

# Brief Summary

## GUIDELINE TITLE

Practice guideline for the treatment of patients with substance use disorders.

## BIBLIOGRAPHIC SOURCE(S)

- Work Group on Substance Use Disorders, Kleber HD, Weiss RD, Anton RF, Rounsaville BJ, George TP, Strain EC, Greenfield SF, Ziedonis DM, Kosten TR, Hennessy G, O'Brien CP, Connery HS, American Psychiatric Association Steering Committee on Practice Guidelines, McIntyre JS, Charles SC, Anzia DJ, Nininger JE, Cook IA, Summergrad P, Finnerty MT, Woods SM, Johnson BR, Yager J, Pyles R, Lurie L, Cross CD, Walker RD, Peele R, Barnovitz MA, Gray SH, Shemo JP, Saxena S, Tonnu T, Kunkle R, Albert AB, Fochtman LJ, Hart C, Regier D. Treatment of patients with substance use disorders, second edition. American Psychiatric Association. Am J Psychiatry 2006 Aug;163(8 Suppl):5-82. [PubMed](#)

## GUIDELINE STATUS

According to the guideline developer, this guideline is still considered to be current as of April 2007. A Guideline Watch, which summarizes significant developments in practice since the publication of the original guideline, was published in April 2007 and is available from the [American Psychiatric Association Web site](#) (see also the "Availability of Companion Documents" field below).

## \*\* REGULATORY ALERT \*\*

### FDA WARNING/REGULATORY ALERT

**Note from the National Guideline Clearinghouse:** This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- [July 1, 2005, Antidepressants](#): Public Health Advisory issued to update patients and healthcare providers in response to recent scientific publications that report the possibility of increased risk of suicidal behavior in adults treated with antidepressants.

## BRIEF SUMMARY CONTENT

[\\*\\* REGULATORY ALERT \\*\\*](#)

[RECOMMENDATIONS](#)

[EVIDENCE SUPPORTING THE RECOMMENDATIONS](#)

[IDENTIFYING INFORMATION AND AVAILABILITY](#)

[DISCLAIMER](#)

[Go to the Complete Summary](#)

## RECOMMENDATIONS

### MAJOR RECOMMENDATIONS

Each recommendation is identified as falling into one of three categories of endorsement, based on the level of confidence regarding the recommendation, as indicated by a

bracketed Roman numeral after the statement. Definitions of the categories of endorsement are presented at the end of the "Major Recommendations" field.

## **General Treatment Principles**

Individuals with substance use disorders are heterogeneous with regard to a number of clinically important features and domains of functioning. Consequently, a multimodal approach to treatment is typically required. Care of individuals with substance use disorders includes conducting a complete assessment, treating intoxication and withdrawal syndromes when necessary, addressing co-occurring psychiatric and general medical conditions, and developing and implementing an overall treatment plan. The goals of treatment include the achievement of abstinence or reduction in the use and effects of substances, reduction in the frequency and severity of relapse to substance use, and improvement in psychological and social functioning.

### **1. Assessment**

A comprehensive psychiatric evaluation is essential to guide the treatment of a patient with a substance use disorder [I]. The assessment includes 1) a detailed history of the patient's past and present substance use and the effects of substance use on the patient's cognitive, psychological, behavioral, and physiological functioning; 2) a general medical and psychiatric history and examination; 3) a history of psychiatric treatments and outcomes; 4) a family and social history; 5) screening of blood, breath, or urine for substance used; 6) other laboratory tests to help confirm the presence or absence of conditions that frequently co-occur with substance use disorders; and 7) with the patient's permission, contacting a significant other for additional information.

### **2. Psychiatric Management**

Psychiatric management is the foundation of treatment for patients with substance use disorders [I]. Psychiatric management has the following specific objectives: motivating the patient to change, establishing and maintaining a therapeutic alliance with the patient, assessing the patient's safety and clinical status, managing the patient's intoxication and withdrawal states, developing and facilitating the patient's adherence to a treatment plan, preventing the patient's relapse, educating the patient about substance use disorders, and reducing the morbidity and sequelae of substance use disorders. Psychiatric management is generally combined with specific treatments carried out in a collaborative manner with professionals of various disciplines at a variety of sites, including community-based agencies, clinics, hospitals, detoxification programs, and residential treatment facilities. Many patients benefit from involvement in self-help group meetings, and such involvement can be encouraged as part of psychiatric management.

