



Complete Summary

GUIDELINE TITLE

Practice guideline for the treatment of patients with substance use disorders.

BIBLIOGRAPHIC SOURCE(S)

Work Group on Substance Use Disorders, Kleber HD, Weiss RD, Anton RF, Rounsaville BJ, George TP, Strain EC, Greenfield SF, Ziedonis DM, Kosten TR, Hennessy G, O'Brien CP, Connery HS, American Psychiatric Association Steering Committee on Practice Guidelines, McIntyre JS, Charles SC, Anzia DJ, Nininger JE, Cook IA, Summergrad P, Finnerty MT, Woods SM, Johnson BR, Yager J, Pyles R, Lurie L, Cross CD, Walker RD, Peele R, Barnovitz MA, Gray SH, Shemo JP, Saxena S, Tonnu T, Kunkle R, Albert AB, Fochtman LJ, Hart C, Regier D. Treatment of patients with substance use disorders, second edition. American Psychiatric Association. Am J Psychiatry 2006 Aug;163(8 Suppl):5-82. [PubMed](#)

GUIDELINE STATUS

According to the guideline developer, this guideline is still considered to be current as of April 2007. A Guideline Watch, which summarizes significant developments in practice since the publication of the original guideline, was published in April 2007 and is available from the [American Psychiatric Association Web site](#) (see also the "Availability of Companion Documents" field below).

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- [October 24, 2007, Provigil \(modafinil\)](#): Cephalon has agreed to include additional labeling revisions to the WARNINGS, CLINICAL PHARMACOLOGY, PRECAUTIONS, and PATIENT PACKAGE INSERT sections.
- [May 2, 2007, Antidepressant drugs](#): Update to the existing black box warning on the prescribing information on all antidepressant medications to include warnings about the increased risks of suicidal thinking and behavior in young adults ages 18 to 24 years old during the first one to two months of treatment.

COMPLETE SUMMARY CONTENT

** REGULATORY ALERT **

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SCOPE

DISEASE/CONDITION(S)

Substance use disorders, including:

- Nicotine dependence
- Alcohol-related disorders
- Marijuana-related disorders
- Cocaine-related disorders
- Opioid-related disorders

GUIDELINE CATEGORY

Evaluation
Management
Treatment

CLINICAL SPECIALTY

Psychiatry

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To provide guidance to psychiatrists who care for patients with substance use disorders

TARGET POPULATION

Adult patients with substance use disorders, including disorders related to use of nicotine, alcohol, marijuana, cocaine, and opioids

INTERVENTIONS AND PRACTICES CONSIDERED

Assessment

1. Comprehensive psychiatric evaluation
2. Detailed history of past and present substance use
3. General medical and psychiatric history and examination
4. History of psychiatric treatments and outcomes
5. Family and social history
6. Screening of blood, breath, urine for substance use
7. Other laboratory tests
8. Contact of significant other for additional information

Management/Treatment

1. Establishing a treatment plan
2. Establishing a treatment setting (hospital, outpatient, residential treatment)
3. Consideration of clinical features influencing treatment (e.g., pregnancy, comorbid conditions, gay/lesbian/transgender issues, gender, and age)
4. Consideration of legal and confidentiality issues
5. Patient education
6. Pharmacologic treatment
 - Medications to treat intoxication states (e.g., naloxone, flumazenil, anticonvulsants, anticholinergics, anti-arrhythmics, adrenergic pressors)
 - Medications to treat withdrawal syndromes (e.g., methadone, buprenorphine, clonidine, benzodiazepines)
 - Agonist maintenance therapies (e.g., methadone, buprenorphine)
 - Antagonist therapies (e.g., naltrexone)
 - Abstinence promoting and relapse prevention therapies (e.g., disulfiram, naltrexone, acamprosate, bupropion)
 - Medications to treat comorbid psychiatric conditions (e.g., antidepressants, antipsychotics, mood stabilizers)
7. Psychosocial treatment
 - Cognitive behavioral therapies (CBTs)
 - Motivational enhancement therapy (MET)
 - Behavioral therapies, including contingency management, community reinforcement, cue exposure and relaxation training, and aversion therapy
 - Psychodynamic and interpersonal therapies
 - Group therapy
 - Family therapies
 - Self-help groups and 12-step-oriented approaches
 - Brief therapies
 - Self-guided therapies
 - Hypnosis

