


Substance Use Disorder


Pocket Guide Overview

Tab 1:

POCKET GUIDE OVERVIEW

Intended Patient Outcomes of Clinical Practice Guideline Use and Substance Use Disorder (SUD) Pocket Guide:

- Reduction of consumption
- Improvement in quality of life, including social and occupational functioning
- Improvement of symptoms
- Improvement of retention and patient engagement
- Improvement in co-occurring conditions
- Reduction of mortality

OVERVIEW

Background

VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorder

- Developed by the Department of Veterans Affairs (VA) and the Department of Defense (DoD)
  - From recommendations generated by the substance use disorder (SUD) working group — a group of VA/DoD clinical experts from primary care, psychological health and other disciplines
  - Methodology included: determining appropriate treatment criteria (e.g., effectiveness, efficacy, population benefit, patient satisfaction) and reviewing literature to grade the level of evidence and formulate recommendations
  - Last updated in August 2009

Substance Use Disorder Pocket Guide

- Provides medical and psychological health providers with a useful, quick reference tool for treating patients with SUD
- Derived directly from the VA/DoD SUD Clinical Practice Guideline (CPG):
  - Developed by the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) in collaboration with the VA/DoD
  - Content derived from a January 2011 VA/DoD working group

- For more comprehensive information, please refer to the full length VA/DoD CPG for the Management of SUD, available at:
  - www.healthquality.va.gov/Substance_Use_Disorder_SUD.asp
  - https://www.qmo.amedd.army.mil/substance%20abuse/substance.htm

VA/DoD CPG and SUD Pocket Guide Goals

- Identify patients with substance use conditions, including at-risk use, substance use problems and substance use disorders
- Promote early engagement and retention of patients with substance use conditions who can benefit from treatment
- Improve outcomes for patients with substance use conditions, including:
  - Cessation or reduction of substance use
  - Reduction in occurrence and severity of relapse
  - Improved psychological and social functioning and quality of life
  - Improved co-occurring medical and health conditions
  - Reduction in mortality

Target Audience and Patient Population

- Health care providers managing treatment for adult patients with substance use conditions:
  - In any VA/DoD health care setting, including specialty, general and psychological health
  - With any level of symptom severity, from hazardous and problematic substance use to diagnosed SUD

Settings of Care

- **General health care –** screening and brief intervention may be performed in:
  - Outpatient clinic settings, including primary care, psychiatry or other specialty clinics (e.g., HIV, hepatology, medical, pre-operative)
  - Emergency departments and surgical care clinics

- **Specialty SUD care –** focusing on patients in need of further assessment or motivational enhancement, or whom request longer-term rehabilitation goals

SUD Basics

Conditions and Disorders of Unhealthy Alcohol Use

The spectrum of alcohol use extends from abstinence and low-risk use (most common alcohol use patterns) to risky use, problem drinking, harmful use and alcohol abuse as well as the less common but more severe use patterns and alcohol dependence.

Risky Users

- In women **OR** persons > 65 years old, consuming > 7 standard drinks per week **OR** > 3 per occasion
- In men ≤ 65 years old, consuming > 14 standard drinks per week **OR** > 4 per occasion
- One-third of patients in this category are at risk for dependence

Problem Drinking

- Use of alcohol, accompanied by alcohol-related consequences but not meeting Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) criteria

THE RISK OF FUTURE PHYSICAL, PSYCHOLOGICAL OR SOCIAL HARM INCREASES WITH INCREASING LEVELS OF CONSUMPTION

Short-Term Risks (Associated with exceeding the amounts per occasion)	Long-Term Risks (Associated with exceeding the weekly amounts)
■ Injury ■ Trauma	■ Cirrhosis ■ Cancer ■ Other chronic illnesses

SUD Criteria and Specifiers

Note: Specific diagnostic criteria by class of substance can be found in Tab 5: Symptoms of Intoxication and Withdrawal

DSM-IV-TR CRITERIA:

Substance Abuse	Substance Dependence
A maladaptive pattern of substance use, leading to clinically significant impairment or distress as manifested by one or more (abuse), three or more (dependence), of the following, at any time in the same 12-month period:	
▪ Failure to fulfill major role obligations at work, school or home as a result of recurrent substance use ▪ Recurrent substance use in physically hazardous situations ▪ Recurrent substance use-related legal problems ▪ Continued substance use despite persistent or recurrent social or interpersonal problems caused or exacerbated by substance effects	▪ **Tolerance** (need for markedly increased amounts of substance to achieve intoxication or desired effect) ▪ **Withdrawal** (the same or a closely related substance is taken to relieve or avoid withdrawal symptoms) ▪ **Larger amounts** of substance taken, and/or **over a longer period than intended** ▪ **Persistent desire and/or unsuccessful efforts** to cut down or control substance use ▪ **Excessive amount of time spent to obtain, use or recover** from the effects of a substance ▪ **Important social, occupational or recreational activities are given up** or reduced because of substance use ▪ Substance use continues despite knowledge of having a **substance-related, persistent or recurrent physical or psychological problem**

DSM-IV-TR SPECIFIERS:

Dependence	**With Physiological Dependence**	■ Individual has evidence of tolerance or withdrawal
	Without Physiological Dependence	■ Individual has no evidence of tolerance or withdrawal
Course of Remission	**Early Full**	■ For ≥ 1 month, but < 12 months, no criteria for dependence or abuse met
	Early Partial	■ For ≥ 1 month, but < 12 months, ≥ 1 criteria for dependence (but not full criteria) or abuse met
	Sustained Full	■ No criteria for dependence or abuse met at any time during a period of ≥ 12 months
	Sustained Partial	■ ≥ 1 criteria for dependence or abuse met, but full criteria for dependence not yet met for ≥ 12 months
Other	**On Agonist Therapy**	■ Individual is on a prescribed agonist medication (e.g., methadone) and no criteria for dependence or abuse have been met for that class of medication for at least the past month (except tolerance to, or withdrawal from, the agonist) ■ Also applies to those being treated for dependence using a partial agonist or an agonist/antagonist
	In a Controlled Environment	■ Individual is in an environment where access to alcohol or controlled substances is restricted (e.g., closely supervised, substance-free jails, hospital units, therapeutic communities) and no criteria for dependence or abuse have been met for at least the past month

Source: American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000.

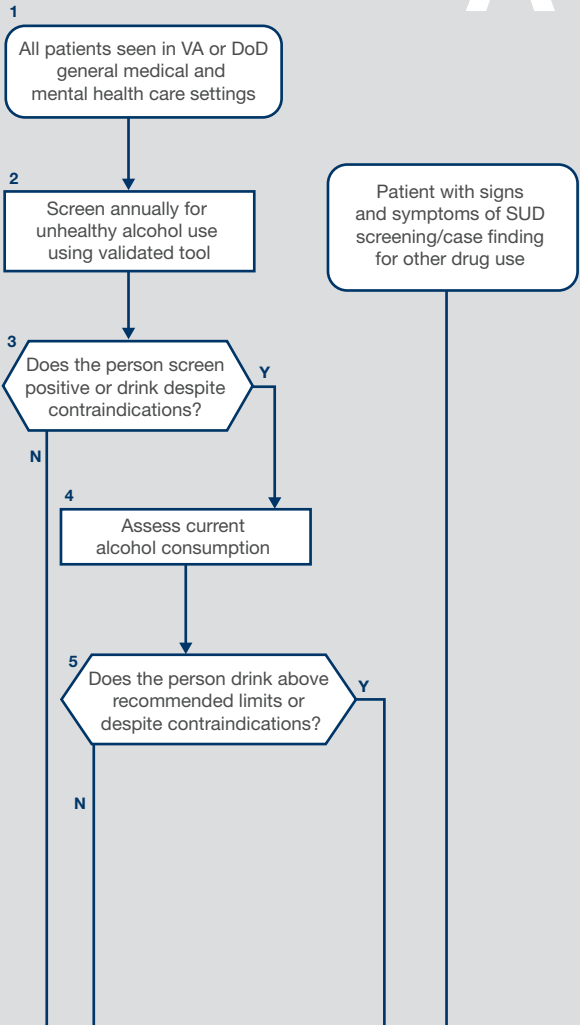
Modules in the Pocket Guide

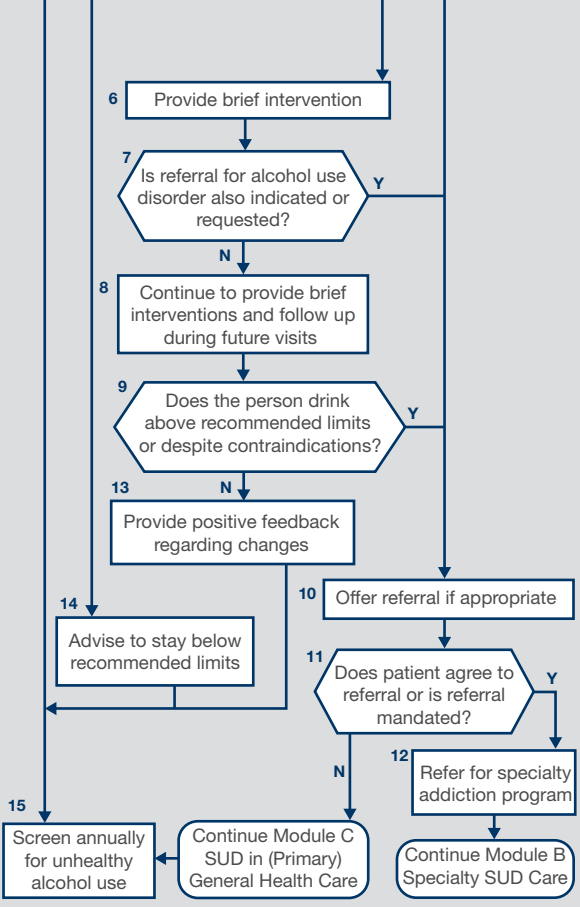
The Pocket Guide references steps from the following selected CPG modules that address interrelated aspects of care for patients with SUD:

Tab 2	**Module A: Screening and Initial Assessment for Substance Use** includes screening, brief intervention and specialty referral considerations
	Module C: Management of SUD in General Health Care Settings emphasizes earlier intervention for less severe SUD, or chronic disease management for patients unwilling or unable to engage in treatment in specialty SUD care or not yet ready to abstain
Tab 3	**Module B: Management of SUD in Specialty Care** focuses on patients in need of further assessment, motivational enhancement or remission
Tab 4	**Module S: Stabilization and Withdrawal Management** addresses withdrawal management, including pharmacological management of withdrawal symptoms

For additional information on addiction-focused pharmacotherapy (e.g., opioid and alcohol dependence), refer to Module P in the full CPG.

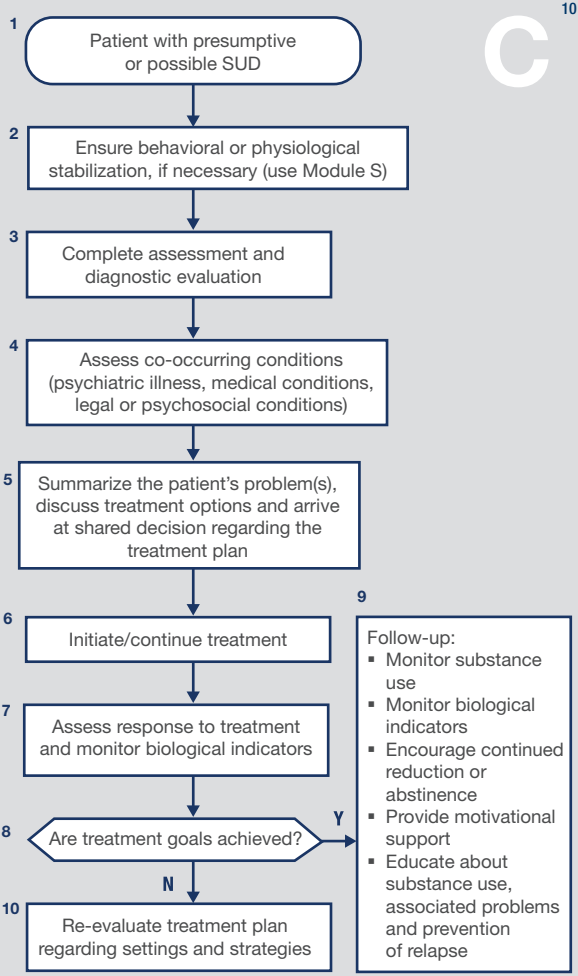
Note: The Pocket Guide recommendations are intended to support clinical decision-making, but should never replace sound clinical judgment.