### **3. Specific Treatments**

The specific pharmacologic and psychosocial treatments reviewed below are generally applied in the context of programs that combine a number of different treatment modalities.

a. *Pharmacologic Treatments*

Pharmacologic treatments are beneficial for selected patients with specific substance use disorders [I]. The categories of pharmacologic treatments are 1) medications to treat intoxication and withdrawal states; 2) medications to decrease the reinforcing effects of abused substances; 3) agonist maintenance therapies, 4) antagonist therapies, 5) abstinence-promoting and relapse prevention therapies, and 6) medications to treat co-occurring psychiatric conditions.

b. *Psychosocial Treatments*

Psychosocial treatments are essential components of a comprehensive treatment program [I]. Evidence-based psychosocial treatments include cognitive-behavioral therapies (CBTs, e.g., relapse prevention, social skills training), motivational enhancement therapy (MET), behavioral therapies (e.g., community reinforcement, contingency management), 12-step facilitation (TSF), psychodynamic therapy/interpersonal therapy (IPT), self-help manuals, behavioral self-control, brief interventions, case management, and group, marital, and family therapies. There is evidence to support the efficacy of integrated treatment for patients with a co-occurring substance use and psychiatric disorder; such treatment includes blending psychosocial therapies used to treat specific substance use disorders with psychosocial treatment approaches for other psychiatric diagnoses (e.g., CBT for depression).

4. **Formulation and Implementation of a Treatment Plan**

The goals of treatment and the specific therapies chosen to achieve these goals may vary among patients and even for the same patient at different phases of an illness [I]. Because many substance use disorders are chronic, patients usually require long-term treatment, although the intensity and specific components of treatment may vary over time [I]. The treatment plan includes the following components: 1) psychiatric management; 2) a strategy for achieving abstinence or reducing the effects or use of substances of abuse; 3) efforts to enhance ongoing adherence with the treatment program, prevent relapse, and improve functioning; and 4) additional treatments necessary for patients with a co-occurring mental illness or general medical condition.

The duration of treatment should be tailored to the individual patient's needs and may vary from a few months to several years [I]. It is important to intensify the monitoring for substance use during periods when the patient is at a high risk of relapsing, including during the early stages of treatment, times of transition to less intensive levels of care, and the first year after active treatment has ceased [I].

## 5. Treatment Settings

Treatment settings vary with regard to the availability of specific treatment modalities, the degree of restricted access to substances that are likely to be abused, the availability of general medical and psychiatric care, and the overall milieu and treatment philosophy.

Patients should be treated in the least restrictive setting that is likely to be safe and effective [I]. Commonly available treatment settings include hospitals, residential treatment facilities, partial hospitalization programs, and outpatient programs. Decisions regarding the site of care should be based on patients' ability to cooperate with and benefit from the treatment offered, refrain from illicit use of substances, and avoid high-risk behaviors, as well as the patient's need for structure and support or particular treatments that may be available only in certain settings [I]. Patients move from one level of care to another on the basis of these factors and an assessment of their ability to safely benefit from a different level of care [I].

Hospitalization is appropriate for patients who 1) have a substance overdose who cannot be safely treated in an outpatient or emergency department setting; 2) are at risk for severe or medically complicated withdrawal syndromes (e.g., history of delirium tremens, documented history of very heavy alcohol use and high tolerance); 3) have co-occurring general medical conditions that make ambulatory detoxification unsafe; 4) have a documented history of not engaging in or benefiting from treatment in a less intensive setting (e.g., residential, outpatient); 5) have a level of psychiatric comorbidity that would markedly impair their ability to participate in, adhere to, or benefit from treatment or have a co-occurring disorder that by itself would require hospital-level care (e.g., depression with suicidal thoughts, acute psychosis); 6) manifest substance use or other behaviors that constitute an acute danger to themselves or others; or 7) have not responded to or were unable to adhere to less intensive treatment efforts and have a substance use disorder(s) that endangers others or poses an ongoing threat to their physical and mental health [I].

