

VHA/D<sub>o</sub>D CLINICAL PRACTICE GUIDELINE FOR THE  
MANAGEMENT OF **SUBSTANCE USE DISORDERS**  
IN THE PRIMARY CARE SETTING

Veterans Health Administration  
Department of Defense

*Prepared by:*

**THE MANAGEMENT OF SUBSTANCE USE DISORDERS**  
Working Group

*with support from:*

The Office of Performance and Quality, VHA, Washington, DC  
&  
Quality Management Directorate, United States Army MEDCOM

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VHA/D<sub>o</sub>D CLINICAL PRACTICE GUIDELINE FOR THE  
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**INTRODUCTION**

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## MANAGEMENT OF SUBSTANCE USE DISORDERS

### Introduction

A report recently released by the Robert Wood Johnson Foundation (Institute for Health Policy, 2001) documents the title's claim that substance abuse is "the nation's number one health problem." In 1999, an estimated 14.8 million Americans were current illicit drug users, 45 million people engaged in binge drinking, and 12.4 million were heavy drinkers (HHS, 2000). In 1999, an estimated 3.6 million Americans (1.6% of the total population, ages 12 and older) were dependent on illicit drugs. An estimated 8.2 million Americans were dependent on alcohol (3.7%). Of these, 1.5 million people were dependent on both alcohol and illicit drugs. Overall, an estimated 10.3 million people (4.7%) were dependent on either alcohol or illicit drugs (SAMHSA, 2000). Substance use disorders (SUD) are currently a major cause of disability-adjusted life years (i.e., the sum of lost life due to mortality and years of life adjusted for the severity of the disability) in industrialized countries (Murray, 1997). Each year, abuse of illicit drugs and alcohol contributes to the death of more than 120,000 Americans, with an additional 400,000 deaths directly attributable to tobacco. Drugs and alcohol cost taxpayers nearly \$276 billion annually in preventable health care costs, extra law enforcement, auto crashes, crime and lost productivity (HHS, 2000).

Because SUD is more common among men, it is a major risk factor for morbidity and mortality within the Veterans Health Administration (VHA) and Department of Defense (DoD) communities. In fiscal year 2000, 21% of the 353,200 unique Veterans Administration (VA) inpatients had a primary or secondary diagnosis of SUD and accounted for 1.20 million days of inpatient care. Of the 3.64 million VA outpatients treated in fiscal year 2000, 9% had a SUD diagnosis and accounted for 14% of VA outpatient utilization (Piette et al., 2001). Co-occurring medical and psychiatric disorders are common. Among veterans assessed in VA substance abuse treatment programs in 1997, 64% had one or more psychiatric diagnoses, in addition to their SUD (Moos et al., 2000).

### Treatment Advances

Over the past 20 years, modern methods of evaluating medical therapies have been increasingly applied to SUD treatment. Some treatments, such as the Twelve-Step self-help programs, have been around for a long time. Others, including brief intervention and addiction-focused pharmacotherapies, are relatively new interventions. The key change that has occurred is the use of more rigorous approaches to the study of the effectiveness of interventions (Gordis, 2000). The approach now often includes the use of control groups for comparison purposes, random assignment of study participants to different treatment groups, and appropriate follow-up (Fuller & Hiller-Sturmhofel, 1999). This guideline incorporates the results of recent controlled clinical studies on the effectiveness of several treatments. The degree of specificity of recommendations in this guideline depends on the quality of available research and the degree of consensus among expert clinicians.

The guideline is not intended to be construed or to serve as a standard of care. Standards of care are determined on the basis of all clinical data available for an individual case and are subject to change, as scientific knowledge and technology advances and patterns evolve. The ultimate judgment regarding a particular clinical procedure or treatment course must be made by the individual clinician, in light of the clinical data presented by the patient, patient preferences, and the diagnostic and treatment options available.

## GUIDELINE DEVELOPMENT PROCESS

### Overview

In July 1998, a guideline for the Management of Persons with SUD was developed for the VHA. The initial guideline was the product of a research and consensus building effort among professionals throughout the VHA. Shortly after the development of the initial guideline, the DoD joined the VHA in developing clinical practice guidelines (CPGs). Since then the DoD has participated with the VHA in developing and disseminating several CPGs. The initial VHA guideline was not published and was used as

the seed for development of the VHA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders in the Primary Care Setting. This guideline is the product of a close collaboration, which started in March 2000. Revisions will take place at 2-3 year intervals or when relevant research results become available.

The current guideline for the management of SUD represents hundreds of hours of diligent effort and consensus building among knowledgeable individuals from the VHA, DoD, academia, and a team of guideline facilitators from the private sector. An experienced moderator facilitated the multidisciplinary working group that included psychiatrists, psychologists, mental health professionals specializing in addiction and withdrawal therapies, family practitioners, nurses, social workers, chaplains, pharmacists, and rehabilitation specialists. Many of the experts involved in developing this guideline have previously participated in the development of the VHA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder (MDD) in Adults and the VHA Clinical Practice Guideline For the Management of Persons with Psychoses, both of which include sections on co-occurring substance abuse.

### **Development Process**

The process of developing the guideline is evidence-based, whenever possible. Where evidence is ambiguous or conflicting, or where scientific data are lacking, the clinical experience of the working group guided the development of consensus-based recommendations.

The development process of the guideline incorporated information from several sources into a format which maximally facilitated clinical decision-making (Woolf, 1992). This effort drew, among others, from the following sources:

- American Psychiatric Association Practice Guideline for the Treatment of Patients with Substance Use Disorders (American Psychiatric Association, 1995).
- Pharmacological Management of Alcohol Withdrawal: A Meta-Analysis and Evidence-Based Practice (Mayo-Smith et al., 1997).
- Evidence review reports published by the COCHRANE DRUGS AND ALCOHOL GROUP of the Cochrane Collaboration (<http://www.update-software.com/cochrane>).
- Several Department of Health and Human Services (DHHS) publications focusing on the assessment and treatment of substance abuse and alcohol problems in primary care.
- Pharmacotherapy for Alcohol Dependence, Evidence Report/Technology Assessment Number 3, January, 1999. Agency for Health Care Policy and Research (AHCPR).

### **Goals of the Guideline**

This CPG on the assessment and treatment of SUDs is intended to improve the quality of care and facilitate the management of persons with these conditions, in both primary care settings and specialized treatment programs. The guideline addresses the critical decision points in management of these disorders.

At the initial meeting, the experts identified several goals:

- Improve the process of screening for substance use
- Formulate an efficient and effective initial assessment process
- Establish initial intervention, including referral, for non-dependent users
- Match treatment to patient need
- Increase use of pharmacotherapy and psychotherapy
- Increase monitoring of treatment
- Improve continuity of care
- Determine referral criteria

The guideline can assist substance abuse treatment specialists and primary medical care providers in early detection of symptoms, assessment of treatment readiness, determination of the appropriate setting and

intensity of treatment, and delivery of individualized interventions. It can also be used as a starting point for innovative implementation plans that improve collaborative effort and focus on key aspects of care. At the same time, the guideline should be applied with sufficient flexibility to accommodate local policies or procedures, including those regarding staffing patterns and referral to, or consultation with, other health care providers. The use of CPGs must always be considered as a recommendation within the context of a provider's clinical judgment, in the care for an individual patient.

The system-wide goal of evidence-based guidelines is to improve patient outcomes. We are confident that the current guideline represents a significant step toward this goal for patients with SUDs in the VHA and DoD. However, as with other CPGs, remaining challenges involve developing effective strategies for guideline implementation and evaluating the effect of guideline adherence on clinical outcomes.

### Content of the Guideline

The guideline consists of five modules that address inter-related aspects of care for patients with SUDs. Each module includes the algorithm, annotations, and bibliography.

- Module A:**            **Assessment and Management in Primary Care** includes screening, brief intervention, and specialty referral considerations.
- Appendix A-1: Substance Use Disorders Screening and Assessment Instruments*
- Appendix A-2: DoD Clinical Instruction DoD 1010.6*
- Module C:**            **Care Management** emphasizes chronic disease management for patients unwilling or unable to pursue rehabilitation goals.
- Module P:**            **Addiction-Focused Pharmacotherapy** addresses use of currently approved medications as part of treatment for alcohol and opioid dependence.
- Module R:**            **Assessment and Management in Specialty Care** focuses on patients in need of further assessment or motivational enhancement or who endorse rehabilitation goals.
- Module S:**            **Stabilization** addresses detoxification and pharmacological management of withdrawal symptoms.

Tobacco use should be addressed in all patients and is a major cause of morbidity and mortality among patients with non-nicotine SUDs. For management of nicotine dependence, refer to the VHA/DoD Clinical Practice Guideline to Promote Tobacco Use Cessation in the Primary Care Setting. For management of patients presenting with SUDs and depression or psychosis, refer to the VHA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder (MDD) in Adults or the VHA Clinical Practice Guideline for the Management of Persons with Psychoses. Future efforts are planned to integrate these guidelines to improve management of co-occurring conditions.

