Clinical Practice Guideline SUMMARY

Management of Substance Use Disorders (SUD)

August, 2009

VA/DoD Evidence Based Practice

VA/DoD CLINICAL PRACTICE GUIDELINE FOR MANAGEMENT OF SUBSTANCE USE DISORDERS

Department of Veterans Affairs

Department of Defense

GUIDELINE SUMMARY

QUALIFYING STATEMENTS

The Department of Veterans Affairs (VA) and The Department of Defense (DoD) guidelines are based on the best information available at the time of publication. They are designed to provide information and assist decision-making. They are not intended to define a standard of care and should not be construed as one. Neither should they be interpreted as prescribing an exclusive course of management.

Variations in practice will inevitably and appropriately occur when providers take into account the needs of individual patients, available resources, and limitations unique to an institution or type of practice. Every healthcare professional making use of these guidelines is responsible for evaluating the appropriateness of applying them in the setting of any particular clinical situation.

Version 2.0 – 2009

Prepared by:

The Management of SUD Working Group

With support from:

The Office of Quality and Performance, VA, Washington, DC

&

Quality Management Directorate, United States Army MEDCOM

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The full version of this guideline is available for download at:
www.healthquality.va.gov

INTRODUCTION

The Clinical Practice Guideline for the Management of Substance Use Disorders (SUD) was developed under the auspices of the Veterans Health Administration (VHA) and the Department of Defense (DoD) pursuant to directives from the Department of Veterans Affairs (VA). VHA and DoD define clinical practice guidelines as:

> "Recommendations for the performance or exclusion of specific procedures or services derived through a rigorous methodological approach that includes:
>
> - Determination of appropriate criteria such as effectiveness, efficacy, population benefit, or patient satisfaction; and
> - Literature review to determine the strength of the evidence in relation to these criteria."

The intent of the guidelines is to:

- Reduce current unwarranted practice variation and provide facilities with a structured framework to help improve patient outcomes
- Provide evidence-based recommendations to assist providers and their patients in the decision-making process
- Identify outcome measures to support the development of practice-based evidence that can ultimately be used to improve clinical guidelines.

Background

Substance use disorders (SUD) constitute a major public health problem with a substantial impact on health, societal costs, and personal consequences.

- **SUD in the VA population:** In 2007 fiscal year, over 375,000 VA patients had a substance use disorder diagnosis and nearly 500,000 additional patients had a nicotine dependence diagnosis in the absence of other substance use disorders. (Dalton A, Saweikis M, McKellar JD: Health Services for VA Substance Use Disorder Patients: Comparison of Utilization Fiscal Years 2005, 2004, 2003 and 2002. Palo Alto, CA, Program Evaluation and Resource Center, 2004.)
- **SUD in the DoD population:** The substantial negative consequences of alcohol use on the work performance, health, and social relationships of military personnel have been a continuing concern assessed in DoD surveys. In 2005, 8.1 percent of military personnel anonymously responding to a survey reported one or more serious consequences associated with alcohol use during the year, a decline from 9.6 percent in 2002. Using AUDIT criteria, 2.9 percent of respondents were estimated to be highly likely to be dependent on alcohol in 2005. (Bray RM, Hourani LL, Olmsted KLR, et al. 2005 Department of Defense Survey of Health Related Behaviors Among Active Duty Military Personnel. Research Triangle Park, NC: Research Triangle International, December, 2006. Available at: http://www.ha.osd.mil/special_reports/2005_Health_Behaviors_Survey_1-07.pdf)

Target population

This guideline applies to **adult patients with substance use conditions** treated in any VA/DoD clinical setting, including patients who have both substance use and other health conditions; and patients with any level of severity ranging from hazardous and problematic use to substance use disorders.

Audiences

The guideline is relevant to all healthcare professionals providing or directing treatment services to patients with substance use conditions in any VA/DoD healthcare setting, including specialty SUD care, and both general and mental healthcare settings.

Goals of the Guideline

- To identify patients with substance use conditions, including at-risk use, substance use problems and substance use disorders
- To promote early engagement and retention of patients with substance use conditions who can benefit from treatment
- To improve outcomes for patients with substance use conditions (cessation or reduction of substance use, reduction in occurrence and severity of relapse, improved psychological and social functioning and quality of life, improved co-occurring medical and health conditions, and reduction in mortality).

Content of the Guideline

The guideline consists of five modules that address inter-related aspects of care for patients with SUDs.

Module A: **Screening and Initial Assessment for Substance Use** includes screening, brief intervention, and specialty referral considerations.

Module B: **Management of SUD in Specialty SUD Care** focuses on patients in need of further assessment or motivational enhancement or who are seeking remission.

Module C: **Management of SUD in General Healthcare** (including primary care) emphasizes earlier intervention for less severe SUD, or chronic disease management for patients unwilling or unable to engage in treatment in specialty SUD care or not yet ready to abstain.

Module P: **Addiction-Focused Pharmacotherapy** addresses use of medication approved by the Food and Drug Administration for the treatment of alcohol and opioid dependence.

Module S: **Stabilization and Withdrawal Management** addresses withdrawal management including pharmacological management of withdrawal symptoms.

Each module consists of an algorithm that describes the step-by-step process of the clinical decision-making and intervention that should occur in the specified group of patients. General and specific recommendations for each step in the algorithm are included in the annotations following the algorithm. The links to these recommendations are embedded in the relevant specific steps in the algorithm.

Each annotation includes a brief discussion of the research supporting the recommendations and the rationale behind the grading of the evidence and the determination of the strength of the recommendations.

Tobacco use should be addressed in all patients and is a major cause of morbidity and mortality among patients with non-nicotine SUDs. For management of nicotine dependence, refer to the Clinical Practice Guideline: Treating Tobacco Use & Dependence: 2008 Update from the U.S. Department of Health and Human Services available at: http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf and the VA/DoD Clinical Practice Guideline for Management of Tobacco Use.

For management of patients presenting with SUDs and depression, refer to the VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder (MDD). For management of prescribed opioids for chronic pain, refer to the VA/DoD Clinical Practice Guideline for the Management of Chronic Opioid Therapy. Additional recommendations for patients with co-occurring conditions may be found in the VA/DoD Clinical Practice Guideline for the Management of Post Traumatic Stress (ASD and PTSD).

Development Process

The development process of this guideline follows a systematic approach described in "Guideline-for-Guidelines," an internal working document of VA/DoD Evidence-Based Practice Working Group.

The literature was critically analyzed and evidence was graded using a standardized format. The evidence rating system for this document is based on the system used by the U.S. Preventive Services Task Force (see Appendix A to the full guideline – Development Process).

If evidence exists, the discussion of the recommendations includes an evidence table that indentifies the studies that have been considered, the quality of the evidence, and the rating of the strength of the recommendation [SR]. The strength of recommendation, based on the level of the evidence and graded using the USPSTF rating system (see Table: Evidence Rating System), is presented in brackets following each guideline recommendation. Recommendations that are based on consensus of the Working Group include a discussion of expert opinion on the given topic. No [SR] is presented for these recommendations. A complete bibliography of the references found in this guideline can be found in Appendix H.

Strength of Recommendation and Evidence Rating System

SR*	
A	A strong recommendation that the clinicians provide the intervention to eligible patients. *Good evidence was found that the intervention improves important health outcomes and concludes that benefits substantially outweigh harm.*
B	A recommendation that clinicians provide (the service) to eligible patients. *At least fair evidence was found that the intervention improves health outcomes and concludes that benefits outweigh harm*.
C	No recommendation for or against the routine provision of the intervention is made. *At least fair evidence was found that the intervention can improve health outcomes, but concludes that the balance of benefits and harms is too close to justify a general recommendation.*
D	Recommendation is made against routinely providing the intervention. *At least fair evidence was found that the intervention is ineffective or that harms outweigh benefits.*
I	The conclusion is that the evidence is insufficient to recommend for or against routinely providing the intervention. *Evidence that the intervention is effective is lacking, or poor quality, or conflicting, and the balance of benefits and harms cannot be determined.*

* SR= Strength of Recommendation

Lack of Evidence – Consensus of Experts

Where existing literature was ambiguous or conflicting, or where scientific data were lacking on an issue, recommendations were based on the clinical experience of the Working Group. These recommendations are indicated in the evidence tables as based on "Working Group Consensus."

This Guideline is the product of many months of diligent effort and consensus-building among knowledgeable individuals from the VA, DoD, and academia, and a guideline facilitator from the private sector. An experienced moderator facilitated the multidisciplinary Working Group. The draft document was discussed in one face-to-face group meeting. The content and validity of each section was thoroughly reviewed in a series of conference calls. The final document is the product of those discussions by all members of the Working Group.

The list of participants is included in Appendix G to the full guideline.

Implementation

The guideline and algorithms are designed to be adapted to individual facility needs and resources. The algorithms will serve as a guide that providers can use to determine best interventions and timing of care for their patients to optimize quality of care and clinical outcomes. This should not prevent providers from using their own clinical expertise in the care of an individual patient. Guideline recommendations are intended to support clinical decision-making but should never replace sound clinical judgment.

Although this guideline represents the state of the art practice at the time of its publication, medical practice is evolving and this evolution will require continuous updating of published information. New technology and more research will improve patient care in the future. The clinical practice guideline can assist in identifying priority areas for research and optimal allocation of resources. Future studies examining the results of clinical practice guidelines such as these may lead to the development of new practice-based evidence.

Outcomes

1. Reduction of consumption
2. Improvement in quality of life (social and occupational functioning)
3. Improvement of symptoms
4. Improvement of retention (keeping patients engaged in the program)
5. Improvement in co-occurring conditions
6. Reduction of mortality.

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DEFINITIONS

CONDITIONS AND DISORDERS OF UNHEALTHY ALCOHOL USE

The spectrum of alcohol use extends from abstinence and low-risk use (the most common patterns of alcohol use) to risky use, problem drinking, harmful use and alcohol abuse, and the less common but more severe alcoholism and alcohol dependence. (Saitz, 2005)

UNHEALTHY ALCOHOL USE

Risky users: For women and persons > 65 years of age, > 7 standard drinks per week or > 3 drinks per occasion; for men ≤ 65 years of age, > 14 standard drinks per week or >4 drinks per occasion; there are no alcohol-related consequences, but the risk of future physical, psychological, or social harm increases with increasing levels of consumption; risks associated with exceeding the amounts per occasion that constitute "binge" drinking in the short term include injury and trauma; risks associated with exceeding weekly amounts in the long term include cirrhosis, cancer, and other chronic illnesses; "risky use" is sometimes used to refer to the spectrum of unhealthy use but usually excludes dependence; one third of patients in this category are at risk for dependence.

Problem drinking: Use of alcohol accompanied by alcohol-related consequences but not meeting DSM-IV criteria; sometimes used to refer to the spectrum of unhealthy use but usually excludes dependence.

DIAGNOSED SUBSTANCE USE DISORDERS (DSM IV, American Psychiatric Association, 1994)

DSM-IV-TR Criteria for Substance Abuse:

"A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring at any time in the same 12-month period:

- Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home
- Recurrent substance use in situations in which it is physically hazardous
- Recurrent substance-related legal problems
- Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance."

DSM-IV-TR Criteria for Substance Dependence:

"A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following seven criteria, occurring at any time in the same *12-month period*:

1. Tolerance, as defined by either of the following:
   - A need for markedly increased amounts of the substance to achieve intoxication or desired effect
   - Markedly diminished effect with continued use of the same amount of the substance.
2. Withdrawal, as defined by either of the following:
   - The characteristic withdrawal syndrome for the substance (refer to DSM-IV-TR for further details)
   - The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.
3. The substance is often taken in larger amounts or over a longer period than was intended.

4. There is a persistent desire or there are unsuccessful efforts to cut down or control substance use.
5. A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances to see one), use the substance (e.g., chain smoking), or recover from its effects.
6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

   Dependence exists on a continuum of severity: remission requires a period of at least 30 days without meeting full diagnostic criteria and is specified as *Early* (first 12 months) or *Sustained* (beyond 12 months) and *Partial* (some continued criteria met) versus *Full* (no criteria met).

SETTINGS OF CARE

General healthcare settings can be broadly defined as outpatient clinic settings including primary care, psychiatry, or other specialty clinics (e.g., HIV, hepatology clinics, medical, pre-operative) and may include emergency departments and surgical care clinics.

Specialty SUD Care focuses on patients in need of further assessment or motivational enhancement or who endorse rehabilitation goals.

AGORITHMS AND ANNOTATIONS

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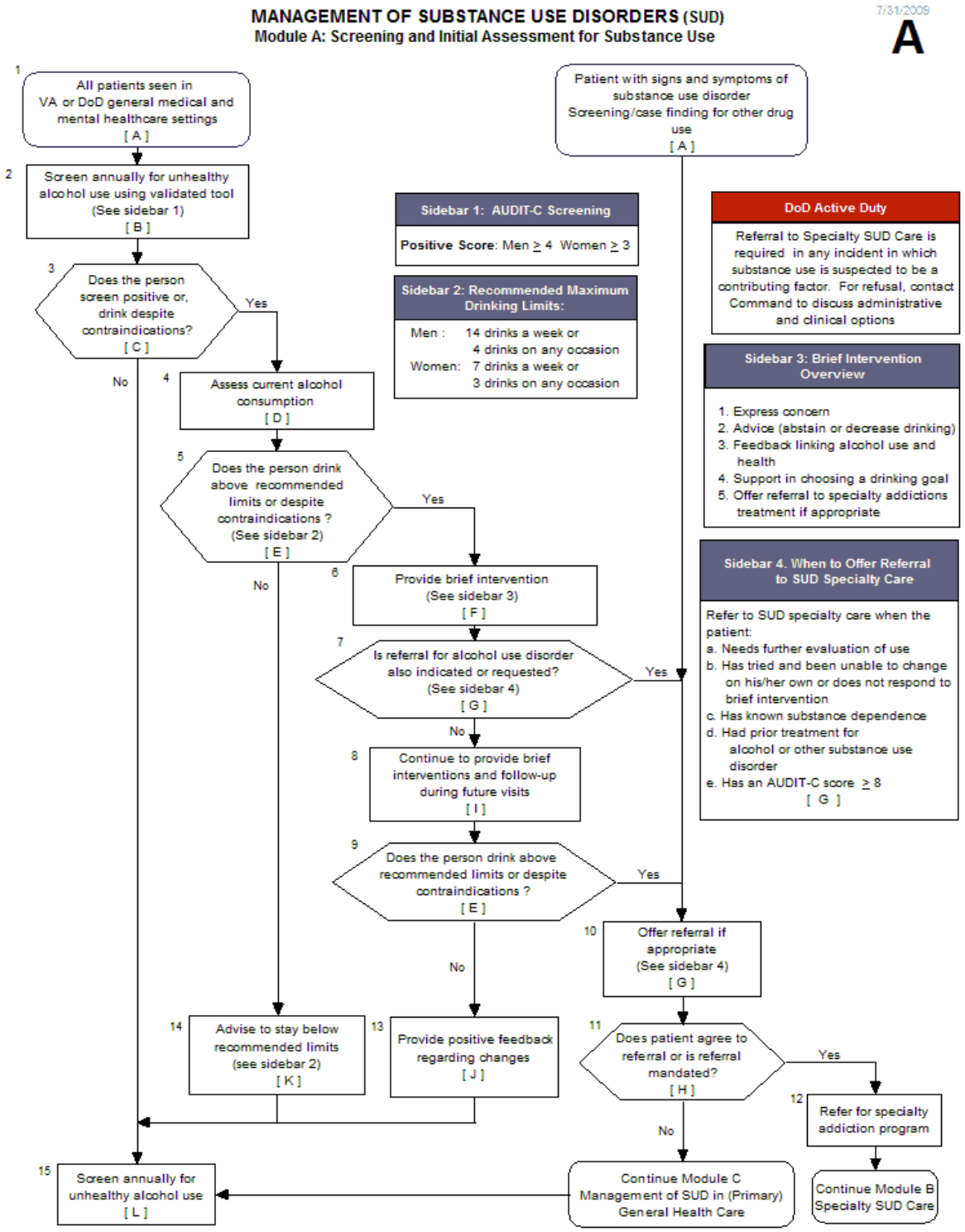

MANAGEMENT OF SUBSTANCE USE DISORDERS (SUD)
Module A: Screening and Initial Assessment for Substance Use
7/31/2009
A
1
All patients seen in VA or DoD general medical and mental healthcare settings [A]
Patient with signs and symptoms of substance use disorder Screening/case finding for other drug use [A]
2
Screen annually for unhealthy alcohol use using validated tool (See sidebar 1) [B]
Sidebar 1: AUDIT-C Screening
Positive Score: Men ≥ 4 Women ≥ 3
Sidebar 2: Recommended Maximum Drinking Limits:
Men : 14 drinks a week or 4 drinks on any occasion
Women: 7 drinks a week or 3 drinks on any occasion
DoD Active Duty
Referral to Specialty SUD Care is required in any incident in which substance use is suspected to be a contributing factor. For refusal, contact Command to discuss administrative and clinical options
Sidebar 3: Brief Intervention Overview
1. Express concern
2. Advice (abstain or decrease drinking)
3. Feedback linking alcohol use and health
4. Support in choosing a drinking goal
5. Offer referral to specialty addictions treatment if appropriate
3
Does the person screen positive or, drink despite contraindications? [C]
Yes
No
4
Assess current alcohol consumption [D]
5
Does the person drink above recommended limits or despite contraindications ? (See sidebar 2) [E]
Yes
No
6
Provide brief intervention (See sidebar 3) [F]
7
Is referral for alcohol use disorder also indicated or requested? (See sidebar 4) [G]
Yes
No
Sidebar 4. When to Offer Referral to SUD Specialty Care
Refer to SUD specialty care when the patient:
a. Needs further evaluation of use
b. Has tried and been unable to change on his/her own or does not respond to brief intervention
c. Has known substance dependence
d. Had prior treatment for alcohol or other substance use disorder
e. Has an AUDIT-C score ≥ 8 [G]
8
Continue to provide brief interventions and follow-up during future visits [I]
9
Does the person drink above recommended limits or despite contraindications ? [E]
Yes
No
10
Offer referral if appropriate (See sidebar 4) [G]
11
Does patient agree to referral or is referral mandated? [H]
Yes
No
12
Refer for specialty addiction program
13
Provide positive feedback regarding changes [J]
14
Advise to stay below recommended limits (see sidebar 2) [K]
15
Screen annually for unhealthy alcohol use [L]
Continue Module C Management of SUD in (Primary) General Health Care
Continue Module B Specialty SUD Care

MODULE A: SCREENING AND INITIAL ASSESSMENT FOR SUBSTANCE USE

A. All Patients Seen in VA or DoD General Medical and Mental Healthcare Settings

All patients seen in general medical and general mental health settings are the target population for alcohol screening.