Residential treatment is indicated for patients who do not meet the clinical criteria for hospitalization but whose lives and social interactions have come to focus predominantly on substance use, who lack sufficient social and vocational skills, and who lack substance-free social supports to maintain abstinence in an outpatient setting [II]. Residential treatment of  $\geq 3$  months is associated with better long-term outcome in such patients [II]. For patients with an opioid use disorder, therapeutic communities have been found effective [II].

Partial hospitalization should be considered for patients who require intensive care but have a reasonable probability of refraining from illicit use of substances outside a restricted setting [II]. Partial hospitalization settings are frequently used for patients leaving hospitals or residential settings who remain at high risk for relapse. These include patients who are thought to lack sufficient motivation to continue in treatment, have severe psychiatric comorbidity and/or a history of

relapse to substance use in the immediate posthospitalization or postresidential period, and are returning to a high-risk environment and have limited psychosocial supports for abstaining from substance use. Partial hospitalization programs are also indicated for patients who are doing poorly in intensive outpatient treatment [II].

Outpatient treatment of substance use disorders is appropriate for patients whose clinical condition or environmental circumstances do not require a more intensive level of care [I]. As in other treatment settings, a comprehensive approach is optimal using, where indicated, a variety of psychotherapeutic and pharmacological interventions, along with behavioral monitoring [I]. Most treatment for patients with alcohol dependence or abuse can be successfully conducted outside the hospital (e.g., in outpatient or partial hospitalization settings) [III], although patients with alcohol withdrawal must be detoxified in a setting that provides frequent clinical assessment and any necessary treatments [I]. For many patients with a cocaine use disorder, clinical and research experience suggests the effectiveness of intensive outpatient treatment in which a variety of treatment modalities are simultaneously used and in which the focus is the maintenance of abstinence [II]. The treatment of patients with nicotine dependence or a marijuana use disorder occurs on an outpatient basis unless patients are hospitalized for other reasons [I].

#### 6. **Clinical Features Influencing Treatment**

In planning and implementing treatment, a clinician should consider several variables with regard to patients: comorbid psychiatric and general medical conditions, gender-related factors, age, social milieu and living environment, cultural factors, gay/lesbian/bisexual/transgender issues, and family characteristics [I]. Given the high prevalence of comorbidity of substance use disorders and other psychiatric disorders, the diagnostic distinction between substance use symptoms and those of other disorders should receive particular attention, and specific treatment of comorbid disorders should be provided [I]. In addition to pharmacotherapies specific to a patient's substance use disorder, various psychotherapies may also be indicated when a patient has a co-occurring psychiatric disorder, psychosocial stressors, or other life circumstances that exacerbate the substance use disorder or interfere with treatment [I]. A patient's cessation of substance use may also be associated with changes in his or her psychiatric symptoms or the metabolism of medications (e.g., altered antipsychotic metabolism via cytochrome P450 1A2 with smoking cessation) that will necessitate adjustment of psychotropic medication doses [I].

In women of childbearing age, the possibility of pregnancy needs to be considered [I]. Each of the substances discussed in this practice guideline has the potential to affect the fetus, and psychosocial treatment to encourage substance abstinence during pregnancy is recommended [I]. With some substances, concomitant agonist treatment may be preferable to continued substance use. In pregnant smokers, treatment with nicotine replacement therapy (NRT) may be helpful [III].

For pregnant women with an opioid use disorder, treatment with methadone [I] or buprenorphine [II] can be a useful adjunct to psychosocial treatment.

