



## **Substance Use Disorder and Recovery Services**

### **Clinical Practice Guidelines for the Management of Substance Use Disorders**

**2020**



## QUALIFYING STATEMENTS

These Substance Use Disorder and Recovery Services (SUDRS) Clinical Practice Guidelines (CPG) for SUD management have been developed to provide clinical treatment information and assist SUD service providers with decision making. They are not intended to define a recommended standard of care or be construed as - nor be interpreted as - prescribing an exclusive course of action or treatment in providing SUD treatment and care for SUD clients. The guidelines *are* intended to provide a clear explanation of the logical relationship(s) between various care options and health outcomes, while rating both the quality of the evidence and the strength of the recommendation(s).

The CPGs are not intended to be all inclusive of Department clinical practices, which must consider applicable laws, regulations, policies, procedures and processes, etc. Appropriate, professional experience should be exercised to arrive at an informed decision in providing SUD treatment and care for the individual circumstance and client. Variations in practice will inevitably and appropriately occur when clinicians take into account the needs of individual client(s), available resources, and limitations unique to an institution or type of practice. Every SUD service provider/clinical professional utilizing these guidelines is responsible for evaluating the appropriateness of applying them in the setting of any particular clinical situation.

For additional information, please visit the DBH website or contact DBH Substance Use Disorder and Recovery Services at: [www.sbcounty.gov/dbh](http://www.sbcounty.gov/dbh).

As the Medical Director of the Department of Behavioral Health Drug Medi-Cal Organized Delivery System Plan, I approve of these Clinical Practice Guidelines.

DocuSigned by:

A handwritten signature of Teresa Frausto.

EAE2F302F58C4FA..

12/14/2020

Teresa Frausto MD, Chief Psychiatric Officer

Date

As the SUD Addiction Specialist of the Department of Behavioral Health Drug Medi-Cal Organized Delivery System Plan, I approve of these Clinical Practice Guidelines.

A handwritten signature of Jonathan D Avalos.

12/11/2020

Jonathan D Avalos MD, Addiction Medicine Physician II

Date

## Table of Contents

<b>I. Introduction.....</b>	<b>4</b>
<b>II. About The Clinical Practice Guidelines .....</b>	<b>4-5</b>
1. Scope of the Clinical Practice Guidelines .....	5
2. Individualized Treatment .....	5
3. Shared Decision Making (SDM) .....	6
4. Engagement Strategies .....	6-7
5. Certification and Credentialing Standards .....	7
6. Management of Substance Use Disorders .....	7-9
7. Coordination of Treatment.....	9
8. Co-occurring Conditions.....	9
<b>III. Treatment .....</b>	<b>13</b>
1. Alcohol Use Disorder .....	13
2. Opioid Use Disorder.....	14
3. Cannabis Use Disorder.....	14-15
4. Stimulant Use Disorder .....	16
<b>IV. Promoting Group Mutual Help Involvement.....</b>	<b>17</b>
<b>V. Co-occurring Mental Health Conditions and Psychosocial Problems.....</b>	<b>18</b>
<b>VI. Follow-up.....</b>	<b>19-21</b>
<b>VII. Stabilization and Withdrawal.....</b>	<b>21</b>
1. Standardized Withdrawal Assessment .....	21
2. High Risk Scenarios .....	22
3. Alcohol Use Disorder Stabilization and Withdrawal .....	23
4. Medication .....	24
5. Mild to Moderate Withdrawal.....	24
6. Opioid Use Disorder Stabilization and Withdrawal.....	24-25
7. Sedative Hypnotic Use Disorder Stabilization and Withdrawal.....	25
8. Emergency Department Bridge Buprenorphine Medication Assisted Treatment Stabilization Visit.....	26
<b>VIII. Knowledge Gaps and Recommended Research.....</b>	<b>27-28</b>
1. Determination of Treatment Settings .....	28
2. Pharmacotherapy.....	28
3. Psychosocial Interventions.....	28
4. Follow-up.....	28
5. Telehealth.....	28
<b>Addendum I.....</b>	<b>29-30</b>
<b>Addendum II.....</b>	<b>32</b>
<b>Addendum III .....</b>	<b>33</b>

## I. Introduction

The Substance Use Disorder and Recovery Services (SUD) Clinical Practice Guidelines (CPG) are intended to offer SUD service providers with a framework by which to evaluate, treat, and manage client needs and preferences, thereby leading to improved clinical outcomes. Improved recognition of the complex nature of these conditions has led to new strategies in managing and treating SUD clients, including new developments related to pharmacotherapy and other treatment options.

The SUD-CPG supports DBH's system-wide goal of implementing evidence-based guidance to improve the health and wellbeing of DBH system of care clients. It is intended to assist SUD providers in all aspects of providing SUD care including, but not limited to, diagnosis, treatment, and follow-up. By utilizing this CPG, in addition to consideration for existing resources and/or limitations as well as individual client, SUD providers will be able to provide evidenced-based care in a manner that is most effective and efficient. If any content and/or application of guidance provided within the SUD-CPG conflicts with state or federal laws, regulations and/or mandates, adherence to said state or federal laws/regulations/mandates supersede recommendations made herein. The expected outcome(s) of successful implementation of this SUD-CPG include:

- Assessment of the client's condition and determination of the best treatment method(s) in collaboration with the client
- Optimization of client's recovery to decrease or eliminate substance use, improve health and wellness, live a self-directed life, and strive to reach his or her full potential
- Minimize preventable complications and morbidity
- Emphasize the use of individualized client care.

## II. About the Clinical Practice Guidelines

The CPG represents a significant step towards improving the treatment and management of SUD clients. As with other CPGs, these guidelines are not all inclusive of best practices and/or potential treatment methods. Each unique individual scenario and client should be evaluated and assessed with the application of expert experience and knowledge, as well as recommendations made in this CPG. This CPG should be followed by SUD clinical professional staff and DBH SUD contracted provider staff whom are: Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologists (LCP), Licensed Clinical Social Workers (LCSW), Licensed Professional Clinical Counselors (LPCC), Licensed Marriage and Family Therapists (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians, Certified Alcohol and Other Drug (AOD) Counselors, Peer support staff and others involved in the care of SUD clients.

As stated in the Qualifying Statements, this CPG is not intended to serve as a standard of care. Standards of care are determined on the basis of all clinical data available for a SUD client and are subject to change as scientific knowledge, technology advances and patterns evolve, etc. This CPG is based on current information available and is intended to provide a general guide for best practices. Use of guidelines referenced herein must always be considered as a recommendation within the context of a provider's clinical judgment, as well as the values and

preferences of a client seeking and obtaining SUD services.

## 1. Scope of Guidelines

This CPG was developed to assist SUD providers in managing or co-managing SUD clients. Regardless of the service setting, any client in the DBH SUD system should be offered access to the interventions that are recommended, after taking into consideration the client's specific circumstances and applying clinical expertise accordingly.

