

# VA/DOD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF SUBSTANCE USE DISORDERS

## Guideline Summary

### SPECIALTY CARE REHABILITATION

#### KEY POINTS

##### ASSESSMENT AND DIAGNOSIS

- Identify the patient's current problems, relevant history, and life context as a basis for the integrated summary and initial treatment plan.
- Identify patients with nicotine dependence for which cessation treatment may be effective.
- Identify the patient who does not require specialty care and coordinate with primary care.
- In VA, complete the Addiction Severity Index.
- Integrate and prioritize biopsychosocial assessment information as a basis for formulating the diagnosis and treatment recommendations.

##### TREATMENT

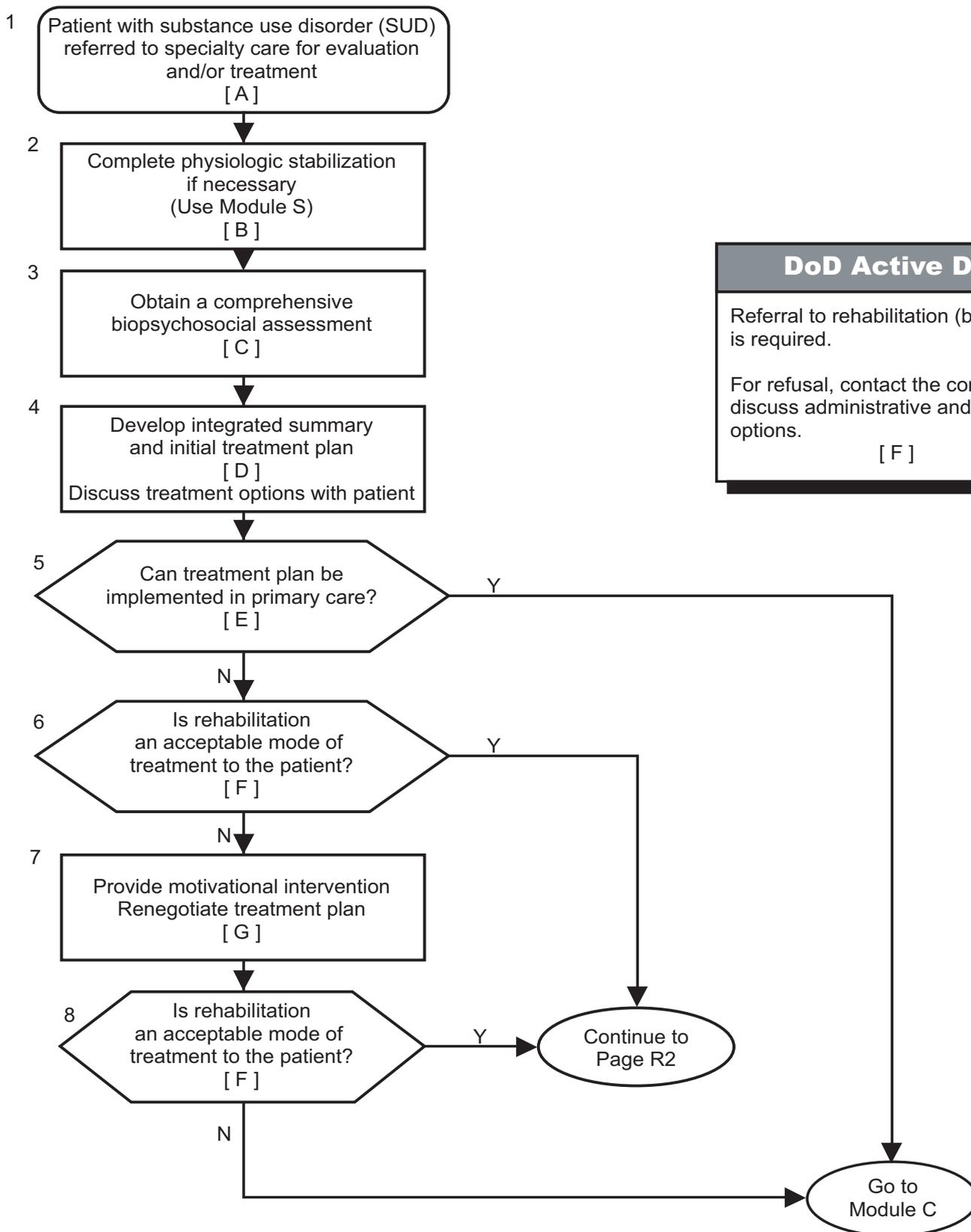
- Actively involve the patient in the creation of a treatment plan.
- Determine, along with the patient, the most appropriate treatment approach.
- Clarify and/or encourage patient commitment to rehabilitation goals.
- Identify the least restrictive level of initial treatment intensity that will safely help the patient achieve early remission and prevent relapse.
- Facilitate access to treatment and promote a supportive recovery environment.
- Initiate addiction-focused psychosocial treatment including self-help group involvement.
- Consider addiction-focused pharmacotherapy for all patients
- Individualize treatment to address co-morbid conditions.
- Summarize, simplify, and solidify the recovery plan to maximize the patient's chances for achieving his/her rehabilitation goals.

##### FOLLOW-UP

- Periodically reassess response to treatment, change in treatment goals, or other indications for change in the treatment plan.
- Provide appropriate continuity of care with primary medical or behavioral health care providers.
- Promote abstinence or reduced use.

# MANAGEMENT OF SUBSTANCE USE DISORDERS

## Module R: Assessment and Management - Specialty Care



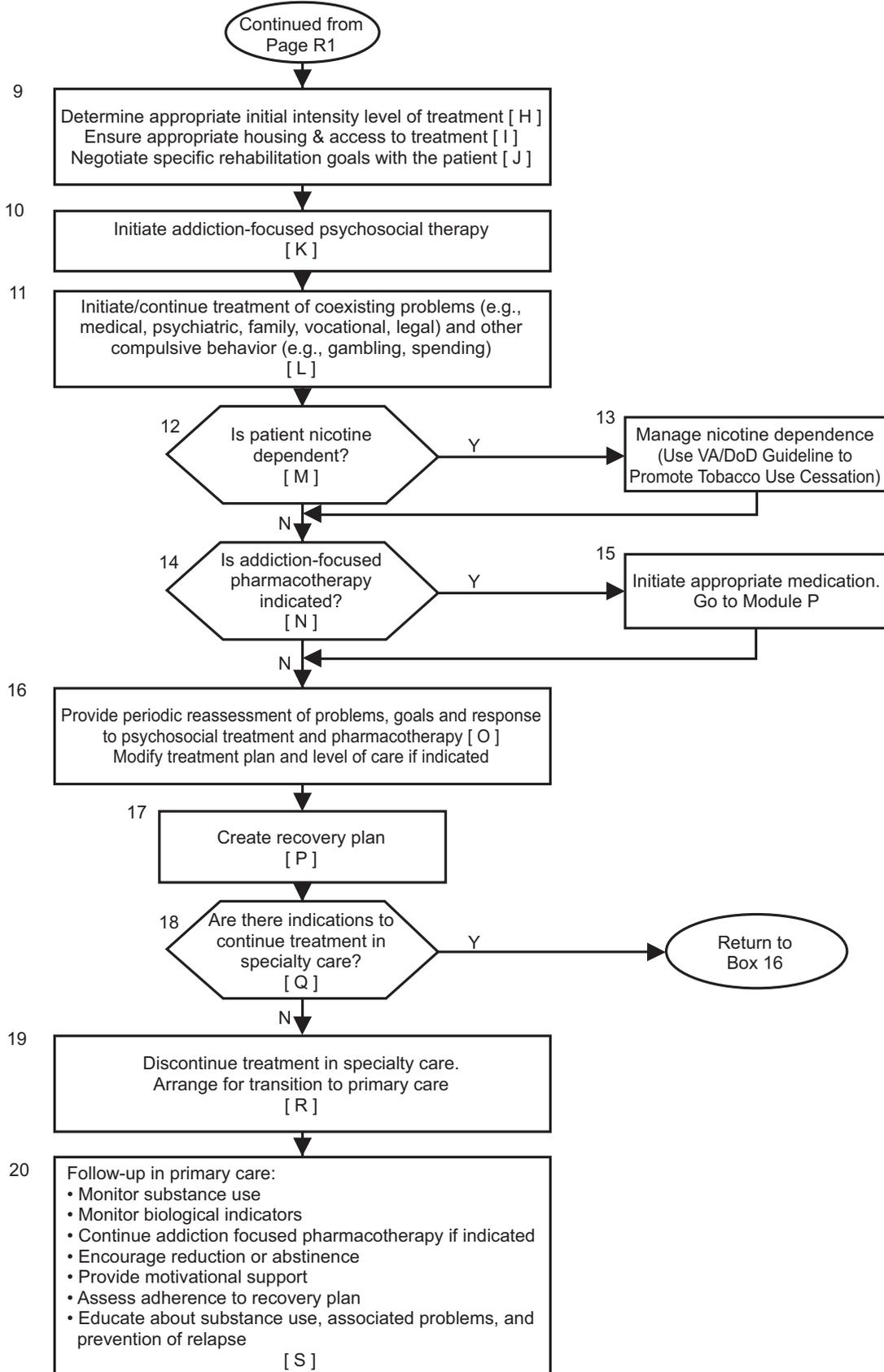
**DoD Active Duty**

Referral to rehabilitation (box 6 & 8) is required.

