

CONDENSED CLINICAL PRACTICE GUIDELINE TREATMENT OF CLIENTS WITH SUBSTANCE USE DISORDERS (SUD)

- I. General treatment principles.
 - A. Not all principles are applicable to the treatment of every SUD.
 - B. Individuals with SUD are heterogeneous with regard to numerous clinically significant variables.
 1. Number and type of substances used; genetic vulnerability for developing a SUD; severity of SUD and degree of functional impairment; motivation for treatment; general medical and psychiatric conditions; resiliency and vulnerability factors; social, environmental and cultural contexts.
 - C. Use of substance may or may not be clinically significant.
 1. Helpful terms to describe use are: *use, misuse, abuse, dependence*.
 2. Only the last two terms represent formal diagnostic categories.
 - D. Clinically significant markers for SUD are:
 1. Inability to stop using substances on one's own.
 2. Functional impairments across many categories.
 3. History of chronic or relapsing episodes of problematic substance use.
 - E. Treatment occurs in temporal phases.
 1. Initial assessment.
 2. Acute intervention.
 3. Long-term intervention and/or maintenance.
 4. Frequent reassessment during episodic flares in substance use.
 - F. Assessment phase of treatment.
 1. Evaluate specific variables associated with client's substance use.
 2. Evaluate level of risk of morbidity or mortality.
 - G. Acute phase.
 1. Immediate intervention is recommended to provide safety in a medically monitored setting to clients who present with high-risk intoxication or withdrawal states or altered mental states associated with risk of harm to self/others.
 2. After stabilization, the client's needs regarding safety and stability should be addressed to prepare the client to enter into long-term treatment of SUD.
 3. Goals may include preserving health, achieving financial security, finding stable housing and including client's family/social network in treatment process.
 - H. General treatment strategies depending on clinical circumstances and readiness for change.
 1. Motivational enhancement.
 2. Teaching risk-reduction and relapse prevention skills.
 3. Achievement of abstinence.
 4. Combining substitution agonist therapies with therapy to foster relapse prevention skills.

5. Use of multimodal treatment (e.g., pharmacological and psychosocial treatments together) may be required to address associated conditions that have contributed to or resulted from SUD.

II. Goals of treatment.

- A. Treatment retention.
 1. Goals for treating SUD begin with retaining client in treatment.
 2. Engaging the client to participate and remain in treatment is a critical early goal of treatment planning and is often enhanced by motivational interviewing techniques.
- B. Substance use reduction or abstinence as initial goals of treatment.
 1. Evidence suggests that substance-dependent clients who achieve sustained abstinence from the abused substance have best long-term outcomes.
 2. A goal of moderate substance use is unrealistic for most SUD clients.
 3. However, the clinician may facilitate treatment by accepting the client's goal for moderation while sharing with the client any reservations the clinician may have about the prospect of success.
 4. Clients who are unmotivated to seek abstinence as an initial goal can still be helped to minimize the direct and indirect negative effects of SUD.
- C. Reduction in frequency and severity of substance use episodes.
 1. Reduction in frequency and severity of substance use episodes is a primary goal of long-term treatment and involves several key interventions.
 2. Education about common types of triggers to substance use.
 3. Development of skills to prevent substance use.
 4. Identification and avoidance of high-risk situations.
 5. Development of alternative responses to high-risk situations.
 6. Anticipation of potential future substance use and planning strategies for recovery in the event of relapse.
- D. Improvement in psychological, social and adaptive functioning.
 1. It is important to provide comprehensive treatments when clients have co-occurring psychiatric or general medical conditions that raise risk of relapse.
 2. Best treatment outcomes include strategies that target repairing losses that resulted from substance use, learning of coping skills and building social skills that will support an abstinent lifestyle.

III. Assessment.

- A. Substance use and substance dependence are two disorders that are often encountered, and their criteria are applicable across substances.
- B. Comprehensive psychiatric evaluation is essential to guide treatment of SUD.
- C. The approach to assessing a SUD will differ depending on the context in which a client presents for treatment.
 1. Factors include level of client insight, motivation for treatment and willingness for assessment.
 2. Assessment should be adapted to client insight and motivation.
 3. Efforts to help the client recognize SUD as a problem may be needed.