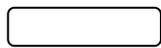
### Format of the Guideline

The guideline is presented in an algorithmic format. There are indications that this format improves data collection and clinical decision-making and helps to change patterns of resource use. A clinical algorithm is a set of rules for solving a clinical problem in a finite number of steps. It allows the clinician to follow a linear approach to critical clinical information needed at the major decision points in the disease management process, and stepwise evaluation and management strategies that include the following:

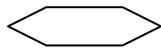
- Ordered sequence of steps of care
- Recommended observations
- Decisions to be considered
- Actions to be taken

The clinical experts subjected all decision points in the algorithms to simulated patients. Hypothetical "patients" were run through the algorithm to test whether it was likely to work in a real clinical situation. Based on these tests, the necessary changes were made to assure accurate clinical logic. Treatment must always reflect the unique clinical issues in an individual patient-clinician situation. Due to the nature of the algorithmic format, the specific pharmacological and psychosocial treatments for patients with SUDs are included in separate boxes. It is recognized, however, that clinical practice often requires a nonlinear approach and concurrent processes that combine a number of different treatment modalities. For example, a threat to self or others may be the initial presenting complaint, but such threats may also require immediate attention at other points throughout the evaluation and treatment process. Similarly, given the high rates of co-occurring psychiatric or medical conditions among patients with SUDs in the VHA (Kazis et al., 1998), much treatment needs to proceed concurrently.

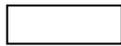
A clinical algorithm diagrams a guideline into a step-by-step decision tree. Standardized symbols are used to display each step in the algorithm (Society for Medical Decision Making Committee on Standardization of Clinical Algorithms, 1992). Arrows connect the numbered boxes indicating the order in which the steps should be followed.



Rounded rectangles represent a clinical state or condition.



Hexagons represent a decision point in the guideline, formulated as a question that can be answered Yes or No. A horizontal arrow points to the next step if the answer is YES. A vertical arrow continues to the next step for a negative answer.



Rectangles represent an action in the process of care.



Ovals represent a link to another section within the guideline.

A letter within a box of an algorithm refers the reader to the corresponding annotation. The annotations elaborate on the recommendations and statements that are found within each box of the algorithm. Following more complex annotations, a brief discussion provides the underlying rationale.

A complete bibliography of all the sources used in the development of the annotations and discussion is provided at the end of each module.

## Literature

The literature supporting the decision points and directives in the guideline is referenced in Evidence Tables and Discussions. The working group leaders were solicited for input on focal issues prior to a review of the literature. Electronic searches of Cochrane Controlled Trials Register (COCHRANE DRUGS AND ALCOHOL GROUP: <http://www.update-software.com/cochrane>) were undertaken. Papers selected for further review were those published in English-language peer-reviewed journals. Preference was given to papers based on randomized, controlled clinical trials, or nonrandomized case-control studies. Studies involving meta-analysis were also reviewed.

Selected articles were identified for inclusion in a table of information that was provided to each expert participant. The table of information contained: Title, Author(s), Author(s) affiliation, Publication type, Abstract and Source. Copies of these tables were made available to all participants. In addition, the assembled experts suggested numerous additional references. Copies of specific articles were provided to participants on an as-needed basis. This document includes references through the year 2000.

## Rating of the Evidence

Evidence-based practice involves integrating clinical expertise with the best available clinical evidence derived from systematic research. The working group reviewed the articles for relevance and graded the evidence using the rating scheme published in U. S. Preventive Service Task Force (U. S. PSTF) Guide to Clinical Preventive Services, Second Edition (1996), displayed in Table 1. The experts themselves formulated QE ratings, after an orientation and tutorial on the evidence grading process. Each reference was appraised for scientific merit, clinical relevance, and applicability to the populations served by the Federal health care system. The QE rating is based on experimental design and overall quality. RCTs received the highest ratings (QE=I), while other well-designed studies received a lower score (QE=II-1, II-2, or II-3). The QE rating is based on the quality, consistency, reproducibility, and relevance of the studies.

**Table 1. Quality of Evidence Rating Scheme (U. S. PSTF, 1996)**

Quality of Evidence (QE)	
Grade	Description
I	Evidence is obtained from at least one properly randomized controlled trial (RCT).
II-1	Evidence is obtained from well-designed controlled trials without randomization.
II-2	Evidence is obtained from well-designed cohort or case-control analytical studies, preferably from more than one center or research group.
II-3	Evidence is obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of the introduction of penicillin treatment in the 1940's) could also be regarded as this type of evidence.
III	Opinions of respected authorities are based on clinical experience, descriptive studies and case reports, or reports of expert committees.

Often, the most basic patient management questions and the well-accepted care strategies are the most difficult to test through QE-I studies (i.e., RCT), especially when assessments and interventions are multifactorial and interdisciplinary. Even QE-II studies may be difficult when a primary unit of analysis is a social group, rather than the individual patient. For example, a Tri-service Navy alcohol treatment program reported a 1-2 year abstinence rate of 77% with an occupational retention rate of 90% amongst patients diagnosed with alcohol dependence (Wright, 1990). This was consistent with Army and Air Force studies of their own programs. The military programs attributed their high success rates to a combination of interventions that included physical conditioning, nutrition, stress management, spirituality, 1-year follow-up care, occupational commitment, and positive social support networks. RCTs are most useful when exposure and outcome variables are highly focused and there is a need to study treatment efficacy rather than treatment effectiveness. In SUDs, dimensions such as social support networks and occupational investment—found to be important in highly effective programs—may not lend themselves to study through an RCT. Therefore, the strength of evidence grade does not always reflect the importance of the recommendation to patient care. The specific language used to formulate each recommendation conveys panel opinion of both the clinical importance attributed to the topic and the strength of evidence available.

The working group formulated a recommendation rating (R), using a rating scale from A to E, displayed in Table 2. The rating of R is influenced primarily by the significance of the scientific evidence. Other factors that are considered when making the R determination include standards of care, policy concerns, and cost of care.

**Table 2. Recommendation Rating Scheme (adapted from Gibbons et al., 1999)**

<b>Recommendation (R)</b>	
<b>Grade</b>	<b>Description</b>
A	A strong recommendation, based on evidence or general agreement, that a given procedure or treatment is useful/effective, always acceptable, and usually indicated.
B	A recommendation, based on evidence or general agreement, that a given procedure or treatment be considered useful/effective.
C	A recommendation that is not well established, or for which there is conflicting evidence regarding usefulness or efficacy, but which may be made on other grounds.
D	A recommendation, based on evidence or general agreement, that a given procedure or treatment be considered not useful/effective.
E	A strong recommendation, based on evidence or general agreement, that a given procedure or treatment is not useful/effective, or in some cases may be harmful, and should be excluded from consideration.

### **For the Future**

The inability of consumers and health care purchasers to determine if medical care is appropriate and effective has given rise to the concept that the health care system should be held accountable for what is done and the outcomes achieved. The VHA and DoD are developing indicators to measure the impact of this guideline on the quality of care.

This guideline represents the consensus, at the time of the guideline's development, of a group of experts in the Addictions field as to how to structure an evidence-based approach to the evaluation and treatment of SUDs in both primary care and specialized treatment settings. New research and practice-based evidence will undoubtedly dictate modifications in these guidelines in the future. The sense of the developers of this guideline was that this should always be considered a "work in progress."

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#### EDITORIAL PANEL OF THE WORKING GROUP

**Daniel Kivlahan, PhD**

Director, VA Center of Excellence in Substance  
Abuse Treatment and Education  
VA Puget Sound  
Associate Professor, Department of Psychiatry and  
Behavioral Sciences  
University of Washington  
Seattle, WA

**Laura F. McNicholas, MD, PhD**

Director, VA Center of Excellence in Substance  
Abuse Treatment and Education  
Philadelphia VMAC  
Philadelphia, PA

**Shannon Miller, MD, CMRO MAJ, USAF, MC**

Chief, Triservice Addiction Recovery Center  
Malcolm Grow USAF Medical Center  
Andrews AFB, MD

**Mark Willenbring, MD**

Medical Director, Addictive Disorders Section  
VA Medical Center  
Associate Professor, Department of Psychiatry  
University of Minnesota  
Minneapolis, MN

**FACILITATOR**

**Oded Susskind, MPH**

Medical Education Consultant  
Brookline, MA

#### PARTICIPANTS OF THE WORKING GROUP

**Carolyn Barrett-Ballinger, MA**

Clinical Operations  
Bureau of Medicine and Surgery  
Washington, DC

**Stuart Bokser, MSW**

Clinical Director  
Ft. Monmouth, NJ

**Sandra Brake, ACSW**

Acting Director of Social Work  
VHA Headquarters  
Washington, DC

**Peter Durand, LTC, MC, USAF**

AFMOA/SGOC  
Bolling AFB, DC

**Noreen Durkin, MSN**

Assoc. QM Coordinator  
James A. Haley VAMC  
Tampa, FL

**Joanne Fertig, PhD**

Treatment Research Branch  
Division of Clinical & Prevention Research  
National Institute on Alcohol Abuse and  
Alcoholism  
Bethesda, MD

**Roger W. Hartman**

Health Policy Analyst  
OASD (HA)/TMA  
Falls Church, VA

**Ken Hoffman, COL, MC, USA**

Medical Director  
Military and Veterans Health Coordinating Board, and  
Persian Gulf Veterans Coordinating Board  
Washington, DC

**Vern Hunter, EdM**

Clinical Director  
Community Counseling Center  
MEDDAC  
Ft. Eustis, VA

**David Jones, LTC, MC USA**

Chief, Internal Medicine Service  
Walter Reed Army Medical Center  
Washington, DC