BACKGROUND

Screening for Unhealthy Alcohol Use

Unhealthy Alcohol Use screening and counseling is ranked third of the top five prevention priorities for US adults among preventive practices recommended by the U.S. Preventive Services Task Force (USPSTF).

Screening for Other Drug Use

Population-based screening for drug use disorder is not recommended. This reflects the lower prevalence of drug use disorder and the lack of high-quality randomized controlled trials (RCT) demonstrating the efficacy of primary care interventions for drug abuse and dependence. Instead, selective case finding in high-risk populations (e.g., Hepatitis C or HIV clinics), is recommended so that substance use disorders can be addressed (National Quality Forum, 2007; USPSTF, 2008).

B. Screen Annually for Unhealthy Alcohol Use Using a Validated Tool

BACKGROUND

Screening should identify patients along the entire continuum of Unhealthy Alcohol Use including those who drink above recommended limits (often called risky or hazardous drinking) to those with severe alcohol dependence. Most screen-positive patients will *not* be in treatment for alcohol use disorders and the initial approach to Unhealthy Alcohol Use will include brief alcohol counseling (often termed "brief interventions") or referral.

RECOMMENDATIONS

1. Patients in general and mental healthcare settings should be screened for Unhealthy Alcohol Use annually. [A]
2. Use a validated screening questionnaire for past-year Unhealthy Alcohol Use. [A]
3. Select one of two brief methods of screening: [A]
    a. The Alcohol Use Disorders Identification Test Consumption Questions (AUDIT-C) or
    b. Ask whether patient drank any alcohol in the past year and administer the Single-Item Alcohol Screening Questionnaire (SASQ) to assess the frequency of heavy drinking in patients who report any drinking. (see Annotation C)
4. The CAGE questionnaire alone is not a recommended screen for past-year Unhealthy Alcohol Use (e.g., risky or hazardous drinking). [D]
5. The CAGE questionnaire, used as a self -assessment tool, may be used in addition to an appropriate screening method to increase patient's awareness to unhealthy use or abuse of alcohol.

See Appendix B for examples of the Screening Instruments

C. Does the Person Screen Positive or Drink Despite Contraindications?

BACKGROUND

Screening is intended to identify patients with Unhealthy Alcohol Use but also patients who are drinking despite contraindications to alcohol use even if they screen negative for Unhealthy Alcohol Use.

RECOMMENDATIONS

1. Consider a screen positive for Unhealthy Alcohol Use if: [B]
    a. AUDIT-C score (range from 0 to 12) is $\geq$ 4 points for men or $\geq$ 3 points for women
    b. Patients report drinking 4 or more (women) or 5 or more (men) drinks in a day in the past year on the single-item screening question.
2. Identify contraindications for any alcohol use [C]. Contraindications to alcohol use include:
    a. Pregnancy or trying to conceive
    b. Liver disease including hepatitis C
    c. Other medical conditions potentially exacerbated or complicated by drinking (e.g., pancreatitis, congestive heart failure)
    d. Use of medications with clinically important interactions with alcohol or intoxication (e.g., warfarin)
    e. An alcohol use disorder.

D. Assess Current Alcohol Consumption

BACKGROUND

If a patient does not have contraindications to any drinking, experts recommend that alcohol consumption be evaluated as the first step in a brief intervention. Most, if not all, clinical trials of brief alcohol counseling have assessed patients' drinking after screening and only included those who reported drinking above recommended limits on reassessment.

Epidemiologic studies have shown that drinking above weekly or daily limits is associated with development of alcohol-related problems.

RECOMMENDATIONS

1. Determine the number of drinks consumed by patient in a typical week and the maximum number of drinks on an occasion in the past month.

E. Does the Person Drink Above Recommended Limits OR Despite Contraindications?

BACKGROUND

Patients who drink above the recommended limits or those who have clinical conditions that contraindicate alcohol use are candidates for a brief intervention.

RECOMMENDATIONS

1. Determine whether patient drinks above recommended limits. [A]

a. The recommended limits are:

- FOR MEN— no more than 14 standard-sized drinks a week and no more than 4 standard-sized drinks on any day
- FOR WOMEN— no more than 7 standard-sized drinks a week and no more than 3 standard-sized drinks on any day

Standard-sized drinks are: 12 oz beer, 5 oz wine, or 1.5 oz hard liquor.

2. Contraindications for any alcohol use include:

a. Pregnancy or trying to conceive

b. Liver disease including hepatitis C

c. Other medical conditions potentially exacerbated or complicated by drinking (e.g., pancreatitis, congestive heart failure)

d. Use of medications with clinically important interactions with alcohol or intoxication (e.g., warfarin)

e. An alcohol use disorder.

Table A- 1: Recommended Drinking Limits

Men	No more than 14 drinks a week; and No more than 4 drinks on any occasion	Women	No more than 7 drinks a week; and No more than 3 drinks on any occasion
Standard-sized drinks are: 12 oz beer, 5 oz wine, or 1.5 oz hard liquor			

F. Provide Brief Intervention

BACKGROUND

A brief intervention typically lasts from several minutes up to an entire visit and is a patient-centered, empathetic brief counseling intervention that can be offered by a clinician who is not a specialist addictions provider or counselor.

A brief intervention for Unhealthy Alcohol Use is a single session or multiple sessions that include motivational discussion focused on increasing insight and awareness regarding alcohol use and motivation toward behavioral change. Brief interventions can be tailored for variance in population or setting and can be used as a stand-alone treatment for those at-risk as well as a vehicle for engaging those in need of more extensive levels of care.

RECOMMENDATIONS

1. Provide a brief intervention (counseling) for Unhealthy Alcohol Use, which includes the following components: [A]

a. Express concern that the patient is drinking at unhealthy levels known to increase his/her risk of alcohol-related health problems

b. Provide feedback linking alcohol use and health, including:

- Personalized feedback (i.e., explaining how alcohol use can interact with patient's medical concerns [e.g., hypertension, depression/anxiety, insomnia, injury, congestive heart failure (CHF), diabetes mellitus (DM), breast cancer risk, interactions with medications]) OR
- General feedback on health risks associated with drinking.

c. Advise :
   - To abstain (if there are contraindications to drinking) OR
   - To drink below recommended limits (specified for patient age and gender).

d. Support the patient in choosing a drinking goal, if he/she is ready to make a change

e. Offer referral to specialty addictions treatment if appropriate.

G. Is Referral for Alcohol Use Disorder Also Indicated or Requested? / Offer Referral, if Appropriate

BACKGROUND

Scores of controlled studies over several decades consistently show that a variety of forms of alcohol dependence treatment including behavioral interventions and pharmacotherapies significantly reduce alcohol consumption among alcohol-dependent patients.

Specialty addictions programs or mental health providers integrated in primary care settings who have addictions expertise can be helpful for assessment, motivational interviewing and treatment. Patients who are open to assessment or who are ready for assistance should be referred to a specialty addictions provider or program, or mental health provider integrated in primary care.

RECOMMENDATIONS

1. Offer referral to specialty SUD care for addiction treatment if the patient:
   a. May benefit from additional evaluation of his/her drinking or substance use and related problems or from motivational interviewing
   b. Has tried and been unable to change drinking or substance use on his/her own or does not respond to brief intervention
   c. Has been diagnosed for alcohol or other substance dependence
   d. Has previously been treated for an alcohol or other substance use disorders
   e. Has an AUDIT-C score $\geq$ 8.
2. DoD active duty members involved in an incident in which substance use is suspected to be a contributing factor are required to be referred to specialty SUD care for evaluation. Command should be contacted to discuss administrative and clinical options if the member refuses to be evaluated (see Appendix D to the full guideline).

H. Does Patient Agree to the Referral or is the Referral Mandated?

BACKGROUND

Many patients may initially decline voluntary referral, but provider encouragement and support may improve patient willingness to complete the referral.

RECOMMENDATIONS

1. Agree on a set of specific goals with the patient.
   a. Review with the patient results of previous efforts of self-change and formal treatment experience, including reasons for treatment dropout
   b. Ask patient about willingness to accept referral

c. Consider bringing an addiction specialist into a general medical or mental health visit to assist with referral decision.

2. Patients at high risk for alcohol use disorder but who are not ready for specialty addictions treatment should be engaged in monitoring of alcohol-related medical problems in the medical setting.

3. DoD active duty members involved in an incident in which substance use is suspected to be a contributing factor are required to be referred to specialty SUD care for evaluation. Command should be contacted to discuss administrative and clinical options if the member refuses to be evaluated. (See Appendix D to the full guideline)

I. Continue to Provide Brief Interventions and Follow-up During Future Visits

BACKGROUND

Patients should be frequently re-evaluated to follow progress, assessed for changes in alcohol-related biomarkers if possible, and supported to problem-solve if barriers to improvement are encountered. Periodically, the patient's interest in specialty treatment and mutual support groups should be re-evaluated. Patient-centered approaches such as motivational interviewing may be helpful.

The interval of follow-up for a particular patient will depend on individual circumstances including (but not limited to) the severity of their Unhealthy Alcohol Use, the existence of co-occurring conditions, readiness to change, and personal circumstances (difficulty making appointments due to employment or other responsibilities).

RECOMMENDATIONS

1. Address alcohol at the next medical visit scheduled to address other issues, or schedule a separate appointment to specifically address drinking if the patient agrees. [B]

2. Repeat brief intervention at the follow-up visit if the patient has not responded to a previous brief intervention. [B]

J. Provide Positive Feedback Regarding Changes

BACKGROUND

Expert opinion supports optimistic, empathetic interventions that note the importance of the changes patients have made to their health and encouragement for continued abstinence or drinking below recommended limits.

RECOMMENDATIONS

1. Provide positive feedback to patients for decreases in drinking.

2. Relate changes in drinking to any changes in presenting health conditions.

K. Advise to Stay Below Recommended Limits

BACKGROUND

Patients who screen positive near the screening threshold of the AUDIT-C (scores of 3-5) can report drinking within recommended limits, but many are under-reporting actual drinking. Therefore, based on Working Group consensus, patients who initially screen positive for Unhealthy Alcohol Use but

report drinking below recommended limits should nevertheless be explicitly advised about recommended limits and encouraged to continue drinking below those limits.

RECOMMENDATIONS

1. Advise patients who screen positive for Unhealthy Alcohol Use but who report drinking below recommended limits to continue to drink below recommended limits.

L. Screen Annually for Unhealthy Alcohol Use

BACKGROUND

No trials have compared different intervals of screening. This recommendation for annual screening is based on Working Group consensus consistent with routine annual preventive screening for other disorders in VA/DoD primary care settings and the past-year assessment window of the AUDIT-C.

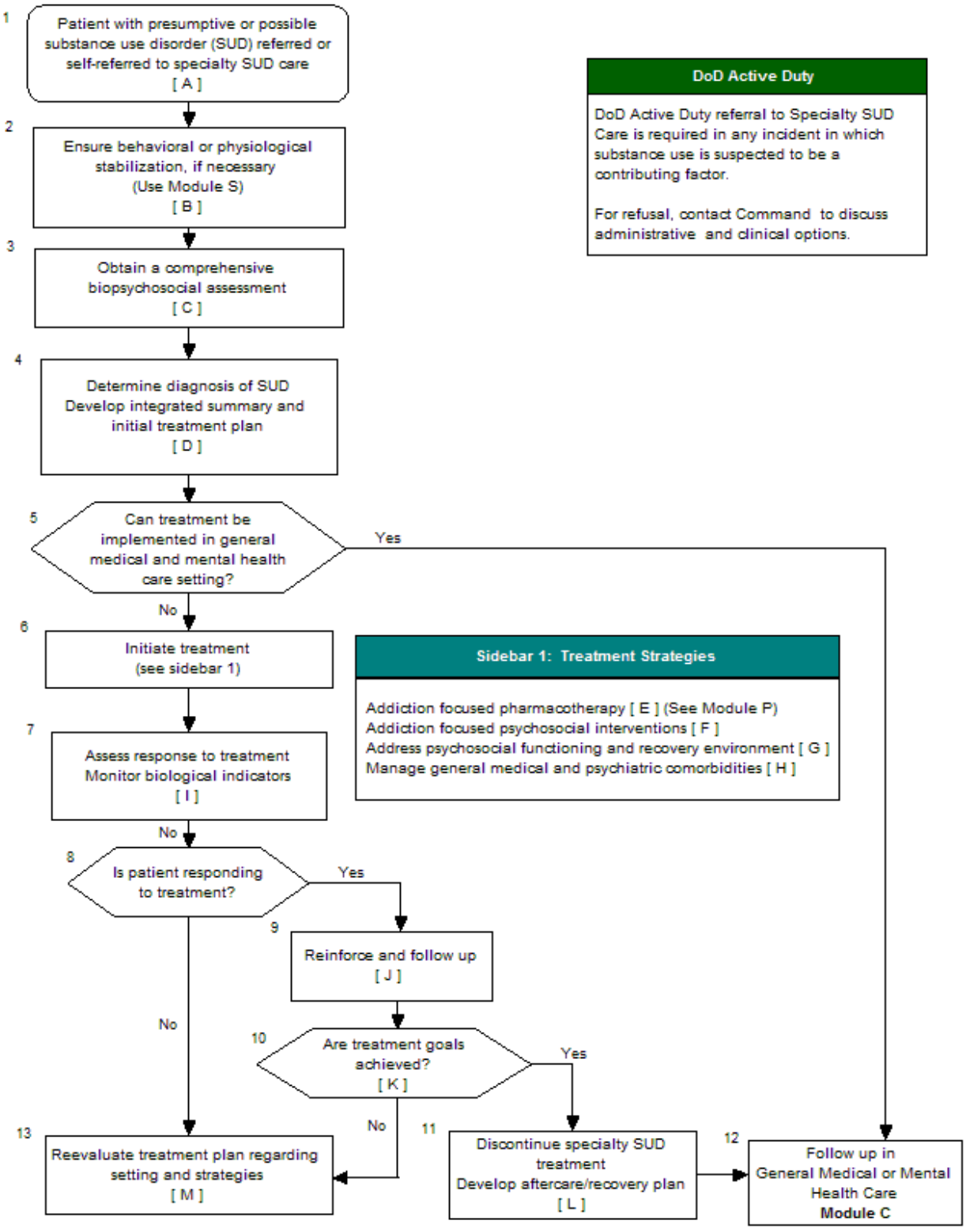
RECOMMENDATIONS

1. Repeat alcohol screening annually.

7/25/2009

B

Management of Substance Use Disorder
Module B: Specialty SUD Care



MODULE B: MANAGEMENT OF SUBSTANCE USE DISORDERS IN SUD SPECIALTY CARE

A. Patient with Presumptive or Possible Substance Use Disorder (SUD) Referred or Self-Referred to Specialty SUD Care

BACKGROUND

Patients may be referred to this module based on the following indications for treatment: hazardous substance use, substance abuse, substance dependence, risk of relapse, suspected or possible SUD, or mandated referral within the DoD. Patients seeking to achieve remission may be appropriately managed using this module. Other patients may be ambivalent about rehabilitation goals and may benefit from more comprehensive assessment and discussion of treatment options. Finally, patients may be referred to a specialist for more extensive evaluation of risks related to substance use.

