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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.

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.

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

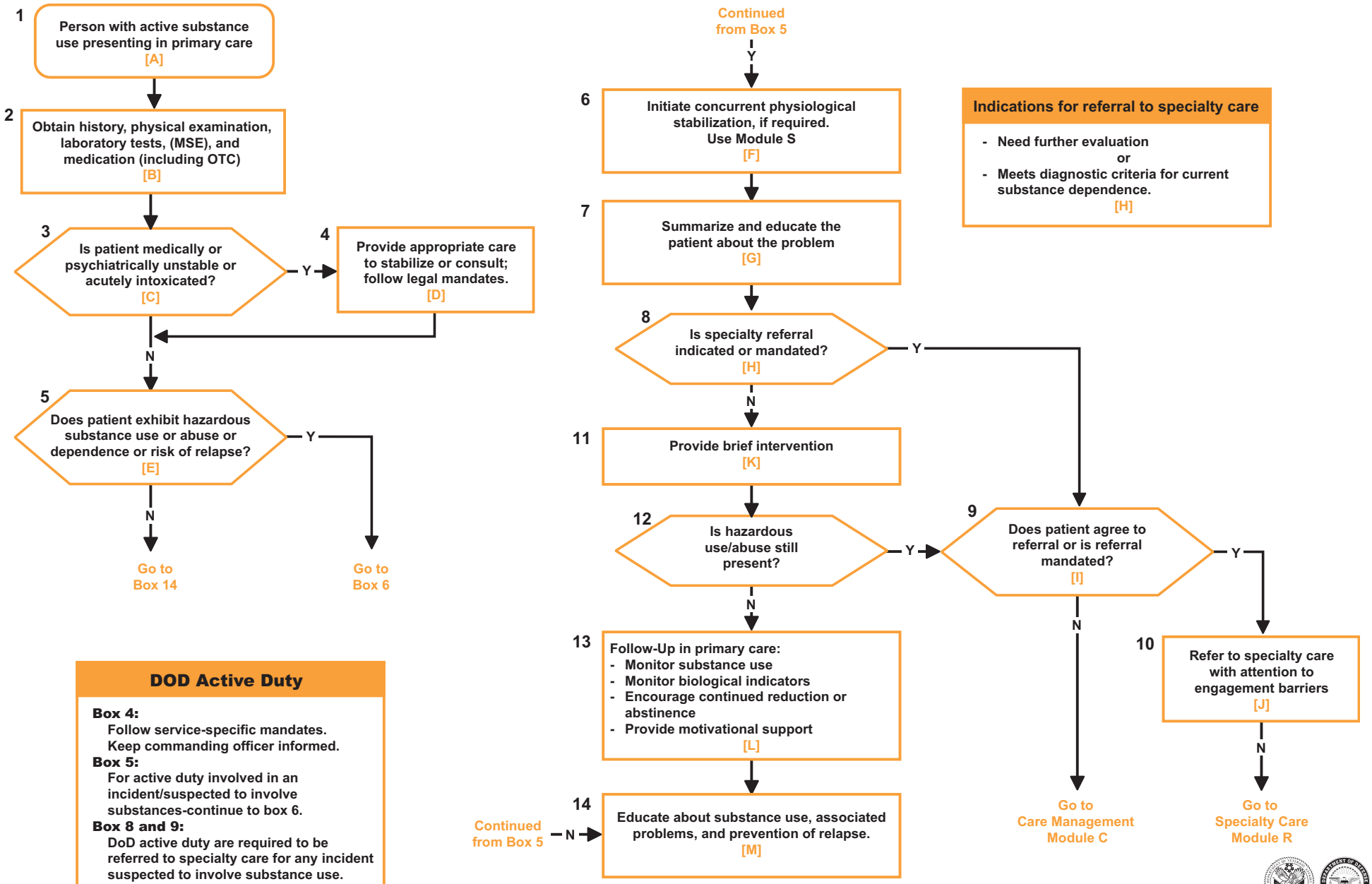
A simple and brief patient inquiry will often suffice, such as "Have you had any 'close calls' with drinking or other drug use?"

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	• Slurred speech • Incoordination • Unsteady gait • Nystagmus • Impairment in attention or memory • Stupor or coma *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).*	• 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	• 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	• Dysphoric mood • Fatigue • Vivid, unpleasant dreams • Insomnia or hypersomnia • Increased appetite • Psychomotor retardation or agitation
Opiate	• 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 *Note: Acute opiate intoxication can present as a medical emergency with unconsciousness, apnea, and pinpoint pupils.*	• 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.

Algorithm A:
Substance Use Disorder (SUD) in the Primary Care Setting
Assessment and Management



DOD Active Duty

Box 4:
Follow service-specific mandates.
Keep commanding officer informed.

Box 5:
For active duty involved in an incident/suspected to involve substances-continue to box 6.

Box 8 and 9:
DoD active duty are required to be referred to specialty care for any incident suspected to involve substance use.

Key Elements

ASSESSMENT
- 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.

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, typical and maximum number of drinks per occasion).
- Monitor and discuss biological indicators (e.g., transaminase levels and urine toxicology).
- 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.

DoD active duty are required to be referred to specialty care for any incident suspected to involve substance use.

