BEHAVORIAL HEALTH DEPARTMENT – PRIMARY CARE CENTER AND FIREWEED
TREATMENT GUIDELINES FOR

ALCOHOL AND OTHER SUBSTANCE ABUSE

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Executive Summary

Introduction and statement of Intent

This treatment guideline is intended to assist clinicians in the Behavioral Health department in treatment planning and service delivery for patients with Alcohol or other substance abuse or dependence. It may also assist clinicians treating patients who have some overuse or misuse of alcohol or drugs, but who do not meet the full criteria substance abuse or dependence. The treatment guideline is not intended to cover every aspect of clinical practice, but to focus specifically on the treatment models and modalities that clinicians in our outpatient treatment setting could provide. These guidelines were developed through a process of literature review and discussion amongst clinicians in the Behavioral Health department and represent a consensus recommendation for service provision for this disorder. The guideline is intended to inform both clinical and administrative practices with the explicit goals of outlining treatment that is: effective, efficient, culturally relevant and acceptable to clinicians, program managers, and patients

Definition of Disorder

Because problems with alcohol and other intoxicants have been so pervasive over time, and approached from so many points of view, there are many different definitions of misuse, abuse, addiction and dependence. DSM-IV-TR criteria for abuse and dependence are outlined in the tables below and are generally used in mental health settings such as ours. Specialized substance abuse treatment facilities often use ASAM criteria for assessment, and self-help groups such as AA have their own definitions as well. Most diagnostic systems and theories of substance abuse and addiction recognize some aspect of use despite negative consequences, and a lack of control over use. Most recognize the need for some combination of biological, psychological, social and environmental approaches the treatment and recovery.

Table: DSM-IV TR Substance Abuse:

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
   - recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g. repeated substances or poor work performance related to substance use; substance related absences, suspensions, or expulsions from school; neglect of children or household)
   - recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)
   - recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)
   - continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g. arguments with spouse about consequences of intoxication, physical fights)

B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

The DSM-IV TR substance dependence:

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

A. tolerance, as defined by either of the following:
   - a need for markedly increased amounts of the substance to achieve intoxication or desired effect
   - markedly diminished effect with continued use of the same amount of the substance

B. withdrawal, as manifested by either of the following:
   - the characteristic withdrawal syndrome for the substance
   - the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

C. the substance is often taken in larger amounts or over a longer period than was intended
D. 40 there is a persistent desire or unsuccessful efforts to cut down or control substance use
E. A great deal of time is spent in activities necessary to obtain the substance (e.g. visiting multiple doctors or driving long distances), use the substance (e.g. chain smoking), or recover from its effects
F. Important social, occupational, or recreational activities are given up or reduced because of substance use
G. The substance use I continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (.e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption.

General Goals of Treatment

As with treatment of all psychiatric illnesses, the goals of treatment are to reduce or eliminate symptoms and to restore function. For alcohol abuse and dependence, remission means no use of alcohol for 12 or more months. Recovery is a less measurable and more personal goal or process that acknowledges the constant threat of relapse, but also the capacity of people to move forward in their lives, and to engage in activities and roles they may have lost to drugs or alcohol, such as parenting, or employment. It often includes a spiritual aspect, where patients describe feeling more aware and attuned to the people and things around them, to their own strengths and weaknesses and to their source of faith, morality, or purpose. The focus of treatment is often on the elimination of symptoms such as urges to drink, and on learning and using skills that will help a person avoid relapse. However these treatments should be seen in a greater context of recovery. Interventions that are not tailored to an individual's stage of change or recovery cannot be expected to succeed.

Summary of 1st, 2nd and 3rd line treatment

As with many disorders, the first line of treatment often depends on severity and the presense or absence of other problems, rather than simply on diagnosis. This makes a rank ordered list of treatments challenging. However, psychosocial and environmental interventions are usually first line, with medication usually reserved for those at risk of complications from withdrawal, or with multiple failed efforts to remain abstinent and high levels of craving. For example, group psychotherapy combined with avoidance of people and places associated with substance use is often the first intervention.