MAJOR OUTCOMES CONSIDERED

- The reduction of use and effects of abused substances
- Achievement and maintenance of abstinence
- Frequency and severity of relapse
- Psychological, social, and occupational functioning
- Morbidity and mortality due to substance use disorders

- Societal costs including costs of treatment, related health problems, absenteeism, lost productivity, drug-related crime and incarceration, and efforts in education and prevention

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Relevant updates to the literature were identified through a MEDLINE literature search for articles published since the initial guideline edition, published in 1995. Thus, MEDLINE was searched, using PubMed, between 1995 and 2002 using the keywords "substance use disorder OR substance use disorders OR substance use OR substance withdrawal OR substance intoxication OR substance abuse OR substance dependence OR alcohol abuse OR alcohol dependence OR cocaine abuse OR cocaine dependence OR cocaine use OR marijuana use OR marijuana abuse OR marijuana dependence OR opiate abuse OR opiate dependence OR opiate use OR opioid abuse OR opioid dependence OR opioid use OR heroin abuse OR heroin dependence OR heroin use OR cigarette OR cigarettes OR smoking OR tobacco OR tobacco use OR tobacco use disorder OR tobacco use cessation OR smoking cessation." This search yielded 89,231 references, of which 4,373 were controlled clinical trials; randomized, controlled trials; or meta-analyses; 4,101 of the 4,373 references were studies in humans, were written in the English language, and had abstracts. Evidence tables were developed for these results. Later in the development process, a second MEDLINE literature search, using PubMed, on the same keywords for the period 2003 to February 2005 yielded an additional 25,003 references, of which 1,114 were controlled clinical trials; randomized, controlled trials; or meta-analyses; 1,063 of these 1,114 references were studies in humans, were written in the English language, and had abstracts. Additional, less formal literature searches were conducted by APA staff and individual members of the Work Group on Substance Use Disorders. The Cochrane databases were also searched for relevant meta-analyses.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

The Work Group on Substance Use Disorders constructed evidence tables to illustrate the data regarding risks and benefits for each treatment and to evaluate the quality of the data. These tables facilitated group discussion of the evidence and agreement on treatment recommendations before guideline text was written. Evidence tables do not appear in the guideline; however, they are retained by American Psychiatric Association (APA) to document the development process in case queries are received and to inform revisions of the guideline.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

This practice guideline was developed under the auspices of the Steering Committee on Practice Guidelines. The development process is detailed in "APA Guideline Development Process," which is available from the American Psychiatric Association (APA) Department of Quality Improvement and Psychiatric Services. The key features of this process with regard to this document include the following:

- A comprehensive literature review to identify all relevant randomized clinical trials as well as less rigorously designed clinical trials and case series when evidence from randomized trials was unavailable
- The development of evidence tables that summarized the key features of each identified study, including funding source, study design, sample sizes, subject characteristics, treatment characteristics, and treatment outcomes
- Initial drafting of the guideline by a work group that included psychiatrists with clinical and research expertise in substance use disorders
- The production of multiple revised drafts with widespread review (23 organizations and 70 individuals submitted significant comments)
- Approval by the APA Assembly and Board of Trustees
- Planned revisions at regular intervals

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Each recommendation is identified as meriting one of three categories of endorsement, based on the level of clinical confidence regarding the recommendation, as indicated by a bracketed Roman numeral after the statement. The three categories are as follows:

[I] Recommended with substantial clinical confidence.

[II] Recommended with moderate clinical confidence.

[III] May be recommended on the basis of individual circumstances.