DSM – IV DIAGNOSTIC CRITERIA for SUBSTANCE DEPENDENCE

DSM-IV defines the diagnostic criteria for substance dependence as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by three or more of the following, occurring at any time in the same 12 month period:

1. Tolerance, as defined by either of the following:
   (a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect
   (b) markedly diminished effect with continued use of the same amount of the substance
2. Withdrawal, as manifested by either of the following:
   (a) the characteristic withdrawal syndrome for the substance
   (b) 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 unsuccessful efforts to cut down or control substance use
5. Spending a great deal of time in activities necessary to obtain or use the substance or to recover from its effects
6. Giving up or reducing important social, occupational, or recreational activities because of substance use
7. Continuing the substance use despite the knowledge that it is causing or exacerbating a persistent or recurrent physical or psychological problem

DSM – IV DIAGNOSTIC CRITERIA for SUBSTANCE ABUSE

DSM-IV defines the diagnostic criteria for substance abuse as 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:

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home
2. Recurrent substance use in situations in which it is physically hazardous
3. Recurrent substance-related legal problems
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance

ASSESSMENT of SUBSTANCE USE DISORDER - "CAGE"

The CAGE is a beneficial mnemonic consisting of questions about alcohol use.

1. Have you ever felt that you should **C**ut down on your drinking?
2. Have people **A**nnoyed you by criticizing your drinking?
3. Have you ever felt bad or **G**uilty about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (**E**ye-opener)?

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

Reprinted with permission from the American Journal of Psychiatry, 1974, 131:1121-1123.

DRUG ABUSE / DEPENDENCE SCREENER

Here is a list of drugs:

- Marijuana, hashish, pot, grass
- Amphetamines, stimulants, uppers, speed
- Tranquilizers, Valium, Librium
- Heroin
- Barbiturates, sedatives, downers, sleeping pills, seconal, quaaludes
- Cocaine, coke, crack
- Opiates, codeine, Demerol, morphine, methadone, Darvon, opium
- Psychedelics, LSD, Mescaline, peyote, psilocybin, DMT, PCP

1. Have you ever used one of these drugs on your own more than 5 times in your life? By "on your own," I mean to get high or without a prescription or more than was prescribed.
   Yes = 1; No = 0 (skip questions 2 and 3)
2. Did you ever find you needed larger amounts of these drugs to get an effect or that you could no longer get high on the amount you used to use?
   Yes = 1, No = 0
3. Did you ever have emotional or psychological problems from using drugs – such as feeling crazy or paranoid or depressed or uninterested in things?
   Yes = 1, No = 0

Consider screen positive for lifetime drug abuse/dependence if item 1 = Yes and either item 2 or 3 = Yes

Source: Rost, Burnam & Smith, 1993

ASSESSMENT of SUBSTANCE USE DISORDER - ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT)

Instruct patient to circle the answer that is correct for him/her. This test can be administered by interview or self-report.

1. How often do you have a drink containing alcohol?				
Never	Monthly or less	Two to four times a month	Two to three times a week	Four 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, 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

Scoring: Questions 1-8 are scored 0, 1, 2, 3, or 4 Questions 9 & 10 are scored 0, 2 and 4 only. The response is as follows:

	0	1	2	3	4
Question 1	Never or less	Monthly	2-4 times per month	2-3 times per week	4 or more times per week
Question 2	1 or 2	3 or 4	5 to 6	7 to 9	10 or more
Question 3 - 8	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Question 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.
Source: Babor & Higgins-Biddle, 2001

INTERVIEW APPROACHES BASED on the PATIENT'S READINESS for BEHAVIORAL CHANGE

PRECONTEMPLATION
- Express concern about the patient and substance use
- State nonjudgmentally that substance abuse is a problem
- Consider a trial of abstinence to clarify the issue
- Suggest bringing a family member to an appointment
- Explore the patient's perception of a substance use problem
- Emphasize the importance of seeing the patient again

CONTEMPLATION
- Elicit positive and negative aspects of substance use
- Ask about positive and negative aspects of past periods of abstinence
- Summarize patient's comments on substance use and abstinence
- Make explicit discrepancies between values and action
- Consider a trial of abstinence

PREPARATION
- Acknowledge the significance of the decision to seek treatment
- Support self-efficacy
- Affirm the patient's ability to successfully seek treatment
- Help the patient decide on appropriate, achievable action
- Caution that the road ahead is tough but very important
- Explain that relapse should not disrupt the patient-clinician relationship

ACTION
- Be a source of encouragement and support
- Acknowledge the uncomfortable aspects of withdrawal
- Reinforce the importance of remaining in recovery

MAINTENANCE
- Anticipate difficulties as a means of relapse prevention
- Recognize the patient's struggle
- Support the patient's resolve
- Reiterate that relapse should not disrupt the medical care approach

RELAPSE
- Explore what can be learned from the relapse
- Express concern and even disappointment about relapse
- Emphasize positive aspects of the effort to seek care
- Support the patient's self-efficacy so that recovery seems achievable

Family care providers can provide *brief interaction* during regular office visits. Refer to Specialty Care if the patient needs further evaluation or meets the diagnostic criteria for current substance dependence. DoD active duty are required to be referred to specialty care for any incident suspected to involve substance use. Review/Follow Substance Use Disorder Algorithm Module A for DoD service-specific mandates.
Source: Prochaska & DiClemente, 2001