Approaches for patients who do not respond to initial treatment

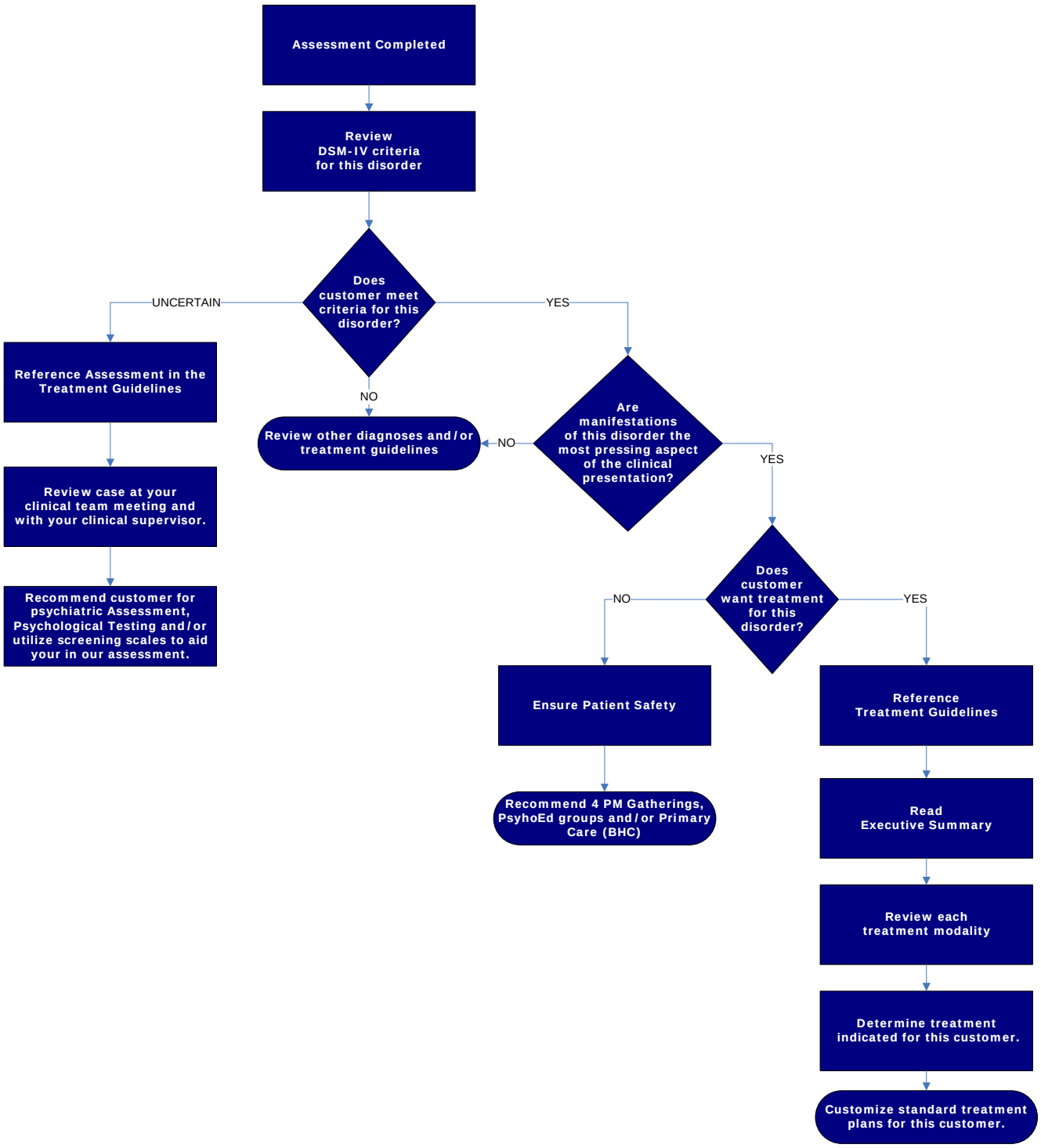
Adding medication, trying non-traditional strategies, that ironically may be more traditional…

Clinical and demographic issues that influence treatment planning

The purpose of this guideline is not to describe all of the aspects of a person that go into creating an individualized approach to recovery from substance abuse or dependence. But some general issues include age and gender matching to form a more supportive or uniform peer group.