The client population of interest for this CPG is adults and/or youth who are eligible for treatment in SUD's continuum of care. Focus should be on *client-centered* treatment and care, accounting for the individual client's needs, preferences and circumstances. Family and support system-involvement should be considered when deemed appropriate in maintaining recovery and fulfilling identified goals. Exceptional communication between SUD professionals and the client seeking/receiving SUD services is essential to the delivery and continued effectiveness of evidence-based service(s). Use of an empathetic and open-minded (versus confrontational or judgmental) approach facilitates discussions that enhance sensitivity to gender, culture, ethnicity, and other culturally-specific considerations and differences. Engagement, treatment and continued care should be provided in a linguistically and culturally appropriate manner in accordance with DBH standards and policies - accommodating for any cultural, physical, sensory, and/or learning disabilities to ensure equitable service delivery across cultures and groups.

This CPG provides practice recommendations for the care of populations with any level of severity. Although screening for, and addressing co-occurring mental disorders, is considered good clinical practice, specific guidance on management of co-occurring mental health conditions and SUD is beyond the scope of this CPG.

A structured algorithm is included in the CPG to provide an illustration of the recommendations in the context of the flow of client care and clinical decision making. It will also assist with training service providers and help facilitate translation of described recommendations into an effective practice.

## 2. Individualized Treatment

It is encouraged that clinicians use an individualized treatment approach that is based on an SUD client's capabilities, needs, and goals, *prior to* treatment experience and preferences. When properly executed, individualized treatment may decrease client anxiety, increase trust in service providers and improve adherence to treatment. Improved SUD client-clinician communication through individualized treatment can be used to enhance openness to discuss future concerns. Regardless of the setting, all clients in the DBH SUD system should be offered access to evidence-based interventions appropriate to the client.

As part of the individualized treatment approach, clinicians should review the outcomes of previous self-change efforts, past treatment experiences, and outcomes (including reasons for treatment drop-out) with the client. The clinician should ask the client about willingness to accept a referral to SUD treatment and/or referrals to other services as recommended by the service provider. Lastly, the clinician should involve the client in prioritizing problems to be addressed and in setting specific goals regardless of the selected SUD setting or level of care.

### 3. Shared Decision Making (SDM)

It is encouraged to focus on shared decision making (SDM) during the delivery and discussion of services. It is most effective and efficient when SUD clients make decisions regarding treatment and care together with their clinicians, sufficient information must be provided by the clinicians to assist the client with making the most informed decision. SUD clinicians must be adept at presenting information to SUD clients regarding client treatment, levels and locations for SUD treatment to ensure effective practices.

### 4. Engagement Strategies

The following principles are fundamental to the engagement/re-engagement process for SUD clients:

- Indicate to the client and significant others that treatment is more effective than no treatment (i.e., “Treatment works”);
- Consider the client’s prior treatment experience and respect client preference for the initial intervention approach(es), since no single intervention approach has emerged as the treatment of choice;
- Use motivational interviewing (MI) style during therapeutic encounters with clients and emphasize the common elements of effective interventions including: improving self-efficacy for change, promoting a therapeutic relationship, strengthening coping skills, changing reinforcement contingencies for recovery, and enhancing social support for recovery;
- Emphasize that the most consistent predictors of successful outcome are retention in formal treatment and/or active involvement with community support for recovery;
- Use strategies demonstrated to be efficacious to promote active involvement in available mutual self-help programs, such as but not limited to; Alcoholics Anonymous (AA), Narcotics Anonymous (NA);
- Coordinate substance use disorder-focused psychosocial interventions with evidence-based intervention(s) for other biopsychosocial problems to address identified concurrent problems consistent with the client’s priorities;
- Provide services utilizing evidence based curriculums. (See Addendum I for examples and descriptions);
- Provide services that are culturally relevant, such as Gender Specific Treatment (See Addendum II);
- Provide services based on needs to be addressed in treatment, such as trauma (See Addendum III);
- Provide intervention in the least restrictive setting necessary to promote access to care, safety and effectiveness;
- If a client drops out of SUD treatment, the treatment team should make efforts to contact the client and re-engage him/her in treatment;
- If the client remains unwilling to engage in any substance use disorder-focused care, maintain an MI style of interaction. Emphasize that options remain available in the future and determine if treatment for medical and psychiatric problems can be effectively and safely provided while identifying opportunities to engage the client in SUD treatment.

Even when clients refuse an SUD referral or are unable to participate in SUD treatment, many are accepting of general medical or mental health care. The chronic illness approach is consistent with management approaches for many other disorders treated in medical and psychiatric settings.

## 5. Certification and Credentialing Standards

This CPG was developed with a focus on evidence-based practices to help improve SUD-client outcomes. Although they are not explicitly evidence-based, attention should be given to standards provided by various certifications and credentialing agencies, such as:

- Department of Health Care Services (DHCS) Alcohol and Other Drug Certification Standards;
- DHCS Drug Medi-Cal Certification;
- Other agencies that provide certification such as:
  - The Joint Commission (TJC). TJC standards at: [http://www.jointcommission.org/standards\\_information/standards.aspx](http://www.jointcommission.org/standards_information/standards.aspx).
  - Commission on Accreditation of Rehabilitation Facilities (CARF) at: <http://www.carf.org/home/>.

A current AOD Counselor Certification is required by law for all individuals providing counseling services in any SUD program licensed or certified by the DHCS.

Certification requirements address important standards and operational functions relating to the engagement and treatment of clients, as well as management of health care organizations. They provide a framework to help manage risk and enhance quality and safety, treatment, and varied services. For DBH, and all other state-licensed and certified providers and facilities/organizations, including DBH, these requirements are considered to be the “standard of care”.

## 6. Management of Substance Use Disorders

If a client is involved in the abuse of alcohol or use of illicit substances they can seek SUD treatment services from DBH SUD by calling the SUD Access Line at (800) 968-2636, or presenting directly to a DBH SUD Contracted Provider or County treatment facility. Referrals can be processed in a variety of ways, including self-referral, referral from other agencies such as Children and Family Services (CFS), Probation/Parole, Primary Care Physicians, Managed Care Plans, or Social Services. SUD treatment consists of the following components:

- **Intake:** The process of determining that a client meets the medical necessity criteria and is then admitted into a substance use disorder treatment program. Intake includes the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment;
- **Individual Counseling:** Contacts between a client and a therapist or counselor. Services provided in-person, by telephone or using telehealth