1
All patients seen in VA or DoD general medical and mental health care settings
2
Screen annually for unhealthy alcohol use using validated tool
Patient with signs and symptoms of SUD screening/case finding for other drug use
3
Does the person screen positive or drink despite contraindications?
Y
N
4
Assess current alcohol consumption
5
Does the person drink above recommended limits or despite contraindications?
Y
N



See Tab 2 Screening, Intervention and Referral for additional information

Source: VA/DoD, retrieved from http://www.healthquality.va.gov/Substance_Use_Disorder_SUD.asp



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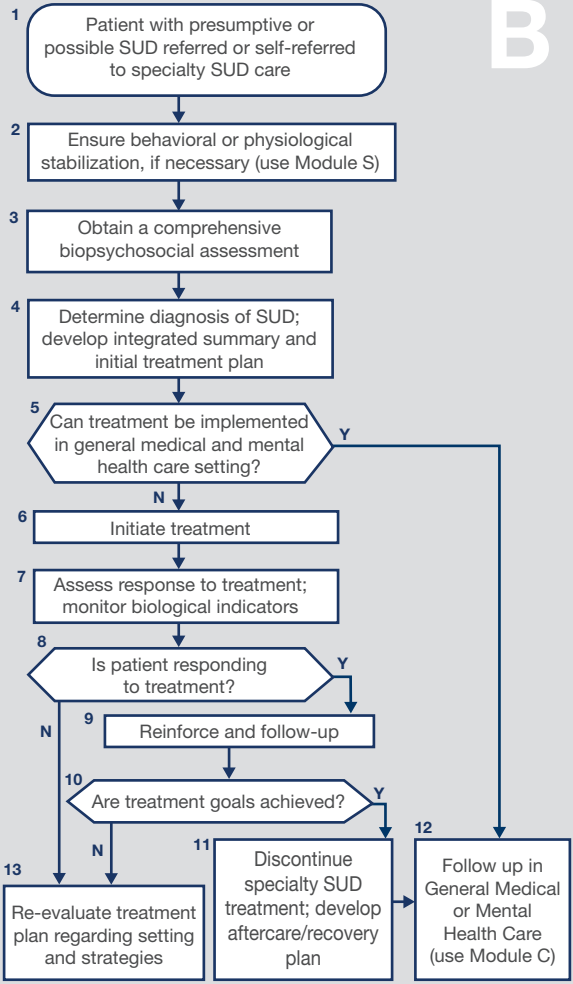

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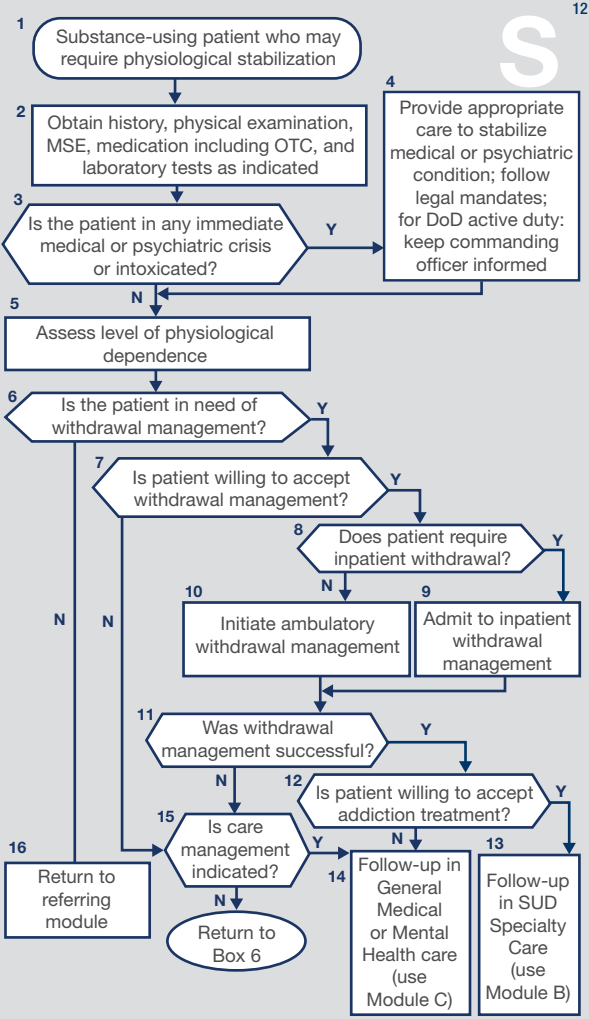
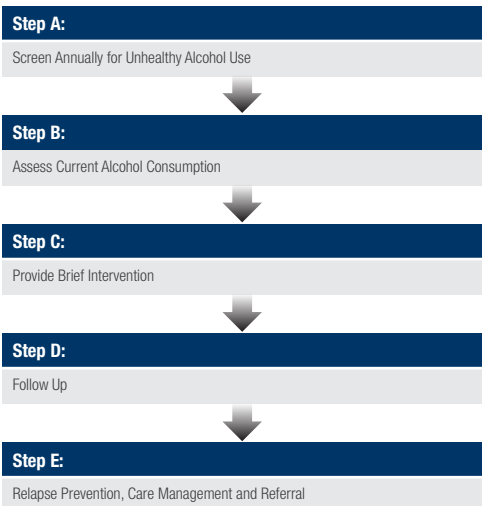


Source: VA/DoD, retrieved from http://www.healthquality.va.gov/Substance_Use_Disorder_SUD.asp

Screening, Intervention and Referral

Tab 2:

SCREENING, INTERVENTION AND REFERRAL



The following steps correspond with Module A: Screening and Initial Assessment and Module C: Management of SUD in General Health Care. They include guidance for screening, educating and providing brief interventions, referrals or care management, if necessary, to patients who may present with unhealthy alcohol use.

Step A: Screen Annually for Unhealthy Alcohol Use Using Validated Tool

(Boxes 1 to 3 in Module A)

- All patients seen in general medical and general psychological health settings are the target population for alcohol screening.
- Use the Alcohol Use Disorders Identification Test (AUDIT-C) (preferred) or Single-Item Alcohol Screening Questionnaire (SASQ) to identify where patients fall on the continuum of unhealthy alcohol use, including those who drink above recommended limits (i.e., risky or hazardous drinking) to those with severe alcohol dependence.

Scoring AUDIT-C

Question	0 points	1 point	2 points	3 points	4 points
1. How often did you have a drink containing alcohol in the past year?	☐ Never	☐ Monthly or less	☐ 2 to 4 times per month	☐ 2 to 3 times per week	☐ 4 or more times per week
2. On days in the past year when you drank alcohol how many drinks did you typically drink?	☐ 1 or 2	☐ 3 or 4	☐ 5 to 6	☐ 7 to 9	☐ 10 or more
3. How often do you have 6 or more drinks on an occasion in the past year?	☐ Never	☐ Less than Monthly	☐ Monthly	☐ Weekly	☐ Daily or almost daily

When the Audit-C is administered by self-report add a "0 drinks" response option to question #2 (0 points based on validations studies). In addition, it is valid to input responses of 0 points to questions #2-3 for patients who indicate "never" in response to question #1 (past year non-drinkers).

The minimum score (for non-drinkers) is 0 and the maximum possible score is 12. **Consider a screen positive for unhealthy alcohol use if AUDIT-C score is ≥ 4 points for men OR ≥ 3 points for women.**

Source: Bush, K., Kivlahan, D.R., McDowell, M.B., Fihn, S.D., & Bradley, K. A. The AUDIT Alcohol Consumption Questions (AUDIT-C): An Effective Brief Screening Test for Problem Drinking. Archives of Internal Medicine, 158, pp. 1789-1795, 1998.

SASQ Recommended by National Institute on Alcohol Abuse and Alcoholism (NIAAA)

1. **Do you sometimes drink beer, wine or other alcoholic beverages? (Followed by the screening question)**

2. **How many times in the past year have you had.... 5 or more drinks in a day (men) 4 or more drinks in a day (women)**

One standard drink = 12 ounces of beer, or 5 ounces of wine, or 1.5 ounces of 80-proof spirits (see Tab 7, page 65 for pictures of standard drinks.)

A positive screen is any report of drinking 5 or more (men) or 4 or more (women) drinks on an occasion in the past year.

Source: Smith, P. C., Schmidt, S.M., Allensworth-Davies, D. & Saitz, R. Primary Care Validation of a Single-Question Alcohol Screening Test. Journal of General Internal Medicine, 24, 783-788, 2009.

Step B: Assess Current Alcohol Consumption

(Boxes 4 and 5 in Module A)

- If patient screens positive for unhealthy alcohol use on the AUDIT-C or SASQ, assess current alcohol consumption further.
- If patient drinks above the recommended limits or has clinical conditions that contraindicate alcohol use, consider brief intervention (See Step C, page 16).

Positive Screen for Unhealthy Alcohol Use

- For MEN: AUDIT-C score ≥ 4 **OR** SASQ score ≥ 5
- For WOMEN: AUDIT-C score ≥ 3 **OR** SASQ score ≥ 4

Recommended Drinking Limits

- For MEN: ≤ 14 standard-sized drinks a week **OR** ≤ 4 standard-sized drinks a day
- For WOMEN: ≤ 7 standard-sized drinks a week **OR** ≤ 3 standard-sized drinks a day

Contraindications for Any Alcohol Use

- Pregnancy or trying to conceive
- Liver disease, including Hepatitis C
- Other medical conditions potentially exacerbated or complicated by alcohol use (e.g., pancreatitis, congestive heart failure)
- Use of medications with clinically important interactions* with alcohol or intoxication (e.g., fluoxetine)
- Alcohol use disorder

*A list of drug-alcohol interactions can be accessed at: http://pubs.niaaa.nih.gov/publications/medicine/medicine.htm

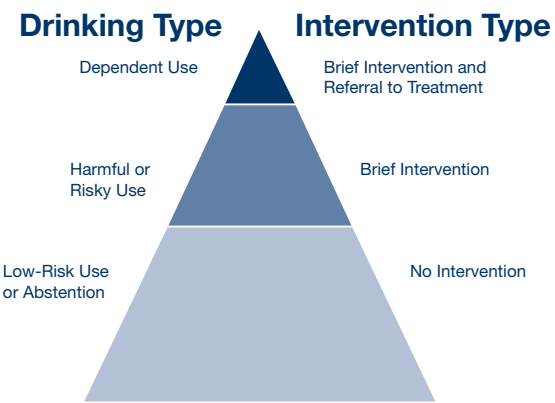
Assess Current Alcohol Consumption	Results	Action
Does the patient: ■ Screen positive	If yes to any	Provide brief intervention
■ Drink above recommended limits ■ Drink despite contraindications	If no to all	Reinforce current behaviors

Step C: Provide Brief Intervention

(Box 6 in Module A, and Boxes 4 and 5 in Module C)

Characteristics of Brief Interventions

- Patient-centered, empathetic, brief counseling
- Single or multiple session(s)
- Includes motivational discussion focused on increasing alcohol use awareness and behavioral change
- Offered by a clinician who is not an addictions provider specialist or counselor
- Can be a stand-alone treatment for those at risk **and/or** to engage those in need of higher levels of care



Source: American Public Health Association and Education Development Center, Inc. (2008). Alcohol screening and brief intervention: A guide for public health practitioners. Washington DC: National Highway Traffic Safety Administration, U.S. Department of Transportation. Retrieved from http://www.adp.ca.gov/SBI/pdfs/Alcohol_SBI_Manual.pdf

Brief Intervention Sample Dialogue: Remember "E-PASS"

Recommendations	
Express concern about patient's risk for drinking-related health problems	"I am concerned about your use of alcohol because you are drinking above recommended limits."
Provide education on links between alcohol use and patient's **co-occurring health conditions** (if present), for example: 1. Diabetes 2. Hypertension 3. Depression or anxiety 4. Insomnia 5. Pain condition	"Because of your [chronic or co-occurring condition], I am concerned that your alcohol use may impact your health by [relevant repercussion]."
Advise patient to abstain (if contraindications) or drink below recommended limits (specified for patient)	"What do you see as the possible benefits to cutting down?" If patient indicates no desire to change: "Would you be willing to review these materials and discuss them at a follow up visit?" Provide information handout.
Support patient in setting a drinking goal and arrive at a **shared decision** in treatment plan	"What changes are you willing to make to meet this goal?" Encourage specificity, e.g., cutting down to X number of drinks and documenting intended steps.
Suggest treatment **referral**, if appropriate	"[I need to refer you to / Would you be willing to have an] additional evaluation at the alcohol treatment program?"