Summarize clinical or demographic issues that influence treatment planning (such as age, gender, culture, common co-morbidity, past history or aggression towards self or others)

Flow Diagram



Assessment

The Diagnostic Testing team will be reviewing and commenting on the Psychological Testing column for every disorder.

	Psychiatric Assessment	Psychological Testing	Screening/Scales
Indications	▪ Diagnostic dilemma or clarification of co-morbidity ▪ Unmanageable behavior or other symptoms that have not improved with standard interventions ▪ Patient is already on psychotropic medication and is requesting continuation ▪ Cravings for alcohol or opiates are prominent, suggesting treatment with an agent that lessens or blocks cravings might be helpful ▪ Rule out organic cause and/or contributions to symptoms	▪ Diagnostic clarification following assessment by PCP or ANP. ▪ Question only answerable by psychological testing ▪ Appropriate physical assessment completed	• Establish baseline and/or monitor treatment effectiveness • Clarify symptoms • Urine Toxocology
Contraindications	▪ Diagnosed severe cognitive disorder or developmental delay and collateral source not available ▪ Consent not available (if patient has guardian) ▪ Patient or guardian has forensic rather than therapeutic goal (i.e. compliance with court or parole requirements, disability determination, etc.)	▪ Extremely dangerous to self and/or others ▪ Untreated psychosis ▪ Initial evaluation / assessment is not done ▪ Referral question not answerable and/or not clear ▪ Any physical causes of the disorder have not been ruled out ▪ Attention span inadequate ▪ School or other source has already conducted psychological testing within the last year ▪ Severely depressed	▪ Limited English proficiency. ▪ Attention span inadequate ▪ Lack of cooperation
Structure	In patients with cognitive impairment who cannot give adequate history, parent or guardian with knowledge of the patient's history must be available for assessment.	▪ Depends on the referral question	▪ Self-administered for adults and adolescents ▪ Completed by Parent and/or care giver for children or incompetent adults. ▪ CAGE, SASSI, Obsessive Compulsive Drinking Scale

Modalities & Treatment Models

Group Therapy

Please refer to the Psychoeducational Groups and/or Referral section of this guideline. Also reference the Dual Diagnosis treatment guidelines documented for this modality.

Individual Therapy

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
• Group therapy contraindicated • Sufficient verbal and/or cognitive ability to benefit from treatment • Moderate to Severe severity • Unable to tolerate affect without behavior destructive to group ▪ Customer is 3 years old or older • Recent sexual, physical, abuse and/or neglect • For customers under 18 years old, parental education and involvement is predictive of good outcome and should be integrated whenever possible. • SBIRT screening tool tested positive for brief intervention and/or brief therapy.	▪ Imminent dangerousness to self or others ▪ Lack of commitment from customer and if customer not competent, lack of commitment from parent and/or legal guardian ▪ Court ordered treatment with no buy in from child and/or guardian ▪ Child abuse investigation incomplete ▪ Untreated Psychosis or mania ▪ Acute intoxication or withdrawal from alcohol or other substances	

STRUCTURE

Duration	60 minutes
Frequency	▪ Weekly ▪ Up to 11 sessions for treatment

TREATMENT MODEL

Not reviewed. BHS clinicians are receiving additional training in Motivational Enhancement, one of several therapeutic models with evidence of effectiveness. Moral Recognition and Cognitive Behavioral Therapy also have evidence based and may be practical in our outpatient setting. Additional program development or linkage to other services is needed in this area.

