way.

Reference

Dawson DA, Li TK, Grant BF. A prospective study of risk drinking: at risk for what? *Drug Alcohol Depend.* 2008;95(1-2):62-72.

This summary was adapted from text previously published in *Alcohol, Other Drugs, and Health: Current Evidence* (www.aodhealth.org).

Telephone-based Stepped Care for Unhealthy Alcohol Use

Telephone-based, stepped care strategies have the potential to improve delivery of alcohol interventions in primary care settings. In a controlled trial, researchers randomized 408 primary care patients with at-risk drinking,* heavy drinking,** alcohol abuse, and alcohol dependence to full care (computerized feedback plus four 30-minute telephone interventions), stepped care (computerized feedback plus up to three 40-minute telephone interventions, depending on response), or a control group (no alcohol intervention).

Telephone interventions were based on motivational interviewing and delivered by trained psychologists. Overall mortality was 8.8 deaths per 1000 person-years of follow-up (0.66 during opioid maintenance treatment and 14.3 while out of treatment).

- The baseline ranges of unhealthy alcohol use levels among the 3 arms were as follows:
 - at-risk drinking, 21–33%
 - heavy drinking, 24– 30%
 - alcohol abuse, 12–17%
 - alcohol dependence, 26–38%
- Compared with controls, participants in the intervention groups (full care and stepped care combined) reported a greater decrease in grams of alcohol per day from baseline to 12 months (-12.6 versus -6.3 in the overall sample; -17.9 versus -3.7 in the alcohol abuse/at-risk drinking subgroup) and a lower proportion of binge drinking at 12 months (25% versus 41%) in the alcohol abuse/at-risk drinking subgroup.
- Outcomes did not differ between the control and intervention groups for subjects with alcohol dependence or heavy drinking.
- Outcomes were similar in the full care and stepped care groups. The stepped care group received 50% of the counseling time (40 versus 80 minutes) received by the full care group.

*Average use of >30 grams of alcohol (about 3 drinks) per day for men and >20 grams of alcohol (about 2 drinks) per day for women over the past 4 weeks.

**Average use of >80 grams of alcohol (about 8 drinks) for men and >60 grams of alcohol (about 6 drinks) for women on 2 or more occasions over the past 4 weeks.

Comments by Tommie Ann Bower, MA

Although the value of brief intervention for problem drinking has been established, the time it takes to administer it remains a barrier in clinical settings. This study shows that a pared down approach can have an equal impact, although this may surprise some practitioners. Finding financial coverage for such a simple approach and embedding it as a care option will likely prove less simple.

Reference

Bischof G, Grothues JM, Reinhardt S, et al. Evaluation of a telephone-based stepped care intervention for alcohol-related disorders: a randomized controlled trial. *Drug Alcohol Depend.* 2008;93(3):244–251.

This summary was adapted from text previously published in *Alcohol, Other Drugs, and Health: Current Evidence* (www.aodhealth.org).

Methadone Detoxification Remains No Match for Methadone Maintenance, Even with Minimal Counseling

No controlled studies have compared short-term methadone maintenance (MM) to methadone detoxification (MD), although it is known that open-ended MM is more effective than MD. Gruber et al. took advantage of a randomized controlled trial (RCT) assessing the effect of 6-month MM on adherence to latent tuberculosis therapy to compare 21-day MD to 6-month MM with either minimal or standard counseling.

In this RCT (n=111), outcomes were substance use and depressive symptoms. Doses of methadone were between 60 and 90 mg per day. Minimal counseling involved a single 15-minute session per month with no contingencies (e.g., take-home medication). Standard counseling involved 2 sessions per month (more, if needed, as determined by the counselor) with the opportunity to earn take-home medications. The majority of subjects were male, nonwhite, poor, and not interested in stopping heroin but rather in cutting down on use.

- Compared with 6-week MD, 6-month MM resulted in a greater decrease from baseline in self-reported opiate use, opiate positive urines and days of alcohol use.
- No difference between groups was found for cocaine use or depressive symptoms.
- Results for MM with standard counseling did not differ from those for MM with minimal counseling.

Comments by James Harrison, MHS, CADC

Methadone maintenance is the preferred treatment approach for heroin dependence. In this study, most of the participants were interested in limiting heroin use rather than abstaining from it. Although standard and brief counseling yielded similar outcomes, the use of counseling supported by the best evidence, e.g., use of motivational enhancement therapy, might have improved outcomes over those achieved by the counseling studied. The most significant results of this RCT suggest that cocaine use and depressive symptoms need to be addressed regardless of the treatment modality for opioid dependence.

Reference

Gruber VA, Delucchi KL, Kielstein A, et al. A randomized trial of 6-month methadone maintenance with standard or minimal counseling versus 21-day methadone detoxification. *Drug Alcohol Depend.* 2008;94(1-3):199-206.