B. Ensure Behavioral or Physiological Stabilization, if Necessary

BACKGROUND

Most patients referred to specialty SUD care are not acutely intoxicated or in need of immediate physiological stabilization prior to initiating assessment and treatment planning. Others may have been stable at the time of referral, but require stabilization when they present for specialty SUD care evaluation or treatment and should be managed using Module S: Stabilization and Withdrawal Management.

RECOMMENDATIONS

1. Assure patient safety and readiness to cooperate with further assessment by referring the patient to an emergency department or appropriate setting for stabilization as needed.

C. Obtain a Comprehensive Biopsychosocial Assessment

BACKGROUND

Comprehensive and multidimensional assessment procedures are needed to evaluate an individual's strengths, needs, abilities, and preferences, and to determine priorities so that an initial treatment plan can be developed. In less severe cases, the assessment should at least involve screening of these elements, through the use of a multidimensional screening instrument.

RECOMMENDATIONS

1. Obtain a comprehensive biopsychosocial assessment that includes all of the following: *
    a. History of recent substance use and related problems, including precipitating factors, current symptoms and pertinent present risks:
        - Family history:
            - Family alcohol and drug use history, including past treatment episodes

- Family social history, including profiles of parents (or guardians or other caretakers), home atmosphere, economic status, religious affiliation, cultural influences, leisure activities, monitoring and supervision, and relocations
- Family medical and psychiatric history

- Developmental history, including pregnancy and delivery, developmental milestones and temperament
- Comprehensive substance use history, including onset and pattern of progression, past sequelae and past treatment episodes (include all substances, e.g., alcohol, illicit drugs, tobacco, caffeine, over-the-counter medications, prescription medications, inhalants)
- Nearly all daily nicotine users are nicotine dependent. Identification and treatment of co-morbid nicotine dependence may improve recovery rates of other SUDs. For patients using nicotine, offer and recommend tobacco use cessation treatment. Use the Clinical Practice Guideline: Treating Tobacco Use & Dependence: 2008 Update from the U.S. Department of Health and Human Services at: http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf and the VA/DoD Clinical Practice Guideline for Management of Tobacco Use
- Recent pattern of substance use based on self-report and urine drug screening
- Personal/social history (including housing issues, religious/spiritual affiliation, cultural influences)
- School history
- Military history
- Marital history
- Peer relationships and friendships
- Leisure activities
- Sexual activity
- Physical or sexual abuse
- Legal/non-judicial punishment history, including past behaviors and their relation to substance use, arrests, adjudications and details of current status
- Psychiatric history, including symptoms and their relation to substance use, current and past diagnoses, treatments and providers
- Medical history, including pertinent medical problems and treatment, surgeries, head injuries, present medications and allergies
- Review of systems, including present and past medical and psychological symptoms.

b. Laboratory tests for infectious diseases (HIV, Hepatitis C, sexually transmitted disease) and consequences of substance use (e.g., liver function tests)

c. Mental status examination

d. Survey of assets, vulnerabilities and supports

e. Patient's perspective on current problems, treatment goals and preferences.

2. Use empathic and non-judgmental (versus confrontational) therapist style, being sensitive to gender, cultural and ethnic differences.

**Adapted from ASAM Patient Placement Criteria, 2nd Edition-Revised (ASAM PPC-2R, 2001)*

D. Determine Diagnosis of SUD; Develop Integrated Summary and Initial Treatment Plan

BACKGROUND

The comprehensive intake assessment report should integrate assessment information from various sources, as a basis for formulating the diagnosis and treatment recommendations, followed by involvement of the patient in prioritizing problems and negotiating the initial treatment plan. The patient's motivational level and personal goals should be assessed and considered in selecting treatment goals and options.

RECOMMENDATIONS

1. Provide a narrative to consolidate and interpret the information obtained during the assessment process.
2. Include a diagnostic formulation.
3. Include past treatment response and patient's perspective on current problems.
4. Review the patient's motivational level, treatment preferences and goals, and consider these factors, along with an interdisciplinary perspective and available programming, in recommending specific treatment options. [B]
5. Present and discuss the treatment options with the patient and significant others.
6. Determine whether the treatment plan can be implemented in general healthcare (including primary care) based on availability of a willing provider, severity and chronicity of the SUD, active involvement with recovery supports in the community, prior treatment response, and patient preference and likelihood of adherence.
7. If treatment in specialty SUD care is appropriate, determine the appropriate initial intensity and level of specialty SUD care, based on ASAM patient placement criteria. [B]
8. If treatment in specialty SUD care is recommended, determine if it is an acceptable mode of treatment to the patient.
9. Involve the patient in prioritizing problems to be addressed in the initial treatment plan, and in selecting specific treatment goals, regardless of the level of care selected. (See Table B-1)
10. If the patient does not agree to the treatment plan, provide motivational intervention and offer to renegotiate the treatment plan.

For DoD Active Duty Members

11. A treatment team shall convene with the patient and command to review the treatment plan and goals.

Table B- 1. Treatment Goal and Expected Outcomes

Treatment Goal	Expected Outcomes
Patient seeking to achieve remission	Complete and sustained remission of all SUDs Resolution of, or significant improvement in, all coexisting biopsychosocial problems and health-related quality of life
Patient seeking help but not committed to abstinence	Short- to intermediate-term resolution or partial improvement of SUDs for a specified period of time Resolution or improvement of at least some coexisting problems and health-related quality of life
Patient not willing to engage in treatment and not yet ready to abstain	Engagement in general health treatment process, which may continue for long periods of time or indefinitely Continuity of care Continuous enhancement of motivation to change Availability of crisis intervention Improvement in SUDs, even if temporary or partial Improvement in coexisting medical, psychiatric, and social conditions Improvement in quality of life Reduction in the need for high-intensity healthcare services Maintenance of progress Reduction in the rate of illness progression

E. Initiate Addiction-Focused Pharmacotherapy (If Indicated)

BACKGROUND

Addiction-focused pharmacotherapy should be considered, available and offered if indicated, for all patients with opioid dependence and/or alcohol dependence. Addiction-focused pharmacotherapy should be provided in addition to indicated pharmacotherapy for co-occurring psychiatric conditions. In addition, it should be directly coordinated with specialty psychosocial treatment and adjunctive services for psychosocial problems as well as with the patient's primary care and/or general mental health providers.

RECOMMENDATIONS

1. Discuss addiction-focused pharmacotherapy options with all patients with opioid and/or alcohol dependence.
2. Initiate addiction-focused pharmacotherapy if indicated and monitor adherence and treatment response.

(See Module P for specific recommendations and evidence.)

F. Initiate Addiction-Focused Psychosocial Interventions

BACKGROUND

The goals of evidence-based psychosocial treatment for SUD are to engage the patient to establish early problem resolution or remission, improve psychosocial functioning and prevent relapse to substance use. A number of effective psychosocial interventions have been developed and evaluated, and there is no clear evidence that any one of these approaches is the treatment of choice or can be accurately matched to specific patient characteristics. There is considerable evidence from psychotherapy research that general factors such as therapist skill, the strength of the therapeutic

alliance, and the structure provided by regular treatment contact can have as powerful an effect as the specific content or conceptual approach of the interventions. Therefore, attention to these general therapeutic factors is at least as important as the specific treatment approach selected.

RECOMMENDATIONS

1. Indicate to the patient and significant others that treatment is more effective than no treatment (i.e., "Treatment works").
2. Consider the patient's prior treatment experience and respect patient preference for the initial psychosocial intervention approach, since no single intervention approach has emerged as the treatment of choice.
3. Regardless of the particular psychosocial intervention chosen, use motivational interviewing style during therapeutic encounters with patients and emphasize the common elements of effective interventions including: enhancing patient motivation to stop or reduce substance use, improving self-efficacy for change, promoting a therapeutic relationship, strengthening coping skills, changing reinforcement contingencies for recovery, and enhancing social support for recovery.
4. Emphasize that the most consistent predictors of successful outcome are retention in formal treatment and/or active involvement with community support for recovery.
5. Use strategies demonstrated to be efficacious to promote active involvement in available mutual help programs (e.g., Alcoholics Anonymous, Narcotics Anonymous).
6. Based on locally available expertise, initiate addiction-focused psychosocial interventions with empirical support. Consider the following interventions that have been developed into published treatment manuals and evaluated in randomized trials:
    a. Behavioral Couples Counseling
    b. Cognitive Behavioral Coping Skills Training
    c. Community Reinforcement Approach
    d. Contingency Management/Motivational Incentives
    e. Motivational Enhancement Therapy
    f. Twelve-Step Facilitation.
7. Addiction-focused psychosocial interventions should be coordinated with evidence-based intervention(s) for other biopsychosocial problems to address identified concurrent problems.
8. Intervention should be provided in the least restrictive setting necessary for safety and effectiveness.

(See Appendix C for description of evidence-based psychosocial interventions.)

G. Address Psychosocial Functioning and Recovery Environment

BACKGROUND

Many patients have co-existing psychosocial problems that affect their likelihood of establishing and maintaining good clinical outcome and improved functional status.

Some of these problems are consequences of SUD that persist even after early recovery is established. Others occur independently of SUD, but can complicate access to care or present relapse risk. These problems include access to a supportive recovery environment (housing and social support for sobriety), difficulties with family and social relationships, unemployment/underemployment, and/or unresolved legal issues.

RECOMMENDATIONS

1. Prioritize and address other coexisting biopsychosocial problems with services targeted to these problem areas, rather than increasing intensity of addiction-focused psychosocial treatment alone. [B]
2. Address transitional housing needs to facilitate access to treatment and promote a supportive recovery environment.
3. Provide social/vocational/legal services in the most accessible setting to promote engagement and coordination of care.
4. Address deferred problems as part of treatment plan updates and monitor emerging needs.
5. Coordinate care with other social service providers or case managers.

H. Manage General Medical and Psychiatric Co-occurring Conditions

BACKGROUND

In addition to the standard addiction-focused services, programs should address psychiatric and general medical conditions that exist in association with the SUD. Treatment services directed toward these additional problems, when they exist, are associated with improvement. Problems typically show little spontaneous improvement if services are not provided.

RECOMMENDATIONS

1. Prioritize and address other medical and psychiatric co-occurring conditions.
2. Recommend and offer cessation treatment to patients with nicotine dependence.
3. Treat concurrent psychiatric disorders consistent with VA/DoD clinical practice guidelines (e.g., Major Depressive Disorder, Bipolar Disorder, Post Traumatic Stress, Psychoses) including concurrent pharmacotherapy.
4. Provide or arrange treatment via referral for medical conditions (e.g. management of diabetes, chronic heart failure, management of unexplained medical symptoms). (See other VA/DoD Clinical Practice Guidelines at: www.healthquality.va.gov)
5. Provide multiple services in the most accessible setting to promote engagement and coordination of care.
6. Monitor and address deferred problems and emerging needs through ongoing treatment plan updates.
7. Coordinate care with other providers.

I. Assess Response to Treatment / Monitor Biological Indicators

BACKGROUND

At each periodic reassessment, the patient may have achieved the goals set for specialty SUD care, be successfully completing interim steps toward each goal, not improving, or may have dropped out of treatment altogether. Periodic monitoring of progress toward treatment goals helps to coordinate care and to motivate the patient and treatment team members to accomplish interim steps. Periodic reassessments also provide opportunities to address emerging problems and to change treatment strategies when the initial plan is not fully successful.

RECOMMENDATIONS

1. Reassess response to treatment periodically and systematically, using standardized and valid self-report instrument(s) and laboratory tests. Indicators of treatment response include ongoing substance use, craving, side effects of medication, emerging symptoms, etc. (see example for a treatment response monitor; Appendix B-9: Brief Addiction Monitor).

J. Reinforce and Follow Up

BACKGROUND

For many patients, substance use disorders are chronic conditions that warrant extended efforts at relapse prevention and encouragement by providers for progress.

RECOMMENDATIONS

1. For patients who accomplish their initial goals in early recovery, the treatment team should collaborate with the patient to develop a continuing care plan (e.g., aftercare plan) which may include:
    a. Transition to an appropriate alternative specialty care setting (see Annotation L - Aftercare), such as PTSD specialty treatment, etc.
    b. Return to primary care.
2. For patients who are progressing toward goals, providers should:
    a. Provide positive feedback and encouragement to remain engaged in specialty SUD care
    b. Involve patients in identifying the next interim steps toward achieving the goals.

K. Are Treatment Goals Achieved?

BACKGROUND

In general, longer lengths of time in treatment correlate with better outcomes for more severely dependent patients. However when no further addiction-focused specialty treatment visits are scheduled, care should be transitioned to their primary medical or behavioral healthcare provider for relapse monitoring and ongoing management of co-occurring general medical and/or psychiatric conditions.

RECOMMENDATIONS

1. Use the patient's progress in attaining recovery goals to individualize treatment continuation and avoid adopting uniform treatment plans with standardized duration and intensity.
2. Consider patient report of craving and other subjective indications of relapse risk.
3. For patients who achieve sustained remission or problem resolution, provide appropriate continuity of care and follow-up with providers in the general medical or mental healthcare setting (see Module C).

L. Discontinue Specialty SUD Treatment; Develop Aftercare/Recovery Plan

BACKGROUND

An aftercare or recovery plan is a mutual effort between the patient and treatment team to identify and promote those aspects of continuing care for SUDs that are associated with success in recovery. At the point that the patient has achieved the initial stabilization goals of intensive treatment, he/she receives a written plan for continuing care to maintain recovery.

RECOMMENDATIONS

1. Provide continuing care following intensive outpatient or residential rehabilitation (individual, group or telephone follow-up).
2. Consider objective monitoring of substance use and medical consequences. [A]
3. Encourage active involvement in community support for recovery (e.g., Alcoholics Anonymous, Cocaine Anonymous). [A]
4. As part of the discharge instructions from the intensive phase, provide the patient a written plan to facilitate compliance with aftercare which may include "the basic things I need to do to meet my treatment goals," such as:
    a. Information on treatment appointments and prescribed medications
    b. Recognizing relapse warning signs and triggers and appropriate coping responses
    c. Maintaining contact with recovery support network and identifying mutual help meetings to attend.
5. For DoD Active Duty: Rehabilitation and Referral Services for Alcohol and Drug Abusers, requires an individualized aftercare plan designed to identify the continued support of the patient with monthly monitoring (minimally) during the first year after inpatient treatment.

M. Reevaluate Treatment Plan Regarding Setting and Strategies

BACKGROUND

Relapse can be used as a signal to reevaluate the treatment plan rather than evidence that the patient cannot succeed or that the patient was not sufficiently motivated.