Family Therapy / Couples Therapy

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ First line of treatment for 0 to 5 year old ▪ Disorder is impacting the family and/or relationship ▪ Family dynamic exacerbating or triggering symptoms ▪ Sufficient verbal and/or cognitive ability to benefit from treatment ▪ No buy-in to group and/or individual therapy ▪ For customers under 18 years old, parental education and involvement is predictive of good outcome and should be integrated whenever possible. ▪ Concurrent with group and/or individual treatment for children or adults with severe mental illness	▪ Imminent dangerousness to self or others ▪ Lack of commitment from customer and if customer not competent, lack of commitment from parent and/or legal guardian ▪ Court ordered treatment with no buy in from child and/or guardian ▪ Child abuse investigation incomplete ▪ Current Domestic violence or abuse of child ▪ Custody dispute ▪ Untreated Psychosis ▪ Acute intoxication or withdrawal from alcohol or other substances	

STRUCTURE

Duration	60 minutes
Frequency	▪ Weekly or Twice a Month ▪ Up to 8 sessions for treatment

TREATMENT MODEL

CBT, IPT, SFT

A good model for couples willing to address alcohol issues is alcohol behavioral couples therapy. The reader is referred to “Couples Therapy in the Treatment of Alcohol Problems” in the book Clinical Handbook for Couples Therapy, 3rd edition, edited by Alan Gurman and Neil Jacobson.

Individual Medication Management

There are no empirically validated pharmacological interventions for Alcohol & Other Subatnce Abuse for customers up to 17 years old.

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
• Customer is over 17 years old • Parent and/or legal guardian consent • Current biopsychosocial intake or psychiatric assessment is available.	▪ Refuses Medication Management ▪ Disorder is caused by an untreated physiological disorder. ▪ Acute intoxication or withdrawal from alcohol or other substances	▪ Documented history of medication non-compliance ▪ Benzodiazepines should be used with caution in patients with a history of substance abuse and dependence.

STRUCTURE

Duration	30 minutes
Frequency	Monthly

There is insufficient evidence on which to make clear recommendations for the duration of pharmacotherapy in this disorder. General Treatment at this time is probably 6-12 months beyond resolution of symptoms, and indefinitely if symptoms have improved but not resolved, or have returned when the drug is discontinued.

Most medications must be taken daily, some more frequently. Follow up appointments or phone check within 2 weeks of initiation of treatment is usually recommended. Minimum frequency of visits is every 3 months to ensure continued benefit and safety.

TREATMENT MODEL

Recommended concurrent with psychotherapy and/or psychoeducation.

Group Medication Management

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ Alcohol dependence and/or Opiate dependence ▪ Cravings for Alcohol or opiates that might benefit from pharmacologic treatment targeting these symptoms ▪ Motivated for treatment -Must be willing to engage in treatment plan -At minimum must attend Alcoholics Anonymous or other self-help support groups with sponsor ▪ Able to tolerate affect without behavior destructive to group	▪ Acute dangerousness to self or others ▪ Untreated psychosis ▪ Sexually acting out behaviors ▪ Severe untreated hyperactivity ▪ Acute intoxication or withdrawal from alcohol or other substances ▪ Refuses Medications ▪ Adverse reaction to Naltrexone in the past (consider Antabuse) ▪ Cannot be actively using opiates ▪ Inability to communicate and/or interact ▪ History of extreme disruptive behavior in groups ▪ Liver enzymes are 3 times the normal level or has/had liver failure or acute hepatitis	• Diagnosis social phobia (May need individual therapy for group preparation) • Relatives or significant others in the same group • No child care available • Pregnant • Customers with elevated liver enzymes

STRUCTURE

Duration	Three to four months is typical duration of treatment. Reasons for extension or continuation beyond that include: - Refractory cases - Still experiencing craving - Court ordered - Patient anticipates upcoming events when cravings likely
Frequency	Monthly, 60-90 minutes
Size	4-6 customers
Open vs. Closed	Open

TREATMENT MODEL

At present, Behavioral Health offers naltrexone to appropriate customers in a group setting. Antabuse is also on formulary. Acamprosate and buprenorphine are not available through the ANMC formulary at this time, but could be prescribed in a group setting if they become available.