For refusal, contact the command to discuss administrative and clinical options.

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**MANAGEMENT OF SUBSTANCE USE DISORDERS**  
**Module R: Rehabilitation - Specialty Care**



# REHABILITATION

Patients managed in specialty care may be referred by their primary care provider based on the following indications for treatment: hazardous substance use, substance abuse, substance dependence, risk of relapse, or mandated referral within the DoD. Some patients may identify or be willing to consider optimal or intermediate rehabilitation goals and select specialty care as their first choice. 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 specialty clinic merely for a more extensive evaluation of substance use.

## ASSESSMENT AND DIAGNOSIS

### Physiologic Stabilization

Most patients managed within specialty rehabilitation care are not acutely intoxicated or in need of immediate physiological stabilization. Patients may have been stable at the time of referral, but have since relapsed and now require stabilization.

### Comprehensive Biopsychosocial Assessment

- Patient's demographics and identifying information, including housing, legal, and occupational status.
- Patient's chief complaint and history behind it.
- Recent substance use and severity of substance-related problems, including screening for gambling addiction and other compulsive behaviors.
- Lifetime and family history of substance use.
- Co-morbid psychiatric conditions and psychiatric history.
- Social and family context.
- Developmental and military history.
- Current medical status and medical history, including risk for HIV or hepatitis C.
- Mental status and physical examinations.
- Patient's perspective on current problems, stage of change, and treatment goals or preferences.

## TREATMENT

### Determine the Appropriate Level Of Care

Is primary care the appropriate mode for treatment?  
Consider the following:

- Integrated summary and initial treatment plan.
- Availability of a willing and knowledgeable primary care provider with whom the patient has an ongoing, positive clinical relationship.
- Severity and chronicity of the substance use disorder.
- Active involvement with support for recovery in the community.
- Prior treatment response.
- Patient preference and likelihood of adherence.

Consider rehabilitation in specialty care for more complex clinical presentations, especially where problem severity is greater or patient motivation is less clear.

Is rehabilitation an acceptable mode of treatment?

- When acceptable to the patient, a specialty care rehabilitation plan is generally indicated.
- Care management is likely to be a more acceptable and effective alternative when one of the following applies:
  - The patient refuses referral to rehabilitation, but continues to seek some services, especially medical and/or psychiatric services.
  - The patient has serious co-morbidity that precludes participation in available rehabilitation programs.
  - The patient has been engaged repeatedly in rehabilitation treatment with minimal progress toward optimal or intermediate rehabilitation goals.

### For DoD Active Duty

If a DoD active duty patient refuses referral despite encouragement, notify the commanding officer to discuss the situation further. The commander has the ultimate authority to either (a) order the patient to comply, (b) invoke administrative options (e.g., administrative separation from service), or (c) do nothing administratively. This is the commander's decision, with input from the medical staff.

Treatment Plan	Expected Outcomes
Rehabilitation with optimal goals	<ul style="list-style-type: none"> <li>• Complete and sustained remission of all substance use disorders</li> <li>• Resolution of, or significant improvement in, all coexisting biopsychosocial problems and health-related quality of life</li> </ul>
Rehabilitation with intermediate goals	<ul style="list-style-type: none"> <li>• Short- to intermediate-term remission of substance use disorders or partial remission of substance use disorders for a specified period of time</li> <li>• Resolution or improvement of at least some coexisting problems and health-related quality of life</li> </ul>
Care Management	<ul style="list-style-type: none"> <li>• Engagement in the treatment process, which may continue for long periods of time or indefinitely</li> <li>• Continuity of care (case management)</li> <li>• Continuous enhancement of motivation to change</li> <li>• Availability of crisis intervention</li> <li>• Improvement in substance use disorders, even if temporary or partial</li> <li>• Improvement in coexisting medical, psychiatric, and social conditions</li> <li>• Improvement in quality of life</li> <li>• Reduction in the need for high-intensity health care services</li> <li>• Maintenance of progress</li> <li>• Reduction in the rate of illness progression</li> </ul>

### Motivational Intervention and Renegotiation of the Treatment Plan

- Establish treatment goals in the context of a negotiation between the treatment provider and the patient.
- Review with the patient results of previous efforts at self-change and formal treatment, including reasons for treatment dropout.
- Use motivational enhancement techniques reflecting the FRAMES model:
  - Feedback: Provide personalized feedback based on patient report of substance-related harm.
  - Responsibility: Emphasize patient responsibility and freedom of choice for changing behavior.
  - Advice: Provide clear and direct advice about the importance of change and availability of help.
  - Menu: Acknowledge and discuss alternative strategies for change.
  - Empathy: Maintain a patient-centered approach and accurately reflect patient statements and feelings.
  - Self-Efficacy: Emphasize the role of patient self-efficacy in their ability to make needed change and convey optimism in their potential to be successful.
- Use an empathic and non-judgmental (versus confrontational) therapist style.

### Coexisting Problems and Other Compulsive Behaviors

- Prioritize and address other coexisting biopsychosocial problems (e.g., medical, psychiatric, family, vocational, or legal) with services targeted to these areas, rather than increasing drug and alcohol counseling alone.
- Treat concurrent psychiatric disorders consistent with VA/DoD clinical practice guidelines (e.g., those for treating patients with Major Depressive Disorder or Psychoses) including concurrent pharmacotherapy.
- Treat other compulsive behaviors (e.g., gambling or spending)
- Provide multiple services in the most accessible setting to promote engagement and coordination of care.
- Monitor and address deferred problems and emerging needs through ongoing treatment plan updates.
- Coordinate care with other providers to improve clinical outcomes and functional status.

### Housing And Access To Treatment

The term "housing" is used generically as the residence of a patient while receiving treatment. It can involve the same setting within which treatment takes place or it can refer to a variety of living situations with varying degrees of supervision that are separate from the location of treatment services.

Types of Housing Options	Indications	Examples
Intensive Medical Management or Monitoring	<ul style="list-style-type: none"> <li>• Medical or psychiatric instability requiring hospitalization (includes severe intoxication or withdrawal)</li> <li>• ASAM PPC-2* Levels III.7 and IV</li> </ul>	<ul style="list-style-type: none"> <li>• Inpatient medical bed section</li> <li>• Inpatient addiction/psychiatry bed section</li> </ul>
Professional Monitoring	<ul style="list-style-type: none"> <li>• Medical or psychiatric instability requiring 24-hour professional monitoring, but not of sufficient severity to require hospitalization</li> <li>• ASAM PPC-2 Levels III.3-III.5</li> </ul>	<ul style="list-style-type: none"> <li>• Social detoxification setting</li> <li>• VA Substance Abuse Residential Rehabilitation Treatment Programs (SARRTP) and VA Domiciliaries (if professional staff are present 24-hours/day)</li> </ul>
24-Hour Supervision	<ul style="list-style-type: none"> <li>• Mild to moderately severe psychiatric or medical conditions requiring some supervision that may be provided by paraprofessionals, volunteers, or patients in advanced stages of treatment</li> <li>• Demonstrated inability to remain abstinent in unsupervised setting or homeless</li> <li>• Lacking own social support system, such as family members willing and able to assist</li> <li>• ASAM PPC-2 Levels III.1-III.2</li> </ul>	<ul style="list-style-type: none"> <li>• Halfway houses</li> <li>• Sober houses or safe houses</li> <li>• Use of hospital bed space for lodging purposes (e.g., self-care wards in DoD &amp; lodger status in VA)</li> <li>• VA SARRTP and VA Domiciliaries (if staffed only by non-professionals at least part of the day or night)</li> </ul>
Non-Supervised Housing	<ul style="list-style-type: none"> <li>• Homeless</li> <li>• Lives at too great a distance to travel to outpatient program</li> <li>• Able to care for self, including use of medications</li> <li>• Able to remain abstinent in an unsupervised setting</li> <li>• ASAM PPC-2 Levels I, II.1, or II.3</li> </ul>	<ul style="list-style-type: none"> <li>• Patient's own home</li> <li>• Transitional living facility</li> <li>• Temporary housing provided on-site or in the community</li> </ul>

\*ASAM Patient Placement Criteria, 2nd Edition (ASAM, 1996)

## EVIDENCE-BASED PSYCHOSOCIAL INTERVENTION

- Indicate to the patient and significant others that treatment is more effective than no treatment.
- Respect patient preference for the initial psychosocial intervention approach, since no single intervention has emerged as the treatment of choice.
- Consider addiction-focused psychosocial interventions with the most consistent empirical support, several of which have been developed into published treatment manuals:
  - Behavioral marital therapy
  - Cognitive-behavioral coping skills training
  - Community reinforcement and other contingency-based approaches
  - Individual and group drug counseling
  - Motivational enhancement
  - Twelve-Step facilitation training

- Emphasize that the most consistent predictor of successful outcome is retention in formal treatment or community support.
- Promote active involvement in Twelve-Step programs.
- Use effective strategies for referral to mutual help programs in the community, addressing patient preferences and prior experiences.

