



Health Net

Clinical Practice Guideline

Subject: Substance Use Disorder

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**This Clinical Practice Guideline is subject to the terms in the
IMPORTANT NOTICE
at the end of this document**

OVERVIEW

The National Survey on Drug Use and Health (NSDUH) for 2005 found that within the month^{1,4} prior to survey among Americans age 12 and over 6.6% (16 million people) reported heavy drinking, 34.6% (84 million people) were current tobacco users and 8.1% (19.7 million people) used illicit substances. The 2016 Survey reports that within the month prior to taking the survey 28.5 million people used illicit substances and 6.2 million misused prescription medication. National Institute of Alcohol Abuse and Alcoholism (NIAAA) released data from a 2012 survey of Americans 18 and older showing that 29% of women and 43% of men reported at least one episode of binge drinking (4+ drinks for women/ 5+ for men within 2 hours). 8% of men and 2.5% of women surveyed drank daily.³⁴ Alcohol was the fifth-leading risk factor for premature death and disability globally in 2010, according to data from NIAAA. Costs associated with just alcohol abuse in the US were \$223.5 billion in 2006. More than 70% of total costs were attributed to lost productivity. It is estimated that 15% of the U.S. workforce or about 19.2 million workers consume enough alcohol to lead to workplace impairment and 9% of them reported heavy use (defined as 5 or more drinks on same occasion on 5 or more days in the past 30 days). A 2011 estimate of Substance Use Disorders Costs to the American Economy is over \$700 billion.⁷ All health care professionals, therefore, are likely to come in contact with individuals who abuse or are dependent upon substances and are in a unique position to evaluate for these conditions and motivate patients to seek appropriate treatment interventions.

Despite the growing diversity of treatment options, however, only 14.6% of people with alcohol abuse or dependence receive treatment according to the data from the NIAAA's 2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions. In 2009, an estimated 7 million Americans were abusing prescription drugs, more than the number abusing cocaine, heroin, hallucinogens and inhalants combined. Emergency-room visits related to non-medical use of opioids rose 111% between 2004 and 2008. Between 1998 and 2008 the rate of opioid prescription misuse is estimated to have increased 400%. According to the National Institute of Drug Abuse (NIDA) young adults (age 18-25) are the biggest abusers of prescription opiate pain relievers, stimulants and anxiolytics. In 2010

almost 3000 young adults died (8 persons per day) as a result of prescription drug overdoses (mostly opiates) and that is more than overdoses with any other drug, including heroin and cocaine combined. Many more required emergency care (for every death due to Rx drug overdose, there were 17 treatment admissions and 66 emergency room visits). In the United States, drug overdose is now the leading cause of accidental death, as well as the leading cause of death in those under 50. According to CDC, drug-poisoning deaths involving opioids have quadrupled from 1999 (1.4/ 100000) to 2011 (5.4/100000). Benzodiazepines were involved in 31% of such poisonings in 2011 (a 13% increase from 1999).

DIAGNOSTIC CONSIDERATIONS

Substance Use Disorder

Substance use disorder is defined as a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems. These maladaptive pattern of behaviors leading at the minimum to **clinically significant impairment or distress**, as manifested by at least **two** of the following:



IMPAIRED CONTROL

- larger amounts taken or over a longer period than was originally intended
- persistent desire to cut down or regulate use and may report multiple unsuccessful efforts to decrease or discontinue use
- great deal of time to obtain, use or recovering from its effects

craving: defined as a manifestation by an intense desire or urge for the drug that may occur at any time but is more likely when in an environment where the drug previously was obtained or used

SOCIAL IMPAIRMENT

- Recurrent substance abuse resulting in a failure to fulfill major role obligations at work, school, or home
- Continued substance use despite persistent or recurrent social or interpersonal problems related to the substance.

