

VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF SUBSTANCE USE DISORDERS

Guideline Summary

PRIMARY CARE

KEY POINTS

ASSESSMENT AND DIAGNOSIS

- Use a standardized alcohol screening procedure (e.g., the CAGE or AUDIT).
- Arrange detoxification or stabilization, if indicated.
- Identify patients with hazardous substance use who should receive a brief intervention.
- Identify patients with substance abuse or dependence who require a referral to specialty care.
- DoD active duty are required to be referred to specialty care for any incident suspected to involve substance use.

BRIEF INTERVENTION

- Give feedback about screening results and health risks.
- Inform about safer consumption limits.
- Assess readiness for change.
- Negotiate goals and strategies for change.
- If unsuccessful, consider referral to specialty care.

REFERRAL TO SPECIALTY CARE

- Referral to specialty care is clinically indicated for substance dependence.
- Help overcome barriers to successful referral.

CARE MANAGEMENT

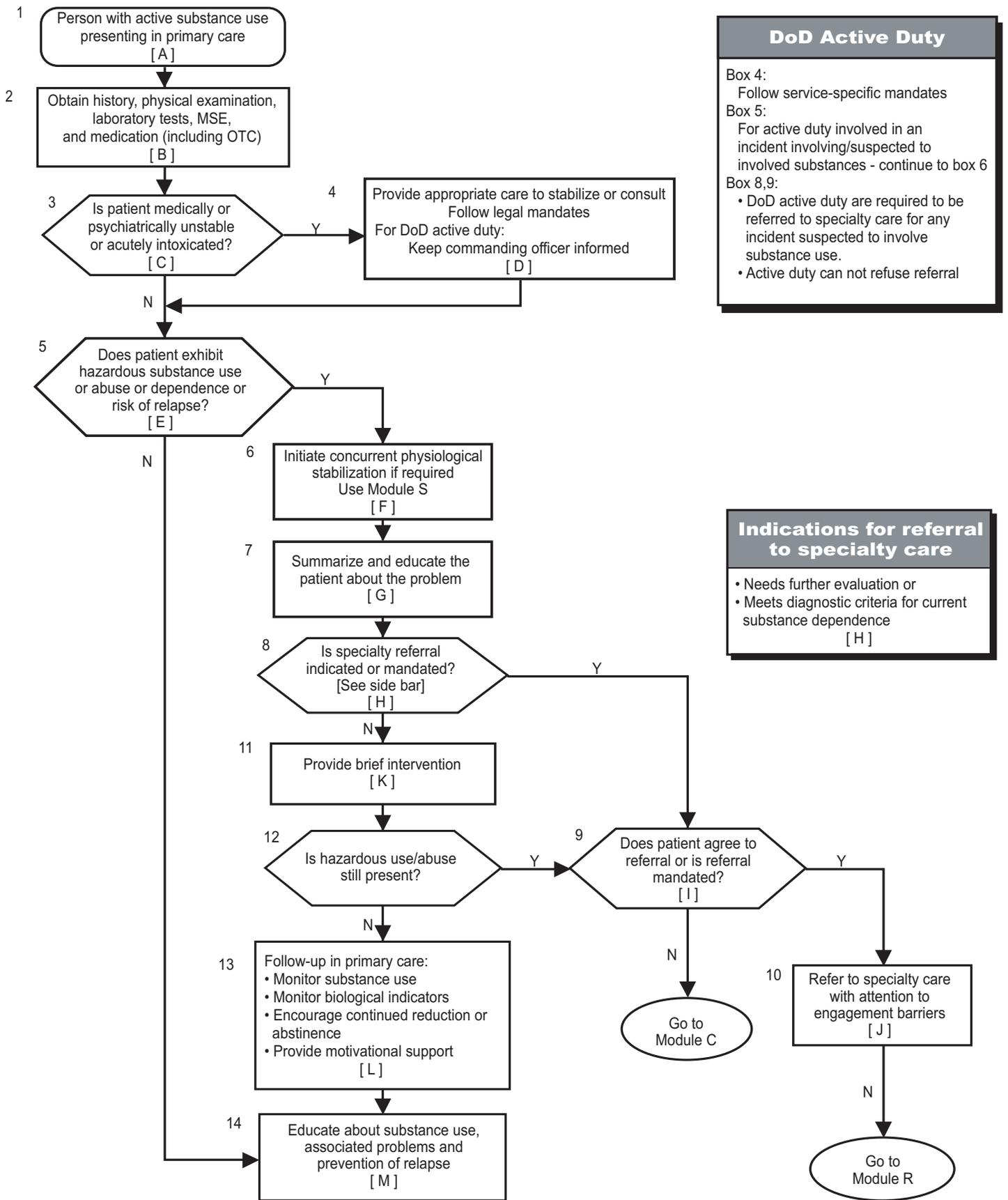
- Document specific substance use at each contact by patient report (e.g., number of drinking or substance-using days in the past month and typical and maximum number of drinks per occasion.)
- Monitor biological indicators (e.g., transaminase levels and urine toxicology screens) and discuss results with the patient.
- 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 care 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.