### Nicotine Dependence

- Identification and treatment of co-morbid nicotine dependence may improve recovery rates of other substance use disorders. Use the VA/DoD Clinical Practice Guideline for tobacco cessation.

## ADDICTION-FOCUSED PHARMACOTHERAPY

- Consider addiction-focused pharmacotherapy.
- Evaluate indications for pharmacotherapy in all patients with opioid and alcohol dependence.

### Indications for Using Naltrexone and Disulfiram for Alcohol Dependence

Naltrexone	Disulfiram
<p>Alcohol dependence with:</p> <ul style="list-style-type: none"> <li>• Ability to achieve at least 3 to 5 days of abstinence to rule out the need for detoxification</li> <li>• Drinking within the past 30 days and/or reports of craving</li> <li>• Most effective when the patient is engaged in addiction-focused counseling</li> </ul>	<p>Alcohol dependence with:</p> <ul style="list-style-type: none"> <li>• Abstinence &gt;24 hours and BAL equal to 0</li> <li>• Combined cocaine and alcohol dependence</li> <li>• Failure of or contraindication to naltrexone</li> <li>• Previous response to disulfiram</li> <li>• Patient preference</li> <li>• Capacity to appreciate risks and benefits and to consent to treatment</li> </ul> <p><i>Note: Most effective with monitored administration (e.g., in clinic or with spouse or probation officer)</i></p>

### Indications for Using Naltrexone and Opioid Agonists for Opioid Dependence

Naltrexone	Opioid Agonists: Methadone and LAAM
<p>Opioid dependence with:</p> <ul style="list-style-type: none"> <li>• Ability to achieve at least 7 to 10 days of abstinence to rule out the need for detoxification</li> <li>• Most effective when the patient is engaged in addiction-focused counseling with monitored administration</li> </ul>	<ul style="list-style-type: none"> <li>• Opioid dependence <math>\geq</math>1 year</li> <li>• Two or more unsuccessful opioid detoxification episodes within a 12-month period</li> <li>• Relapse to opioid dependence within 2 years from Opioid Agonist Therapy (OAT) discharge</li> </ul>

## **FOLLOW-UP**

### **Provide Periodic Reassessment of Problems, Goals, and Response to Psychosocial Treatment and Pharmacotherapy**

- Modify treatment plans individually based on changes in a patient's clinical and psychosocial condition rather than imposing uniform treatment plans.
- Indications to change treatment intensity or provide adjunctive treatments may include:
  - Relapse based on self-report or urine toxicology
  - Increased risk of relapse (e.g., craving or personal loss)
  - Emergence or exacerbation of comorbid medical and psychiatric conditions
  - Suboptimal response to medication
  - Emergence of medication side effects
- Discuss relapse as a signal to reevaluate the treatment plan rather than evidence that the patient cannot succeed or was not sufficiently motivated.
- Target services to identified problems (e.g., psychiatric, medical, family/social, legal, vocational, and housing) that increase the risk of relapse, rather than increasing drug and alcohol counseling alone.
- Consider care management for patients with persistently sub-optimal response, rather than routinely intensifying rehabilitation or discharging.
- Consider reducing treatment intensity or discontinuing some treatment components based on:
  - Full, sustained remission
  - Greater involvement in community support
  - Improvements in other associated problem areas
- Coordinate follow-up with the patient's primary medical or behavioral health provider during transitions to less intensive levels of care in order to reinforce progress and improve monitoring of relapse risks.

### **Discontinue Treatment in Specialty Care and Transition to Primary Care**

Discuss the impact of changes in substance use on other medical and psychiatric conditions and identify relapse risks for future monitoring. Arrange for continued monitoring of substance use and co-morbid conditions either in addiction specialty care or by the patient's primary medical or behavioral health care provider.

- Schedule primary care follow-up within 90 days to reinforce recovery progress during the post-discharge period of highest risk for relapse.
- Encourage patients to re-contact addiction-focused treatment providers for additional help as needed in preventing or promptly interrupting relapse.

#### **For DoD Active Duty**

Addiction-focused treatment follow-up may be mandated for a period of 6 to 12 months from the time of initial referral (this may be referred to as “aftercare” in the DoD community).

# SPECIALTY CARE REHABILITATION

## STABILIZATION KEY POINTS

### Assessment of Level of Intoxication

- Obtain clinical background information on the patient.
- Patients who are medically or psychiatrically unstable need to be stabilized before continuing with detoxification.

### Use of Prescribed Opioid or Sedative-Hypnotics

- Clarify the underlying clinical condition being managed through opioid or sedative-hypnotic use.
- Assure appropriate symptom management and safety monitoring for medically indicated opioid or sedative-hypnotic prescription.
- If indicated, provide a safe withdrawal from alcohol or sedative-hypnotics and prepare the patient for ongoing addiction treatment.

### Opioid Agonist Therapy (OAT)

- Assure careful consideration of OAT as the first line treatment for opioid dependence.
- For DoD active duty, OAT is generally not a treatment option.

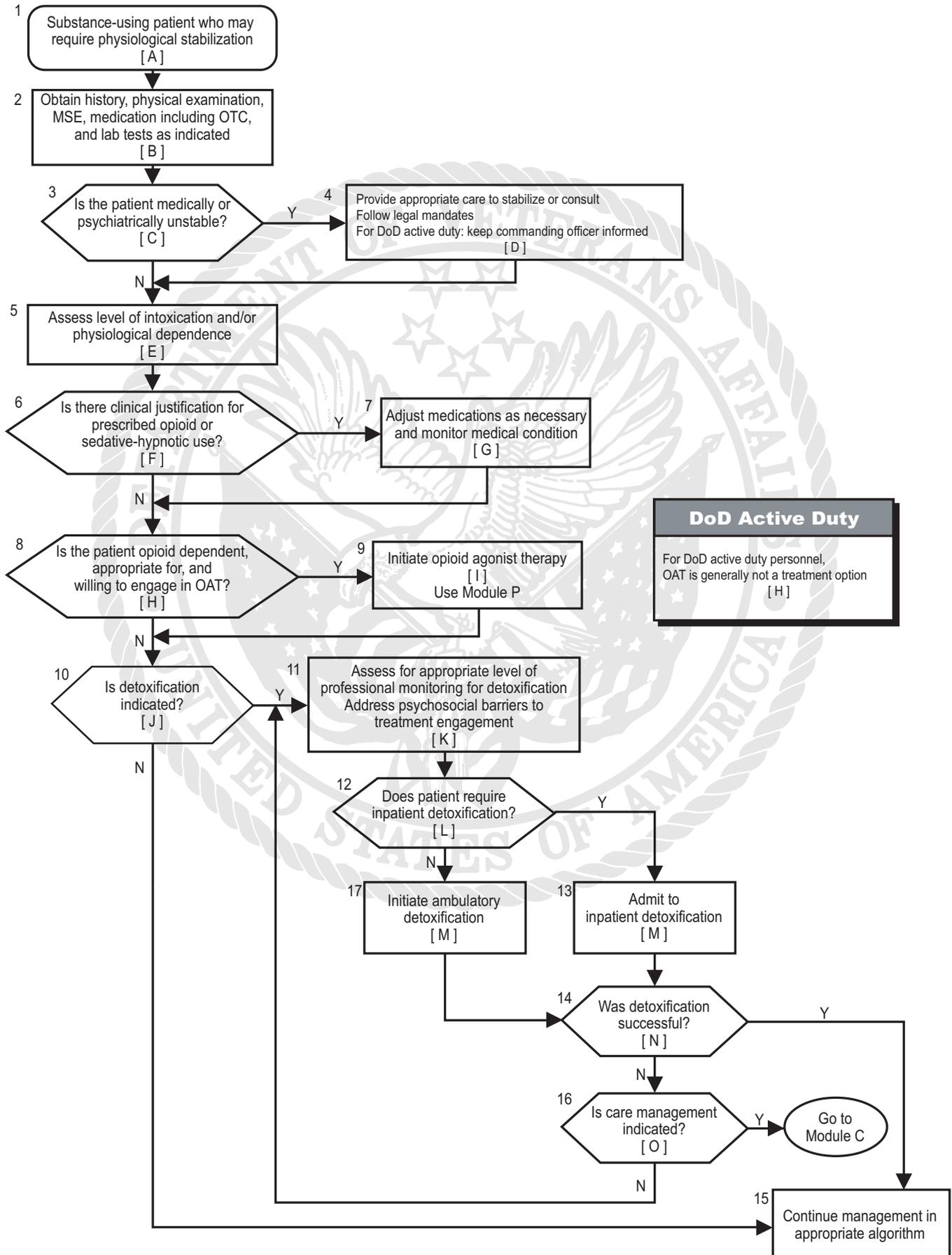
### Detoxification

- Obtain the necessary data to guide the patient's detoxification process.
- Identify patients who need detoxification from alcohol, sedative-hypnotics, or opioids.
- Ensure safety during detoxification in the least restrictive environment and promote long-term successful recovery.
- Identify the appropriate setting for safe and effective withdrawal management.
- Identify patients in need of additional detoxification or stabilization before proceeding with further evaluation or treatment.

