

VA/DoD CLINICAL PRACTICE GUIDELINE

Management of Substance Use Disorders
A. SCREENING and TREATMENT

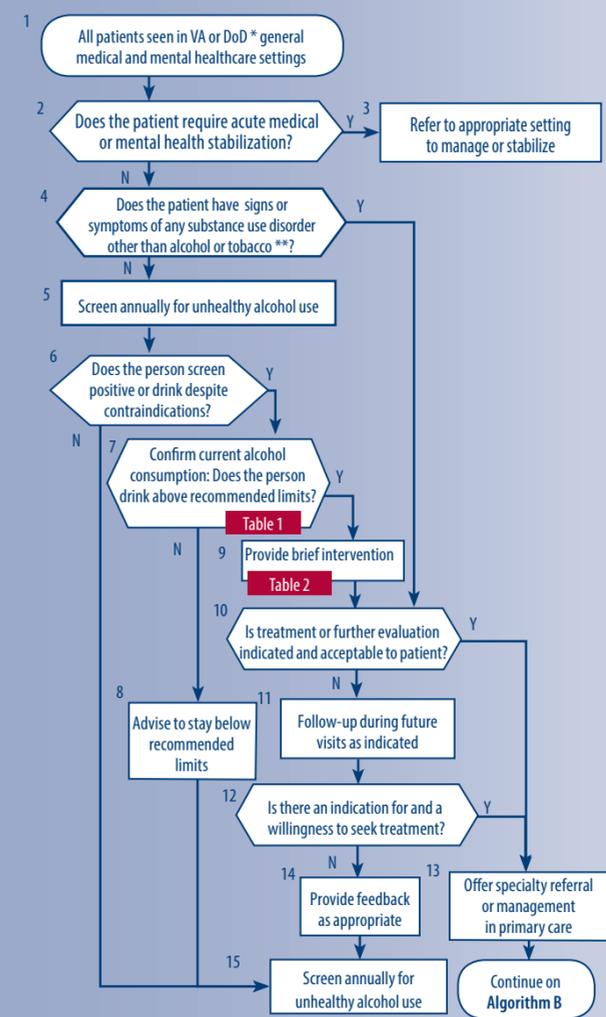
KEY ELEMENTS OF THE GUIDELINE

- Screening for Unhealthy Alcohol Use
 - Use of standardized alcohol screening tools.
 - Identify patients with Unhealthy Alcohol Use who would benefit from a brief intervention regarding alcohol-related risks and advice to abstain or drink within recommended limits for daily/weekly consumption.
- Management of Substance Use Disorder
 - Promote early engagement and retention of patients with conditions who can benefit from addiction-focused treatment.
 - Apply a patient-centered care approach that is individualized based on patient capabilities, needs, goals, prior treatment experience, and preferences.
 - Focus on shared decision making (SDM) where patients, together with their clinicians, make decisions regarding care in which they choose to engage.
 - Offer SUD focused pharmacotherapy and/or psychosocial interventions as indicated.
 - Provide addiction-focused Medical Management, alone or in conjunction with another psychosocial intervention, delivered by a medical professional in a primary care or general mental health care setting:
 - Provides strategies to increase medication adherence, as well as monitoring of substance use and consequences
 - Supports abstinence through education and referral to support groups
 - Provides ongoing systematic relapse prevention efforts or recovery support that based on treatment response.
- Stabilization (See Pocket Card B)
 - Use of standardized assessment measures of the severity of withdrawal symptoms in patients with AUD or OUD in early abstinence.
 - Provide inpatient medically supervised alcohol withdrawal management for patients with alcohol withdrawal symptoms.

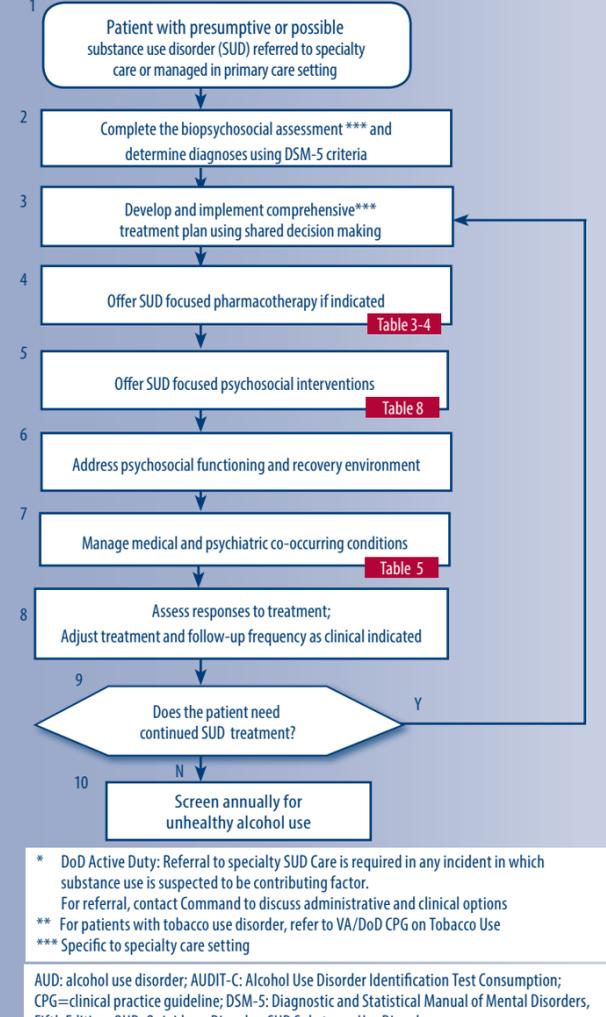
Access to full guideline and toolkit:
<http://www.healthquality.va.gov> or
<https://www.qmo.amedd.army.mil>
 December 2015



