



## Medical Necessity Criteria for Substance Abuse and Dependence

### Initial Authorization

#### Admission/No admission Criteria (Yes to any will require admission)

- 1 Is the patient unable to cease substance use outside of a secure, inpatient environment?
- 2 Is the patient in danger of serious withdrawal symptoms?
- 3 Does the patient have a physical disorder that will complicate the treatment of patient?
- 4 Is the patient a danger to self or others?
- 5 Is the patient incapable of meeting basic needs?

### Continued Stay

#### Inpatient treatment (Yes to questions 1, 2, 3 requires inpatient care)

- 1 Does the patient's condition require 24-hour care in a structured therapeutic environment?
- 2 Does the patient have a significant psychiatric disorder that is complicating substance abuse treatment?
- 3 Does the patient have a physical illness(es) that requires continued inpatient care?
- 4 Has a treatment plan been developed that addresses the problems described in the initial authorization for treatment? Describe plan.
- 5 Has discharge planning been an integral part of the treatment process?

### Discharge Criteria

#### Yes to all required for discharge

- 1 Have the indications for admission been stabilized sufficiently to be managed at a lower level of care?
- 2 Is the patient sufficiently stable to no longer require 24-hour nursing care?

- 3 Has a discharge plan been developed that addresses the individual needs of the patient?
  - A. Does the patient have access to all medications needed to maintain stability in an outpatient setting?
  - B. Have community-based support systems been identified and the patient informed of these programs?
  - C. Has outpatient care been scheduled for the patient?
  - D. Has any necessary care for physical illness been scheduled?
  - E. Has appropriate housing been arranged?

### Discharge from Rehabilitation Services

#### Yes to 1-5 for a therapeutic discharge:

- 1 Has the patient developed the skills needed to address relapse triggers in a positive manner?
- 2 Has the patient accepted the diagnosis of addiction and recognized its severity?
- 3 Is the patient able to maintain therapeutic gains in a less structured treatment setting?
- 4 Is the patient prepared to cope with a return to a home environment?
- 5 Has the patient sufficiently improved cognitively, emotionally and physically to be able to benefit from therapy at a lower level of care?

#### Sufficient for discharge: Yes to 6, 7, 8, or 9

- 6 Has the patient's progress plateaued and is continued care at this level unlikely to achieve a significant change in the patient's status in a reasonable length of time?
- 7 Is the patient being retained in a rehab setting solely for the purpose of awaiting housing placement?
- 8 Is the patient failing to comply with the expected requirements of the residential treatment setting?
- 9 Has the patient had a UDS indicating use of drugs or alcohol during the stay at the rehabilitation setting?



## Substance Abuse and Dependence Diagnosis and Treatment

### DSM-IV Diagnostic Criteria for Substance Abuse

#### Have any of the following occurred within a 12-month period?

- 1 Has recurrent substance use resulted in a failure to fulfill major role obligations at work, school, or home?
- 2 Has the patient used substances in which it is physically dangerous? (for example, driving while intoxicated)
- 3 Has the patient had any recurrent legal problem due to the substance use?
- 4 Has the patient continued to use substances despite having persistent social or interpersonal problems caused by the substance use?

### DSM-IV Diagnostic Criteria for Substance Dependence

#### Have three or more of the following occurred at any time in the same 12-month period?

- 1 Is the patient tolerant to the substance? (Tolerance is defined as needing increasing amounts of the substance to achieve intoxication or a diminished effect with continued use of the same amount of substance)
- 2 Is the patient in withdrawal? (Signs and symptoms that are characteristic of the withdrawal from specific substances are present, or the substance must be taken to relieve withdrawal.)
- 3 Has the substance been taken in larger amounts or over longer periods of time than was intended?
- 4 Has there been a persistent desire or unsuccessful effort to cut down or control the use of the substance?
- 5 Is a great deal of time being spent in obtaining the substance or recovering from its use?
- 6 Have important social, occupational or recreational activities been given up or reduced because of substance abuse?