There are few treatment models available for group medication management however, informal communication with psychiatrists who have tried it suggests success with groups of patients that share a diagnosis or a medication in common. In this system, we have combined medication management with supportive group therapy for alcohol or opiate dependence. The group format has, so far, been an aide to patient education, an efficient use of clinician time, and provided peer support for patients struggling with alcohol or opiate addiction.

Psychoeducational Groups

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
- Sufficient verbal and/or cognitive ability to benefit from treatment - Able to tolerate affect without behavior destructive to group - Could benefit from skills development	- Dangerousness to self or others - Sexually acting out behaviors - Untreated Psychosis or mania - History of chronic or extreme disruptive behavior in groups - Untreated substance dependence - Severe untreated hyperactivity	

STRUCTURE

Groups will be facilitated by 1 to 2 Case Managers or substance abuse counselors.

Duration	60 to 90 minutes for up to 8 weeks, possibly repeating or continuing
Frequency	Once a week
Open vs. Closed	Open

TREATMENT MODEL

Unlike other areas of mental health, treatment for alcohol dependence and abuse has more commonly been done in groups than individually. There are many variations of groups developed for patients recovering from alcohol or other drug addiction. Psychoeducation plays a role in almost all forms of treatment for alcohol and drug problems and is often done in a group format. Currently psychoeducation is blended with medication management and supportive therapy in the Naltrexone Group, and with peer support in the NaTiaSukan groups.

Case Management

All Ages	
Assessment	▪ Collect psychosocial history ▪ Collect collateral history and/or past treatment records ▪ Obtain patient and/or guardian consent ▪ Liaison with outside agencies and/or link to community resources ▪ Administer standardized scales ▪ Lead orientation to services ▪ Review and/or conduct client initial screening and triage
Treatment	▪ Psychosocial education ▪ Maintain supportive contact ▪ Triage current clients in crisis ▪ Crisis management (e.g. triage, risk assessment, skills coaching, referrals when needed) ▪ Community liaison work and coordination of care ▪ Manage charts ▪ Provide aspects of treatment ▪ Assist with group preparation ▪ Draft treatment plans ▪ Follow-up when customer fails to keep appointments. ▪ Encourage medication and treatment compliance
Follow-up	▪ Liaison with outside agencies ▪ Link to community resources ▪ Gather and disseminate information from external referral sources

Referral

- Consider Referral to SBIRT
- For family members or significant others, consider referral to Alateen, Al-Anon, ACOA, or CODA
- Consider referral to Clitheroe, Nugent's Ranch, CITC, Ernie Turner Center, Akeela, Salvation Army, Na-Tia-Sukan, Home-Ward Board, SBIRT , Dena-A-Coy, Alaska Women's Recovery Project
- Consider referrals to TRAILS/Pathway/Volunteers of America/Alateen

INDICATIONS

- Services needed are not available within the Behavioral Health department.
- Meets CMI criteria and not receiving rehab services
- Legal custody or other issues predominate
- Needed treatment is available elsewhere.

CONTRAINDICATIONS

Meets criteria for treatment within the Behavioral Health department system

Primary Care

INDICATIONS

- Refuses specialty mental health care
- Specialty Mental Health care not available
- Uncomplicated Medication Management
- Maintenance Medication Management