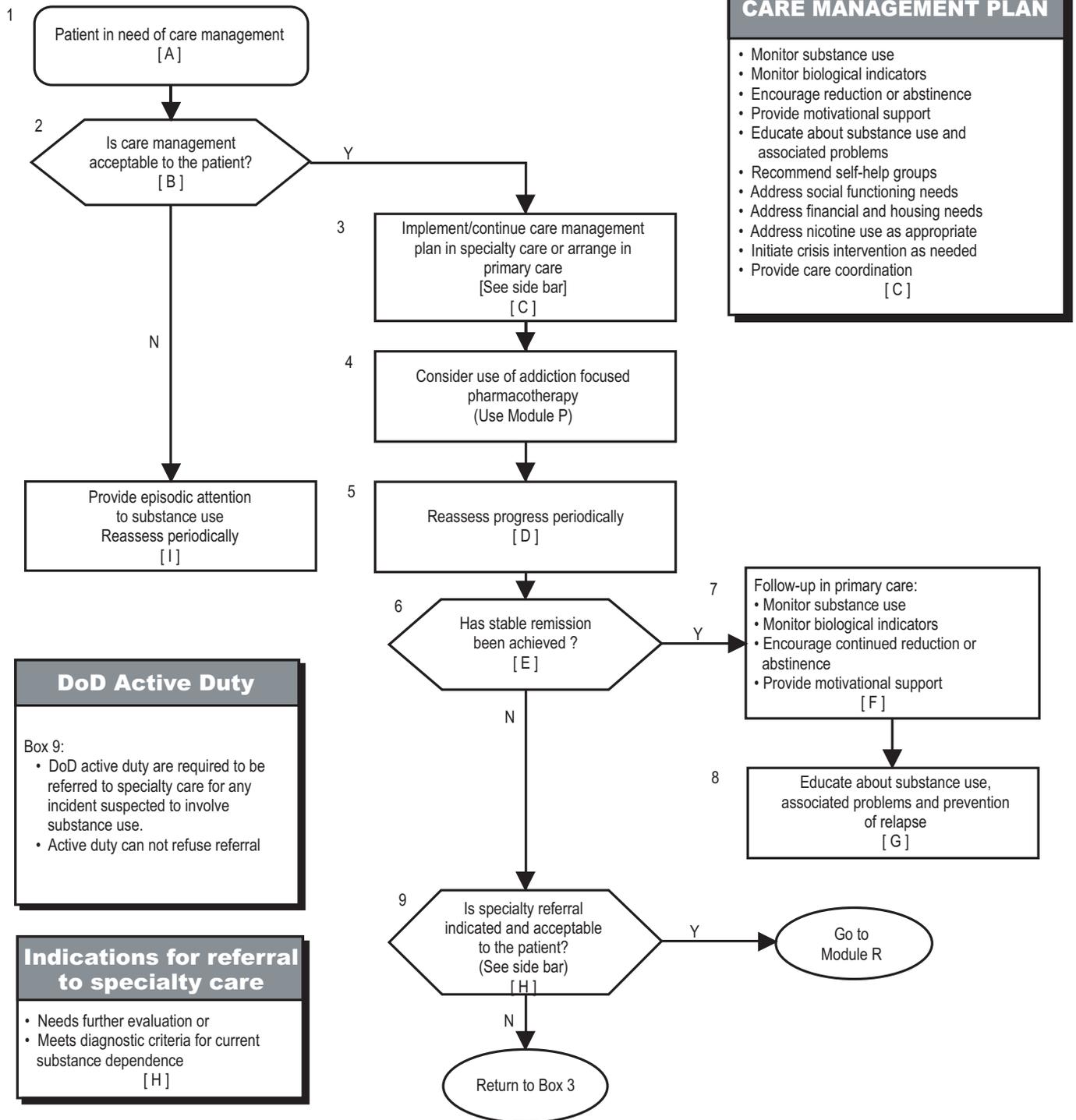
MANAGEMENT OF SUBSTANCE USE DISORDERS

Module A: Assessment and Management in Primary Care



MANAGEMENT OF SUBSTANCE USE DISORDERS

Module C: Care Management



PRIMARY CARE

SCREEN FOR SUBSTANCE USE

All patients should be asked about any current or recent use of nicotine and alcohol at their initial visit or at least annually. This screening is consistent with the VA Preventive Health Index (2001).

ASSESSMENT AND DIAGNOSIS

Acute Intoxication

Patients who are acutely intoxicated are in need of urgent stabilization and should be medically observed at least until the blood alcohol level is decreasing and clinical presentation is improving.

Opioid Withdrawal Symptoms

The opioid withdrawal syndrome can be protracted with intense symptoms, though the syndrome itself poses virtually no risk of mortality. However, there is significant mortality risk from overdose for those who relapse following unsuccessful detoxification attempts, as a result of loss of opioid tolerance.

Signs and symptoms of opioid withdrawal may develop at a time appropriate for the ingested opioid (i.e., within 6–12 hours after the last dose of a short acting opioid, such as heroin or 36–48 hours after the last dose of a long acting opioid, such as methadone).

Sedative-Hypnotics or Alcohol Withdrawal Symptoms

Signs and symptoms of withdrawal from sedative-hypnotics or alcohol develop within several hours to a few days after cessation or reduction in heavy and prolonged use. The potential for a withdrawal syndrome can be gauged only imprecisely by asking the patient the pattern, type, and quantity of recent and past substance use.

Interview the Patient and Consider Using the Following