- 7 Has the use of the substance continued despite knowledge of having recurrent or persistent physical or psychological problems that are caused or made worse by the substance abuse?
  - ▶ **Specify:**  
With Physiological Dependence: Evidence of withdrawal or tolerance  
(Meets criteria 1 or 2 or both.)

### Treatment Goals: Acute Phase of Treatment

- 1 Identify the drug(s) the patient has been taking
- 2 Identify risk of severe withdrawal symptoms
- 3 Identify the appropriate setting of the initial treatment of the patient

### Treatment Plan

#### Specific considerations

- 1 In addition to establishing that the patient has substance abuse or dependence, the details of the patient's substance history must be elicited:
  - ▶ Names of all substances
  - ▶ Amounts of the substances ingested
  - ▶ Length of time the substances have been used.
  - ▶ Previous treatment:
    - Type of treatment
      - Detoxification
      - Rehabilitation
      - Outpatient treatment
      - Intensive outpatient
      - Methadone maintenance
    - Success of previous treatment
      - Use during treatment

- Length of time from cessation of treatment to next use
- What part of treatment was most helpful in maintaining sobriety
- Role of 12-step programs in recovery
- Medications used to assist in maintaining sobriety
- Family history of substance abuse/dependence

### Psychiatric diagnoses

- 1 List any diagnosis(es) made concerning the patient
- 2 How long had the patient been sober when the diagnosis was made?
- 3 Treatment(s) for the psychiatric diagnosis:
  - ▶ Medication
  - ▶ Psychotherapy
  - ▶ Compliance
  - ▶ Date of last psychiatric treatment
  - ▶ Family history of psychiatric disorders



## Alcohol

### DSM-IV Diagnostic Criteria for Alcohol Withdrawal

Use same criteria for withdrawal from sedatives or benzodiazepines (Valium, Xanax)

- A** Has there been a recent cessation of (or reduction of) alcohol use that has been heavy and prolonged?
- B** Have two or more of the following developed within several hours to a few days after Criterion A?
  1. Autonomic hyperactivity (sweating, rapid pulse)
  2. Increased hand tremor
  3. Insomnia
  4. Nausea or vomiting
  5. Transient visual, tactile, or auditory hallucinations or illusions
  6. Psychomotor agitation
  7. Anxiety
  8. Grand mal seizures

### Treatment Plan

#### Initial

Ninety percent of all patients experience only mild to moderate alcohol withdrawal symptoms.

- ▶ Severe alcohol withdrawal is a medical emergency and must be promptly treated.
- ▶ Detoxification
- ▶ Prevention of onset of withdrawal symptoms is key to treatment:
  - To retain patients in treatment
  - To prevent medical complications

**SYMPTOMS OF ALCOHOL WITHDRAWAL**

Time of Appearance	Symptoms: Mild to Moderate Alcohol Withdrawal	Symptoms: Severe Alcohol Withdrawal
<b>Start: First 6-8 hours</b>	Nausea, vomiting, tremor, insomnia, decreased appetite pulse increase	Same as mild to moderate, plus visual and auditory hallucinations  Seizures
<b>Next 1-2 days</b>	Sweating, anxiety, irritability, blood pressure increase, headache, agitation, sensitivity to light and sound, concentration and orientation problems	Seizures, delirium tremens, increased agitation, disorientation, tremulousness, large increases in blood pressure, pulse and respiratory rate, increased body temperature, persistent visual and auditory hallucinations, disorientation
<b>Up to six days</b>		Seizures

**TREATMENT REGIMENS FOR ALCOHOL WITHDRAWAL**

**Clonidine Withdrawal**

Day	Time	Procedure and Dose
<b>1</b>	9:00 pm	0.2 mg clonidine orally Two transdermal clonidine #2 patches, one on each arm
<b>3</b>	Morning	Patch on one arm removed
<b>4</b>	Morning	Patch on other arm removed Patient closely observed
<b>5</b>	Morning	Patient observation concluded