A: Screening



B: Management of SUD



* DoD Active Duty: Referral to specialty SUD Care is required in any incident in which substance use is suspected to be contributing factor. For referral, contact Command to discuss administrative and clinical options
 ** For patients with tobacco use disorder, refer to VA/DoD CPG on Tobacco Use
 *** Specific to specialty care setting
 AUD: alcohol use disorder; AUDIT-C: Alcohol Use Disorder Identification Test Consumption; CPG=clinical practice guideline; DSM-5: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition; OUD: Opioid Use Disorder; SUD Substance Use Disorders;

TABLE 1 Recommended Limits for Alcohol Consumption

- Men age 65 or below: ≤ 4 standard drinks per day; ≤ 14 per week
- Men over 65 and all women: ≤ 3 standard drinks per day; ≤ 7 per week
- Patients with contraindications include potential drug-drug interactions: 0 standard drinks per day

TABLE 2 Brief Interventions Overview

- Express concern
- Advise the patient to abstain or decrease drinking
- Provide feedback linking alcohol use and health
- Offer referral to addictions treatment if appropriate

TABLE 3 Pharmacotherapy

- Alcohol Use Disorder
- Recommended: acamprostate, disulfiram, naltrexone, topiramate
 - Suggested: gabapentin
- Opioid Use Disorder
- Recommended: buprenorphine/naloxone, methadone
 - Suggested: extended-release naltrexone; in pregnancy, buprenorphine alone

TABLE 4 Components of Addiction-focused Medical Management

- Monitoring self-reported use, laboratory markers, and consequences
- Monitoring adherence, response to treatment, and adverse effects
- Education about AUD/OUD, health consequences, and treatment
- Encouragement to abstain from illicit opioids and other addictive substances
- Encouragement to attend and referral to community supports for recovery
- Encouragement to attend community supports for recovery (e.g., Alcoholics Anonymous [AA], Narcotics Anonymous [NA], Self-Management and Recovery Training [SMART] Recovery) and to make lifestyle changes that support recovery

TABLE 5 SUD and Co-occurring Conditions

- Refer to corresponding section of CPG on SUD and Co-occurring conditions
- Consult other VA/DoD CPGs (e.g., Tobacco Use Disorder, Major Depression Disorder, Posttraumatic Stress Disorder, Low Back Pain, Assessment and Management of patients at Risk of Suicide, Chronic Multisymptom Illness, Concussion, Diabetes, Hypertension, Chronic Kidney Disease)

TABLE 6 Brief Intervention

- Elements offered consistently as part of a brief intervention (BI):
- Providing individualized feedback on patient's level of alcohol-related risk (i.e., mild, moderate, high) and any alcohol-related adverse health effects
 - Providing brief advice to abstain or drink within recommended limits
- Additional components: Discussion of benefits of and effective strategies for reducing alcohol consumption; supporting patient in choosing a drinking goal when he/she is ready to make a change

TABLE 7 Criteria to Consider Referral to Specialty Care

- A referral to specialty SUD care should be offered if the patient has at least one of the following:
- Potential benefit from additional evaluation of his/her substance use and related problems
 - A substance use disorder diagnosis
 - Willingness to engage in specialty care

Addiction-focused Medical Management:

Addiction-focused Medical Management is a manualized psychosocial intervention designed to be delivered by a medical professional (e.g., physician, nurse, physician assistant) in a primary care (or general mental health care) setting. The treatment uses a shared decision making approach and provides strategies to increase medication adherence and monitoring of substance use and consequences, as well as supporting abstinence through education and referral to support groups.

Session structure varies according to the patient's substance use status and treatment compliance. An initial session (40-60 minutes) includes assessment and initial treatment. Subsequent monitoring visits typically last 15-25 minutes and occur twice weekly for the first week, tapering to once weekly then once every two weeks for 12 weeks.

TABLE 8 Psychosocial Interventions by SUD

For patients with any substance use disorder, choice of psychosocial intervention should be made considering patient preference and provider training/competence.			
Alcohol Use Disorder	Opioid Use Disorder	Cannabis Use Disorder	Stimulant Use Disorder
<ul style="list-style-type: none"> Behavioral Couples Therapy for alcohol use disorder Cognitive Behavioral Therapy for substance use disorders Community Reinforcement Approach Motivational Enhancement Therapy 12-Step Facilitation 	<ul style="list-style-type: none"> For patients in office-based buprenorphine treatment: Addiction-focused Medical Management with choice of psychosocial intervention based on patient preference and provider training/competence For patients in Opioid Treatment Program: Individual counseling and/or Contingency Management 	<ul style="list-style-type: none"> Cognitive Behavioral Therapy Motivational Enhancement Therapy Combined Cognitive Behavioral Therapy/ Motivational Enhancement Therapy 	<ul style="list-style-type: none"> Cognitive Behavioral Therapy Recovery-focused behavioral therapy General Drug Counseling Community Reinforcement Approach Contingency Management in combination with one of the above

Suggested Patient Resources:

- In addition to the VA/DoD SUD CPG patient summary, consider referring patients to the following resources (also included in the patient summary):
- Department of Veterans Affairs:
 - Treatment Programs for Substance Use Problems: <http://www.mentalhealth.va.gov/substanceabuse.asp>
 - Substance Use Disorder Program Locator, which will help you find local VA Substance Use Disorder Treatment Programs: http://www.va.gov/directory/guide/SUD_flash.asp?isFlash=1
 - Substance Abuse and Mental Health Services Administration: <http://www.samhsa.gov/atod> Toll-free Number: 1-877-SAMHSA-7 (1-877-7264727) For a teletype device (TTY): 1-800-4874889
 - National Institute on Alcohol Abuse and Alcoholism (NIAAA)'s resources: Toll-free Number: 1-800-662-HELP (4357) For a teletype device (TTY): 1-800-487-4889
 - Rethinking Drinking: <http://rethinkingdrinking.niaaa.nih.gov/Default.aspx>
 - Treatment for Alcohol Problems: Finding and Getting Help: <http://pubs.niaaa.nih.gov/publications/Treatment/treatment.htm>
 - Seeking Drug Abuse Treatment: Know What To Ask: <http://www.drugabuse.gov/publications/seeking-drug-abuse-treatment-know-what-to-ask/introduction>
 - Alcoholics Anonymous: <http://www.aa.org/>
 - Narcotics Anonymous: <https://www.na.org/>
 - SMART Recovery: <http://www.smartrecovery.org/>
 - Smoke Free Vet: www.smokefree.gov/vet/

TABLE 9 Screening Tools for Unhealthy Alcohol Use

	Alcohol Use Disorders Identification Test- Consumption (AUDIT-C)	Single-Item Alcohol Screening Questionnaire (SASQ)																														
When to use this tool	<ul style="list-style-type: none"> May be preferable in the following situations: <ul style="list-style-type: none"> When the clinician preference is to obtain information regarding: <ul style="list-style-type: none"> Any drinking (for those with contraindications) Typical drinking (for medication interactions) Episodic heavy drinking Severity of unhealthy alcohol use provided by the AUDIT-C When there is a specific service requirement When an electronic medical record can score the AUDIT-C and provide decision support 	Easier to integrate into clinician interviews"																														
Items	<ol style="list-style-type: none"> How often did you have a drink containing alcohol in the past year? <table border="1"> <tr><td>Never</td><td>0 point</td></tr> <tr><td>Monthly or less</td><td>1 point</td></tr> <tr><td>2-4 times per month</td><td>2 points</td></tr> <tr><td>2-3 times per week</td><td>3 points</td></tr> <tr><td>4 or more times per week</td><td>4 points</td></tr> </table> On days in the past year when you drank alcohol how many drinks did you typically drink? <table border="1"> <tr><td>0, 1, or 2</td><td>0 point</td></tr> <tr><td>3 or 4</td><td>1 point</td></tr> <tr><td>5 or 6</td><td>2 points</td></tr> <tr><td>7 - 9</td><td>3 points</td></tr> <tr><td>10 or more</td><td>4 points</td></tr> </table> How often did you have 6 or more drinks on an occasion in the past year? <table border="1"> <tr><td>Never</td><td>0 point</td></tr> <tr><td>Less than monthly</td><td>1 point</td></tr> <tr><td>Monthly</td><td>2 points</td></tr> <tr><td>Weekly</td><td>3 points</td></tr> <tr><td>Daily or almost daily</td><td>4 points</td></tr> </table> 	Never	0 point	Monthly or less	1 point	2-4 times per month	2 points	2-3 times per week	3 points	4 or more times per week	4 points	0, 1, or 2	0 point	3 or 4	1 point	5 or 6	2 points	7 - 9	3 points	10 or more	4 points	Never	0 point	Less than monthly	1 point	Monthly	2 points	Weekly	3 points	Daily or almost daily	4 points	<ol style="list-style-type: none"> Do you sometimes drink beer, wine, or other alcoholic beverages? <p>(Followed by the screening question)</p> <p>Men: 5 or more drinks in a day</p> <p>Women: 4 or more drinks in a day</p> How many times in the past year have you had... <p>Men: 5 or more drinks in a day</p> <p>Women: 4 or more drinks in a day</p>
Never	0 point																															
Monthly or less	1 point																															
2-4 times per month	2 points																															
2-3 times per week	3 points																															
4 or more times per week	4 points																															
0, 1, or 2	0 point																															
3 or 4	1 point																															
5 or 6	2 points																															
7 - 9	3 points																															
10 or more	4 points																															
Never	0 point																															
Less than monthly	1 point																															
Monthly	2 points																															
Weekly	3 points																															
Daily or almost daily	4 points																															
Scoring	The minimum score (for non-drinkers) is 0 and the maximum possible score is 12. Consider a screen positive for unhealthy alcohol use if AUDIT-C score is ≥ 4 points for men or ≥ 3 points for women. Note: For VA, documentation of brief alcohol counseling is required for those with AUDIT-C ≥ 5 points, for both men and women. This higher score for follow-up was selected to minimize the false-positive rate and to target implementation efforts. Follow-up of lower screening scores <5 is left to provider discretion.	A positive screen is any report of drinking 5 or more (men) or 4 or more (women) drinks on an occasion in the past year.																														