Important social, occupational, or recreational activities may be given up or reduced because of substance use

RISKY USE

- Recurrent substance use in situations in which it is physically hazardous
- Failure to abstain from substances despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance

PHARMACOLOGICAL CRITERIA

- Tolerance – either requiring a markedly increased dose of the substance or the chemical group the substance belongs to, for achievement of desired effect or a markedly reduced effect when usual dose is used
- Withdrawal – a symptom cluster that occurs characteristic for that substance or the chemical group the substance belongs to, potentially requiring a similar chemical substance to be taken to relieve or avoid the withdrawal

SEVERITY and SPECIFIERS

*Based on a number of above symptom criteria, use as a general estimate to quantify severity:

- MILD- presence of two or three symptoms
- MODERATE- four or five symptoms
- SEVERE- six or more symptoms

Substance-Induced Disorders includes **Intoxication, Withdrawal** and **Other Substance/MEDICATION Induced Mental Disorders and medical complications.**

Substance Intoxication: Development of a reversible substance specific syndrome due to the recent use of a substance followed by:

- Psychological changes attributable to physiological effects of the substance on the Central Nervous System (CNS) such as disturbance in perception, wakefulness, attention, thinking, judgment, psychomotor activity and/ or interpersonal relatedness.
- Changes occur during or shortly after the use of the substance, and could not be readily explained by another mental disorder nor attributable to another medical condition.
- NOTE: This does not apply to tobacco.

Withdrawal: Physiological and psychological effects of cessation or reduction in heavier and prolonged use of a specific substance.

- Clinically significant distress that may be associate with impairment in social, occupational and/ or other areas of functioning.
- Symptoms could not be readily explained by another mental disorder nor attributable to another medical condition.

**Note: Tolerance and Withdrawal criteria do NOT count if it applies only to medication (opioids, sedatives, stimulants) taken under appropriate medical supervision*

Substance/Medication-Induced Mental Disorder: Potentially severe, usually temporary, but sometimes persisting CNS syndrome developing in the context of the effects of substances of abuse, medications or several toxins. All substance/medication-induced mental disorders may be induced by the 10 classes of substances use disorders or by variety of medications used in medical treatment. Common characteristics and features are described below:

Clinically significant symptomatic presentation of a relevant mental disorder.

Evidence from the history, physical examination, or laboratory findings of both of the following;

- Disorder developed during or within 1 month of substance intoxication or withdrawal or taking a medication; AND
- Involved substance/medication is capable of producing a mental disorder

Disorder is not better explained by an independent mental disorder which includes the following:

- The disorder preceded the onset or severe intoxication or withdrawal or exposure to the medication; OR
- The full mental disorder persisted for a substantial period of time (e.g. at least 1 month) after the cessation of acute withdrawal or severe intoxication or taking the medication or hallucinogen persisting perception disorder, which persist beyond the cessation of acute intoxication or withdrawal.

Delirium is not the cause

- Disorder causes clinically significant distress or impairment in social, occupational and/or other areas of functioning.

Assessment

Given the statistical data cited above, it is clear that patients of all ages should be screened for substance use.

When assessing for substance use disorders (SUD), it is important to ask very specific questions. Patients will often downplay their use of substances. Obtaining information from additional sources (family, employer, medical) can be helpful.

The following are factors that should be assessed to determine the severity of SUD and the appropriate level of care. (Nicotine dependence as a primary substance use disorder will be considered elsewhere.)

Include the following in the assessment:



- Primary substances of choice and method of administration
- Onset and history of use
- All current substances used, including prescriptions, over-the-counter medications and supplements, and substances obtained from illicit sources or over the Internet
- Level and pattern of current use
- History of attempts to stop or control use
- Psychosocial assessment, including current support systems
- Medical Examination to rule out comorbid medical conditions, including screening of blood, breath or urine for substances used

- Psychiatric Evaluation to rule out comorbid psychiatric conditions and potential consequences of drug use on cognition
- Evaluate readiness for change to establish motivation for treatment
- Risk of withdrawal syndrome
- Potential for abuse/violence
- Suicide potential
- Social, family, legal, and occupational problems related to substance use
- Family history of SUD
- Current stressors
- Consider the use of assessment tools such as the CAGE, AUDIT, TWEAK and/or MAST and Opioid Risk Tool (ORT) for adults and the CRAAFT for adolescents (links to these tools can be found in the "Resources for Professionals" section)