COST ANALYSIS

Published cost analyses were reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Each practice guideline is extensively reviewed at multiple draft stages. Draft 1 is reviewed by the Steering Committee. Draft 2 is reviewed by approximately 50 reviewers with expertise in the topic, representatives of allied organizations, the American Psychiatric Association (APA) Assembly, District Branches, the Joint Reference Committee, the Board of Trustees, the Council on Quality Care, other components related to the subject area, and any APA member by request. Draft 3 is reviewed and approved for publication by the Assembly and the Board of Trustees.

Twenty-three organizations and 70 individuals are acknowledged in the original guideline document for having submitted significant comments to the draft guideline.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Each recommendation is identified as falling into one of three categories of endorsement, based on the level of confidence regarding the recommendation, as indicated by a bracketed Roman numeral after the statement. Definitions of the categories of endorsement are presented at the end of the "Major Recommendations" field.

General Treatment Principles

Individuals with substance use disorders are heterogeneous with regard to a number of clinically important features and domains of functioning. Consequently, a multimodal approach to treatment is typically required. Care of individuals with substance use disorders includes conducting a complete assessment, treating intoxication and withdrawal syndromes when necessary, addressing co-occurring psychiatric and general medical conditions, and developing and implementing an overall treatment plan. The goals of treatment include the achievement of abstinence or reduction in the use and effects of substances, reduction in the frequency and severity of relapse to substance use, and improvement in psychological and social functioning.

1. Assessment

A comprehensive psychiatric evaluation is essential to guide the treatment of a patient with a substance use disorder **[I]**. The assessment includes 1) a detailed history of the patient's past and present substance use and the effects of substance use on the patient's cognitive, psychological, behavioral, and physiological functioning; 2) a general medical and psychiatric history and examination; 3) a history of psychiatric treatments and outcomes; 4) a family and social history; 5) screening of blood, breath, or urine for substance used; 6) other laboratory tests to help confirm the presence or absence of conditions that frequently co-occur with substance use disorders; and 7) with the patient's permission, contacting a significant other for additional information.

2. **Psychiatric Management**

Psychiatric management is the foundation of treatment for patients with substance use disorders **[I]**. Psychiatric management has the following specific objectives: motivating the patient to change, establishing and maintaining a therapeutic alliance with the patient, assessing the patient's safety and clinical status, managing the patient's intoxication and withdrawal states, developing and facilitating the patient's adherence to a treatment plan, preventing the patient's relapse, educating the patient about substance use disorders, and reducing the morbidity and sequelae of substance use disorders. Psychiatric management is generally combined with specific treatments carried out in a collaborative manner with professionals of various disciplines at a variety of sites, including community-based agencies, clinics, hospitals, detoxification programs, and residential treatment facilities. Many patients benefit from involvement in self-help group meetings, and such involvement can be encouraged as part of psychiatric management.

3. **Specific Treatments**

The specific pharmacologic and psychosocial treatments reviewed below are generally applied in the context of programs that combine a number of different treatment modalities.

a. *Pharmacologic Treatments*

Pharmacologic treatments are beneficial for selected patients with specific substance use disorders **[I]**. The categories of pharmacologic treatments are 1) medications to treat intoxication and withdrawal states; 2) medications to decrease the reinforcing effects of abused substances; 3) agonist maintenance therapies, 4) antagonist therapies, 5) abstinence-promoting and relapse prevention therapies, and 6) medications to treat co-occurring psychiatric conditions.

b. *Psychosocial Treatments*

Psychosocial treatments are essential components of a comprehensive treatment program **[I]**. Evidence-based psychosocial treatments include cognitive-behavioral therapies (CBTs, e.g., relapse prevention, social skills training), motivational enhancement therapy (MET), behavioral therapies (e.g., community reinforcement, contingency

management), 12-step facilitation (TSF), psychodynamic therapy/interpersonal therapy (IPT), self-help manuals, behavioral self-control, brief interventions, case management, and group, marital, and family therapies. There is evidence to support the efficacy of integrated treatment for patients with a co-occurring substance use and psychiatric disorder; such treatment includes blending psychosocial therapies used to treat specific substance use disorders with psychosocial treatment approaches for other psychiatric diagnoses (e.g., CBT for depression).