### Follow-Up Detoxification

- Provide appropriate dosing and relapse monitoring to promote effective outcomes.
- For DoD active duty, keep the commanding officer informed of progress, or lack thereof.

**MANAGEMENT OF SUBSTANCE USE DISORDERS**  
**Module S: Stabilization**



**DoD Active Duty**

For DoD active duty personnel, OAT is generally not a treatment option [H]

# STABILIZATION

## PHYSIOLOGICAL STABILIZATION

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

Patients who require emergency care or urgent action should not be further managed in this algorithm.

Emergency or urgent actions include unstable medical problems (e.g., acute trauma, myocardial infarction, and stroke) or unstable psychiatric problems (e.g., delirium and imminent risk of harm to self and/or others).

### Risk of Harm to Self or Others

- If suicidal ideation is present, the imminent risk increases with one or more of the following risk factors:
  - Prior suicide attempt and lethality of prior acts
  - Level of intent and formulation of plan
  - Greater preoccupation (e.g., frequency, intensity, and duration of thoughts)
  - Availability of lethal means for suicide (e.g., firearms or pills)
  - Family history of completed suicide
  - Presence of active mental illness (e.g., severe depression or psychosis)
  - Presence of substance abuse
  - Current negative life events (e.g., loss in personal relationship)
  - Feelings of hopelessness or helplessness
- Consider the patient's history of violent acts as an increased risk for violence toward self or others.

- Implement suicide or high-risk protocols, as needed.
- Review local policies and procedures with regard to threats to self or others. These policies 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.

### For DoD Active Duty

Follow service-specific mandates, as mental health/emergency referral is likely mandated. Keep the commanding officer informed.

### Withdrawal Symptoms from Sedative-Hypnotics or Alcohol

- Patients should be medically observed at least until the blood alcohol level (BAL) is decreasing and clinical presentation is improving.
- Consider standardized measures to assess the severity of withdrawal symptoms. The Clinical Institute Withdrawal Assessment for Alcohol-Revised (CIWA-Ar) has good reliability and validity for assessing severity of withdrawal symptoms from alcohol.

### Withdrawal Symptoms from Opioids

- 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 detoxification attempts, as a result of loss of opioid tolerance.
- Signs and symptoms of opioid withdrawal may develop at a time appropriate for the ingested opioid (e.g., within 6-12 hours after the last dose of a short acting opioid, such as heroin, or 36-48 hours after the last dose of a long acting opioid, such as methadone).

## ASSESSMENT OF LEVEL OF INTOXICATION

### Signs and Symptoms of Intoxication and Withdrawal

Types of Intoxication	Signs and Symptoms of Intoxication	Signs and Symptoms of Withdrawal
Alcohol and Sedative-Hypnotics	<ul style="list-style-type: none"> <li>• Slurred speech</li> <li>• Incoordination</li> <li>• Unsteady gait</li> <li>• Nystagmus</li> <li>• Disturbances of perception, wakefulness, attention, thinking, judgment, memory, psychomotor behavior, and interpersonal behavior</li> <li>• Stupor or coma</li> </ul> <p><i>Note: Highly tolerant individuals may not show signs of intoxication. For example, patients may appear "sober" even at BALs well above the legal limit (e.g., 80 or 100 mg percent).</i></p>	<ul style="list-style-type: none"> <li>• Autonomic hyperactivity (e.g., diaphoresis, tachycardia, and elevated blood pressure)</li> <li>• Increased hand tremor</li> <li>• Insomnia</li> <li>• Nausea and vomiting</li> <li>• Transient visual, tactile or auditory hallucinations or illusions</li> <li>• Delirium tremens</li> <li>• Psychomotor agitation</li> <li>• Anxiety</li> <li>• Irritability</li> <li>• Grand mal seizures</li> </ul>
Cocaine or Amphetamine	<ul style="list-style-type: none"> <li>• Tachycardia or bradycardia</li> <li>• Pupillary dilation</li> <li>• Elevated or lowered blood pressure</li> <li>• Perspiration or chills</li> <li>• Nausea or vomiting</li> <li>• Psychomotor agitation or retardation</li> <li>• Muscular weakness, respiratory depression, or chest pain</li> <li>• Confusion, seizures, dyskinesias, dystonias, or coma</li> </ul>	<ul style="list-style-type: none"> <li>• Dysphoric mood</li> <li>• Fatigue</li> <li>• Vivid, unpleasant dreams</li> <li>• Insomnia or hypersomnia</li> <li>• Increased appetite</li> <li>• Psychomotor retardation or agitation</li> </ul>
Opiate	<ul style="list-style-type: none"> <li>• Pupillary constriction (or dilation due to anoxia from overdose)</li> <li>• Drowsiness or coma</li> <li>• Slurred speech</li> <li>• Impairment in attention or memory</li> <li>• Shallow and slow respiration or apnea</li> </ul> <p><i>Note: Acute opiate intoxication can present as a medical emergency with unconsciousness, apnea, and pinpoint pupils.</i></p>	<ul style="list-style-type: none"> <li>• Nausea or abdominal cramps</li> <li>• Muscle aches</li> <li>• Pupillary dilation</li> <li>• Autonomic hyperactivity</li> <li>• Piloerection (i.e., gooseflesh)</li> <li>• Vomiting or diarrhea</li> <li>• Yawning</li> <li>• Lacrimation</li> </ul>

(a) Consider intoxication and withdrawal risks from each substance for patients using multiple substances.

## PATIENT USING PRESCRIBED OPIOID OR SEDATIVE-HYPNOTICS

Clarify the underlying clinical condition being managed through opioid or sedative-hypnotic use.

- Distinguish patients with legitimate pain and/or anxiety disorders who develop physiological tolerance during long-term use of prescribed medications, from those with markers of "addict behavior" (e.g., seeking medications for other than pain, seeking prescriptions from multiple providers, increasing the dose without consultation, frequent "losses" of medications, intoxication, or buying medication on the street).
- Prescribe opioid analgesic medication (in cases of severe pain disorders) or sedative-hypnotic medication (in cases of severe anxiety or seizure disorders), when medically indicated, even if the patient has a history of substance use disorders and provided that the patient's medical condition is:
  - Diagnosed correctly, including physical examination, review of past records, and appropriate consultation
  - Acute enough to justify the use of opioid analgesics
  - Documented in the clinical record
- Assure appropriate symptom management and safety monitoring for medically indicated opioid or sedative-hypnotic prescription.
- Set reasonable behavioral and dosing limits and increase monitoring when pharmacologically treating pain or anxiety in patients with a history of substance dependence.
  - Prescribe medication on a fixed schedule, rather than as needed (PRN).
  - Use long-acting medication (such as sustained-release morphine or diazepam), rather than short acting medication (such as oxycodone/ acetaminophen or alprazolam).
  - Limit prescription medication to what is needed until the next appointment.
  - Follow the patient weekly or biweekly, at least at the beginning of therapy.
  - Write out the prescription as you would a check, to prevent alteration.
- Discontinue prescription (with detoxification, if necessary) and refer to a substance use disorder specialist, if abuse of opioid or sedative-hypnotic medications occurs.

## OPIOID AGONIST THERAPY

See Module P: Pharmacotherapy.

### DETOXIFICATION

#### Indications for Alcohol or Sedative-Hypnotic Detoxification

- Medical monitoring of detoxification should be provided for dependence on central nervous system depressants, due to the potential severity of untreated withdrawal in severely dependent persons.
- Detoxification from sedative-hypnotics is indicated when there is physical dependence in the absence of clinical indications for ongoing treatment (e.g., anxiety or panic disorder) or when accompanied by "addict behavior" (e.g., prescriptions from multiple providers, patient escalating doses without provider consultation, or buying medications on the street).

#### Indications for Opioid Detoxification

- It is difficult to identify opioid addicted patients with good prognosis for successful opioid detoxification; however, the following are relative indications:
  - Briefer and less severe addiction history that does not meet regulatory criteria for opioid agonist treatment
  - Active commitment to an abstinence-oriented recovery program (e.g., monitored naltrexone, mutual help program involvement, and therapeutic community participation)
- Detoxification is contraindicated for individuals with two or more unsuccessful detoxification episodes within a 12-month period. Such patients must be assessed by an opioid treatment program physician for alternatives to detoxification.

#### Professional Level of Monitoring for Detoxification

Ensure safety during detoxification in the least restrictive environment and promote long-term successful recovery. Determine the appropriate level of care, based on:

- Severity of current and past withdrawal symptoms (use the CIWA-Ar for alcohol, CIWA-Br for benzodiazepines, Short Opiate Withdrawal Scale (SOWS) or Clinical Institute Narcotics Assessment (CINA) for opioids).
- Severity of comorbid conditions.
- Patient's treatment acceptance and potential to complete detoxification.
- Recovery environment and other ASAM criteria (see Web site: <http://www.asam.org>).