**George Kolodner, MD**

Kolmac Clinic – Suite #2  
Silver Spring, MD

**Charles Miller, MD**

Medical Coordinator, AMEDD  
Clinical Practice Guideline  
USA Medcom MCHO-CL-C  
Fort Sam Houston, TX

**Charlotte A. Mullican, MPH**  
Health Scientist Administrator  
Agency for Health Care & Research Quality  
Rockville, MD

**Robert B. Murphy, CAPT, MC, USN**  
Executive Assistant  
DoD Prevention, Safety and Health Promotion  
Council  
QuIC Substance Abuse Task Force  
Bolling AFB, DC

**Tina Russ, PhD, CPT, BSC, USAF**  
Health Psychology Consultant, OPHSA  
Brooks AFB, TX

**Wendy Smith, PhD**  
Health Services Research Program  
NIAAA  
Bethesda, MD

**Frances Stewart, CAPT, MC, USN**  
Program Director  
Patient Advocacy/Medical Ethics  
Office of the ASD  
Falls Church, VA

**Richard Suchinsky, MD**  
Associate Chief for Addictive Disorders  
Department of Veterans Affairs  
Washington, DC

**Debby Walder, RN, MSN**  
Performance Management Facilitator  
Department of Veterans Affairs  
Washington, DC

**Russ Wolf, MD, MPH**  
Chief Medical Officer  
Boston VAMC  
Lowell, MA

#### CONSULTANTS AND TECHNICAL WORKFORCE

**Rosalie Fishman, RN, MSN, CPHQ**  
Clinical Coordinator  
Birch & Davis Holdings, Inc.  
Silver Spring, MD

**Verna Hightower**  
Research Assistant  
Birch & Davis Associates, Inc.  
Silver Spring, MD

**Sarah Ingersoll, RN, MSN**  
Field Operations Director,  
Birch & Davis Associates, Inc.  
Silver Spring, MD

**Arthur Kaufman, MD**  
Medical Director,  
Birch & Davis Associates, Inc.  
Silver Spring, MD

**Joanne Marko, SLP, MS**  
Senior Consultant  
Birch & Davis Associates, Inc.  
Silver Spring, MD

**Louise Nelson, RN**  
Education and CQI Coordinator  
West Virginia Medical Institute, Inc.  
Charleston, WV

**Janet Spinks, RN**  
Clinical Consultant  
Birch & Davis Associates, Inc.  
Silver Spring, MD

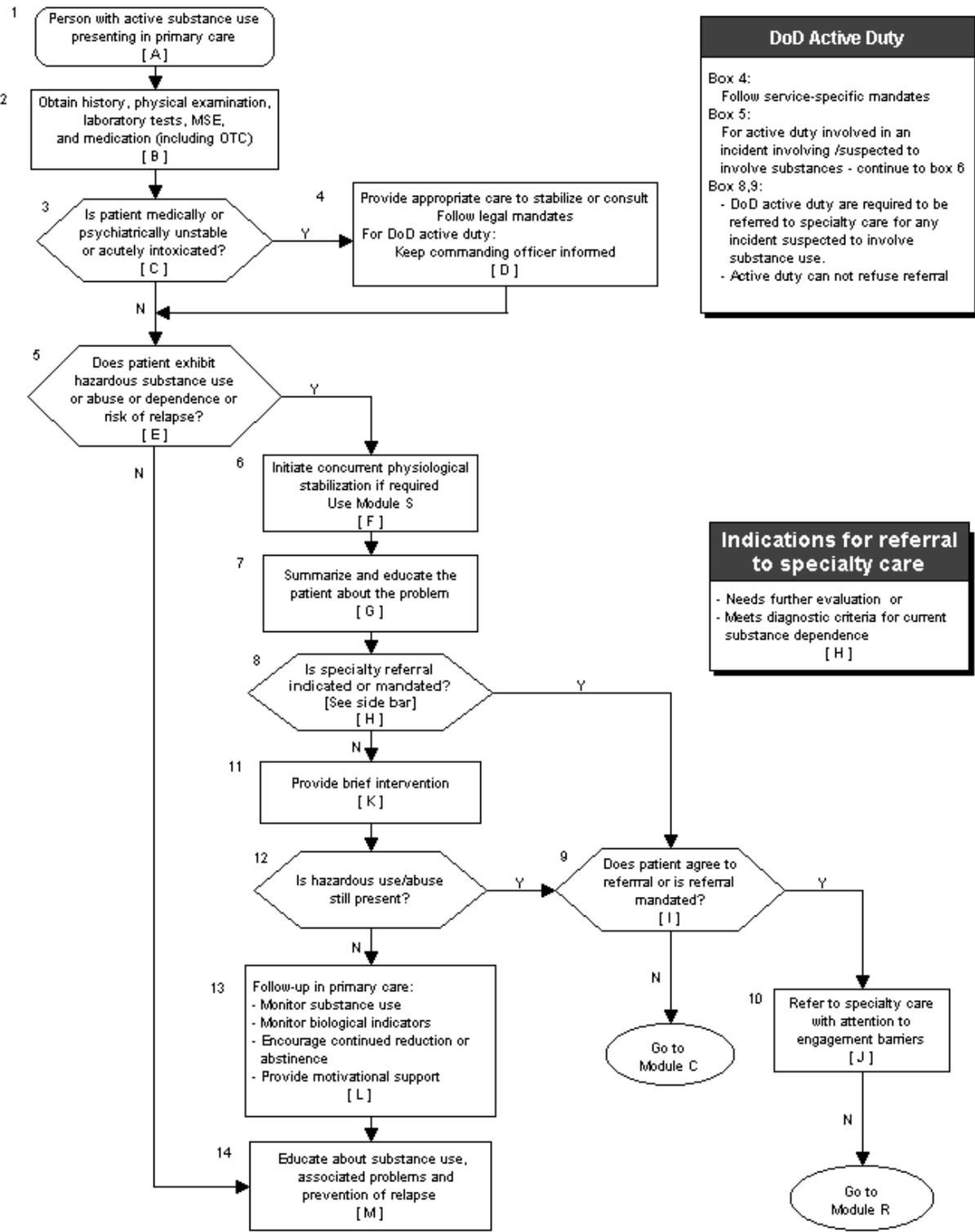
**Christine Winslow**  
Project Development Coordinator  
Birch & Davis Associates, Inc.  
Silver Spring, MD

VHA/D<sub>o</sub>D CLINICAL PRACTICE GUIDELINE FOR THE  
MANAGEMENT OF **SUBSTANCE USE DISORDERS**  
IN THE PRIMARY CARE SETTING

**MODULE A:**  
**ASSESSMENT AND MANAGEMENT**  
**IN PRIMARY CARE**

Version 1.0

**MANAGEMENT OF SUBSTANCE USE DISORDERS**  
**Module A: Assessment and Management in Primary Care**



## ANNOTATIONS

### A. Person With Active Substance Use Presenting In Primary Care

Patients managed within this module either indicated recent substance use, were screened for substance use or referred for further evaluation, or have manifested behaviors that place them at increased risk for relapse. They *may* or *may not* meet the Diagnostic and Statistical Manual of Mental Disorders—4<sup>th</sup> Edition (DSM IV) criteria for substance abuse or dependence.

The purpose of screening for substance use is to identify those who should receive additional screening for hazardous use or substance use disorders (SUDs). The initial screening is intended to rule out those patients for whom the provider identifies “no indications for further screening regarding substance use.” All patients should be asked about any current or recent use of nicotine, alcohol, and/or other substances at their initial visit or at least annually (U.S. PSTF, 1996). Specifically, a clinician must have a high index of suspicion and realize patients with SUDs commonly enter health care through the emergency room, acute care, routine care, and chronic care routes.

### B. Obtain History, Physical Examination, Laboratory Tests, Mental Status Examination (MSE), And Medication (Including Over-The-Counter [OTC])

#### OBJECTIVE

Obtain clinical background information on the patient.

#### ANNOTATION

1. Interview the patient and other collateral informants, where appropriate, about medical history and use of prescription and non-prescription medications before initiating extensive diagnostic testing.
2. Note any history of recent head trauma.
3. Order laboratory tests selectively, aiming to detect potential medical causes for the presenting symptoms where indicated by:
  - Specific symptoms found on the medical review of systems.
  - Evidence of unusual symptom profiles.
  - History of atypical illness course.
4. Screen for cognitive status, particularly in the elderly patient:
  - Consider a standardized instrument such as Folstein’s Mini-Mental State Examination (MMSE) (Folstein et al., 1975), using age and education-adjusted cut-off scores (Crum et al., 1993).
  - History of atypical illness course.
5. For DoD patients the commanding officer can be an excellent source of collateral data.

### C. Is Patient Medically Or Psychiatrically Unstable Or Acutely Intoxicated?

#### OBJECTIVE

Identify the patient who needs to be stabilized before continuing in the algorithm.

#### ANNOTATION

Patients with problems that require emergency care or urgent action should not be further managed by this algorithm. Emergency or urgent actions include unstable medical problems (e.g., acute trauma, myocardial infarction, and stroke) or unstable psychiatric problems (e.g., delirium and imminent risk of harm to self and/or others).