4. Formulation and Implementation of a Treatment Plan

The goals of treatment and the specific therapies chosen to achieve these goals may vary among patients and even for the same patient at different phases of an illness [I]. Because many substance use disorders are chronic, patients usually require long-term treatment, although the intensity and specific components of treatment may vary over time [I]. The treatment plan includes the following components: 1) psychiatric management; 2) a strategy for achieving abstinence or reducing the effects or use of substances of abuse; 3) efforts to enhance ongoing adherence with the treatment program, prevent relapse, and improve functioning; and 4) additional treatments necessary for patients with a co-occurring mental illness or general medical condition.

The duration of treatment should be tailored to the individual patient's needs and may vary from a few months to several years [I]. It is important to intensify the monitoring for substance use during periods when the patient is at a high risk of relapsing, including during the early stages of treatment, times of transition to less intensive levels of care, and the first year after active treatment has ceased [I].

5. Treatment Settings

Treatment settings vary with regard to the availability of specific treatment modalities, the degree of restricted access to substances that are likely to be abused, the availability of general medical and psychiatric care, and the overall milieu and treatment philosophy.

Patients should be treated in the least restrictive setting that is likely to be safe and effective [I]. Commonly available treatment settings include hospitals, residential treatment facilities, partial hospitalization programs, and outpatient programs. Decisions regarding the site of care should be based on patients' ability to cooperate with and benefit from the treatment offered, refrain from illicit use of substances, and avoid high-risk behaviors, as well as the patient's need for structure and support or particular treatments that may be available only in certain settings [I]. Patients move from one level of care to another on the basis of these factors and an assessment of their ability to safely benefit from a different level of care [I].

Hospitalization is appropriate for patients who 1) have a substance overdose who cannot be safely treated in an outpatient or emergency department setting; 2) are at risk for severe or medically complicated withdrawal

syndromes (e.g., history of delirium tremens, documented history of very heavy alcohol use and high tolerance); 3) have co-occurring general medical conditions that make ambulatory detoxification unsafe; 4) have a documented history of not engaging in or benefiting from treatment in a less intensive setting (e.g., residential, outpatient); 5) have a level of psychiatric comorbidity that would markedly impair their ability to participate in, adhere to, or benefit from treatment or have a co-occurring disorder that by itself would require hospital-level care (e.g., depression with suicidal thoughts, acute psychosis); 6) manifest substance use or other behaviors that constitute an acute danger to themselves or others; or 7) have not responded to or were unable to adhere to less intensive treatment efforts and have a substance use disorder(s) that endangers others or poses an ongoing threat to their physical and mental health **[I]**.

Residential treatment is indicated for patients who do not meet the clinical criteria for hospitalization but whose lives and social interactions have come to focus predominantly on substance use, who lack sufficient social and vocational skills, and who lack substance-free social supports to maintain abstinence in an outpatient setting **[II]**. Residential treatment of ≥ 3 months is associated with better long-term outcome in such patients **[II]**. For patients with an opioid use disorder, therapeutic communities have been found effective **[II]**.

Partial hospitalization should be considered for patients who require intensive care but have a reasonable probability of refraining from illicit use of substances outside a restricted setting **[II]**. Partial hospitalization settings are frequently used for patients leaving hospitals or residential settings who remain at high risk for relapse. These include patients who are thought to lack sufficient motivation to continue in treatment, have severe psychiatric comorbidity and/or a history of relapse to substance use in the immediate posthospitalization or postresidential period, and are returning to a high-risk environment and have limited psychosocial supports for abstaining from substance use. Partial hospitalization programs are also indicated for patients who are doing poorly in intensive outpatient treatment **[II]**.