For additional sample dialogue, refer to: American Public Health Association and Education Development Center, Inc. (2008). Alcohol screening and brief intervention: A guide for public health practitioners. Washington DC: National Highway Traffic Safety Administration, U.S. Department of Transportation, available at http://www.apha.org/NR/rdonlyres/B03B4514-CCBA-47B9-82B0-5FEB4D2DC983/0/SBImanualfinal4_16.pdf

Step D: Follow-up

(Boxes 8 to 9 and 13 to 15 in Module A)

Provider Actions for Emergency Referral

- Re-evaluate patient progress
  - Address alcohol at the next scheduled medical visit
  - Schedule separate appointment to specifically address drinking

"What changes have you made in your drinking habits since our last appointment?"

- Provide positive feedback to patient for decreases in drinking
- Support patient in addressing barriers to improvement
- Advise drinking below recommended limits or continued abstinence

"What difficulties have you had in cutting down? What are some steps you could take to overcome these difficulties?"

- Assess changes in alcohol-related biomarkers
- Relate changes in drinking to any changes in health conditions
- Encourage involvement in specialty treatment and mutual support groups
- Repeat brief intervention if patient has not responded to previous brief intervention

"Do you think the goals we discussed last time are still attainable? If not, what is something you are willing to commit to?"

- Repeat AUDIT-C screening annually

Factors That May Increase Follow-up Frequency

- Severity of patient's unhealthy alcohol use
- Existence of co-occurring conditions
- Readiness to change
- Personal circumstances (e.g., flexibility in making appointments due to limited competing responsibilities)

Step E: Relapse Prevention, Care Management and Referral

(Boxes 10 to 12 in Module A, and Boxes 7 to 10 in Module C)

Relapse Prevention

NOTE: Successful relapse prevention requires extended efforts from multiple providers.

For Patients Who Drink Above Recommended Limits or Despite Contraindications

- Educate patient about:
  - Substance use and associated problems
  - Relapse prevention
- Re-evaluate treatment plan:
  - Discuss current use of alcohol and other drugs
  - Convey openness to discuss any future concerns that may arise
  - Address any potential problem areas:
    - Recent initiation or increased use
    - Use to cope with stress
  - Periodically inquire about alcohol and drug use at future visits
  - Encourage drinking below recommended limits

For Patients Who Are Not Improving

- Adapt to any new objectives or goals that patient may express by:
  - Increasing intensity of care
  - Changing to another medication or intervention
  - Increasing the dose of or add medication
- Consider consultation with psychological health or SUD specialty care (See following Tab 3, page 25)

Relapse Prevention (cont.)

For Patients Who Do Not Stabilize and Refuse Ongoing Provider Care

- Continue to prevent relapse
  - Consider episodic attention to substance use
  - Provide crisis intervention, as needed
  - At any contact initiated by the patient:
    - Ask patient about current use and craving
    - Recommend ongoing care in most appropriate setting
    - Try to designate one provider to coordinate care for patients repeatedly in crisis
    - Involve supportive family members or significant others, if patient agrees*
    - Convey openness to discuss any future concerns that may arise
  - Provide feedback on improvement/deterioration in lab tests affiliated with substance use
  - Reinforce and endorse abstinence or reduced use, consistent with patient motivation
- Initiate involuntary treatment procedures if imminent threat to safety occurs

"Nothing we have tried so far seems to be working. We need to take more aggressive measures because it's extremely important for the sake of your health and the people you care about."

*For DoD active-duty service members, this includes unit commander, and potentially, first-line supervisor

Care Management

For patients with unsuccessful withdrawal management or who decline specialty care:

- Consider a more intensive level of care for withdrawal management (e.g., inpatient)
- Implement the following actions to begin a care management plan

Provider Actions for Care Management

- ☐ Complete comprehensive patient substance use assessment
- ☐ Monitor self-reported use, lab markers and consequences
- ☐ Advise reduction in use or abstinence if contraindications are present
- ☐ Provide referrals to community support groups (See Tab 9, page 75 for resources)
- ☐ Prioritize and address psychosocial needs (e.g., vocational, housing, legal)
- ☐ Coordinate care and services with other social service providers or case managers
- ☐ Support patient in choosing a drinking goal, if he/she is ready
- ☐ Monitor progress toward treatment goals, adjusting treatment strategies as needed
- ☐ Offer referral to specialty addiction treatments

Referral to Specialty Care

When initial presentation requires immediate referral or treatment plan is unsuccessful, providers need to know both emergency and non-emergency referral actions.

Emergency Referral

Assure Immediate Safety

- **Determine most appropriate setting** of care
- **Inform and involve** someone close to the patient
- **Limit access to means of suicide**
- **Increase contact** and make a commitment to help patient through crisis

Intervene Medically

- **For comatose patients, maintain airway and adequate ventilation** to preserve respiration and cardiovascular function
- **Consider emergency procedures** (e.g., gastric lavage for sedative, hypnotic and/or opioid intoxication)
- **Use emergency pharmacologic interventions as needed** (e.g., IV naloxone hydrochloride for opioid overdose, flumazenil for benzodiazepine overdose)
- **Manage agitation secondary to intoxication via interpersonal approaches** and by decreasing sensory stimuli, rather than adding medications
- Note: If chemotherapeutic agents are necessary, consider short acting IM benzodiazepines (e.g., lorazepam) and high potency neuroleptics.

- Follow DoD and service-specific policies for active-duty service members, as psychological health or emergency referral is likely mandated, and keep commanding officer informed.
- Adhere to existing local and state laws, policies and procedures with regard to threats to self or others, and the opinion of the VA district council and the DoD.

Non-emergency Referral

- Specialty SUD Care Referral
  - Primary care providers should offer referrals to patients open to assessment or ready for assistance from a specialty addictions provider or program.

Refer to Specialty Care

- **Offer referral to specialty care if patient:**
  - May benefit from additional evaluation or motivational interviewing
  - Has tried unsuccessfully to change substance use independently **or** does not respond to repeated brief intervention
  - Has been diagnosed with substance dependence
  - Has an AUDIT-C score ≥ 8
  - Has previously been treated for SUD
  - Agrees to the referral or if referral is mandated
- **If patient initially declines voluntary referral, provider encouragement and support may improve patient willingness to complete the referral**

Set Specific Goals with Patient

- **Review results of previous efforts**
- **Assess patient willingness** to accept referral
- **Consider bringing an addiction specialist** to assist with decision

Coordinate Care

- **Engage high-risk patients** not yet ready for referral to monitor their alcohol problems in a medical setting
- **Contact the command** to coordinate care for active-duty service members and to discuss administrative and clinical options if member refuses evaluation
- **Always refer active-duty service members involved in an incident in which substance use is suspected to specialty SUD care for evaluation**

Non-emergency Referral (cont.)

- Psychosocial Support Referral
  - Negative life events and stress may contribute to the onset or relapse of a SUD and may influence treatment adherence and outcome. Psychosocial rehabilitation and support resources, including civilian resources for SUD and related psychological health concerns, can be found in Tab 9: Tools and Resources (page 75).

Refer to Psychosocial Rehabilitation

- **Offer referral to psychosocial rehabilitation services to individuals with identified, unmet psychosocial needs:**
  - Regardless of the population or setting
  - Regardless of the type of pharmacotherapy or psychotherapy administered

Address Coexisting Problems

- **Prioritize and address other coexisting biopsychosocial problems with targeted services**, rather than just increasing intensity of addiction-focused psychosocial treatment:
  - Address transitional housing needs to facilitate access to treatment and promote a supportive recovery environment
  - Provide accessible social, vocational and legal services to promote engagement
  - Address deferred problems and monitor emerging needs
- **Coordinate care with other social service providers or case manager**

Management of Substance Use Disorder in Specialty Care

Management of Substance Use Disorder in Specialty Care

Tab 3:

MANAGEMENT OF SUBSTANCE USE DISORDER IN SPECIALTY CARE

The following steps correspond with the steps in Module B: Specialty SUD Care (See Tab 1, page 11) to identify, assess, manage and refer patients with presumptive or possible SUD in specialty care.

Step A: Identify, Stabilize and Assess

(Boxes 1 to 3 in Module B)

Identify

- **Identify Indications:**
  - Hazardous substance use, abuse or dependence
  - Suspected or possible SUD
  - Risk of relapse
  - Mandated referral within the DoD

Stabilize

- **Ensure Behavioral or Physiological Stabilization:**
  - Assure patient readiness to cooperate with further assessment
  - Refer patient to emergency department or appropriate setting for safety and stabilization, as needed (See Tab 4, page 31)

Assess

- **Obtain a Comprehensive Biopsychosocial Assessment:**
  - Demographic and identifying data (e.g., housing, occupation, legal status)
  - Chief complaint and history of complaint
  - Recent substance use and severity of substance-related problems
  - Lifetime or family history of substance use
  - Mental status, highlighting any suicide risk, and co-morbid psychiatric conditions/history
  - Social and family context
  - Developmental and military history
  - Current medical status and history, including risk for HIV or Hepatitis C
  - Patient perspective on current problems and treatment goals

Step B: Diagnose and Develop Treatment Plan

(Boxes 4 and 5 in Module B)

Diagnose

- **Interpret consolidated information obtained during assessment:**
  - Diagnostic formulation
  - Past treatment response
  - Patient perspective on current problems

Plan Treatment

- **Review patient treatment preferences and goals**
- **Discuss treatment options** with patient and significant others
- **Determine appropriate treatment setting**
  - If general health care setting is not appropriate, determine the appropriate initial intensity of specialty care
  - If patient does not agree to treatment plan, provide motivational intervention and offer to renegotiate
  - **For DoD active-duty personnel: A treatment team shall convene with patient and command to review treatment plan**

PATIENT TREATMENT SCENARIOS AND EXPECTED OUTCOMES

Scenario	Expected Outcome
Seeking remission:	■ **Complete and sustained remission** of all SUDs ■ **Resolution of, or significant improvement in, all coexisting biopsychosocial problems** and health-related quality of life
Seeking help but not committed to abstinence:	■ **Short- to intermediate-term resolution** or partial improvement of SUD ■ **Resolution or improvement of at least some coexisting problems** and health-related quality of life
Neither willing to engage in treatment nor ready to abstain:	■ **Engagement in general health treatment** (long periods or indefinitely) ■ **Continuity of care** ■ **Enhanced motivation to change** ■ **Availability of crisis intervention** ■ **Temporary or partial improvement in SUD** ■ **Improvement in coexisting medical, psychiatric and social conditions** ■ **Improvement in quality of life** ■ **Reduced need for high-intensity health care services** ■ **Reduced rate of illness progression**

TREATMENT PRINCIPLES

Treatment works. Treatment is better than no treatment.

- Most consistent predictors of successful outcomes are retention in formal treatment and/or active involvement with mutual help programs

Provide intervention in the least restrictive setting necessary.

- Coordinate addiction-focused psychosocial interventions with evidence-based intervention(s) for concurrent biopsychosocial problems
- Consider patient's prior treatment experience and initial intervention preference

No single intervention represents THE treatment of choice.