### **Delirium (APA, 1994)**

Delirium can be identified through the following:

1. Disturbance of consciousness (e.g., reduced clarity of awareness of the environment with reduced ability to focus, sustain, or shift attention).
2. A change in cognition (such as memory deficit, disorientation, or language disturbance) or the development of a perceptual disturbance that is not accounted for by a preexisting, established, or evolving dementia.
3. The disturbance develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day.
4. There is evidence from the history, physical examination, or laboratory findings that:
  - Illness is characterized by an atypical course.
  - Disturbances are caused by the direct physiological consequences of a general medical condition.
  - Symptoms developed during substance intoxication or medication use are etiologically related to the disturbance.
  - Symptoms are developed during or following a withdrawal syndrome.
  - Delirium has more than one etiology (e.g., a general medical condition plus intoxication or a medication side effect).

### **Risk of harm to self or others**

1. If suicidal ideation is present, the imminent risk increases with one or more of the following risk factors:
  - Prior suicide attempt and lethality of prior acts
  - Level of intent and formulation of plan
  - Greater preoccupation (e.g., frequency, intensity, and duration of thoughts)
  - Availability of lethal means for suicide (e.g., firearms or pills)
  - Family history of completed suicide
  - Presence of active mental illness (e.g., severe depression or psychosis)
  - Presence of substance abuse
  - Current negative life events (e.g., loss in personal relationship)
  - Feelings of hopelessness or helplessness
2. Consider the patient's history of violent acts as an increased risk for violence toward self or others.
3. Offer mental health counseling to patients with evidence of suicidal, assaultive, or homicidal ideation.
4. Arrange voluntary or involuntary emergency psychiatric treatment and possibly hospitalization for patients with definite intent to harm self or others, particularly those with a plan and the available means.

### **Serious psychiatric instability**

Obtain immediate mental health consultation if other psychiatric symptoms (e.g., acute psychosis) significantly interfere with further assessment and require immediate psychiatric treatment before continuing assessment.

### **Acute intoxication**

1. The most common signs and symptoms involve disturbances of perception, wakefulness, attention, thinking, judgment, psychomotor behavior, and interpersonal behavior.
2. Patients should be medically observed at least until blood levels are decreasing and the clinical presentation is improving.
3. Highly tolerant individuals may not show signs of intoxication. For example, patients may appear "sober" even at blood alcohol levels (BAL) well above the legal limit (e.g., 80 or 100).

## DISCUSSION

Recent intake of a substance can be assessed from the history, physical examination (e.g., alcohol on the breath), or toxicological analysis of urine or blood. The specific clinical picture in substance intoxication depends on the substance(s) used, the duration of use at that dose, tolerance, time since last dose, expectations of effects, and the environment or setting of use.

DSM-IV (APA, 1994) criteria for substance intoxication include:

- The development of a reversible substance-specific syndrome due to recent ingestion of (or exposure to) a substance. *Note: Different substances may produce similar or identical syndromes.*
- Clinically significant maladaptive behavioral or psychological changes that are due to the effect of the substance on the central nervous system (e.g., belligerence, mood lability, cognitive impairment, impaired judgment, and impaired social or occupational functioning) and develop during or shortly after use of the substance.

Note: The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

For DoD active duty, follow the DoD legal mandates (see Appendix A-2).

## EVIDENCE TABLE

	<b>Recommendations</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Assess imminent risk for suicide.	U.S. PSTF, 1996	II-2	A
2	Note increased risk for violence.	Hasting & Hamberger, 1997 Thienhaus & Piasecki, 1998	III	A
3	Offer counseling to a patient at risk.	Hirschfield & Russell, 1997 U.S. PSTF, 1996	III	A
4	Arrange emergency treatment or possible hospitalization.	APA, 1993 U.S. DHHS, 1993 & 1995 U.S. PSTF, 1996 Veterans Administration (VA) Task Force, n/d	III	A

QE = Quality of Evidence; R = Recommendation (See Introduction)

### **D. Provide Appropriate Care To Stabilize Or Consult; Follow Legal Mandates; For DoD Active Duty: Keep Commanding Officer Informed**

#### OBJECTIVE

Provide services to stabilize the patient's condition.

#### ANNOTATION

1. Implement suicide or high-risk protocols, as needed.
2. Review local policies and procedures with regard to threats to self or others. These policies reflect local and state laws and the opinion of the VA District Council and the DoD. Primary care, mental health, and administrative staff must be familiar with these policies and procedures.
3. For DoD active duty: Follow service specific mandates, as a mental health/emergency referral is likely mandated.

- E. Does Patient Exhibit:
- I. Hazardous Substance Use?
  - II. Abuse or Dependence?
  - III. Risk Of Relapse?

OBJECTIVE

Identify patients who require clinical intervention related to their substance use beyond routine education about prevention of relapse.

ANNOTATION

Interview the patient and consider use of the following:

1. Brief self-report screening instruments (see section II of this annotation).
2. Reports from responsible others.
3. Laboratory tests (for corroboration only and not for routine screening)—e.g., blood or breath alcohol levels, breath carbon monoxide for smoking, urine toxicology, elevated carbohydrate deficient transferrin, increased mean corpuscular volume (MCV), or gamma glutamic transferase (GGT). Laboratory tests are not recommended for screening of asymptomatic persons (U.S. PSTF, 1996).

**I. Screening for hazardous substance use**

The clinician should identify patients who are currently using substances at hazardous levels whether or not they meet diagnostic criteria for substance abuse or dependence (Reid et al., 1999).

Hazardous Alcohol Use:

Screen current users for hazardous alcohol use at the initial clinic visit or at least annually.

1. Screening for hazardous alcohol use should consider both the volume (e.g., total drinks per week) and pattern of use (e.g., frequency of heavy drinking episodes).
  - Average weekly or daily quantity is most strongly related to chronic health risks.
  - Frequency of heavy drinking is most strongly related to acute health risks and psychosocial risks.
2. Patients are at increased *risk of medical morbidity and dependence* if they report drinking more than the gender specific hazardous use threshold (Bradley et al., 1998) (see Table 1. Hazardous Alcohol Use Screening).

**Table 1. Hazardous Alcohol Use Screening**

Definition	Comments	Male	Female
Typical drinks <i>per week</i> (U.S. PSTF, 1996)	Standard drinks: <ul style="list-style-type: none"> <li>▪ 0.5 fluid ounces of absolute alcohol</li> <li>▪ 12 ounces of beer</li> <li>▪ 5 ounces of wine</li> <li>▪ 1.5 ounces of 80-proof spirits</li> </ul>	≥14	≥7
Maximum drinks <i>per occasion</i> (U.S. DHHS, 1995)	May vary depending on age, ethnicity, medical and psychiatric co-morbidity, pregnancy, and other risk factors.	≥5	≥4

Other Hazardous Substance Use:

1. Screen all patients for nicotine usage. Utilize the VHA/DoD Clinical Practice Guideline to Promote Tobacco Use Cessation in the Primary Care Setting.
2. Determination of hazardous use for other drugs (where criteria for abuse or dependence are not met) is not well studied. There are no unequivocal quantity or frequency risk thresholds for hazardous

use of psychoactive drugs. Any use may impair judgment or performance and involves some degree of risk. However, regular use of any intoxicant (e.g., daily or several days per week) suggests at the least a high risk for abuse or dependence. Some drugs, such as cocaine and heroin, are potentially toxic even with occasional use. Individuals using intoxicants such as cannabis, amphetamines, heroin, or cocaine should be cautioned about the health risks associated with such use and urged to discontinue use. For DoD active duty: follow service specific mandates, as a mental health/emergency referral is likely mandated.

3. Long-term use of *prescribed* opioids, anxiolytics, or hypnotics does not in itself constitute hazardous use, abuse, or dependence. However, use of these medications must be carefully considered in each case. Refer to Module S: Stabilization (Annotation F) for a discussion about prescribing opioids for chronic pain. Many of the same considerations are relevant to long-term prescription of anxiolytics and hypnotics. Clear indications of problematic use include frequent early requests for refills, escalating demands for dose increases beyond that justified by the medical condition, attempts to obtain prescriptions from multiple providers, episodes of intoxication, or use of medications with intoxicants such as alcohol or illicit drugs. When in doubt about whether use is hazardous or abusive, consult a specialist in the management of the underlying disorder (e.g., pain, insomnia, or anxiety) or addiction medicine.

## II. Screening for substance abuse or dependence

### Alcohol Abuse or Dependence (Fiellin et al., 2000):

Consider a screen positive for alcohol abuse or dependence, if a patient:

1. Scores eight or more on the Alcohol Use Disorders Identification Test (AUDIT) (see Appendix A-1).
- or*
2. Endorses two or more of the four items reflected in the acronym CAGE (see Appendix A-1):
    - Have you ever felt you should *cut down* on your drinking?
    - Have people *annoyed* you by criticizing your drinking?
    - Have you ever felt bad or *guilty* about your drinking?
    - Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (*eye opener*)?

### Other Substance Abuse or Dependence:

1. Screening for other drug use may be appropriate in some clinical settings (e.g., adolescent or AIDS clinics), but has not been recommended as routine by the U. S. PSTF.
2. The Drug Abuse/Dependence Screener is a 3-item screen with excellent preliminary validity in community populations (see Appendix A-1). It may be useful in primary care settings when the provider identifies an indication for screening.
3. The Two-Item Conjoint Screen (TICS) has been used in primary care to identify patients with current alcohol or other drug problems.
4. The Drug Abuse Screening Test (DAST) is a 28-item (or abbreviated 10-item version) instrument to identify adverse consequences of substance abuse, but it has not been well studied in primary care settings.