SUBSTANCE USE DISORDERS

Treatment Interventions

General Considerations

When selecting a treatment program:



- If the patient has managed care benefits through MHN, call MHN to coordinate referral. If not, coordinate with the patient's insurance carrier or community programs.
- Programs should encourage each patient to create and manage an individualized recovery plan consistent with the program's treatment planning. This should include a broad spectrum of services, lab and toxicology screening, and pharmacotherapy for withdrawal syndromes, comorbid psychiatric and medical conditions and to assist in maintaining abstinence and building an adequate sober support system.
- Adolescents should be treated in programs specifically designed for that population.
- Consider issues of cultural diversity.
- Programs for all levels of care should stress abstinence and promote a 12-step facilitation (TSF) or other self-help or mutual-help groups (MHGs) orientation.
- It is generally preferable to select a program in the patient's community in order to foster the participation of family or other true personal social supports in treatment, to facilitate discharge planning

and the transition back to the community, and to develop the patient's support system.

■ Programs should start early in treatment to document preparation of referral to effective aftercare programs.

Level of care Considerations:



■ When making referral decisions, refer to the least restrictive level of care likely to be effective⁴.

■ Refer to a **23-hour Bed Observation** when the emerging clinical picture points toward high risks in the context of acute intoxication.

■ Refer to inpatient **detoxification programs** or specialists if there is likelihood of severe withdrawal. While detoxification can be performed in either an inpatient or outpatient setting, patients presenting with medical complications, or a history of organ failure, seizures or delirium tremens, comorbid psychiatric problems, or lack of availability of outpatient detoxification programs would typically necessitate more specialized inpatient detoxification.

- Uncomplicated alcohol and sedative/hypnotic detoxification can generally be accomplished in 2-3 days in an inpatient setting, while more complex detoxification may require 3-5 days.
- Uncomplicated opiate detoxification can generally be accomplished in 3-6 days in an inpatient setting.

■ Refer to **acute inpatient dual diagnosis treatment**, when there is evidence for immediate behavioral safety risk with emergence of a more complex acute psychiatric picture or potential safety risks of psychiatric complications associated with severe impairment in relationships and social role performance. These services can also be employed in case of the acute emergence of a suspected Substance-Induced Mental Disorder.

■ Refer to **acute inpatient rehabilitation programs** when SUD is severe enough to markedly interfere with daily functioning, the patient is not in acute withdrawal, **and** there is medical or psychiatric comorbidity that would interfere with treatment.

■ Refer to **residential treatment** (if covered by benefit structure) when the pattern of SUD is

- severe enough to markedly interfere with functioning and active use could not be stopped outside of a contained environment
- there is no need for acute detoxification
- there is documented evidence of treatment failure at Partial Hospitalization or structured Intensive Outpatient SUD treatment programs despite evidence of active and consistent participation
- history is suggestive that there is a high likelihood of imminent relapse that would place the patient at serious risk of harm if

treated in a less restrictive setting (e.g., no impulse control, comorbid psychiatric complications).

- Refer to **partial hospital treatment** when SUD markedly interferes with functioning **and** the patient needs daily structured treatment and medical supervision for 4 or more hours daily and there is otherwise a home environment that is supportive and conducive to recovery.
- Refer to a **structured intensive outpatient program** when there is significant interference with functioning, no need for acute detoxification, and the patient requires structured intervention for up to 3 hours a day and the recovery environment is sufficiently supportive not to require a higher level of care.
- Individual or group **outpatient treatment** by a therapist credentialed or experienced in SUD treatment using established protocols can be effective if the therapist focuses on abstinence and recovery, incorporates educational techniques and motivational enhancement and promotes active participation in community self-help, MHGs and TSF or other proven forms of recovery.
- **Brief intervention** is effective for patients who abuse substances, but are not substance dependent. Several brief intervention approaches have been identified, including relapse-prevention groups, self-efficacy, motivational enhancement, collaborative, solution-focused, cognitive behavioral, strategic counseling approaches or Internet-based videoconferencing. All share such characteristics as using the simplest, most immediate intervention, integrating the diagnostic process into the intervention activity, and connecting the patient with needed resources including community self-help groups. Emerging technologies are being put to use, such as Alcohol-Comprehensive Health Enhancement Support System (A-CHESS), which uses smartphones to provide information, adherence strategies, decision-making tools, reminders, and social support services in easy –to-use format, and can be downloaded as a smartphone application <https://www.chess.health/>

Recovery from substance use disorders is a long-term process and frequently involves multiples episodes of treatment.