Outpatient treatment of substance use disorders is appropriate for patients whose clinical condition or environmental circumstances do not require a more intensive level of care **[I]**. As in other treatment settings, a comprehensive approach is optimal using, where indicated, a variety of psychotherapeutic and pharmacological interventions, along with behavioral monitoring **[I]**. Most treatment for patients with alcohol dependence or abuse can be successfully conducted outside the hospital (e.g., in outpatient or partial hospitalization settings) **[II]**, although patients with alcohol withdrawal must be detoxified in a setting that provides frequent clinical assessment and any necessary treatments **[I]**. For many patients with a cocaine use disorder, clinical and research experience suggests the effectiveness of intensive outpatient treatment in which a variety of treatment modalities are simultaneously used and in which the focus is the maintenance of abstinence **[II]**. The treatment of patients with nicotine dependence or a marijuana use disorder occurs on an outpatient basis unless patients are hospitalized for other reasons **[I]**.

6. Clinical Features Influencing Treatment

In planning and implementing treatment, a clinician should consider several variables with regard to patients: comorbid psychiatric and general medical conditions, gender-related factors, age, social milieu and living environment, cultural factors, gay/lesbian/bisexual/transgender issues, and family characteristics **[I]**. Given the high prevalence of comorbidity of substance use disorders and other psychiatric disorders, the diagnostic distinction between substance use symptoms and those of other disorders should receive particular attention, and specific treatment of comorbid disorders should be provided **[I]**. In addition to pharmacotherapies specific to a patient's substance use disorder, various psychotherapies may also be indicated when a patient has a co-occurring psychiatric disorder, psychosocial stressors, or other life circumstances that exacerbate the substance use disorder or interfere with treatment **[I]**. A patient's cessation of substance use may also be associated with changes in his or her psychiatric symptoms or the metabolism of medications (e.g., altered antipsychotic metabolism via cytochrome P450 1A2 with smoking cessation) that will necessitate adjustment of psychotropic medication doses **[I]**.

In women of childbearing age, the possibility of pregnancy needs to be considered **[I]**. Each of the substances discussed in this practice guideline has the potential to affect the fetus, and psychosocial treatment to encourage substance abstinence during pregnancy is recommended **[I]**. With some substances, concomitant agonist treatment may be preferable to continued substance use. In pregnant smokers, treatment with nicotine replacement therapy (NRT) may be helpful **[II]**. For pregnant women with an opioid use disorder, treatment with methadone **[I]** or buprenorphine **[II]** can be a useful adjunct to psychosocial treatment.

Nicotine Use Disorders: Treatment Principles and Alternatives

1. Pharmacological Treatments

Pharmacological treatment is recommended for individuals who wish to stop smoking and have not achieved cessation without pharmacological agents or who prefer to use such agents **[I]**. There are six medications approved by the U.S. Food and Drug Administration (FDA) for nicotine dependence, including five NRTs (patch, gum, spray, lozenge, and inhaler) and bupropion. These are all first-line agents that are equally effective in alleviating withdrawal symptoms and reducing smoking. Any of these could be used based on patient preference, the route of administration, and the side-effect profile **[I]**. Significant adverse events to NRTs, including dependence, are rare. Although combined psychosocial and medication treatment produces the best outcomes in treating nicotine use disorders, these medications are effective even when no psychosocial treatment is provided **[I]**. Using a combination of these first-line treatments may also improve outcome **[II]**. Nortriptyline and clonidine have utility as second-line agents but appear to have more side effects **[II]**. Other medications and acupuncture have not been proven to be effective.

2. Psychosocial Treatments

Psychosocial treatments are also effective for the treatment of nicotine dependence and include CBTs [I], behavioral therapies [I], brief interventions [II], and MET [II] provided in individual [I], group [I], or telephone [I] formats or via self-help materials [III] and Internet-based formats [III]. The efficacy of treatment is related to the amount of psychosocial treatment received. The 12-step programs, hypnosis, and inpatient therapy have not been proven effective.

Alcohol Use Disorders: Treatment Principles and Alternatives

1. Management of Intoxication and Withdrawal

The acutely intoxicated patient should be monitored and maintained in a safe environment [II]. Symptoms of alcohol withdrawal typically begin within 4-12 hours after cessation or reduction of alcohol use, peak in intensity during the second day of abstinence, and generally resolve within 4-5 days. Serious complications include seizures, hallucinations, and delirium.