## MEDICAL MANAGEMENT OF ALCOHOL DETOXIFICATION

Symptom Triggered Medication Regimens	Structured Medication Regimens
<p><b>1</b> Monitor the patient every 4-8 hours using CIWA-Ar scale until score is below 8-10 for 24 hours.</p>	<p><b>1</b> One of the following medications is given at a set time interval:</p> <ul style="list-style-type: none"> <li>• Chlordiazepoxide [Librium] 50mg every 6 hours for 4 doses then 25 mg every 6 hours for 8 doses</li> <li>• Diazepam [Valium] 10 every 6 hours for 4 doses, then 5 mg every 6 hours for 8 doses</li> <li>• Lorazepam [Ativan] 2 mg every 6 hours for 4 doses, then 1 mg every 6 hours for 8 doses</li> </ul>
<p><b>2</b> Administer one of the following medications every hour when the CIWA-Ar is &gt;8-10</p> <ul style="list-style-type: none"> <li>• Chlordiazepoxide [Librium] 50-100 mg</li> <li>• Diazepam [Valium] 10-20 mg</li> <li>• Oxazepam [Serax] 30-60 mg</li> <li>• Lorazepam [Ativan] 2-4 mg</li> </ul>	<p><b>2</b> Agitation. If increasing agitation and/or hallucinations are a problem:</p> <ul style="list-style-type: none"> <li>• Haloperidol [Haldol] 2-5 mg IM alone or in combination with Lorazepam [Ativan] 2-4 mg</li> </ul>
<p><b>3</b> Repeat CIWA-Ar one hour after every dose to assess the need for more medication to control symptoms of withdrawal</p>	
<b>SPECIAL NOTES</b>	
<p><b>1</b> Benzodiazepines are well absorbed when taken orally and are, in general, not well absorbed when injected - with the exception of Lorazepam [Ativan].</p>	
<p><b>2</b> Alcohol and benzodiazepines can be a dangerous mix. Early in the detoxification process, the patient must be carefully monitored if alcohol can be detected in the patient</p>	

**NOTE:** Usually, detoxification is a treatment that leads to another level of care such as rehabilitation. Used in isolation, the patient will almost always return to abusing substances soon after the discharge from the detoxification process.

## Discharge Plan

- ◆ Referral/connection to outpatient source of treatment that is at a level of care that meets the needs of the patient.
  - ▶ A specific appointment is made before discharge and patient is aware of appointment.
  - ▶ Patient has means to get to appointment, and, if not, transportation is arranged
- ◆ Appropriate living circumstances are arranged
- ◆ Community supports are identified for patient
- ◆ Patient and family education about medications, signs of condition worsening, availability of emergency services, etc., is conducted before discharge.
- ◆ Crisis plan for patient is developed and communicated to all involved in patient's care
- ◆ Access to medications is arranged
- ◆ Case management, if indicated, is arranged.



## Sedatives, Hypnotics and Anxiolytics

### GENERIC AND BRAND NAMES OF SEDATIVES, HYPNOTICS AND ANXIOLYTICS

Benzodiazepines	Barbiturates	Others
Alprazolam [Xanax]	Amobarbital [Amytal]	Choral Hydrate [Nortec, Somnos]
Chlordiazepoxide [Librium]	Butabarbital [Barbated, Butisol]	Ethchlorvynol [Placidyl]
Clonazepam [Klonopin]	Butalbital [in Fiorinal]	Ethinamate [Valmid]
Clorazepate [Tranxene]	Pentobarbital [Nembutal]	Glutethimide [Doriden]
Diazepam [Valium]	Phenobarbital [Luminal]	Meprobamate [Equanil, Miltown]
Estazolam [ProSom]	Secobarbital [Seconal]	Methaqualone [Quaalude]
Flurazepam [Dalmane]		Methypylon [Noludar]
Halazepam [Paxipam]		
Lorazepam [Ativan]		
Oxazepam [Serax]		
Prazepam [Centrax]		
Quazepam [Doral]		
Temazepam [Restoril]		
Triazolam [Halcion]		

## SEDATIVE-HYPNOTIC DOSE CONVERSION FOR WITHDRAWAL SUBSTITUTION

10 milligrams of Diazepam [Valium] is equal to:

Benzodiazepines		Barbiturates		Other	
Clorazepate [Tranxene]	15 mg	Amobarbital [Amytal]	100 mg	Ethchlorvynol [Placidyl]	300 mg
Clonazepam [Klonopin]	1-2 mg	Butalbital [in Fiorinal]	100 mg	Glutethimide [Doriden]	250 mg
Alprazolam [Xanax]	0.5 mg	Pentobarbital [Nembutal]	50-100 mg	Methyprylon [Noludar]	200 mg
Estazolam [ProSom]	2 mg	Phenobarbital [Luminal]	30 mg	Methaqualone [Quaalude]	300 mg
Chlordiazepoxide [Librium]	25 mg	Secobarbital [Seconal]	100 mg	Meprobamate [Equanil, Miltown]	400 mg
Flurazepam [Dalmane]	15 mg			Carsoprodol [Soma]	700 mg
Lorazepam [Ativan]	2 mg			Choral Hydrate [Nortec, Somnos]	500 mg
Oxazepam [Serax]	10 mg				
Quazepam [Doral]	15 mg				
Temazepam [Restoril]	15 mg				
Triazolam [Halcion]	0.25mg				

## Withdrawal from Sedatives, Hypnotics and Anxiolytics

### Basic Principles

- 1 The intensity of the withdrawal symptomatology and the length of time of withdrawal is influenced by the:
  - ▶ Amount of the dosing
    - Higher doses taken over time produce more intense withdrawal.
  - ▶ The duration of the drug action
    - Medications with a longer duration of action may produce a longer time of withdrawal.
- 2 After the initial phase of withdrawal, there may be a prolonged period of withdrawal symptomatology that may last a year or longer.
- 3 The acute detoxification from this group of drugs may take weeks to accomplish.
- 4 This withdrawal can be quite difficult, with significant patient discomfort despite appropriate medical management.
- 5 Usually phenobarbital is used to accomplish the detoxification.

#### SEDATIVE-HYPNOTIC WITHDRAWAL SYMPTOMS

Mild	Moderate	Severe
Anxiety	Panic	Decreased body temperature
Insomnia	Decreased Concentration	Vital sign instability
Dizziness	Tremor	Muscle fasciculations
Headache	Sweating	Seizures
Loss of appetite	Palpitations	Delirium
Increased perception of sound	Perceptual Distortions	Psychosis
Irritability	Muscle Aches	
Agitation	GI upset	
	Insomnia	
	Elevated vital signs	
	Depression	



## Cocaine

### DSM-IV Diagnostic Criteria for Cocaine Intoxication

- A Is there a history of a recent use of cocaine?
- B Have clinically significant behavioral or psychological changes developed during the use of cocaine?
- C Have two or more developed during or shortly after the use of cocaine?
  1. Increased or decreased heart rate
  2. Dilated pupils
  3. Elevated or lowered blood pressure
  4. Sweating or chills
  5. Nausea or vomiting
  6. Evidence of weight loss
  7. Psychomotor agitation or retardation
  8. Muscular weakness, decreased respiration, chest pain, or irregular heart rate
  9. Confusion, convulsions, abnormal movements, or coma

### Treatment Plan

Specific considerations for the management of cocaine intoxication

**NOTE:** Cocaine is a psychostimulant, often resulting in agitated, disorganized behavior. Medical complications can result from cocaine abuse.

BEHAVIORAL EFFECTS OF ACUTE COCAINE INTOXICATION

Behavior	Degree of presence
Generally "abnormal" in appearance	Mild
Disorientation	Not present
Memory dysfunction	Mild
Inappropriate and degree of affect	Moderate
Altered mood: depressed	Usually mild, sometimes severe
Altered mood: Elated, euphoric	Very common, highly characteristic
Confused, disorganized	Moderate
Hallucinations	Common
Delusions	Usually none, rarely severe
Bizarre Behavior	Moderate
Poor Judgement	Common
Homicidal or danger to others	May be severe
Suicidal or danger to self	May be severe