- **Group Counseling:** Face-to-face contacts in which one or more therapists or counselors treat two (2) or more clients at the same time with a maximum of twelve (12) in the group, focusing on the needs of the clients served;
- **Family Therapy:** The effects of substance use disorders are far-reaching, family members and loved ones are also affected by the disorder. Family Therapy includes family members in the treatment process wherein education about factors that are important to the client's recovery can be conveyed. Family members can provide social support to the client and help motivate the client to remain in treatment. Families receive help and support for their own family recovery as well;
- **Client Education:** Provide research based education on substance use disorders, treatment, recovery, and associated health risks;
- **Medication Services:** The prescription or administration of medication related to substance use treatment services, or the assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services and/or order laboratory testing within their scope of practice or licensure;
- **Collateral Services:** Sessions with therapists or counselors and significant persons to the client that focuses on the treatment needs of the client in terms of supporting the achievement of the client's treatment goals. Significant persons are people that have a personal, not official or professional, relationship with the client in treatment;
- **Crisis Intervention Services:** Contact between a therapist or counselor and a client in crisis. Services focus on alleviating crisis problems. "Crisis" means an actual relapse or an unforeseen event or circumstance which presents to the client an imminent threat of relapse. Crisis intervention services are limited to the stabilization of the client's emergency situation;
- **Treatment Planning:** The SUD provider prepares a written individualized treatment plan (ITP), based upon information obtained in the intake and assessment process. The ITP is completed upon intake and then updated every 90 days unless there is a change in treatment modality or significant event that would require a new ITP. The ITP includes: a statement of problems to be addressed, goals to be reached for each problem, action steps taken by the provider and/or client to accomplish identified goals, target dates for accomplishment of action steps and goals, and a description of services including the type of counseling to be provided and the frequency thereof. ITPs have specific quantifiable goal/treatment objectives related to the client's substance use disorder diagnosis and multidimensional assessment. The ITP identifies the proposed type(s) of interventions/modality that includes a proposed frequency and duration. The ITP is consistent with the qualifying diagnosis and signed by the client's therapist and/or medical doctor.
- **Discharge Services:** The process to prepare the client for referral into another

level of care, post treatment return or reentry into the community, and/or the linkage of the client to essential community treatment, housing and human services.

**Recovery Services:** Treatment designed to emphasize the beneficiary's central role in managing their health, promote the use of effective self-management support strategies, and provide internal and community resources to support ongoing self-management.

## 7. Coordination of Treatment

Clients will be assessed at an approved DBH SUD treatment facility using a biopsychosocial assessment tool and applying the ASAM Criterion to determine the proper level of SUD treatment. In lieu of considering client needs and preference, SUD may recommend a residential treatment episode if a client is assessed as needing residential treatment. The following regulations guide the rehabilitation programs in the various services: DHCS AOD Certification Standards, CCR Title 22, Department of Health Care Services (DHCS) Youth Treatment Guidelines, and DHCS Perinatal Services Network Guidelines.

It is important to recognize strict privacy protections for clients potentially engaging in SUD services or already in treatment. All service providers must adhere to 42 CFR Part 2 Final Rule regulations, which prohibit unauthorized disclosures of client PHI. All DBH staff, including contracted providers, are required to obtain a completed and signed Authorization for Release of Protected Health Information (PHI) form ([COM001\\_E](#)) prior to disclosing client PHI. See DBH Information Notice [18-02](#), Authorization to Release PHI Policy ([COM 0912](#)) and Procedure ([COM 0912-1](#)). It is vitally important that all services provided are in accordance with laws and regulations including applicable policies and procedures.

Care of clients in transition between SUD facilities or services should be coordinated to minimize relapse risk during transitions of care.

## 8. Co-occurring Conditions

### A. Multiple Substance Use Disorders

Clients with multiple substance use disorders should be managed according to the recommendation(s) made for each of type of disorder diagnosed.

### B. Substance Use Disorders and Other Co-occurring Conditions

Clients presenting substance use disorders and a co-occurring chronic medical or psychiatric condition should seek treatment for their medical or psychiatric condition, which may include the following:

- Diabetes;
- Hypertension;
- Major Depressive Disorder (MDD);
- Mild Traumatic Brain Injury (mTBI);
- PTSD;
- Chronic Opioid Therapy;

- Suicidal Ideation or Attempts;
- Eating Disorders;
- Hospital admission within 12months for any reason other than routine child birth.

## A. Medication Assisted Treatment

The proper use of select medications can help treat specific substance use disorders. Clients offered Medications for Addiction Treatment (MAT) should also be offered other appropriate psychosocial treatment interventions, as MAT does not substitute for psychosocial treatment.

Prescribers who treat clients with co-occurring substance use disorders should be familiar with, and include, the use of selected medications recognized as potentially useful for treatment of substance use disorders. Familiarity should include knowledge of proper use of each medication, including proper elements of assessment and management. These parameters do not address the use of medications to ameliorate symptoms of substance intoxication or withdrawal, nor do they address methadone treatment for opioid use disorder. Use of MAT in clients below 18 years of age should be associated with documentation in the medical record of the benefits outweighing the risks for these populations. Authorization should be obtained for any off label use of MAT in individuals under age 18.

### **Alcohol Use Disorder**

Clients who have alcohol use disorder and do not have contraindications for MAT, should be offered treatment trials of naltrexone long acting injectable, naltrexone oral, acamprosate, disulfiram, gabapentin, or topiramate. The order of these trials should be based upon clinical presentation, medical comorbidity and safety with attention paid to hepatic and renal function. The medications, excepting those that are contraindicated or refused, should be offered until one or more of these medications have been found to be effective or the entire series has been tried.

### **Opioid Use Disorder**

Clients, who have opioid use disorder and do not have contraindications for MAT, should be offered buprenorphine/naloxone or naltrexone long acting injectable. The selection of buprenorphine/naloxone or naltrexone long acting injectable shall be based upon the client's clinical characteristics and preferences. Clients who are pregnant or with other validated contraindications to buprenorphine/naloxone shall be offered buprenorphine monotherapy when buprenorphine/naloxone is otherwise indicated.

## B. Medication-Specific Parameters

### **Naltrexone**

In the absence of contraindications, naltrexone long acting injectable should be preferentially selected over other medications for situations involving efforts to reduce ongoing alcohol or opiate consumption or when significant cravings are present. Pregnancy, risk of pregnancy, significant hepatic impairment, concurrent use of narcotic pain medication or chronic pain conditions are considered contraindications. For clients with a history of recent suicidal ideation, suicide attempt, or unstable mood disorder, a trial of oral naltrexone is recommended prior to beginning naltrexone intramuscular.

**Acamprosate**

In the absence of contraindications, acamprosate should be used when limitations in hepatic function preclude the use of other agents.

### **Buprenorphine and Buprenorphine/naloxone**

Buprenorphine or buprenorphine/naloxone should be prescribed for treatment of opioid use disorder by prescribers with the federal waiver authorizing their use of Schedule III, IV, or V medications that are FDA-approved for the treatment of opioid use disorder. Buprenorphine without naloxone should only be used in pregnant clients or when other prohibitions to the use of buprenorphine/naloxone exist.

### **Methadone**

Methadone can be offered to clients with opioid use disorder via a Narcotic Treatment Program (NTP) including pregnant clients. Care should be taken during dosage adjustment to adhere to federal guidelines as respiratory depression can occur.

### **Gabapentin**

Gabapentin should be reserved for treatment of alcohol use disorder in instances in which acamprosate and naltrexone are ineffective, contraindicated, or there is a co-occurring mental disorder that requires gabapentin for treatment.

### **Topiramate**

Topiramate should be reserved for treatment of alcohol use disorder only when acamprosate and naltrexone are ineffective or contraindicated, or in the presence of a comorbid disorder that requires topiramate for treatment. Topiramate is contraindicated in pregnancy and great caution should be exercised when prescribing to women of reproductive age.