## Inpatient Detoxification

- Inpatient detoxification allows closer monitoring of withdrawal symptoms and higher likelihood of completing the detoxification protocol.
  - There are fewer logistic medical and legal concerns (e.g., arranging for patient transportation, driving during the course of detoxification, and the ability to give informed consent).
  - While patients are more likely to complete the inpatient detoxification protocol, long-term outcomes do not indicate a difference between inpatient and outpatient detoxification programs.
- Consider the following indications for inpatient detoxification:
  - Current symptoms of moderate to severe alcohol withdrawal (e.g., CIWA-Ar score  $\geq 10$ )
  - History of delirium tremens or withdrawal seizures
  - Inability to tolerate oral medication
  - Imminent risk of harm to self or others
  - Recurrent unsuccessful attempts at ambulatory detoxification
  - Reasonable likelihood that the patient will not complete ambulatory detoxification (e.g., due to homelessness)
  - Active psychosis or severe cognitive impairment

## Ambulatory Detoxification

- Ambulatory detoxification 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
- While no definitive standard exists for setting up an ambulatory detoxification protocol, there should be systematic assessment and consistent monitoring.

Facilities should develop local alcohol detoxification pathways, taking into consideration the following principles:

- Use either of the following two acceptable pharmacotherapy strategies for managing alcohol withdrawal symptoms:
  - Symptom-triggered therapy, where patients are given medication only when signs or symptoms of withdrawal appear (e.g., PRN dosing).
  - A predetermined fixed medication dose, with gradual tapering over several days.
- Consider the following empirically validated procedures for ambulatory alcohol detoxification monitoring as safe and effective alternatives to inpatient approaches:
  - Medical or nursing staff should assess the patient in person, either daily or every other day.
  - Urine toxicology or a breathalyzer test of BAC should be completed.
  - The patient should be medically cleared before initiating or continuing outpatient detoxification.

## FOLLOW-UP OF DETOXIFICATION

Detoxification is successful to the degree the patient:

- Is physiologically stable
- Avoids hazardous medical consequences of withdrawal
- Experiences minimal discomfort
- Reports being treated with respect
- Completes the detoxification protocol (e.g., no longer requires medication for withdrawal symptom management)
- Engages in continuing care for substance use disorder

If detoxification is unsuccessful, consider one of the following:

- A more intensive level of care for detoxification (e.g., inpatient).
- Care Management, if detoxification is not indicated or acceptable to the patient.

**Addiction Research Foundation Clinical Institute Withdrawal  
Assessment Alcohol (CIWA-Ar)** The scale is not copyrighted and may be used freely.

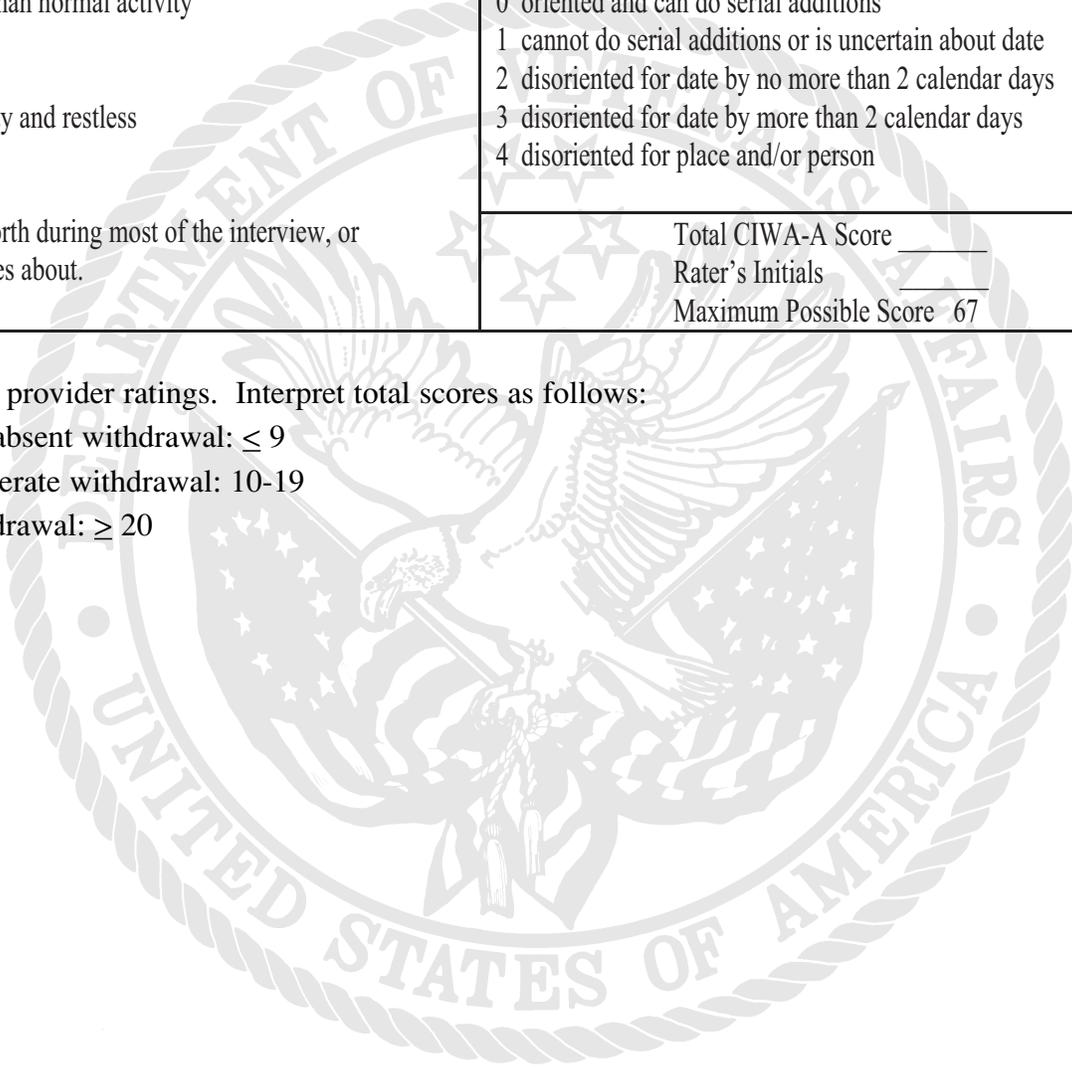
<b>Patient:</b>	<b>Date:</b> /    / y    m    d	<b>Time:</b> _____ (24 hour clock, midnight + 0:00)
<b>Pulse or heart rate, taken for one minute:</b>		<b>Blood Pressure:</b> _____ / _____
<b>NAUSEA AND VOMITING</b> <input type="checkbox"/> Ask "Do you feel sick to your stomach? Have you vomited? Observation. 0 no nausea and no vomiting 1 mild nausea with no vomiting 2 3 4 intermittent nausea with dry heaves 5 6 7 constant nausea, frequent dry heaves and vomiting	<b>TACTILE DISTURBANCES</b> <input type="checkbox"/> Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation. 0 none 1 mild itching, pins and needles, burning or numbness 2 mild itching, pins and needles, burning or numbness 3 moderate itching, pins and needles, burning or numbness 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations	
<b>TREMOR</b> <input type="checkbox"/> Arms extended and fingers spread apart. Observation. 0 no tremor 1 not visible, but can be felt fingertip to fingertip 2 3 4 moderate, with patient's arms extended 5 6 7 severe, even with arms not extended	<b>AUDITORY DISTURBANCES</b> <input type="checkbox"/> Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation. 0 not present 1 very mild harshness or ability to frighten 2 mild harshness or ability to frighten 3 moderate harshness or ability to frighten 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations	
<b>PAROXYSMAL SWEATS</b> <input type="checkbox"/> Observation. 0 no sweat visible 1 barely perceptible sweating, palms moist 2 3 4 beads of sweat obvious on forehead 5 6 7 drenching sweats	<b>VISUAL DISTURBANCES</b> <input type="checkbox"/> Ask "Does the light appear to be too bright? Is the color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation. 0 not present 1 very mild sensitivity 2 mild sensitivity 3 moderate sensitivity 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations	
<b>ANXIETY</b> <input type="checkbox"/> Ask "Do you feel nervous?" Observation. 1 mildly anxious 2 3 4 moderately anxious, or guarded, so anxiety is inferred 5 6 7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions.	<b>HEADACHE, FULLNESS IN HEAD</b> <input type="checkbox"/> Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity. 0 not present 1 very mild 2 mild 3 moderate 4 moderately severe 5 severe 6 very severe 7 extremely severe	