4. Assessments may have to be extended over time to obtain sufficient client information to tailor interventions to the client's stage of change.
5. If a client has been coerced into assessment, the clinician must attempt to establish an alliance to aid the client in viewing the clinician as a source of information and aid rather than as a punitive extension of the referral source.
6. Retaining the client in treatment will take precedence over treating the SUD.
- D. All clients undergoing a psychiatric evaluation should be screened for a SUD.
 1. If screening tools reveal that a client has ever used substances, it is important to obtain a history of current and past substance use and information about current caffeine and nicotine use.
- E. The assessment includes the following elements:
 1. Detailed history of client's past/present substance use and the effects of substance use on client's cognitive, psychological, behavioral and physiological functioning.
 2. General medical and psychiatric history and examination.
 3. History of psychiatric treatments and outcomes.
 4. Family and social history.
 5. Screening of blood, breath or urine for substance used.
 6. Other laboratory tests to confirm presence/absence of co-occurring conditions.
 7. With client's permission, contact of significant other for added information.
- F. Establishing a diagnosis with a new client.
 1. It is important to distinguish between psychiatric symptoms resulting from substance use and those from a co-occurring psychiatric disorder.
 2. It is helpful to use a timeline approach to determine the chronology of symptom development.
 - a. Construct a timeline of all substances used and all psychiatric symptoms and/or disorders.
 - b. Include in this timeline all prior treatments.
 3. The probability of SUD with a co-occurring psychiatric disorder that is not substance-induced is increased with the following risk factors:
 - a. At least one first-degree relative has a history of a similar disorder.
 - b. Client symptoms are not typically observed in conjunction with the use of a particular substance.
 - c. There is a history that psychiatric symptoms preceded onset of the SUD.
 - d. The symptoms were evident during extended substance-free periods.

IV. Treatment settings: description, indications, benefits.

- A. Clients with SUD may receive care in a variety of settings distinguished by:
 1. Availability of resources (e.g., medical monitoring, psychiatric consultation).
 2. Restrictiveness (i.e., freedom allowed the client).
 3. Intensity of treatment duration/participation.
 4. Milieu philosophy of care (e.g., medical model, 12-step, faith-based).
- B. Factors affecting choice of treatment setting.
 1. Least restrictive setting that is likely to prove safe and effective.
 2. Client capacity and willingness to cooperate with treatment.
 3. Client ability for self-care.

4. Social environment.
 5. Need for structure, support and supervision to remain safe and abstinent.
 6. Need for specific treatments for co-occurring disorders/conditions.
 7. Need for specific treatments that may be available only in certain settings.
 8. Preference for a specific treatment setting.
 9. Particular substance(s) used, medical risks associated with substance(s) used.
 10. Accessibility of appropriate levels of care.
 11. Goals of the client's individual treatment plan.
- C. Commonly available treatment settings and services.
1. Settings/services are considered on continuum of care from most to least restrictive.
 2. Hospitals and clients who may require hospital-level care.
 - a. Available data do not support the notion that hospitalization per se has specific benefits over other treatment settings beyond the ability to address treatment objectives that require a medically monitored environment.
 - b. Clients with drug overdoses who cannot be safely treated in an outpatient or emergency department setting.
 - c. Clients in withdrawal who are at risk for severe/complex withdrawal symptoms or who cannot receive the necessary medical services in a less intensive setting.
 - d. Clients with acute or chronic general medical conditions that make detoxification in residential or ambulatory setting unsafe.
 - e. Clients with documented history of not engaging in or benefiting from treatment in a less intensive setting.
 - f. Clients with psychiatric comorbidity who are an acute danger to themselves or others.
 - g. Clients showing substance use or other behaviors who are an acute danger to themselves or others.
 - h. Clients who have not responded to less intensive treatment efforts and whose SUD poses an ongoing threat to their physical/mental health.
 2. Partial hospitalization programs (PHP) and intensive outpatient programs (IOP).
 - a. PHP and IOP provide an intensive, structured treatment for clients with SUD who require more services than those traditionally available in outpatient settings.
 - b. Both PHP and IOP can be used as "step-down" approaches from higher levels of care to stabilize clients and provide more extended monitoring of relapse potential and co-occurring disorders, or as "step-up" approaches for an outpatient in relapse that does not require medical detoxification or who has entered into a high-risk period for relapse.
 - c. PHP and IOP differ in several ways.
 1. ASAM placement criteria define structured programming in PHP as 20 hours per week and in IOP as nine hours per week.
 2. PHP provide ancillary medical and psychotic services, whereas IOP may be more variable in the accessibility of these services.