### DSM-IV Criteria for Substance Abuse (APA, 1994):

1. A maladaptive pattern of substance abuse leading to clinically significant impairment or distress, as manifested by *one or more* of the following, occurring *within a 12-month period*:
  - Recurrent substance use resulting in failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; or neglect of children or household).
  - Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine).
  - Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct).

- Continued substance use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication or physical fights).
2. These symptoms must never have met the criteria for substance dependence for this class of substance.

Assessment of Substance Dependence:

- a. Conduct clinical assessment to see if the patient meets the DSM-IV diagnostic criteria for Substance Dependence (e.g., see 304.30, 304.20, 304.60, 304.00, 304.90, 304.10, 304.80, or 305.1 in DSM-IV, pages 175-272).
- b. Diagnostic criteria required for Substance Dependence involves more than evidence of physiological dependence.
- c. Consider whether the person is dependent on multiple substances.

DSM-IV Criteria for Substance Dependence (APA, 1994):

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

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

Dependence exists on a continuum of severity: remission requires a period of at least 30 days without meeting full diagnostic criteria and is specified as *Early* (first 12 months) or *Sustained* (beyond 12 months) and *Partial* (some continued criteria met) versus *Full* (no criteria met) (APA, 1994).

### III. Screening for risk of relapse

A relapse is defined as any discrete violation of a self imposed rule or set of rules governing the ability to either stay completely free of drug use or maintain a preset goal of reduced drug usage. Variables that may place an individual at increased risk for relapse include the following:

1. Negative/unpleasant emotional states (e.g., anger, frustration, depression, boredom, or anxiety)
2. Interpersonal conflict
3. Social pressure to engage in drug usage (may be direct or indirect)

4. Negative physical states (e.g., chronic or acute pain or substance withdrawal)
5. Testing personal control over the use of the substance
6. Responsivity to substance cues (e.g., cravings or urges)

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

#### EVIDENCE TABLE

	<b>Recommendations</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Use of labs	Anton et al., 1995	II-2	A
2	Screening of asymptomatic patients	U.S. PSTF, 1996	II-2	D
3	Annual screening of hazardous use	U.S. PSTF, 1996 U.S. DHHS, 1995	III	B
4	Consider volume and use	Hawks, 1994 Room et al., 1995 Hasin et al., 1996 Midanik et al., 1996	II-2	A
5	Use of AUDIT score	Saunders et al., 1993	II-1	A
6	Use of CAGE score	Mayfield et al., 1974	II-2	A
7	Routine screening for other drug abuse or dependence	U.S. PSTF, 1996	III	D
8	Use of Drug Abuse/Dependence Screener	Schorling & Buchsbaum, 1997	III	C
9	Use of TICS score	Brown et al., 1997	II-3	B
10	Use of DAST score	Skinner, 1982	III	C

QE = Quality of Evidence; R = Recommendation (See Introduction)

#### F. Initiate Concurrent Physiological Stabilization, If Required

##### OBJECTIVE

Identify patients in need of further assessment within Module S: Stabilization.

##### ANNOTATION

Indications for stabilization include intoxication or risk of withdrawal:

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

**Table 2. Signs and Symptoms of Intoxication (APA, 1994)**

Types of Intoxication	Signs and Symptoms
Alcohol and Sedative-Hypnotics	<ul style="list-style-type: none"> <li>▪ Slurred speech</li> <li>▪ Incoordination</li> <li>▪ Unsteady gait</li> <li>▪ Nystagmus</li> <li>▪ Impairment in attention or memory</li> <li>▪ Stupor or coma</li> </ul>
Cocaine or Amphetamine	<ul style="list-style-type: none"> <li>▪ Tachycardia or bradycardia</li> <li>▪ Pupillary dilation</li> <li>▪ Elevated or lowered blood pressure</li> <li>▪ Perspiration or chills</li> <li>▪ Nausea or vomiting</li> <li>▪ Psychomotor agitation or retardation</li> <li>▪ Muscular weakness, respiratory depression, or chest pain</li> <li>▪ Confusion, seizures, dyskinesias, dystonias, or coma</li> </ul>
Opiate	<ul style="list-style-type: none"> <li>▪ Pupillary constriction (or dilation due to anoxia from overdose)</li> <li>▪ Drowsiness or coma</li> <li>▪ Slurred speech</li> <li>▪ Impairment in attention or memory</li> <li>▪ Shallow and slow respiration or apnea</li> </ul> <p data-bbox="609 1003 1339 1066"><i>Note: Acute opiate intoxication can present as a medical emergency with unconsciousness, apnea, and pinpoint pupils.</i></p>

**Symptoms of opioid withdrawal**

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

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

- Craving for opioids
- Restlessness or irritability
- Nausea or abdominal cramps
- Increased sensitivity to pain
- Muscle aches
- Dysphoric mood
- Insomnia or anxiety
- Pupillary dilation
- Sweating
- Piloerection (i.e., gooseflesh)
- Tachycardia
- Vomiting or diarrhea
- Increased blood pressure
- Yawning
- Lacrimation

### Symptoms of withdrawal from sedative-hypnotics or alcohol

1. Signs and symptoms of withdrawal from sedative-hypnotics or alcohol include two or more of the following developing within several hours to a few days after cessation or reduction in heavy and prolonged use:
  - Autonomic hyperactivity (e.g., diaphoresis, tachycardia, and elevated blood pressure)
  - Increased hand tremor
  - Insomnia
  - Nausea and vomiting
  - Transient visual, tactile or auditory hallucinations or illusions
  - Delirium tremens (DTs)
  - Psychomotor agitation
  - Anxiety
  - Irritability
  - Grand mal seizures
2. The potential for a withdrawal syndrome can be gauged only imprecisely by asking the patient the pattern, type, and quantity of recent and past substance use.
3. Consider standardized measures to assess the severity of withdrawal symptoms. The Clinical Institute Withdrawal Assessment for Alcohol-Revised (CIWA-Ar) has good reliability and validity for assessing severity of withdrawal symptoms from alcohol (see Appendix A-1).
4. CIWA-Ar has 10 provider ratings. Interpret total scores as follows:
  - Minimal or absent withdrawal:  $\leq 9$
  - Mild to moderate withdrawal: 10-19
  - Severe withdrawal:  $\geq 20$

### DISCUSSION

Recent intake of a substance can be assessed from the history, physical examination (e.g., alcohol on the breath), or toxicological analysis of urine or blood. The specific clinical picture in substance intoxication depends on the substance(s) used, the duration of use at that dose, tolerance, time since last dose, expectations of effects, and the environment or setting of use.

DSM-IV (APA, 1994) criteria for substance intoxication include:

- The development of a reversible substance-specific syndrome due to recent ingestion of (or exposure to) a substance. *Note: Different substances may produce similar or identical syndromes.*
- Clinically significant maladaptive behavioral or psychological changes that are due to the effect of the substance on the central nervous system (e.g., belligerence, mood lability, cognitive impairment, impaired judgment, and impaired social or occupational functioning) can develop during or shortly after use of the substance.
- The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

### EVIDENCE TABLE

	Recommendations	Sources of Evidence	QE	R
1	Consider using standardized assessment of withdrawal symptoms.	Sullivan et al., 1989 Gossop, 1990 Zilm & Sellers, 1978	II-2	A

QE = Quality of Evidence; R = Recommendation (See Introduction)

## **G. Summarize And Educate The Patient About The Problem**

### OBJECTIVE

Present assessment information to the patient in a way that motivates ongoing cooperation with the provider and supports subsequent decisions about referral or brief intervention.

### ANNOTATION

1. Discuss the patient's current use of alcohol and other drugs and address any potential problem areas (e.g., recent initiation of use, increase in use, or relationship to presenting medical concerns).
2. Inform the patient about relevant potential age- and gender-related problems, such as:
  - Abusive drinking or other drug use in the young adult
  - Alcohol and other drug use during pregnancy
  - Medication misuse or heavy drinking in the older adult
3. Convey openness to discuss any future concerns that may arise and encourage the patient to discuss them with you.
4. Emphasize appropriate concern and encourage the patient to address the problem.
5. Motivate the patient to seek additional treatment when indicated.

## **H. Is Specialty Referral Indicated Or Mandated?**

### OBJECTIVE

Determine, along with the patient, the most appropriate treatment approach.

### ANNOTATION

1. When acceptable to the patient, a specialty care rehabilitation plan is generally indicated.
2. Care management is likely to be a more acceptable and effective alternative when one of the following applies:
  - The patient refuses referral to rehabilitation but continues to seek some services, especially medical and/or psychiatric services.
  - The patient has serious co-morbidity that precludes participation in available rehabilitation programs.
  - The patient has been engaged repeatedly in rehabilitation treatment with minimal progress toward optimal or intermediate rehabilitation goals.
3. Regarding DoD active duty patients:
  - Referral to addictions specialty care for assessment is required for all active duty patients involved in an incident involving/suspected to involve substances (see Appendix A-2).
  - Should such patients refuse referral, the commanding officer must be notified so consideration can be given to either (a) order the patient to comply, (b) invoke administrative options (administrative separation from service, etc.), or (c) do nothing. This is the commander's decision, with input from the medical staff.