CONTRAINDICATIONS

Higher intensity services needed to ensure safety to patient or others

Appendix A: Glossary

Term or Acronym	Term Definition
Acute Intoxication	A reversible substance-specific syndrome due to recent ingestion of (or exposure to) a substance. Clinically significant maladaptive behavior or psychological changes that are due to the effect of the substance on the central nervous system and develop during or shortly after use of the substance. (Adapted from DSM-IV)
Acute Withdrawal	A substance-specific syndrome due to the cessation of (or reduction in) substance use that has been heavy and prolonged. (Adapted from DSM-IV)
CBT	Cognitive Behavioral Therapy
Closed Group	Customers may enter only at initial formation of group.
Closed Group with Windows	Customer enrollment available intermittently
Eclipse	Overshadow, for example, when the symptoms and dysfunction related to one disorder overshadow another making treatment of one more pressing.
Exposure Therapy	Exposure therapy (Haug et al, 2003) with or without response inhibition is most cited as effective for specific phobia, obsessive compulsive disorder and PTSD. Generally, these run 10 -12 sessions with each session targeting a specific skill, exposure level and cognitive reframing. Manuals are available to guide clinical work.
Intervention	Any thoughtful action taken by a clinician or customer with the purpose of addressing a perceived problem or therapeutic goal
IPT	Interpersonal Therapy
NOS	Not Otherwise Specified
Open Group	Participants can enter at any time.
PDD	Pervasive Developmental Disorder
Play Therapy	Play therapy is a form of psychotherapy for children who have been traumatized. It encourages children to explore their emotions and conflicts through play, rather than verbal expression.
Psychiatric Assessment	Formal assessment by a psychiatrist or ANP
Psychoeducation	teaching and training about the disease or problem for which the customer or family member is seeking treatment. Psychoeducation is frequently presumed to be part of all forms of assessment and treatment, yet additional interventions that emphasize education about an illness are often shown to improve outcomes over treatment as usual. Psychoeducation can be incorporated into many treatments, but can be viewed as an intervention in its own right and can be delivered by non-professional staff such as case managers or health educators.
Psychological Testing	Formal psychological assessment which includes clinical interview and appropriate tests conducted by a psychologist and/or psychometrician. This testing is standardized and normed.
Screening/Scales	Brief, easily administered screening and scales which do not require advance training to interpret.
Social Rhythm Therapy	A structured psychotherapy combining elements of behavioral therapy and psychoeducation and shown to reduce rates of relapse and rehospitalization in bipolar disorder

Term or Acronym	Term Definition
Structural Family Therapy (SFT)	Structural Family Therapy is model of treatment in which a family is viewed as a system with interdependent parts. In this treatment model, the family system is understood in terms of the repetitive patterns of interaction between the parts. From such a perspective, the goal of structural family therapy is to identify maladaptive or ineffective patterns of interactions, then alter them to improve functioning of the subparts and the whole.
TBI	Traumatic Brain Injury
Treatment Modality	For purposes of this guideline, we have defined "modality" as the structure in which the customer receives treatment, for example, individual psychotherapy, group psychotherapy, or psychoeducation.
Treatment Model	For purposes of this guideline, we have defined the "model" of care as the underlying theoretical approach to clinical intervention, for example, Cognitive Behavioral Therapy, Insight Oriented Therapy, Interpersonal Therapy.
Untreated Psychosis	For the purposes of this treatment guideline, we define untreated psychosis as psychotic symptoms that are prominent, disruptive in some way, and for which the customer is not accepting or engaging in care that would mitigate such symptoms. The diagnosis of a psychotic disorder, or the presence of psychotic symptoms at some point in the course of illness or treatment should not be a barrier to participation in treatment that might be helpful. However, nor should a customer with a significant psychotic disorder be treated with some forms of psychotherapy from which they are not likely to benefit. Clinical judgment will be needed in selecting appropriate treatment for each customer.
Untreated Substance Dependence	Because "dual diagnosis" is the norm, rather than the exception in behavioral health settings, customers with substance abuse problems should not be excluded, a priori, from participation in treatment for other mental health conditions. However, the impact of their substance use on their capacity to participate in treatment must be assessed on an ongoing basis. Customers with current substance dependence may not be appropriate candidates for some forms of treatment.