- d. PHP may include a combination of individual/group therapy, family meetings, medication management, random screening and treatment for co-occurring disorders.
 - e. Both programs aim to prepare the client for transition to less intensive outpatient services through skill development and use of self-help programs.
3. Residential treatment (RT).
- a. RT provides a safe and substance-free setting for clients to learn individual and group living skills for preventing relapse. The duration of treatment should be dictated by the length of time necessary for the client to meet specific criteria that predict successful transition to a less restrictive setting.
 - b. RT is indicated for clients who do not meet clinical criteria for hospitalization but whose lives and social interactions have come to focus exclusively on substance use and who currently lack motivation and the social supports to remain abstinent in an ambulatory setting.
 - c. RT programs usually provide psychosocial, occupational and family assessment; psychoeducation; introduction to self-help groups; referral for social or vocational rehabilitative services when necessary; and access to general medical and psychiatric care.
4. Therapeutic communities (TC).
- a. Long-term (two-year commitment) TC are highly structured, substance-free settings in which primary interventions are behavioral modeling, supportive peer confrontation, contingency management, community recreation and work therapy.
 - b. Shorter-term (three to 12 months) and nonresidential programs are offered for those with fewer social and vocational impairments.
 - c. Expanded availability of social services has allowed improved treatment of special populations, and some methadone maintenance programs are provided in this setting.
 - d. TC are indicated for the following persons:
 - 1. Clients with opioid, cocaine or multiple SUD.
 - 2. Clients with some understanding of the severity of their SUD and readiness to change.
 - 3. Clients with the willingness to conform to the structure of the TC and to temporarily sever ties with their support network as they assimilate into the TC environment.
 - e. TC have provided some of the better studied and more successful programs for treatment of incarcerated substance abusers. Otherwise, data regarding the effectiveness of long-term TC are limited because only 15 percent to 25 percent of people admitted voluntarily complete a program.
 - 1. Retention rates differ with program sites.
 - 2. Retention lengths predict outcomes on abstinence and lack of criminal recidivism indexes.
5. Community residential facilities (halfway houses).

- a. Community residential facilities provide an outpatient substance-free housing environment as a transitional setting for persons in recovery who are not yet able to manage independent housing without significant risk of relapse.
 - b. Some studies show that for clients with multiple service needs the provision of stable housing in long-term community residential facilities leads to improved substance use outcomes.
 - c. Community residential facilities show more variability in substance use outcomes for youth than for adults.
6. Aftercare
- a. Aftercare occurs after an intense treatment intervention and generally includes outpatient care and/or involvement in self-help approaches.
 - b. Research on aftercare has examined different treatment models including eclectic, medically oriented, motivational, 12-step, cognitive-behavioral (CBT), group and marital strategies.
 - c. Given the chronic, relapsing nature of many types of SUD, it is expected that aftercare will be recommended with few exceptions.
7. Outpatient settings (OP).
- a. OP include but are not limited to mental health clinics, integrated dual-diagnosis programs, private practice settings, primary care clinics and substance abuse treatment centers.
 - b. OP is appropriate when clinical conditions or environmental and social circumstances do not require a more intensive level of care.
 - c. The best OP approach is comprehensive and includes a variety of psychotherapeutic and pharmacological interventions and behavioral monitoring.
 - d. In addition to medication therapies, OP with strong evidence of effectiveness include CBT, behavioral therapies, 12-step facilitation (TSF), psychodynamic/interpersonal therapy (IPT), self-help manuals, brief interventions, case management and group/marital/family therapies.
8. Case management — an adjunctive treatment.
- a. Case management provides advocacy, coordination of care, psychoeducation, social services and assessment/stabilization of basic necessities to improve client adherence to treatment and aftercare.
 - b. Variability in case management models has complicated research on the effectiveness of this approach.
 - c. Studies show this intervention is effective for clients with an alcohol use disorder or co-occurring psychiatric and SUD, and for youth with SUD.
9. Legally mandated treatment.
- a. It has been estimated that only 1 percent to 20 percent of substance abusers received adequate treatment while incarcerated.
 - b. Treatment of SUD may be legally mandated under a variety of circumstances.
 - c. Drug court programs recognize the effectiveness of diverting offenders with lesser drug-related convictions into court-mandated community programs.