Critical elements of treatment include:



- The **goal of treatment is abstinence** from all substances of abuse.
- A strong **therapeutic alliance** is an important factor in achieving successful treatment.
- **Motivating the client** to seek and/or continue treatment. Make every effort to ensure that patients with SUD:
 - **Initiate** treatment: Receive a second addiction-related outpatient service within 3-14 days of an initial assessment
 - **Engage** in treatment: Receive at least 2 or more addiction-related services within 30 days of initiation of discharge from substance related inpatient admission
- **Developing and facilitating adherence** to a highly individualized treatment plan that addresses relapse and emphasizes available preventive mechanisms. **Individual patients should be encouraged to take full**

responsibility and ownership of their treatment plan.

An individual's treatment plan must be assessed continually and modified as necessary to ensure that it meets the person's changing needs. To this end, treatment facilities should encourage patients to complete daily written recovery assignments that are tailored onto their specific life issues and stress triggers. There should be concerted efforts devoted to seeking and securing adequate sober living arrangements from the beginning of treatment and aftercare plans should be developed and adjusted all throughout treatment.

- Identification of comorbid medical conditions with referral to appropriate treatment providers while encouraging coordination of care.

- Treatment for comorbid psychiatric conditions (dual diagnosis) while encouraging coordination of care.

- Education about the causes and course of SUD, the need for abstinence, relapse triggers, available treatments, and role of family and friends.

- Relapse prevention strategies.

- Family education and counseling and referral to self-help community support groups for family members.

- Coordination of treatment with other healthcare providers, the legal system, EAP and other resources as appropriate.

- Referral to community resources such as self-help groups or MHGs.

- Consideration of referral for family treatment to deal with effects of substance abuse.

- Follow-up after discharge from treatment at each level of care to encourage consistency with treatment plan recommendations.

- Research on addiction indicates that, in general, adequate participation in treatment is essential to effectiveness and longer participation in recovery programs leads to better outcomes.

Specific treatments:

Pharmacological treatments (evidence-based)

- Medications to treat intoxication and withdrawal states; Medications used primarily to treat intoxication and withdrawal states will require consistent use of withdrawal measuring scales (CIWA-Ar, CIWA-B, COWS) to evaluate severity of withdrawal signs and symptoms and determine appropriate taper of substitution meds:

Opioid Detox Protocols

- a. Using opioid substitution:
 - Buprenorphine
 - Methadone
 - Other opioids
- b. Using clonidine

Alcohol Detox Protocols:

- a. Using benzodiazepine substitution
- b. Using phenobarbital substitution
- c. Using anticonvulsants meds (gabapentin, carbamazepine)

Sedative-Hypnotics Detox Protocols:

- a. Using phenobarbital substitution
- b. Using clonazepam substitution
- c. Using other benzodiazepine substitution.