TABLE A Pharmacotherapy For AUD					
Naltrexone Oral	Naltrexone Injectable	Acamprosate	Disulfiram	Topiramate ¹	Gabapentin ¹
Indications²					
• AUD, pretreatment abstinence not required but may improve response	• AUD with difficulty adhering to oral regimen and willingness to receive monthly injections • Pretreatment abstinence not required but may improve response	• AUD with abstinence at treatment initiation	• AUD with BAL=0, abstinence >12 hours, able to appreciate risks/benefits and consents to treatment • Consider in patients with combined cocaine dependence	• AUD, pretreatment abstinence not required but may improve response	• AUD, pretreatment abstinence not required but may improve response
Contraindication³					
• Opioid-related findings ⁴ • Acute hepatitis or liver failure	• Opioid-related findings ⁴ • Acute hepatitis or liver failure, inadequate muscle mass	• Severe renal insufficiency (CrCl ≤30 mL/min)	• Severe cardiovascular, respiratory, or renal disease, hepatic dysfunction, and psychiatric disorders ⁵ • Combination with metronidazole or ketoconazole	• No contraindication in manufacturer's labeling	• Known hypersensitivity to gabapentin or its ingredients
Warnings/Precautions					
• Active liver disease • Severe renal failure	• Active liver disease • Uncertain effects (no data) in moderate to severe renal insufficiency • Use intramuscular injections with caution in patients at risk for bleeding	• Watch for depression/suicidality • Decrease dose in renal insufficiency	• Ensure adequate muscle mass for intramuscular injection	• Should not be abruptly discontinued; taper dosage gradually. Potential CNS effects may include dizziness, somnolence, cognitive dysfunction, and sedation. There is an increased risk of suicidal ideation with all anti-epileptic agents.	
• Pregnancy Category C	• Pregnancy Category C	• Pregnancy Category C	• Pregnancy Category C	• Pregnancy Category D	• Pregnancy Category C
Baseline Lab Evaluation- Obtain urine beta-HCG for females					
• Assess liver function	• Assess liver and renal function • Ensure adequate muscle mass for intramuscular injection	• Assess renal function	• Assess liver function and electrocardiogram • Verify ethanol abstinence	• Assess renal function	• Assess renal function
Monitoring					
• Repeat liver transaminase levels at 6 and 12 months and then every 12 months thereafter • Discontinue medication and consider alternatives if no detectable benefit after an adequate trial (50 mg daily for 3 months)	• Repeat liver transaminase levels at 6 and 12 months and then every 12 months thereafter • Discontinue if there is no detectable benefit within 3 months	• Monitor renal function especially in elderly and in patients with renal insufficiency • Maintain therapy if relapse occurs	• Repeat liver transaminase levels within the first month, then monthly for first 3 months, and periodically thereafter as indicated • Consider discontinuation in event of relapse or when patient is not available for supervision and counseling	• Monitor renal function (especially in elderly and in patients with renal insufficiency) and for behavioral changes indicative of suicidal thoughts or depression • Discontinue medication and consider alternatives if no detectable benefit after an adequate trial (300 mg daily for 3 months)	• Monitor quantities prescribed and usage patterns • Discontinue medication and consider alternatives if no detectable benefit from at least 900 mg daily for 2-3 months
Dosage and Administration					
• 50-100 mg orally 1 time daily	• 380 mg 1 time monthly by deep intramuscular injection	• 666 mg orally 3 times daily, preferably with meals	• 250 mg orally 1 time daily (range: 125-500 mg daily)	• Initiate at 50 mg daily • Titrate gradually to max dose of 100 mg 2 times daily	• Initiate at 300 mg on day 1 & increase gradually by 300 mg 3 times daily

TABLE A Pharmacotherapy For AUD					
Naltrexone Oral	Naltrexone Injectable	Acamprosate	Disulfiram	Topiramate ¹	Gabapentin ¹
Alternative Dosing					
• 25 mg 1-2 times daily with meals to reduce nausea, especially during the first week OR 100 mg on Monday and Wednesday and 150 mg on Friday		• Consider 333 mg orally 4 times daily for patients whose body weight is <60 kg	• Decrease dose to 125 mg to reduce side effects and, for monitored administration, consider giving 500 mg on Monday, Wednesday, and Friday.	• In geriatric patients with CrCl <70 mL/min/1.73m ² , give initial dose of 25 mg/day followed by incremental increases of 25 mg at weekly intervals until an effective dose is reached	
Dosing in Special Populations					
• Use caution in hepatic or renal insufficiency	• No dose adjustment needed for CrCl 50-80 mL/min • Uncertain effects (no data) in moderate to severe renal insufficiency	• Reduce dose by half when CrCl 30-50 mL/min • Do not administer in severe renal insufficiency		• Halve dose and slow titrate when CrCl <70 mL/min/1.73m ² • Dosage adjustment may be required in hepatic impairment	• Consider target dose <1800 mg daily when CrCl <60 mL/min
Adverse Effects					
• Common: Nausea • Other: Headache, dizziness, nervousness, fatigue, insomnia, vomiting, anxiety, somnolence	• Major: Eosinophilic pneumonia, depression, suicidality • Common: Injection-site reactions, nausea, headache, asthenia	• Major: Suicidality • Common: Diarrhea • Other: Anxiety, asthenia, depression, insomnia	• Major: Hepatotoxicity, peripheral neuropathy, psychosis, delirium, severe disulfiram-ethanol reaction • Common: Somnolence, metallic taste, headache	• Major: Paresthesia, dizziness, somnolence, loss of appetite, weight loss • Other: Nervousness, fatigue, decreased concentration, memory impairment, confusion	• Major: Dizziness, somnolence • Other: Peripheral edema, fatigue
Drug Interactions					
• Opioid-containing medications, thioridazine	• Opioid-containing medications, thioridazine	• Naltrexone, antidepressants	• Meds and other alcohol-containing products, phenytoin, isoniazid, warfarin, monoamine oxidase inhibitors, rifampin, tricyclic antidepressants, metronidazole	• Combination with alcohol or other CNS depressants, oral contraceptives	• Combination with alcohol or other CNS depressants, antacids
Patient Education					
• Focus on patient compliance and commitment to treatment plan • Side effects occur early and typically resolve within 1-2 weeks after dosage adjustment • If signs/symptoms of acute hepatitis occur, stop naltrexone and contact provider immediately • Very large doses of opioids may overcome naltrexone effects and result in injury, coma, or death • Opioid-based analgesics, antidiarrheals, or antitussives may be blocked by naltrexone and fail to produce effect • Patients who have previously used opioids may be more sensitive to toxic effects of opioids after discontinuation of naltrexone	• Report injection-site reaction, any new or worsening depression/suicidal thinking • Contact provider for signs/symptoms of pneumonia	• Report any new or worsening depression/suicidal thinking	• Avoid alcohol in food, beverages, and medications • Avoid disulfiram if alcohol intoxicated • May cause sedation • Discuss compliance enhancing methods and provide wallet cards • Family members should not administer disulfiram without informing patient	• Bitter tablets • Do not crush, break or chew • Take without regard to meals • May cause sedation or decreased alertness	• Take first dose on first day at bedtime to minimize somnolence and dizziness • May cause sedation or decreased alertness