The treatment of patients in moderate to severe withdrawal includes efforts to reduce central nervous system (CNS) irritability and restore physiological homeostasis [I] and generally requires the use of thiamine and fluids [I], benzodiazepines [I], and, in some patients, other medications such as anticonvulsants, clonidine, or antipsychotic agents [II]. Once clinical stability is achieved, the tapering of benzodiazepines and other medications should be carried out as necessary, and the patient should be observed for the reemergence of withdrawal symptoms and the emergence of signs and symptoms suggestive of co-occurring psychiatric disorders [I].

2. Pharmacologic Treatments

Specific pharmacotherapies for alcohol-dependent patients have well-established efficacy and moderate effectiveness. Naltrexone may attenuate some of the reinforcing effects of alcohol [I], although data on its long-term efficacy are limited. The use of long-acting, injectable naltrexone may promote adherence, but published research is limited. Acamprosate, a gamma-aminobutyric acid (GABA) analog that may decrease alcohol craving in abstinent individuals, may also be an effective adjunctive medication in motivated patients who are concomitantly receiving psychosocial treatment [I]. Disulfiram is an effective adjunct to a comprehensive treatment program in reliable, motivated patients whose drinking may be triggered by events that suddenly increase alcohol craving [II].

3. Psychosocial Treatments

Psychosocial treatments found effective for selected patients with an alcohol use disorder include MET [I], CBT [I], behavioral therapies [I], TSF [I], marital and family therapies [I], group therapies [II], and psychodynamic therapy/IPT [III]. Recommending that patients participate in self-help groups, such as Alcoholics Anonymous (AA), is often helpful [I].

Marijuana Use Disorders: Treatment Principles and Alternatives

Studies of treatment for marijuana use disorders are limited. No specific pharmacotherapies for marijuana withdrawal or dependence can be recommended **[I]**. In terms of psychosocial therapies, an intensive relapse prevention approach that combines motivational interventions with the development of coping skills may be effective for the treatment of marijuana dependence **[III]**, but further study of these approaches is necessary.

Cocaine Use Disorders: Treatment Principles and Alternatives

1. Management of Intoxication and Withdrawal

Cocaine intoxication is usually self-limited and typically requires only supportive care **[II]**. However, hypertension, tachycardia, seizures, and persecutory delusions can occur with cocaine intoxication and may require specific treatment **[II]**. Acutely agitated patients may benefit from sedation with benzodiazepines **[III]**.

2. Pharmacologic Treatments

Pharmacologic treatment is not ordinarily indicated as an initial treatment for patients with cocaine dependence. In addition, no pharmacotherapies have FDA indications for the treatment of cocaine dependence. However, for individuals who fail to respond to psychosocial treatment alone, some medications (topiramate, disulfiram, or modafinil) may be promising when integrated into psychosocial treatments.

3. Psychosocial Treatments

For many patients with a cocaine use disorder, psychosocial treatments focusing on abstinence are effective **[I]**. In particular, CBTs **[I]**, behavioral therapies **[I]**, and 12-step-oriented individual drug counseling **[I]** can be useful, although efficacy of these therapies varies across subgroups of patients. Recommending regular participation in a self-help group may improve the outcome for selected patients with a cocaine use disorder **[III]**.

Opioid Use Disorders: Treatment Principles and Alternatives

1. Management of Opioid Intoxication and Withdrawal

Acute opioid intoxication of mild to moderate degree usually does not require specific treatment **[II]**. However, severe opioid overdose, marked by respiratory depression, may be fatal and requires treatment in an emergency department or inpatient setting **[I]**. Naloxone will reverse respiratory depression and other manifestations of opioid overdose **[I]**.