- d. Standard procedures include assessment for treatment needs, referral for appropriate treatment after arrest, monitoring of adherence to treatment, reduction in the severity of charges contingent on successful completion of SUD programs and aftercare planning to maintain sobriety.
 - e. The most studied effective programs for incarcerated persons are TC.
10. Employee assistance programs (EAP).
- a. EAP provide an employment-based treatment setting and referral platform for employees with SUD.
 - b. An important difference between substance use treatment in an EAP versus OP is the definition of successful outcomes.
 - 1. EAP defines and measures success primarily through job performance and not sobriety or reduction of related medical and social problems.
 - c. EAP are cost-effective in the short term but post-treatment follow-up rates are poor.

V. Treatment approaches.

A. Psychiatric management.

1. Psychiatric management is the foundation of treatment for clients with SUD and has the following objectives:
 - a. Motivating client to change.
 - b. Establishing and maintaining a therapeutic alliance.
 - c. Assessing client safety and clinical status.
 - d. Managing client intoxication and withdrawal states.
 - e. Developing and facilitating client adherence to treatment plan.
 - f. Preventing client relapse.
 - g. Educating client about SUD.
 - h. Reducing morbidity and consequences of SUD.
2. Psychiatric management is generally combined with specific treatments conducted with professionals of various disciplines at a variety of sites.
3. Specific pharmacological and psychosocial treatments are generally applied in the context of programs that combine various treatment modalities.

B. Pharmacological treatments.

1. Pharmacological treatment is beneficial for selected clients with specific SUD and may include the following:
 - a. Medications to treat intoxication and withdrawal states.
 - b. Medications to decrease the reinforcing effects of abused substances.
 - c. Agonist maintenance therapies.
 - d. Medications to treat comorbid psychiatric conditions.

C. Psychosocial treatments.

1. Psychosocial treatments are essential components of comprehensive treatment and include the following evidence-based interventions:
2. CBT, especially relapse preventing and social skills training.
3. Motivational enhancement therapy (MET).
4. Behavior therapies.
5. 12-step facilitation (TSF).

6. Interpersonal therapy (IPT).
 7. Self-help manuals.
 8. Brief interventions.
 9. Case management.
 10. Group, marital and family therapies.
 11. There is evidence supporting the efficacy of integrated treatment for clients with co-occurring substance use and psychiatric disorders.
- D. Formulation and implementation of a treatment plan.
1. Goals of treatment and specific therapies chosen to achieve goals may vary among clients and vary for the same client at different phases of treatment.
 2. Clients usually require long-term treatment because many SUD are chronic, but the intensity and components of treatment may vary over time.
 3. General clinical factors influencing treatment include the following:
 - a. Comorbid psychiatric and general medical conditions.
 - b. Gender-related factors.
 - c. Age.
 - d. Social milieu and living environment.
 - e. Cultural factors.
 - f. Gay/lesbian/bisexual/transgender issues.
 - g. Family characteristics.
- E. Clinical factors deserving special attention.
1. Co-occurring disorders.
 - a. The diagnostic distinction between substance use symptoms and those of other disorders should receive particular attention.
 - b. Specific treatment of comorbid disorders should be provided.
 - c. In addition to pharmacotherapies, various psychotherapies may also be indicated when a client has a co-occurring psychiatric disorder, psychosocial stressors or other life circumstances that exacerbate the SUD.
 - d. A client's cessation of substance use may also be associated with changes in psychiatric symptoms or the metabolism of medications that will require adjustment of psychotropic medication doses.
 2. Pregnancy.
 - a. In women of childbearing age, the possibility of pregnancy needs to be considered.
 - b. Psychosocial treatment to encourage substance abstinence during pregnancy is recommended.
 - c. With some substances, accompanying agonist treatment may be advisable.
 - d. In pregnant smokers, treatment with nicotine replacement therapy may be helpful.
 - e. For pregnant women with an opioid use disorder, treatment with methadone or buprenorphine can be a useful adjunct to psychosocial treatment.
- F. Treatment plans include the following components:
1. Psychiatric management.
 2. Strategy for achieving abstinence or reducing effects of substances of abuse.

3. Efforts to enhance ongoing adherence with the treatment program, prevent relapse and improve functioning.
 4. Additional treatments necessary for co-occurring mental illness or general medical condition.
- G. Duration of treatment should be adjusted to the client's needs and may vary from a few months to several years.
- H. Increased monitoring for substance use during periods that have high risk of relapse, including early stages of treatment, times of transition to less intensive levels of care and the first year after active treatment has ceased.
- I. Legal and confidentiality issues.

