

MHNet has adopted the American Psychiatric Association's (APA) Practice Guideline for Substance Abuse Disorders. This synopsis is provided as a service to practitioners in the MHNet network and is distributed with permission of the APA. This guideline summary is not designed to stand on its own and should be used in conjunction with the full text of the Practice Guideline, which is available at the APA's web site, [www.psych.org](http://www.psych.org). If you do not have access to this web site and would like a hard copy of the complete practice guideline, please contact MHNet's Corporate Quality Improvement Department at (512) 347-7900.

### PRACTICE GUIDELINES FOR SUBSTANCE USE DISORDERS

MHNet monitors practitioner's adherence to the following elements in the treatment of Substance Use Disorders:

- *Appropriate Use of Detoxification Medications*
- *Appropriate Vital Signs Monitoring During Detoxification*

Substance abuse and dependence are endemic in the population affecting as much as 10% of adults. Substance abuse costs society billions of dollars in lost revenue and medical expenses. Despite the high prevalence of substance abuse, the condition frequently remains undiagnosed and untreated. This is particularly true among the mentally ill where the incidence of concomitant substance abuse may be as high as 30%.

The treatment of substance abuse requires:

- routine screening of all individuals with behavioral, medical and social problems;
- comprehensive assessment of patients suspected of substance abuse;
- medical management of intoxication and withdrawal;
- development of an individualized treatment plan which acknowledges the chronicity of substance abuse; and
- ongoing care, making use of the full spectrum of community support.

#### ASSESSMENT

The initial assessment must include a detailed history of the patient's substance abuse, including all drugs, amounts, frequency of use, and consequences of use including effects on cognitive, psychological, behavioral and physiologic functioning. A medical history must be obtained and a screening physical examination performed. Any previous treatment should be reviewed with emphasis on what appeared to help and what resulted in relapse. The patient's support system should be documented including family, social and vocational supports, with specific reference to deterioration due to substance abuse. Routine screening of blood/breath/urine for alcohol and drugs of abuse and medical testing for resultant conditions (e.g. hepatitis, cardiomyopathy, HIV, etc.) should be performed.

#### INITIAL MANAGEMENT

The initial treatment of substance abuse is directed towards medical stabilization and engaging the patient in the process of recovery. Management of acute intoxication can usually be done in a calm, quiet, supportive environment using the support of friends or relatives. Highly agitated or medically unstable individuals will require referral for emergency care.

The management of withdrawal is dependent on the nature and amount of drugs used, as well as the individual's past history of drug withdrawal symptoms. There are no detoxification protocols for stimulants, inhalants, hallucinogens or marijuana. Therefore symptomatic treatment (for anxiety, insomnia, restlessness, headache) is all that is required. Withdrawal from an opiate, in and of itself, is not life threatening. However, opiate withdrawal is quite painful and should be medically managed [refer to MHNet's Clinical Practice Guideline for Opiate Withdrawal for details]. Of all the drugs of abuse, only the sedatives (alcohol, barbiturates, and, in rare instances, benzodiazepines) may result in severe, life threatening withdrawal.

Withdrawal from alcohol is covered in MHNet's Clinical Practice Guideline for Alcohol Dependence and Abuse. Withdrawal from other sedatives involves

estimating the average daily consumption of drug and, converting that amount to Phenobarbital equivalents (ref. SAMHSA Treatment Improvement Protocol 19). Once the daily dose of Phenobarbital has been determined it is administered in divided doses 3-4 times a day. Patients are carefully monitored for 48 hours for symptoms of toxicity (nystagmus, sedation) which warrants decreasing the dose, or symptoms of withdrawal (agitation, insomnia, confusion) which warrants increasing the dose. Once stable the patient is gradually weaned off the Phenobarbital by decreasing the dose by 30 mg a day or by 10%.

When the treatment provider has the capacity for careful medical monitoring during the acute withdrawal phase, even severely dependent patients can be detoxified on an outpatient basis. Moderate doses of cross-reacting drugs can be administered during the observation period and a small amount of PRN medication given to a responsible caretaker for administration at home.

Psychosis and agitation associated with hallucinogens may require parenteral antipsychotics although care must be taken to prevent compounding an anticholinergic toxic delirium.

#### FORMULATION AND IMPLEMENTATION OF A TREATMENT PLAN

Once the acute phase of drug withdrawal is resolved and the patient is cognitively clear, an individualized treatment plan should be implemented. The fundamental goal of treatment is to reduce the frequency and severity of substance abuse either through a program of abstinence or drug substitution (i.e. methadone maintenance). The treatment plan must also address remedying the consequences of drug abuse, including physical, psychological, family, social and vocational dysfunction.

Successful treatment of substance abuse requires the development of a therapeutic alliance. The patient must be able to trust that the therapist and the program will be available during the process of recovery. Intensive therapy (i.e. inpatient rehabilitation) cannot compensate for the lack of a therapeutic alliance.

