

ALCOHOL AND SUBSTANCE USE DISORDERS / ADDICTION

[Practice Guidelines for Substance Abuse - APA \(May 2006\)](#)
[DSM-5 \(vs DSM-IV\) Criteria: Substance Abuse](#)
[Treatment Options: Quick Guide to Understanding ASAM Levels of Care](#)
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SUBSTANCE USE DISORDERS

A Brief Overview

Substance Use Disorders are defined in the DSM-5 as patterns of symptoms resulting from the use of a substance that an individual continues to take, despite experiencing problems as a result. The drug use disorders are inter-related disorders resulting from the use of illicit or prescription, over the counter, or unregulated substances from one of 10 separate classes of drugs: alcohol; caffeine; cannabis; hallucinogens (phencyclidine or similarly acting arylcyclohexylamines, and other hallucinogens, such as LSD); inhalants; opioids; sedatives, hypnotics, or anxiolytics; stimulants (including amphetamine-type substances, cocaine, and other stimulants); tobacco; and other or unknown substances.

To be considered a substance use disorder (as opposed to substance use) use of the substance must be causing problems in the individual's life in some way. There are 11 criteria utilized in making the diagnosis including:

- Taking the substance in larger amounts or for longer than you're meant to.
- Wanting to cut down or stop using the substance but not managing to.
- Spending a lot of time getting, using, or recovering from use of the substance.
- Cravings and urges to use the substance.
- Not managing to do what you should at work, home, or school because of substance use.
- Continuing to use, even when it causes problems in relationships.
- Giving up important social, occupational, or recreational activities because of substance use.
- Using substances again and again, even when it puts you in danger.
- Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance.
- Needing more of the substance to get the effect you want (tolerance).
- Development of withdrawal symptoms, which can be relieved by taking more of the substance.

According to the National Survey on Drug Use and Health 2016 data, **20.1million individuals over the age of 12 met criteria for a Substance Use Disorder (SUD)** in 2016.

Of those with SUD 15.1 million were estimated to have Alcohol Use Disorder (AUD) while 7.4million were reported to have substance use disorder for an illicit drug. The illicit drug most commonly abused was marijuana by 4.1 million, followed by opioids, at 2.1 million.

See: <https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.pdf>

Do you Suspect a SUD in a patient or a family member? Trying to determine if a SUD is the issue?
 Common signs that an individual may be struggling with drug abuse are listed below:

- Mixing with different groups of people or changing friends
- Spending time alone and avoiding time with family and friends
- Losing interest in activities
- Not bathing, changing clothes or brushing their teeth
- Being very tired and sad
- Eating more or less than usual
- Being overly energetic, talking fast and saying things that don't make sense
- Being nervous or cranky
- Quickly changing moods
- Sleeping at odd hours
- Missing important appointments
- Getting into trouble with the law
- Attending work or school on an erratic schedule
- Experiencing financial hardship

Which Drugs Are Most Commonly Abused?