## MEDICAL EFFECTS OF COCAINE INTOXICATION

Organ System	Medical Effects
<b>Head and Neck</b>	Dilated pupils Sudden headache Grinding of teeth
<b>Pulmonary</b>	Increased rate and depth of respiration Difficulty breathing Pulmonary edema Respiratory failure
<b>Cardiovascular</b>	Increased pulse, 30-50% above normal Increased blood pressure, 15-20% above normal Pale skin due to vasoconstriction Possible circulatory failure Myocardial ischemia Arrhythmia Myocardial infarction, cardiogenic shock
<b>Neurological</b>	Tremor Twitching of small muscles of face, hands and feet Cold sweats Pre-convulsive movements (muscle jerks) Seizures Coma Cerebral edema Stroke
<b>Gastrointestinal</b>	Nausea and vomiting
<b>Renal</b>	Renal failure Urinary incontinence
<b>Body Temperature</b>	Increased body temperature from mild elevations to severe hyperthermia
<b>Other</b>	Skeletal muscle breakdown Hepatic insufficiency

SYMPTOMS AND TREATMENT OF COCAINE WITHDRAWAL

Phase	Time Course	Symptoms	Treatment
<b>Crash</b>			
	Starts right after binge	Stimulant craving	Assess neurological and physical status Obtain urine drug screen.
Initial crash		Intense dysphoria-depression, anxiety, agitation	Obtain history of other drug and past psychiatric history.
Middle crash	Starts 1-4 hours after binge	Craving replaced by a desire for sleep, despite having insomnia	Observe closely, take suicide precautions, if necessary.
Late Crash	Last 3-4 days	Hypersomnia, increased appetite	Allow patient 3-4 days in a quiet environment to recover and to eat and to sleep as much as is needed.
<b>Withdrawal</b>			
Honeymoon phase	Lasts 12 hours to 4 days	Normalization of sleep  Fairly normal mood (with only mild dysphoria)  Reduced craving	Evaluate for other drug use and past history of psychopathology  Pharmacotherapy for stimulant withdrawal has not yet been established
Dysphoria, craving	Lasts 6-18 weeks	Withdrawal symptoms emerge: depression, lethargy, anhedonia	Initiate outpatient treatment program: groups, individual psychotherapy, education, urine monitoring, steps to avoid drug taking situations
<b>Extinction</b>			
	Lasts months to years	Gradual return of mood, interest in environment, and ability to experience pleasure. Gradual extinction of periodic craving episodes.	Relapse prevention techniques and participation in long-term and self-help groups.

 **Inhalants****DSM-IV Diagnostic Criteria for Inhalant Intoxication**

- A** Is there a history of recent intentional use of exposure to volatile inhalants (aerosol propellants, gasoline, glue, etc.)?
- B** Have clinically significant maladaptive behavioral and/or psychological changes developed during or shortly after exposure to the inhalant?
- C** Have two or more of the following developed during or shortly after the use of inhalants?
  1. Dizziness
  2. Nystagmus (abnormal eye movements)
  3. Incoordination
  4. Slurred speech
  5. Unsteady gait
  6. Lethargy
  7. Abnormal reflexes (decreased)
  8. Psychomotor retardation
  9. Tremor
  10. Generalized muscle weakness
  11. Blurred or double vision
  12. Decreased level of consciousness
  13. Euphoria

**Treatment Plan****Specific Considerations**

- ▶ Inhalants are most commonly used by children and adolescents.
- ▶ Inhalants are readily available in the patient's environment.
- ▶ Inhalants are inexpensive and easy to obtain.
- ▶ Certain inhalants [hydrocarbons] can cause severe permanent neurological damage.