## **C. Psychosocial Interventions**

**Cognitive-Behavioral Therapy (CBT)** was developed as a method to prevent relapse when treating problem drinking and later it was adapted for cocaine-addicted clients. Cognitive-behavioral strategies are based on the theory that in the development of maladaptive behavioral patterns like substance abuse, learning processes play a critical role. Clients in CBT learn to identify and correct problematic behaviors by applying a range of different skills that can be used to stop drug abuse and to address a range of other problems that often co-occur.

**Motivational Interviewing (MI)** is a psychotherapeutic approach for substance use disorders that attempts to move a client away from a state of indecision or uncertainty towards finding motivation to making positive decisions and accomplishing established goals. Motivational Interviewing responds to the fact that no single technique is especially effective in resolving substance use disorders or creating psychological change. Instead, the client's motivation determines their success in recovery, whichever technique or method they choose to pursue.

MI is a process that can be completed in a small number of sessions. The typical steps are as follows:

- Engaging: Talking to the client about issues, concerns, hopes and establish a trusting relationship;
- Focusing: Narrowing the conversation to the topic of patterns and habits the client desires to change;
- Evoking: Eliciting client motivation for change by increasing the sense of th

- importance of change, confidence that change can occur, and readiness for change;
- Planning: Developing a set of practical steps the client can use to implement the desired changes.

There are seven key points to MI that should be maintained across variations in motivational technique which are:

1. Motivation comes from the client, not from outside sources;
2. The client is responsible for resolving ambivalence, not the counselor;
3. Ambivalence cannot be resolved through direct persuasion;
4. The counselor quietly elicits information from the client;
5. The counselor guides the client in recognizing and resolving ambivalence;
6. Readiness to change is a fluctuating result of interpersonal interaction, not a trait;
7. The client-counselor relationship should resemble a partnership.

**12-Step Participation** - Twelve-step programs serve as readily available and easily accessible at no cost resources for SUD clients. There is clear evidence from a variety of sources that early involvement in the form of meeting attendance and engagement in recovery activities is associated with better substance use and psychosocial outcomes as well as reduced health care costs. Social workers, health care providers, and behavioral health professionals can increase the likelihood of linking substance abusers, in specialty and non-specialty settings, to 12-Step programs by the methods and style they use in their referral process. Professionals are encouraged to become more familiar with 12-Step programs in general and those in their specific locales, to be aware of the positive outcomes associated with active involvement in such programs, to attempt to match client needs to specific mutual support groups, to incorporate the use of community-based 12-Step volunteers to serve as “bridges” into such groups, and to utilize empirically supported 12-Step facilitative approaches that are adapted to the unique features of their practice settings.

### III. Treatment

#### 1. Alcohol Use Disorder

##### A. Pharmacotherapy

###### **Recommendation**

There is sufficient evidence to recommend the use of MAT in the treatment of alcohol use disorder to manage cravings with the most robust evidence in favor of naltrexone long acting injectable.

##### B. Psychosocial Interventions

###### **Recommendation**

For clients with alcohol use disorder we recommend offering one or more of the following interventions considering the client's preference and provider training/competence:

- Cognitive Behavioral Therapy for substance use disorder;
- Motivational Interviewing;
- 12-Step Facilitation.

## 2. Opioid Use Disorder

### A. Pharmacotherapy

#### **Recommendation**

For clients with opioid use disorder, recommend offering MAT considering client preference:

- Buprenorphine/naloxone;
- Long acting injectable buprenorphine;
- Methadone in an Opioid Treatment Program;
- Naltrexone long acting injectable;
- All clients with opioid use disorder should be offered naloxone and training/education about its use for themselves and for those caring for them.

In pregnant women with opioid use disorder for whom buprenorphine is selected, suggest offering buprenorphine alone (i.e., without naloxone) considering client preferences.

For clients with opioid use disorder for whom buprenorphine is indicated, it is recommended to individualize the choice of appropriate treatment setting (i.e., Opioid Treatment Program or office- based) considering client preferences.

For individuals in whom buprenorphine medication assisted treatment is favored but who may struggle to effectively manage a controlled substance prescription, long acting injectable buprenorphine is recommended. This medication is injected into the subcutaneous tissue by a licensed medical provider every 4 weeks.

For clients with opioid use disorder for whom opioid agonist treatment is contraindicated, unacceptable, unavailable, or discontinued and who have established abstinence for a sufficient period of time (see narrative), we recommend offering:

- Extended-release injectable naltrexone (IE; Vivitrol).

There is insufficient evidence to recommend for or against oral naltrexone for treatment of opioid use disorder.

At initiation of office-based buprenorphine, we recommend addiction-focused Medical Management alone or in conjunction with another psychosocial intervention.

## 3. Cannabis Use Disorder

### A. Pharmacotherapy

#### **Recommendation**

There is insufficient evidence to recommend for or against the use of pharmacotherapy

in the treatment of cannabis use disorder.

### **Discussion**

Some clients seek pharmacologic assistance in cutting down or abstaining from marijuana use. The preliminary evidence for N-acetyl cysteine in the management of cannabis use disorder requires further investigation but has shown promise in the reduction of cannabis cravings in youth.

## **B. Psychosocial Interventions**

### **Recommendation**

For clients with cannabis use disorder, recommend offering one of the following interventions as initial treatment considering client preference and provider training/competence:

- Cognitive Behavioral Therapy;
- Motivational Interviewing;
- 12-Step Participation.

## 4. Stimulant Use Disorder

### A. Pharmacotherapy

#### **Recommendation**

There is insufficient evidence to recommend for or against the use of any pharmacotherapy for the treatment of cocaine use disorder or methamphetamine use disorder.

#### **Discussion**

Despite many different trials using a wide variety of medications, no single medication has demonstrated sufficient efficacy in the treatment of stimulant use disorder.

Given the absence of clear evidence of benefit for pharmacotherapy, clinicians must consider psychosocial interventions.

### B. Psychosocial Interventions

#### **Recommendation**

For clients with stimulant use disorder, we recommend offering one or more of the following interventions as initial treatment considering client preference and provider training/competence:

- Cognitive Behavioral Therapy;
- Motivational Interviewing;
- 12-Step Participation;
- Matrix Model Programs
- Contingency Management

## IV. Promoting Group Mutual Help Involvement

### Recommendation

For SUD clients in early recovery or following relapse, we recommend promoting active involvement in group mutual help programs using one of the following systematic approaches considering client preference and provider training/competence:

- Peer linkage;
- Network support;
- 12-Step Facilitation.

### Discussion

In a peer-helping-peer service alliance, a **peer leader** in stable recovery provides social support services to a **peer** who is seeking help in establishing or maintaining his or her recovery. Both parties are helped by the interaction as the recovery of each is strengthened.