1. **Alcohol:** Alcohol consumption can damage the brain and most body organs. Areas of the brain that are especially vulnerable to alcohol-related damage are the cerebral cortex (largely responsible for our higher brain functions, including problem solving and decision making), the hippocampus (important for memory and learning), and the cerebellum (important for movement coordination).
2. **Marijuana:** Marijuana is a mixture of the dried and shredded leaves, stems, seeds, and flowers of the Cannabis plant intended for use as a psychoactive drug and as medicine. The intoxicating effect of marijuana comes from the amount of delta-9-tetrahydrocannabinol (or THC) content found in the drug. Cannabis law firm may assist you with issues related to licensing and regulatory compliance, if needed. Common street names for marijuana are: "pot," "grass," "herb," "weed," "Mary Jane," "reefer," "skunk," "boom," "gangster," "kif," "chronic," and "ganja."
3. **Pain Relievers (other than heroin):** Prescription drugs are the #1 most abused drug in this category. Whether obtained from a friend or family member or prescribed by their own doctor, people often misuse or abuse pain relievers such as morphine, codeine, methadone, oxycodone and hydrocodone to experience euphoria or intense excitement.
4. **Cocaine /Stimulants:** Cocaine is a powerful stimulant. Stimulants are a class of drugs that can elevate mood, increase feelings of well-being, and increase energy and alertness, but they also have dangerous effects like raising heart rate and blood pressure. Cocaine may also be called "coke," "Coca," "C," "snow," "flake," "blow," "bump," "candy," "Charlie," "rock," and "toot."
5. **Depressants (Tranquilizers & Sedatives):** Depressants are usually prescribed to promote sleep or to reduce anxiety. As measured by national surveys, depressants are often categorized as sedatives or tranquilizers. Sedatives primarily include barbiturates (e.g., phenobarbital) but also comprise sleep medications such as Ambien and Lunesta. Tranquilizers primarily include benzodiazepines such as Valium and Xanax, but also include muscle relaxants and other anti-anxiety medications.
6. **Heroin:** Heroin is an opioid drug that is made from morphine, a naturally occurring substance taken from the seed pod of the Asian opium poppy plant. Opioids, also known as opiates, are known for their pain-relieving properties. Only licensed and authorized physicians may prescribe opiates for use to relieve pain. Street names for heroin: "Smack," "Junk," "H," "Black tar," "Ska," and "Horse."
7. **Hallucinogens:** Hallucinogens are mind or perception-altering drugs that cause a state of euphoria in the brain. LSD and Ecstasy are the most abused drugs in this category. Use of these drugs may cause abusers to see vivid colors and images, hear sounds, and feel sensations that seem real but do not exist. Abusers also may have traumatic experiences and emotions that can last for many hours. Some short-term effects can include increased body temperature, heart rate, and blood pressure; sweating; loss of appetite; sleeplessness; dry mouth; and tremors.
8. **Inhalants:** Inhalants are volatile substances found in many household products, (such as oven cleaners, gasoline, spray paints, and other aerosols,) that induce mind-altering effects. Inhalants are extremely toxic and can damage the heart, kidneys, lungs, and brain. Commonly abused inhalants include solvents with loud fumes (paint thinner, nail polish remover, degreaser, dry-cleaning fluid, cement glue), aerosol sprays (deodorant spray, hair spray, air fresheners, spray paint), and gases (gasoline, kerosene, anesthesia, ether, chloroform, halothane, and nitrous oxide).

Screening Tools for Substance Use

A. [National Institute for Drug Abuse Drug Screening Tool](#) (2013). This tool can be used by providers to screen patients for drug use.

B. Substance Abuse Screening Instrument

The Drug Abuse Screening Test (DAST) was developed in 1982 and is still an excellent screening tool. It is a 28-item self-report scale that consists of items that parallel those of the Michigan Alcoholism Screening Test (MAST). The DAST has “exhibited valid psychometric properties” and has been found to be “a sensitive screening instrument for the abuse of drugs other than alcohol.

The Drug Abuse Screening Test (DAST)

Directions: The following questions concern information about your involvement with drugs. Drug abuse refers to (1) the use of prescribed or “over-the-counter” drugs in excess of the directions, and (2) any non-medical use of drugs. Consider the past year (12 months) and carefully read each statement. Then decide whether your answer is YES or NO and check the appropriate space. Please be sure to answer every question.

	YES	NO
1. Have you used drugs other than those required for medical reasons?	_____	_____
2. Have you abused prescription drugs?	_____	_____
3. Do you abuse more than one drug at a time?	_____	_____
4. Can you get through the week without using drugs (other than those required for medical reasons)?	_____	_____
5. Are you always able to stop using drugs when you want to?	_____	_____
6. Do you abuse drugs on a continuous basis?	_____	_____
7. Do you try to limit your drug use to certain situations?	_____	_____
8. Have you had “blackouts” or “flashbacks” as a result of drug use?	_____	_____
9. Do you ever feel bad about your drug abuse?	_____	_____
10. Does your spouse (or parents) ever complain about your involvement with drugs?	_____	_____
11. Do your friends or relatives know or suspect you abuse drugs?	_____	_____
12. Has drug abuse ever created problems between you and your spouse?	_____	_____
13. Has any family member ever sought help for problems related to your drug use?	_____	_____
14. Have you ever lost friends because of your use of drugs?	_____	_____
15. Have you ever neglected your family or missed work because of your use of drugs?	_____	_____
16. Have you ever been in trouble at work because of drug abuse?	_____	_____
17. Have you ever lost a job because of drug abuse?	_____	_____
18. Have you gotten into fights when under the influence of drugs?	_____	_____
19. Have you ever been arrested because of unusual behavior while under the influence of drugs?	_____	_____
20. Have you ever been arrested for driving while under the influence of drugs?	_____	_____
21. Have you engaged in illegal activities in order to obtain drug?	_____	_____
22. Have you ever been arrested for possession of illegal drugs?	_____	_____
23. Have you ever experienced withdrawal symptoms as a result of heavy drug intake?	_____	_____
24. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	_____	_____
25. Have you ever gone to anyone for help for a drug problem?	_____	_____
26. Have you ever been in a hospital for medical problems related to your drug use?	_____	_____
27. Have you ever been involved in a treatment program specifically related to drug use?	_____	_____
28. Have you been treated as an outpatient for problems related to drug abuse?	_____	_____