- Medications to decrease urges or cravings of abused substances:
 - Alcohol
 - Acamprosate: 666mg TID; this should be offered as part of the SUD treatment recommendation to all alcoholic patients reporting cravings >3/10 as soon as they have completed Detox and throughout their SUD treatment stages for as long as they experience cravings.
- Medications to decrease the reinforcing effects of abused substances:
 - Alcohol
 - Naltrexone: usual daily dose is 50mg; this should be offered as part of the SUD treatment recommendation to all alcoholic patients reporting ongoing cravings and showing early recovery impaired coping skills, living and or working in triggering settings and longing for the alcohol high.
 - Naltrexone depot IM (Vivitrol): 380mg IM every 4 weeks; this should be offered to the same patients as noted above after they have shown good tolerance to Naltrexone PO and continue to be considered at high risk for relapse.
 - Opiates
 - Naltrexone: must be opioid free 5-7 days; this should be offered as part of the SUD treatment recommendation to all opioid use disorder patients reporting ongoing cravings and showing early recovery impaired coping skills, living and or working in triggering settings and longing for the opioid high.
 - Naltrexone depot IM (Vivitrol): 380mg IM every 4 weeks; this should be offered to the same patients as noted above after they have shown good tolerance to Naltrexone PO and continue to be considered at high risk for relapse.
- Agonist or mixed agonist/ antagonist maintenance therapies:
 - Opiates
 - Methadone: 40mg/day – 60mg/day (sometimes even less) of methadone is usually sufficient to block opioid withdrawal symptoms. Higher doses (80-120mg/ day) have been shown to curb dramatically additional use of opioids.
 - Buprenorphine: used only in an inpatient or controlled setting
 - Buprenorphine/naloxone combination (ranging between 4mg/0.5mg – 32mg/8mg per day, sublingual in divided doses). Doses used more frequently in the outpatient ambulatory setting include 16mg/4mg per day sublingual or less and typically require monthly visits for renewal as well

as continued participation in SUD treatment or recovery community support systems

- Abstinence-promoting and relapse prevention therapies:
 - Alcohol
 - Disulfiram: usual dose 250mg/day, rarely: 125mg/day – 500mg/day (potentially aversive if used with alcohol). This medication can be helpful in those patients who have a track record consistent with frequent relapse and inability to maintain abstinence for an extended period of time. Breathalyzer testing to assure compliance and continued abstinence and liver function tests should be checked periodically.

Evaluating Pain Patients for Risk of Opioid Abuse or Dependence and Pain Management Treatment Recommendations

- Refer patient to a Pain Management Specialist, if available
- Use the concept of “universal precautions,” implying that any patient in pain could develop a drug misuse problem
- Use Tools for Patient Risk Assessment such as Opioid Risk Tool (ORT) or Screener and Opioid Assessment for Patients with Pain (SOAPP-R), links in the reference section below
- Use written agreements encompassing the full range of patient’s care, starting with assessments, informed consent (including benefits and risks, clarifying the physician’s and patient’s realistic expectations, roles and responsibilities, treatment termination contingencies), treatment plan, and outlined best practices in working out a clear understanding of how treatment works, that should be preferably shared with the patient, the patient’s family and other clinicians involved in the patient’s care. Opioid treatment agreements are a standard of care when prescribing long-term opioid therapy.
- Creating Function-based Realistic Measurable Goals Opioid Treatment Plans
- Follow the FDA Blueprint for Prescriber Education to refresh latest knowledge on opioid products and drug interactions (<http://www.er-la-opioidrems.com>)
- Build into the treatment protocol periodic Progress Review against the agreed Goals and Monitor Adherence (including drug testing where possible) and use Prescription Drug Monitoring Programs where available.

Psychosocial Treatments

- Cognitive-behavioral therapies (e.g. relapse prevention, social skills training)
- Motivational Enhancement Therapy (MET is a short term intervention, usually 3-5 sessions as per the Patient Placement Criteria 2-Revision (PPC-2R), and it is not a general method of trying to convince someone to engage.
- Behavioral therapies (e.g. community reinforcement, contingency management)
- Group therapy
- Twelve-step facilitation
- Interpersonal therapy
- Family/Marital therapy
- Brief therapies (A-FRAMES model)
 - **A**ssessment
 - Providing objective **F**eedback
 - Emphasizing that the **R**esponsibility for change belongs to the patient
 - Giving clear **A**dvice about the benefits of change
 - Providing a **M**enu of options for treatment
 - Using **E**mpathic listening
 - Emphasizing and encouraging **S**elf-efficacy

- Self-guided therapies (for heavy users of legal substances who do not yet meet criteria for an SUD)
 - Manual-guided self-help programs
 - Manual-guided therapies with a clinician
 - Computer-guided programs on the Internet
- Internet-based videoconferencing
 - Allows patients to participate from their own homes
 - Manual-guided therapies with a clinician
 - Preferred due to convenience and increased confidentiality