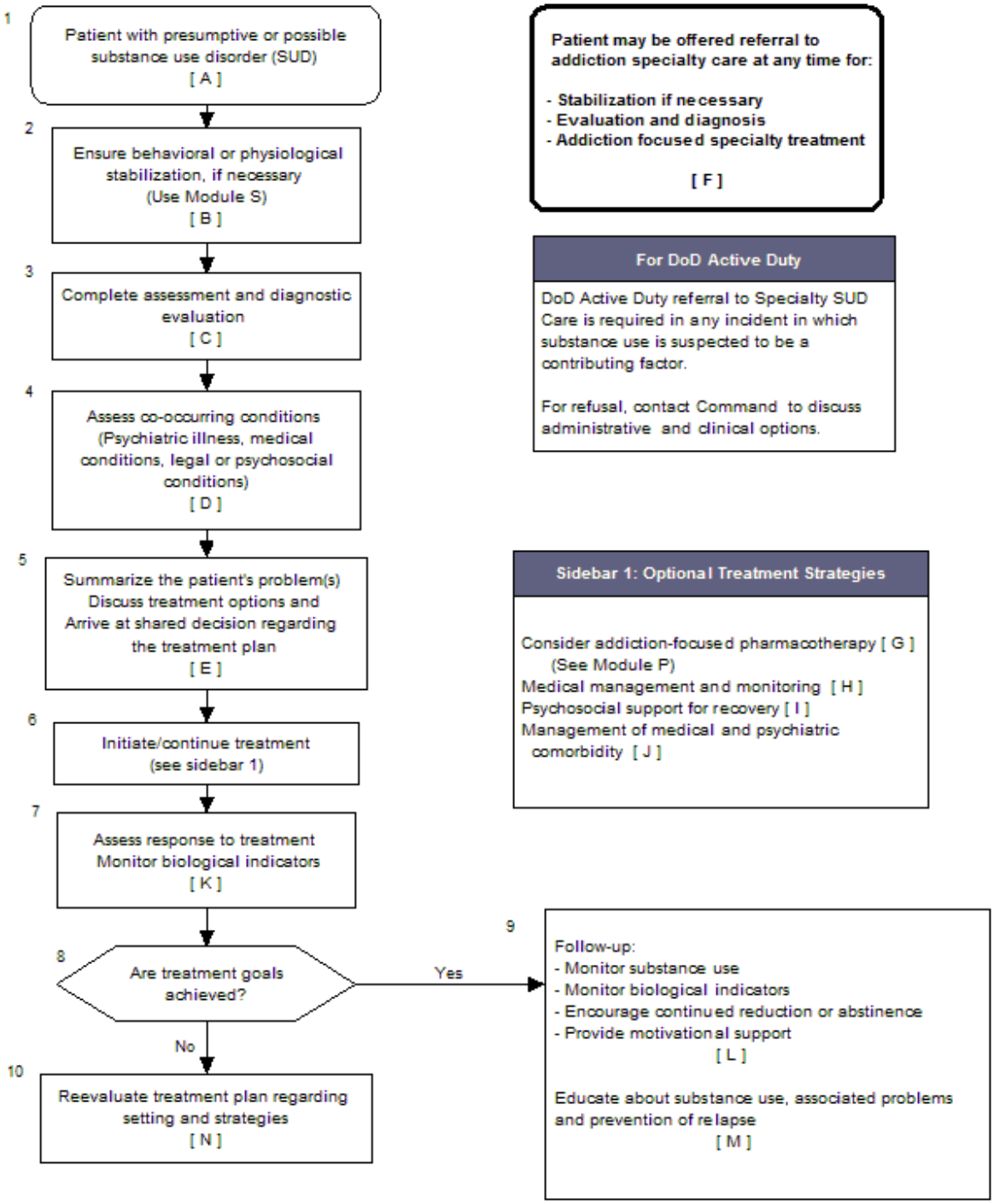
RECOMMENDATIONS

1. For patients who are not improving, providers should consider either:
    a. Adding or substituting another medication or psychosocial intervention, or
    b. Changing treatment intensity by:
        - Increasing the intensity of care, or
        - Increasing the dose of the medication, or
        - Decreasing the intensity to a minimum level of care that is agreeable to the patient such as monitoring in general healthcare (see Module C).
2. If patients drop out of treatment, the treatment team should make efforts to contact the patient and re-engage him/her in treatment.

Management of Substance Use Disorder
Module C: General Health Care

7/24/2009

C



MODULE C: MANAGEMENT OF SUD IN (PRIMARY) GENERAL HEALTHCARE

A. Patient with Presumptive or Possible Substance Use Disorder

BACKGROUND

Clinicians in general medical and in mental healthcare settings are likely to encounter patients with presumptive or possible substance use who are either referred, self-referred, or otherwise seek help related to substance use. Substance use can include Unhealthy Alcohol Use, misuse of prescription medications, and illegal substance use (e.g., heroin, cocaine). Substance use conditions are prevalent among outpatient clinic populations.

General healthcare settings can be broadly defined as outpatient clinic settings including primary care, psychiatry, or other specialty clinics (e.g., HIV, hepatology clinics, medical sub-specialty, pre-operative) and may include emergency departments and surgical care clinics.

All patients in general or in mental healthcare settings should be screened for Unhealthy Alcohol Use. Population-based screening for other drug use disorder is not recommended. This reflects the lower prevalence of drug use disorder and the lack of high-quality randomized controlled trials demonstrating the efficacy of primary care interventions for drug abuse and dependence. Instead, selective case finding in high-risk populations (e.g., Hepatitis C or HIV clinics), is recommended.

Patients who are diagnosed with SUD or who are seeking help with problem drinking or drug use, should be offered treatment and/or a referral to specialty addiction treatment, and monitored for unstable medical or psychiatric conditions. Patients should be referred for acute stabilization or withdrawal management if needed.

Management of SUD in the general or mental healthcare settings is likely to be a more acceptable and effective alternative for the patient when one of the following applies:

a. The patient refuses referral to specialty SUD care but continues to seek some services, especially medical and/or psychiatric services
b. The patient has serious co-morbidity that precludes participation in available specialty SUD care
c. The patient has been engaged repeatedly in specialty SUD treatment with minimal progress toward abstinence or sustained improvement.

B. Ensure Behavioral or Physiological Stabilization, if Necessary

BACKGROUND

Patients who are intoxicated, undergoing withdrawal, or at risk for imminent severe harm associated with their substance use may be considered medically unstable or at risk for harm of self or others. These patients may be delirious or otherwise not able to engage collaboratively with a provider regarding their assessment and treatment. Screening, assessment, or treatment of substance use disorders should occur in patients who are medically stable.

For example, patients with severe physical dependence on alcohol may undergo alcohol withdrawal syndrome and may incur hallucinations, seizures, delirium, and delirium tremens. Treatment of withdrawal symptoms, as well as intoxication with alcohol or opioids, may require specialty treatments in an inpatient acute care or addiction specialty setting. Patients with cocaine intoxication may require close cardiac monitoring.

RECOMMENDATIONS

1. Assure patient safety and readiness to cooperate with further assessment by referring the patient to an emergency department or appropriate acute care setting for stabilization as needed.

   (See Module S – Stabilization and Withdrawal Management)

C. Complete Assessment and Diagnostic Evaluation

BACKGROUND

Comprehensive and multidimensional assessment procedures are needed to evaluate an individual's strengths, weaknesses, needs, and preferences and to determine priorities so that an initial treatment plan can be developed. In less severe cases, the assessment should at least involve screening of these elements through the use of a multidimensional screening instrument.

A complete evaluation that includes history, physical, and laboratory assessments is important to properly diagnose patients with SUD. Many patients may be involved with more than one substance and poly-substance use may not be readily apparent.

For diagnostic criteria of substance abuse and dependence, see Introduction: Definitions (page 5).

RECOMMENDATIONS

1. Patients with suspected, presumed, or identified substance use disorder (SUD) should receive a comprehensive assessment to include:
   a. Medical history, including pertinent medical problems and treatment, surgeries, head injuries, present medications and allergies and family history of substance use
   b. Physical examination including mental status examination (MSE)
   c. Laboratory evaluation as indicated.
2. Comprehensive substance use history, including onset and pattern of progression, past sequelae and past treatment episodes (include all substances, e.g., alcohol, illicit drugs, tobacco, caffeine, over-the-counter medications, prescription medications, inhalants).
3. Use empathic and non-judgmental (versus confrontational) therapist style, being sensitive to gender, cultural and ethnic differences.
4. DoD active duty members involved in an incident in which substance use is suspected to be a contributing factor are required to be referred to specialty SUD care for evaluation. Command should be contacted to discuss administrative and clinical options if the member refuses to be evaluated. (See Appendix D to the full guideline.)

D. Assess Co-Occurring Conditions (Psychiatric Illness, Medical Conditions, Legal or Psychosocial Conditions)

BACKGROUND

Co-occurring disorders (CODs) are common with SUD and must be identified and addressed as a part of comprehensive care. CODs, also termed co-morbid disorders, are defined as sub-clinical or diagnosed medical and/or behavioral health conditions that occur with and influence the SUD condition. CODs threaten the health of patients and may complicate the treatment of SUD.

SUD is highly correlated with posttraumatic stress disorder and other psychological disorders that may occur after stressful and traumatic events, such as those associated with war.

RECOMMENDATIONS

1. Identify and document any co-occurring disorders (COD) in patients with substance use disorders.
    a. Psychiatric history, including symptoms and their relation to substance use, current and past diagnoses, treatments and providers
    b. Infectious diseases (HIV, Hepatitis C, sexually transmitted disease)
    c. Nearly all daily nicotine users are nicotine dependent. Identification and treatment of co-morbid nicotine dependence may improve recovery rates of other SUDs. For patients using nicotine offer and recommend tobacco use cessation treatment. Use the Clinical Practice Guideline: Treating Tobacco Use & Dependence: 2008 Update from the U.S. Department of Health and Human Services at: http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf and the VA/DoD Clinical Practice Guideline for Management of Tobacco Use
    d. Medical COD that may be related to or affected by substance use (e.g., diabetes, cardiovascular disease, digestive disorders, skin infections, respiratory disorders).
2. Individuals with SUD should be assessed for any significant, unmet psychosocial needs or situational stressors. These include but are not limited to:
    a. Inadequate or no housing
    b. Financial difficulties, especially if unable to meet basic needs
    c. Problematic family relationships or situations (including caregiver burden or domestic violence)
    d. Poor social support
    e. Religious and spiritual problems
    f. Occupational problems
    g. Difficulties with activities of daily living or instrumental activities of daily living
    h. Any other acute or chronic situational stressors.

E. Summarize the Patient's Problem(s), Discuss Treatment Options, and Arrive at Shared Decision Regarding the Treatment Plan

BACKGROUND

Informed decision-making involves explaining the medical condition, outlining treatment options, and guiding the patient to a decision about their own care. Even when patients refuse referral or are unable to participate in specialized addiction treatment, many are accepting of general medical or psychiatric care.

RECOMMENDATIONS

1. Recognize that feedback about laboratory assessments may improve patients' motivation to change and may serve as a baseline to monitor SUD treatment progress.
2. Review the assessment, including diagnosis, past treatment response and the patient's perspective on current problems; co-occurring disorders related to SUD; the patient's motivational level, treatment preferences and short- and long-term goals.
3. Present and discuss with the patient appropriate treatment options in a way that motivates ongoing cooperation with the provider and supports subsequent decisions about referral or brief intervention.

4. Present and discuss the treatment options with the patient and significant others.
5. Determine which treatments could be offered in general healthcare (including primary care), based on availability of a provider, severity and chronicity of the SUD, active involvement with recovery supports in the community, prior treatment response, and patient's preference and likelihood of adherence.
6. Involve the patient in prioritizing problems to be addressed in the initial treatment plan, and in selecting specific treatment goals, regardless of the level of care selected (See Table C – 1).
7. If the patient is not willing to engage in any addictions focused care, provide motivational intervention and determine whether treatment for medical and psychiatric problems can be effectively and safely provided. Continue to try to engage the patient in addictions treatment (see annotation K).

Table C- 1. Treatment Goals and Expected Outcomes

Treatment Goals	Expected Outcomes
Patient seeking to achieve remission	Complete and sustained remission of all substance use disorders (SUDs) Resolution of, or significant improvement in, all coexisting biopsychosocial problems and health-related quality of life
Patient seeking help but not committed to abstinence	Short- to intermediate-term remission of SUDs or partial remission of SUDs for a specified period of time Resolution or improvement of at least some health-related quality of life
Patient not willing to engage in treatment and not yet ready to abstain	Engagement in general health treatment process, which may continue for long periods of time or indefinitely Continuity of care (case management) Continuous enhancement of motivation to change Availability of crisis intervention Improvement in SUDs, even if temporary or partial Improvement in coexisting medical, psychiatric, and social conditions Improvement in quality of life Reduction in the need for high-intensity healthcare services Maintenance of progress Reduction in the rate of illness progression

F. Referral to Specialty SUD Care

BACKGROUND

Referral should be offered to patients who are open to assessment or who are ready for assistance from a specialty addictions provider or program.

RECOMMENDATIONS

1. Offer referral to specialty SUD care for addiction treatment if the patient: [A]
    a. May benefit from additional evaluation or motivational interviewing regarding his/her substance use and related problems
    b. Has tried and been unable to change substance use on his/her own or does not respond to repeated brief intervention

c. Has been diagnosed with substance dependence

d. Has previously been treated for an alcohol or other substance use disorder

e. Has an AUDIT-C score of ≥ 8.

For active duty members, coordinate care with the unit commander.

2. DoD active duty members involved in an incident in which substance use is suspected to be a contributing factor are required to be referred to specialty SUD care for evaluation. Command should be contacted to discuss administrative and clinical options if the member refuses to be evaluated (see Appendix D to the full guideline).

G. Treatment: Consider Addiction-Focused Pharmacotherapy

BACKGROUND

Currently, the Food and Drug Administration (FDA) has approved pharmacotherapy for patients diagnosed with alcohol or opioid dependence. While non-pharmacologic treatment has been the mainstay of treatment for SUD, recent scientific advances have encouraged the use of pharmacologic treatments. Pharmacologic treatments can serve as an effective adjunct to non-pharmacologic treatments to help patients reduce or eliminate alcohol consumption.

RECOMMENDATIONS

1. Discuss pharmacotherapy options with all patients with opioid and/or alcohol dependence.
2. Initiate pharmacotherapy if indicated and monitor adherence and treatment response.

(See **Module P** for specific recommendations and evidence.)

H. Treatment: Medical Management and Monitoring

BACKGROUND

The provider in general healthcare settings can and should provide evidence-based medical management to reduce substance use. A structured, focused format can provide an initial pathway towards recovery. Brief interventions are effective in the initial phase and may be repeated as part of medical monitoring. For patients who do not respond to brief intervention, comprehensive medical management and monitoring as well as opportunistic referral to specialty SUD care are the emphases of general healthcare treatment. In some cases, medical management will lead to remission of the SUD or referral for specialty SUD care, while in others it serves a more palliative function.

RECOMMENDATIONS

1. Provide a brief intervention (counseling) for Unhealthy Alcohol Use , which includes the following components: [A]

    a. Express concern that the patient is drinking at unhealthy levels known to increase his/her risk of alcohol-related health problems

    b. Provide feedback linking alcohol use and health, including:

        - Personalized feedback (i.e., explaining how alcohol use can interact with the patient's medical concerns [e.g., hypertension, depression/anxiety, insomnia, injury, diabetes, breast cancer risk, interactions with medications]) OR
        - General feedback on health risks associated with drinking.

c. Advise:

- To abstain (if there are contraindications to drinking) OR
- To drink below recommended limits (specified for the patient by gender, age and health status)

d. Support the patient in choosing a drinking goal, if he/she is ready to make a change.

2. Provide medical management in the treatment of alcohol use disorder and consider medical management for other substance use disorders that includes: [C]
   - Monitoring self-reported use, laboratory markers and consequences
   - Use of medication, adherence monitoring, response to treatment and adverse effects
   - Education and referral to community support for recovery (e.g., Alcoholics Anonymous).
3. Offer referral to a specialty addictions program when indicated.

I. Treatment: Psychosocial Support for Recovery

BACKGROUND

Psychosocial rehabilitation services can be an important part of the treatment of SUD when indicated. Negative life events and stressful circumstances may contribute to the onset or relapse of a substance use disorder. They also may influence treatment adherence and outcome.

RECOMMENDATIONS

1. Referral to psychosocial rehabilitation services should be offered to individuals with identified, unmet psychosocial needs, regardless of the population or setting, and regardless of the type of pharmacotherapy or psychotherapy being administered.
2. Prioritize and address other coexisting biopsychosocial problems with services targeted to these problem areas, rather than increasing intensity of addiction-focused psychosocial treatment alone. [B]
   a. Address transitional housing needs to facilitate access to treatment and promote a supportive recovery environment
   b. Provide social/vocational/legal services in the most accessible setting to promote engagement and coordination of care
   c. Address deferred problems as part of treatment plan updates and monitor emerging needs
   d. Coordinate care with other social service providers or case managers.

J. Treatment: Management of Medical and Psychiatric Co-occurring Conditions

BACKGROUND

In addition to the standard addiction-focused services, providers should address psychiatric and general medical conditions that exist in association with the SUD. Treatment services directed toward these additional problems, when they exist, are associated with improvement. Problems typically show little spontaneous improvement if services are not provided.