Scoring and interpretation: A score of “1” is given for each YES response, except for items 4,5, and 7, for which a NO response is given a score of “1.” Based on data from a heterogeneous psychiatric patient population, cutoff scores of 6 through 11 are considered to be optimal for screening for substance use disorders. Using a cutoff score of 6 has been found to provide excellent sensitivity for identifying patients with substance use disorders as well as satisfactory specificity (i.e., identification of patients who do not have substance use disorders). Using a cutoff score of <11 somewhat reduces the sensitivity for identifying patients with substance use disorders, but more accurately identifies the patients who do not have a substance use disorders. Over 12 is definitely a substance abuse problem. In a heterogeneous psychiatric patient population, most items have been shown to correlate at least moderately well with the total scale scores. The items that correlate poorly with the total scale scores appear to be items 4,7,16,20, and 22.

Additional Resources Professionals Treating Substance Use

[Motivational Interviewing](#): Motivational Interviewing is a clinical approach that helps people with mental health and substance use disorders and other chronic conditions such as diabetes, cardiovascular conditions, and asthma make positive behavioral changes to support better health. The approach upholds four principles— expressing empathy and avoiding arguing, developing discrepancy, rolling with resistance, and supporting self-efficacy (client's belief s/he can successfully make a change)

[Enhancing Motivation for Change Inservice Training](#), a SAMHSA publication provides a training manual for introducing substance abuse treatment counselors, clinicians, and other professionals to basic concepts and techniques of motivational enhancement interventions presented in [TIP 35](#).

[A Tour of Motivational Interviewing: An Interprofessional Road Map for Behavior Change](#): Prepared by the University of Missouri Kansas City School of Nursing and Health Studies' Mid-America Addiction Technology Transfer Center (Mid-America ATTC), this is a **free self-paced online course** reviews the essential skills used to strengthen an individual's motivation for behavior change.

[mhGAP Intervention Guide \(mhGAP-IG\) for mental, neurological and substance use disorders for non-specialist health settings](#): a model guide developed by WHO. It presents protocols for clinical decision-making. The priority conditions included are: depression, psychosis, bipolar disorders, epilepsy, developmental and behavioural disorders in children and adolescents, dementia, alcohol use disorders, drug use disorders, self-harm/suicide and other significant emotional or medically unexplained complaints.

[My Reminder Card \(Am I Doing This Right?\)](#) is a quick guide for Motivational Interviewing, the evidence-based treatment. The 11 questions on this card assist in building self-awareness about your attitudes, thoughts, and communication style as you conduct your work.

["Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide"](#) is designed to help health care professionals quickly identify youth at risk for alcohol-related problems. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) developed the guide in collaboration with the American Academy of Pediatrics, a team of underage drinking researchers and clinical specialists, and practicing health care professionals.

[The National Institute on Alcohol Abuse and Alcoholism's computer-based tools](#): Diagnosis and treatment of alcohol-related problems are time-intensive procedures that often are difficult to implement in busy clinical settings. One approach that may enhance the availability and cost-effectiveness of assessment and intervention and also may offer other advantages over face-to-face interventions.

[Substance Use Screening and Assessment Database](#)

This resource created by the **Alcohol and Drug Abuse Institute Library** at the University of Washington is intended to help clinicians and researchers find instruments used for screening and assessment of substance use and substance use disorders. Instruments whose validity and reliability have been well-studied are marked with a star.

[SBIRT](#) is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders for use in community settings. The **SAMHSA SBIRT page** also includes curricula, online resources, and publications designed to help implement SBIRT initiatives.

[AUDIT](#) (Alcohol Use Disorders Identification Test) is a 10-item questionnaire that screens for hazardous or harmful alcohol consumption. Developed by the World Health Organization (WHO), the test correctly classified 95% of people into either alcoholics or non-alcoholics. The AUDIT is particularly suitable for use in primary care settings and has been

used with a variety of populations and cultural groups. It should be administered by a health professional or paraprofessional.