This summary was adapted from text previously published in *Alcohol, Other Drugs, and Health: Current Evidence* (www.aodhealth.org).

Trends and Complications among Hospitalized Pregnant Women with Stimulant Abuse

Maternal and fetal complications associated with stimulant abuse during pregnancy are substantial and reported to be similar for cocaine and amphetamines. Researchers from the Centers for Disease Control and Prevention queried the Healthcare Cost and Utilization Project National Inpatient Sample to determine trends in cocaine and amphetamine-related hospitalizations, and complications during these hospitalizations, among pregnant women between 1998 and 2004. During the study period,

- The annual cocaine-related hospitalization rate decreased from 0.74 per 100 deliveries to 0.41, while the amphetamine-related rate increased from 0.11 to 0.22.
- 82% of the amphetamine-related hospitalizations were in Western states.
- The proportion of women younger than 24 years was higher in the amphetamine group than in the cocaine group.
- Amphetamine-related hospitalizations were more common than cocaine-related hospitalizations among rural hospitals.
- Psychiatric disorders, poor fetal growth, and premature delivery were more common in the cocaine group compared with the amphetamine group; while cardiovascular disorders, hypertension complicating pregnancy, and placenta previa were more common in the amphetamine group.
- No significant differences between cocaine and amphetamine groups were detected for anemia, genitourinary infections, hepatitis, seizure disorder, injury, placental abruption, or premature labor.
- Psychiatric disorders, anemia, genitourinary tract infections, hepatitis, epilepsy, cardiovascular disorders, injury, hypertension complicating pregnancy, premature rupture of membranes, placenta previa, placental abruption, infection of amniotic cavity, intrauterine death, and poor fetal growth were all more common among the amphetamine group compared with the non-substance abuse group.

Comments by Tommie Ann Bower, MA

This study carefully teases out the impact of amphetamine versus cocaine use in pregnant women and highlights the urgent need to improve prenatal screening and intervention. Over the years, sound bites about an epidemic have all but stopped. The authors rightly conclude that "clinicians who serve reproductive-age women have an ethical obligation to provide complete and comprehensive medical care . . . universal screening, brief interventions, and referral." An "epidemic" of one infant lost to the consequences of cocaine and amphetamine use is one too many for clinicians not to broach the subjects of treatment and prenatal care.

Reference

Cox S, Posner SF, Kourtis AP, et al. Hospitalizations with amphetamine abuse among pregnant women. *Obstet Gynecol.* 2008;111(2):341-347.

This summary was adapted from text previously published in *Alcohol, Other Drugs, and Health: Current Evidence* (www.aodhealth.org).

Contingency Management Added to Methadone Maintenance Lowers HIV Risk Behaviors in Patients with Cocaine Abuse or Dependence

Contingency management (CM) reduces drug use, but its effect on HIV/AIDS risk behaviors is not known. Researchers analyzed data from 3 randomized controlled studies of the effect of CM added to methadone maintenance (MM) treatment in persons who had cocaine abuse or dependence to measure its impact on HIV/AIDS risk behaviors. Participants in each of the combined studies (N=165) received either standard MM treatment or MM treatment with CM for 3 months.

- Compared with the standard MM treatment groups, patients in the CM groups had:
 - Lower overall scores on the HIV Risk Behavior Scale (HRBS) at 12-week and 6-month follow-up.
 - Less injection drug use at 12-week and 6-month follow-up.
 - Fewer drug-positive urine samples.
- No significant differences were demonstrated on the HRBS sexual behavior subscores.
- Longer term abstinence was a substantial mediating factor.

Comments by Michael Boyle, MA

These results show that an additional benefit of CM is a reduction in HIV risk behaviors. Although many providers dismiss the use of CM as too expensive, a case could be made that it increases attendance at group sessions and retains existing patients in treatment, thus lowering administrative costs and improving care and outcomes. Also, payors could provide new funding for drug treatment based on these results.

Reference

Hanson T, Alessi SM, Petry NM. Contingency management reduces drug-related human immunodeficiency virus risk behaviors in cocaine-abusing methadone patients. *Addiction*. 2008; 103(7):1187-1197.

Substance Abuse Treatment among Patients with HIV and Mental Illness

Untreated substance use and mental health conditions are associated with increased HIV transmission risk, decreased adherence to highly active antiretroviral therapy (HAART), and poor response to HAART. Researchers sought to determine the receipt of substance abuse and mental health treatment over a 3-month period in a cohort of 803 HIV-infected individuals who met diagnostic criteria for substance use and mental health disorders. Primary findings were as follows:

- Forty-seven percent of subjects had drug and alcohol dependence, 33% had drug dependence, 15% had alcohol dependence, and 5% had drug and/or alcohol abuse but not dependence.
- Only 33 percent had received concurrent treatment for substance abuse and mental illness in the past 3 months; 26 percent had received only mental health services, 15 percent had received only substance abuse services, and 26 percent had received no services.
- Use of concurrent substance abuse and mental health services was lower among nonwhites and Hispanics ($p < 0.05$) but was positively associated with Veterans Affairs Civilian Health and Medical Program of the Uniformed Services (VA CHAMPUS) insurance coverage ($p < 0.05$).
- African American, Hispanic, and nonwhite subjects were more likely to use self-help groups than white non-Hispanic subjects ($p < 0.001$).

