

ACUTE INTOXICATION

- The most common signs and symptoms involve disturbances of perception, wakefulness, attention, thinking, judgment, psychomotor behavior, and interpersonal behavior.
- Patients should be medically observed at least until the blood alcohol level (BAL) is decreasing and clinical presentation is improving.
- Highly tolerant individuals may not show signs of intoxication. For example, patients may appear "sober" even at BALs well above the legal limit (e.g., 80 or 100 mg percent).
- Consider withdrawal risk from each substance for patients using multiple substances.

HAZARDOUS ALCOHOL USE

Definition	Comments
Typical Drinks per week: Male: ≥14 Female: ≥7	Standard Drinks: • 0.5 fluid ounces of absolute alcohol • 12 ounces of beer • 5 ounces of wine • 1.5 ounces of 80-proof spirits
Maximum drinks per occasion: Male: ≥5 Female: ≥4	May vary depending on age, ethnicity, medical and psychiatric comorbidity, pregnancy, and other risk factors.

RISK OF RELAPSE

A simple and brief patient inquiry will often suffice, such as "Have you had any 'close calls' with drinking or other drug use?"

**DSM-IV CRITERIA (APA, 1994)
Substance Abuse**

1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more of the following, occurring within a 12-month period:
 - Recurrent substance use resulting in failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; or neglect of children or household).
 - Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine).
 - Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct).
 - Continued substance use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication or physical fights).
2. These symptoms must never have met the criteria for substance dependence for this class of substance.

Substance Dependence

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three or more of the following seven criteria, occurring at any time in the same 12-month period:

1. Tolerance, as defined by either of the following:
 - A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
 - Markedly diminished effect with continued use of the same amount of the substance.
2. Withdrawal, as defined by either of the following:
 - The characteristic withdrawal syndrome for the substance (refer to DSM-IV for further details).
 - The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.
3. The substance is often taken in larger amounts or over a longer period than was intended.
4. There is a persistent desire or there are unsuccessful efforts to cut down or control substance use.
5. A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances to see one), use the substance (e.g., chain smoking), or recover from its effects.
6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

Remission

Dependence exists on a continuum of severity; remission requires a period of at least 30 days without meeting full diagnostic criteria and is specified as Early (first 12 months) or Sustained (beyond 12 months) and Partial (some continued criteria met) versus Full (no criteria met)

CARE MANAGEMENT

Care management is a clinical approach to the management of chronic SUDs where full remission (e.g., abstinence) is not a realistic goal or one the patient endorses. Conceptually, the care management approach is similar to managing other chronic illnesses, such as diabetes or schizophrenia. Practically, the care management framework provides specific strategies designed to enhance motivation to change, relieve symptoms and improve function where possible, and monitor progress towards goals. Care management is a flexible approach that may be integrated into medical and psychiatric care in any setting. In some cases, care management will lead to remission of the SUD or referral for specialty care rehabilitation, while in other cases it serves a more palliative function.

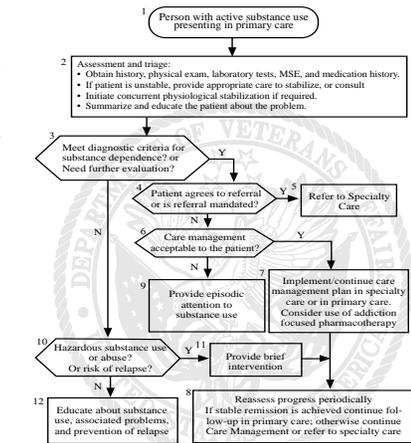
**CARE MANAGEMENT COMPONENTS
INCLUDE THE FOLLOWING:**

- Document specific substance use at each contact by patient report (e.g., number of drinking or substance-using days in the past month, typical and maximum number of drinks per occasion).
- Monitor and discuss biological indicators (e.g., transaminase levels and urine toxicology screens)
- Encourage reduction or cessation of use at each visit and support motivation to change.
- Recommend self-help groups.
- Address or refer for social, financial, and housing problems.
- Coordinate treatment with other care providers.
- Monitor progress and periodically assess for possible referral to specialty rehabilitation.

FOLLOW-UP

- Monitor substance use and encourage continued reduction or abstinence.
- Educate about substance use and associated problems.
- For DoD active duty, keep the commanding officer informed of progress, or lack thereof

**VA/DoD Clinical Practice Guideline for
Management of Substance Use Disorders(SUD)
Primary Care Pocket Guide**



Regarding DoD Active Duty

Referral to addictions specialty care for assessment is required for all active duty patients in an incident involving/suspected to involve legal/illegal substances.



ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT)

The AUDIT can be administered by interview or self-report.