<https://documentcloud.adobe.com/link/track?uri=urn%3Aaaid%3Ascds%3AUS%3Ac41bbabf-89e6-41c9-94ba-9b4b597ed25b>

AUDIT-C is a simple 3-question screen for hazardous or harmful drinking that can stand alone or be incorporated into general health history questionnaires.

<https://documentcloud.adobe.com/link/track?uri=urn%3Aaaid%3Ascds%3AUS%3Ae9a47463-a4a0-40c7-bcd5-8f818725bbcd>

NIDAMED is a comprehensive Physicians' Outreach Initiative that gives medical professionals tools and resources to screen their patients for tobacco, alcohol, illicit drug, and nonmedical prescription drug use. Developed by the National Institute on Drug Abuse, NIDAMED resources include an online screening tool, a companion quick reference guide, and a comprehensive resource guide for clinicians.

CAGE AID is a commonly used tool used to screen for drug and alcohol use. The CAGE Assessment is a quick questionnaire to help determine if an alcohol assessment is needed. If a person answers yes to two or more questions, a complete assessment is advised.

DAST-10 (Drug Abuse Screen Test) is a 10-item, yes/no self-report instrument that has been condensed from the 28-item FAST and should take less than 8 minutes to complete. The DAST-10 was designed to provide a brief instrument for clinical screening and treatment evaluation and can be used with adults and older youth

[Faculty Development CME](#)

[Quick Reference Guide for Integrating Substance Use Treatment into Primary Care](#)

Gambling Disorder

DESCRIPTION:

The Diagnostic and Statistical Manual of Mental Disorders; Fifth Ed. (DSM-5) was published in 2013, replacing the prior fourth edition version of the same name (DSM-IV). Notable changes to the newest DSM involved a re-conceptualization of addictive disorders, moving away from the terms “abuse and dependence,” to a classification of addictive disorders in terms of their severity levels (from mild - severe). A new/re-characterized diagnosis, **“Gambling Disorder” was added to the Substance-Related and Addictive Disorders’ section of the DSM-5,** (and the diagnosis pathological gambling, previously within the impulse control disorders, was removed). This change was in response to evidence suggesting that *gambling behaviors activate reward systems similar to those activated by drugs of abuse* and may produce some behaviors similar to those seen in substance use disorders¹.

Gambling Disorder is defined in the DSM – 5 as: “A. **Persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress, as indicated by the individual exhibiting four (or more) of the following in a 12-month period:**

1. Needs to gamble with increasing amounts of money in order to achieve the desired excitement.
2. Is restless or irritable when attempting to cut down or stop gambling.
3. Has made repeated unsuccessful efforts to control, cut back, or stop gambling.
4. Is often preoccupied with gambling (e.g., having persistent thoughts of reliving past gambling experiences, handicapping or planning the next venture, thinking of ways to get money with which to gamble).
5. Often gambles when feeling distressed (e.g., helpless, guilty, anxious, depressed).
6. After losing money gambling, often returns another day to get even (“chasing” one’s losses).
7. Lies to conceal the extent of involvement with gambling.
8. Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling.
9. Relies on others to provide money to relieve a desperate financial situation caused by gambling. B. The gambling behavior is not better explained by a manic episode.”

While gambling disorder has thus been defined and characterized within the DSM-5, other non-substance-based patterns of repetitive or excessive behaviors (often referred to colloquially as “addictions”) were NOT included as an addition to the DSM-5. Examples of these repetitive behaviors include internet or gaming “addiction”, “exercise addiction,” “sex addiction,” “pornography addiction,” and “shopping addiction.” While these behavior patterns have been described in a limited way by researchers and have received considerable attention by the media, authors of the DSM-5 concluded that “there is currently “insufficient peer reviewed evidence to establish the diagnostic criteria and course descriptions needed to identify these behaviors as mental disorders.”¹ Furthermore, because these behavior patterns are not established as mental health diagnoses at this time, there is minimal evidence from which to base appropriate or effective treatment recommendations and/or identify levels of care for individuals presenting with these behaviors. Given that, treatment interventions to address these behaviors in the absence of another DSM-5 diagnoses are still considered investigational.