RECOMMENDATIONS

1. Prioritize and address co-occurring medical and psychiatric conditions.
2. Recommend and offer cessation treatment to patients with nicotine dependence. Use the Clinical Practice Guideline: Treating Tobacco Use & Dependence: 2008 Update from the U.S. Department of Health and Human Services at: http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf and the VA/DoD Clinical Practice Guideline for Management of Tobacco Use
3. Treat concurrent psychiatric disorders consistent with VA/DoD clinical practice guidelines (e.g., Major Depressive Disorder, Post Traumatic Stress, Bipolar Disorder, Psychoses) including concurrent pharmacotherapy.
4. Provide multiple services in the most accessible setting to promote engagement and coordination of care.
5. Monitor and address deferred problems and emerging needs through ongoing treatment plan updates.
6. Coordinate care with other providers.

K. Assess Response to Treatment / Monitor Biological Indicators

BACKGROUND

Periodic monitoring of progress toward treatment goals helps to coordinate care and to motivate the patient and members of the treatment team to accomplish interim steps. Periodic reassessment also provides opportunities to address emerging problems and change treatment strategies when the initial plan is not fully successful.

There is no uniformly successful treatment plan. Some patients may respond to psychosocial interventions, others to pharmacotherapy. Some patients may respond to one medication and not to another. The provider should be flexible in modifying the medical regimen based on the patient's needs or preferences.

RECOMMENDATIONS

1. Reassess response to treatment periodically and systematically, using standardized and valid instrument(s) whenever possible. Indicators of treatment response include ongoing substance use, craving, side effects of medication, emerging symptoms, etc.
2. Consider obtaining biological markers of recent substance use.
3. Assess co-occurring medical problems associated with substance use through history, physical exam and appropriate laboratory evaluation.

L. Follow-Up

BACKGROUND

For many patients, substance use disorders are chronic conditions that warrant extended efforts at relapse prevention and encouragement by multiple providers for progress.

RECOMMENDATIONS

1. Ask the patient about any use, craving, or perceived relapse risk.

2. Provide feedback to patient regarding improvement or deterioration in laboratory assessments affiliated with substance use.
3. Encourage abstinence or reduced use, consistent with the patient's motivation and agreement.
4. Convey openness to discuss any future concerns that may arise and encourage the patient to discuss them with you.

M. Educate About Substance Use, Associated Problems, and Prevention of Relapse

BACKGROUND

Expert opinion supports optimistic, empathetic interventions that note the importance of the changes patients have made to their health, provide positive feedback and encourage continued drinking below recommended limits.

RECOMMENDATIONS

1. Discuss the patient's current use of alcohol and other drugs and address any potential problem areas, such as recent initiation of use, increase in use, and use to cope with stress.
2. Inform patient about potential age- and gender-related problems, such as:
    a. Hazardous drinking or other drug use in the young adult
    b. Alcohol and other drug use during pregnancy
    c. Medication misuse or heavy drinking in the older adult.
3. Convey openness to discuss any future concerns that may arise and encourage the patient to discuss them with you.
4. Periodically inquire about alcohol and drug use at future visits.

N. Reevaluate Treatment Plan Regarding Setting and Strategies

BACKGROUND

Patients' goals may change over time, and providers should adapt to new objectives that the patient may express. Partial remission may be common and requires an ongoing reevaluation of the treatment plan rather than evidence that the patient cannot succeed or that the patient was not sufficiently motivated. Even after examining the reasons for partial remission and intensifying or modifying psychosocial treatment or pharmacotherapy, some patients may not reduce alcohol consumption.

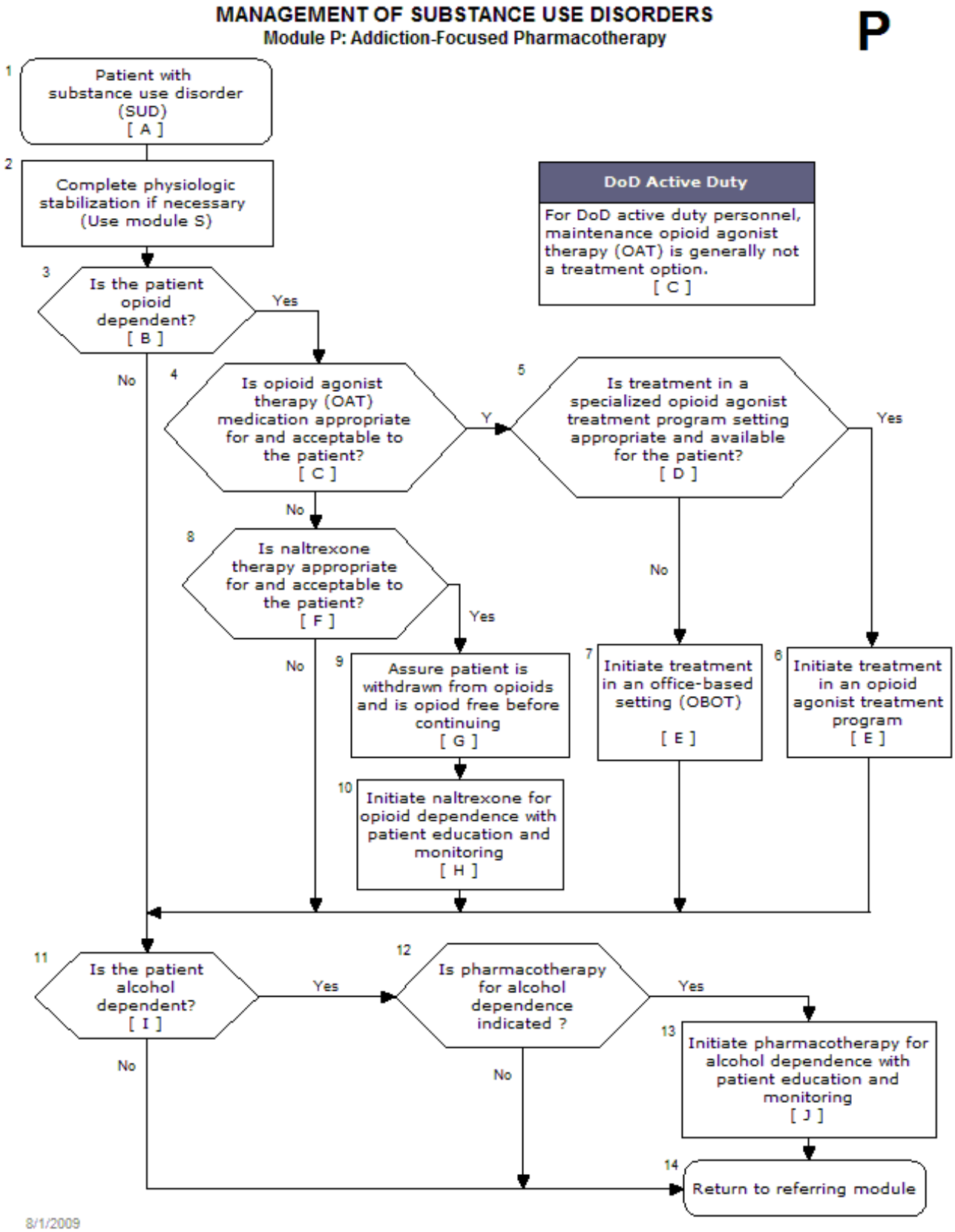
Treatment of chronic relapsing patients is difficult. For those willing to accept referral, treatment should be undertaken by addiction professionals in specialty treatment settings that employ a multi-faceted approach incorporating social, environmental, medical, behavioral, and motivational interventions.

RECOMMENDATIONS

1. For patients who are not improving, providers should consider either:
    a. Changing to another medication or intervention; or
    b. Changing treatment intensity by:
        - Increasing the intensity of care, or
        - Increasing the dose of the medication, or

- Adding a medication.

2. For patients who do not stabilize and refuse to engage in any type of ongoing care with any provider, (e.g., medical, psychiatric, or addiction specialty) episodic attention to substance use may be accomplished by the following:
    a. Provide crisis intervention, as needed
    b. At any contact initiated by the patient:
        - Assess current substance use
        - Recommend that the patient accept ongoing care in the most appropriate setting
        - Designate a single provider to coordinate care for patients who repeatedly present in crisis
        - Consider involving supportive family members or significant others, if the patient agrees. For DoD active duty members, this may include first line supervisor when appropriate and will necessarily include the unit commander
        - Initiate involuntary treatment procedures, if imminent threat to safety occurs (e.g., suicidal, violent, or unable to care for self).
    c. Continue to reinforce and endorse increased appropriate engagement and adherence.
3. Consider consultation with mental health or SUD specialty.


MANAGEMENT OF SUBSTANCE USE DISORDERS
Module P: Addiction-Focused Pharmacotherapy
P
1
Patient with substance use disorder (SUD) [A]
2
Complete physiologic stabilization if necessary (Use module S)
3
Is the patient opioid dependent? [B]
Yes
No
4
Is opioid agonist therapy (OAT) medication appropriate for and acceptable to the patient? [C]
Y
5
Is treatment in a specialized opioid agonist treatment program setting appropriate and available for the patient? [D]
Yes
No
DoD Active Duty
For DoD active duty personnel, maintenance opioid agonist therapy (OAT) is generally not a treatment option. [C]
8
Is naltrexone therapy appropriate for and acceptable to the patient? [F]
Yes
No
9
Assure patient is withdrawn from opioids and is opiod free before continuing [G]
10
Initiate naltrexone for opioid dependence with patient education and monitoring [H]
7
Initiate treatment in an office-based setting (OBOT) [E]
6
Initiate treatment in an opioid agonist treatment program [E]
11
Is the patient alcohol dependent? [I]
Yes
No
12
Is pharmacotherapy for alcohol dependence indicated ?
Yes
No
13
Initiate pharmacotherapy for alcohol dependence with patient education and monitoring [J]
14
Return to referring module
8/1/2009

MODULE P: ADDICTION-FOCUSED PHARMACOTHERAPY

A. Patient with Substance Use Disorder (SUD)

BACKGROUND

Patients managed within this module meet the criteria for DSM-IV-TR substance abuse or dependence and are considered for addiction-focused pharmacotherapy.

B. Does the Patient Meet DSM-IV Criteria for Opioid Dependence?

BACKGROUND

Addiction focused pharmacotherapy is indicated for patients who meet DSM-IV-TR opioid dependence criteria. The American Academy of Pain Medicine, the American Pain Society, and the American Society of Addiction Medicine issued a consensus statement that distinguished addiction from physical dependence. References to opioid dependence elsewhere in this module are based on the diagnostic condition reflecting addiction rather than physical dependence alone.

See Introduction: Definitions (page 5)

RECOMMENDATION

1. Assess opioid dependence using DSM-IV-TR criteria.

PHARMACOTHERAPY FOR OPIOID DEPENDENCE

C. Is Opioid Agonist Treatment (OAT) Medication Appropriate for, and Acceptable to, the Patient?

BACKGROUND

Opioid agonist treatment (OAT) is the first line treatment for chronic opioid dependence that meets DSM-IV-TR criteria. For DoD active duty members, OAT is generally not a treatment option.

RECOMMENDATIONS

1. Provide access to opioid agonist treatment (OAT) for all opioid dependent patients, under appropriate medical supervision and with concurrent addiction-focused psychosocial treatment as indicated. [A]
2. Strongly recommend methadone or sublingual buprenorphine/naloxone maintenance as first line treatments due to their documented efficacy in improving retention and reducing illicit opioid use and craving. [A]

Note: In pregnancy, buprenorphine monotherapy is preferred.

See Table P-1 for indications, contraindications, side effects, and drug interactions of methadone and sublingual buprenorphine/naloxone.

Refer to Appendix C: Addiction-Focused Psychosocial Treatment

Table P- 1. Agonist Therapy for Opioid Dependence

	Methadone	Buprenorphine / Naloxone or Buprenorphine*
Indications	Opioid dependence (DSM diagnosis) and patient meets Federal Opioid Treatment Standards (42 CFR 8.12)	Opioid dependence (DSM diagnosis) plus one or more of the following: 1 New patients not currently receiving OAT AND who meet at least one of the following 3 criteria: a. Do not have timely access to a VA-supported OAT center. b. Do not meet regulatory criteria for treatment in an OAT program. (http://www.dpt.samhsa.gov/) c. Will have difficulty adhering to scheduled visits at a VA supported OAT program (e.g., because of restrictive clinic hours). 2 Appropriately selected patients on stable methadone maintenance who have difficulty adhering to scheduled visits at a VA-supported OAT center or may not need close supervision. 3 Patients who have a documented severe, uncontrollable adverse effect or true hypersensitivity to methadone.
Contraindications	Hypersensitivity	Hypersensitivity
Warnings / Precautions	Concurrent enrollment in another OTP Significant liver failure Use of opioid antagonists (e.g., naloxone, nalmefene, or naltrexone) Concurrent benzodiazepines or other CNS depressants (potential respiratory depression) Cardiac arrhythmias with prolonged QTc interval	Buprenorphine/naloxone may precipitate withdrawal in patients on full agonist opioids Concurrent benzodiazepines or other CNS depressants, including active alcohol abuse /dependence (potential respiratory depression) Use caution in patients with respiratory, liver, or renal impairment Use of opioid antagonists (e.g., naloxone, nalmefene, or naltrexone)
Baseline evaluation	Consider baseline ECG and physical examination for patients at risk for QT prolongation or arrhythmias	Liver transaminases
Dosage and Administration	Initial dose: 15–20 mg single dose, max. 30 mg. Daily dose: Max. 40 mg/d on first day. Usual dosage range for optimal effects: 60–120 mg/d. Titrate carefully, consider methadone's delayed cumulative effects Give orally in single dose Individualize dosing regimens (AVOID same fixed dose for all patients)	Induction dose: 2–8 mg sublingually once daily Day 2 and onward: Increase dose by 2–4 mg/d; target dose in first week, 12–16 mg/d. Stabilization / Maintenance: Titrate by 2–4 mg per week; usual dose 12–16 mg/d (up to 32 mg/d) Individualize dosing regimens
Alternative Dosing Regimens	Give in divided daily doses based on peak and low levels that document a metabolic rate that justifies divided doses	Give equivalent weekly maintenance dose divided over extended dosing intervals (2 or 3 times a week or every 2, 3, or 4 days)
Dosing in Special Populations	Renal or Hepatic Impairment: Reduce dose Elderly or Debilitated: Reduce dose	Hepatic Impairment: Reduce dose

	Methadone	Buprenorphine / Naloxone or Buprenorphine*
Adverse Effects	Major: respiratory depression, shock, cardiac arrest, possible prolongation of QTc interval on ECG and torsades de pointes ventricular tachycardia Common: lightheadedness, dizziness, sedation, nausea, vomiting, sweating, constipation, edema Less common: sexual dysfunction	Major: hepatitis, hepatic failure, respiratory depression (usually when misused intravenously with other CNS depressants) Common: headache, pain, abdominal pain, insomnia, nausea, vomiting, sweating, constipation
Drug Interactions	Drugs that reduce serum methadone levels: ascorbic acid, barbiturates, carbamazepine, ethanol (chronic use), interferon, phenytoin, rifampin, efavirenz, nevirapine, other antiretrovirals with CYP3A4 activity Drugs that increase serum methadone level: amitriptyline, atazanavir, atazanavir / ritonavir, cimetidine, delavirdine, diazepam, fluconazole, fluvoxamine, ketoconazole, voriconazole Opioid antagonists may precipitate withdrawal	Drugs that reduce serum buprenorphine level: ascorbic acid, barbiturates, carbamazepine, ethanol (chronic use), interferon, phenytoin, rifampin, efavirenz, nevirapine, other antiretrovirals with CYP3A4 activity Drugs that increase serum buprenorphine level: amitriptyline, atazanavir, atazanavir / ritonavir, cimetidine, delavirdine, diazepam, fluconazole, fluvoxamine, ketoconazole, voriconazole Opioid agonist: buprenorphine/naloxone or buprenorphine may precipitate withdrawal Opioid antagonists may precipitate withdrawal
Patient Education	Strongly advise patient against self-medicating with CNS depressants during methadone therapy Serious overdose and death may occur if benzodiazepines, sedatives, tranquilizers, antidepressants, or alcohol are taken with methadone Store in a secure place out of the reach of children	Strongly advise patient against self-medicating with CNS depressants during buprenorphine therapy Serious overdose and death may occur if benzodiazepines, sedatives, tranquilizers, antidepressants, or alcohol are taken with buprenorphine Store in a secure place out of the reach of children

D. Is Treatment in a Specialized Opioid Agonist Treatment Program (OATP) Setting Appropriate for the Patient?

BACKGROUND

In general, patients requiring greater structure and intensity of comprehensive treatment services including mental health, medical, and social services, may be better served in an Opioid Agonist Treatment Program (OATP). Provision of care at OATPs is highly regulated, with provider and patient-level requirements including limited take home medications provided, mandated laboratories and assessments, appropriate psychosocial intervention, and formal agreements for the provision of OAT. In office-based opioid treatment (OBOT) for medical maintenance by credentialed physicians, patients usually receive less intensive services (e.g., less psychosocial services needed to prevent relapse) either within an addiction specialty care program or in a setting similar to treatment of other medical conditions.