Comments by James Harrison, MHS, CADC

Historically, persons with co-occurring substance use disorders and mental health diagnoses have been treated for either one disorder or the other. This approach fails to meet the unique needs of such patients. In the substance abuse field, clients with co-occurring mental illness are often seen as noncompliant, and negative staff attitudes and beliefs create a barrier to effectively serving this population. In addition, lack of adequate training and lack of interaction across treatment tracks creates a gap in treatment coordination. These findings show that changes in direct services, as well as system changes, must occur to treat patients with co-occurring substance use disorders and mental illness effectively.

Reference

Weaver MR, Conover CJ, Proescholdbell RJ, et al. Cost Subcommittee of the HIV/AIDS Treatment Adherence, Health Outcomes, and Cost Study Group. Utilization of mental health and substance abuse care for people living with HIV/AIDS, chronic mental illness, and substance abuse disorders. *J Acquir Immune Defic Syndr*. 2008;47(4):449-458.

This summary was adapted from text previously published in *Alcohol, Other Drugs, and Health: Current Evidence* (www.aodhealth.org).

Incentives Increase Naltrexone Treatment Adherence in Persons with Schizophrenia and Alcohol Use Disorders

Naltrexone is an effective treatment for alcohol dependence when taken consistently; however, poor adherence to medication is common in patients with severe mental illness. To recruit and retain participants in a study of the effectiveness of naltrexone, a subset of 61 participants who had both schizophrenia and an alcohol use disorder were offered vouchers that could be cashed in for tangible items when they attended clinic visits to receive oral naltrexone.

Clinic visits were scheduled 3 days a week for 12 weeks at the participants' community mental health centers. Vouchers started at \$5 per visit and increased \$1 a day for consecutive visits to a maximum of \$10. An unexcused absence reset the amount to \$5.

- Overall average visit attendance was 82%.
- Consistent attendance, defined as attending 80% of all sessions, was achieved in 77% of participants.
- The average cost per participant for the vouchers was \$330.
- The severity of psychosis at the start of the study was not a factor in attendance.

Comments by Michael Boyle, MA

Although the study design precludes determination of causality, the high adherence rate supports the need for further investigation of the effectiveness of motivational incentives in treating patients with schizophrenia and alcohol dependence. System changes at both the provider and state level are needed if effective adherence measures are to be implemented. The Strengthening Treatment Access and Retention—State Implementation (STAR-SI) project implemented by the Center for Substance Abuse Treatment (CSAT), which promotes the use of incentives and motivational interviewing to engage clients in the early phases of treatment, is a good example of how state/provider partnerships can promote these system changes.

Reference

Leontieva L, Dimmock JA, Gately PW, et al. Voucher-based incentives for naltrexone treatment attendance in schizophrenia and alcohol use disorders. *Psychiatr Serv.* 2008;59(3):310–314.

Prescription Drug Misuse Is Prevalent and Associated with Youth, Psychiatric Problems, and Other Substance Use

Nonmedical use of prescription drugs is a growing problem among adolescents and young adults. Three recent articles examine this problem using cross-sectional data from the National Survey on Drug Use and Health (NSDUH), a representative US sample survey assessing the prevalence, patterns, and consequences of alcohol, tobacco, and illegal drug use.

- Analyzing data from 91,804 persons over age 18 who participated in the survey between 2002–2004, Becker and colleagues found past-year nonmedical use of prescription opioids in 4.5% of subjects, 12.9% of whom met criteria for abuse or dependence. Correlates of nonmedical use included younger age, depressive and anxiety symptoms, cigarette smoking, alcohol misuse, Latino ethnicity, unemployment, and low education attainment.
- Wu and colleagues examined data from 18,678 adolescents aged 12–17 who participated in the 2005 survey and found that 10% reported lifetime nonmedical use of prescription opioids. Of these, 61% had used prescription opioids nonmedically before age 15, and 18% had used them weekly or more in the previous year. Risk factors for lifetime use included age 16–17 (compared with age 12–13), younger age at first drug use, fair or poor health, and 3 or more emergency department visits in the past year. Mental-health service use was a significant correlate for girls.
- In an analysis of the 2003 survey, Simoni-Wastila and colleagues found a 9.3% prevalence of nonmedical prescription drug use by adolescents. They similarly detected a relationship between past-year nonmedical use of prescription drugs with age 16–17, cigarette smoking, and alcohol use.