**ADDICTION RESEARCH FOUNDATION CLINICAL INSTITUTE WITHDRAWAL  
ASSESSMENT ALCOHOL (CIWA-AR) (CONTINUED)**

<p><b>AGITATION</b> <input type="checkbox"/> Observation.</p> <p>0 normal activity</p> <p>1 somewhat more than normal activity</p> <p>2</p> <p>3</p> <p>4 moderately fidgety and restless</p> <p>5</p> <p>6</p> <p>7 paces back and forth during most of the interview, or constantly thrashes about.</p>	<p><b>ORIENTATION AND CLOUDING OF SENSORIUM</b> <input type="checkbox"/> Ask "What day is this? Where are you? Who am I?"</p> <p>0 oriented and can do serial additions</p> <p>1 cannot do serial additions or is uncertain about date</p> <p>2 disoriented for date by no more than 2 calendar days</p> <p>3 disoriented for date by more than 2 calendar days</p> <p>4 disoriented for place and/or person</p> <hr/> <p>Total CIWA-A Score _____</p> <p>Rater's Initials _____</p> <p>Maximum Possible Score 67</p>
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CIWA-Ar has 10 provider ratings. Interpret total scores as follows:

- Minimal or absent withdrawal:  $\leq 9$
- Mild to moderate withdrawal: 10-19
- Severe withdrawal:  $\geq 20$



Clinical Institute Narcotic Assessment (CINA)

Patient \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

**NAUSEA AND VOMITING: Ask, Do you feel sick to your stomach? Have you vomited? Observation**

- 0 No nausea, no vomiting
- 1
- 2 Mild nausea, with no retching or vomiting
- 3
- 4 Intermittent nausea with dry heaves
- 5
- 6 Constant nausea, frequent dry heaves, and/or vomiting

**GOOSE FLESH: Observation**

- 0 No goose flesh visible
- 1 Occasional goose flesh but not elicited by touch, not prominent
- 2 Prominent goose flesh, in waves and elicited by touch
- 3 Constant goose flesh over chest and arms

**SWEATING: Observation**

- 0 No sweat visible
- 1 Barely perceptible sweating, palms moist
- 2 Beads of sweat obvious on forehead
- 3 Drenching sweat over face and chest

**RESTLESSNESS: Observation**

- 0 Normal activity
- 1 Somewhat more than normal activity (may move legs up and down, shift position occasionally)
- 2 Moderately fidgety and restless, shifting position frequently
- 3 Gross movements most of the time or constantly thrashing about

**TREMOR: Arms extended and fingers spread apart Observation**

- 0 No tremor
- 1 Not visible but can be felt finger tip to finger tip
- 2 Moderate, with patient's arms extended
- 3 Severe, even if arms not extended

**LACRIMATION: Observation**

- 0 No lacrimation
- 1 Eyes watering, tears at corners of eyes
- 2 Profuse tearing from eyes over face

**NASAL CONGESTION: Observation**

- 0 No nasal congesting, sniffing
- 1 Frequent sniffing
- 2 Constant sniffing with watery discharge

**YAWNING: Observation**

- 0 No yawning
- 1 Frequent yawning
- 2 Constant, uncontrolled yawning

**ABDOMINAL CHANGES: Ask, Do you have any pains in your lower abdomen?**

- 0 No abdominal complaints, normal bowel sounds
- 1 Reports waves of abdominal crampy pain, active bowel sounds
- 2 Reports crampy abdominal pain, diarrheal movements, active bowel sounds

**CHANGES IN TEMPERATURE: Ask, Do you feel hot or cold?**

- 0 No report of temperature change
- 1 Reports feeling cold, hands cold and clammy to touch
- 2 Uncontrollable shivering

**MUSCLE ACHES: Ask, Do you have any muscle aches?**

- 0 No muscle aching reported (arm and neck muscles soft at rest)
- 1 Mild muscle pains
- 2 Reports severe muscle pains; muscles of legs, arms, and neck in constant state of contraction

**HEART RATE (X•80)/10= \_\_\_\_\_**

**SYSTOLIC BLOOD PRESSURE (Supine)**

**(X-130)/10= \_\_\_\_\_**

**METHADONE DOSE, based on total CINA**

**Total CINA Score \_\_\_\_\_**

**Rater's Initials \_\_\_\_\_**

**If CINA < 10**

**If CINA = 10-14**

**If CINA = 15-19**

**If CINA > 20**

**no methadone**

**5 mg methadone**

**10 mg methadone**

**20 mg methadone**

**Addiction Research Foundation  
Clinical Institute Withdrawal Assessment for Benzodiazepines, Revised  
CIWA-Br**

<b>TO BE GRADED BY OBSERVER</b>	Time of Rating	Time of Rating	Time of Rating
For each of the following items, please enter the number that best describes the severity of each sign or symptom:			
1. Observe behavior for restlessness and agitation: 0 none, normal activity 1 2 restless 4 5 paces back and forth, unable to sit still			
2. Ask the patient to extend arms with fingers apart: observe tremor (may place a sheet of paper over hand to accentuate tremor): 0 no tremor 1 not visible, can be felt in fingers 2 visible but mild 3 moderate, with arms extended 4 severe, with arms not extended			
3. Observe for sweating: observe palms: 0 no sweating visible 1 barely perceptible sweating, palms moist 2 palms and forehead moist, report armpit sweating 3 beads of sweat on forehead 4 severe drenching sweats			
Total Observer Score			
<b>SEVERE WITHDRAWAL SYMPTOMS</b> <b>If Yes, notify physicians STAT.</b>			
4. Record whether the patient has had a seizure since last assessment.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Inquire from the patient as to whether there have been auditory or visual hallucinations.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is there any evidence of psychotic symptoms, e.g., delusions?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Describe Time 1:			
Describe Time 2:			
Describe Time 3:			

**Addiction Research Foundation  
Clinical Institute Withdrawal Assessment for Benzodiazepines, Revised  
CIWA-Br**

Date (mm/dd/yy) \_\_\_\_\_

To be answered by the patient under supervision

Since your last assessment, for each of the following items, please enter the item that best describes how you feel:	not at all					very much									
	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
7. Did you feel irritable?															
8. Did you feel anxious or tense?															
9. Did you feel fatigued?															
10. Have you experienced:															
a) did you feel irritable?															
b) increased sensitivity to loud sounds?															
c) altered sense of smell (increased, altered, decreased)?															
d) metallic taste?															
e) increased sensitivity to touch or pain?															
f) increased sensitivity to bright lights?															
g) visual disturbances (sensitivity to light, blurred vision)?															
h) ringing or sound in your ears?															
11. Did you have difficulty concentrating?															
12. Did you have any change of appetite?															
13. Did you feel restless?															
14. Has there been a change in your bowel habits?															
15. Did you have difficulty expressing your thoughts when you speak?															
16. Did you feel your heart racing or beating irregularly (palpitations)?															
17. Did your head feel full or achy?															
18. Did you feel muscle aches, cramps, twitches, or stiffness?															
19. Did you feel nervous, anxious, or jittery?															
20. Did you feel weaker than usual?															
21. Are you fearful?															
22. Have you been worrying about possible misfortunes lately?															
23. How restless was your sleep last night?															
24. Have you had a change in your dreams (nightmares)?															
<b>Total Score:</b>															
25. How many hours of sleep do you think you had last night?															
26. How many minutes do you think it took to fall asleep last night?															