- Employ motivational interviewing style in clinical interactions

Common elements of effective interventions include:

- Enhancing patient motivation to stop or reduce substance use
- Improving self-efficacy for change
- Promoting a therapeutic relationship
- Strengthening coping skills
- Changing reinforcement contingencies for recovery
- Promoting active engagement in mutual help programs and social supports

Step C: If Indicated, Initiate Addiction-Focused Interventions

(Box 6 in Module B)

Pharmacotherapy	Psychosocial
■ **Provide addiction-focused intervention,** in addition to indicated pharmacotherapy for co-occurring conditions ■ **Coordinate with specialty psychosocial treatment and adjunctive services** ■ **Coordinate with primary care and/or general psychological health providers**	■ **Engage patient** to establish early problem resolution or remission ■ **Improve psychosocial functioning** ■ **Prevent relapse** to substance use

Step D: Address Recovery Environment, Manage Co-occurring Conditions and Monitor

(Boxes 7 and 8 in Module B)

Address Psychosocial Functioning

- **Prioritize and address coexisting biopsychosocial problems**
- **Address transitional housing needs and other emerging needs**
- **Provide social, vocational and legal services**
- **Coordinate care with other social service providers**

Manage Co-occurring Conditions

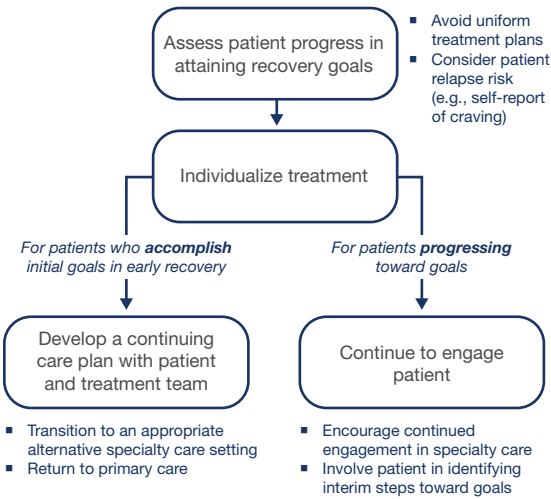
- **Involve patient** in prioritizing other medical and psychiatric co-occurring conditions
- **Treat co-occurring psychiatric disorders** consistent with VA/DoD guidelines
- **Refer for treatment** of medical conditions (e.g., diabetes)
- **Promote engagement and coordination of care** with other providers
- **Address emerging and deferred needs** through ongoing treatment plan updates

Monitor Response

- **Monitor progress** toward treatment goals periodically
- **Motivate patient** and treatment team members to accomplish interim steps
- **Reassess** (periodically and systematically) treatment response using standardized and valid self-report instrument(s) and lab tests
- **Adapt treatment** to achieve success

Step E: Reinforce and Follow-up for Relapse Prevention

(Boxes 9 and 10 in Module B)



Step F: Develop Aftercare and Recovery Plan

(Boxes 11 and 12 in Module B)

Promote Aspects of Continuing Care Associated with Recovery Success

- **Provide continuing care following intensive outpatient or residential rehabilitation** (individually, in a group or via telephone)
- **Consider objective monitoring of substance use and medical consequences**
- **Provide patient with a written plan with information to facilitate compliance:**
  - Treatment, appointments and prescriptions
  - Relapse warning signs, triggers and coping responses
  - Mutual help networks and resources

Step G: Re-evaluate Treatment Plan

(Box 13 in Module B)

Relapse can be a signal to re-evaluate the treatment plan:	■ Relapse is not evidence that the patient cannot succeed
For patients who are not improving:	■ Add or substitute another medication or psychosocial intervention, OR ■ Change treatment by: – Increasing intensity – Increasing medication dose – Decreasing intensity to minimum level of care agreeable (e.g., monitoring in general health care)
If patient drops out of treatment:	■ Contact patient ■ Re-engage in treatment

Stabilization and Withdrawal Management

Tab 4:

STABILIZATION AND WITHDRAWAL MANAGEMENT

The following steps correspond with the steps in Module S: Stabilization and Withdrawal Management (See Tab 1, page 12) to manage patients who are physiologically dependent on alcohol and/or other substances, at risk of withdrawal and who may require physiological stabilization.

Step A: Obtain History, Exams, Medication and Laboratory Tests

(Boxes 1 and 2 in Module S)

History	Exams	Lab Tests
▪ Clinical background and prior assessment information ▪ History of alcohol-withdrawal seizures, delirium tremens, recent head traumas, atypical illness ▪ Patient and informant interview (medical and psychological health history) ▪ Prescription and non-prescription use	▪ Physical examination ▪ Mental status examination (MSE) and abnormal cognitive status screen (especially for elderly patients)	▪ Detect adjunctive conditions and potential medical causes for specific and/or unusual symptoms to inform withdrawal treatment course – BAC – CBC – LFTs – Chem 7 – Urine Drug Screen – Carbohydrate Deficient Transferrin

Step B: Assess for Immediate Crisis or Intoxication and Stabilize

(Boxes 3 and 4 in Module S)

Assess

- **Determine presence of immediate medical or psychiatric crisis or intoxication:**
  - Delirium tremens
  - Risk of patient harming self or others
  - Acute alcohol intoxication
- **Refer patient to emergency care as needed**

Stabilize

- **Stabilize patient before withdrawal management:**
  - Maintain airway and adequate ventilation (comatose patients)
  - Consider emergency procedures (e.g., gastric lavage) for sedative, hypnotic and/or opioid intoxication
  - Consider emergency pharmacologic interventions for overdoses (e.g., IV naloxone hydrochloride for opioids, flumazenil for benzodiazepines)
- **Assure patient's immediate safety and limit suicide means (e.g., do not leave alone):**
  - Follow local policies for threats to self or others
  - Decrease sensory stimuli to manage agitation from multiple substance intoxication — if chemotherapeutic agents are necessary, consider IM benzodiazepines (e.g., lorazepam) and high-potency neuroleptics
- **Inform and involve someone close to the patient**
- **Refer for psychological health treatment or schedule follow-up appointment**
- **For active-duty service members:**
  - Follow DoD and service-specific policies (psychological health or emergency referral is likely mandated)
  - Inform service member's commanding officer

Step C: Determine Physiological Dependence Level and Withdrawal Risk

(Box 5 in Module S)

Estimate Withdrawal Potential

- **Ask patient about substance use pattern, type and quantity:**
  - Untreated, severe alcohol or other sedative hypnotic withdrawal may lead to autonomic instability, seizures, delirium or death
  - Opioid withdrawal poses low mortality risk but is associated with intense symptoms; significant mortality risk exists for patients who relapse after unsuccessful medically-supervised withdrawal attempts and tolerance loss

Classify Withdrawal Level

- **Identify factors influencing withdrawal level:**
  - Type of substance
  - Time since last use
  - Concurrent use of other substances and/or prescriptions
  - Co-occurring medical and psychiatric disorders
  - Past withdrawal experiences

Assess Severity

- **Use lab results and patient observation to determine tolerance level**
- **Assess withdrawal symptom severity using standard measures:**
  - Clinical Institute Withdrawal Assessment of Alcohol (CIWA-Ar)
  - Clinical Opiate Withdrawal Scale (COWS)

CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT OF ALCOHOL (CIWA-Ar)

Patient:_____

Date:_____

Time:_____(24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute:_____

Blood pressure:_____

NAUSEA AND VOMITING –
Ask "Do you feel sick to your stomach? Have you vomited?" Observation.

0 no nausea and no vomiting
1 mild nausea with no vomiting
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves and vomiting

TACTILE DISTURBANCES –
Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.

0 none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning or numbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

TREMOR – Arms extended and fingers spread apart. Observation.

0 no tremor
1 not visible, but can be felt fingertip to fingertip
2
3
4 moderate, with patient's arms extended
5
6
7 severe, even with arms not extended

AUDITORY DISTURBANCES – Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.

0 not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

PAROXYSMAL SWEATS – Observation.

0 no sweat visible
1 barely perceptible sweating, palms moist
2
3
4 beads of sweat obvious on forehead
5
6
7 drenching sweats

VISUAL DISTURBANCES – Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.

0 not present
1 very mild sensitivity
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations

Interpretation of total CIWA-Ar scores:

- Minimal or absent withdrawal: ≤ 9
- Mild to moderate withdrawal: 10-19
- Severe withdrawal: > 20

Source: Sullivan, J.T.; Sykora, K.; Schneiderman, J.; Naranjo, C.A.; and Sellers, E.M. Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-Ar). British Journal of Addiction, 84:1353-1357, 1989.

CLINICAL OPIATE WITHDRAWAL SCALE (COWS)

For each item, circle the number that best describes the patient's signs or symptoms as related to the apparent relationship to opioid withdrawal.

Patient:_____

Date:_____

Time:_____

1. RESTING PULSE RATE: _____beats/minute measured after patient is sitting or lying for one minute.
- **0** Pulse rate 80 or below
- **1** Pulse rate 81-100
- **2** Pulse rate 101-120
- **4** Pulse rate greater than 120

2. SWEATING: Over past 1/2 hour not accounted for by room temperature or patient activity
- **0** No report of chills or flushing
- **1** Subjective report of chills or flushing
- **2** Flushed or observable moistness on face
- **3** Beads of sweat on brow or face
- **4** Sweat streaming off face

3. RESTLESSNESS: Observation during assessment
- **0** Able to sit still
- **1** Reports difficulty sitting still, but is able to do so
- **3** Frequent shifting or extraneous movements of legs/arms
- **5** Unable to sit still for more than a few seconds

4. PUPIL SIZE
- **0** Pupils pinned or normal size for room light
- **1** Pupils possibly larger than normal for room light
- **2** Pupils moderately dilated
- **5** Pupils so dilated that only the rim of the iris is visible

7. GI UPSET: Over last 1/2 hour
- **0** No GI symptoms
- **1** Stomach cramps
- **2** Nausea or loose stool
- **3** Vomiting or diarrhea
- **5** Multiple episodes of diarrhea or vomiting

8. TREMOR OBSERVATION OF OUTSTRETCHED HANDS
- **0** No tremor
- **1** Tremor can be felt, but not observed
- **2** Slight tremor observable
- **4** Gross tremor or muscle twitching

9. YAWNING: Observation during assessment
- **0** No yawning
- **1** Yawning once or twice during assessment
- **2** Yawning three or more times during assessment
- **4** Yawning several times/minute

10. ANXIETY OR IRRITABILITY
- **0** None
- **1** Patient reports increasing irritability or anxiousness
- **2** Patient obviously irritable/anxious
- **4** Patient so irritable or anxious that participation in the assessment is difficult

5. BONE OR JOINT ACHES: If patient was having pain previously, only the additional component attributed to opiate withdrawal is scored.

0 Not present
1 Mild diffuse discomfort
2 Patient reports severe diffuse aching of joints/muscles
4 Patient is rubbing joints or muscles and is unable to sit still because of discomfort

6. RUNNY NOSE OR TEARING: Not accounted for by cold symptoms or allergies

0 Not present
1 Nasal stuffiness or unusually moist eyes
2 Nose running or tearing
4 Nose constantly running or tears streaming down cheeks

11. GOOSEFLESH SKIN

0 Skin is smooth
3 Piloerection of skin can be felt or hairs standing up on arms
5 Prominent piloerection

TOTAL SCORE_____

[The total score is the sum of all 11 items.]

Initials of person completing assessment:

_____

Interpretation of total COWS scores:

- Mild: 5-12
- Moderate: 13-24
- Moderately severe: 25-36
- Severe withdrawal: > 36

Source: Adapted from Wesson et. al. 1999, Reprinted with permission.

Step D: Assess Withdrawal Management Need and Appropriate Setting of Care

(Boxes 6 to 8 in Module S)

Assess Withdrawal Management Need*

- **Utilize withdrawal management to:**
  - Prevent patient from experiencing adverse events
  - Prepare patient for ongoing addiction treatment
- Consider pharmacologically-supervised withdrawal for alcohol, sedative-hypnotics, opioids and potentially other illicit substances

Evaluate Patients Individually

- Opioid dependent patients with severe, acute or chronic physical pain may require appropriate short-acting opioid agonist medication in addition to medication needed for opioid withdrawal
- Distinguish patients with legitimate pain or anxiety disorders who develop only physiological tolerance during long-term prescribed medication use from those with prescription misuse markers

Determine Appropriate Setting of Care

- **Inpatient indications:**
  - Current symptoms of at least mild alcohol withdrawal (e.g., CIWA-Ar score > 10)
  - History of delirium tremens or withdrawal seizures
  - Inability to tolerate oral medication
  - Imminent risk of harm to self or others
  - Recurrent, unsuccessful attempts at ambulatory medically-supervised withdrawal
  - Reasonable likelihood that ambulatory medically-supervised withdrawal will not be completed
  - Active psychosis or severe cognitive impairment
  - Chronic liver or cardiovascular disease, pregnancy or lack of medical support system

*See indications and contraindications on next page

INDICATIONS AND CONTRAINDICATIONS FOR MEDICALLY-SUPERVISED WITHDRAWAL MANAGEMENT

	Indications	Contraindications
Alcohol:	■ Alcohol dependence with observed withdrawal symptoms ■ CIWA-Ar score > 10 ■ Dependence on Central Nervous System (CNS) depressants, due to risks of untreated withdrawal	■ Minimal withdrawal symptoms not accompanied by co-occurring disorders (provide support, reassurance and monitoring)
Opioid:	■ Physical dependence: – Absence of clinical indications for ongoing treatment – Addictive or non-compliant behavior ■ Agreement to provide naltrexone for treatment of opioid dependence ■ Patient does not want opioid agonist medical therapy but wants alternative treatment for opioid dependence	■ Chronic, severe opioid dependence (first-line therapy is methadone or sublingual buprenorphine/naloxone maintenance treatment) ■ Two or more unsuccessful medically-supervised withdrawals in 12 months (assess for opioid agonist therapy)

ADVANTAGES OF INPATIENT VS. AMBULATORY MEDICALLY-SUPERVISED WITHDRAWAL MANAGEMENT

Inpatient Advantages	Outpatient Advantages
■ Fewer logistical, medical and legal concerns ■ Closer monitoring of withdrawal symptoms ■ Higher likelihood of completing withdrawal protocol (long-term outcomes do not differ)	■ Facilitated continuity of care ■ Reduced disruption to patient life ■ Lower costs

Step E: Manage Withdrawal in Ambulatory **OR** Inpatient Care

(Boxes 9 and 10 in Module S)