Deciding on whether a patient requires opioid agonist treatment in a specialized OATP depends on matching treatment resources to each individual patient's needs.

RECOMMENDATIONS

1. Individualize the choice of setting based on patient characteristics and availability of facilities to treat patients with opioid agonist therapy (OAT). See Table P-2.
2. Appropriate psychosocial interventions should be provided as part of the opioid agonist therapy (OAT). [A]

Table P- 2. Patient Suitability for Office-Based Opioid Treatment versus Opioid Agonist Treatment Program*

Criteria	Office-Based Opioid Treatment (OBOT)	Opioid Agonist Treatment Program (OATP)
Can an office-based setting provide needed resources for the patient	Yes	No
Patient's psychosocial supports	Good	Poor
Severity of opioid dependence	Mild to Moderate	High
Co-occurring psychiatric disorders	Stable	Unstable (e.g., chronically suicidal)
Co-occurring medical disorders	Stable	Unstable
Dependence on CNS depressants (e.g. alcohol, benzodiazepines)	No	Yes
Pregnant	No	Yes
Previous failed treatment attempts, especially with opioid agonists	None/Few	Many
Response to sublingual buprenorphine in the past	Good	Poor
Expected to be reasonably compliant in treatment	Yes	No

* A considerable amount of medical decision-making is required to determine the best setting for each individual patient. If the setting chosen initially is not appropriate, the patient can be switched to the alternative setting with appropriate monitoring.

E. Initiate Opioid Agonist Treatment in an Opioid Agonist Treatment Program (OATP) or Office-Based Opioid Treatment (OBOT) with Patient Education and Monitoring

RECOMMENDATIONS

1. Opioid Agonist Treatment Program (OATP) and office-based opioid treatment (OBOT) must be provided in the context of a complete treatment program that includes:
    a. Appropriate adjustment of opioid agonist doses to maintain a therapeutic range between signs/symptoms of overmedication (e.g., somnolence, miosis, itching, hypotension, and flushing) and opioid withdrawal (e.g., drug craving, anxiety, dysphoria, and irritability)
        - Usual dosage range for optimal effects: 60–120 mg/day [A]
        - Buprenorphine target dose is generally up to 16mg daily; doses above 32mg are rarely indicated. **In all cases, except pregnancy, the combination product of buprenorphine/naloxone should be used**.

b. Relapse monitoring to promote effective outcomes

c. Adequate frequency of toxicology for alcohol and other drugs of abuse

d. Appropriate psychosocial interventions. [A]

F. Is Naltrexone Therapy Appropriate for and Acceptable to the Patient?

BACKGROUND

Naltrexone is an FDA approved alternative to opioid agonist treatment for patients with opioid dependence who are highly motivated and have psychosocial support for treatment and medication adherence. However, the number of individuals maintained on naltrexone continues to be low and its usefulness in the treatment of opioid dependency has been limited. It has no opioid agonist effects. Patients may continue to experience cravings and may thereby not be motivated to maintain adherence to the medication regimen. Patients addicted to opioids must be fully withdrawn for up to 7-10 days from all opioids before beginning naltrexone treatment. Unfortunately, during this period, many patients relapse to use of opioids and are unable to start on naltrexone.

RECOMMENDATIONS

1. Consider monitored administration of naltrexone maintenance in highly motivated opioid dependent patients. [C] See Table P-3.
2. Consider opioid agonist treatment (OAT) or long-term therapeutic community before naltrexone as first line approaches for chronic opioid dependent patients.

Table P- 3. Pharmacotherapy with Naltrexone for Opioid Dependence

Indications	Opioid dependence with ability to achieve at least 7-10 days of abstinence to prevent precipitated withdrawal with first dose Engagement in comprehensive management program that includes measures to ensure medication adherence Note: Most effective when the patient is engaged in addiction-focused counseling with monitored administration
Contraindications	Acute hepatitis or liver failure Hypersensitivity to naltrexone or product components Current physiological dependence on opioids with use within past 7 days Ongoing acute opioid withdrawal or failed naloxone challenge test Receiving opioid agonists Positive urine opioid screen
Warnings / Precautions	Active liver disease Severe hepatic dysfunction (i.e., transaminase levels > 3 times normal and abnormal bilirubin) Severe renal failure Pregnancy Category C
Baseline Evaluation	Consider naloxone challenge test Transaminase levels Urine toxicology

G. Assure Patient is Withdrawn from Opioids and Opioid Free Before Continuing

BACKGROUND

Avoid an adverse opioid withdrawal reaction precipitated by naltrexone during lingering physiological dependence. Such reactions can result in extreme reluctance to trust treatment of any modality.

RECOMMENDATIONS

1. Prior to starting naltrexone, ensure that the patient is opioid-free as naltrexone is an opioid antagonist and may precipitate withdrawal.
2. Consider pharmacologically assisted withdrawal (See Module S: Stabilization and Withdrawal Management, Annotation F), unless the patient successfully completed a naloxone challenge and/or has had at least 7-10 days of verified abstinence.

H. Initiate Naltrexone for Opioid Dependence with Patient Education and Monitoring

BACKGROUND

Patients who have successfully completed a naloxone challenge and/or have had at least 7 to 10 days of verified abstinence and who lack contraindications can be safely started on naltrexone maintenance therapy.

RECOMMENDATIONS

1. Provide appropriate dosing, treatment retention- and adherence-enhancing techniques, and relapse monitoring to promote effective outcomes.
2. Carefully start oral naltrexone at a dose of 25 mg once daily. If no signs of withdrawal occur, the dose may be increased to 50 mg daily on the following day. Extended dosing intervals, using equivalent weekly doses, may be used for supervised administration (see Table P-4).

Table P- 4. Pharmacotherapy Management with Naltrexone for Opioid Dependence

Dosage and Administration	25 mg orally once daily initially; if no withdrawal reaction, increase to 50 mg once daily Observed administration improves adherence
Alternative Dosing Schedules	- 25 mg orally twice daily with meals to reduce nausea, especially during the first week - 100 mg on Monday and Wednesday, 150 mg on Friday
Adverse Effects	Common: nausea Other: headache, dizziness, nervousness, fatigue, insomnia, vomiting, anxiety, somnolence
Drug Interactions	Opioid-containing medications, including over-the-counter (OTC) preparations Thioridazine Oral hypoglycemics Antiretrovirals
Monitoring	Monitor for opioid use with urine toxicology at least weekly during early recovery Repeat transaminase levels monthly for the first 3 months and every 3 months thereafter Discontinue or reduce naltrexone if transaminase levels rise significantly
Patient Education	Discuss compliance-enhancing procedures Negotiate commitment from the patient regarding monitored ingestion, if necessary Side effects, if any, tend to occur early in treatment and can typically resolve within 1-2 weeks after dosage adjustment If signs and symptoms of acute hepatitis occur, discontinue naltrexone and contact provider immediately

PHARMACOTHERAPY FOR ALCOHOL DEPENDENCE

I. Is the Patient Alcohol Dependent?

BACKGROUND

For the purposes of this guideline, alcohol dependence is defined via DSM-IV-TR criteria.

RECOMMENDATION

1. Identify patients with alcohol dependence who should be offered addiction-focused pharmacotherapy.

See Introduction: Definitions (page 5)

J. Initiate Pharmacotherapy for Alcohol Dependence with Patient Education and Monitoring

BACKGROUND

Established pharmacologic treatments, notably disulfiram and naltrexone, (see Table P-5) combined with addiction-focused counseling may reduce the amount of drinking, the risk of relapse, the number of days of drinking, and craving in some alcohol-dependent individuals. For many patients, however, these treatments are not effective. Research in molecular and behavioral genetics are guiding the development of new drugs seeking to identify pharmacologic pathways relevant to alcohol dependence and to more effectively match treatments to individuals according to their genetic characteristics. Medications such as ondansetron, topiramate, sertraline, aripiprazole, quetiapine and baclofen represent novel lines of research and are currently being tested for use in the treatment of alcoholism.

RECOMMENDATIONS

1. Routinely consider oral naltrexone, an opioid antagonist, and acamprosate for patients with alcohol dependence. [A]
   Note that in VA, acamprosate is currently a non-formulary medication with criteria for use posted at http://vaww.national.cmop.va.gov/PBM/Clinical%20Guidance/Forms/AllItems.aspx
2. Medications should be offered in combination with addiction-focused counseling.
3. Injectable naltrexone should be considered when medication adherence is a significant concern in treating alcohol dependence and should be combined with addiction-focused counseling. [A]
   Note that in VA, injectable naltrexone is currently a non-formulary medication with criteria for use posted at http://vaww.national.cmop.va.gov/PBM/Clinical%20Guidance/Forms/AllItems.aspx
4. If patient does not respond to one of the approved medications, a trial on one of the other approved medications is warranted.
5. Because of the risk of significant toxicity and limited evidence of effectiveness, risk and benefits of disulfiram should be considered and disulfiram should only be used when abstinence is the goal and when combined with addiction-focused counseling. [B] The informed consent discussion with the patient should be documented.
6. Dosing of these pharmacotherapies should be consistent with medication trials and recommendations in appropriate drug references (see Table P-5).

Table P- 5. Pharmacotherapy of Alcohol Dependence

	Naltrexone Oral	Naltrexone Injectable	Acamprosate	Disulfiram
Indications	Alcohol dependence (DSM diagnosis) with: - At least 3-5 days of pretreatment abstinence (1) - Engagement in a comprehensive management program that includes psychosocial therapy	Alcohol dependence (DSM diagnosis) with: - Pretreatment abstinence not required but improves response (2) - Willingness to receive monthly injections - Difficulty adhering to an oral regimen - Engagement in a comprehensive management program that includes psychosocial therapy	Alcohol dependence (DSM diagnosis) with: - Abstinence at treatment initiation - Engagement in a comprehensive management program that includes psychosocial therapy.	Alcohol dependence (DSM diagnosis) with: - Abstinence > 24 hours and BAL equal to 0 - Combined cocaine dependence - Failure of or contraindication to naltrexone - Previous response to disulfiram - Capacity to appreciate risks and benefits and to consent to treatment *Note: More effective with monitored administration (e.g., in clinic or with spouse or probation officer.)*
Contra-indications	-Receiving opioid agonists Physiologic opioid dependence with use within past 7 days Acute opioid withdrawal Failed naloxone challenge test Positive urine opioid screen Acute hepatitis or liver failure Hypersensitivity	Receiving opioid agonists Physiologic opioid dependence with use within past 7 days Acute opioid withdrawal Failed naloxone challenge Positive urine opioid screen Acute hepatitis or liver failure Hypersensitivity Inadequate muscle mass Discontinue intramuscular naltrexone if there is NO detectable benefit within 3 months	Hypersensitivity Severe renal impairment (CrCl ≤ 30 mL/min).	Severe cardiovascular, respiratory, or renal disease Severe hepatic dysfunction (i.e., transaminase levels > 3 times upper limit of normal or abnormal bilirubin) Severe psychiatric disorders, especially psychotic and cognitive disorders and suicidal ideation Poor impulse control Metronidazole or ketoconazole therapy which already induce a similar reaction to alcohol Hypersensitivity
Warnings / Precautions	Active liver disease Severe renal failure Pregnancy Category C	Active liver disease Moderate to severe renal insufficiency (no data) Injection site reactions Use intramuscular injections with caution in patients with thrombocytopenia or coagulation disorders Pregnancy Category C	Monitor for emergence of depression or suicidality Reduce dose in patients with renal impairment, including elderly Pregnancy Category C	Pregnancy Category C

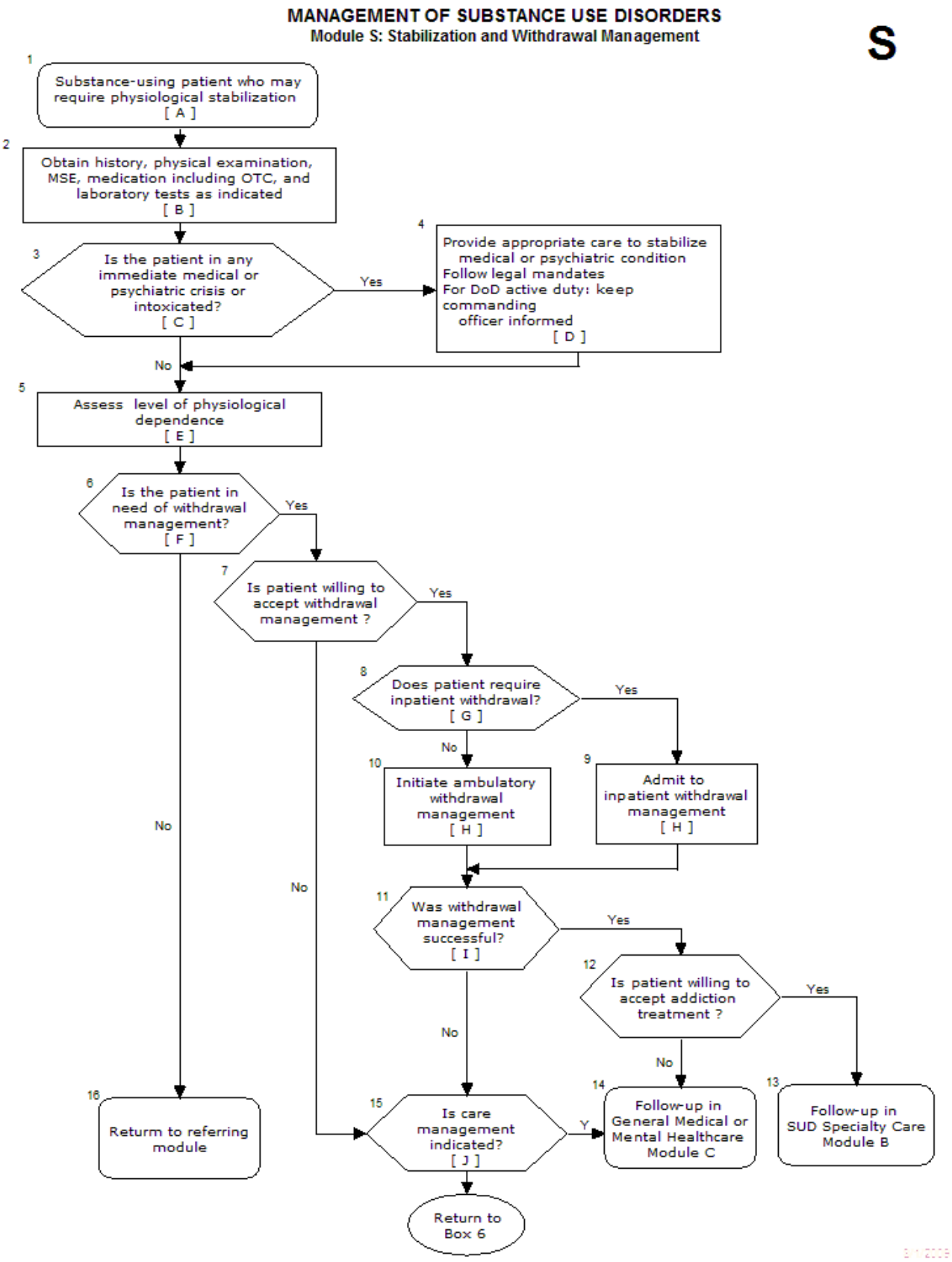
	Naltrexone Oral	Naltrexone Injectable	Acamprosate	Disulfiram
Baseline Evaluation	Liver transaminase levels Bilirubin within normal limits Urine beta-HCG for females	Liver transaminase levels Bilirubin within normal limits Creatinine clearance (estimated or measured) 50 ml/min or greater Ensure patient has adequate muscle mass for injection Urine beta-HCG for females	Creatinine clearance (estimated or measured) Urine beta-HCG for females	Liver transaminase levels Physical assessment Psychiatric assessment Electrocardiogram Verify abstinence with breath or blood alcohol level Urine beta-HCG for females
Dosage and Administration	50 to 100 mg orally once daily	380 mg once monthly by deep intramuscular injection	666 mg orally three times daily, preferably with meals	250 mg orally once daily (range, 125–500 mg daily)
Alternative Dosing Schedules	25 mg once or twice daily with meals to reduce nausea, especially during the first week 100 mg on Monday and Wednesday and 150 mg on Friday	None	None	Reduce dose to 125 mg to reduce side effects For monitored administration, consider giving 500 mg on Monday, Wednesday, and Friday
Dosing in Special Populations	Hepatic or renal impairment: Use caution	Mild renal impairment (CrCl 50–80 ml/min): No dosage adjustment necessary Moderate–Severe renal impairment: No data	Moderate renal impairment (CrCl 30–50 ml/min): 333 mg three times daily Do not administer to patients with severe renal impairment (CrCl ≤ 30 ml/min)	