VI. Nicotine use disorders and nicotine replacement therapy (NRT): treatment principles and alternatives.

A. Pharmacological treatments.

1. Recommended for clients who want to stop smoking and have not achieved cessation without pharmacological agents or who prefer to use such agents.
2. There are six medications approved by the FDA for nicotine dependence. They can all be used based on client preference, route of administration and side-effect profile.
 - a. NRT: patch, gum, spray, lozenge, inhaler.
 - b. Bupropion.
 - c. They are all first-line agents that are equally effective in lessening withdrawal symptoms and reducing smoking.
 - d. NRT adverse effects are rare.
 - e. Combinations of these treatments may also improve outcomes.
3. Combined psychosocial and medication treatments produce the best outcomes, but these medications are effective even without psychosocial treatment.
4. Nortriptyline and clonidine have utility as second-line agents but have more side effects. Other medications and acupuncture have not been proven effective.

B. Psychosocial treatments.

1. Effective psychosocial treatments include CBT, behavioral therapies, brief interventions, MET (individual, group, phone, self-help, Internet-based formats).
2. Treatment efficacy is related to the amount of treatment received.
3. TSF, hypnosis and inpatient therapy have not proven effective.

VII. Alcohol use disorders: treatment principles and alternatives

A. Management of intoxication and withdrawal.

1. Acute intoxication: clients should be monitored and maintained in a safe environment.
2. Moderate to severe withdrawal: goal is to reduce central nervous system irritability and restore physiological homeostasis.

a. Requires use of thiamine and fluids, benzodiazepines and in some clients other medications such as anticonvulsants, clonidine or antipsychotic agents.

b. Once stability is achieved, tapering of medications should be conducted.

3. Client should be observed for reemergence of withdrawal symptoms and emergence of signs/symptoms suggesting co-occurring psychiatric disorders.

B. Pharmacological treatments.

1. Specific pharmacotherapies for alcohol-dependent clients have well-established efficacy and moderate effectiveness.

2. Data on the long-term efficacy of naltrexone are limited.

3. Published research on the use of long-acting, injectable naltrexone is limited and FDA approval is pending.

4. Acamprosate may decrease alcohol craving in abstinent clients and may also be effective as an adjunct medication in motivated clients who also receive psychosocial treatment.

5. Disulfiram is an effective adjunct to a comprehensive treatment program for reliable, motivated clients whose drinking may be triggered by events that suddenly increase alcohol craving.

C. Psychosocial treatments.

1. Treatments found effective for some clients include MET, CBT, behavioral therapies, TSF, marital/family/group therapies and IPT.

2. Client participation in self-help groups is often helpful.

VIII. Marijuana use disorders: treatment principles and alternatives.

A. Studies for the treatment of marijuana use disorders are limited.

B. No specific pharmacotherapies for marijuana withdrawal or dependence can be recommended.

C. Psychosocial treatment.

1. An intensive relapse prevention approach that combines motivational interventions with development of coping skills may be effective for the treatment of marijuana dependence.

2. Further study of these approaches is necessary.

IX. Cocaine use disorders: treatment principles and alternatives.

A. Management of intoxication and withdrawal.

1. Intoxication is usually self-limited and requires only support care.

2. Hypertension, tachycardia, seizures and persecutory delusions can occur with intoxication and may require specific treatment.

3. Acutely agitated clients may benefit from sedation with benzodiazepines.

B. Pharmacological treatments and cocaine dependence.

1. Pharmacological treatment is usually not indicated as initial treatment.

2. No pharmacotherapies have FDA indications for treatment.

3. For clients who fail to respond to psychosocial treatment alone, some medications (topiramate, disulfiram, modafinil) may be promising when integrated into psychosocial treatments.

C. Psychosocial treatments for cocaine use disorders.

1. For many clients, treatments focusing on abstinence are effective.
2. CBT, behavioral therapies and 12-step-oriented drug counseling can be useful, although efficacy of these therapies varies across subgroups of clients.
3. Regular participation in a self-help group may improve outcomes for some clients with a cocaine use disorder.

X. Opioid use disorders: treatment principles and alternatives.

A. Management of intoxication and withdrawal.

1. Mild to moderate intoxication usually does not require specific treatment.
2. Severe overdose, marked by respiratory depression, may be fatal and requires treatment in an emergency room or inpatient setting.
3. Opioid withdrawal treatment is directed at lessening acute symptoms and facilitating the client's entry into a long-term treatment program.
4. Strategies found to be effective treatment of opioid withdrawal:
 - a. Substitution of methadone or buprenorphine for the opioid followed by gradual tapering.
 - b. Abrupt discontinuation of opioids with use of clonidine to suppress withdrawal symptoms.
 - c. Clonidine-naltrexone detoxification.
5. When treating withdrawal, the physician must assess the client for the presence of other substances, because the concurrent use of or withdrawal from other substances can complicate treatment.
6. Anesthesia-assisted rapid opioid detoxification (AROD) is not recommended because of lack of proven efficacy and adverse risk-benefit ratios.