Appendix B: Literature Summary

Evidence Based Clinical Guidelines
Southcentral Foundation Research Project
Summary Sheet
Substance Abuse Medications Only

Diagnosis: Substance related disorders occupy a significant section of the DSM IV. Each drug of abuse has a section with the attending symptoms. Generally, substance related disorders are constituted of two main patterns: abuse and dependency. Abuse is a functionally-based diagnosis wherein the use of a substance (e.g. cocaine, alcohol) leads to disruptions in personal and social functioning as well as decreased control. Dependency is constructed more in a biological sphere with cardinal symptoms being tolerance and withdrawal. Tolerance is the need for larger or more frequent use to achieve the desired effect. Withdrawal is a physiological response to the abstinence of the substance usually in the opposite direction of the desired use response (i.e. depression instead of the cocaine mania). Dependency also has the social and personal problems that attend the physiological manifestations.

General Information: Substance abuse is a large topic with numerous technologies and systems of care touted as functional. Individual, group, couples, multifamily, 12 steps, rational recovery, motivational interviewing, and medication interventions all are seen as having some effectiveness. For this summary, the target was evidence-based medication management for substance related disorders. The topic produced numerous hits with a limited ranged of substances being represented in the defined search. The topic was researched using the Am. Psychiatric Association, American Psychological Association, SAMHSA, NIAAA, National Guidelines, NIMH, Cochrane Reviews, Evidence Bases Mental Health and Medscape. Keywords were Substance abuse, Alcoholism, cocaine, drugs, psychopharmacology, medications, Naltrexone, Buprenorphine, and Drug dependency and the Boolean combinations.

Results of the search: To date, there is not sufficient research to justify medication monotherapy for any category of substance abuse. There are no medications that can prevent, cure or stop relapse for any category of substances. The literature suggests the following interventions.

Dopamine agonists and antidepressants are not effective in monotherapy treatment of cocaine dependency (Soares et al. 2001; Lima et al. 2001). This literature in the Cochrane Review suggest that psychosocial interventions are superior but provide the caveat that simple conclusions about use of these medications is premature. The use of these medications in concert with other treatment might be superior and would be necessary when in a co-occurring disordered patient. One review (Grabowski et al. 2001) suggested that use of sustained release dextroamphetamine improved treatment retention for cocaine dependent clients. This would represent, in the cohort of clients where effective, a significant contribution in helping other treatment compliance.

Naltrexone, an opioid antagonist, has received lots of press and hype as the cure to alcoholism. Used in the courts and more sophisticated treatment settings, Naltrexone has been the subject of intense research and promotion. In the Treatment Improvement Protocol series published by SAMHSA (2000), the authors note the two following important considerations: 1) Naltrexone has been approved as an adjunct to psychosocial treatment and **should not be seen as a replacement for psychosocial interventions;** 2) naltrexone is to help motivated clients maintain treatment gains during the critical early period of abstinence. This guideline underscored the reality of no quick cure, even with medications, of substance related problems.

Modesto-Lowe (2002) reviewed the evidence of Naltrexone and concludes similarly to the SAMHSA TIP. He cautiously notes that the medication is a very useful tool in the treatment of alcoholism and opioid dependency (heroin and pain medications). He contends that it is most effective in conjunction with well structured treatment, aftercare and compliance programs. The Cochrane Review by Kirchmayer et al. (2002) confirm this conclusion. Monotherapy is not supported by the evidence but, according to this review, Naltrexone has benefit when used in combination with treatment. This is echoed in Garbutt et al. 1999, where the conclusion is that studies with sufficiently long follow up efforts do not support the pharmacotherapy with alcoholism provided clear benefits.

Lastly, Anton et al. (1999) confirm that the combination of Naltrexone and Cognitive Behavioral therapy showed modest increases in maintenance and relapse prevention in clients with alcohol dependency. The conjunctive therapies helped clients to withstand cravings and gain control over thought about drinking that fall under the conditioned learning paradigm.

Buprenorphine was recently approved for use in alcohol and opioid-based addictions. In quick summary, this medication lacks adequate research and clinical use to know the full effectiveness in this population. The strongest evidence found in the limited search were combination treatments using Buprenorphine as an adjunct. This medication has been shown to improve resistance to cravings and urges helping to have more negative urine samples in treatment cohorts (Downey et al. 2000, Gold et al. 2003). It has been used in conjunction with Naloxone (another opiate blocker) and, most successfully, with psychosocial interventions (Fudala et al. 2003;).