## CHEMICALS FOUND IN INHALANTS

Product	Chemicals
<b>Adhesives</b>	
Airplane glue	Toluene, ethyl acetate
Rubber Cement	Hexane, toluene, methyl chloride, methyl ethyl ketone, methyl butyl ketone
PVC Cement	Trichloroethylene
<b>Aerosols</b>	
Paint Sprays	Butane, propane, fluorocarbons, toluene, hydrocarbons
Hair Sprays	Butane, propane, fluorocarbons
Deodorants, air fresheners.	Butane, propane, fluorocarbons
Analgesic spray	Fluorocarbons
Asthma spray	Fluorocarbons
<b>Anesthetics</b>	
Gases	Nitrous oxide
Liquid	Halothane, enflurance
Locals	Ethyl chloride
<b>Cleaning Agents</b>	
Dry cleaning fluid	Tetrachloroethylene, trichloroethane
Spot removers	Tetrachloroethylene, trichloroethane, trichloroethylene
Degreasers	Tetrachloroethylene, trichloroethane, trichloroethylene
<b>Solvents</b>	
Nail polish remover	Acetone
Paint remover	Toluene, methylene chloride, methanol
Paint thinners	Toluene, methylene chloride, methanol
Correction fluid thinner	Trichloroethylene, trichloroethane
Fuel gas	Butane
Lighter fluid	Butane, isopropane
Fire extinguisher propellant	Bromochlorodifluoromethane
<b>Food Products</b>	
Whipped cream	Nitrous oxide
<b>Other</b>	
"Rush". "poppers"	Amyl nitrite, butyl nitrite, isopropyl nitrite, butyl nitrite

 **Marijuana (Cannabis)****DSM-IV Diagnostic Criteria for Cannabis Intoxication**

- 1 Has the individual used cannabis recently?
- 2 Have clinically significant maladaptive behavioral or psychological changes developed during or shortly after cannabis use? Examples include:
  - ▶ Impaired motor coordination
  - ▶ Anxiety
  - ▶ Sensation of slowed time
  - ▶ Impaired judgement
  - ▶ Social withdrawal
- 3 Have two or more of the following signs developed within two hours of cannabis use?
  - ▶ Conjunctival injection (red eyes)
  - ▶ Increased appetite
  - ▶ Dry mouth
  - ▶ Tachycardia (increased heart rate)

**DSM-IV Diagnostic Criteria for Cannabis Dependence**

- 1 Use criteria for Substance Dependence (see above)

## Treatment

### Specific Considerations

- ◆ Marijuana is a gateway drug, its use frequently leading to other drug use.
- ◆ Marijuana is an addicting substance with a physiological withdrawal syndrome with the following symptoms:
  - ▶ Insomnia
  - ▶ Nausea
  - ▶ Anorexia
  - ▶ Agitation
  - ▶ Irritability
  - ▶ Depression
  - ▶ Tremor
- ◆ The withdrawal syndrome from marijuana looks very much like the withdrawal from opiate dependence.
- ◆ The withdrawal from marijuana does not require detoxification or special medical management.
- ◆ Marijuana use is frequently a part of the picture with the individual who is abusing many substances.
- ◆ Tolerance to marijuana develops quickly and continues for a long time after the last dose.
- ◆ Marinol is a medical form of marijuana used to stimulate appetite in individuals with certain physical illnesses such as AIDS and cancer. Taking this medication will make the urine drug screen positive for marijuana.
- ◆ Passive inhalation (such as being in a car or a room where marijuana is being smoked, but the individual not smoking marijuana) will not produce positive urine drug screens for marijuana.

 **Opiates****DSM-IV Diagnostic Criteria for Opioid Intoxication**

- A** Is there a history of a recent use of an opiate?
- B** Have clinically significant maladaptive behavioral and/or psychological changes developed during or shortly after exposure to the opioid?
- C** Is there evidence of constricted pupils and one or more of the following:
  1. drowsiness or coma
  2. slurred speech
  3. impairment in attention or memory

**DSM-IV Diagnostic Criteria for Opioid Withdrawal**

- A** Is either of the following present?
  1. Reduction or cessation of opiate use after use that is prolonged and heavy
  2. Administration of an opiate antagonist after a period of opiate use.
- B** Are there three or more of the following present?
  1. Dysphoric mood
  2. Nausea or vomiting
  3. Muscle aches
  4. Tearing or runny nose
  5. Pupils are dilated, goose flesh, sweating
  6. Diarrhea
  7. Yawning
  8. Fever
  9. Insomnia

## Treatment Plan

### Specific Considerations

- ✦ Heroin is the most commonly abused opiate, although any opiate can be abused, including prescription opiates.
- ✦ Currently, the heroin in the Philadelphia area is very pure.
- ✦ Heroin is becoming a common drug of abuse among adolescents.
- ✦ The treatment of the opiate addict should be considered to be a long-term process.
- ✦ The treatment of opiate addicts involves a number of approaches, including agonist treatment (methadone).
- ✦ Death from accidental overdose is not uncommon.
- ✦ Withdrawal symptoms from opiates are very unpleasant, but not life threatening.
- ✦ Concurrent addiction to other substances (alcohol and benzodiazepines) is quite common.
- ✦ Heroin addicts require a dose of heroin (a fix) approximately every 4-6 hours to prevent withdrawal.