The treatment of opioid withdrawal is directed at safely ameliorating acute symptoms and facilitating the patient's entry into a long-term treatment program for opioid use disorders **[I]**. Strategies found to be effective include substitution of methadone or buprenorphine for the opioid followed by gradual tapering **[I]**; abrupt discontinuation of opioids, with the use of clonidine to suppress withdrawal symptoms **[II]**; and clonidine-naltrexone detoxification

[II]. It is essential that the treating physician assess the patient for the presence of other substances, particularly alcohol, benzodiazepines, or other anxiolytic or sedative agents, because the concurrent use of or withdrawal from other substances can complicate the treatment of opioid withdrawal **[I]**. Anesthesia-assisted rapid opioid detoxification (AROD) is not recommended because of lack of proven efficacy and adverse risk-benefit ratios.

2. Pharmacologic Treatments

Maintenance treatment with methadone or buprenorphine is appropriate for patients with a prolonged history (>1 year) of opioid dependence **[I]**. The goals of treatment are to achieve a stable maintenance dose of opioid agonist and facilitate engagement in a comprehensive program of rehabilitation **[I]**. Maintenance treatment with naltrexone is an alternative strategy **[I]**, although the utility of this strategy is often limited by lack of patient adherence and low treatment retention.

3. Psychosocial Treatments

Psychosocial treatments are effective components of a comprehensive plan for patients with an opioid use disorder **[II]**. Behavioral therapies (e.g., contingency management) **[II]**, CBTs **[II]**, psychodynamic psychotherapy **[III]**, and group and family therapies **[III]** have been found to be effective for some patients with an opioid use disorder. Recommending regular participation in self-help groups may also be useful **[III]**.

Definition of the Three Categories of Endorsement

[I] Recommended with substantial clinical confidence.

[II] Recommended with moderate clinical confidence.

[III] May be recommended on the basis of individual circumstances.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated.

The evidence base for practice guidelines is derived from two sources: research studies and clinical consensus. Where gaps exist in the research data, evidence is derived from clinical consensus, obtained through extensive review of multiple drafts of each guideline. In addition, each reference at the end of the original guideline document is followed by a letter code in brackets that indicates the nature of the supporting evidence, as follows:

- **[A]** *Double-blind, randomized clinical trial.* A study of an intervention in which subjects are prospectively followed over time; there are treatment and control groups; subjects are randomly assigned to the two groups; both the subjects and the investigators are blind to the assignments.
- **[A-]** *Randomized clinical trial.* Same as above but not double-blind.
- **[B]** *Clinical trial.* A prospective study in which an intervention is made and the results of that intervention are tracked longitudinally; study does not meet standards for a randomized clinical trial.
- **[C]** *Cohort or longitudinal study.* A study in which subjects are prospectively followed over time without any specific intervention.
- **[D]** *Case-control study.* A study in which a group of patients is identified in the present and information about them is pursued retrospectively or backward in time.
- **[E]** *Review with secondary data analysis.* A structured analytic review of existing data, e.g., a meta-analysis or a decision analysis.
- **[F]** *Review.* A qualitative review and discussion of previously published literature without a quantitative synthesis of the data.
- **[G]** *Other.* Textbooks, expert opinion, case reports, and other reports not included above.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Treatment retention
- Substance use reduction or abstinence
- Reduction in the frequency and severity of substance use episodes
- Improvement in psychological, social, and adaptive functioning
- Relapse prevention

POTENTIAL HARMS

Side effects of pharmacological treatments (see the original guideline document for details) and potential for abuse of certain medications used in treatment

CONTRAINDICATIONS

CONTRAINDICATIONS

Contraindications to the use of clonidine include acute or chronic cardiac disorders, renal or metabolic disease, and moderate to severe hypotension.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

This guideline is not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all clinical data available for an individual patient and are subject to change as scientific knowledge and technology advance and practice patterns evolve. These

parameters of practice should be considered guidelines only. Adherence to them will not ensure a successful outcome for every individual, nor should they be interpreted as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgment regarding a particular clinical procedure or treatment plan must be made by the psychiatrist in light of the clinical data presented by the patient and the diagnostic and treatment options available.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Quick Reference Guides/Physician Guides