Tobacco Use Disorder

- Tobacco use is common in patients with other substance use and psychiatric disorders, as well as medical conditions
- Clinicians in all treatment settings should identify smokers and smokeless tobacco users and be prepared to offer them motivational interventions to encourage them to quit
- Patients who are hospitalized in smoke-free environments need to be
 - assessed and treated for tobacco withdrawal
 - provided education about the rationale for the smoke-free unit
 - educated about the goal of smoking cessation and, if the patient is interested, helped to begin a cessation program
- Assessment should include
 - The current level of tobacco use (e.g., number of cigarettes per day)
 - The degree of nicotine dependence (consider using the CAGE and the Fagerstrom Test for Nicotine Dependence to establish this)
<http://www.aafp.org/afp/20000801/579.html>
 - The patient's motivation(s) for quitting
 - Questions about past attempts to quit, duration of any periods of abstinence, factors that undermined abstinence, the patient's fears about quitting (e.g., weight gain, another failure) and barriers to another attempt
- The treatment of Tobacco Use Disorders differs from that of other substance dependencies in several ways:
 - A specific "quit date" is usually set in advance of stopping use
 - Nicotine-dependent patients generally do not experience substantial occupational problems due to use
 - There is a decreased need for family involvement, unless there are other smokers in the home
 - Effective over-the-counter medication treatments are available
- Pharmacological treatments
 - Should be offered to all patients who wish to stop smoking
 - Are often effective even when no psychosocial treatment is provided
 - Include
 - Nicotine replacement therapy, or NRT: gum, patch, lozenge, nasal spray, inhaler
 - Bupropion: 150 mg/day starting one week prior to quit date, increase to 150 mg bid after 3-4 days
 - Varenicline: 0.5 mg days 1-3, 0,5 mg bid days 4-7, then 1 mg/day for 12 weeks⁷
- Psychosocial treatments
 - Social support (spouse, partner, buddy system) is recommended
 - Brief therapies such as behavioral supportive cessation counseling
 - Include elements of Motivational Enhancement Therapy

- Encourage patients to examine reasons for and against quitting tobacco use
- Can be successfully and economically implemented in a broad range of healthcare settings
- May lead to a greater likelihood of success in smoking cessation
- Behavioral therapies
- Cognitive-behavioral therapies, particularly for patients with comorbid depressive symptoms, Major Depression and other substance use disorders
- Self-guided therapies such as those mentioned in the previous section as well as
 - Community support groups
 - Telephonic counseling
- The use of multiple modes of therapy such as written materials plus phone contact improves the effectiveness of self-help methods
- There is insufficient data to support the use of 12-step programs, hypnosis, biofeedback, family therapy, interpersonal therapy and psychodynamic therapies in the treatment of nicotine dependence

Resources for Patients:

- National Institute on Drug Abuse
<http://www.drugabuse.gov/Infofacts/Infofaxindex.html>
- National Institute on Alcohol Abuse and Alcoholism: <http://www.niaaa.nih.gov/>
- American Lung Association Freedom from Smoking Program:
<http://www.freedomfromsmoking.org/>
- Patient Counseling Document on Extended-Release Long-Acting Opioid Analgesics:
<http://dailymed.nlm.nih.gov>
- Self-help groups can be located via the Internet or by looking in the telephone book. There are Twelve Step programs for alcoholics as well as specific groups for those who use marijuana, cocaine or narcotics. These should be searched for using the specific substance for which self-help is being sought (e.g. "alcoholics anonymous" or "narcotics anonymous"). In addition to Twelve Step programs, there are other non-twelve step groups such as Women for Sobriety, Secular Organizations for Sobriety (SOS) and Self-Management and Recovery Training (SMART) for those individual for whom the Twelve Step approach is not appropriate. It should be noted, however, that the non-Twelve Step programs are not nearly as widely available as their Twelve-Step counterparts.