1 Not FDA labeled for treatment of AUD
2 Patients should be engaged in a comprehensive management program that includes psychosocial intervention; disulfiram is more effective with monitored administration (in clinic or with spouse or probation officer).
3 Hypersensitivity to the agent is a contraindication to use for each medication listed.
4 Receiving opioid agonists, physiologic opioid dependence with use within past seven days, acute opioid withdrawal, failed naloxone challenge test, or positive urine opioid screen are contraindications to oral or intramuscular naltrexone.
5 Disulfiram is contraindicated in patients with severe and unstable psychiatric disorders (especially psychotic and cognitive disorders, suicidal ideation) and impulsivity

Table B Pharmacotherapy For OUD		
Methadone	Buprenorphine/Naloxone or Buprenorphine	Naltrexone Injectable
Indications		
• OUD and patient meets Federal OTP Standards (42 C.F.R. 58.12)	• OUD	• OUD with pretreatment abstinence from opioids and no signs of opioid withdrawal; willingness to receive monthly injections
Contraindications		
• Hypersensitivity	• Hypersensitivity	• Hypersensitivity • Opioid-related findings ¹ • Acute hepatitis or liver failure • Inadequate muscle mass
Warnings/Precautions		
• Concurrent enrollment in another OTP • Prolonged QTc interval • Footnote 2	• Buprenorphine/naloxone and buprenorphine may precipitate withdrawal in patients on full agonist opioids • Footnote 2	• Active liver disease • Uncertain effects (no data) in moderate to severe renal insufficiency • Use intramuscular injections with caution in patients at risk for bleeding • Pregnancy Category C
Baseline Evaluation- Obtain urine beta-HCG for females		
• Baseline electrocardiogram and physical examination for patients at risk for QT prolongation or arrhythmias	• Liver transaminases	• Assess liver and renal function • Ensure adequate muscle mass for intramuscular injection
Dosage and Administration		
• Give as single daily oral dose; individualize dosing • Titrate carefully; consider methadone's delayed cumulative effects • Initial dose: 15-20 mg single dose, maximum 30 mg • Daily dose: Maximum 40 mg/day on first day • Usual dosage range for optimal effects: 60-120 mg/day	• Individualize dosing regimens • For any formulation: Do not chew, swallow, or move after placement • Sublingual induction dose: 2-8 mg once daily. Day 2 and onward: Increase dose by 2-4 mg/day until withdrawal symptoms and craving are relieved • Sublingual stabilization/maintenance dose: Titrate by 2-4 mg/day targeting craving and illicit opioid use • Sublingual usual dose: 12-16 mg/day (up to 32 mg/day)	• 380 mg 1 time monthly by deep intramuscular injection

Table B Pharmacotherapy For OUD		
Methadone	Buprenorphine/Naloxone or Buprenorphine ¹	Naltrexone Injectable ¹
Alternative Dosing Schedules		
• Give in divided daily doses based on peak and low levels that document rapid metabolism	Give equivalent weekly maintenance dose divided over extended dosing intervals (every 2, 3, or 4 days)	
Dosing in Special Populations		
• Reduce dose in renal or hepatic impairment and in the elderly or debilitated	• Hepatic impairment: Reduce dose • For concurrent chronic pain, consider dividing total daily dose into 2- or 3-time daily administration	• No dosage adjustment needed for CrCl 50-80 mL/min • Uncertain effects (no data) in moderate to severe renal insufficiency
Adverse Effects		
• Major: Respiratory depression, shock, cardiac arrest, prolongation of QTc interval/torsade de pointes/ventricular tachycardia • Common: Lightheadedness, dizziness, sedation, nausea, vomiting, sweating, constipation, edema • Less common: Sexual dysfunction	• Major: Hepatitis, hepatic failure, respiratory depression (with intravenous misuse or combined with other CNS depressants) • Common: Headache, pain, abdominal pain, insomnia, nausea and vomiting, sweating, constipation • Sublingual buprenorphine/naloxone: Oral hypoesthesia, glossodynia, oral mucosal erythema	• Major: Eosinophilic pneumonia, depression, suicidality • Common: Injection site reactions, nausea, headache, asthenia
Drug Interactions		
• ↓Methadone levels: Footnote 3 • ↑Methadone levels: Footnote 4 • Opioid antagonists: May precipitate withdrawal	• ↓Buprenorphine levels: Footnote 3 • ↑Buprenorphine levels: Footnote 4 • Opioid agonist: buprenorphine/naloxone or buprenorphine may precipitate withdrawal • Opioid antagonists: May precipitate withdrawal	• Opioid-containing medications • Thioridazine
Monitoring		
• Signs of respiratory/CNS depression	Liver function tests prior to initiation and during therapy	• Repeat liver transaminase levels at 6 and 12 months and every 12 months thereafter