The physical signs of opiate withdrawal are easy to observe.

#### CLINICAL MANIFESTATIONS OF OPIOID WITHDRAWAL

<b>Vital Signs</b>	Increased heart rate Elevated blood pressure Fever
<b>Central Nervous System</b>	Restlessness Irritability Insomnia Craving Yawning
<b>Eyes</b>	Dilation of pupils Tears
<b>Nose</b>	Runny nose
<b>Skin</b>	Goose flesh
<b>Gastrointestinal</b>	Nausea Vomiting Diarrhea

## Detoxification Schedules

### Methadone

- 1 Detoxification with methadone, usually starting at 30-40 mgs and remaining there for 3-4 days, then decreasing by 10 mg until the last 10mg then down by 5 mg—a fairly fast detoxification.
  - ▶ Day 1 - 30mg in a single dose
  - ▶ Day 2 - 20 mg
  - ▶ Day 3 - 10mg
  - ▶ Day 4 - 5 mg
  - ▶ Stop
- 2 Start with 30-40 mg; stay there for 3-4 days then decrease by 15% per day.

### Clonidine

0.2 mg every 4 hours for 3 days, then taper the dose by 0.2 mg every day or every other day until dose is zero.

## Opiate Maintenance Treatment

Currently, methadone and levo-alpha-acetylmethadol (LAAM) are the only opioid agonist medications approved for maintenance of opiate addicts. New medications are expected to be approved in the near future.

### Goals of Methadone Maintenance Treatment (MMT) or LAAM

- ◆ Prevention or reduction of withdrawal symptoms
- ◆ Prevention of relapse
- ◆ Prevention of drug craving
- ◆ Restoration to (or toward) normal of any physiological disruption of any physiological function disrupted by chronic drug abuse
- ◆ Patients are neither intoxicated nor in withdrawal over a 24-hour period

**Process of entry into a Methadone Maintenance Program**

- ◆ Individuals may self-present to Methadone Maintenance Programs.
- ◆ Individuals may be referred to Methadone Maintenance Programs.
- ◆ Methadone Maintenance is a long-term treatment (2 years or more)
- ◆ Methadone Maintenance may not be started on an inpatient basis, except at facilities having a special state license to do so.
- ◆ There are no emergency admissions to MMT programs.



## Substance-Induced Mood Disorder

### DSM-IV Diagnostic Criteria for Substance-Induced Mood

- A Is there a prominent and persistent disturbance in mood that dominates the clinical picture? Either or both of the following must be present:
  1. Depressed mood or markedly diminished in all or almost all pleasurable activities
  2. Elevated, expansive or irritable mood.
- B Is there evidence of either of the following?
  1. The symptoms in Criterion A developed during or within a month of Substance Intoxication or withdrawal.
  2. The use of medication is causally related to the disturbance
- C Is the disorder better accounted for by the diagnosis of another Mood Disorder?
- D Did the disturbance occur during a delirium? (**must be no**)
- E Did the symptoms cause significant distress or impairment in important areas of life function?

### Treatment Goals: Acute Phase of Treatment

- ◆ Identify the substance used or abused by the patient. (This may a substance with a known potential for abuse and addiction, or a medication, such as a blood pressure medication).
- ◆ Identify risk of severe withdrawal symptoms.
- ◆ Identify time of last use of substance.
- ◆ Diagnosis cannot be made if signs and symptoms of intoxication are present.

### Specific Considerations

- 1 Mood disorders are the most common of all the substance induced disorders
- 2 A thorough history from friends, family and other health professionals may be required to establish the diagnosis.