ALCOHOL WITHDRAWAL MANAGEMENT RECOMMENDATIONS:

General Strategies:	▪ **Use one of two pharmacotherapy strategies:** – **Withdrawal symptom-triggered therapy** (preferred method) (e.g., PRN) – **Predetermined fixed dose** (taper several days) ▪ **Engage patient in ongoing addiction treatment** during and after medically-supervised withdrawal ▪ **Do not use alcohol as an agent** for medically-supervised withdrawal
Ambulatory Care:	▪ **Conduct in-person assessment** daily or every other day, to assess: – Previous day alcohol use and medication intake vs. dispensed – Standardized tests (e.g., CIWA-Ar) – Tremor, restlessness and previous night's sleep – Skin (e.g., color and turgor) – Urine toxicology, breathalyzer or BAC ▪ **Admit to hospital if daily screening reveals any of the following:** – Blood sugar level ≥ 400 or positive anion gap – GI bleeding disorder (e.g., melena, hematemesis) – Bilirubin level ≥ 3.0 – Creatinine level ≥ 2.0 – SBP ≥ 180 or DBP ≥ 110 – Unstable angina – Temperature ≥ 101°F – BAC ≥ 0.08 on 2 outpatient visits
Inpatient Care:	▪ **Use carbamazepine and valproic acid** as benzodiazepine supplements or alternatives for patients with benzodiazepine abuse or allergy for mild to moderate withdrawal ▪ **Other agents** (e.g., beta-blockers, clonidine) may be used in conjunction with benzodiazepines (not as monotherapy) in certain patients

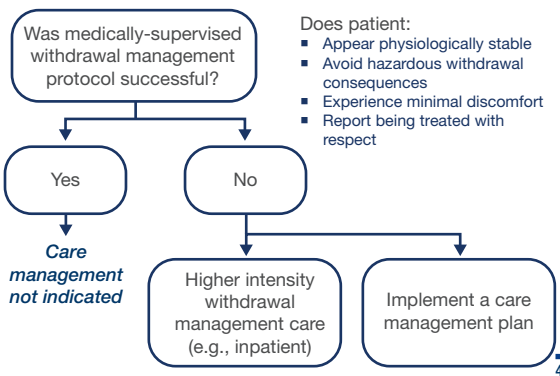
SEDATIVE-HYPNOTIC AND OPIOID WITHDRAWAL MANAGEMENT RECOMMENDATIONS:

Sedative-Hypnotics* (e.g., Benzodiazepines):	▪ **Substitute phenobarbital for the addicting agent and taper** – Convert average daily sedative-hypnotic dose to a phenobarbital equivalent and divide into 3 doses per day for two days – Reduce phenobarbital dose by 30 mg per day, beginning on day 3 ▪ **For patients on a shorter-acting benzodiazepine, substitute a longer acting benzodiazepine at an equivalent dose and taper** 10% per day, during one to two weeks (e.g., chlordiazepoxide)
Opioids:	▪ **High relapse rates** have been found with long term medically-supervised opioid withdrawal ▪ **Treatment of choice (in most cases): opioid maintenance with buprenorphine/naloxone or methadone** ▪ **Medically-supervised withdrawal in an inpatient setting can usually be accomplished in four to seven days to quickly achieve opioid abstinence prior to treatment in a drug-free setting** (prefer initiation of naltrexone)

*For withdrawal at doses above therapeutic range, for a month or more

Step F: Assess Need for Care Management

(Boxes 11 to 15 in Module S)



Symptoms of Intoxication and Withdrawal

Tab 5:

SYMPTOMS OF INTOXICATION AND WITHDRAWAL

DSM-IV-TR Symptoms of Intoxication and Withdrawal for:

- Alcohol
- Amphetamines
- Cannabis
- Dextromethorphan (DXM)
- Hallucinogens
- Inhalants
- Opioids
- Phencyclidine
- Sedatives, Hypnotics, Anxiolytics

DSM-IV-TR SYMPTOMS OF INTOXICATION AND WITHDRAWAL

(292.89 and 292.0 for Illicit Drugs, 303.00 and 291.81 for Alcohol, respectively):

- The following tables present the symptoms that support the diagnoses of intoxication and withdrawal for select substances of abuse.
- For all diagnoses listed below, symptoms should not be attributed to a general medical condition or another psychological condition.
- Population-based screening for SUD is not recommended due to:
  - Lower prevalence of SUD
  - Lack of high-quality randomized controlled trials demonstrating the efficacy of primary care interventions for substance abuse and dependence
- Selective case finding in high-risk populations (e.g., Hepatitis C or HIV clinics) is recommended so that SUD can be addressed (National Quality Forum, 2007; U.S. Preventative Services Taskforce, 2008).

ALCOHOL

Intoxication	
Recent ingestion of alcohol, with clinically significant maladaptive behavioral or psychological changes that develop during or shortly after, such as:	
▪ Slurred speech ▪ Incoordination ▪ Unsteady gait ▪ Nystagmus ▪ Impairment in attention or memory	▪ Inappropriate sexual or aggressive behavior ▪ Impaired judgment or impaired social or occupational functioning ▪ Mood lability ▪ Stupor or coma

ALCOHOL (CONT.)

Withdrawal

Cessation of or reduction in alcohol use that has been heavy and prolonged, with two or more of the following developing within several hours to a few days:

- Autonomic hyperactivity (e.g., sweating or pulse rate > 100)
- Increased hand tremor
- Insomnia
- Nausea or vomiting
- Transient visual, tactile or auditory hallucinations or illusions
- Psychomotor agitation
- Anxiety
- Grand mal seizures
- Clinically significant distress or impairment in social, occupational or other important areas of functioning

AMPHETAMINES (INCLUDING MDMA) OR COCAINE

Intoxication

Recent amphetamine or related substance use, with clinically significant maladaptive behavioral or psychological changes that develop during or shortly after, such as:

- Euphoria or affective blunting
- Changes in sociability
- Hypervigilance
- Interpersonal sensitivity
- Anxiety
- Tension
- Anger
- Stereotyped behaviors
- Impaired judgment
- Impaired social or occupational functioning

Two or more of the following that develop during or shortly after amphetamine use:

- Tachycardia or bradycardia
- Pupillary dilation
- Elevated or low blood pressure
- Perspiration or chills
- Nausea or vomiting
- Evidence of weight loss
- Psychomotor agitation or retardation
- Muscular weakness
- Chest pain
- Cardiac arrhythmia
- Respiratory depression
- Confusion
- Seizures
- Dyskinesia
- Dystonia
- Coma

Withdrawal

Cessation of or reduction in amphetamine or related substance use that has been heavy and prolonged, with dysphoric mood and two or more of the following that develop within several hours to a few days after apparent intoxication:

- Fatigue
- Vivid, unpleasant dreams
- Insomnia or hypersomnia
- Increased appetite
- Psychomotor agitation or retardation
- Clinically significant distress or impairment in social, occupational or other important areas of functioning

CANNABIS

Intoxication

Recent cannabis use, with clinically significant maladaptive behavioral or psychological changes that develop during or shortly after, such as:

- Impaired motor coordination
- Euphoria
- Anxiety
- Sensation of slowed time
- Impaired judgment
- Social withdrawal

Two or more of the following that develop within two hours of cannabis use:

- Conjunctival injection
- Increased appetite
- Dry mouth
- Tachycardia

DEXTRAMETHORPHAN (DXM)

Intoxication

Clinically significant maladaptive behavioral or psychological changes that develop during or shortly after DXM use, such as:

- Hallucinations
- Impaired senses, including vision
- Mind-body dissociation
- Slurred speech
- Memory loss
- Psychomotor agitation
- Impaired judgment
- Impaired social or occupational functioning

HALLUCINOGENS (INCLUDING LSD)

Intoxication

Recent hallucinogen use, with clinically significant maladaptive behavioral or psychological changes that develop during or shortly after:

- Marked anxiety or depression
- Ideas of reference
- Fear of losing one's mind
- Paranoid ideation
- Impaired judgment
- Impaired social or occupational functioning

Perceptual changes occurring in a state of full wakefulness and alertness (subjective intensification of perceptions, depersonalization, illusions, hallucinations, synesthesias) that develop during or shortly after hallucinogen use:

Two or more of the following that develop during or shortly after hallucinogen use:

- Pupillary dilation
- Tachycardia
- Sweating
- Palpitations
- Blurring of vision
- Tremors
- Lack of coordination

INHALANTS (SOLVENTS, NITROUS OXIDE, NITRITES)

Intoxication

Recent intentional use or short-term high dose exposure to volatile agents, excluding anesthesia gases and short-acting vasodilators, with clinically significant maladaptive behavioral or psychological changes that develop during or shortly after, such as:

- Belligerence
- Assaultiveness
- Apathy
- Impaired judgment
- Impaired social or occupational functioning

Two or more of the following that develop during or shortly after inhalant use or exposure:

- Pupillary dilation
- Tachycardia
- Sweating
- Palpitations
- Dizziness
- Nystagmus
- Lack of coordination
- Slurred speech
- Unsteady gait
- Lethargy
- Depressed reflexes
- Psychomotor retardation
- Tremor
- Generalized muscle weakness
- Blurred vision or diplopia
- Stupor
- Coma
- Euphoria

OPIOIDS

Intoxication

Recent opioid use, with clinically significant maladaptive behavioral or psychological changes that develop during or shortly after, such as:

- Initial euphoria followed by apathy, dysphoria, psychomotor
- Impaired judgment or impaired social or occupational functioning

Pupillary constriction or dilation due to anoxia from severe overdose, and one or more of the following:

- Drowsiness or coma
- Slurred speech
- Impaired attention or memory

OPIOIDS (CONT.)

Withdrawal

Cessation of or reduction in opioid use that has been heavy and prolonged (several weeks or longer):

Administration of opioid antagonist after a period of opioid use:

Three or more of the following within minutes to several days of both conditions above:

- Dysphoric mood
- Nausea or vomiting
- Muscle aches
- Lacrimation or rhinorrhea
- Pupillary dilation
- Piloerection
- Sweating
- Diarrhea
- Yawning
- Fever
- Insomnia
- Clinically significant distress or impairment in social, occupational or other important areas of functioning

PHENCYCLIDINE (PCP)

Intoxication

Recent PCP or related substance use, with clinically significant maladaptive behavioral or psychological changes that develop during or shortly after, such as:

- Belligerence
- Assaultiveness
- Impulsiveness
- Unpredictability
- Psychomotor agitation
- Impaired judgment
- Impaired social or occupational functioning

Two or more of the following that develop within one hour (or less when smoked, "snorted" or used intravenously):

- Vertical or horizontal nystagmus
- Hypertension or tachycardia
- Numbness or diminished responsiveness to pain
- Ataxia
- Dysarthria
- Muscle rigidity
- Seizures or coma
- Hyperacusis

SEDATIVES, HYPNOTICS, ANXIOLYTICS

Intoxication

Recent sedative, hypnotic or anxiolytic use, with clinically significant maladaptive behavioral or psychological changes that develop during or shortly after, such as:

- Inappropriate sexual or aggressive behavior
- Mood lability
- Impaired judgment
- Impaired social or occupational functioning

One or more of the following developing during or shortly after sedative, hypnotic or anxiolytic use:

- Slurred speech
- Lack of coordination
- Unsteady gait
- Nystagmus
- Impaired attention or memory
- Stupor
- Coma

Withdrawal

Cessation of or reduction in sedative, hypnotic or anxiolytic use that has been heavy and prolonged, with two or more of the following developing within several hours to a few days of apparent intoxication:

- Autonomic hyperactivity (sweating or pulse rate > 100)
- Increased hand tremor
- Insomnia
- Nausea or vomiting
- Transient visual, tactile or auditory hallucinations or illusions
- Psychomotor agitation
- Anxiety
- Grand mal seizures
- Clinically significant distress or impairment in social, occupational or other important areas of functioning

Source: American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000.

Medication Tables

Tab 6:

MEDICATION TABLES

Medications Used in the Management of SUD:

- Opioid Agonist Therapy
- Opioid Antagonist Therapy
- Medication Therapy for Alcohol Dependence

MEDICATIONS USED FOR THE MANAGEMENT OF SUD

MEDICATION TABLE: Refer to the pharmaceutical manufacturer's literature for full prescribing information. The tables below show commonly prescribed medications for opioid and alcohol dependence. The decision to use one medication over another should be based on individual patient factors, the symptom complaints and the basic features and potential side effects of the medication in question. The drug interactions listed are not comprehensive. Please see the full prescribing information and appropriate references for additional drug interaction information.