Comments by Tom Delaney, MSW, MPA

These findings show the prevalence of prescription drug misuse among youth, particularly those with medical, social, and behavioral problems. Substance abuse counselors need to be knowledgeable and vigilant in screening all of their adolescent and young adult patients for prescription drug misuse, particularly if they smoke, drink, use other substances, or have depressive or anxiety symptoms.

Reference

Becker WC, Sullivan LE, Tetrault JM, et al. Non-medical use, abuse and dependence on prescription opioids among U.S. adults: psychiatric, medical and substance use correlates. *Drug Alcohol Depend.* 2008; 94(1–3):38–47.

Wu LT, Pilowsky DJ, Patkar AA. Non-prescribed use of pain relievers among adolescents in the United States. *Drug Alcohol Depend.* 2008;94(1–3):1–11.

Simoni-Wastila L, Yang HWK, Lawler J. Correlates of prescription drug nonmedical use and problem use by adolescents. *J Addict Med.* 2008;2(1):31–39.

This summary was adapted from text previously published in *Alcohol, Other Drugs, and Health: Current Evidence* (www.aodhealth.org).

Association between Bipolar Disorder, Substance Use Disorders, and Smoking in Youth

Although previous research suggests that juvenile-onset bipolar disorder (BPD) increases the risk for cigarette smoking and other substance use disorders (SUDs), the literature on this subject is limited. To examine whether an association exists, researchers compared 105 youths with BPD to 98 youths without BPD (controls).

- Youths with BPD were significantly more likely to have an SUD (34%) compared with controls (4%).
- Youths with BPD were also more likely than controls to have alcohol abuse (23% versus 3%), alcohol dependence (6% versus 0%), drug abuse (22% versus 1%), drug dependence (14% versus 1%), and cigarette smoking (22% versus 4%) than controls.
- The increased risk for an SUD was independent of conduct disorder, attention deficit/hyperactivity disorder (ADHD), or multiple anxiety disorders.
- The onset of mood disorders (e.g., depression or mania) during adolescence was specifically associated with elevated risk for an SUD compared with mood disorders that began prior to puberty.
- Of the 33 subjects with both an SUD and BPD, 22 (67%) experienced the onset of BPD prior to the onset of their SUD, 8 (24%) experienced the onset of BPD and their SUD within the same year, and 3 (9%) experienced the onset of BPD after the onset of their SUD.

Comments by Michael Levy, PhD

These results clearly demonstrate that adolescent BPD is a significant risk factor for SUDs and cigarette smoking, independent of psychiatric comorbidity. This was particularly evident among youth who first experienced BPD symptoms during adolescence. In light of these findings, it is important for clinicians to screen youth with BPD for cigarette and other substance use.

Reference

Wilens TE, Biederman J, Adamson JJ, et al. Further evidence of an association between adolescent bipolar disorder with smoking and substance use disorders: a controlled study. *Drug Alcohol Depend.* 2008;95(3):188–198.

Youth Cannabis Use Commonly Extends into Adulthood

Data from Western countries suggest that up to half of adolescents have used cannabis at least once, and up to 10% may develop cannabis abuse or dependence. To examine the natural history of cannabis use, German investigators analyzed 4- and 10-year follow-up data from 3021 youth (ages 14–24 years at baseline) enrolled in a prospective population-based cohort study. Cannabis use and dependence were measured using the Munich Composite International Diagnostic Interview-Substance Abuse Module (CIDI-SAM).

- At baseline, 7% had used cannabis once only; 11% had used it 2 to 4 times only, and 16% had used it 5 times or more (repeated use).
- Of those who had repeated cannabis use at baseline, 56% still used it 4 years later, and 46% still used it 10 years later.
- Predictors of repeated use at 10-year follow-up included repeated use at baseline, younger age of initial use, male gender, drug-using peers, distressing life events, and alcohol dependence.
- Cannabis abuse or dependence was found in 12% of subjects at baseline, 15% at 4 years, and 13.5% at 10 years.
- Cannabis dependence at baseline was significantly associated with dependence at 10-year follow-up.

Comments by Michael Levy, PhD

This study found that cannabis dependence early in life heightened vulnerability to a chronic cannabis disorder well into adulthood. Early interventions to delay first use and reduce frequency of use in adolescents and young adults may be helpful in offsetting future difficulties, since both these factors related to cannabis dependence later in life.

Reference

Perkonig A, Goodwin RD, Fiedler A, et al. The natural course of cannabis use, abuse and dependence during the first decades of life. *Addiction*. 2008;103(3):439–449.

This summary was adapted from text previously published in *Alcohol, Other Drugs, and Health: Current Evidence* (www.aodhealth.org).

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