- Brief self-report screening instruments (e.g., the first three questions of the Alcohol Use Disorders Identification Test (AUDIT)).
- Reports from responsible others.
- Laboratory tests (for corroboration only; not for routine screening)—e.g., blood or breath alcohol levels, breath carbon monoxide for smoking, urine toxicology, elevated carbohydrate deficient transferrin, increased mean corpuscular volume (MCV), or gamma glutamic transferase (GGT).

Screen for Hazardous Substance Use

The clinician should identify patients who are currently using substances at hazardous levels whether or not they meet diagnostic criteria for substance abuse or dependence.

Hazardous Alcohol Screening:

Screen current users for hazardous alcohol use at the initial clinic visit or at least annually. Screening for hazardous alcohol use should consider both the volume (e.g., total drinks per week) and pattern of use (e.g., frequency of heavy drinking episodes).

- Average weekly or daily quantity is most strongly related to chronic health risks.
- Frequency of heavy drinking is most strongly related to acute health risks and psychosocial risks.

Patients are at increased risk of medical morbidity and dependence if they report drinking more than the gender specific hazardous use threshold.

Hazardous Alcohol Use Screening

Definition	Comments
Typical Drinks <i>per week</i> : Male: ≥14 Female: ≥7	Standard Drinks: <ul style="list-style-type: none">• 0.5 fluid ounces of absolute alcohol• 12 ounces of beer• 5 ounces of wine• 1.5 ounces of 80-proof spirits
Maximum drinks <i>per occasion</i> : Male: ≥5 Female: ≥4	May vary depending on age, ethnicity, medical and psychiatric co-morbidity, pregnancy, and other risk factors.