	Naltrexone Oral	Naltrexone Injectable	Acamprosate	Disulfiram
Adverse Effects	Common: nausea Other: headache, dizziness, nervousness, fatigue, insomnia, vomiting, anxiety, somnolence	Major: Eosinophilic pneumonia, depression, suicidality Common: Injection-site reaction, injection-site tenderness, injection-site induration, nausea, headache, asthenic conditions	Major: suicidality 2.4% (vs. 0.8% on placebo during the first year in clinical trials) Common: diarrhea (16%) Other: anxiety, asthenia, depression, insomnia	Major: Hepatotoxicity, peripheral neuropathy, psychosis, delirium, severe disulfiram-ethanol reaction Common: somnolence, metallic taste, headache
Drug Interactions	Opioid-containing medications, including OTC preparations Thioridazine (increased lethargy and somnolence)	Opioid-containing medications, including OTC preparations Thioridazine (increased lethargy and somnolence)	Naltrexone: 33% increase in Cmax of acamprosate (no dosage adjustment is recommended) Antidepressants: weight gain and weight loss more common than with either medication alone	Alcohol containing medications, including OTC preparations Drug-drug interactions may occur with phenytoin, warfarin, isoniazid, rifampin, diazepam, chlordiazepoxide, imipramine, desipramine, and oral hypoglycemic agents.
Monitoring	Repeat liver transaminase levels at 6 and 12 months and then every 12 months thereafter	Repeat liver transaminase levels at 6 and 12 months and every 12 months thereafter	Monitor serum creatinine / CrCl, particularly in patients with renal impairment and the elderly	Repeat liver transaminase levels in 10 to 14 days and every 12 months thereafter

<table>
<tr><th></th><th>Naltrexone Oral</th><th>Naltrexone Injectable</th><th>Acamprosate</th><th>Disulfiram</th></tr>
<tr><td rowspan="2">Patient Education</td><td>Discuss compliance-enhancing methods
Negotiate commitment from the patient regarding monitored ingestion
Side effects, if any, tend to occur early in treatment and can typically resolve within 1-2 weeks after dosage adjustment</td><td>Report any concerning injection-site reactions
Report any new or worsening depression or suicidal thinking
May cause allergic pneumonia; contact provider if patient develops signs and symptoms of pneumonia</td><td rowspan="2">Report any new or worsening depression or suicidal thinking</td><td rowspan="2">Avoid alcohol in food and beverages, including medications
Avoid disulfiram if alcohol intoxicated
May cause sedation; caution operating vehicles and hazardous machinery
Discuss compliance-enhancing methods
Family members should not administer disulfiram without informing patient
Provide patients with wallet cards that indicate the use of disulfiram</td></tr>
<tr><td colspan="2">If signs and symptoms of acute hepatitis occur, discontinue naltrexone and contact provider immediately
Very large doses of opioids may overcome the effects of naltrexone and lead to serious injury, coma, or death
Small doses of opioids, such as in analgesic, antidiarrheal, or antitussive drugs, may be blocked by naltrexone and fail to produce a therapeutic effect
Patients who have previously used opioids may be more sensitive to toxic effects of opioids after discontinuation of naltrexone</td></tr>
</table>

(1) Most trials for oral NTX required as an inclusion criterion pretreatment abstinence of ≥ 4 or ≥ 7 days. This is the subgroup of patients in which oral NTX was shown to be efficacious. Expert opinion suggests a less restrictive requirement. This description of "appropriate" candidates is consistent with FDA-approved product information

(2) While documented abstinence is not required for therapeutic benefit with injectable naltrexone, even greater benefit may be seen in patients who achieve some duration of alcohol abstinence (e.g. 2–4 days) prior to the initial injection of naltrexone. The evidence supports 7 days of prior abstinence for improved outcomes.


MANAGEMENT OF SUBSTANCE USE DISORDERS
Module S: Stabilization and Withdrawal Management
S
1
Substance-using patient who may require physiological stabilization
[A]
2
Obtain history, physical examination, MSE, medication including OTC, and laboratory tests as indicated
[B]
3
Is the patient in any immediate medical or psychiatric crisis or intoxicated?
[C]
Yes
4
Provide appropriate care to stabilize medical or psychiatric condition
Follow legal mandates
For DoD active duty: keep commanding officer informed
[D]
No
5
Assess level of physiological dependence
[E]
6
Is the patient in need of withdrawal management?
[F]
Yes
No
7
Is patient willing to accept withdrawal management ?
Yes
No
8
Does patient require inpatient withdrawal?
[G]
Yes
No
9
Admit to inpatient withdrawal management
[H]
10
Initiate ambulatory withdrawal management
[H]
11
Was withdrawal management successful?
[I]
Yes
No
12
Is patient willing to accept addiction treatment ?
Yes
No
13
Follow-up in SUD Specialty Care Module B
14
Follow-up in General Medical or Mental Healthcare Module C
15
Is care management indicated?
[J]
Y
Return to Box 6
16
Return to referring module

MODULE S: STABILIZATION and WITHDRAWAL MANAGEMENT

A. Substance-Using Patient Who May Require Physiological Stabilization

This module addresses the management of patients who are physiologically dependent on alcohol and/or other substances and who are at risk of withdrawal symptoms, or for whom the provider is uncertain about the level of withdrawal risk and seeks further evaluation.

B. Obtain History, Physical Examination, Mental Status Examination (MSE), Medication Including Over-The-Counter (OTC), and Lab Tests as Indicated

BACKGROUND

The provider should review or obtain clinical background information on the patient, including any prior assessment.

RECOMMENDATIONS

1. Interview the patient and other collateral informants, where appropriate, about medical and mental health history and use of prescription and non-prescription medications before initiating extensive diagnostic testing.
2. Note any history of recent head trauma.
3. Order laboratory tests selectively, aiming to detect potential medical causes for the presenting symptoms, where indicated by:
    a. Specific symptoms found on the medical review of systems
    b. Evidence of unusual symptom profiles
    c. History of atypical illness course
    d. Abnormal screen for cognitive status, particularly in the elderly patient.

C. Is the Patient in Any Immediate Medical or Psychiatric Crisis or Intoxicated?

BACKGROUND

Emergency or urgent clinical situations include unstable medical problems (e.g., acute trauma, myocardial infarction, and stroke) or unstable psychiatric problems (e.g., imminent risk of harm to self and/or others and delirium, including alcohol-related delirium [withdrawal/intoxication]).

RECOMMENDATIONS

1. Refer patients with problems that require emergency care or urgent action to emergency care for further action as needed.

D. Provide Appropriate Care to Stabilize Prior to Management of Withdrawal; Follow Policies For DoD Active Duty Members: Keep Commanding Officer Informed

BACKGROUND

Existing local policies and procedures with regard to threats to self or others reflect local and state laws and the opinion of the VA District Council and the DoD. Primary care, mental health, and administrative staff must be familiar with these policies and procedures.

RECOMMENDATIONS

1. Assure the patient's immediate safety and determine the most appropriate setting
2. Refer for mental health treatment or assure that follow-up appointment is made
3. Inform and involve someone close to the patient
4. Limit access to means of suicide
5. Increase contact and make a commitment to help the patient through the crisis
6. For comatose patients, maintain airway and adequate ventilation in order to preserve respiration and cardiovascular function.
7. Emergency procedures should be considered, including the use of gastric lavage for sedative, hypnotic, and/or opioid intoxication.
8. Emergency pharmacologic interventions should be utilized as appropriate, including the use of intravenous naloxone hydrochloride for opioid overdose and flumazenil for benzodiazepine overdose.
9. Agitation secondary to intoxication from a variety of substances is best initially managed through decreasing sensory stimuli and interpersonal approaches rather than additional medications. If chemotherapeutic agents are necessary, the short acting IM benzodiazepines (e.g., lorazepam) and high potency neuroleptics should be considered.

For DoD active duty members: follow DoD and Service-specific policies, as mental health/emergency referral is likely mandated.

E. Assess Level of Physiological Dependence and Indications for Stabilization Including Risk of Withdrawal

BACKGROUND

Untreated severe alcohol and other sedative hypnotic withdrawal, in particular, can lead to autonomic instability, seizures, delirium, or even death.

The opioid withdrawal syndrome can be protracted with intense symptoms, though the syndrome itself poses virtually no risk of mortality. However, there is significant mortality risk from overdose for those who relapse following unsuccessful medically supervised withdrawal attempts as a result of loss of opioid tolerance.

The potential for a withdrawal syndrome can be gauged only imprecisely by asking the patient the pattern, type, and quantity of recent and past substance use. Systematic monitoring of withdrawal symptoms is indicated until patients are stabilized.

RECOMMENDATIONS

1. Obtain and document necessary information to classify level of withdrawal and factors that may influence the severity of the withdrawal (see Appendix B-6 for a list of withdrawal signs and symptoms for the different types of substances):
    a. Determine type of substance of use
    b. Determine time since last use
    c. Determine concurrent use of other substances or prescriptions
    d. Determine co-occurring medical and/or psychiatric disorders
    e. Consider past withdrawal experiences.
2. Use laboratory results and patient observation to determine the level of tolerance (e.g., high blood level in patient who appears to be not intoxicated).
3. Use standardized measures to assess the severity of withdrawal symptoms such as CIWA-Ar (see Box S-1) or COWS (see Box S-2). [B]
4. Evaluate patients using multiple substances (e.g., opioids and sedative-hypnotics) for risk of withdrawal from each substance.

Box S-1. Assessment of Alcohol Withdrawal (See Appendix B-7)

The Clinical Institute Withdrawal Assessment for Alcohol-Revised (CIWA-Ar) has good reliability and validity for assessing severity of withdrawal symptoms from alcohol.

CIWA-Ar has 10 provider ratings. Interpret total scores as follows:

- Minimal or absent withdrawal: ≤ 9
- Mild to moderate withdrawal: 10-19
- Severe withdrawal: > 20.

Box S-2. Assessment of Opioid Withdrawal (see Appendix B-8)

The Objective, Subjective and Clinical Opiate Withdrawal Scales (OOWS, SOWS, and COWS) can be used for assessing severity of withdrawal symptoms from opioids

COWS has 10 provider ratings. Interpret total scores as follows:

- Mild withdrawal: 5-12
- Moderate withdrawal: 13-24
- Moderately severe withdrawal: 25-36
- Severe withdrawal: > 36.

F. Is the Patient in Need of Withdrawal Management?

BACKGROUND

Withdrawal management from a substance is defined as non-pharmacologic and/or pharmacologic medical care with a goal of safely transitioning a patient from active use to sustained treatment for the

patient's substance use disorder. Withdrawal management is an essential initial gateway in preparing many patients for additional treatment.

Pharmacologically supervised withdrawal is warranted only for alcohol, sedative-hypnotics, and opioids; however, patients who use other illicit substances may find benefit in initiation of treatment during their withdrawal period. For nicotine dependence, refer to Clinical Practice Guideline: Treating Tobacco Use & Dependence: 2008 Update from the U.S. Department of Health and Human Services available at: http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf and the VA/DoD Clinical Practice Guideline for the Management of Tobacco Use. Other substances do not require pharmacological management for withdrawal.

It is important to distinguish patients with legitimate pain and/or anxiety disorders who develop only physiological tolerance during long-term use of prescribed medications from those with markers of prescription misuse.

RECOMMENDATIONS

1. Indications for withdrawal management from alcohol or sedative-hypnotics
    - Patient with alcohol dependence with observed withdrawal symptoms
    - CIWA-Ar score for at least mild withdrawal (>10)
    - Patients with dependence on central nervous system depressants, due to the risks of untreated withdrawal in severely dependent persons.
2. Relative contraindication for medically supervised withdrawal management from alcohol
    - Patients with minimal withdrawal symptoms that are not accompanied by complicating co-occurring disorders. Such patients may respond sufficiently to generalized support, reassurance, and frequent monitoring.
3. Potential indications for medically supervised opioid withdrawal:
    - Patient with physical dependence in the absence of clinical indications for ongoing treatment (e.g., severe pain disorder)
    - Patient with physical dependence accompanied by aberrant or non-adherent behavior (e.g., obtaining prescriptions from multiple providers, escalating doses without provider consultation, or buying medications on the street)
    - Agreement to provide naltrexone for treatment of opioid dependence
    - Patient who does not request or want opioid agonist medical therapy but wants non-pharmacologic treatment for opioid dependence
4. Contraindication for opioid withdrawal management:
    - Chronic severe opioid dependence. For such patients, first line therapy is methadone or sublingual buprenorphine/naloxone maintenance treatment (see Module P - Addiction Focused Pharmacotherapy)
    - Two or more unsuccessful medically supervised withdrawal episodes within a 12-month period. Such patients should be assessed for opioid agonist therapy.
5. Consider using a structured assessment tool to evaluate and track behaviors suggestive of addiction such as inappropriate medication use and to increase the provider's confidence in determinations of appropriate vs. inappropriate opioid use.
6. Evaluate opioid dependent patients for severe acute or chronic physical pain that may require appropriate short-acting opioid agonist medication in addition to the medication needed to prevent opioid withdrawal symptoms (see also VA/DoD Clinical Practice Guideline for Management of Chronic Opioid Therapy at http://www.healthquality.va.gov).

G. Does Patient Require Inpatient Medically Supervised Withdrawal?

BACKGROUND

Patients are more likely to complete an inpatient medically supervised withdrawal protocol; however, long-term outcomes do not differ between inpatient and outpatient medically supervised withdrawal programs. Relative advantages to consider include:

Ambulatory withdrawal management has the potential advantages of:

- Facilitating continuity of care in the outpatient setting
- Reducing disruption to the patient's life
- Lowering costs in the outpatient setting.

Inpatient withdrawal management has the advantages of:

- Fewer logistic medical and legal concerns (e.g., arranging for patient transportation, driving during the course of medically supervised withdrawal, and the ability to give informed consent)
- Allowing closer monitoring of withdrawal symptoms
- Having higher likelihood of completing the withdrawal management protocol

RECOMMENDATIONS

1. Consider the following indications for inpatient medically supervised withdrawal: [C]
    a. Current symptoms of at least mild alcohol withdrawal (e.g., CIWA-Ar score ≥10)
    b. History of delirium tremens or withdrawal seizures
    c. Inability to tolerate oral medication
    d. Imminent risk of harm to self or others
    e. Recurrent unsuccessful attempts at ambulatory medically supervised withdrawal
    f. Reasonable likelihood that the patient will not complete ambulatory medically supervised withdrawal (e.g., due to homelessness)
    g. Active psychosis or severe cognitive impairment
    h. Chronic liver disease or cardiovascular disease, pregnancy, or lack of medical support system.

H. Admit to Inpatient Withdrawal Management or Initiate Ambulatory Withdrawal Management

BACKGROUND

The objectives of withdrawal management from alcohol, sedative-hypnotics, or opioids in either inpatient or ambulatory settings are to prevent the patient from experiencing adverse events and prepare the patient for ongoing addiction treatment.