I. **Outpatient treatments** for gambling addiction may include:

- A. Outpatient therapy for Gambling Disorder in the form of brief interventions, office-based individual treatment, motivational enhancement therapy, and family therapy are supported in the literature. Prior authorization for these services is not required.
- B. Group Therapy: Certain types of group therapy treatment (notably CBT, mindfulness training, and self-help support groups) for gambling disorder may be useful as adjuncts to other professional therapy services. Group therapy for gambling disorder may be considered **medically appropriate**. Group therapy treatment must be time-limited, administered by a state licensed therapist, must have clearly defined admission and discharge criteria, and must clearly delineate the group treatment goals.

- C. Medication-assisted treatment: Currently, there is no specific FDA-approved pharmacotherapy for the treatment of gambling disorder. There are randomized clinical trials (though some involved a small number of patients) that have shown favorable outcomes for escitalopram, lithium, valproate, topiramate, paroxetine, and naltrexone. These medications do not require prior authorization by the health plan.
 - D. Intensive Outpatient Treatment: IOP treatment in the community will be considered for individuals with gambling disorder when that treatment is provided by a state-licensed provide and when the individual's symptom severity is such that it is significantly impairing the individual's level of function. Functional impairment will be defined as a significant deterioration from baseline in two or more areas including: family functioning and relationships, work/school functioning (probation, suspension, expulsion, written warnings, or demotion at school or work), and social/peer functioning/relationships. (Note: while financial problems and legal repercussions are very common among individuals with gambling disorders, financial and/or legal concerns alone are not considered an indicator of severity of illness in the absence of functional impairment as defined above).
- II. **Partial Hospital Programs, Inpatient Rehabilitation and Residential Levels of Care**: There is currently little research re: the efficacy and appropriateness of high-intensity treatments such as php, inpatient rehabilitation, and residential services for the treatment of gambling disorder. Given that, at the current time, these levels of care are considered **investigational** for the treatment of gambling disorder occurring in the absence of another DSM-5 diagnosis. Inpatient mental health and mental health php services will be considered for individuals for whom gambling disorder is comorbid with other psychiatric disorders and symptoms such as severe mood symptoms or evidence of lethality. In addition, for individuals for whom gambling disorder is comorbid with a substance use disorder, php, residential, and or inpatient rehabilitation levels of care will be considered for prior authorization subject to the medical necessity criteria currently utilized for substance use disorder treatment. In these cases, the significance of the gambling disorder diagnosis will be considered as it contributes to the symptom burden and functional impairment in that individual (see Guidelines section) .
 - III. Treatment interventions to address other behaviors of non-substance-based patterns of repetitive or excessive behaviors (other than gambling addiction) in the absence of another DSM-5 diagnoses are considered **investigational**.

GUIDELINES:

- I. Gambling disorder nearly always involves some element of financial risk taking. As a result, many individuals, especially those with severe symptoms, benefit from financial counseling and/or restriction from access to monies or valuables. This is frequently cited in treatment recommendations by various medical associations and government bodies and is similarly endorsed by the health plan as a prudent element of treatment for gambling disorder regardless of level of care.
- II. Gambling D/O is often associated with other severe, comorbid mental health and/or substance use disorders. For members presenting with co-occurring disorders, the impact of gambling disorder symptoms on the individual's functioning should be considered in medical necessity decision making regarding intensive levels of care.
- III. As with any psychiatric disorder, any individual who is believed to be an immediate danger to him or herself or others should be referred to an emergency room and considered for acute inpatient mental health treatment, regardless of diagnosis.

RATIONALE:

With the exception of gambling disorder, other non-substance- related patterns of repetitive or excessive behaviors are not currently defined as distinct diagnoses in the DSM-5, as the authors concluded that there is currently "insufficient peer reviewed evidence to establish the diagnostic criteria and course descriptions needed to identify these behaviors as mental disorders." Given that, there are no currently accepted, evidenced-based treatments for

these challenging behavior patterns. While these behaviors may be considered inasmuch as they contribute to functional impairment in a given individual, treatments for problematic behavior patterns involving sex, pornography, internet or gaming, shopping, exercise, and others are currently considered experimental.

MEETINGS for Gambling Disorder: All meetings are open to anyone who is affected by the gambling problem of a family member, loved one or friend. Meetings that are noted as "combined GA/Gam-Anon" are meetings in which the members of both Gam-Anon and Gamblers Anonymous have joined together to create one meeting.

Website: www.gamblersanonymous.org

ALCOHOL USE DISORDER

Overview

(Also See: [Practice Guideline for Pharmacologic Treatment of Alcohol Use Disorder \(Jan 2018\)](#))

Alcohol is available across the world. Though the risks are frequently minimized, **alcohol kills more people and causes more harm to individuals and societies** than any other single drug.