Other Hazardous Substance Use:

- Screen all patients for nicotine usage. Utilize the VA/DoD Clinical Practice Guideline for tobacco cessation.
- Although there are no unequivocal well-documented risk thresholds for hazardous use, regular use of any intoxicant (e.g., daily or several days per week) suggests at the least a high risk for abuse or dependence. This can be best assessed by determining the number of using days in the past 30 days.

- Long-term use of prescribed opioids, anxiolytics, or hypnotics does not in itself constitute hazardous use, abuse, or dependence. Refer to Module S: Stabilization for a discussion about prescribing anxiolytics or opioids for chronic pain. When in doubt about whether use is hazardous or abusive, consult a specialist in management of the underlying disorder (e.g., pain, insomnia, or anxiety) or addiction medicine.

Screen for Substance Abuse or Dependence

Consider a screen positive for alcohol abuse or dependence if a patient scores eight or more on the AUDIT or endorses two or more of the four items reflected in the acronym CAGE (CAGE and AUDIT forms are included in the Guideline).

Screening for other drug use may be appropriate in some clinical settings (e.g., adolescent or AIDS clinics), but has not been recommended as routine by the United States Preventive Services Task Force (U.S. PSTF).

Diagnosis of Substance Dependence

- Conduct clinical assessment of whether the patient meets the DSM-IV diagnostic criteria for Substance Dependence.
- Diagnostic criteria required for Substance Dependence involve more than evidence of physiological dependence.
- Consider whether the person is dependent on multiple substances.

Screen for Risk of Relapse Among Patients in Remission

A relapse is defined as any discrete violation of a self-imposed rule or set of rules governing the ability to either stay completely free of drug use or maintain a preset goal of reduced drug usage. A simple and brief patient inquiry will often suffice, such as “Have you had any ‘close calls’ with drinking or other drug use?”

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 • Disturbances of perception, wakefulness, attention, thinking, judgment, memory, psychomotor behavior, and interpersonal behavior • 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.

BRIEF INTERVENTION

Educate the Patient

- Discuss the patient's current use of alcohol and other drugs and address any potential problem areas, especially relationship to presenting medical concerns.
- Inform the patient about relevant potential age- and gender-related problems (e.g., pregnancy and drug-drug interactions).
- Convey openness to discuss any future concerns that may arise and encourage the patient to discuss them with you.
- Encourage the patient to address the problem and seek additional treatment when indicated.

Provide 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 the patient's degree of readiness for change (e.g., "How willing are you to consider reducing your use at this time?").
- Negotiate goals and strategies for change.
- Schedule the initial follow-up appointment in two to four weeks.
- Monitor changes at follow-up visits by asking the patient about use, health effects, and barriers to change.
- If the patient declines indicated referral to specialty evaluation or treatment, continue to encourage reduction or cessation of use and reconsider referral to specialized treatment at subsequent visits.

Treatment Plan	Expected Outcomes
Rehabilitation with optimal goals	<ul style="list-style-type: none"> • Complete and sustained remission of all substance use disorders • Resolution of, or significant improvement in, all coexisting biopsychosocial problems and health-related quality of life
Rehabilitation with intermediate goals	<ul style="list-style-type: none"> • Short- to intermediate-term remission of substance use disorders or partial remission of substance use disorders for a specified period of time • Resolution or improvement of at least some coexisting problems and health-related quality of life
Care management	<ul style="list-style-type: none"> • Engagement in the treatment process, which may continue for long periods of time or indefinitely • Continuity of care (case management) • Continuous enhancement of motivation to change • Availability of crisis intervention • Improvement in substance use disorders, even if temporary or partial • Improvement in coexisting medical, psychiatric, and social conditions • Improvement in quality of life • Reduction in the need for high-intensity health care services • Maintenance of progress • Reduction in the rate of illness progression

CARE MANAGEMENT

Care Management

Care management is a clinical approach to the management of chronic substance use disorders 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 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 substance use disorders or referral for specialty care rehabilitation, while in other cases it serves a more palliative function.

