

# VA/DoD Clinical Practice Guideline Substance Use Disorders – Specialty Care Pocket Guide

## TREATMENT OF CO-OCCURRING DISORDERS

- Prioritize and address other coexisting biopsychosocial problems (e.g., Medical, Psychiatric, Family, Vocational, And/Or Legal) with services targeted to these areas, rather than increasing drug and alcohol counseling alone.
- Identify and treat concurrent psychiatric disorders consistent with VA/DoD clinical practice guidelines (e.g., Major Depressive Disorder or Psychoses) including concurrent pharmacotherapy.
- Identify and treat other compulsive behaviors (e.g., gambling or spending).
- Identify and treat nicotine dependence.
- Provide multiple services in the most accessible setting to promote engagement and coordination of care.
- Monitor and address deferred problems and emerging needs through ongoing treatment plan updates.

## INDICATIONS FOR PHARMACOTHERAPY FOR ALCOHOL DEPENDENCE

Naltrexone	Disulfiram
<p>Alcohol dependence with:</p> <ul style="list-style-type: none"> <li>• Ability to achieve at least 3-5 days of abstinence to rule out the need for detoxification</li> <li>• Drinking within the past 30 days and/or reports of craving</li> <li>• Most effective when the patient is engaged in addiction-focused counseling</li> </ul>	<p>Alcohol dependence with:</p> <ul style="list-style-type: none"> <li>• Abstinence &gt; 24 hours and BAL equal to 0</li> <li>• Combined cocaine and alcohol dependence</li> <li>• Failure of or contraindication to naltrexone</li> <li>• Previous response to disulfiram</li> <li>• Patient preference</li> <li>• Capacity to appreciate risks and benefits and to consent to treatment</li> </ul> <p>Note: Most effective with monitored administration (e.g., in clinic or with spouse or probation officer)</p>

## BIOPSYCHOSOCIAL ASSESSMENT OF SUDS

1. Patient's demographics and identifying information, including housing, legal, and occupational status
2. Patient's chief complaint and history of the presenting complaint
3. Recent substance use and severity of substance-related problems
4. Lifetime and family history of substance use
5. Co-morbid psychiatric conditions and psychiatric history
6. Social and family context
7. Developmental and military history
8. Current medical status and history, including risk for HIV or hepatitis C
9. Mental status and physical examinations
10. Patient's perspective on current problems and treatment goals or preferences

## MOTIVATIONAL ENHANCEMENT TECHNIQUES

**Feedback:** Provide personalized feedback based on patient report of substance-related harm.

**Responsibility:** Emphasize patient responsibility and freedom of choice for changing behavior.

**Advice:** Provide clear and direct advice about the importance of change and availability of help.

**Menu:** Acknowledge and discuss alternative strategies for change.

**Empathy:** Maintain a patient-centered approach and accurately reflect patient statements and feelings.

**Self-Efficacy:** Emphasize the role of patient self-efficacy in their ability to make needed change and convey optimism in their potential to be successful.

## EVIDENCE-BASED PSYCHOSOCIAL INTERVENTIONS

- Behavioral marital therapy
- Cognitive-behavioral coping skills training
- Community reinforcement and other contingency-based approaches
- Individual and group drug counseling
- Motivational enhancement
- Twelve-Step facilitation training

### CONTINUING CARE

- Modify treatment plans individually based on changes in a patient’s clinical and psychosocial condition rather than imposing uniform treatment plans.
- Discuss relapse as a signal to reevaluate the treatment plan rather than evidence that the patient cannot succeed or was not sufficiently motivated.
- Consider care management for patients with persistently sub-optimal response, rather than routinely intensifying rehabilitation or discharging.
- Coordinate follow-up with the patient’s primary medical or behavioral health provider during transitions to less intensive levels of care in order to reinforce progress and improve monitoring of relapse risks.
- For DoD active duty patients, addiction-focused treatment follow-up may be mandated for a period of 6-12 months from the time of initial referral (this may be referred to as “aftercare” in the DoD community).

### SPECIALTY CARE DISCHARGE PLANNING

- Schedule primary care follow-up within 90 days of specialty discharge to reinforce recovery progress.
- Encourage patients to re-contact specialty treatment providers for additional help to prevent or promptly interrupt relapse.

### OPTIMAL GOALS OF REHABILITATION

- Complete and sustained remission of all SUDs
- Resolution of, or significant improvement in, all coexisting biopsychosocial problems and health-related quality of life

### INTERMEDIATE GOALS OF REHABILITATION

- Short- to intermediate-term remission of SUDs or partial remission of SUDs for a specified period of time
- Resolution or improvement of at least some coexisting problems and health-related quality of life

### GOALS OF CARE MANAGEMENT

- Engagement in the treatment process, which may continue for long periods of time or indefinitely
- Continuity of care
- Enhanced motivation to change
- Improvement in SUDs, 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

Types of Housing	Indications	ASAM Level Of Care	Examples
Intensive Medical Management or Monitoring	<ul style="list-style-type: none"> <li>• Medical or psychiatric instability requiring hospitalization (includes severe intoxication or withdrawal)</li> </ul>	III.7 & IV	<ul style="list-style-type: none"> <li>• Inpatient medical bed section</li> <li>• Inpatient addiction/psychiatry bed section</li> </ul>
Professional Monitoring	<ul style="list-style-type: none"> <li>• Medical or psychiatric instability requiring 24-hour professional monitoring, but not of sufficient severity to require hospitalization</li> </ul>	III.3-III.5	<ul style="list-style-type: none"> <li>• Social detoxification setting</li> <li>• VA Substance Abuse Residential Rehabilitation Treatment Programs (SARRTP) and VA Domiciliaries (professional staff present 24-hours/day)</li> </ul>
24-Hour Supervision	<ul style="list-style-type: none"> <li>• Conditions requiring supervision that may be provided by paraprofessionals, volunteers, or patients in advanced stages of treatment</li> <li>• Demonstrated inability to remain abstinent in unsupervised setting</li> <li>• Lacking own social support system, such as family members willing and able to assist, or homeless</li> </ul>	III.1-III.2	<ul style="list-style-type: none"> <li>• Halfway houses</li> <li>• Sober houses or safe houses</li> <li>• Use of hospital bed space for lodging purposes (e.g., self-care wards in DoD &amp; lodger status in VA)</li> <li>• VA SARRTP and VA Domiciliaries (staffed only by non-professionals at least part of the day or night)</li> </ul>
Non-Supervised Housing	<ul style="list-style-type: none"> <li>• Lives at too great a distance to travel to outpatient program</li> <li>• Able to care for self, including use of medications</li> <li>• Able to remain abstinent in an unsupervised setting</li> </ul>	I, II.1, or II.3	<ul style="list-style-type: none"> <li>• Patient’s own home</li> <li>• Transitional living facility</li> <li>• Temporary housing provided on-site or in the community</li> </ul>