## **Nicotine Use Disorders: Treatment Principles and Alternatives**

### **1. Pharmacological Treatments**

Pharmacological treatment is recommended for individuals who wish to stop smoking and have not achieved cessation without pharmacological agents or who prefer to use such agents [I]. There are six medications approved by the U.S. Food and Drug Administration (FDA) for nicotine dependence, including five NRTs (patch, gum, spray, lozenge, and inhaler) and bupropion. These are all first-line agents that are equally effective in alleviating withdrawal symptoms and reducing smoking. Any of these could be used based on patient preference, the route of administration, and the side-effect profile [I]. Significant adverse events to NRTs, including dependence, are rare. Although combined psychosocial and medication treatment produces the best outcomes in treating nicotine use disorders, these medications are effective even when no psychosocial treatment is provided [I]. Using a combination of these first-line treatments may also improve outcome [II]. Nortriptyline and clonidine have utility as second-line agents but appear to have more side effects [II]. Other medications and acupuncture have not been proven to be effective.

### **2. Psychosocial Treatments**

Psychosocial treatments are also effective for the treatment of nicotine dependence and include CBTs [I], behavioral therapies [I], brief interventions [II], and MET [II] provided in individual [I], group [I], or telephone [I] formats or via self-help materials [III] and Internet-based formats [III]. The efficacy of treatment is related to the amount of psychosocial treatment received. The 12-step programs, hypnosis, and inpatient therapy have not been proven effective.

## **Alcohol Use Disorders: Treatment Principles and Alternatives**

### **1. Management of Intoxication and Withdrawal**

The acutely intoxicated patient should be monitored and maintained in a safe environment [II]. Symptoms of alcohol withdrawal typically begin within 4-12 hours after cessation or reduction of alcohol use, peak in intensity during the second day of abstinence, and generally resolve within 4-5 days. Serious complications include seizures, hallucinations, and delirium.

The treatment of patients in moderate to severe withdrawal includes efforts to reduce central nervous system (CNS) irritability and restore physiological homeostasis [I] and generally requires the use of thiamine and fluids [I], benzodiazepines [I], and, in some patients, other medications such as anticonvulsants, clonidine, or antipsychotic agents [II]. Once clinical stability is achieved, the tapering of benzodiazepines and other medications should be carried out as necessary, and the patient should be observed for the reemergence of

withdrawal symptoms and the emergence of signs and symptoms suggestive of co-occurring psychiatric disorders [I].

## 2. Pharmacologic Treatments

Specific pharmacotherapies for alcohol-dependent patients have well-established efficacy and moderate effectiveness. Naltrexone may attenuate some of the reinforcing effects of alcohol [I], although data on its long-term efficacy are limited. The use of long-acting, injectable naltrexone may promote adherence, but published research is limited. Acamprosate, a gamma-aminobutyric acid (GABA) analog that may decrease alcohol craving in abstinent individuals, may also be an effective adjunctive medication in motivated patients who are concomitantly receiving psychosocial treatment [I]. Disulfiram is an effective adjunct to a comprehensive treatment program in reliable, motivated patients whose drinking may be triggered by events that suddenly increase alcohol craving [II].

## 3. Psychosocial Treatments

Psychosocial treatments found effective for selected patients with an alcohol use disorder include MET [I], CBT [I], behavioral therapies [I], TSF [I], marital and family therapies [I], group therapies [II], and psychodynamic therapy/IPT [III]. Recommending that patients participate in self-help groups, such as Alcoholics Anonymous (AA), is often helpful [I].

## **Marijuana Use Disorders: Treatment Principles and Alternatives**

Studies of treatment for marijuana use disorders are limited. No specific pharmacotherapies for marijuana withdrawal or dependence can be recommended [I]. In terms of psychosocial therapies, an intensive relapse prevention approach that combines motivational interventions with the development of coping skills may be effective for the treatment of marijuana dependence [III], but further study of these approaches is necessary.

## **Cocaine Use Disorders: Treatment Principles and Alternatives**

### 1. Management of Intoxication and Withdrawal

Cocaine intoxication is usually self-limited and typically requires only supportive care [II]. However, hypertension, tachycardia, seizures, and persecutory delusions can occur with cocaine intoxication and may require specific treatment [II]. Acutely agitated patients may benefit from sedation with benzodiazepines [III].

### 2. Pharmacologic Treatments

Pharmacologic treatment is not ordinarily indicated as an initial treatment for patients with cocaine dependence. In addition, no pharmacotherapies have FDA indications for the treatment of cocaine dependence. However, for individuals who fail to respond to psychosocial treatment alone, some medications (topiramate, disulfiram, or modafinil) may be promising when integrated into psychosocial treatments.