**Figure 1 - Type of Social Support and Associated Peer Recovery Support Services**

Type of Support	Description	Peer Support Service Examples
<b>Emotional</b>	Demonstrate empathy, caring, or concern to bolster person's self-esteem and confidence.	Peer mentoring Peer-led support groups
<b>Informational</b>	Share knowledge and information and/or provide life or vocational skills training.	Parenting class Job readiness training Wellness seminar
<b>Instrumental</b>	Provide concrete assistance to help others accomplish tasks.	Child care Transportation Help accessing community health and social services
<b>Affiliational</b>	Facilitate contacts with other people to promote learning of social and recreational skills, create community, and acquire a sense of belonging.	Recovery centers Sports league participation Alcohol- and drug-free socialization opportunities

Center for Substance Abuse Treatment, *What are Peer Recovery Support Services - HHS Publication No. (SMA) 09-4454*. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009.

## V. Co-occurring Mental Health Conditions and Psychosocial Problems

### **Recommendation**

Among clients in early recovery stages or following relapse, it is recommended to prioritize other needs through shared decision making (e.g., related to other mental health conditions, housing, supportive recovery environment, employment, or related recovery-relevant factors) among identified biopsychosocial problems and arranging services to address these needs.

### **Discussion**

Co-occurring psychosocial problems may affect a client's likelihood of establishing and maintaining good clinical outcomes and improved functional status. Some of these problems are consequences of SUD that persist even after early recovery is established. Others occur independently of substance use disorders, but can complicate access to care or present relapse risk. These problems include co-occurring mental health conditions, access to a supportive recovery environment (housing and social support for sobriety), difficulties with family and social relationships, unemployment or underemployment, and/or unresolved legal issues. Clients are likely to have priorities for when and how these needs are addressed, however, these issues are often related and interact with one another, and can be difficult to prioritize. Although it may be optimal to have services coordinated by a single treatment team, there is likely to be variability in the availability of comprehensive services in different clinical settings.

An important consideration is providing adjunctive recovery services in the least restrictive setting that promotes engagement in continuing SUD care (e.g., via transitional housing that improves access to treatment, accommodating employment schedules and other service appointments). For practical purposes, it is common to defer attention to some initially identified problems and monitor for emerging clinical needs until initial factors stabilize.

## VI. Follow-up

### 1. Response to Treatment

#### **Recommendation**

It is recommended that response to treatment be assessed periodically and systematically, using standardized and validated instrument(s) whenever possible. Indicators of treatment response include ongoing substance use, craving, side effects of medication, emerging symptoms, etc.

#### **Discussion**

Periodic monitoring of clients' progress offers clients and providers the opportunity to identify barriers to adequate progress on problems identified at intake and any new problems that emerge, thereby facilitating needed changes in treatment strategies. Periodic intervals for follow-up or monitoring may include, but are not limited to:

- At agreed upon milestones during treatment;
- At discontinuation or change in level of care;
- Based on other monitoring;
- If client is non-adherent;
- Barriers to adherence with treatment;

With periodic monitoring there are a number of benefits to consider which include:

- Client accountability ("No one will know" is a common trigger for relapse);
- Continual feedback and monitoring of treatment response;
- Compliance with accrediting expectations of outcome evaluation.

When indicated, monitoring should be adjusted to optimize treatment outcomes. There is large variation in client and provider preferences that should be taken into consideration when determining the specific outcomes to measure as well as the methods and frequency. Other implications to consider when customizing care may include client acceptability, resource use, feasibility, and administrative workload.

## 2. Aftercare

### **Recommendation**

For clients who have initiated outpatient or residential treatment, the recommendation is to offer and encourage ongoing systematic relapse prevention efforts or recovery support individualized on the basis of treatment response.

### **Discussion**

Clinicians commonly emphasize that many or most clients in treatment will benefit from continuing care ("aftercare") after participating in a more intensive, initial phase of treatment. The National Institute on Drug Abuse (NIDA) has also stressed that retaining clients for longer treatment durations, in particular 90 days or more, is more likely to lead to successful outcomes.

Appropriate continuing care should be made on the basis of client preference and the availability of treatment options, using evidence-based SUD interventions whenever possible. Continuing care efforts should be directed at preventing relapse and limiting the severity of relapses that do occur, and should address other issues that can interfere with recovery, as needed. Services can be provided via client or group sessions, some continuing care can also be provided over the telephone.

There is variation in client's willingness to engage in continuing care. Moreover, accessibility can be an issue in more rural areas and for clients with disabilities or other issues that make travel to a continuing care program more difficult. For such clients, continuing care by telephone may be considered.

## 3. Discharges

### **Recommendation**

Automatic discharge from care for clients who do not respond to treatment or who relapse is not recommended. Engagement and exploration of barriers to treatment or treatment adherence is recommended.

### **Discussion**

Relapse during the course of treatment is common, even for clients who are receiving effective, evidence-based interventions. Moreover, some clients who eventually abstain may not achieve abstinence early in treatment. At one point, it was common practice in SUD treatment programs to continue to provide standard, unmodified care to such clients or to discharge them. However, it may be possible to improve the outcomes of treatment non-responders by retaining them in care and modifying their treatment in some way. For example, a client who has poor progress toward achieving their goals with outpatient treatment, particularly those who fail to stop using alcohol or illicit drugs, will have better substance use outcomes if they receive treatment in a higher more intense level of care. On the other hand, some clients who are not responding may benefit from a lower intensity treatment approach if they find the current level of care too burdensome. Lower intensity engagement strategies also provide the opportunity to monitor client readiness for involvement in more intensive or other treatment interventions to promote recovery.

It has become standard practice in most areas of medicine to regularly and systematically monitor response to treatment and, on the basis of response to treatment, make modifications to care as needed over time. Therefore, rather than discharge clients who have not responded to treatment, or who responded initially but subsequently resumed problematic substance use, it is suggested providers consider modifying treatment in one of the following ways:

- Add or substitute another medication or psychosocial intervention, and/or
- Change treatment intensity by:
  - Increasing or decreasing the level of care, or
  - Modifying the choice or dose of the medication.
  - Facilitate application of healthcare or behavioral health resources to manage barriers to treatment.

Finally, some non-responders are simply not interested in further SUD treatment of any kind regardless of efforts made to retain them or treatment options made available. Discussions of this should aspect of care should retain a non-punitive tone and clients should be invited to re engage at a more appropriate time.

## VII. Stabilization and Withdrawal

### 1. Standardized Withdrawal Assessments

#### **Recommendation**

For clients with alcohol or opioid use disorder in early abstinence, use of standardized measures to assess the severity of withdrawal symptoms such as Clinical Institute Withdrawal Assessment for Alcohol (revised version) (CIWA-Ar) for alcohol or Clinical Opiate Withdrawal Scale (COWS) for opioids is suggested.

#### **Discussion**

Standardized scales to quantify the severity of alcohol and opioid withdrawal have been developed for clinical and research purposes to aid in the diagnosis of withdrawal, to indicate the need for medications, and to predict severity of alcohol withdrawal and need for intensive care.