Review the clinical assessment and note past treatment response, motivational level and patient goals in order to match patient needs and available programming.

**Table 3. Treatment Plan and Expected Outcomes**

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

## DISCUSSION

Substance use disorders often follow a chronic, relapsing course, making individualized treatment more complicated (McLellan et al., 1996; O'Brien & McLellan, 1996). Treatment has not yet been well-conceptualized for many patients who either have responded with minimal improvement to repeated rehabilitative treatments or are unable or unwilling to engage in rehabilitation efforts, but who desire other services. Even when patients are unable and/or unwilling to participate in rehabilitation or show minimal benefit, there are opportunities to address SUDs in other care settings.

Care management approaches for SUDs are similar to management of other severe and persistent disorders for which no cure has been identified, such as bipolar disorder or diabetes mellitus (McLellan et al., 2000). Recent evidence suggests that approaches emphasizing engagement with the patient over long periods of time, case management, and integration of substance abuse treatment interventions with treatment for the coexisting conditions result in reduced substance use and associated complications (Drake & Mueser, 2000; Osher & Drake, 1996; U.S. DHHS, 1994; Willenbring et al., 1995; Willenbring et al., 1999). In the absence of serious co-morbidity or with appropriate specialist consultation, care management can be provided within some addiction treatment clinics.

Even when patients refuse referral or are unable to participate in specialized addiction treatment, many are accepting of general medical or psychiatric care. Clinicians in multiple settings can deliver care management for patients with SUDs. The chronic illness approach is consistent with management approaches for many other disorders treated in medical and psychiatric settings (Drake & Mueser, 2000; McLellan et al., 2000; Willenbring et al., 1999).

EVIDENCE TABLE

	<b>Recommendations</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Referral to specialty care.	Gerstein & Harwood, 1990 Institute of Medicine, 1990	I	A
2	Consider care management for medically ill alcoholics.	Willenbring et al., 1995 Willenbring et al., 1999	I	B
3	Consider care management for combined serious psychiatric disorders and SUDs, where participation in rehabilitation programs is precluded.	Drake & Mueser, 2000 Osher & Drake, 1996 U.S. DHHS, 1994	II-1	B
4	Match patient's motivational level and needs with available programming.	American Society of Addiction Medicine (ASAM), 1996	III	A

QE = Quality of Evidence; R = Recommendation (See Introduction)

**I. Does Patient Agree To Referral Or Is Referral Mandated?**

OBJECTIVE

Promote enhanced patient commitment to change and adherence to the planned treatment regimen.

ANNOTATION

Negotiate and set specific rehabilitation goals with the patient:

1. Establish treatment goals in the context of a negotiation between the treatment provider and the patient.
2. Review with the patient results of previous efforts at self-change and formal treatment experience, including reasons for treatment dropout.
3. Use motivational enhancement techniques, when appropriate.
4. Consider bringing the addiction specialist into your office to assist with referral decisions.
5. Regarding DoD active duty:
  - Referral to addictions specialty care for assessment is required for all active duty patients involved in an incident involving/suspected to involve substances (see Appendix A-2).
  - Should such patients refuse referral, notify the commanding officer so consideration can be given to either (a) order the patient to comply, (b) invoke administrative options (e.g., administrative separation from service), or (c) do nothing. This is the commander's decision, with input from the medical staff.

DISCUSSION

When both parties agree on what is to be accomplished and how this is to be done, the chances of achieving a favorable outcome are enhanced (Putnam et al., 1994; Sanches-Craig & Lei, 1986). Discussing treatment history and expectations can reduce reliance on previously ineffective treatment approaches and increase the likelihood of realistic goals for the current episode of care.

EVIDENCE TABLE

	<b>Recommendations</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Establish treatment goals through negotiation.	Heinssen et al. 1995 Miller, 1995 Miller & Rollnick, 1991 Sanchez-Craig & Lei, 1986 Sobell et al., 1992 Stark, 1992	II-1	A
2	Review prior treatment experience.	Stark, 1992	III	B

QE = Quality of Evidence; R = Recommendation (See Introduction)

**J. Refer To Specialty Care With Attention To Engagement Barriers**

OBJECTIVE

Ensure adequate financial, housing, transportation, and social resources to support access to treatment at the appropriate level of care and provide a supportive recovery environment.

ANNOTATION

Address and remove barriers to treatment. If resources are not present or readily available refer to social work services for assistance.

Accessible transportation, appropriate for individual needs, is necessary for patient participation in treatment and follow-through on plans. Resources to meet basic needs for food, clothing, and personal care should also be allocated. Patient assessment and referral requires a thorough understanding of needs, present resources, preferences, expectations and perceptions, and eligibilities, as well as community resources and regulations.

**K. Provide Brief Intervention**

OBJECTIVE

Promote reduced hazardous use of alcohol and other drugs and prevent future complications or dependence.

ANNOTATION

A brief intervention may be accomplished in the following general sequence:

1. Give feedback about screening results, relating the risks of negative health effects to the patient's presenting health concerns.
2. Inform the patient about safe consumption limits and offer advice about change.
3. Offer to involve family members in this process to educate them and solicit their input (consent is required).
4. Assess patient's degree of readiness for change (e.g., "How willing are you to consider reducing your use at this time?").
5. Negotiate goals and strategies for change.
6. Schedule an initial follow-up appointment in two to four weeks.

7. Monitor changes at follow-up visits by asking patient about use, health effects, and barriers to change.
8. If patient declines referral to specialty evaluation or treatment, continue to encourage reduction or cessation of use and reconsider referral to specialized treatment at subsequent visits.

## DISCUSSION

Multiple randomized clinical trials have demonstrated the efficacy of brief interventions by physicians in primary care settings. Training in brief provider intervention has been demonstrated to increase rates of alcohol counseling in primary care when accompanied by real-time cues for screening and facilitative clinic support services (Adams et al., 1998; Buchsbaum et al., 1993).

## EVIDENCE TABLE

	<b>Recommendations</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Provide feedback for screening results.	Samet et al., 1996 U.S. DHHS, 1995 & 1997	I	A
2	Address consumption limits and advise about change.	Bien et al., 1993 Fleming et al., 1997 Poikolainen, 1999 Wilk et al., 1997	I	A
3	Assess readiness for change.	Adams et al., 1998 Miller & Rollnick, 1991	I	A

*QE = Quality of Evidence; R = Recommendation (See Introduction)*

## L. Follow-Up In Primary Care

### OBJECTIVE

Monitor substance use and encourage reduction or abstinence.

### ANNOTATION

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

1. Look for spontaneous signs of use and ask the patient about their specific use and frequency of that use.
2. When possible, discuss other areas of concern in the patient's life since these constitute collateral assessment and prognostic indicators.
3. Use biological assessments concurrently with the ongoing dialogue including the breathalyzer, urine toxicology, and BAL.
4. Encourage abstinence or reduced use, consistent with the patient's motivation and agreement.

**M. Educate About Substance Use, Associated Problems, And Prevention Of Relapse**

OBJECTIVE

Prevent the development of problematic alcohol or other drug use, abuse, and dependence (primary prevention) or resumption of problems following a period of remission.

ANNOTATION

1. Discuss the patient’s current use of alcohol and other drugs and address any potential problem areas, such as recent initiation of use, increase in use, and use to cope with stress.
2. Inform patient about potential age- and gender-related problems, such as:
  - Abusive drinking or other drug use in the young adult
  - Alcohol and other drug use during pregnancy
  - Medication misuse or heavy drinking in the older adult
3. Convey openness to discuss any future concerns that may arise and encourage the patient to discuss them with you.
4. Periodically inquire about alcohol and drug use at future visits.

EVIDENCE TABLE

	<b>Recommendations</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Future monitoring of substance use.	Bradley et al., 1993 U.S. DHHS, 1995	III	B

*QE = Quality of Evidence; R = Recommendation (See Introduction)*

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VHA/DoD CLINICAL PRACTICE GUIDELINE FOR THE  
MANAGEMENT OF **SUBSTANCE USE DISORDERS**  
IN THE PRIMARY CARE SETTING

**MODULE A:  
APPENDICES**

Version 1.0

**APPENDIX A-1**

**SUBSTANCE USE DISORDERS SCREENING INSTRUMENTS**

### ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT)

Please circle the answer that is correct for you.

1. How often do you have a drink containing alcohol?

Never	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week
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2. How many drinks containing alcohol do you have on a typical day when you are drinking?

1 or 2	3 or 4	5 or 6	7 to 9	10 or more
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3. How often do you have six or more drinks on one occasion?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
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4. How often during the last year have you found that you were not able to stop drinking once you had started?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
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5. How often during the last year have you failed to do what was normally expected from you because of drinking?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
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6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
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7. How often during the last year have you had a feeling of guilt or remorse after drinking?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
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8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
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9. Have you or someone else been injured as a result of your drinking?

No		Yes, but not in the last year		Yes, during the last year
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**ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT) (continued)**

10. Has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

No	Yes, but not in the last year	Yes, during the last year
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**Procedure for Scoring AUDIT**

NOTE: The audit can be administered by interview or self-report.

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

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

*The minimum score (for non-drinkers) is 0 and the maximum possible score is 40.*

*A score of 8 or more indicates a strong likelihood of hazardous or harmful alcohol consumption.*

**REFERENCE**

Saunders, J. B., Aasland, O. G., Babor, F., et al. (1993). Development of the alcohol use disorders screening test (AUDIT). WHO collaborative project on early detection of persons with harmful alcohol consumption, II. *Addiction*, 88, 791-804.