### 3. Psychosocial Treatments

For many patients with a cocaine use disorder, psychosocial treatments focusing on abstinence are effective [I]. In particular, CBTs [I], behavioral therapies [I], and 12-step-oriented individual drug counseling [I] can be useful, although efficacy of these therapies varies across subgroups of patients. Recommending regular participation in a self-help group may improve the outcome for selected patients with a cocaine use disorder [III].

## **Opioid Use Disorders: Treatment Principles and Alternatives**

### 1. Management of Opioid Intoxication and Withdrawal

Acute opioid intoxication of mild to moderate degree usually does not require specific treatment [II]. However, severe opioid overdose, marked by respiratory depression, may be fatal and requires treatment in an emergency department or inpatient setting [I]. Naloxone will reverse respiratory depression and other manifestations of opioid overdose [I].

The treatment of opioid withdrawal is directed at safely ameliorating acute symptoms and facilitating the patient's entry into a long-term treatment program for opioid use disorders [I]. Strategies found to be effective include substitution of methadone or buprenorphine for the opioid followed by gradual tapering [I]; abrupt discontinuation of opioids, with the use of clonidine to suppress withdrawal symptoms [II]; and clonidine-naltrexone detoxification [II]. It is essential that the treating physician assess the patient for the presence of other substances, particularly alcohol, benzodiazepines, or other anxiolytic or sedative agents, because the concurrent use of or withdrawal from other substances can complicate the treatment of opioid withdrawal [I]. Anesthesia-assisted rapid opioid detoxification (AROD) is not recommended because of lack of proven efficacy and adverse risk-benefit ratios.

### 2. Pharmacologic Treatments

Maintenance treatment with methadone or buprenorphine is appropriate for patients with a prolonged history (>1 year) of opioid dependence [I]. The goals of treatment are to achieve a stable maintenance dose of opioid agonist and facilitate engagement in a comprehensive program of rehabilitation [I]. Maintenance treatment with naltrexone is an alternative strategy [I], although the utility of this strategy is often limited by lack of patient adherence and low treatment retention.

### 3. Psychosocial Treatments

Psychosocial treatments are effective components of a comprehensive plan for patients with an opioid use disorder [II]. Behavioral therapies (e.g., contingency management) [II], CBTs [II], psychodynamic psychotherapy [III], and group and family therapies [III] have been found to be effective for some patients with an opioid use disorder. Recommending regular participation in self-help groups may also be useful [III].

## **Definition of the Three Categories of Endorsement**

[I] Recommended with substantial clinical confidence.

[II] Recommended with moderate clinical confidence.

[III] May be recommended on the basis of individual circumstances.

## **CLINICAL ALGORITHM(S)**

None provided

[Top^](#)

## **EVIDENCE SUPPORTING THE RECOMMENDATIONS**

### **TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS**

The type of evidence supporting the recommendations is not specifically stated.

The evidence base for practice guidelines is derived from two sources: research studies and clinical consensus. Where gaps exist in the research data, evidence is derived from clinical consensus, obtained through extensive review of multiple drafts of each guideline. In addition, each reference at the end of the original guideline document is followed by a letter code in brackets that indicates the nature of the supporting evidence, as follows:

- [A] *Double-blind, randomized clinical trial.* A study of an intervention in which subjects are prospectively followed over time; there are treatment and control groups; subjects are randomly assigned to the two groups; both the subjects and the investigators are blind to the assignments.
- [A-] *Randomized clinical trial.* Same as above but not double-blind.
- [B] *Clinical trial.* A prospective study in which an intervention is made and the results of that intervention are tracked longitudinally; study does not meet standards for a randomized clinical trial.
- [C] *Cohort or longitudinal study.* A study in which subjects are prospectively followed over time without any specific intervention.
- [D] *Case-control study.* A study in which a group of patients is identified in the present and information about them is pursued retrospectively or backward in time.
- [E] *Review with secondary data analysis.* A structured analytic review of existing data, e.g., a meta-analysis or a decision analysis.
- [F] *Review.* A qualitative review and discussion of previously published literature without a quantitative synthesis of the data.
- [G] *Other.* Textbooks, expert opinion, case reports, and other reports not included above.