The CIWA-Ar is perhaps the most widely adopted standardized scale for assessing alcohol withdrawal,. This is due in part to its ability to meet all three purposes for standardized withdrawal assessment. It has validity and interrater reliability in assessing the severity of alcohol withdrawal, is relatively quick to administer (about one minute for trained administrators), and is able to distinguish alcohol withdrawal symptoms in clients whose vital signs are elevated due to concurrent medical illnesses, such as infections and cardiovascular disease, rather than due to withdrawal itself. It can help predict those clients at risk for more complicated alcohol withdrawal. CIWA-Ar does not predict risk of complicated alcohol withdrawal in clients before the onset of alcohol withdrawal syndrome (AWS).

## 2. High Risk Scenarios

### **Recommendation**

Recommend medical clearances and/or higher-level of withdrawal management for clients with any of the following conditions:

- History of delirium tremens or withdrawal seizures;
- Inability to tolerate oral medication;
- Inability to tolerate oral nutrition/hydration;
- Co-occurring medical conditions that would pose serious risk for ambulatory withdrawal management (e.g., severe coronary artery disease, congestive heart failure, liver cirrhosis);
- Severe alcohol withdrawal (i.e., Clinical Institute Withdrawal Assessment for Alcohol [revised version] [CIWA-Ar] score  $\geq 20$ );
- Risk of withdrawal from other substances in addition to alcohol (e.g., sedative hypnotics).

### **Recommendation**

Medical clearances and/or higher-level of withdrawal management for clients with any of the following conditions with symptoms of at least moderate alcohol withdrawal (i.e., Clinical Institute Withdrawal Assessment for Alcohol [revised version] [CIWA-Ar] score  $\geq 10$ ) and including any of the following conditions is recommended:

- Recurrent unsuccessful attempts at ambulatory withdrawal management;
- Reasonable likelihood that the client will not complete ambulatory withdrawal management (e.g., due to homelessness);
- Active psychosis or severe cognitive impairment;
- Medical conditions that could make ambulatory withdrawal management problematic (e.g., pregnancy, nephrotic syndrome, cardiovascular disease, limited access to medical care or support).

### **Discussion**

AWS includes: insomnia, autonomic symptoms, tremors, nausea and/or vomiting, psychomotor agitation, anxiety, seizures, and hallucinations. There are also specific potential harms (including death) associated with severe AWS and, in the presence of other risk factors, moderate AWS. A client's history of delirium tremens, previous episodes of AWS, and co-occurring medical conditions are all commonly accepted as indications for a higher level of withdrawal management.

### 3. Alcohol Use Disorder Stabilization and Withdrawal

#### **Recommendation**

Recommended pharmacotherapy strategies for managing alcohol withdrawal symptoms:

- A predetermined fixed medication tapering schedule with additional medication as needed.
- Symptom-triggered therapy where clients are given medication only when signs or symptoms of withdrawal occur.

#### **Discussion**

In the fixed dose approach, medication is given in advance of the emergence of anticipated withdrawal signs and symptoms. The advantages of a fixed-dose approach with additional medication as needed are that the client will likely receive sufficient medication to prevent the emergence of alcohol withdrawal signs and symptoms and that the level of clinical monitoring needed may be somewhat less than with the symptom-triggered approach.

The disadvantage of the fixed-dose approach is that, since it is challenging to predict the severity of alcohol withdrawal for any given client, the client may receive more medication than is actually needed and could incur side effects from the medications used to treat withdrawal.

The advantage of the symptom-triggered approach is that the client only receives the amount of medication needed to manage alcohol withdrawal during that specific episode of care. The symptom-triggered approach requires trained staff to assess severity of alcohol withdrawal frequently using a validated measure (typically the CIWA-Ar).

## 4. Medication

### **Recommendation**

Symptom triggered therapy with adequate monitoring is recommended for treatment of moderate to severe alcohol withdrawal because of documented efficacy and a high margin of safety.

### **Discussion**

Evidence supports the use of medium to long acting benzodiazepines in the treatment of Alcohol Withdrawal Syndrome (AWS). Benzodiazepines are generally well tolerated, although some sedation can occur.

## 5. Mild to Moderate Withdrawal

### **Recommendation**

Alternative medications are suggested for managing mild to moderate alcohol withdrawal in clients for whom risks of certain medications outweigh benefits. Using alcohol as an agent for medically supervised withdrawal is not recommended.

### **Discussion**

Studies to date examining the effectiveness of withdrawal medications demonstrate improved outcomes, such as reduction of withdrawal symptoms and reduced time to withdrawal completion.

## 6. Opioid Use Disorder Stabilization and Withdrawal

### **Recommendation**

Withdrawal management alone is not recommended for clients not yet stabilized from opioid use disorder, due to high risk of relapse and overdose (see recommendations 8 and 11).

Among clients with opioid use disorder for whom *maintenance* agonist treatment is contraindicated, unacceptable, or unavailable, using a methadone (in Opioid Treatment Program only) or a buprenorphine/naloxone taper for opioid withdrawal management is recommended.

For clients with opioid use disorder for whom methadone and buprenorphine/naloxone are contraindicated, unacceptable, or unavailable, offering symptom management with ancillary medications which may include clonidine, lofexidine, loperamide etc. is recommended.

### **Discussion**

Administration of long-term opioid agonists or partial agonists is generally preferred over short tapers of opioid agonists in “detoxification” protocols for the treatment of opioid use disorder in clients who are not stabilized.. Most clients who are provided detoxification, particularly those who do not receive formal, structured non-pharmacotherapy treatment, relapse with resultant risk of morbidity and mortality. Methadone has been used effectively over long periods of time with proper monitoring.

The preferred approaches for medically supervised opioid withdrawal are initial stabilization followed by a short or extended taper. Client preferences play an important role in medication selection. The stigma of Narcotic Treatment Programs (NTPs) may prevent a client from choosing this option. In addition, access to care in NTPs and/or buprenorphine/naloxone (from a provider with the appropriate DEA authorization) can be considered. According to the federal regulation, a physician must have “the capacity to refer the clients for appropriate counseling and other appropriate ancillary services.”

## **7. Sedative Hypnotic Use Disorder Stabilization and Withdrawal**

### **Recommendation**

One of the following is suggested for clients in need of withdrawal management for sedative hypnotics:

- Gradually taper the original benzodiazepine;
- Substitute a longer acting benzodiazepine then taper gradually;
- Substitute phenobarbital for the substance of concern and taper gradually.

### **Discussion**

Benzodiazepine discontinuation is associated with a characteristic triad of symptoms: recurrence, rebound, and withdrawal. While the pattern and intensity of recurrent symptoms often resemble those of the original illness, rebound symptoms may be more intense and withdrawal symptoms may be severe and debilitating. Optimal clinical management of benzodiazepine discontinuation, including avoidance of abrupt drug discontinuation, can lessen withdrawal symptoms and promote successful drug discontinuation or dose reduction.

The clinical approach to benzodiazepine discontinuation is gradual dose tapering. Data varies on the optimal rate of withdrawal; optimal duration of withdrawal may vary from client to client.

Management of benzodiazepine withdrawal and client outcomes can be improved when extended tapering interventions take place in a structured clinical environment which includes close monitoring, optimized client instruction/education, and Cognitive Behavioral Therapy (CBT). Clients should be monitored throughout the tapering period for withdrawal symptoms as well as for the disorder being treated; emergence of severe withdrawal symptoms signals a need to slow the tapering process.