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Work Group on Substance Use Disorders, Kleber HD, Weiss RD, Anton RF, Rounsaville BJ, George TP, Strain EC, Greenfield SF, Ziedonis DM, Kosten TR, Hennessy G, O'Brien CP, Connery HS, American Psychiatric Association Steering Committee on Practice Guidelines, McIntyre JS, Charles SC, Anzia DJ, Ninninger JE, Cook IA, Summergrad P, Finnerty MT, Woods SM, Johnson BR, Yager J, Pyles R, Lurie L, Cross CD, Walker RD, Peele R, Barnovitz MA, Gray SH, Shemo JP, Saxena S, Tonnu T, Kunkle R, Albert AB, Fochtmann LJ, Hart C, Regier D. Treatment of patients with substance use disorders, second edition. American Psychiatric Association. *Am J Psychiatry* 2006 Aug;163(8 Suppl):5-82. [PubMed](#)

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1995 (revised 2006 Aug; reviewed 2007 Apr)

GUIDELINE DEVELOPER(S)

American Psychiatric Association - Medical Specialty Society

SOURCE(S) OF FUNDING

American Psychiatric Association (APA)

GUIDELINE COMMITTEE

Work Group on Substance Use Disorders
Steering Committee on Practice Guidelines

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Work Group Members: Herbert D. Kleber, MD (Chair); Roger D. Weiss, MD (Vice-Chair); Raymond F. Anton Jr., MD; Tony P. George, MD; Shelly F. Greenfield, MD, MPH; Thomas R. Kosten, MD; Charles P. O'Brien, MD, PhD; Bruce J. Rounsaville, MD; Eric C. Strain, MD; Douglas M. Ziedonis, MD; Grace Hennessy, MD (Consultant); Hilary Smith Connery, MD, PhD (Consultant)

Steering Committee on Practice Guidelines Members: John S. McIntyre, MD (Chair); Sara C. Charles, MD (Vice-Chair); Daniel J. Anzia, MD; Ian A. Cook, MD; Molly T. Finnerty, MD; Bradley R. Johnson, MD; James E. Nininger, MD; Paul Summergrad, MD; Sherwyn M. Woods, MD, Ph.D.; Joel Yager, MD

Area and Component Liaisons: Robert Pyles, MD (Area I); C. Deborah Cross, MD (Area II); Roger Peele, MD (Area III); Daniel J. Anzia, MD (Area IV); John P. D. Shemo, MD (Area V); Lawrence Lurie, MD (Area VI); R. Dale Walker, MD (Area VII); Mary Ann Barnovitz, MD; Sheila Hafter Gray, MD; Sunil Saxena, MD; Tina Tonnu, MD

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GUIDELINE STATUS

According to the guideline developer, this guideline is still considered to be current as of April 2007. A Guideline Watch, which summarizes significant developments in practice since the publication of the original guideline, was published in April 2007 and is available from the [American Psychiatric Association Web site](#) (see also the "Availability of Companion Documents" field below).

GUIDELINE AVAILABILITY

Electronic copies: Available from the [American Psychiatric Association \(APA\) Web site](#).

Print copies: Available from the American Psychiatric Press, Inc (APPI), 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901; (703) 907-7322; (800) 368-5777; fax (703) 907-1091

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Treating substance abuse disorders. Quick reference guide. Arlington, VA: APA, 2006 Aug. Electronic copies: Available in Portable Document Format (PDF) from the [American Psychiatric Association \(APA\) Web site](#).
- American Psychiatric Association practice guideline development process. Washington, DC: APA, 2006 May. Electronic copies: Available in Portable Document Format (PDF) from the [APA Web site](#).
- Connery HS, Kleber HD. Guideline watch (April 2007): practice guideline for the treatment of patients with substance use disorders, 2nd edition. Arlington (VA): American Psychiatric Association; 2007 Apr. 4 p. Electronic copies available in Portable Document Format (PDF) from the [American Psychiatric Association Web site](#).

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PATIENT RESOURCES

None available

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