Reassess Progress Periodically

Reassessment of initial care management plans should occur within 90 days. The patient's progress and goals should be reassessed and the treatment plan updated, at least annually, in established patients. Treatment plans should also be reviewed after significant clinical change (e.g., hospital admission, relapse, and accomplishment of care goals).

Some patients refuse to engage in any type of ongoing care with any provider (e.g., medical, psychiatric, or addiction). These patients may require substantial emergency care and stabilization and may repeatedly present in crisis, but are not willing to return for outpatient visits or engage in alcohol and/or drug treatment.

Assess Progress Towards Current Goals

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).

If the patient is not in stable remission, identify new problems and goals to promote treatment engagement and modify the care management plan consistent with the patient's goals and preferences. Patients frequently become more accepting of treatment over time, particularly with worsening of substance-associated problems. If the patient indicates willingness to consider engaging in more intensive treatment, consider his or her appropriateness for rehabilitation.

REFERRAL TO SPECIALTY CARE

Negotiate and Set Goals with the Patient

- Establish treatment goals in the context of a negotiation between the treatment provider and the patient.
- Review with the patient results of previous efforts at self-change and formal treatment experience, including reasons for treatment dropout.
- Use motivational enhancement techniques, when appropriate.
- 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.

For 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.

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.

Refer to Specialty Care

When acceptable to the patient, a specialty care rehabilitation plan is generally indicated. Review the clinical assessment and note past treatment response, motivational level, and patient goals in order to match patient needs and available programming.

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 optimal or intermediate rehabilitation goals.

PROVIDE FOLLOW-UP

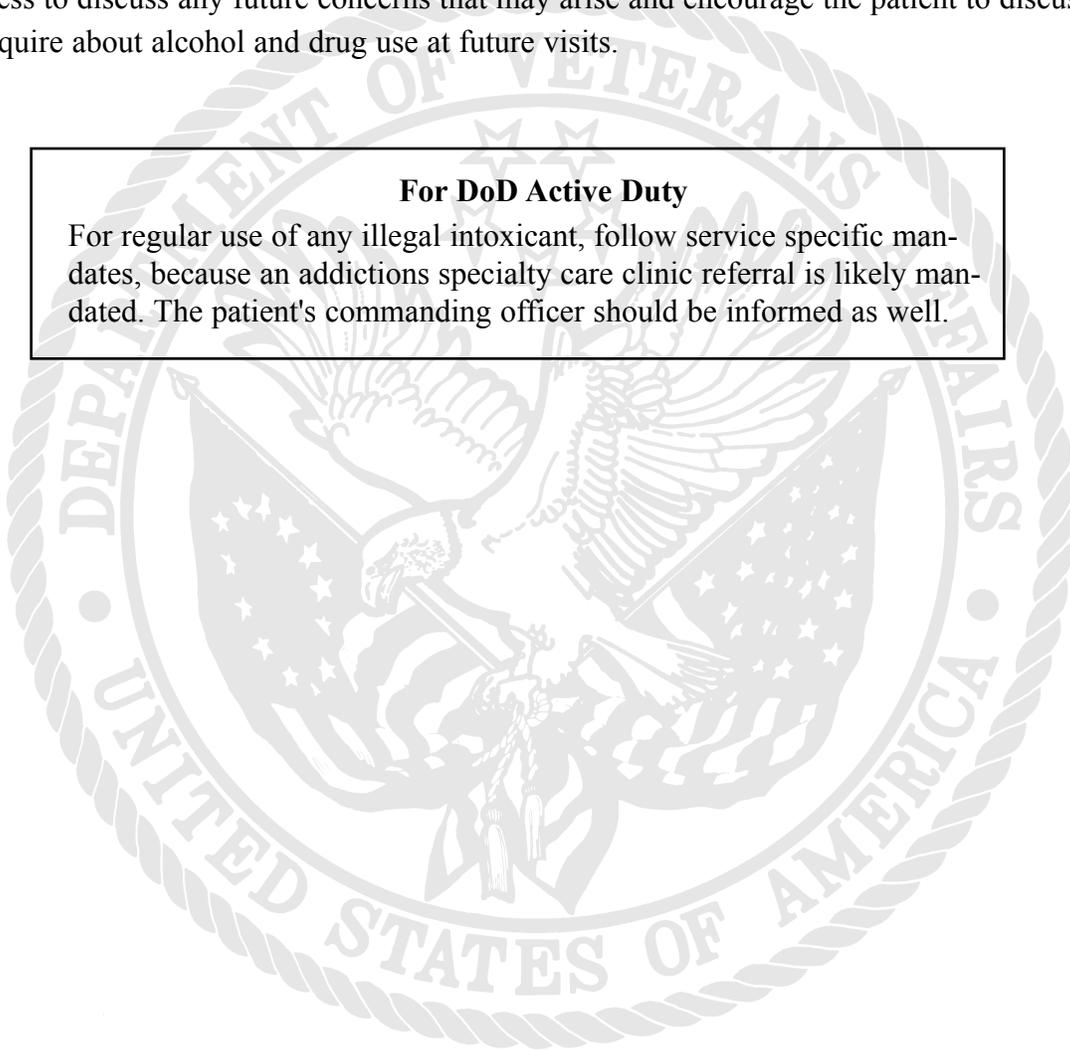
Maintain vigilant review of alcohol and other drug use by multiple modes of assessment, ranging from careful observation by provider during medical appointments to the use of biological measures. Promote abstinence or reduction, as indicated, and offer supportive verbal encouragements.