## CAGE Questionnaire

	YES	NO
Have you ever felt you should <u>cut</u> down on your drinking?	<input type="checkbox"/>	<input type="checkbox"/>
	1	0
Have people <u>annoyed</u> you by criticizing your drinking?	<input type="checkbox"/>	<input type="checkbox"/>
	1	0
Have you ever felt bad or <u>guilty</u> about your drinking?	<input type="checkbox"/>	<input type="checkbox"/>
	1	0
Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover ( <u>eye opener</u> )?	<input type="checkbox"/>	<input type="checkbox"/>
	1	0

---

### SCORING

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

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### REFERENCE

Mayfield, D., McLeod, G. & Hall, P. (1974). The CAGE questionnaire: validation of a new alcoholism instrument. American Journal of Psychiatry, 131, 1121-1123.

## CAGE Questionnaire

The CAGE is a very brief, relatively nonconfrontational questionnaire for detection of alcoholism, usually directed “have you ever” but may be focused to delineate past or present.

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<b>Target Population</b>	Adults  Adolescents (over 16 years)  Usually used in a general medical population being examined in a primary care setting.
<b>Administrative Issues</b>	4 items  Pencil and paper or computer self-administered or interview  Time required: less than 1 minute  Administered by professional or technician  No training required for administration; it is easy to learn, easy to remember, and easy to replicate.
<b>Scoring</b>	Time required: instantaneous  Scored by tester  No computerized scoring or interpretation available  Norms are available
<b>Psychometrics</b>	Reliability studies done: Internal consistency  Measures of validity derived: Criterion (predictive, concurrent, “postdictive”)
<b>Clinical Utility of Instrument</b>	Very useful bedside, clinical desk instrument. Has become the favorite of family practice and general internists—also very popular in nursing.

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### Drug Abuse/Dependence Screener

Here is a list of drugs:

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

1. **Have you ever used one of these drugs on your own more than 5 times in your life? By "on your own", I mean to get high or without a prescription or more than was prescribed.**

Yes = 1; No = 0 (skip questions 2 and 3)

2. **Did you ever find you needed larger amounts of these drugs to get an effect or that you could no longer get high on the amount you used to use?**

Yes = 1; No = 0

3. **Did you ever have emotional or psychological problems from using drugs - such as feeling crazy or paranoid or depressed or uninterested in things?**

Yes = 1; No = 0

---

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

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#### REFERENCE

- Rost, K., Burnam, A., & Smith, G. R. (1993). Development of screeners for depressive disorders and substance disorder history. Medical Care, 31, 189-200.
- Schorling, J. B., & Buchsbaum, D. G. (1997). Screening for alcohol and drug abuse. Medical Clinics of North America, 81, 845-65.

<b>Addiction Research Foundation Clinical Institute Withdrawal Assessment Alcohol (CIWA-Ar)</b> The scale is not copyrighted and may be used freely.	
<b>Patient:</b>	<b>Date:</b> ___/___/___ y    m    d
	<b>Time:</b> _____ (24 hour clock, midnight + 0:00)
<b>Pulse or heart rate, taken for one minute:</b>	<b>Blood Pressure:</b> _____/_____
<p><b>NAUSEA AND VOMITING</b> — Ask “Do you feel sick to your stomach? Have you vomited? Observation.</p> <p>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</p>	<p><b>TACTILE DISTURBANCES</b> — 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.</p> <p>0 none 1 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</p>
<p><b>TREMOR</b> — Arms extended and fingers spread apart. Observation.</p> <p>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</p>	<p><b>AUDITORY DISTURBANCES</b> — 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.</p> <p>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</p>
<p><b>PAROXYSMAL SWEATS</b> — Observation.</p> <p>0 no sweat visible 1 barely perceptible sweating, palms moist 2 3 4 beads of sweat obvious on forehead 5 6 7 drenching sweats</p>	<p><b>VISUAL DISTURBANCES</b> — Ask “Does the light appear to be too bright? Is the 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.</p> <p>0 not present 1 very mild sensitivity 2 mild sensitivity 3 moderate sensitivity 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations</p>
<p><b>ANXIETY</b> — Ask “Do you feel nervous?” Observation.</p> <p>1 mildly anxious 2 3 4 moderately anxious, or guarded, so anxiety is inferred 5 6 7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions.</p>	<p><b>HEADACHE, FULLNESS IN HEAD</b> — Ask “Does your head feel different? Does it feel like there is a band around your head?” Do not rate for dizziness or lightheadedness. Otherwise, rate severity.</p> <p>0 not present 1 very mild 2 mild 3 moderate 4 moderately severe 5 severe 6 very severe 7 extremely severe</p>

**Addiction Research Foundation Clinical Institute Withdrawal  
 Assessment Alcohol (CIWA-Ar) (continued)**

<p><b>AGITATION</b> — Observation.</p> <p>0 normal activity</p> <p>1 somewhat more than normal activity</p> <p>2</p> <p>3</p> <p>4 moderately fidgety and restless</p> <p>5</p> <p>6</p> <p>7 paces back and forth during most of the interview, or constantly thrashes about.</p>	<p><b>ORIENTATION AND CLOUDING OF SENSORIUM</b> — Ask “What day is this? Where are you? Who am I?”</p> <p>0 oriented and can do serial additions</p> <p>1 cannot do serial additions or is uncertain about date</p> <p>2 disoriented for date by no more than 2 calendar days</p> <p>3 disoriented for date by more than 2 calendar days</p> <p>4 disoriented for place and/or person</p> <p>Total CIWA-A Score _____</p> <p>Rater’s Initials _____</p> <p>Maximum Possible Score 67</p>
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REFERENCE

Sullivan, J. T., Sykora, K., Schneiderman, J., et al. (1989). Assessment of alcohol withdrawal: the revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-AR). British Journal of Addiction, 84, 1353-1357.

**APPENDIX A-2**

**Department Of Defense Instruction (DODI 1010.6)**

**Rehabilitation and Referral Services for Alcohol and Drug Abusers**

**Executive Summary**

### **Action Plan Item C.3:**

Assess service programs for early intervention and/or rehabilitation for all personnel involved in an alcohol incident.

All services have existing policies in place regarding assessment and intervention for any service member who has an alcohol-related incident (as defined by each service).

#### **1. US Army: AR 600-85**

The critical functions of the US Army's Substance Abuse and Prevention (ASAP) program are the identification, referral and screening, and rehabilitation of members who abuse substances. Commanders may use one of five methods to identify potential substance abusers: voluntary (self) identification, command identification, biochemical identification, medical identification, or investigation or apprehension. Any member with an alcohol-related incident is referred to the ASAP Program for an evaluation. Treatment is provided according to severity. Identification of an abuser who cannot be rehabilitated or involvement in serious alcohol related misconduct would be referred to their command for separation.

#### **2. US Navy: OPNAVINST 5250.4C**

Navy policy emphasizes responsible alcohol use. Members with an alcohol incident are referred by the command for an evaluation by a provider in the medical facility. Individuals may also self-refer for medical screening or treatment without disciplinary action. ALCOHOL-IMPACT is an educational program offered to individuals following an alcohol-related incident if it is determined that they do not require more intensive treatment. Treatment is provided to members based on the severity of their condition and after care programs are initiated upon return to the command. Members whose alcohol related misconduct is severe or members who are repeat offenders and those determined to be unresponsive to treatment are processed for administrative separation. Members who incur an alcohol incident subsequent to receiving treatment that resulted from a prior incident are also processed for administrative separation. However, waivers to separation provisions may be requested by the command.

Note: Alcohol incident defined as: an offense punishable under the UCMJ or civilian authority committed by a member where, in the judgment of the Commanding Officer, the consumption of alcohol was the primary contributing factor.

#### **3. US Marine Corps: MCO P1700.24B Appendix L Substance Abuse Treatment Services**

The USMC is required to identify, counsel, or rehabilitate those identified as alcohol/drug abusers or alcohol/drug dependent. The Substance Abuse Counseling Center (SACC) provides screening, early intervention, comprehensive biopsychosocial assessments, and individualized treatment (except for drug dependence). All Marines referred to SACC will be screened and accordingly provided either the Early Intervention Program (minimum of three hours of education instruction) or a more formal assessment which leads to an Individualized Treatment Plan (may include outpatient services, intensive outpatient services, or inpatient services as well as 12 months of an aftercare program). Marines who are referred to a program for rehabilitation for personal alcohol abuse may be separated from service for failure of or refusal to participate in treatment.

#### **4. US Air Force: AFI 44-121**

Members are referred to Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program for evaluation whenever substance use is suspected to be a contributing factor in any incident, e.g., DUI, public intoxication, drunk and disorderly, family maltreatment/neglect, under-age drinking, medical treatment, positive drug test, inappropriate behavior or substandard performance. Members can also self-refer for an evaluation. If member is not diagnosed with alcohol abuse or dependence, a minimum of 6 hours of

awareness education is provided. If a diagnosis is warranted, a treatment plan is established with the member, based on the severity of the condition, and an after care program is begun following completion of treatment. Treatment is provided in the least restrictive environment possible, according to severity. Members determined to be unresponsive to treatment will be processed for administrative separation.