Table B Pharmacotherapy For OUD		
Methadone	Buprenorphine/Naloxone or Buprenorphine ¹	Naltrexone Injectable ¹
Patient Education		
• Give strong advice against self-medicating with CNS depressants during methadone therapy; serious overdose and death may occur • Store in a secure place out of the reach of children • Strongly advise patient to continue in long-term methadone maintenance • If discontinuing methadone, recommend transition to extended-release injectable naltrexone • Serious overdose and death may occur if patient relapses to opioid use after withdrawal from methadone	• Give strong advice against self-medicating with CNS depressants during buprenorphine/naloxone or buprenorphine therapy; serious overdose and death may occur • Store in a secure place out of the reach of children • Strongly advise patient to continue in long-term buprenorphine maintenance • If discontinuing buprenorphine, recommend transition to extended-release injectable naltrexone • Serious overdose and death may occur if patient relapses to opioid use after withdrawal from buprenorphine	• Report any injection site reactions, new or worsening depression, or suicidal thinking • Contact provider for signs and symptoms of pneumonia • 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 • Opioid-based analgesics, antidiarrheals, or antitussives may be blocked by naltrexone and fail to produce effect • Patients who have previously used opioids may be more sensitive to toxic effects of opioids after discontinuation of naltrexone

Footnotes:
1. Receiving opioid agonists, physiologic opioid dependence with use within past seven days, acute opioid withdrawal, failed naloxone challenge test, or positive urine opioid screen are contraindications to intramuscular naltrexone
2. Use caution in patients with 1) Respiratory, liver, or renal insufficiency 2) Concurrent benzodiazepines or other CNS depressants including active AUD 3) Use of opioid antagonists (e.g., parenteral naloxone, oral or parenteral nalmefene, naltrexone)
3. Drugs that decrease methadone or buprenorphine levels: Ascorbic acid, barbiturates, carbamazepine, ethanol (chronic use), interferon, phenytoin, rifampin, efavirenz, nevirapine, other antiretrovirals with CYP3A4 activity
4. Drugs that increase methadone or BUP levels: Amitriptyline, atazanavir, atazanavir/ritonavir, cimetidine, delavirdine, diazepam, fluconazole, fluvoxamine, ketoconazole, voriconazole
Table B is an abbreviated version of the table included in the full CPG. Please see Appendix B, Table B-2 for the full version of the table.
Abbreviations: AUD: alcohol use disorder; BAL: blood alcohol level; CNS: central nervous system; CrCl: creatinine clearance; IV: intravenous; kg: kilogram(s); m: meter(s); mg: milligram(s); mL: milliliter(s); min: minute(s) OTP: Opioid Treatment Program; OUD: opioid use disorder; QTc: the heart rate corrected time from the start of the Q wave to the end of the T wave

VA/DoD CLINICAL PRACTICE GUIDELINE

**Management of Substance Use Disorders
B. STABILIZATION**

KEY ELEMENTS OF THE GUIDELINE

Screening for Unhealthy Alcohol Use (See Pocket Card A)

- » Use of standardized alcohol screening tools.
- » Identify patients with Unhealthy Alcohol Use who would benefit from a brief intervention regarding alcohol-related risks and advice to abstain or drink within recommended limits for daily/weekly consumption.

Management of Substance Use Disorder (See Pocket Card A)

- » Promote early engagement and retention of patients with conditions who can benefit from addiction-focused treatment.
- » Apply a patient-centered care approach that is individualized based on patient capabilities, needs, goals, prior treatment experience, and preferences.
- » Focus on shared decision making (SDM) where patients, together with their clinicians, make decisions regarding care in which they choose to engage.
- » Offer SUD focused pharmacotherapy and/or psychosocial interventions as indicated.
- » Provide addiction-focused Medical Management, alone or in conjunction with another psychosocial intervention, delivered by a medical professional in a primary care or general mental health care setting:
 - ◊ Provides strategies to increase medication adherence, as well as monitoring of substance use and consequences
 - ◊ Supports abstinence through education and referral to support groups
 - ◊ Provides ongoing systematic relapse prevention efforts or recovery support that is based on treatment response.

Stabilization

- » Use of standardized assessment measures of the severity of withdrawal symptoms in patients with AUD or OUD in early abstinence.
- » Provide inpatient medically supervised alcohol withdrawal management for patients with alcohol withdrawal symptoms.

Access to full guideline and toolkit:
<http://www.healthquality.va.gov> or
<https://www.qmo.amedd.army.mil>
 December 2015