## **8. Emergency Department Bridge Buprenorphine Medication Assisted Treatment Stabilization Visit**

### **Recommendation**

SUD recommends that clients be scheduled for an Outpatient stabilization visit within three (3) days of their last treatment with a buprenorphine product in the Emergency Department (ED) for clients who receive Medication Assisted Treatment (MAT) induction with a buprenorphine product in an ED setting.

### **Discussion**

Obtain a history with the client noting the details of the client's opiate use including any other substance use disorder, current or past medical conditions, current or past psychiatric condition as well as current medications. For females of reproductive age, a urine pregnancy test can be completed. Effort should also be made to explore any history of renal, hepatic or cardiac impairment as well as any history of chronic pain and related conditions.

Review a plan of action for managing the medical, psychiatric or social issues raised during the history and physical exam. Case management services can be engaged to connect the client to services as needed. Referral to treatment as determined by the American Society for Addiction Medicine (ASAM) is recommended.

## VIII. Knowledge Gaps and Recommended Research

Further evidence is needed in particular areas of management for SUD. The items listed below are selected examples of gaps in knowledge. Organizations such as the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) put forth strategic plans which also can be used as resources on the current gaps and areas of focus for research in the future.

### 1. Determination of Treatment Setting

Future research is needed to evaluate whether recently developed software to conduct the multidimensional assessment and yield an algorithmically derived placement recommendation leads to better outcomes than clinical judgment that may rely more generally on the six ASAM assessment dimensions and placement principles.

### 2. Pharmacotherapy

There are many unanswered questions regarding use of pharmacotherapy in SUD. The following are select examples of these questions. More research is needed to identify medications for the majority of the categories of SUD, including cannabis use disorder.

#### Opioid Use Disorder

While strong evidence supports opioid agonist therapy (OAT), as well as MAT with buprenorphine/naloxone or naltrexone extended release injectable, further research is needed to determine additional measures to improve treatment retention and medication adherence.

#### Stimulant Use Disorder

Further research into the use of MAT to treat methamphetamine use disorder is indicated. Additional research should be conducted on pharmacotherapy for stimulant use disorders.

### **3. Psychosocial Interventions**

#### **Substance Use Disorders**

Further research is needed regarding appropriate additional non-pharmacological therapy specific to the client and to the setting of care. Additionally, research is needed regarding the comparative effectiveness of interventions when delivered to clients in groups. Current staffing models are based on care being delivered in a group format for all SUDs. More research is needed to determine specific protocols, efficacy and effectiveness of the group approach.

#### **Opioid Use Disorder**

Further research is needed to determine the benefits of additional psychosocial interventions to address co-occurring conditions in opioid treatment settings.

### **4. Follow-up**

Further research is needed to determine models for effective and cost-effective continuing care. Further research may also be needed to compare the risks and benefits of automatic discharge from care and of various models of adjusting care based on response to treatment.

Further research is needed to define the risks and benefits of systematic assessment scales and decision support tools for withdrawal treatment in common treatment settings.

### **5. Telehealth**

Additional research on the use of telehealth in SUD may be beneficial, as evidence-based psychosocial interventions are not currently offered in all locations and as demonstrated during the COVID-19 pandemic, psychosocial interventions may be more safely provided via remotely under certain circumstances. Telehealth may help address barriers to care that contribute to low engagement in treatment in the SUD client population.

## Evidence Based Curriculums

### The Matrix Model

The Matrix Model is a style of treatment developed to aid in recovery from stimulant substances like methamphetamine and cocaine. The method was created in the 1980's and has seen widespread success. The Matrix Model is:

- An integrative treatment includes aspects of many different therapeutic styles and psychological orientations;
- An intensive outpatient program (IOP) entails several hours of treatment each day as well as several days per week while allowing the client to still live at home;
- A highly-structured program is developed to be thorough while engineered with planned topics and sequencing for each session and phase of treatment;
- A time-limited treatment is a model that is intended to last for 16 weeks, but can be extended for a year depending on the needs of the client;
- A proven treatment: Multiple studies have shown the benefit of the treatment based on extending recovery and client consistency. Beyond stimulants, the model is helpful for a range of substance use issues. The efficacy has been so clear that many organizations support the treatment protocol, including the National Institute on Drug Abuse (NIDA).

The Matrix Model is a proven and effective system. The organizing principles of the Matrix Model have been developed and modified over a 20 year period, using data from the treatment experience of over 6,000 cocaine and 2,500 methamphetamine addicted individuals. The Matrix Model works because it:

- Creates explicit structure and expectations;
- Establishes a positive, collaborative relationship with each client;
- Teaches information and cognitive-behavioral concepts;
- Positively reinforces positive behavior change;
- Provides corrective feedback when necessary, roll with resistance;
- Educates family regarding stimulant abuse recovery;
- Introduces and encourages self-help participation;
- Uses urinalysis to monitor drug use.

The Matrix Model considers that treatment outcomes grow when the entire family and support network of the client are active in treatment. It allows family to be informed of addiction and recovery. Additionally, they will receive education regarding the signs of relapse and methods to modify their behavior to be more desirable and helpful for the client. Clients and families are encouraged to attend weekly sessions together. These groups can expand on information discussed during the client/family sessions. The Model is federally recognized by:

- Center for Substance Abuse Treatment (CSAT);
- National Institute on Drug Abuse (NIDA);
- Office of National Drug Control Policy and Department of Justice (National Synthetic Drugs Action Plan);
- Drug Strategies;
- Under review by the National Registry of Effective Programs and Practices (SAMHSA).

## **Living in Balance**

Living in Balance (LIB) is a research based, flexible, practical and user friendly substance abuse treatment curriculum that helps clients address issues in lifestyle areas that may have been neglected during addiction. LIB was developed by Danya International with funding from National Institute on Drug Abuse (NIDA). LIB was developed for all addiction professionals who provide professional therapeutic services to clients for addiction treatment.

The LIB approach was also developed to provide addiction professionals with a practical guideline in performing a series of 36 group treatment sessions. The intent of the LIB program is to save addiction professional time and expense by providing pre-prepared sessions, similar to a teacher's lesson plans. Each of the 36 treatment sessions allows for approximately 90 minutes of counselor interventions, presentations, or client training and includes sufficient time for questions. The LIB approach improves group counseling in any type of drug treatment setting as well can be used as a primary modality over a period of 4 to 6 months, in combination with other treatment approaches, and for varying lengths of time.

The goal of the psychoeducational approach of LIB is to provide education, information, and experiences that will allow people to lead healthy and productive lives without the use of alcohol and other drugs by providing:

- Accurate information about the substances of abuse, relapse prevention, self-help programs, medical and physical health, emotional and social health, sexual and spiritual health, and daily living skills;
- Information for each session divided into manageable segments;
- Written exercises for each session that engage and help clients to better understand the information and receive reinforcement for learned information;
- Several role-play exercises that encourage intense interaction, discussion, and thought-provoking experiences among clients;
- Relaxation and visualization exercises.