Web Resources for Professionals:

- SAMHSA: <https://www.samhsa.gov/medication-assisted-treatment>
- <https://knowledge.samhsa.gov/ta-centers/medication-assisted-treatment>
- <https://www.samhsa.gov/medication-assisted-treatment/training-resources/support-organizations>
- Opiate Risk Tool (ORT):
<https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf>
- Screener and Opioid Assessment for Patients with Pain, version I, Revised (SOAPP-R): <http://www.inflexxion.com/SOAPP/>
- FDA Opioid Blueprint for Prescriber Education: <http://www.er-la-opioidrems.com>
- American Academy of Pain Medicine: www.painmed.org
- National Institute of Drug Abuse
<https://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction>
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- Centers for Disease Control and Prevention: NCHS Data Brief. Drug-poisonings Deaths Involving Opioid Analgesics: United States 1999-2011.
<http://www.cdc.gov/nchs/data/databriefs/db166.htm>
- American Psychiatric Association Practice Guidelines:
<http://ps.psychiatryonline.org/doi/abs/10.1176/ps.46.11.1202>
- American Psychiatric Association Practice Guidelines: Guideline Watch: Practice Guideline for the Treatment of Patients With Substance Use Disorders, 2nd Edition Updates, 2007
<http://focus.psychiatryonline.org/doi/abs/10.1176/foc.5.2.foc163?journalCode=foc>
- DSM-5 Criteria for Substance Use Disorders: Recommendations and Rationale at
<http://ajp.psychiatryonline.org/doi/abs/10.1176/appi.ajp.2013.12060782?journalCode=ajp>

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References

1. Results from the 2005 and 2016 National Survey on Drug Use and Health: National Findings. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies
2. American Psychiatric Association (2013), *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Text Revision*. Washington, D.C., American Psychiatric Association Press.
3. American Psychiatric Association (2006). *Practice Guideline for the Treatment of Patients with Substance Use Disorders, 2nd Edition*. American Journal of Psychiatry, Vol. 163, No. 8.
4. Mee-Lee, D., Shulman, G.D., Fishman, M., Gastfriend, D.R., & Griffith J.H. (2001). ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (ASAM PPC-2R). Chevy Chase, MD: American Society of Addiction Medicine, Inc
5. Parrino, MW. State Methadone Treatment Guidelines: Treatment Improvement Protocol 1. Center for Substance Abuse Treatment; U.S. Department of Health & Human Services, 47-58.

6. Hales, R.E., Bourgeois, J.A., Shahrokh, N.C., & Gallanter, M. (2008). Study Guide to Substance Abuse Treatment: A Companion to The American Psychiatric Publishing Textbook of Substance Abuse Treatment, Fourth Edition.
7. National Drug Intelligence Center. National Drug Threat Assessment. Washington, DC: United States Department of Justice; 2011. www.justice.gov/archive/ndic/pubs44/44849/44849p.pdf