Algorithm B: STABILIZATION

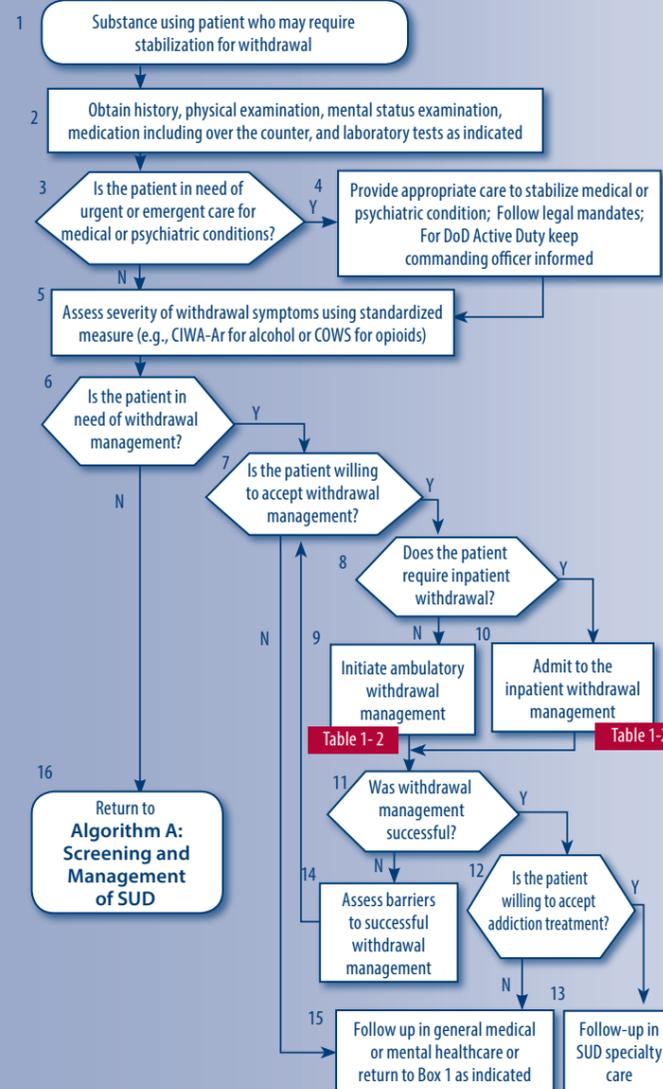


Table 1 Pharmacological Treatment

Alcohol Withdrawal
 For managing moderate to severe alcohol withdrawal:
 • Benzodiazepines
 For patients without severe alcohol withdrawal for whom risks of benzodiazepines outweigh benefits:
 • Carbamazepine
 • Gabapentin
 • Valproic acid

Opioid Withdrawal
 For patients with OUD for whom maintenance agonist treatment is contraindicated, unacceptable, or unavailable, we recommend a taper using:
 • Methadone in an Opioid Treatment Program only
 • Buprenorphine
 For patients with OUD for whom methadone and/or buprenorphine are contraindicated, unacceptable, or unavailable:
 • Clonidine

Table 2 Tapering Strategies

Alcohol Withdrawal (use one of the following)
 • A predetermined fixed medication tapering schedule with additional medication as needed
 • Symptoms-triggered therapy where patients are given medication only when signs or symptoms of withdrawal occur (e.g., PRN dosing)

Opioid Withdrawal
 • Use structured taper for methadone and buprenorphine

AUD: alcohol use disorder; CIWA-Ar: Clinical Institute Withdrawal Assessment for Alcohol (revised version); COWS: Clinical Opiate Withdrawal Scale; CPG: clinical practice guideline; OUD: Opioid use disorder; SUD: Substance Use Disorders; PRN: as needed

Patients Appropriate for Inpatient Medically Supervised Withdrawal Management

Patients for Whom Inpatient Medically Supervised Withdrawal Management is Recommended	Patients for Whom Inpatient Medically Supervised Withdrawal Management is Suggested
Patients with any of the following conditions: • History of delirium tremens or withdrawal seizures • Inability to tolerate oral medication • Co-occurring medical conditions that would pose serious risk for ambulatory withdrawal management (e.g., severe coronary artery disease, congestive heart failure, liver cirrhosis) • Severe alcohol withdrawal (i.e., CIWA-Ar score ≥ 20) • Risk of withdrawal from other substances in addition to alcohol (e.g., sedative hypnotics)	Patients with at least moderate alcohol withdrawal (i.e., CIWA-Ar score ≥ 10 and any of the following conditions): • Recurrent unsuccessful attempts at ambulatory withdrawal management • Reasonable likelihood that the patient will not complete ambulatory withdrawal management (e.g., due to homelessness) • Active psychosis or severe cognitive impairment • Medical conditions that could make ambulatory withdrawal management problematic (e.g., pregnancy, nephrotic syndrome, cardiovascular disease, lack of medical support system)

Abbreviation: CIWA-Ar: Clinical Institute Withdrawal Assessment for Alcohol (revised version)

Table 3. Sedative-hypnotic Conversion Table

Generic Name	Approximate Equivalents to Diazepam 10 mg or Phenobarbital 30 mg ¹	Time to Peak Plasma level (in Hours)	Half-life Parent Drug (in Hours) ²	Metabolite Activity (Maximal Half-life in Hours) ³
Alprazolam	1 mg	1-2	12 ± 2	Inactive
Chlordiazepoxide	25 mg	1-4	10 ± 3.4	Active (up to 120)
Clonazepam	1 mg	1-4	23 ± 5	Inactive
Clorazepate	15 mg	Variable	2 ± 0.9	Active (up to 120)
Diazepam	10 mg	1-2	43 ± 13	Active (up to 120)
Estazolam	1 mg	0.5-0.6	10-24	Inactive
Flurazepam	15 mg	0.5-1.0	74 ± 24	Active (up to 100)
Lorazepam	2 mg	2-4	14 ± 5	Inactive
Oxazepam	30 mg	2-3	8.0 ± 2	Inactive
Quazepam	10 mg	1.5	39	Active (up to 75)
Temazepam	15 mg	2.5	11 ± 6	Inactive
Triazolam	0.25 mg	1-2	2.9 ± 1.0	Inactive
Eszopiclone	15 mg	1	6	Active (<parent)
Zaleplon	20 mg	1	1	Inactive
Zolpidem	20 mg	1.6	2	Inactive
Butalbital	50 mg	1-2	35	Inactive
Pentobarbital	100 mg	0.5-1	15-50	Inactive
Phenobarbital	30 mg	1+	53-140	Inactive
Meprobamate	400 mg	2-3	10	Inactive
Carisoprodol	350 mg	1-3	2	Active (see Meprobamate)
Choral hydrate	250 mg	0.5	<1	Active (up to 94)

Abbreviation: mg: milligrams
 1 Withdrawal doses of diazepam or phenobarbital are those sufficient to suppress most withdrawal symptoms and may not reflect therapeutic dose equivalency.
 2 Half-life of active metabolite(s) may differ.
 3 Primary route of barbiturate elimination is renal excretion.