Methadone (Dolophine, Methadose, generic)

Adult Dose	Advantages	Disadvantages
■ Initial dose: 15 to 20 mg PO, single dose, maximum 30 mg ■ Daily dose: Maximum 40 mg/day on first day ■ Usual dosage range for optimal effects: 60 to 120 mg once daily ■ Titrate carefully, consider methadone's delayed cumulative effects ■ Individualize dosing regimens (AVOID the same fixed dose for all patients)	■ First-line treatment option for chronic opioid dependence that meets DSM-IV-TR criteria ■ Food and Drug Administration (FDA) approved for medically-supervised withdrawal and maintenance treatment of opioid dependence in conjunction with appropriate social and medical services	■ **Boxed Warning:** Death and life-threatening adverse events, including respiratory depression and cardiac arrhythmias, have occurred upon initiation of treatment for opioid dependence. Select dosage carefully, titrate slowly and monitor the patient carefully. Use may prolong the QTc interval and increase the risk for torsade de pointes. ■ **Contraindications:** – Hypersensitivity – Respiratory depression in absence of resuscitative equipment in unmonitored situations, and in patients with acute bronchial asthma or hypercarbia and known or suspected paralytic ileus – May prolong QTc interval on electrocardiogram (ECG) and increase the risk of torsades de pointes ventricular tachycardia in a dose-related manner, so consider baseline ECG – Discontinue or taper the methadone dose and consider an alternative therapy if the QTc interval is more than 500 milliseconds

Methadone (Dolophine, Methadose, generic) (cont.)

		Disadvantages
		■ **Major Adverse Effects:** Respiratory depression, shock, cardiac arrest, possible prolongation of QTc interval on ECG and torsades de pointes ventricular tachycardia ■ When used for management of opioid dependence, methadone is available only in the Substance Abuse and Mental Health Services Administration (SAMHSA) certified opioid treatment programs ■ Multiple drug interactions (check appropriate references)

Buprenorphine/Naloxone (Suboxone) and Buprenorphine (Subutex or generic)

Adult Dose	Advantages	Disadvantages
■ Before initiating buprenorphine therapy, wait at least 12 to 24 hours after the last dose of short-acting opioids or at least 24 hours after the last dose of methadone or other long-acting opioids ■ Patients should preferably be showing signs of early opioid withdrawal before initiating buprenorphine therapy ■ Induction dose: 2 to 8 mg SL once daily ■ Day two and onward: Increase dose by 2 to 4 mg/day. Target dose in the first week: 12 to 16 mg/day SL ■ Stabilization and maintenance: Titrate by 2 to 4 mg per week; usual dose 12 to 16 mg/day (up to 32 mg/day SL)	■ Addition of naloxone is intended to decrease the potential for parenteral abuse ■ Provided by physicians who have met training, experience and other requirements set by SAMHSA, www.buprenorphine.samhsa.gov ■ First-line treatment option for chronic opioid dependence that meets DSM-IV-TR criteria ■ FDA approved for management of opioid dependence, including medically supervised withdrawal ■ Can be prescribed in office-based settings by physicians with Drug Addiction Treatment Act (DATA) 2000 waivers and certification or dispensed in opiod treatment programs, www.buprenorphine.samhsa.gov	■ **Major Adverse Effects:** Hepatitis, hepatic failure and respiratory depression, usually when misused intravenously with other CNS depressants ■ **Common Adverse Effects:** Headache, pain, abdominal pain, insomnia, nausea, vomiting, sweating and constipation ■ May induce severe opioid withdrawal in patients with physical dependence on opioids ■ May block analgesic effects of full opioid agonists ■ Respiratory depression from buprenorphine is not readily reversed by naloxone; thus, high and prolonged doses of naloxone may be required

Buprenorphine/Naloxone (Suboxone) and Buprenorphine (Subutex or generic) (cont.)

Adult Dose

- Individualize dosing regimens
- Tablets should be placed under the tongue until dissolved, and should not be swallowed
- Drinking warm fluids before administration may help dissolution
- Extended dosing intervals may be used (give equivalent weekly maintenance doses divided two or three times a week or every two, three or four days)
- Reduce dose in hepatic impairment
- Combination tablets are the preferred formulation for most patients. They contain either 2 mg buprenorphine/0.5 mg naloxone or 8 mg buprenorphine/2 mg naloxone
- Monodrug tablets contain either 2 or 8 mg of buprenorphine and are preferred in patients who are pregnant or have a naloxone allergy

Methadone, Buprenorphine/Naloxone and Buprenorphine

Drug Interactions for OAT

- Serious overdose and death may occur if benzodiazepines, sedatives, tranquilizers, antidepressants, alcohol or other CNS depressants are taken in addition to OATs
- Methadone contraindicated and should be avoided with:
  - Artemether, dronedarone, lumefantrine, mesoridazine, nilotinib, pimozide, quinine, tetrabenazine, thioridazine and ziprasidone because of increased risk of QTc prolongation and torsades de pointes
  - MAOIs, including isocarboxazid, linezolid, moclobemide, phenelzine, procarbazine, rasagiline, selegiline and tranylcypromine, because of potential risk of serotonin syndrome
  - Rasagiline and selegiline because of risk of serotonin syndrome
- Buprenorphine/Naloxone or Buprenorphine contraindicated with atazanavir and MAOIs
- Strongly advise patient against self-medicating with CNS depressants

Methadone, Buprenorphine/Naloxone and Buprenorphine

General Information

- OATs stimulate opiate receptors
- Methadone or SL buprenorphine/naloxone maintenance are first-line therapies because of documented efficacy in improving retention and reducing illicit opioid use and cravings
- Adjust opioid agonist doses to avoid or minimize over-medication (e.g., somnolence, miosis, itching, hypotension and flushing) and opioid withdrawal (e.g., drug craving, anxiety, dysphoria and irritability)
- Opioid antagonists and abrupt cessation may precipitate withdrawal
- Store in a secure place out of the reach of children
- On VA National Formulary (VANF): Methadone, buprenorphine/naloxone, buprenorphine
- On DoD Uniform Formulary (UF): Methadone, buprenorphine/naloxone, buprenorphine
- See TIP 43 for Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment, www.ncbi.nlm.nih.gov/books/NBK14677/
- See TIP 40 for Clinical Guidelines for the Use of Buprenorphine In the Treatment of Opioid Addiction, www.ncbi.nlm.nih.gov/books/NBK14901/
- **PREGNANCY WARNING:** Medications listed above are all category C except methadone, which is category C/D. Currently, the gold-standard treatment of a pregnant opioid-dependent patient is opioid agonist treatment program care using methadone. In all cases, except pregnancy or naloxone allergy, use the combination product of buprenorphine/naloxone.
- **MONITORING, REFERRALS AND WARNINGS:**
  - Consider baseline ECG and physical examination for methadone patients at risk for QT prolongation or arrhythmias
  - Perform baseline liver transaminases for buprenorphine or buprenorphine/naloxone therapy
  - Drug test for methadone and buprenorphine to ensure compliance with the prescription and detect possible diversion
  - Monitor relapse to promote effective outcomes
  - Monitor respiratory status, mental status and blood pressure

OPIOID ANTAGONIST THERAPY FOR OPIOID DEPENDENCE

Naltrexone PO (Depade, ReVia, generic)

Adult Dose	Advantages	Disadvantages
■ Initial dose: 25 mg PO once daily; if no withdrawal reaction, increase to 50 mg once daily ■ Since naltrexone is an opioid antagonist, patients must be off all opioids for a minimum of 7 to 10 days before beginning naltrexone treatment to avoid precipitating opioid withdrawal ■ Extended dosing intervals, using equivalent weekly doses, may be used with supervised administration ■ Take with food to minimize nausea especially during the first week	■ Side effects (e.g., nausea, vomiting and transient headache), if any, tend to occur early in treatment and can typically resolve within one to two weeks ■ FDA-approved for maintenance therapy of opioid dependence, as an alternative to OAT for patients with an opioid dependence and for use in alcohol dependency	■ **Boxed Warning:** Naltrexone has the capacity to cause hepatocellular injury when given in excessive doses. Patients should be warned of the risk of hepatic injury and advised to stop the use of naltrexone and seek medical attention if they experience symptoms of acute hepatitis. ■ **Contraindications:** – Acute hepatitis or liver failure – Current physical dependence on opioids with use within past 7 days – Ongoing acute opioid withdrawal or failed naloxone challenge test – Receiving opioid agonists or positive urine opioid screen ■ **Common Adverse Effects:** Nausea ■ No opioid agonist effects ■ Patients continue to have cravings and may thereby not be motivated to maintain adherence to the medication regimen ■ Precautions include active liver disease, severe hepatic dysfunction and severe renal failure ■ Naltrexone is unpopular with many opioid-dependent patients since maintenance therapy requires abstinence from opioids. Treatment dropouts are common ■ Limited clinical experience with over dosage in humans

OPIOID ANTAGONIST THERAPY FOR OPIOID DEPENDENCE (cont.)

Naltrexone PO

Drug Interactions

- Very large doses of opioids may overcome the effects of naltrexone and lead to serious injury, coma or death. Attempts to overcome opioid blockade could lead to fatal overdose
- Opioid-containing medications, OTC preparations, thioridazine, oral hypoglycemic and antiretroviral agents
- Small doses of opioids, such as in analgesic, antidiarrheal or antitussive drugs, may be blocked by naltrexone and fail to produce a therapeutic effect

General Information

- Opioid antagonists do not have agonist activity at opioid receptor sites
- Antagonists block the opiate receptor, inhibit pharmacological activity of the agonist and precipitate withdrawal in the physically dependent patient
- Consider OAT or long-term therapeutic community before naltrexone treatment as a first-line approach for chronic opioid dependent patients
- Consider engagement in a comprehensive management program that includes measures to ensure medication adherence
- Therapy is most effective when the patient is engaged in addiction-focused counseling with monitored administration
- On VANF and DoD UF
- See TIP 43 for Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs, www.ncbi.nlm.nih.gov/books/NBK14677/
- **PREGNANCY WARNING:** Naltrexone is pregnancy category C
- **MONITORING, REFERRALS AND WARNINGS:**
  - Baseline evaluation includes naloxone challenge test, transaminase levels and urine toxicology
  - Repeat transaminase levels monthly for the first three months and every three months thereafter
  - Discontinue or reduce naltrexone if transaminase levels rise significantly. If signs and symptoms of acute hepatitis occur, discontinue naltrexone and contact patient's provider immediately.

MEDICATION THERAPY FOR ALCOHOL DEPENDENCE

Naltrexone PO (Depade, ReVia, generic)		
Adult Dose	**Advantages**	**Disadvantages**
■ 50 mg once daily ■ Take with food to minimize nausea, especially during the first week	■ Side effects (e.g., nausea, vomiting and transient headache), if any, tend to be transient, occurring early in treatment and typically resolving within one to two weeks ■ FDA approved for the treatment of alcohol or opioid dependence	■ **Contraindications:** – Receiving opioid agonists – Physical opioid dependence with use within past seven days – Acute opioid withdrawal – Failed naloxone challenge test – Positive urine opioid screen – Acute hepatitis or liver failure ■ **Common Adverse Effects:** Nausea ■ Precautions for use in active liver disease or severe renal failure

MEDICATION THERAPY FOR ALCOHOL DEPENDENCE (cont.)

Naltrexone Injection (Vivitrol)

Adult Dose	Advantages	Disadvantages
■ 380 mg by deep intramuscular (IM) injection in the upper outer quadrant of the gluteal muscle every four weeks	■ Pretreatment abstinence is not required but improves response ■ Once monthly IM injections ■ Should be considered in patients when medication adherence with oral medication therapy is a significant concern ■ FDA approved for the treatment of alcohol dependence	■ **Boxed Warning:** Naltrexone injection may cause hepatocellular injury when given in excessive doses. There is only a 5-fold or smaller margin of separation between safe and hepatotoxic doses. Naltrexone injection does not appear to be a hepatotoxin at the recommended doses. Patients should be warned and advised to seek medical attention if they experience symptoms of acute hepatitis. Use of naltrexone IM should be discontinued in the event of symptoms and/or signs of acute hepatitis. ■ **Contraindications:** – Receiving opioid agonists – Physical opioid dependence with use within the past 7 days – Acute opioid withdrawal – Failed naloxone challenge – Positive urine opioid screen – Acute hepatitis or liver failure – Inadequate muscle mass ■ Precautions for use in active liver disease or moderate to severe renal insufficiency ■ **Major Adverse Effects:** Eosinophilic pneumonia, depression and suicidality ■ **Common Adverse Effects:** Injection-site reactions, nausea, headache and asthenic conditions ■ Discontinue IM naltrexone if there is NO detectable benefit within three months

MEDICATION THERAPY FOR ALCOHOL DEPENDENCE (cont.)