[Top^](#)

## **IDENTIFYING INFORMATION AND AVAILABILITY**

### **BIBLIOGRAPHIC SOURCE(S)**

- Work Group on Substance Use Disorders, Kleber HD, Weiss RD, Anton RF, Rounsaville BJ, George TP, Strain EC, Greenfield SF, Ziedonis DM, Kosten TR, Hennessy G, O'Brien CP, Connery HS, American Psychiatric Association Steering Committee on Practice Guidelines, McIntyre JS, Charles SC, Anzia DJ, Nininger JE, Cook IA, Summergrad P, Finnerty MT, Woods SM, Johnson BR, Yager J, Pyles R, Lurie L, Cross CD, Walker RD, Peele R, Barnovitz MA, Gray SH, Shemo JP, Saxena S, Tonnu T, Kunkle R, Albert AB, Fochtman LJ, Hart C, Regier D. Treatment of patients with substance use disorders, second edition. American Psychiatric Association. Am J Psychiatry 2006 Aug;163(8 Suppl):5-82. [PubMed](#)

## **ADAPTATION**

Not applicable: The guideline was not adapted from another source.

## **DATE RELEASED**

1995 (revised 2006 Aug; reviewed 2007 Apr)

## **GUIDELINE DEVELOPER(S)**

American Psychiatric Association - Medical Specialty Society

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American Psychiatric Association (APA)

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Steering Committee on Practice Guidelines

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## **FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST**

This practice guideline has been developed by psychiatrists who are in active clinical practice. In addition, some contributors are primarily involved in research or other academic endeavors. It is possible that through such activities some contributors, including work group members and reviewers, have received income related to treatments discussed in this guideline. A number of mechanisms are in place to minimize the potential for producing biased recommendations due to conflicts of interest. Work group members are selected on the basis of their expertise and integrity. Any work group member or reviewer who has a potential conflict of interest that may bias (or appear to bias) his or her work is asked to disclose this to the Steering Committee on Practice Guidelines and the work group. Iterative guideline drafts are reviewed by the Steering Committee, other experts, allied organizations, American Psychiatric Association (APA) members, and the APA Assembly and Board of Trustees; substantial revisions address or integrate the comments of these multiple reviewers. The development of the APA practice guidelines is not financially supported by any commercial organization.

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## **GUIDELINE AVAILABILITY**

Electronic copies: Available from the [American Psychiatric Association \(APA\) Web site](#).

Print copies: Available from the American Psychiatric Press, Inc (APPI), 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901; (703) 907-7322; (800) 368-5777; fax (703) 907-1091

## **AVAILABILITY OF COMPANION DOCUMENTS**

The following are available:

- Treating substance abuse disorders. Quick reference guide. Arlington, VA: APA, 2006 Aug. Electronic copies: Available in Portable Document Format (PDF) from the [American Psychiatric Association \(APA\) Web site](#).
- American Psychiatric Association practice guideline development process. Washington, DC: APA, 2006 May. Electronic copies: Available in Portable Document Format (PDF) from the [APA Web site](#).
- Connery HS, Kleber HD. Guideline watch (April 2007): practice guideline for the treatment of patients with substance use disorders, 2nd edition. Arlington (VA): American Psychiatric Association; 2007 Apr. 4 p. Electronic copies available in Portable Document Format (PDF) from the [American Psychiatric Association Web site](#).

Print copies: Available from the American Psychiatric Press, Inc (APPI), 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901; (703) 907-7322; (800) 368-5777; fax (703) 907-1091

## **PATIENT RESOURCES**

None available

## **NGC STATUS**

This summary was completed by ECRI on December 1, 1998. The information was verified by the guideline developer on January 11, 1999. This NGC summary was updated by ECRI on July 3, 2006. The updated information was verified by the guideline developer on August 10, 2006.

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[Top^](#)

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[Top^](#)