- 3 Establishing the relationship between the use of psychoactive substances and the symptoms of mood disorder is a crucial step.
- 4 Exploring the mood during periods of sustained abstinence from all depressive drugs is critical for the diagnosis.
- 5 Chronic use of alcohol, sedatives and opiates can cause depressed mood.
- 6 Withdrawal from stimulants and sedatives can also cause depressed mood.

### Specific Substances

- ◆ **Alcohol:** alcohol induced depression should remit over the first 2-3 weeks of abstinence.
- ◆ **Cocaine:**
  - ▶ Usually the depression induced by cocaine is short lived, a day or two.
  - ▶ The depression caused by cocaine withdrawal may be more serious and last considerably longer.
- ◆ **Benzodiazepines:** the depression induced by benzodiazepines can be serious and severe.

### Suicidality

- ◆ Individuals with substance induced disorder may be seriously suicidal.
- ◆ Relapse into substance use may place the patient at special risk because:
  - ▶ Intoxication causes disinhibition.
  - ▶ While intoxicated, the consequences of actions are not taken into account.

## Diagnosis

For the individual with a valid diagnosis of a substance abuse disorder and a substance-induced mood disorder, the initial treatment setting must be able to address:

- ▶ Withdrawal
- ▶ Detoxification
- ▶ Engagement in recovery process
- ▶ Education about addictions
- ▶ Medications used (and avoided) in the treatment of Substance-Induced Mood Disorder
- ▶ Issues of patient safety
- ▶ Psychiatric emergencies

## Discharge Plan

- ◆ Referral/connection to outpatient source of treatment that is at a level of care that meets the needs of the patient.
  - ▶ A specific appointment is made before discharge and patient is aware of appointment.
  - ▶ Patient has means to get to appointment, and, if not, transportation is arranged.
- ◆ Appropriate living circumstances are arranged.
- ◆ Community supports are identified for patient.
- ◆ Patient and family education about medications, signs of condition worsening, availability of emergency services, etc., is conducted before discharge.
- ◆ Crisis plan for patient is developed and communicated to all involved in patient's care.
- ◆ Access to medications is arranged.
- ◆ Case management, if indicated, is arranged.



## Substance-Induced Psychotic Disorder

### DSM-IV Criteria for Substance-Induced Psychotic Disorder

- A** Are there prominent hallucinations or delusions? (Do not include hallucinations if the person has insight that the hallucinations are substance-induced.)
- B** Is there evidence from the history, physical examination, or laboratory findings or either (1) or (2)?
  1. The symptoms in Criterion A developed during or within a month of substance intoxication or withdrawal.
  2. Medication use is related to the disturbance.
- C** Is the disturbance better accounted for by a psychotic disorder that is not substance induced?

Evidence that the psychotic disorder is not substance induced includes:

- ▶ The symptoms precede the onset of the substance use.
- ▶ The symptoms persist for a substantial period of time (about a month) after acute withdrawal or intoxication.
- ▶ The symptoms are in excess of what would be normally expected from the type or amount of the substance.

### Treatment Planning

#### Specific Considerations

- ◆ The accurate diagnosis of this condition may be difficult depending on the particular circumstances of the patient's situation.
- ◆ This disorder is time limited.
- ◆ Antipsychotics may be required but usually only on a short-term basis.
- ◆ The patient's behavior may be significantly disturbed and the safety of the patient and others must be carefully considered.

## Discharge Plan

- ◆ Referral/connection to outpatient source of treatment that is at a level of care that meets the needs of the patient.
  - ▶ A specific appointment is made before discharge and patient is aware of appointment.
  - ▶ Patient has means to get to appointment, and if not, transportation is arranged.
- ◆ Appropriate living circumstances are arranged.
- ◆ Community supports are identified for patient.
- ◆ Family education, if indicated, is conducted before discharge.
- ◆ Patient education about medications, signs of condition worsening, availability of emergency services, etc., is conducted before discharge.
- ◆ Crisis plan for patient is developed and communicated to all involved in patient's care.
- ◆ Access to medications is arranged.
- ◆ Case management, if indicated, is arranged.