Acamprosate (Campral)

Adult Dose	Advantages	Disadvantages
■ Two tablets, 666 mg, 3 times per day, preferably with meals ■ A lower dose may be effective in some patients ■ If CrCl is 30 to 50 ml/min, starting dose is 333 mg three times per day ■ Tablets should be swallowed whole, do not chew or crush	■ Renal excretion, no hepatic metabolism ■ No relevant drug interactions ■ May be used in patients on opioid therapy ■ FDA approved for the treatment of alcohol dependence	■ **Contraindications:** Severe renal impairment (CrCl ≤ 30 ml/min) ■ **Major Adverse Effects:** Suicidality ■ **Common Adverse Effects:** Diarrhea ■ Abstinence at treatment initiation and during treatment

MEDICATION THERAPY FOR ALCOHOL DEPENDENCE (cont.)

Disulfiram (Antabuse, generic)

Adult Dose	Advantages	Disadvantages
▪ Before starting disulfiram, patient must be abstinent for ≥ 24 hours and have blood alcohol level of 0 ▪ 250 mg once daily (range, 125 to 500 mg daily) ▪ Use caution in the elderly	▪ Can be used for alcohol dependence co-occurring with cocaine dependence ▪ Can be used when there is failure of or contraindication to naltrexone therapy ▪ More effective with monitored administration (e.g., in clinic or with spouse or probation officer) ▪ FDA approved for the treatment of alcohol dependence	▪ **Boxed Warning:** Disulfiram should never be administered to a patient in a state of alcohol intoxication or without his or her full knowledge. Patient's relatives should be advised that disulfiram should not be used to treat alcohol intoxication. ▪ **Contraindications:** – Hypersensitivity to disulfiram or thiram and related compounds (e.g., rubber) or any component of the formulation – Patients receiving or using ethanol, metronidazole, paraldehyde or oral or topical ethanol-containing preparations like cough syrup, mouthwashes or tonics – Psychosis – Severe myocardial disease and coronary occlusion ▪ **Major Adverse Effects:** Hepatotoxicity, peripheral neuropathy, psychosis, delirium and severe disulfiram ethanol reaction ▪ **Common Adverse Effects:** Somnolence, metallic taste and headache ▪ Consider use in only those individuals who have the capacity to appreciate risks and benefits. Written consent strongly recommended prior to treatment.

MEDICATION THERAPY FOR ALCOHOL DEPENDENCE (cont.)

Naltrexone PO, Naltrexone Injection, Acamprosate and Disulfiram

Drug Interactions

- Very large doses of opioids may overcome the effects of naltrexone and lead to serious injury, coma or death
- Limited clinical experience with over dosage of naltrexone in humans
- Drug interactions for naltrexone include opioid-containing medications, including OTC preparations, thioridazine, oral hypoglycemic and antiretroviral agents
- Small doses of opioids, such as in analgesic, antidiarrheal or antitussive drugs, may be blocked by naltrexone and fail to produce a therapeutic effect
- Avoid concurrent use of disulfiram with metronidazole, ketoconazole or paraldehyde therapy; alcohol in sauces, vinegars or beverages; medications such as cough syrups
- Avoid disulfiram if alcohol intoxicated

MEDICATION THERAPY FOR ALCOHOL DEPENDENCE (cont.)

Naltrexone PO, Naltrexone Injection, Acamprosate and Disulfiram

General Information

- Success is enhanced by engagement in a comprehensive management program that includes psychosocial therapy
- Naltrexone PO or IM or acamprosate should be routinely considered when treating alcohol dependence with addiction counseling
- Disulfiram should only be used when abstinence is the goal
- Compliance improves when disulfiram administration is directly observed
- Inform the patient to use caution when operating vehicles and hazardous machinery since disulfiram may cause sedation
- On VA VANF: Naltrexone PO, disulfiram
- On DoD UF: Naltrexone PO, acamprosate and disulfiram
- See TIP 49 for Incorporating Alcohol Pharmacotherapies into Medical Practice: www.ncbi.nlm.nih.gov/books/NBK14764/

Naltrexone PO, Naltrexone Injection, Acamprosate and Disulfiram (cont)

General Information

- **PREGNANCY WARNING:** Recommend pregnancy testing. The medications listed above are all category C
- **MONITORING, REFERRALS AND WARNINGS:**
- **Naltrexone:**
  - PO and IM baseline evaluation include liver transaminase, bilirubin, renal function and urine beta-HCG for females
  - Repeat naltrexone liver transaminase levels at 6 and 12 months and then every 12 months thereafter
  - Naltrexone IM may cause allergic pneumonia; monitor appropriately
  - Monitor for signs and symptoms of acute hepatitis; discontinue naltrexone if signs appear and contact provider immediately
  - Patients who have previously used opioids may be more sensitive to toxic effects of opioids after discontinuation of naltrexone
- **Acamprosate:**
  - Check renal function
- **Disulfiram:**
  - If the patient consumes alcohol with disulfiram, then a disulfiram-alcohol reaction will occur and may persist for 30 minutes to several hours afterwards. Reaction can include flushing, throbbing in the head or neck, nausea, vomiting, sweating, chest pain, palpitation, tachycardia, hypotension, syncope, weakness, vertigo, blurred vision and confusion.
  - Severe reactions include respiratory depression, cardiovascular collapse, arrhythmias, myocardial infarction, convulsions and death
  - Warn patients accordingly and provide them with wallet cards that indicate the use of disulfiram
  - Advise family members to not administer disulfiram without informing the patient
  - Check liver transaminase levels initially, repeat in 10 to 14 days and every 12 months thereafter
- Monitor closely for suicidal thoughts and depression

Patient and Family Education

Patient and
Family
Education

Tab 7:

PATIENT AND FAMILY EDUCATION

- What Counts As a Drink?
- Which Group Are You In?
- Recommended Daily and Weekly Drinking Limits
- What's "At risk" or "Heavy" Drinking?
- Effects of High Risk Drinking
- Why Are Women's Risk Limits Different from Men's?
- What Are Symptoms of an Alcohol Use Disorder?
- Importance of Family Member Intervention and Support
- Reassure and Refer Your Loved One
- Referral Resources

PATIENT AND FAMILY EDUCATION:

Please note that all information contained in this section should be shared with both the patient and family, as both parties may benefit.

Patient Education

What counts as a drink?

- Many people are surprised to learn what counts as one drink.
- In the United States, a standard drink is any drink that contains about 0.6 fluid ounces or 14 grams of pure alcohol.
- Although the drinks below are different sizes, each contains approximately the same amount of alcohol and counts as one standard drink.

THE PERCENT OF PURE ALCOHOL, EXPRESSED HERE AS ALCOHOL BY VOLUME (ALC/VOL), VARIES BY BEVERAGE

12 fl oz of regular beer		about 5% alcohol
8-9 fl oz of malt liquor (shown in a 12-oz glass)		about 7% alcohol
5 fl oz of table wine		about 12% alcohol
3-4 oz of fortified wine (such as sherry or port; 3.5 oz shown)		about 17% alcohol
2-3 oz of cordial, liqueur, or aperitif (2.5 oz shown)		about 24% alcohol
1.5 oz of brandy (a single jigger or shot)		about 40% alcohol
1.5 fl oz shot of 80-proof spirits (hard liquor)		about 40% alcohol

Source: NIAAA, retrieved from http://pubs.niaaa.nih.gov/publications/RethinkingDrinking/Rethinking_Drinking.pdf

WHICH GROUP ARE YOU IN?

Drinking Patterns in U.S. Adults		
 9%	Drink more than ***both*** the single-day limits **and** the weekly limits	Highest risk
 19%	Drink more than ***either*** the single-day limits **or** the weekly limits	Increased risk
 37%	**Always** drink **within** low-risk limits	Low risk
 35%	**Never** drink alcohol	_____

Source: National Institute on Alcohol Abuse and Alcoholism, retrieved from http://pubs.niaaa.nih.gov/publications/RethinkingDrinking/Rethinking_Drinking.pdf

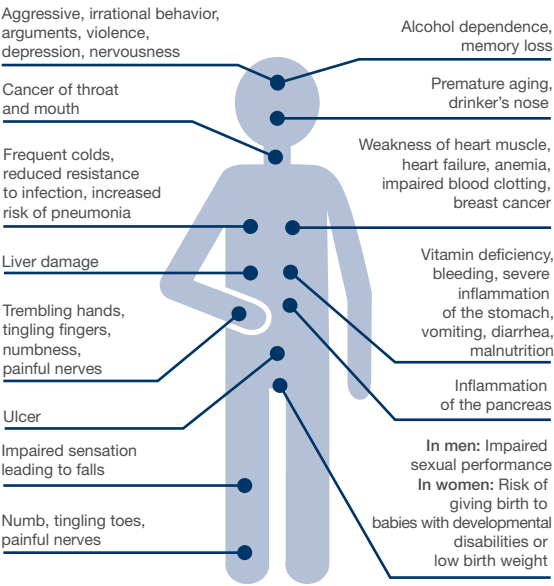
RECOMMENDED DAILY AND WEEKLY DRINKING LIMITS FOR MEN AND WOMEN

	Single-day Limit	Weekly Limit
MEN	≤ 4 standard-sized drinks	≤ 14 standard-sized drinks
WOMEN	≤ 3 standard-sized drinks	≤ 7 standard-sized drinks

What's "at-risk" or "heavy" drinking?

- Nearly 1 in 4 people who exceed the limits above has alcoholism or an alcohol abuse problem.
- The rest are at greater risk for developing alcoholism, an alcohol abuse problem and other problems, but individual risks vary.
- People who drink lower amounts can still be considered at-risk, particularly if they drink too quickly.

EFFECTS OF HIGH RISK DRINKING



Source: Department of Mental Health and Substance Dependence/World Health Organization, retrieved from http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf

Why are women's risk limits different from men's?

Research shows that women have alcohol-related problems at lower drinking levels than men because:

- Women usually weigh less than men.
- Alcohol disperses in body water, which women have less of than men (i.e., if a man and woman of equal weight drink the same amount of alcohol, the woman's blood alcohol concentration will be higher). (For more information, see Alcohol: A Women's Health Issue, available at: http://pubs.niaaa.nih.gov/publications/brochurewomen/women.htm#drinking)

In short:
↑ daily drinks + ↑ heavy drinking days over time =
↑ risk for alcoholism, alcohol abuse and other health problems

WHAT ARE SYMPTOMS OF AN ALCOHOL USE DISORDER?

	In the past year, have you:
☐	Had times when you ended up drinking more or longer than you intended?
☐	More than once wanted or tried to cut down or stop drinking, but couldn't?
☐	More than once gotten into situations while or after drinking that increased your chances of getting hurt, such as driving, swimming, using machinery, walking in a dangerous area or having unsafe sex?
☐	Had to drink much more than you once did to get the effect you want? Or found your usual number of drinks had much less effect than before?
☐	Continued to drink even though it was making you feel depressed or anxious or adding to another health problem? Or after having had a memory blackout?
☐	Spent a lot of time drinking? Or being sick or getting over other after effects?
☐	Continued to drink even though it was causing trouble with your family or friends?
☐	Found that drinking (or being sick from drinking) often interfered with taking care of your home or family? Or caused job troubles? Or school problems?
☐	Given up or cut back on activities that were important or gave you pleasure, to drink?
☐	More than once gotten arrested, been held at a police station or had other legal problems because of your drinking?
☐	Found that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, restlessness, nausea, sweating, a racing heart or a seizure? Or sensed things that were not there?

If you have any of the above symptoms, alcohol may be a cause for concern. The more symptoms you have, the more urgent the need for change.

Source: NIAAA, retrieved from http://pubs.niaaa.nih.gov/publications/RethinkingDrinking/Rethinking_Drinking.pdf

Family Education

Importance of family member intervention and support:

- Alcohol or drug addiction is a continuous cycle among families.
- Children whose parents are addicted to alcohol or drugs are 4 times more likely to develop a SUD than children who aren't in that environment.
- Stress contributes to alcohol or drug use; a family member's addiction may also cause long-lasting emotional stress that can create serious health and developmental outcomes for children.