Educate About Substance Use, Behavioral Problems, and Prevention of Relapse

- Continue to discuss the patient's current use of alcohol and other drugs and address any potential problem areas.
- Convey openness to discuss any future concerns that may arise and encourage the patient to discuss them with you.
- Periodically inquire about alcohol and drug use at future visits.

For DoD Active Duty

For regular use of any illegal intoxicant, follow service specific mandates, because an addictions specialty care clinic referral is likely mandated. The patient's commanding officer should be informed as well.



DSM-IV CRITERIA

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).

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).

CAGE Questionnaire

1. Have you ever felt you should Cut down on your drinking?

YES

1

NO

0

2. Have people Annoyed you by criticizing your drinking?

1

0

3. Have you ever felt bad or Guilty about your drinking?

1

0

4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (Eye opener)?

1

0

SCORING: Item responses on the CAGE are scored 0 or 1, with a higher score an indication of alcohol problems. A total score of 2 or greater is considered clinically significant.

ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT)

Please circle the answer that is correct for you.

1. How often do you have a drink containing alcohol?
 Never Monthly or less 2 to 4 times a month 2 to 3 times a week 4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?
 1 or 2 3 or 4 5 or 6 7 to 9 10 or more
3. How often do you have six or more drinks on one occasion?
 Never Less than monthly Monthly Weekly Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?
 Never Less than monthly Monthly Weekly Daily or almost daily
5. How often during the last year have you failed to do what was normally expected from you because of drinking?
 Never Less than monthly Monthly Weekly Daily or almost daily
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?
 Never Less than monthly Monthly Weekly Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?
 Never Less than monthly Monthly Weekly Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
 Never Less than monthly Monthly Weekly Daily or almost daily
9. Have you or someone else been injured as a result of your drinking?
 No Yes, but not in the last year Yes, during the last year
10. Has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?
 No Yes, but not in the last year Yes, during the last year

Procedure for Scoring AUDIT: The AUDIT can be administered by interview or self-report. Questions 1-8 are scored 0, 1, 2, 3 or 4. Questions 9 and 10 are scored 0, 2 or 4 only. The response is as follows:

	0	1	2	3	4
Question 1	Never	Monthly or Less	Two to four times per month	Two to three times per week	Four or more times per 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.