Relapse Prevention (RP) is the single most important component of LIB program. The first section of the program is devoted primarily to developing RP skills. Sessions are scheduled strategically throughout the program. The LIB RP helps clients:

- Identify situations that trigger cravings;
- Understand the chain of events, including "small decisions," that lead from trigger to drug use;
- Disrupt the chain at an early point;
- Cope with triggers by using thought-stopping, visualization, and relaxation techniques;
- Develop immediate alternatives to drug use;
- Develop a long-term plan for full recovery.

## **Seeking Safety**

Seeking Safety is a present-focused therapy to help people attain safety from trauma/Post-traumatic Disorder (PTSD) and substance abuse. The treatment is available as a book, providing both client

handouts and a clinician guide allowing treatment to be flexible. It has been conducted in group and client format; for females, males, and mixed-gender; with adults and adolescents; using all topics or fewer topics; in a variety of settings (outpatient, inpatient, residential); and for both substance abuse and dependence. It has also been used with people who have a trauma history, but do not meet criteria for PTSD; or for those with substance use disorder, but no trauma/PTSD.

Seeking Safety offers 25 topics that can be conducted in any order and as few or many as time allows. Clients do not have to meet formal criteria for Post-traumatic Stress Disorder (PTSD) or substance abuse; it is often used as a general model to teach coping skills. Seeking Safety has been successfully implemented for many years across vulnerable populations including homeless, criminal justice, domestic violence, severely mentally ill, veterans, military, and others.

The key principles of Seeking Safety:

1. Safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions);
2. Integrated treatment (working on both trauma and substance abuse at the same time);
3. A focus on ideals to counteract the loss of ideals in both trauma and substance abuse;
4. Four content areas: cognitive, behavioral, interpersonal, case management;
5. Attention to clinician processes clinicians' emotional responses, self-care, etc.

**GENDER SPECIFIC TREATMENT**

Gender does not appear to predict retention in substance abuse treatment. Women are as likely as men to stay in treatment once treatment is initiated. Factors that encourage a woman to stay in treatment include supportive therapy, a collaborative therapeutic alliance, onsite child care and children services, and other integrated and comprehensive treatment services. Sociodemographics also play a role in treatment retention. Studies suggest that support and participation of significant others, being older, and having at least a high school education are important factors that improve retention. Criminal justice system or child protective service involvement also is associated with longer lengths of treatment. Women are more likely to stay in treatment if they have had prior successful experiences in other life areas and possess confidence in the treatment process and outcome. Although pregnancy may motivate women in initiating treatment, studies suggest that pregnant women do not stay in treatment as long and that retention may be significantly affected by stage of pregnancy and the presence of co-occurring psychiatric disorders.

Limited research is available highlighting specific therapeutic approaches for women outside of trauma-informed services. In recent years, more attention has been given to effective women's treatment programming across systems with considerable emphasis on integrated care and the identification of specific treatment issues and needs for women. Gender specific factors may influence the treatment process and recovery revolve around the importance of relationships, the influence of family, and the role of substance use in sexuality, the prevalence and history of trauma and violence, and common patterns of co-occurring disorders. Substance use disorders and co- occurring mental disorders, diagnoses of posttraumatic stress and other anxiety disorders, postpartum depression and other mood disorders, and eating disorders are more prevalent than among women than men. Consequently, clinical strategies, treatment programming, and administrative treatment policies must address these issues to adequately treat women. Likewise, women often need clinical and treatment services tailored to effectively address pregnancy, child care, children services, and parenting skills.

Empirical data suggests that women are as likely as men to attend continuing care services. Transition from a more intensive level of care to less intensive services has proven to be challenging for all clients, but evidence suggests that women will continue with services if they stay within the same agency and/or effort is made to connect them to the new service provider prior to transition.

Gender-responsive treatment involves a safe and non-punitive atmosphere, where staff holds a hopeful and positive attitude toward women and show investment in learning about women's experiences, treatment needs, and appropriate interventions. Administrators need to invest in staff training and supervision and show a commitment to training beyond immediate services. Training should include other social and healthcare facilities and personnel within the community to enhance awareness, identify women with substance use disorders, and increase appropriate referrals. As research, programming, and clinical experience expand along gender lines in substance abuse treatment, clinicians and administrators alike will have considerable opportunities in adapting new standards of care for women. (SAMHSA TIP 51: Addressing Specific Needs of Women)

**TRAUMA INFORMED CARE**

According to SAMHSA's Trauma and Justice Strategic Initiative, "trauma results from an event, series of events, or set of circumstances that is experienced by a client as physically or emotionally harmful or threatening and that has lasting adverse effects on the client's functioning and physical, social, emotional, or spiritual well-being" (SAMHSA, 2012, p. 2). Trauma can affect people of every race, ethnicity, age, sexual orientation, gender, psychosocial background, and geographic region. A traumatic experience can be a single event, a series of events, and/or chronic condition (e.g., childhood neglect, domestic violence). Traumas can affect clients, families, groups, communities, specific cultures, and generations. It generally overwhelms a client's or community's resources to cope, and it often ignites the "fight, flight, or freeze" reaction at the time of the event(s). It frequently produces a sense of fear, vulnerability, and helplessness.

For some people, reactions to a traumatic event are temporary, whereas others have prolonged reactions that move from acute symptoms to more severe, prolonged, or enduring mental health consequences (e.g., posttraumatic stress and other anxiety disorders, substance use and mood disorders) and medical problems (e.g., arthritis, headaches, chronic pain).

Trauma was once considered an abnormal experience. However, the first National Comorbidity Study established how prevalent traumas were in the lives of the general population of the United States. In the study, 61 percent of men and 51 percent of women reported experiencing at least one trauma in their lifetime, with witnessing a trauma, being involved in a natural disaster, and/or experiencing a life-threatening accident ranking as the most common events (Kessler et al., 1999). Integrating Trauma Informed Care (TIC) into behavioral health services provides many benefits not only for clients, but also for their families' and communities, for behavioral health service organizations, and for staff. Trauma-informed services bring to the forefront the belief that trauma can pervasively affect a client's well-being, including physical and mental health. For behavioral health service providers, trauma-informed practice offers many opportunities. It reinforces the importance of acquiring trauma-specific knowledge and skills to meet the specific needs of clients; of recognizing that clients may be affected by trauma regardless of its acknowledgment; of understanding that trauma likely affects many clients who are seeking behavioral health services; and of acknowledging that organizations and providers can traumatize clients through standard or unexamined policies and practices. TIC stresses the importance of addressing the client individually rather than applying general treatment approaches.

TIC provides clients more opportunities to engage in services that reflect a compassionate perspective of their presenting problems. TIC can potentially provide a greater sense of safety for clients who have histories of trauma and platform for preventing more serious consequences of traumatic stress (Fallot & Harris, 2001). Although many clients may not identify the need to connect with their histories, trauma-informed services offer clients a chance to explore the impact of trauma, their strengths and creative adaptations in managing traumatic histories, their resilience, and the relationships among trauma, substance use, and psychological symptoms.