Reassure and refer your loved one

- **It's not your fault!**
  - It is a disorder — you didn't cause it and you can't make it stop.
  - You need and deserve help for yourself and your family members.
- **You are not alone!**
  - One in four children under the age of 18 live in a family where a person abuses alcohol or suffers from alcoholism.
- **You don't have to take abuse because someone you love has a problem!**
- **There is help available!**

Remember the Seven C's	
I didn't	**C**ause it
I can't	**C**ure it
I can't	**C**ontrol it
I can take better	**C**are of myself by… **C**ommunicating my feelings
Making healthy	**C**hoices… **C**elebrating myself

Referral Resources

External Resources	
SAMHSA's "Find Substance Abuse and Mental Health Treatment" Site	www.samhsa.gov/treatment
SAMHSA's "National Helpline"	800-662-HELP or 800-487-4889 (TDD) (24-hour free and confidential information and treatment referrals in English and Spanish)
DoD and VA Specific Resources	
Air Force Family Advocacy Program	www.wpafb.af.mil/library/factsheets/factsheet.asp?id=9390
Army Family Advocacy Program	www.myarmyonesource.com/familyprogramsandservices/familyprograms/familyadvocacyprogram/default.aspx
Family Fleet Services	www.cnic.navy.mil/CNIC_HQ_Site/WhatWeDo/FleetAndFamilyReadiness/FamilyReadiness/FleetAndFamilySupportProgram
Marine Corps Family Life	www.usmc-mccs.org/family
Military OneSource	www.militaryonesource.com
My Health*e*Vet	www.myhealth.va.gov
Veterans Crisis Line	www.mentalhealth.va.gov/suicide_prevention/index.asp or 1-800-273-8255 and press 1

ICD-9-CM Coding

Tab 8:

ICD-9-CM CODING

COMMONLY USED CODING FOR SUD:

SUD is coded based on documentation contained within the medical record and in accordance with Military Health System and International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) coding guidelines.

Source: Centers for Disease Control and Prevention, retrieved from ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD9-CM/2010/

Special Screening for Mental Disorders and Developmental Handicaps	
Series Code	Description
V79.1	Alcoholism

291–292 Series Codes			
Series Code	Series Code Description	Detailed Codes	Detailed Code Descriptions
291	Alcohol-induced mental disorders	291.0	Alcohol withdrawal delirium
		291.3	Alcohol-induced psychotic disorder with hallucinations
		291.8	Other specified alcohol-induced mental disorders
		291.81	Alcohol withdrawal
		291.82	Alcohol-induced sleep disorder
		291.89	Other specified alcohol-induced mental disorders
		291.9	Unspecified alcohol-induced mental disorders
292	Drug-induced mental disorders	292.0	Drug withdrawal
		292.1	Drug-induced psychotic disorders
		292.89	Other specified drug-induced mental disorders
		292.9	Unspecified drug-induced mental disorders

Note:
- **Clinical documentation must support these codes**
- **A 4th digit is required, and a 5th digit may be required, to further describe the 291–292 series**

303–305 Series Codes			
Series Code	Series Code Description	Detailed Codes	Detailed Code Descriptions
303	Alcohol dependence syndrome	303.0	Acute alcoholic intoxication
		303.9	Other and unspecified alcohol dependence

303–305 Series Codes (cont.)			
Series Code	Series Code Description	Detailed Codes	Detailed Code Descriptions
304	Drug dependence	304.0	Opioid type dependence
		304.1	Sedative, hypnotic or anxiolytic dependence
		304.2	Cocaine dependence
		304.3	Cannabis dependence
		304.4	Amphetamine and other psychostimulant dependence
		304.5	Hallucinogen dependence
		304.6	Other specified drug dependence
		304.7	Combinations of opioid type drug with any other
		304.8	Combinations of drug dependence excluding opioid type drug
		304.9	Unspecified drug dependence
305	Non-dependent abuse of drugs	305.0	Non-dependent alcohol abuse
		305.1	Non-dependent tobacco use disorder
		305.2	Non-dependent cannabis abuse
		305.3	Non-dependent hallucinogen abuse
		305.4	Non-dependent sedative, hypnotic or anxiolytic abuse
		305.5	Non-dependent opioid abuse
		305.6	Non-dependent cocaine abuse
		305.7	Non-dependent amphetamine or related acting sympathomimetic abuse
		305.8	Non-dependent antidepressant type abuse
		305.9	Non-dependent other, mixed or unspecified drug abuse

Note:

- **Clinical documentation must support these codes**
- **A 4th digit is required that further describes the 303–305 series**
- **A 5th digit is required to denote further sub-classification of codes 303–305 (with the exception of 305.1): 0 – Unspecified; 1 – Continuous; 2 – Episodic; 3 – In remission**

Tools and Resources

Tab 9:

TOOLS AND RESOURCES

- Tools
- VA/DoD Resources
- Additional SUD-Related Military Resources
- Additional SUD-Related Civilian Resources
- Community Resources

TOOLS AND RESOURCES

Tools

- Alcohol Use Disorders Identification Test (AUDIT-C)
- Single-Item Alcohol Screening Questionnaire (SASQ)
- Clinical Institute Withdrawal Assessment of Alcohol (CIWA-Ar)
- Clinical Opiate Withdrawal Scale (COWS)

Scoring AUDIT-C

Question	0 points	1 point	2 points	3 points	4 points
1. How often did you have a drink containing alcohol in the past year?	☐ Never	☐ Monthly or less	☐ 2 to 4 times per month	☐ 2 to 3 times per week	☐ 4 or more times per week
2. On days in the past year when you drank alcohol how many drinks did you typically drink?	☐ 1 or 2	☐ 3 or 4	☐ 5 to 6	☐ 7 to 9	☐ 10 or more
3. How often do you have 6 or more drinks on an occasion in the past year?	☐ Never	☐ Less than Monthly	☐ Monthly	☐ Weekly	☐ Daily or almost daily

When the Audit-C is administered by self-report add a "0 drinks" response option to question #2 (0 points based on validations studies). In addition, it is valid to input responses of 0 points to questions #2-3 for patients who indicate "never" in response to question #1 (past year non-drinkers).
The minimum score (for non-drinkers) is 0 and the maximum possible score is 12. **Consider a screen positive for unhealthy alcohol use if AUDIT-C score is ≥ 4 points for men OR ≥ 3 points for women.**

Source: Bush, K., Kivlahan, D.R., McDowell, M.B., Fihn, S.D., & Bradley, K. A. The AUDIT Alcohol Consumption Questions (AUDIT-C): An Effective Brief Screening Test for Problem Drinking. Archives of Internal Medicine, 158, pp. 1789-1795, 1998.

SASQ Recommended by National Institute on Alcohol Abuse and Alcoholism (NIAAA)

1. **Do you sometimes drink beer, wine or other alcoholic beverages? (Followed by the screening question)**
2. **How many times in the past year have you had.... 5 or more drinks in a day (men) 4 or more drinks in a day (women)**

One standard drink = 12 ounces of beer, or 5 ounces of wine, or 1.5 ounces of 80-proof spirits (see Tab 7, page 65 for pictures of standard drinks.)
A positive screen is any report of drinking 5 or more (men) or 4 or more (women) drinks on an occasion in the past year.

Source: Smith, P. C., Schmidt, S.M., Allensworth-Davies, D. & Saitz, R. Primary Care Validation of a Single-Question Alcohol Screening Test. Journal of General Internal Medicine, 24, 783-788, 2009.

CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT OF ALCOHOL (CIWA-AR)

Patient:_____

Date:_____

Time:_____(24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute:_____

Blood pressure:_____

NAUSEA AND VOMITING –
Ask "Do you feel sick to your stomach? Have you vomited?" Observation.

0 no nausea and no vomiting
1 mild nausea with no vomiting
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves and vomiting

TACTILE DISTURBANCES –
Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.

0 none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning or numbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

TREMOR – Arms extended and fingers spread apart. Observation.

0 no tremor
1 not visible, but can be felt fingertip to fingertip
2
3
4 moderate, with patient's arms extended
5
6
7 severe, even with arms not extended

AUDITORY DISTURBANCES – Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.

0 not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

PAROXYSMAL SWEATS – Observation.

0 no sweat visible
1 barely perceptible sweating, palms moist
2
3
4 beads of sweat obvious on forehead
5
6
7 drenching sweats

VISUAL DISTURBANCES – Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.

0 not present
1 very mild sensitivity
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations

Interpretation of total CIWA-Ar scores:

- Minimal or absent withdrawal: ≤ 9
- Mild to moderate withdrawal: 10-19
- Severe withdrawal: > 20

Source: Sullivan, J.T.; Sykora, K.; Schneiderman, J.; Naranjo, C.A.; and Sellers, E.M. Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-Ar). British Journal of Addiction, 84:1353-1357, 1989.

CLINICAL OPIATE WITHDRAWAL SCALE (COWS)

For each item, circle the number that best describes the patient's signs or symptoms as related to the apparent relationship to opioid withdrawal.

Patient:_____

Date:_____

Time:_____

1. RESTING PULSE RATE: _____beats/minute measured after patient is sitting or lying for one minute.
- **0** Pulse rate 80 or below
- **1** Pulse rate 81-100
- **2** Pulse rate 101-120
- **4** Pulse rate greater than 120

2. SWEATING: Over past 1/2 hour not accounted for by room temperature or patient activity
- **0** No report of chills or flushing
- **1** Subjective report of chills or flushing
- **2** Flushed or observable moistness on face
- **3** Beads of sweat on brow or face
- **4** Sweat streaming off face

3. RESTLESSNESS: Observation during assessment
- **0** Able to sit still
- **1** Reports difficulty sitting still, but is able to do so
- **3** Frequent shifting or extraneous movements of legs/arms
- **5** Unable to sit still for more than a few seconds

4. PUPIL SIZE
- **0** Pupils pinned or normal size for room light
- **1** Pupils possibly larger than normal for room light
- **2** Pupils moderately dilated
- **5** Pupils so dilated that only the rim of the iris is visible

7. GI UPSET: Over last 1/2 hour
- **0** No GI symptoms
- **1** Stomach cramps
- **2** Nausea or loose stool
- **3** Vomiting or diarrhea
- **5** Multiple episodes of diarrhea or vomiting

8. TREMOR OBSERVATION OF OUTSTRETCHED HANDS
- **0** No tremor
- **1** Tremor can be felt, but not observed
- **2** Slight tremor observable
- **4** Gross tremor or muscle twitching

9. YAWNING: Observation during assessment
- **0** No yawning
- **1** Yawning once or twice during assessment
- **2** Yawning three or more times during assessment
- **4** Yawning several times/minute

10. ANXIETY OR IRRITABILITY
- **0** None
- **1** Patient reports increasing irritability or anxiousness
- **2** Patient obviously irritable/anxious
- **4** Patient so irritable or anxious that participation in the assessment is difficult

5. BONE OR JOINT ACHES: If patient was having pain previously, only the additional component attributed to opiate withdrawal is scored.

0 Not present
1 Mild diffuse discomfort
2 Patient reports severe diffuse aching of joints/muscles
4 Patient is rubbing joints or muscles and is unable to sit still because of discomfort

6. RUNNY NOSE OR TEARING: Not accounted for by cold symptoms or allergies

0 Not present
1 Nasal stuffiness or unusually moist eyes
2 Nose running or tearing
4 Nose constantly running or tears streaming down cheeks

11. GOOSEFLESH SKIN

0 Skin is smooth
3 Piloerection of skin can be felt or hairs standing up on arms
5 Prominent piloerection

TOTAL SCORE_____

[The total score is the sum of all 11 items.]

Initials of person completing assessment:

_____

Interpretation of total COWS scores:

- Mild: 5-12
- Moderate: 13-24
- Moderately severe: 25-36
- Severe withdrawal: > 36

Source: Adapted from Wesson et. al. 1999, Reprinted with permission.

VA/DoD 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
- Updated VA/DoD CPGs for additional psychological health disorders, including bipolar disorder, major depressive disorder and post-traumatic stress, can be accessed at www.healthquality.va.gov/ and https://www.qmo.amedd.army.mil/pguide.htm

Additional SUD-Related Military Resources

- www.dcoe.health.mil/ForHealthPros/Resources.aspx
- www.oefoif.va.gov/substanceabuseprograms.asp
- http://acsap.army.mil/sso/pages/index.jsp

Additional SUD-Related Civilian Resources

- **National Institute on Alcohol Abuse and Alcoholism (NIAAA)**
  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 patient 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 patient-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.

Community Resources (Specialists, Community Support Groups, Treatment Facilities, Suicide Hotline)

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) 202-408-8600

Mutual-Help Groups

- **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

Groups for Family and Friends

- **Al-Anon/Alateen**
  (www.al-anon.alateen.org) 888-425-2666 for meetings

- **Adult Children of Alcoholics**
  (www.adultchildren.org) 310-534-1815

Suicide Hotline

- **Veterans Crisis Line**
  (www.mentalhealth.va.gov/suicide_prevention/index.asp)
  800-273-8255 and press 1

Treatment Facilities

- **Substance Abuse Treatment Facility Locator**
  (www.findtreatment.samhsa.gov) 800-662-HELP (4357)

DEFENSE CENTERS OF EXCELLENCE
For Psychological Health & Traumatic Brain Injury