B. Pharmacological treatments.

1. Maintenance treatment with methadone or buprenorphine is appropriate for clients with a prolonged history of opioid dependence.
2. Goals of treatment are to achieve a stable maintenance dose of opioid agonist and facilitate engagement in a rehabilitation program.
3. Maintenance treatment with naltrexone is an alternative strategy, although the utility of this strategy is often limited by lack of client adherence and low treatment retention.

C. Psychosocial treatments.

1. Such treatments are an effective component of a comprehensive treatment plan for clients with opioid disorders.
2. CBT, behavioral therapies, psychodynamic psychotherapy and group/family therapies have been found to be effective for some clients.
3. Regular participation in self-help groups may also be useful.

References

American Psychiatric Association: *Practice guideline for the treatment of clients with substance use disorders*. 2nd Ed. Arlington (VA). (August 2006).

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition (DSM-V)*. Arlington, VA: American Psychiatric Publishing, Inc.; 2013.

Commonwealth of Pennsylvania, Department of Health, Bureau of Drug and Alcohol Programs. *Pennsylvania's Client Placement Criteria for Adults*, 2nd ed. 1999.

Mee-Lee, D., Shulman, G.D., Fishman, M., Gastfriend, D.R., Griffith, J.H. (eds): *ASAM Client Placement Criteria for the Treatment of Substance-Related Disorders*, 2nd ed., revised. Chevy Chase, MD, American Society of Addiction Medicine, 2001.

VA/DoD Clinical Practice Guideline. *Management of Substance Use Disorders*. VA/DoD Evidence Based Practice. Veterans Health Administration/Department of Defense. Version 2.0 (2009).

Other Resources

The full VA/DoD SUD guideline can be accessed at www.healthquality.va.gov/ and <https://www.qmo.amedd.army.mil/substance%20abuse/substance.htm>

PCPC Manual pdf. www.portal.state.pa.us/portal/server

National Institute on Alcohol Abuse and Alcoholism (NIAAA)
[www.niaaa.nih.gov/Publications/
EducationTrainingMaterials/Pages/guide.aspx](http://www.niaaa.nih.gov/Publications/EducationTrainingMaterials/Pages/guide.aspx)

On the NIAAA website, providers can find resources that include clinical guides and videos on alcohol screening and brief intervention, alcohol use disorder screening instruments and assessment support materials, medication wallet cards and client materials. For additional resources, visit www.RethinkingDrinking.niaaa.nih.gov

National Institute on Drug Abuse (NIDA)
www.drugabuse.gov/nidamed/

NIDA provides resources that include screening tools, charts of commonly abused drugs, drug abuse reports, multilingual education packets and client-physician conversation posters.

Substance Abuse and Mental Health Services Administration (SAMHSA)

www.dpt.samhsa.gov/providers/providerindex.aspx

SAMHSA provides resources for provider training on substance abuse, addiction, prescribing and risk management, as well as resources on addiction treatment forums, treatment protocols and drug interactions.

Medical and Non-Medical Addiction Specialists

American Academy of Addiction Psychiatry

(www.aaap.org) 401-524-3076

American Psychological Association

(<http://apa.org>) 800-964-2000

American Society of Addiction Medicine

(www.asam.org) 301-656-3920

The Association for Addiction Professionals

(www.naadac.org) 800-548-0497

National Association of Social Workers

(www.socialworkers.org or www.helpstartshere.org)

Alcoholics Anonymous

(www.aa.org) 212-870-3400 or check your local phone directory under “Alcoholism.”

Secular Organizations for Sobriety

(www.cfiwest.org/sos/index.htm) 323-666-4295

Al-Anon/Alateen

(www.al-anon.alateen.org) 888-425-2666 for meetings

Adult Children of Alcoholics

(www.adultchildren.org) 310-534-1815

Veterans Crisis Line

(www.mentalhealth.va.gov/suicide_prevention/index.asp)

800-273-8255 and press 1

Substance Abuse Treatment Facility Locator

(www.findtreatment.samhsa.gov) 800-662-HELP

(4357)www.healthquality.va.gov/Substance_Use_Disorder_SUD.asp