There remains considerable debate as to the most appropriate treatment setting for early recovery. Many treatment providers advocate for residential treatment. However, there is little evidence that residential treatment results in superior outcomes than intensive outpatient treatment (IOP) for the majority of patients. Therefore, residential care should be restricted to individuals who have failed at outpatient treatment, including both IOP and partial programs. The support of family/friends and self help groups should be sufficient to maintain individuals exhibiting minimal commitment to abstinence and high degrees of craving between outpatient visits. Refer to CSAT publication, [Intensive Outpatient Treatment for Alcohol and Other Drug Abuse](#) for the particulars of an IOP.

The treatment of individuals with no social support, no vocational skills, living in an environment conducive to relapse is particularly problematic. The therapist's goal is to protect the individual while they work through early recovery. Referral for long-term halfway house treatment for these patients is preferable to short-term residential care since little can be expected to change in the patient's home environment while he is in short-term treatment.

Since substance abuse is a chronic, relapsing condition, all patients should receive continuing support. For many this will involve transition to self-help groups and other community support. However, others will need to build new support systems to supplant the time and effort previously expended on substance abuse. For many patients this involves increasing the significance of religion or spirituality in their lives.

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Several agents have shown some efficacy in preventing relapse to alcohol abuse (disulfiram, naltrexone and acamprosate). Ingestion of alcohol in the presence of disulfiram results in a severe physical reaction that can be life threatening. Therefore it should only be used with extreme caution. Naltrexone and acamprosate appear to reduce the craving for alcohol. Therefore they may be a helpful adjunct for a patient who is actively involved in treatment.

## COMORBID MENTAL ILLNESS

Whether primary or secondary, a diagnosable mental illness in addition to substance abuse results in a poorer prognosis and requires more complicated treatment. Dual diagnosed patients fall into two broad categories: those with serious and persistent mental illness, usually a psychotic disorder, and those with less severe illnesses such as anxiety or depression.

Patients with serious mental illness should be case managed by individuals with specialized skills in the dually diagnosed patient. Treatment is geared toward controlling the psychosis with medications (frequently requiring depot antipsychotics to increase compliance) while simultaneously providing:

- continuing monitoring of substance abuse (urine drug screening),
- early intervention in the event of relapse, and
- ongoing support in an environment that tolerates individuals with serious mental illness.

Substance abusing patients who suffer from anxiety and depression represent a unique therapeutic challenge. Since anxiety and depression are frequently associated with substance abuse, the therapist must decide how long to wait in the process of recovery before recommending pharmacological intervention for these conditions. When recommending medications, the therapist must consider the possible harmful consequences to the patient who abuses prescription drugs or mixes the medications with other drugs of abuse. In the absence of clear guidelines, psychoactive medications should only be prescribed if:

- the patient is significantly incapacitated by their symptoms or the symptoms clearly predate the onset of substance abuse,
- the prescriber is highly knowledgeable about the signs and symptoms of substance abuse,
- the prescriber carefully monitors the individual in conjunction with the substance abuse therapist, and
- the prescriber limits the amount of medications prescribed at any given time.

## NICOTINE DEPENDENCE

Nicotine is unique, among licit drugs of dependence in the fact that when consumed at the manufacturers expected level (i.e. daily use for many years), it will always lead to physical dependence and physical harm. Consumption of nicotine, primarily through smoking causes four times more deaths than alcohol and ten times more deaths than all illicit drugs combined.

It is imperative that every clinician at initial assessment inquire about use of nicotine. Users should be reminded of the detrimental effects of continued use they should be encouraged to quit and supported in efforts to abstain or cut back. Users should be referred to nicotine specific treatment programs. In conjunction with individual and group counseling, the use of nicotine patches or gum can relieve some of the abstinence associated cravings. Bupropion (Zyban® or Wellbutrin®) has been shown to be an effective adjunct to smoking cessation programs.

## INTENT

This practice guideline is not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns evolve. These parameters of practice should be considered guidelines only. Adherence to them will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable

methods of care aimed at the same results. The practitioner, in light of the clinical data presented by the patient and the diagnostic and treatment options available, must make the ultimate judgment regarding a particular clinical procedure or treatment plan.

## REFERENCES

These guidelines were adapted from the American Psychiatric Association's practice guidelines [American Psychiatric Association: Practice Guidelines for the Treatment of Patients With Substance Use Disorders: Alcohol, Cocaine, Opioids. Am J Psychiatry 2006; August suppl] and [American Psychiatric Association: Practice Guideline for the Treatment of Patients with Nicotine Dependence. Am J Psychiatry 1996; 153(October suppl) and subsequently modified by consensus among a stratified sample of MHNNet providers and clients. The reader is referred to the original articles for detailed references (481) as well as the work group that prepared the APA guidelines.

Detoxification protocols can be found in: Substance Abuse and Mental Health Services Administration: Treatment Improvement Protocol Series # 19, "Detoxification from Alcohol and Other Drugs," U.S. Department of Health and Human Services, Rockwall II, 5600 Fishers Lane, Rockville, MD 20857.

Particulars of IOP programs can be found in: Center for Substance Abuse Treatment: Treatment Improvement Protocol Series # 8, "Intensive Outpatient Treatment of Alcohol and Other Drug Abuse," U.S. Department of Health and Human Services, Rockwall II, 5600 Fishers Lane, Rockville, MD 20857.