The National Survey on Drug Use and Health estimated 15.1 million people (5.6%) in the US met the criteria for alcohol use disorder in 2016. Yet as many as 70% of those affected do not receive needed treatment.

At the same time, most people who consume alcohol do not meet criteria for alcohol use disorder.

The symptoms of alcohol intoxication include disinhibition, euphoria, talkativeness, confusion, stupor, coma, and death at higher blood alcohol concentration (BAC).

Symptoms overlap with other central nervous system (CNS) depressants so the presence of these symptoms alone is not specific to alcohol intoxication. Breathalyzers can be useful tools for detecting the presence of alcohol.

Screening and Diagnosis

DSM-5 Alcohol Use Disorder:

When alcohol use leads to ongoing negative consequences it is considered a disorder as defined by the Diagnostic and Statistical Manual, 5th Edition.

Specifically, having two or more of the following symptoms present in a 12 month period meets criteria for AUD. (The more symptoms, the greater the severity):

- Tolerance
- Withdrawal
- More use for more time than intended
- Difficulty cutting down
- Craving alcohol
- Excessive time spent seeking alcohol
- Reduction in other activities
- Failure to fulfill obligations
- Continued use despite problems
- Use in physically hazardous situations
- Use despite knowledge of problems

CAGE Questionnaire: CAGE questions are widely used to screen for AUD. (Score: 0 for “no” and 1 for “yes” answers. Score of 2 or greater is clinically significant but a score of 1 still suggests need for follow-up):

1. Have you ever felt you should Cut down on your drinking?
2. Have people Annoyed you by criticizing your drinking?
3. Have you ever felt bad or Guilty about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (Eye-opener)?

[CAGE AID](#) link

SBIRT Model: Screening, Brief Intervention, and Referral to Treatment is an evidenced based intervention in community settings is the SBIRT model:

1. Screening - assessment for the existence of problematic drinking
2. Brief Intervention- provide advice, guidance
3. Refer to Treatment:@ appropriate care level.

For More information on SBIRT:

<https://www.integration.samhsa.gov/clinical-practice/sbirt>

Alcohol Withdrawal

All patients who have been drinking heavily or consistently for two weeks or more should be assessed for signs of withdrawal. Larger quantities of alcohol over longer duration are associated with greater risk of developing significant alcohol withdrawal, as is any previous history of serious withdrawal. Alcohol withdrawal is always risky, and may evolve into a medical emergency. If alcohol withdrawal can be managed outside of a hospital, friends or relatives **MUST** be available to assist with medications and must monitor for the development of symptoms requiring immediate treatment.

Medically supervised detox services are recommended for anyone who:

- *pregnant
- *is unable to stop drinking in outpatient setting
- *is abusing multiple substances
- *has a history of severe withdrawal
- *has serious medical comorbidities

Prediction of Alcohol Withdrawal Severity Scale (PAWSS):

PAWSS is a screening tool to assess the risk of severe alcohol withdrawal. A PASS score of four or higher is considered high risk.

If untreated, alcohol withdrawal can lead to Delirium Tremens (DT), which is characterized by hallucinations, change in mental status, agitation, hypertension, hyperthermia, tachycardia, and diaphoresis. Patients with a history of sustained alcohol consumption are also at risk for developing Wernicke’s encephalopathy (WE) and Korsakoff’s psychosis due to malnutrition and a deficiency in thiamine. WE is a confusional state with ophthalmoplegia, nystagmus, and ataxia. Korsakoff’s psychosis consists of memory loss, learning deficits, and confabulation. It is thought to be the consequence of episodes of WE.

Stages of Alcohol Withdrawal:

Onset: after last drink or decrease in intake

Symptoms:

****6-12 hours:** Minor withdrawal symptoms-sweating, tremor, anxiety, agitation, insomnia, headaches, nausea/vomiting Usually lasts 24-48 hours, but can persist for several days to weeks

****12-24 hours:** Alcoholic hallucinosis-usually visual but can also be auditory or tactile Usually resolves within 48 hours

****24-48 hours:** Withdrawal seizures-generalized tonic-clonic. Life-threatening. May occur as early as 2 hours after the last drink. Rarely progresses to status epilepticus

****48 to 72 hours:** Delirium tremens-sweating, agitation, hallucinations, disorientation, tachycardia, hypertension, fever

Life-threatening symptoms peak at 3-5 days

Alcohol Withdrawal Monitoring Scales:

There are a number of scales for monitoring the severity of alcohol withdrawal symptoms.