1. How often do you have a drink containing alcohol?
2. How many drinks containing alcohol do you have on a typical day when you are drinking?
3. How often do you have six or more drinks on one occasion?
4. How often during the last year have you found that you were not able to stop drinking once you had started?
5. How often during the last year have you failed to do what was normally expected from you because of drinking?
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
7. How often during the last year have you had a feeling of guilt or remorse after drinking?
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
9. Have you or someone else been injured as a result of your drinking?
10. Has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

Scoring	0	1	2	3	4
Question 1	Never	Monthly or less	2 to 4 times /month	2 to 3 times /week	>4 times /week
Question 2	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
Questions 3-8	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Questions 9-10	No		Yes, but not in the last year		Yes, during the last year

The minimum score (for non-drinkers) is 0 and the maximum possible score is 40. A score of 8 or more indicates a strong likelihood of hazardous or harmful alcohol consumption.

CAGE QUESTIONNAIRE

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

SCORING

Item responses on the CAGE are scored 0 (No) or 1 (Yes). A total score of 2 or greater is considered clinically significant.

BRIEF INTERVENTION

- Give feedback about screening results, relating the risks of negative health effects to the patient's presenting health concerns.
- Inform the patient about safer consumption limits and offer advice about change.
- Offer to involve family members (or, for DoD active duty, commanders or First Sergeants) in this process to educate them and solicit their input (consent is required for family members).
- Assess patient's degree of readiness for change (e.g., "How willing are you to consider reducing your use at this time?").
- Schedule initial follow-up appointment in two to four weeks.

NEGOTIATE AND SET GOALS WITH THE PATIENT

- Negotiate treatment goals.
- Review results of previous efforts at self-change and formal treatment experience, including reasons for treatment dropout.
- Use non-confrontational motivational enhancement techniques.
- Consider bringing the addiction specialist into your office to assist with referral decisions.
- Consider referring to social work services for assistance in addressing barriers to treatment engagement.

REFERRAL TO SPECIALTY CARE

- Assess patient's needs, past treatment response, readiness for change, motivational level, and patient goals.
- When acceptable to the patient, a specialty care rehabilitation plan is generally indicated.
- Care management is likely to be a more acceptable and effective alternative when one of the following applies:
 - The patient refuses referral to rehabilitation but continues to seek some services, especially medical and/or psychiatric services.
 - The patient has serious co-morbidity that precludes participation in available rehabilitation programs.
 - The patient has been engaged repeatedly in rehabilitation treatment with minimal progress toward rehabilitation goals.
- If a DoD active duty patient refuses referral despite encouragement, notify the commanding officer to discuss the situation further. The commander has the ultimate authority to either (a) order the patient to comply, (b) invoke administrative options (e.g., administrative separation from service), or (c) do nothing administratively. This is the commander's decision, with input from the medical staff.

Signs and Symptoms of Intoxication and Withdrawal (a)

Types of Intoxication	Signs and Symptoms of Intoxication	Signs and Symptoms of Withdrawal
Alcohol and Sedative-Hypnotics	<ul style="list-style-type: none"> • Slurred speech • Incoordination • Unsteady gait • Nystagmus • Impairment in attention or memory • Stupor or coma <p><i>Note: Highly tolerant individuals may not show signs of intoxication. For example, patients may appear "sober" even at BALs well above the legal limit (e.g., 80 or 100 mg percent).</i></p>	<ul style="list-style-type: none"> • Autonomic hyperactivity (e.g., diaphoresis, tachycardia, and elevated blood pressure) • Increased hand tremor • Insomnia • Nausea and vomiting • Transient visual, tactile or auditory hallucinations or illusions • Delirium tremens (DTs) • Psychomotor agitation • Anxiety • Irritability • Grand mal seizures
Cocaine or Amphetamine	<ul style="list-style-type: none"> • Tachycardia or bradycardia • Pupillary dilation • Elevated or lowered blood pressure • Perspiration or chills • Nausea or vomiting • Psychomotor agitation or retardation • Muscular weakness, respiratory depression, or chest pain • Confusion, seizures, dyskinesias, dystonias, or coma 	<ul style="list-style-type: none"> • Dysphoric mood • Fatigue • Vivid, unpleasant dreams • Insomnia or hypersomnia • Increased appetite • Psychomotor retardation or agitation
Opiate	<ul style="list-style-type: none"> • Pupillary constriction (or dilation due to anoxia from overdose) • Drowsiness or coma • Slurred speech • Impairment in attention or memory • Shallow and slow respiration or apnea <p><i>Note: Acute opiate intoxication can present as a medical emergency with unconsciousness, apnea, and pinpoint pupils.</i></p>	<ul style="list-style-type: none"> • Nausea or abdominal cramps • Muscle aches • Pupillary dilation • Autonomic hyperactivity • Piloerection (i.e., gooseflesh) • Vomiting or diarrhea • Yawning • Lacrimation

(a) Consider intoxication and withdrawal risks from each substance for patients using multiple substances.