RECOMMENDATIONS

Alcohol Withdrawal Management

Follow local alcohol withdrawal management pathways, taking into consideration the following principles:

1. Use either of the following two acceptable pharmacotherapy strategies for managing alcohol withdrawal symptoms:
    a. Symptom-triggered therapy, where patients are given medication only when signs or symptoms of withdrawal appear (e.g., PRN dosing) [A]
    b. A predetermined fixed medication dose, with gradual tapering over several days may be considered for some patients, although it is inferior to symptom-triggered therapy. [B]
2. Repeat standardized assessments, such as the CIWA-Ar scale for alcohol withdrawal, to guide dosing decisions (e.g., if and when to dose) until stabilized.
3. Consider the following procedures for monitoring ambulatory alcohol withdrawal management as safe and effective alternatives to inpatient approaches:
    a. Medical or nursing staff should assess the patient in person, either daily or every other day (patient contact may be made by telephone on other days), to include:
        - Patient report of any alcohol use the previous day
        - Reported medication intake compared to the medication dispensed the previous day
        - Tremor, restlessness, and previous night's sleep
        - Skin (e.g., color and turgor).
    b. Urine toxicology or a breathalyzer test or blood alcohol content should be completed.
    c. If the daily screening is positive for any one of the following, the patient should be medically evaluated before initiating or continuing outpatient withdrawal management, or hospital admission should be considered:
        - Blood sugar ≥ 400 or positive anion gap
        - History of recent hematemesis, melena, or other gastrointestinal bleeding disorder
        - Bilirubin ≥ 3.0
        - Creatinine ≥ 2.0
        - Systolic blood pressure ≥ 180 or diastolic blood pressure ≥ 110
        - Unstable angina
        - Temperature ≥ 101 degrees
        - BAC ≥ 0.08 on two outpatient visits.
4. For inpatient treatment of alcohol withdrawal, use benzodiazepines over non-benzodiazepine sedative-hypnotics because of documented efficacy, and a greater margin of safety. Benzodiazepines are the drug of choice in this setting, given adequate monitoring, because they reduce withdrawal severity, incidence of delirium, and seizures. All benzodiazepines appear to be effective, but agents without active metabolites such as lorazepam or oxazepam may be preferred in patients with liver impairment. [A]

5. Dose and withdrawal scales should be individualized for each patient. Geriatric patients should start with lower doses of benzodiazepines than younger adults. [A]
6. For managing mild to moderate alcohol withdrawal, carbamazepine and valproic acid can be used as an effective supplement or alternative to benzodiazepines. They may be considered in patients that cannot use benzodiazepines (e.g., abuse liability or allergy/adverse reactions). [B]
7. Other agents, such as beta-blockers, and clonidine, are generally not considered as appropriate monotherapy for alcohol withdrawal, [D] but may be considered in conjunction with benzodiazepines in certain patients. [C]
8. During and after medically supervised withdrawal, emphasis should be placed on engagement in ongoing addiction treatment. [C]
9. Use of alcohol as an agent for medically supervised withdrawal is contraindicated. [D]

Sedative-Hypnotics Medically Supervised Withdrawal (e.g., Benzodiazepines)

There are three general treatment strategies for patients withdrawing from other sedative-hypnotic medications at doses above the therapeutic range, for a month or more:

1. Substitute phenobarbital for the addicting agent and taper gradually. [A]
    a. The average daily sedative-hypnotic dose is converted to a phenobarbital equivalent and divided into 3 doses per day for 2 days (see Appendix E for phenobarbital equivalencies for sedative hypnotics)
    b. Phenobarbital dose should be reduced by 30 mg per day, beginning on day 3.
2. Substitution then tapering: For patients on a shorter acting benzodiazepine, substitute a longer acting benzodiazepine at an equivalent dose (e.g., chlordiazepoxide) and taper 10 percent per day, over 1 to 2 weeks.
3. Simple tapering: Gradually decrease the dosage of the long-acting substance the patient is currently taking.

Opioid Withdrawal Management

1. Medically supervised opioid withdrawal is rarely effective as a long-term strategy for treatment of opioid dependence because of high relapse rates. Opioid maintenance with buprenorphine/naloxone or methadone is the definitive treatment of choice in most cases. [B]
2. If pursuing medically supervised opioid withdrawal, the preferred approaches are initial stabilization and subsequent short or extended taper with opioid agonist therapy.
3. Set the length of the outpatient taper period based on the treatment setting and severity of the dependence.
4. Medically supervised withdrawal can usually be accomplished in 4 to 7 days in an inpatient setting, to quickly achieve opioid abstinence prior to treatment in a drug-free setting preferably with initiation of naltrexone.
5. Withdrawal using buprenorphine/naloxone:
    a. Only physicians with a waiver from the US Department of Health and Human Services can prescribe buprenorphine/naloxone
    b. Initial stabilization is accomplished via induction with buprenorphine/naloxone just as it would be for maintenance with this agent. To reduce the risk of precipitated withdrawal, the patient must be in sufficient opioid withdrawal to be manifesting objective signs of withdrawal prior to starting buprenorphine/naloxone usually at least 8 hours since the patient's last use of heroin or other short-acting opioid or at least 24 hours and preferably at least 48 hours have elapsed since the last use of methadone or other long-acting opioid

c. Within 1-3 days, a daily dose of buprenorphine/naloxone should be achieved that eliminates signs and symptoms of opioid withdrawal, suppresses opioid craving, and eliminates illicit opioid use. This dose could range from 2/0.5 mg per day to 16/4mg per day and would rarely exceed that amount

d. Once stabilization has been achieved the dose can be rapidly tapered over 5-7 days. There is little evidence that prolonging the taper leads to better results. (If the patient and physician prefer a longer taper, there is also no evidence that a longer taper is harmful).

6. Withdrawal using methadone:

   a. Withdrawal using methadone can only be performed in the context of a federally licensed opioid treatment program where daily medication dispensing can occur. For patients not engaged in methadone maintenance through an opioid treatment program, withdrawal should be managed with buprenorphine

   b. Initial stabilization is accomplished via induction with methadone just as it would be for maintenance with this agent. Withdrawal signs do not have to be observed prior to starting methadone, but with methadone there is risk of medication accumulation, toxicity, and overdose. Initial dosing should be very conservative with careful daily observation of the patient. Initial daily doses can range from 5 mg to a maximum of 30 mg

   c. Within days to weeks, a daily dose of methadone should be achieved that eliminates signs and symptoms of opioid withdrawal, suppresses opioid craving, and eliminates illicit opioid use. This dose could range from 30 mg per day to doses as high as 120 mg per day

   d. Once stabilization has been achieved, the dose can be gradually tapered over a period of weeks to months. Dose decreases of more than 5 - 10 mg/day of methadone are generally poorly tolerated. [C] In contrast to the evidence with buprenorphine/naloxone, with methadone, longer taper periods should be used in the outpatient setting to minimize patient discomfort and maximize chances of success

   e. A period of two to three weeks is generally sufficient for short-term outpatient medically supervised withdrawal in the most stable and motivated individual. The higher the stabilization dose, the longer the taper is likely to take. The taper should proceed more gradually as the dose becomes lower.

7. The 180-day stabilization/medically supervised withdrawal regimen should be considered to facilitate work on patients' early recovery problems, while stabilized on sublingual buprenorphine or a relatively low dose (50-60 mg/day) of methadone. Stabilization is followed by short-term medically supervised withdrawal from buprenorphine or methadone and transition to a drug-free rehabilitation program.

8. Clonidine, an alpha-adrenergic agonist, can be considered as an adjunctive agent for symptom relief during inpatient medically supervised opioid withdrawal; however, outpatient success is much lower. If using clonidine, adjunctive medications for anxiety, restlessness, insomnia, muscle aches, nausea, and diarrhea can also be prescribed.

I. Was Withdrawal Management Successful?

BACKGROUND

Treatment of opioid withdrawal should focus on facilitating entrance into comprehensive long-term treatment, as well as alleviating acute symptoms. Withdrawal management can be attempted with patients who wish to detoxify from all opioids. There is a high relapse rate to heroin or other opioid use

unless stabilization is combined with psychosocial interventions. As such, withdrawal management is not a stand-alone treatment modality.

RECOMMENDATIONS

1. Identify patients in need of additional withdrawal management or stabilization before proceeding with further evaluation or treatment.
2. Medically supervised withdrawal is successful to the degree the patient:
    a. Is physiologically stable
    b. Avoids hazardous medical consequences of withdrawal
    c. Experiences minimal discomfort
    d. Reports being treated with respect
    e. Completes the medically supervised withdrawal protocol (e.g., no longer requires medication for withdrawal symptom management).

J. Is Care Management Indicated?

BACKGROUND

Among patients for whom withdrawal management is unsuccessful or who decline engagement in specialty care for rehabilitation, some patients may benefit from implementation of an ongoing care management plan outside of specialty SUD care.

RECOMMENDATIONS

1. If medically supervised withdrawal is unsuccessful or treatment engagement is not achieved, consider one of the following:
    a. A more intensive level of care for withdrawal management (e.g., inpatient)
    b. Identify patients who can benefit from implementation of a care management plan, if acceptable to the patient (see Module C, Annotation K).

APPENDICES

Note: Appendices A, B, D, E, G, and H will be included in the full guideline

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Appendix C: Addiction-Focused Psychosocial Interventions

Summary of Effectiveness of Psychosocial Interventions during early recovery (first 90 days) on condition specific outcomes of SUD (use or consequences) or general psychosocial functioning

		First line alternatives at least as effective as other bona fide active interventions or treatment as usual (TAU)				Added effectiveness as adjunctive interventions in combination with pharmacotherapy and/or other first line psychosocial interventions				
	Interventions (alphabetical)	Alcohol	Opioids	Stimulants/ mixed	Cannabis	Alcohol	Opioids	Stimulants/ mixed	Cannabis	Comments
C-1	Behavioral Couples Therapy	+++	N/A	+++	N/A	+/-	+	?	N/A	Effective for male or female patients with SUD and partners; improves marital satisfaction
C-2	Cognitive Behavioral Coping Skills Training	+++	N/A	+++	++	+	+++	N/A	++	
C-4	Contingency Management/ Motivational Incentives	N/A	N/A	N/A	N/A	+	+++	+++	N/A	
C-3	Community Reinforcement Approach	+++	N/A	+	N/A	N/A	N/A	+	N/A	Complex intervention
C-5	Motivational Enhancement Therapy (MET)	+++	N/A	N/A	?	+++	?	+/-	+	May improve treatment engagement as adjunct to TAU for stimulants; Some evidence for those with low readiness or high anger
C-6	Twelve-Step Facilitation	+++	N/A	N/A	N/A	++	N/A	+	N/A	AA participation is correlated with outcome – appears to mediate TSF effects

+++ based on meta analysis of comparison with bona fide alternative interventions

+ or ++ Based on one (+) or more (++) individual trials in comparison with bona fide alternatives

N/A: evidence not available; +/- evidence inconsistent across outcomes; ?: benefit questionable

C-1. Behavioral Couples Therapy (BCT)

Most versions of behavioral couples therapy (BCT) are focused both on reducing alcohol or drug use in the identified patient and on improving overall marital satisfaction for both partners. In BCT sessions, the therapist arranges a daily Sobriety Contract in which the patient states his or her intent not to drink or use drugs that day, and the partner expresses support for the patient's efforts to stay abstinent. The Sobriety Contract can also include urine drug screens for the patient, attendance at other agreed-to counseling sessions, or 12-step meetings by the patient and partner. To improve relationship functioning, BCT uses a series of behavioral assignments to increase positive feelings, shared activities, and constructive communication because these relationship factors are conducive to sobriety.

C-2. Cognitive-Behavioral Coping Skills Therapy

Cognitive-behavioral coping skills therapy consists of related treatment approaches for substance use disorders that focus on teaching patients to modify both thinking and behavior related not only to substance use, but to other areas of life functionally related to substance use. Patients learn to track their thinking and activities and identify the affective and behavioral consequences of those thoughts and activities. Patients then learn techniques to change thinking and behaviors that contribute to substance use, strengthen coping skills, improve mood and interpersonal functioning and enhance social support. Primary therapeutic techniques include education of the patient about the treatment model, collaboration between the patient and therapist to choose goals, identifying unhelpful thoughts and developing experiments to test the accuracy of such thoughts, guided discovery (facilitating the patient in identifying alternative beliefs through the use of questions designed to explore current beliefs), interpersonal skill building through communication and assertiveness training, behavioral rehearsal, and role-play. In addition, treatment incorporates structured practice outside of session, including scheduled activities, self-monitoring, thought recording and challenging, and interpersonal skills practice.

C-3. Community Reinforcement Approach (CRA)

Community Reinforcement Approach (CRA) is a comprehensive cognitive-behavioral intervention for the treatment of substance abuse problems by focusing on environmental contingencies that impact and influence the patient's behavior. Developed in accordance with the belief that these environmental contingencies play a crucial role in an individual's addictive behavior and recovery, CRA utilizes familial, social, recreational, and occupational events to support the individual in changing his or her drinking/using behaviors and promoting recovery. The goal is to rearrange multiple aspects of an individual's life so that a sober lifestyle is more rewarding than one that is dominated by alcohol and/or drugs. CRA integrates several treatment components, including building the patient's motivation to quit drinking/using, helping the patient initiate sobriety, analyzing the patient's drinking/using pattern, increasing positive reinforcement, learning new coping behaviors, and involving significant others in the recovery process.

C-4. Contingency Management for SUD Treatment

Contingency Management (CM) approaches are based on behavioral principles of reinforcement that reward specific behavioral goals related to recovery. Either monetary or nonmonetary rewards are made contingent on objective evidence such as negative toxicology results (e.g., biological tests for recent drug or alcohol use), treatment adherence, or progress toward treatment goals. The most common form of contingencies provided to reinforce desired behaviors are vouchers with monetary value that can be redeemed for goods and services, specific material prizes, or draws from a "fishbowl" that contains cards which vary in their reinforcing value from simple praise to vouchers worth $1 to $100. Schedules (fixed or intermittent) and magnitude of reinforcement have varied and have implications for overall cost of clinical implementation.

C-5. Motivational Enhancement Therapy (MET)

Motivational enhancement therapy (MET) is a less intensive form of specialized psychosocial intervention for patients with substance use disorders. MET uses principles of motivational interviewing including an empathic, client-centered, but directive approach intended to heighten awareness of ambivalence about change, promote commitment to change and enhance self-efficacy. MET differs from MI in that it is a more structured intervention that is based to a greater degree on systematic assessment with personalized feedback. The therapeutic style using motivational interviewing elicits client reactions to assessment feedback, commitment to change and collaboration on development of an individualized change plan. Involvement of a significant other is encouraged in at least one of the MET sessions.

C-6. Twelve-Step Facilitation (TSF)

Twelve Step Facilitation (TSF) therapy aims to increase the patient's active involvement in Alcoholics Anonymous (AA) or other twelve-step based mutual- (self-) help groups. This approach was systematized in a manual for NIAAA's Project MATCH and delivered as 12-sessions of individual therapy in which the therapist actively encourages engagement in AA, and walks the patient through the first four steps of the AA program. The therapist conveys the concept that addiction is a chronic, progressive and potentially fatal illness for which the only successful strategy is abstinence achieved one day at a time by following a 12-step program of recovery. Each therapy session is divided into three parts. The first part reviews relevant events of the last week (including urges to use, drinking behavior and recovery-oriented activities) and a homework assignment. The middle portion introduces new material related to the 12-steps. The conclusion of the session includes a homework assignment and development of a plan for recovery-oriented activities (meeting attendance, sponsor contact).

Appendix F: Acronym List

ASI	Addiction Severity Index
AUD	Alcohol Use Disorders
AUDIT-C	Alcohol Use Disorders Identification Test Consumption Questions
BAL	Blood Alcohol Levels
BCT	Behavioral Couples Therapy
BI	Brief Interventions
CDT	Carbohydrate Deficient Transferrin
CHF	Congestive Heart Failure
CIDI	Composite International Diagnostic Interview
CM	Contingency Management
CMEP	Case Management Enhancement Program
COD	Co-Occurring Disorders
CPG	Clinical Practice Guideline
CRA	Community Reinforcement Approach
DATA	Drug Addiction Treatment Act of 2000
DIS	Diagnostic Interview Schedule
DM	Diabestes Mellitus
EtG	Ethyl Glucuronide
EtS	Ethyl Sulfate
HIV	Human Immunodeficiency Virus
HR-QOL	Health Related-Quality of Life
ICMP	Iowa Case Management Project
IDU	Injection Drug Use
IOM	Institutes of Medicine
LFT	Liver Function Test
MET	Motivational Enhancement Therapy
MI	Motivational Interviewing
MM	Medical Management
MSE	Medical Status Examination
NCU	National Comorbidity Survey
NESARC	National Epidemiologic Study on Alcohol and Related Conditions
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
NSDUH	National Survey on Drug Use and Health
OAT	Opioid Agonist Treatment
OATP	Opioid Agonist Treatment Program
OBOT	Office-Based Opioid Treatment
OTC	Over-The-Counter
RCT	Randomized Controlled Trial
RT	Response to Treatment
SARRTP	Substance Abuse Residential Rehabilitation Treatment Programns
SASQ	Single Item Alcohol Screening Questionnaire

SBI	Screening and Brief Intervention
SCID	Structured Clinical Interview for the DSM
SUD	Substance Use Disorders
SUR	Substance Use Report
TRISARC	Tri-Service Addiction Recovery Center
TSF	Twelve-Step Facilitation
UDS	Urine Drug Screen
USPSTF	U.S. Preventive Services Task Force
VBRT	Voucher-Based Reinforcement Therapy