Staff initials: \_\_\_\_\_

# SPECIALTY CARE REHABILITATION

## PHARMACOTHERAPY KEY POINTS

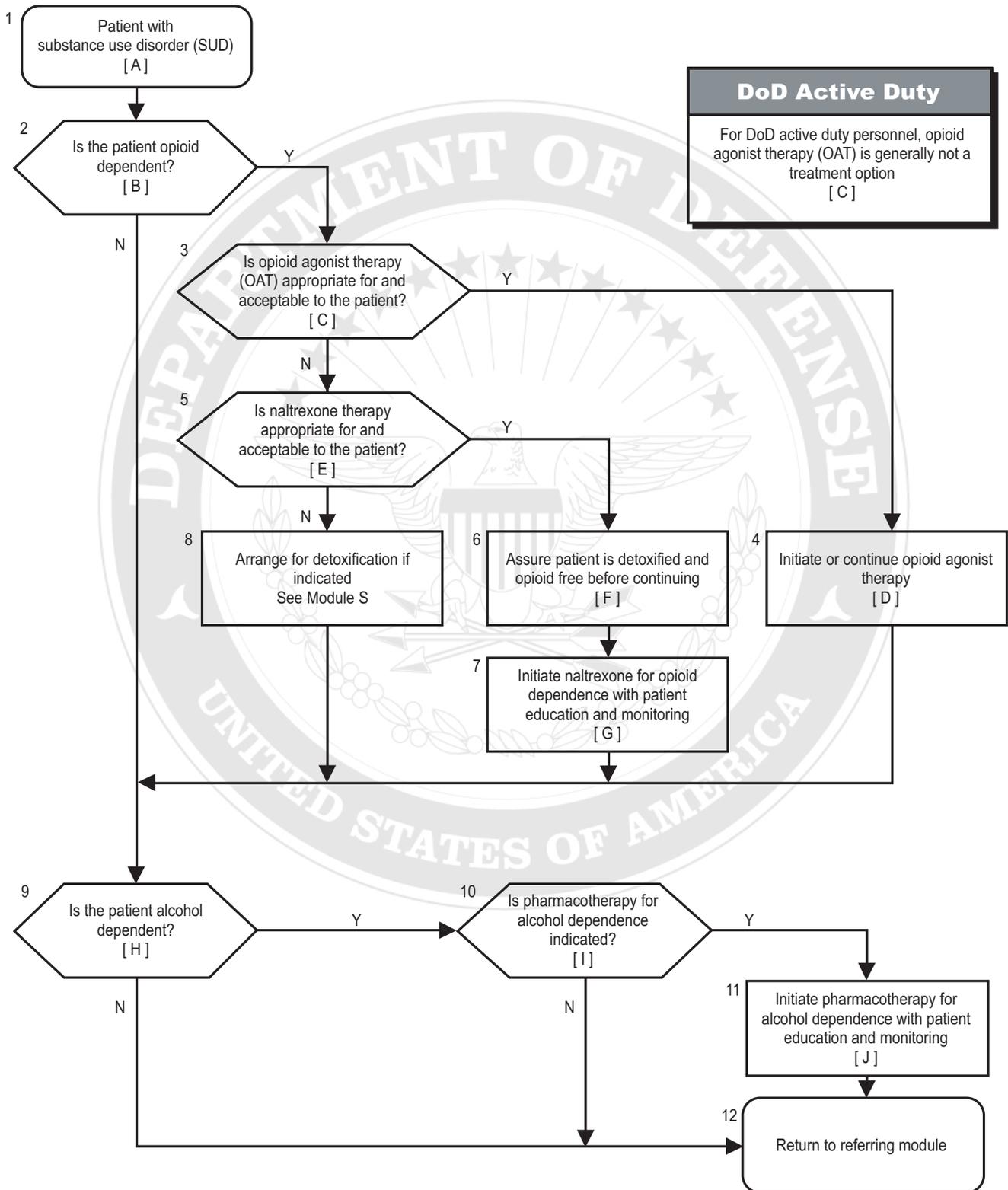
### **Opioid Dependence**

- Consider Opioid Agonist Therapy (OAT) the first-line treatment for opioid dependence.
- Methadone maintenance at adequate doses, with regular counseling, is effective in reducing opioid use.
- Levo-alpha-acetylmethadol (LAAM) maintenance at adequate doses is an effective alternative to methadone maintenance.
- Naltrexone should be used selectively, combined with monitored administration, for highly motivated patients.
- Avoid precipitating an opioid withdrawal syndrome.

### **Alcohol Dependence**

- Consider naltrexone for alcohol dependence when combined with addiction counseling.
- Monitored naltrexone administration significantly improves compliance.
- Consider disulfiram for coexisting cocaine and alcohol dependence.
- Disulfiram should only be used when abstinence is the goal.

## MANAGEMENT OF SUBSTANCE USE DISORDERS Module P: Addiction-Focused Pharmacotherapy



## PHARMACOTHERAPY

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

### OPIOID DEPENDENCE

Assure careful consideration of Opioid Agonist Therapy (OAT) as the first line treatment for opioid dependence. *For DoD active duty, OAT is generally not a treatment option.*

While new federal regulatory language uses the term “opiate addiction,” the diagnostic term opioid dependence will be used here for consistency with the rest of the guideline. OAT for opioid dependence consists of administering an opioid agonist medication, such as methadone or levo-alpha-acetylmethadol (LAAM), in combination with a comprehensive range of medical, counseling, and rehabilitative services. By administering an opioid to prevent withdrawal, reduce craving, and reduce the effects of illicit opioids, the opioid dependent patient is able to focus more readily on recovery activities.

When compared to detoxification attempts, OAT is more successful in achieving the long-term goal of reducing opioid use and the associated negative medical, legal, and social consequences.

Provide access to OAT for all opioid dependent patients under appropriate medical supervision and with concurrent addiction-focused psychosocial treatment.

- Consider methadone maintenance for its documented efficacy in reducing illicit opioid use, human immunodeficiency virus (HIV) risk behavior, and drug-related criminal behavior.
- Consider LAAM, a long-acting, synthetic mu-agonist, a safe and effective second line alternative to methadone maintenance.
- Consider the acceptability and feasibility of regular clinic attendance. Under Federal regulations of OAT programs, for the first 90 days of treatment the patient should attend clinic at least six days per week for methadone or three times per week for LAAM.

### Agonist Therapy for Opioid Dependence

	<b>Opioid Agonists: Methadone and LAAM</b>
Indications	<ul style="list-style-type: none"> <li>• Opioid dependence <math>\geq 1</math> year</li> <li>• 2 or more unsuccessful opioid detoxification episodes within a 12-month period</li> <li>• Relapse to opioid dependence within 2 years from OAT discharge</li> </ul>
Contraindications	<ul style="list-style-type: none"> <li>• Allergy to agent</li> <li>• Concurrent enrollment in another OAT</li> <li>• Significant liver failure</li> <li>• Use of opioid antagonists (e.g., naloxone, nalmefene, or naltrexone)</li> <li>• For LAAM, EKG with QTc interval <math>&gt; 0.45</math> seconds</li> </ul>
Side Effects	<ul style="list-style-type: none"> <li>• Common: constipation</li> <li>• Less common: sexual dysfunction</li> <li>• QT interval prolongation (LAAM)</li> </ul>
Drug Interactions	<ul style="list-style-type: none"> <li>• Drugs that reduce serum methadone level: phenytoin, carbamazepine, rifampin, barbiturate sedative-hypnotics, anti-virals involving CYP3A4 activity (including interferon and HIV protease inhibitors), ascorbic acid, and chronic ethanol use</li> <li>• Drugs that increase serum methadone level: cimetidine, ketoconazole, fluconazole, amitriptyline, diazepam, and fluvoxamine maleate</li> </ul>

## Opioid Agonist Therapy (OAT)

Providers should adjust opioid agonist doses to maintain a therapeutic range between signs/symptoms of over-medication (e.g., somnolence, miosis, itching, hypotension, and flushing) and opioid withdrawal (e.g., drug craving, anxiety, dysphoria, and irritability).

Deliver OAT in the context of a complete treatment program that includes counseling or psychotherapy.

- Methadone, combined with weekly counseling for at least four weeks after admission, followed by at least monthly counseling, has been shown to be more effective than methadone alone.
- Availability of more frequent counseling is associated with less illicit drug use.
- No specific form of psychosocial intervention has consistently been shown to be more or less efficacious.
- Programs with high-quality social services show better treatment retention.

- Programs must provide adequate urine toxicology for drugs of abuse, including a minimum of eight random tests per year, per patient.

## Naltrexone Therapy

- Naltrexone has no positive psychoactive effects and is unpopular with many opioid dependent patients. However, some highly motivated patients can be successful using naltrexone therapy.
- Subpopulations with better prognosis for response include:
  - Patients highly motivated for abstinence without obvious external pressure
  - Patients in the criminal justice system, with monitored administration
  - Health care workers with employment-related monitoring
- Consider OAT programs or long-term therapeutic community approaches for chronic opioid dependent patients.

## Pharmacotherapy with Naltrexone for Opioid Dependence

<b>Naltrexone</b>	
<b>Indications for Use</b>	Opioid dependence with: <ul style="list-style-type: none"> <li>• Ability to achieve at least 7 to 10 days of abstinence to rule out the need for detoxification</li> </ul> <p><i>Note: Most effective when the patient is engaged in addiction-focused counseling with monitored administration</i></p>
<b>Contraindications for Use</b>	<ul style="list-style-type: none"> <li>• Pregnancy</li> <li>• Opioid withdrawal</li> <li>• Opioid dependence, with use within past week</li> <li>• Medical condition requiring opioid medication</li> <li>• Severe hepatic dysfunction (i.e., transaminase levels &gt;3 times normal, or liver failure)</li> <li>• Severe renal failure</li> <li>• Allergy to naltrexone</li> </ul>
<b>Side Effects</b>	<ul style="list-style-type: none"> <li>• Common: nausea (~10%)</li> <li>• Other: headache, dizziness, nervousness, fatigue, insomnia, vomiting, anxiety, and somnolence</li> </ul>
<b>Drug Interactions</b>	<ul style="list-style-type: none"> <li>• Opioid containing medications, including over-the-counter (OTC) preparations</li> <li>• Thioridazine</li> <li>• Oral hypoglycemics</li> </ul>

## Pharmacotherapy Management with Naltrexone for Opioid Dependence (PDR, 1999)

	Naltrexone
<b>Dosage</b>	<ul style="list-style-type: none"> <li>• 50 mg/day</li> </ul>
<b>Alternative Dosing Schedules</b>	<ul style="list-style-type: none"> <li>• 25 mg daily or twice a day (b.i.d.) with meals to reduce nausea, especially during the first week</li> <li>• Observed administration improves compliance. Full opioid blockage is produced with a schedule of 100 mg on Monday and Wednesday and 150 mg on Friday</li> </ul>
<b>Baseline Evaluation</b>	<ul style="list-style-type: none"> <li>• Assure patient completed a naloxone challenge and/or has had at least 7 to 10 days of verified abstinence.</li> <li>• Transaminase levels</li> <li>• Urine toxicology</li> </ul>
<b>Patient Education</b>	<ul style="list-style-type: none"> <li>• Discuss compliance-enhancing procedures.</li> <li>• Negotiate commitment from the patient regarding monitored ingestion, if necessary.</li> <li>• Provide patients with wallet cards that indicate use of naltrexone.</li> </ul>
<b>Monitoring</b>	<ul style="list-style-type: none"> <li>• Monitor for opioid use at least weekly during early recovery, via urine toxicology.</li> <li>• Repeat transaminase levels monthly for the first 3 months and every 3 months thereafter.</li> <li>• Discontinue/reduce naltrexone, if transaminase levels rise significantly.</li> <li>• Reevaluate patient compliance and progress at least every 3 months and adjust the treatment plan as necessary.</li> <li>• Continue treatment for 12 to 24 months, if the patient maintains abstinence.</li> <li>• Consider reinstating naltrexone if the patient relapses to opioid use after discontinuation of naltrexone.</li> </ul>

### Naloxone Challenge

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.