Table 4. Clinical Institute Withdrawal Assessment of Alcohol (CIWA-Ar)

Patient and Time Information	
Name, date, time, pulse or heart rate taken for one minute, and blood pressure	
Items	
<p>Nausea and vomiting: Ask, "Do you feel sick to your stomach? Have you vomited?" Observation.</p> <p>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</p>	<p>Tactile disturbances: Ask, "Have you had any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.</p> <p>0: None 1: Very 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</p>
<p>Tremor: Arms extended and fingers spread apart. Observation.</p> <p>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</p>	<p>Auditory disturbances: 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.</p> <p>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</p>
<p>Paroxysmal sweats: Observation.</p> <p>0: No sweat visible 1: Barely perceptible sweating, palms moist 2 3 4: Beads of sweat obvious on forehead 5 6 7: Drenching sweats</p>	<p>Visual disturbances: Ask, "Does the light appear to be too bright? Is its 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.</p> <p>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</p>

Table 5. Clinical Opiate Withdrawal Scale (COWS)

Patient and Time Information	
Name, date, time, reason for this assessment	
Items	
<p>Pulse Rate: Record Beats per Minute. Measured after patient is sitting or lying for one minute</p> <p>0: Pulse rate 80 or below 1: Pulse rate 81-100 2: Pulse rate 101-120 4: Pulse rate greater than 120</p>	<p>Gastrointestinal Upset: Over Last 1/2 Hour</p> <p>0: No gastrointestinal symptoms 1: Stomach cramps 2: Nausea or loose stool 3: Vomiting or diarrhea 5: Multiple episodes of diarrhea or vomiting</p>
<p>Sweating: Over Past 1/2 Hour not Accounted for by Room Temperature or Patient Activity</p> <p>0: No report of chills or flushing 1: Subjective report of chills or flushing 2: Flushed or observable moistness on face 3: Beads of sweat on brow or face 4: Sweat streaming off face</p>	<p>Tremor Observation of Outstretched Hands</p> <p>0: No tremor 1: Tremor can be felt, but not observed 2: Slight tremor observable 4: Gross tremor or muscle twitching</p>
<p>Restlessness Observation During Assessment</p> <p>0: Able to sit still 1: Reports difficulty sitting still, but is able to do so 3: Frequent shifting or extraneous movements of legs/arms 5: Unable to sit still for more than a few seconds</p>	<p>Yawning Observation During Assessment</p> <p>0: No yawning 1: Yawning once or twice during assessment 2: Yawning three or more times during assessment 4: Yawning several times/minute</p>
<p>Pupil Size</p> <p>0: Pupils pinned or normal size for room light 1: Pupils possibly larger than normal for room light 2: Pupils moderately dilated 5: Pupils so dilated that only the rim of the iris is visible</p>	<p>Anxiety or Irritability</p> <p>0: None 1: Patient reports increasing irritability or anxiousness 2: Patient obviously irritable/anxious 4: Patient so irritable or anxious that participation in the assessment is difficult</p>
<p>Bone or Joint Aches if Patient was Having Pain Previously, only the Additional Component Attributed to Opiate Withdrawal is Scored</p> <p>0: Not present 1: Mild diffuse discomfort 2: Patient reports severe diffuse aching of joints/muscles 4: Patient is rubbing joints or muscles and is unable to sit still because of discomfort</p>	<p>Gooseflesh Skin</p> <p>0: Skin is smooth 3: Piloerection of skin can be felt or hairs standing up on arms 5: Prominent piloerection</p>
<p>Runny Nose or Tearing Not Accounted for by Cold Symptoms or Allergies</p> <p>0: Not present 1: Nasal stuffiness or unusually moist eyes 2: Nose running or tearing 4: Nose constantly running or tears streaming down cheeks</p>	
Scoring	
<p>Total COWS Score _____ Rater's Initials _____ Maximum Possible Score: 48</p>	<p>Interpret sum of total scores as follows:</p> <ul style="list-style-type: none"> Mild withdrawal: 5-12 Moderate withdrawal: 13-24 Moderately severe withdrawal: 25-36 Severe withdrawal: >36

Items	
<p>Anxiety: Ask, "Do you feel nervous?" Observation.</p> <p>0: No anxiety, at ease 1: Mild 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</p>	<p>Headache, fullness in head: 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.</p> <p>0: Not present 1: Very mild 2: Mild 3: Moderate 4: Moderately severe 5: Severe 6: Very severe 7: Extremely severe</p>
<p>Agitation: Observation.</p> <p>0: Normal activity 1: Somewhat more than normal activity 2 3 4: Moderately fidgety and restless 5 6 7: Paces back and forth during most of the interview, or constantly thrashes about</p>	<p>Orientation and clouding of sensorium: Ask, "What day is this? Where are you? Who am I?"</p> <p>0: Oriented and can do serial additions 1: Cannot do serial additions or is uncertain about date 2: Disoriented for date by no more than 2 calendar days 3: Disoriented for date by more than 2 calendar days 4: Disoriented for place/or person</p>
Scoring	
<p>Total CIWA-Ar Score _____ Rater's Initials _____ Maximum Possible Score: 67</p>	<p>Interpret sum of total scores as follows:</p> <ul style="list-style-type: none"> Minimal or absent withdrawal: ≤9 Mild to moderate withdrawal: 10-19 Severe withdrawal: ≥20