1. The Clinical Institute Withdrawal Assessment for Alcohol Revised (CIWA-Ar)

Clinician administered scale

CIWA-Ar scores > 10 --> pharmacologic treatment indicated

CIWA-Ar can be used to monitor the progress of withdrawal

2. The Short Alcohol Withdrawal Scale (SAWS)

Patient-report scale

Scores >12 indicate moderate to severe withdrawal

Medication Management of Withdrawal:

****Benzodiazepines are the treatment of choice** to minimize or prevent the symptoms of alcohol withdrawal and prevent seizures and D. PRN dosing (symptom based) and scheduled dosing are both effective.

*All benzodiazepines are effective at stopping withdrawal, but some patients may be better on a 'preferred' med based on individual considerations:

- Longer-acting medications (chlordiazepoxide) provide consistent coverage & avoid rebound symptoms.
- Shorter-acting medications without active metabolites (lorazepam, oxazepam) are better in patients with liver compromise, the elderly, and easily oversedated patients.

***Outpatient Fixed Schedule Benzodiazepine Dosing Protocols:**

(Chlordiazepoxide, Lorazepam)

Day 1: 25-50mg every 6 hours, 2mg every 8 hours

Day 2: 25-50mg every 8 hours, 2mg every 8 hours

Day 3: 25-50mg every 12 hours, 1mg every 8 hours

Day 4: 25-50mg at bedtime, 1mg every 12 hours

Day 5: 25-50mg at bedtime, 1mg at bedtime

(breakthrough withdrawal sx → higher doses, over sedation → lower doses. Longer tapering schedules are occasionally necessary).

Patients who have worsening withdrawal despite treatment should be referred to a higher level of care or an ICU. CIWA-Ar should be administered regularly and patients assessed at least daily by an advanced provider, while noting the total dose of benzodiazepines taken in the last 24 hours. Outpatients should receive a few days supply to encourage monitoring and follow through.

Other Medications for Alcohol Withdrawal:

- **Anticonvulsants** should not be used to manage isolated withdrawal seizures but *may be considered as an adjunctive treatment* to benzodiazepines or for mild to moderate alcohol withdrawal symptoms of low risk patients in outpatient settings.
- **Gabapentin and carbamazepine** appear to have the best evidence.
- **Dosing:**

- Gabapentin 1200mg/day in divided doses tapered over 4-6 days
- Carbamazepine 800mg/day in divided doses tapered over 5-9 days.

- All patients in alcohol withdrawal treatment should receive dietary supplements to correct nutritional deficiencies and lessen the risk of WE, (precipitated by the consumption of carbohydrates). *During withdrawal and for at least one month, patients should receive:*
 - Daily multivitamin
 - Folic acid 1mg daily
 - Thiamine 100mg daily

**** Treatment of Alcohol Use Disorder see the following links:**

- [Practice Guideline for Pharmacologic Treatment of Alcohol Use Disorder \(Jan 2018\)](#)
- [CME](#) Vignette and Self-Test
- [Clinician Summary/Training Slides](#)
- [Podcast](#): New Tools for Alcohol Treatment

Treatment of Alcohol Use Disorder Summarized:

- **Stop Alcohol Use, Assisted Detox or Inpatient as Needed.**
- **Benzo's, Anticonvulsants, Fluids, Thiamine, Folate, B12**
- **Support Labs**
- **Address Cravings:**
 - **Naltrexone (an opiate receptor blocker) blocking the opiate receptor acts powerfully in enhancing self-regulation, modifying dopamine responses, decreasing trauma, etc.**
 - **Acomprosatate (GABA analog, modifies GABA)**
 - **Antabuse: Causes violent illness if combined with EtOH (not ideal)**
 - **Wellbutrin (decreases reward w alcohol use)**
 - **Gabapentin: Can modify anxiety associated with withdrawal**
 - **Other antidepressants as indicated.**
 - **ADHD? Use stimulants with extreme caution, Strattera or Bupropion, use a long acting stimulant if needed.**
 - **Motivational Interviewing, CBT, IPT, DBT, group therapy, art and music therapy (especially in those who intellectualize)**
 - **12 step supports (not studied scientifically but highly powerful).**

REFERENCES:

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