Confirming the physiological dependence can be accomplished with a challenge using naloxone, a short acting narcotic antagonist, to elicit signs and symptoms of precipitated withdrawal. A naloxone challenge should be done selectively and with great care (e.g., by or in close consultation with a physician experienced in management of opioid withdrawal) since patients can rapidly experience serious opioid withdrawal.

- Give 0.2 mg to 0.4 mg of naloxone, subcutaneously or intravenously, and the precipitated withdrawal usually begins within minutes.
- Patients with low levels of opioid use may require up to a total dose of 0.8 mg of naloxone to precipitate withdrawal, given in increments of 0.2 mg every 30 minutes.
- Symptoms usually peak within 30 minutes and subside in 3 to 4 hours.

- An oral dose of 5mg or 10 mg of methadone may attenuate the withdrawal.

### ALCOHOL DEPENDENCE

There are two medications currently approved for the treatment of alcohol dependence: naltrexone and disulfiram. Pharmacotherapy has been shown to be effective when combined with addiction-focused counseling. Efficacy in the absence of counseling is uncertain.

- Naltrexone, an opioid antagonist, should be routinely considered when treating alcohol dependence. It has been shown to significantly reduce the relapse rate during the first 12 weeks of treatment when combined with addiction counseling.
- Disulfiram should be considered more selectively. Monitored administration significantly improves compliance. When cocaine and alcohol dependence occur together (which they frequently do) use of disulfiram is associated with reductions in both cocaine and alcohol use. Disulfiram should only be used when abstinence is the goal.

## Pharmacotherapy of Alcohol Dependence

	Naltrexone	Disulfiram
<b>Indications for Use</b>	<p>Alcohol dependence with:</p> <ul style="list-style-type: none"> <li>• Ability to achieve at least 3 to 5 days of abstinence to rule out the need for detoxification</li> <li>• Drinking within the past 30 days and/or reports of craving</li> </ul> <p><i>Note: It has been shown to significantly reduce the relapse rate during the first 12 weeks of treatment when combined with addiction counseling.</i></p>	<p>Alcohol dependence with:</p> <ul style="list-style-type: none"> <li>• Abstinence &gt;24 hours and BAL equal to 0</li> <li>• Combined cocaine and alcohol dependence</li> <li>• Failure of or contraindication to naltrexone</li> <li>• Previous response to disulfiram</li> <li>• Patient preference</li> <li>• Capacity to appreciate risks and benefits and to consent to treatment</li> </ul> <p><i>Note: Most effective with monitored administration (e.g., in clinic or with spouse or probation officer).</i></p>
<b>Contraindications for Use</b>	<ul style="list-style-type: none"> <li>• Pregnancy</li> <li>• Opioid withdrawal</li> <li>• Opioid dependence with use within past week</li> <li>• Medical condition requiring opioid medication</li> <li>• Severe hepatic dysfunction (i.e., transaminase levels &gt;3 times normal, or in liver failure)</li> <li>• Severe renal failure</li> <li>• Allergy to naltrexone</li> <li>• Need for alcohol detoxification</li> </ul>	<ul style="list-style-type: none"> <li>• Pregnancy</li> <li>• Severe cardiovascular, respiratory, or renal disease</li> <li>• Severe hepatic dysfunction (i.e., transaminase levels &gt;3 times upper limit of normal or in liver failure)</li> <li>• Severe psychiatric disorders, especially psychotic and cognitive disorders and suicidal ideation</li> <li>• Poor impulse control</li> <li>• Previous disulfiram-ethanol reaction</li> <li>• Metronidazole or ketoconazole therapy, which already induce a similar reaction to alcohol</li> <li>• Allergy to disulfiram</li> </ul>
<b>Side Effects</b>	<ul style="list-style-type: none"> <li>• Common: nausea (~10%)</li> <li>• Other: headache, dizziness, nervousness, fatigue, insomnia, vomiting, anxiety, and somnolence</li> </ul>	<ul style="list-style-type: none"> <li>• Common (usually mild and self-limiting): somnolence, metallic taste, and headache</li> <li>• Less common, but more serious: Hepatotoxicity, peripheral neuropathy, psychosis, and delirium</li> </ul>
<b>Drug Interactions</b>	<ul style="list-style-type: none"> <li>• Opioid containing medications, including OTC preparations</li> <li>• Thioridazine</li> <li>• Oral hypoglycemics</li> </ul> <p><i>Note: Does not alter ethanol absorption or metabolism or have major effects when combined.</i></p>	<ul style="list-style-type: none"> <li>• Alcohol containing medications, including OTC preparations</li> <li>• Severity of disulfiram-ethanol reaction varies considerably among patients and is generally dose-related, causing vasodilatation, flushing, hypotension, nausea, vomiting, dizziness, tachycardia, cardiac arrhythmias, myocardial infarction/stroke in susceptible patients, and even death from cardiac complications in older patients.</li> <li>• Drug-drug interactions may occur with phenytoin, warfarin, isoniazid, rifampin, diazepam, chlordiazepoxide, imipramine, desipramine, and oral hypoglycemic agents.</li> </ul>

## Pharmacotherapy Management For Alcohol Dependence (PDR, 1999)

	Naltrexone	Disulfiram
<b>Dosage</b>	<ul style="list-style-type: none"> <li>• 50 mg/day up to 100 mg/day</li> </ul>	<ul style="list-style-type: none"> <li>• 250 mg/day</li> </ul>
<b>Alternative Dosing Schedules</b>	<ul style="list-style-type: none"> <li>• 25 mg daily or b.i.d. with meals to reduce nausea, especially during the first week</li> <li>• Full therapeutic effect is produced with a schedule of 100 mg on Monday and Wednesday and 150 mg on Friday</li> </ul>	<ul style="list-style-type: none"> <li>• Reduce dose to 125 mg to reduce side effects.</li> <li>• For monitored administration, consider giving 500 mg on Monday, Wednesday, and Friday.</li> <li>• If a patient taking 250 mg of disulfiram daily drinks alcohol and has no reaction, consider increasing dose to 500 mg daily.</li> </ul>
<b>Baseline Evaluation</b>	<ul style="list-style-type: none"> <li>• Transaminase levels</li> </ul>	<ul style="list-style-type: none"> <li>• Transaminase levels</li> <li>• Physical assessment</li> <li>• Psychiatric assessment</li> <li>• Electrocardiogram</li> <li>• Verify abstinence with breath or blood alcohol level.</li> </ul>
<b>Patient Education</b>	<ul style="list-style-type: none"> <li>• Discuss compliance-enhancing procedures.</li> <li>• If necessary, negotiate commitment from the patient regarding monitored ingestion.</li> <li>• Provide patients with wallet cards indicating use of naltrexone.</li> <li>• Note that side effects, if any, tend to occur early in treatment and can typically be resolved within 1 to 2 weeks with dose adjustment</li> </ul>	<ul style="list-style-type: none"> <li>• Instruct patients to avoid alcohol in food and beverages, including medications.</li> <li>• Provide patients with wallet cards that indicate the use of disulfiram.</li> <li>• Because of the risk of significant toxicity and limited evidence of effectiveness: <ul style="list-style-type: none"> <li>—Give careful consideration to risks and benefits.</li> <li>—Document informed consent discussion with the patient.</li> <li>—Obtain written informed consent for VA patients.</li> </ul> </li> </ul>
<b>Monitoring</b>	<ul style="list-style-type: none"> <li>• Repeat transaminase levels monthly for the first 3 months and then every 3 months thereafter. Discontinue naltrexone if transaminase levels significantly rise.</li> <li>• Continue treatment 3 to 12 months and reevaluate patient compliance and progress at least every 3 months. Adjust the treatment plan as necessary.</li> <li>• Consider reinstating naltrexone, if the patient relapses.</li> </ul>	<ul style="list-style-type: none"> <li>• Repeat transaminase levels monthly for the first 3 months and every 3 months thereafter.</li> <li>• Discontinue disulfiram if transaminase levels significantly rise.</li> <li>• Reevaluate the need for disulfiram at least every 3 months and discontinue use once stable abstinence is achieved or if patient adherence cannot be safely maintained.</li> </ul>