Disulfiram is an older medication that has been used for decades. It is used as a deterrent and should be monitored in the motivated client. It works by decreasing the body's ability to clear the metabolites of alcohol breakdown and causes sickness. It has an aversion effect and does not create significant changes in the brain.

Acomprosate is a very recently approved substance abuse related medication. It targets the negative mood states that triggers relapse in substance abusing clients. It is like the other newer medications that look to help early period maintenance of recovery (Rawson et al. 2004).

Other drugs of choice and abuse: There was paucity of evidence literature concentrated on other recreational and drugs of abuse (marijuana, methamphetamine, ecstasy, etc). Many medications are used in off-label prescriptions to address correlated symptoms with their use. There were no hits noted that outlined medications specific for these categories of drugs.

Medications for withdrawal: There are many medications for withdrawal. The use of benzodiazepines and other medications in alcohol withdrawal is common. Antidepressants for the depression of withdrawn cocaine and methamphetamine clients are use regularly and generally well known. Withdrawal medications are used to facilitate the safety of withdrawal and are not generally held as an intervention of the underlying disease process.

DISCLAIMER: All medications must be prescribed and monitored by medical personnel. Individual reactions, side effects and effectiveness make this an activity that requires vigilance, strong psychosocial support and careful case management.

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Appendix C: Sample Treatment Plans

Treatment Plan for Naltrexone

Problem #1:
Intense cravings to use, leading to excessive use of _____ leading to impairment in occupational/academic functioning, interpersonal functioning, and legal involvement. Can include physiological dependence as indicated by tolerance and withdrawal. Person may have unsuccessfully attempted to quit.

Goal:
1. Reduce/eliminate relapse.
2. Decrease frequency and intensity of cravings for _____ (i.e. provide metrics such as __ #/week or ___ on 10 point scale.)

Objectives:
1. Maintain 100% compliance with Naltrexone.
2. Will attend four self-help groups per week
3. Will obtain a sober support system, which may include a sponsor
4. Will increase engagement in sober activities.
5. If in adjunctive treatment, maintains compliance with set requirements.
6. Identify and list at least three triggers, and avoid high-risk situations

Treatment Plan for Alcohol and Other Substance Abuse

Problem #1:
- Inability to stop or cut down the use of mood-altering drug once started, despite the verbalized desire to do so and the negative consequences continued use brings.
- Denial that chemical dependence is a problem despite direct feedback from others that the use of the substance is negatively affecting them and others.
- Continued substance use/abuse despite experiencing persistent or reoccurring physical, legal, vocational, social or relationship problems are directly caused by the use of the substance use.

Goal:
1. Increase knowledge of the physiological effects of substance abuse and the process of recovery.
2. Reduce relapse episodes in frequency and intensity.
3. Improve quality of life by maintaining an ongoing personal recovery plan.

Objectives:
1. Attend and complete a substance abuse assessment such as First Step.
2. Complete physical exam with medical provider to assess for biomedical conditions and/or complications such as withdrawal, chronic pain, chronic illnesses or high risk pregnancy which may complicate treatment.
3. Write out a Relapse Prevention Plan found at http://www.draonline.org/relapse_plan.html and discuss plan with therapist.
4. Begin to identify triggers and substance seeking behaviors which lead to relapse.
5. Identify and list sober individuals/supports and their phone numbers which will be written in a journal. Will journal when triggers occur and note the attempts to call sober supports. Journal to be shared with therapist weekly.
6. Attend two sober activities per week (attend DRA/AA/NA, church or other religious activity, cultural activities) and noted in journal.
7. Learn and memorize recovery slogans to utilize encouraging positive self talk (ie: One day at a time; H.A.L.T –don't get to Hungry, Angry, Lonely or Tired; First things first; Let go and let God or the Serenity Prayer) and noted in journal.
8. Assess living environment to determine if it adequately supports recovery
9. Identify a same sex sponsor/mentor who has been in recovery at least three years.