Additional References

1. Brief intervention for alcohol problems. Alcohol Alert, No. 43, 1999.
2. McCoffrey, B.R. Protocol effectiveness Study. *Journal of Substance Abuse Treatment*, 13(4) 295-319. 1996.
3. Miller, W.R. & Brown, S.A. Why psychologists should treat alcohol and drug problems. *American Psychologist*, 1997, 52 (12) 1269-1279.
4. National Community Mental Healthcare Council. *Preferred Clinical Practices Guide of Behavioral Health Network of Vermont*. National Community Mental Healthcare Council, 1995
5. National Institute of Drug Abuse, Principles on Drug Addiction Treatment: A research-based guide, 2002.
6. NIDA NOTES. Adolescent Treatment Programs reduce drug abuse, produce others improvements, 17(1), 2002.
7. Pacione, T. Using Clinical Guidelines to enhance the value of chemical dependency treatment in managed care setting in the *Complete Guide to Managed Behavioral Healthcare*, John Wiley & Sons, N.Y., I.L. 3-9, 1997.
8. Petry, N.M. & Bickel, W.K. The Brown University Digest of Addiction Theory & Application, 18(7), 1-2, 1999.
9. Treatment methods, NIDA Infobox, 13559, 1999.
10. Whittinghill, D., Rudenga, L., & Loesch, L. The benefits of a self-efficacy approach to substance abuse counseling in the era of managed care. *Journal of Addictions and Offender Counseling*, 20(2), 64-75, 2000.
11. King, V.L., Stoiler, K.B., et al. Assessing the Effectiveness of an Internet-Based Videoconferencing Platform for Delivering Intensified Substance Abuse Counseling. *Journal of Substance Abuse Treatment*, 36, 331-338, 2009.
12. Adamson, S.J., Sellman, J.D., & Frampton, C.M.A. Patient Predictors of Alcohol Treatment Outcome: A Systematic Review. *Journal of Substance Abuse Treatment*, 36, 75-86, 2009.
13. Orford, J., Hodgson, R. et al. To What Factors do Clients Attribute Change? Content Analysis of Follow-up Interviews with Clients of the UK Alcohol Treatment Trial. *Journal of Substance Abuse Treatment*, 36, 49-58, 2009.
14. Huebner, R.B. and Kantor, L.W. Advances in Alcoholism Treatment. *Alcohol Research & Health* 33(4):295-299, 2011.
15. Moos, R.H. & Moos, B.S. Participation in Treatment and Alcoholics Anonymous: A 16-year follow-up of initially untreated individuals. *Journal of Clinical Psychology* 62(6):735-750, 2005.
16. Cunningham, J.A., Kypros, K. and McCambridge, J. The use of emerging technologies in alcoholism treatment. *Alcohol Research & Health* 33(4):320-326, 2011.
17. Gustavson, D.H., Boyle, M.G., et al. Focus on E-Health Solutions: An E-Health Solution for People with Alcohol Problems. *Alcohol Research & Health* 33(4):327-337, 2011.
18. Monteiro, M.G.: The Road to a World Health Organization Global Strategy for Reducing the Harmful Effects of Alcohol. *Alcohol Research & Health* 34(2)257-260, 2011.
19. Bouchery, E.E., Harwood, H.J. & Brewer, R.D. Economic Costs of Alcohol Consumption in the US. *American Journal of Preventive Medicine* 41(5) 516-524, 2011.
20. Ames, G.M. & Bennett, J.B. Prevention Interventions of Alcohol Problems in the Workplace: A review and Guiding Framework. *Alcohol Research & Health* 34(2)175-187, 2011.
21. Gorsane MA et al. Is baclofen a revolutionary medication in alcohol addiction management? Review and recent updates. *Subst Abus.* 33(4):336-49, 2012.

22. Cooper E, & Vernon J. The effectiveness of pharmacological approaches in the treatment of alcohol withdrawal syndrome (AWS): a literature review. *J Psychiatr Ment Health Nurs.* 2012 Sep 18. doi: 10.1111/j.1365-2850, 2012.
23. Noori HR, Spanagel R, Hansson AC. Neurocircuitry for modeling drug effects. *Addict Biol.* 17(5):827-64. doi: 10.1111/j.1369-1600, 2012.
24. Zeinali A et al. The mediational pathway among parenting styles, attachment styles and self-regulation with addiction susceptibility of adolescents. *J Res Med Sci.* 16(9):1105-21, 2011.
25. Parker A.J., The appropriate use of opiates in chronic pain. *J Clin Psychiatry.*73(8):e26, 2012.
26. Aklin WM et al., Risk-taking propensity as a predictor of induction onto naltrexone treatment for opioid dependence. *J Clin Psychiatry.* 73(8):e1056-61, 2012.
27. Results from the NIAAA's Laboratory of Epidemiology and Biometrics, waves 1 and 2 NESARC Surveys, 2012 <http://www.niaaa.nih.gov/about-niaaa/our-work/advisory-council/directors-reports-council/directors-report-institute-1NIDA> statistics: <http://www.drugabuse.gov/related-topics/trends-statistics/infographics/abuse-prescription-rx-drugs-affects-young-adults-most>
28. Quintero GC. Role of nucleus accumbens glutamatergic plasticity in drug addiction. *Neuropsychiatr Dis Treat.* 2013;9:1499-1512. Epub 2013 Sep 30.
29. Deborah S. Hasin,, Charles P. O'Brien, Marc Auriacombe, et al.: DSM-5 Criteria for Substance Use Disorders – Recommendations and Rationale. *American Journal of Psychiatry,* 170:8, 834-851, 2013

Important reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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