#### REFERENCE

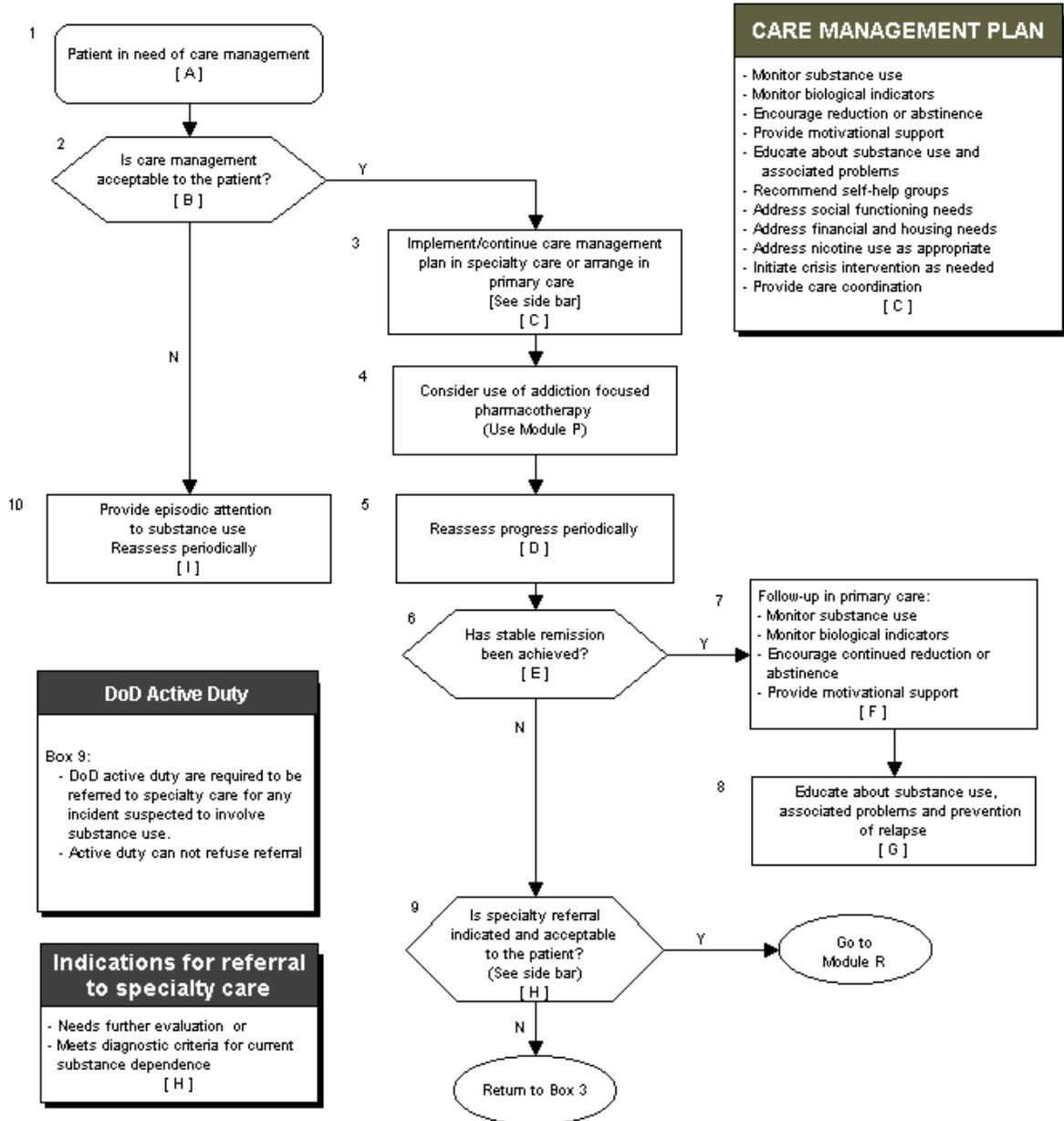
A complete copy of DoDI 1010.6 is available on the following Web site: <http://www.tricare.osd.mil>.

VHA/DoD CLINICAL PRACTICE GUIDELINE FOR THE  
MANAGEMENT OF **SUBSTANCE USE DISORDERS**  
IN THE PRIMARY CARE SETTING

**MODULE C:**  
**CARE MANAGEMENT**

Version 1.0

**MANAGEMENT OF SUBSTANCE USE DISORDERS**  
**Module C: Care Management**



## ANNOTATIONS

### A. Patient In Need Of Care Management

Patients with hazardous substance use/abuse, dependence, or risk of relapse who may benefit from a care management plan.

### B. Is Care Management Acceptable To The Patient?

#### OBJECTIVE

Identify and engage patients with substance use disorders (SUDs) who can benefit from implementation of a care management plan.

#### ANNOTATION

The provider should distinguish the patient's refusal of all ongoing care from unwillingness to engage in specialized treatment for SUDs. Some patients refuse to engage in any type of ongoing care with any provider (e.g., medical, psychiatric, or addiction).

#### DISCUSSION

Patients appropriate for care management may have a range of medical and psychiatric co-morbid conditions that require integrated care, with concurrent attention to their substance dependence or abuse. These patients may require substantial emergency care and stabilization and may repeatedly present in crisis, but are unwilling to return for outpatient visits or engage in alcohol and/or drug treatment. Patients who are willing to engage in ongoing medical or psychiatric care have not refused all help. Such patients may also receive integrated care management from addiction treatment providers in some settings (e.g., Opioid Agonist Therapy [OAT], dual disorders programs, or programs for chronic SUDs) (Willenbring et al., 1995).

#### EVIDENCE TABLE

	<b>Recommendations</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Identify the patient's willingness to engage in ongoing care.	Willenbring et al., 1995	III	B

QE = Quality of Evidence; R = Recommendation (See Introduction)

### C. Implement/Continue Care Management Plan In Specialty Care Or Arrange In Primary Care

#### OBJECTIVE

Begin care management in the setting most conducive to treatment engagement and management of co-morbid conditions.

#### ANNOTATION

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

care management will lead to remission of the SUD or referral for specialty care rehabilitation, while in others it serves a more palliative function.

### Care management components

1. Monitor and record *specific* substance use at each contact by patient report (e.g., drinking days during the past month, days of any substance use during the past month, and typical and maximum number of drinks per occasion).
2. Monitor biological indicators (e.g., transaminase levels and urine toxicology screens).
3. Encourage abstinence or reduced substance use.
4. Enhance motivation to change using non-confrontational motivational interviewing techniques.
5. Educate about substance use and associated problems.
6. Recommend self-help groups.
7. Address or refer for social functioning needs.
8. Address or refer for financial and housing needs.
9. Address nicotine use as appropriate.
10. Initiate crisis intervention as needed.
11. Provide care coordination.

### Encourage regular visits with medical or behavioral health care provider

1. Encourage patients to return for medical or psychiatric visits even if they will not accept specialty care for SUDs.
2. Encourage reduction or cessation of use at each subsequent visit and support motivation to change.
3. Address substance use as a health care issue in all health care settings:
  - Obtain and record *specific* usage patterns at each visit (e.g., drinking days during the past month, days of any substance use during the past month, and typical number of drinks per occasion).
  - Clarify the link between presenting medical and psychiatric conditions and substance use, with feedback about physical findings and lab results (e.g., blood pressure and GGT).
  - Use a non-confrontational, health education approach to enhance the patient's motivation for change.

## DISCUSSION

The care management approach to alcohol use disorders has been shown to improve outcome in two randomized controlled trials. One trial (Kristensen et al., 1983) involved middle-aged male heavy drinkers, some of whom were alcohol dependent, with elevated GGT activity. Patients were randomized to either usual medical care or monthly visits with a nurse combined with feedback about GGT levels and advice to reduce or stop drinking. Patients receiving the intervention had substantially lower rates of hospital use, morbidity, and mortality over the two to five year follow-up period.

In a quasi-experimental comparison, severely medically ill heavy drinkers were willing to engage in an integrated brief alcohol intervention through a clinic offering medical care (Willenbring et al., 1995). Patients in the integrated clinical approach had a lower two-year mortality rate. In a subsequent randomized controlled trial, integrated clinic patients had a 75% abstinence rate after two years, compared to 50% in subjects receiving routine medical care and a referral to alcohol treatment (Willenbring et al., 1999). Integrated clinic patients also had a lower two-year mortality rate, although this finding was confounded by an age difference between groups.

On a pragmatic basis, little is to be lost by systematically addressing alcohol use in the course of medical care and these studies strongly suggest that doing so can improve outcomes. Clinical consensus increasingly favors integrating psychiatric and addiction treatment for patients with concurrent disorders, with limited empirical support for greater efficacy compared to separate treatments (Drake & Mueser, 2000; U.S. DHHS, 1994). Even for patients who are not currently engaged in formal treatment for their substance-related problems, much can be accomplished in a psychiatric or general medical setting, especially when it comes to enhancing the patient's willingness to address his or her substance-related

problems (Bien et al., 1993; Drake & Mueser, 2000; U. S. DHHS, 1994; Ziedonis & Brady, 1997). Although less well documented than similar approaches for medical patients, it is likely that this approach will work with psychiatric patients as well. On a pragmatic basis, it is better than simply ignoring substance use among seriously ill patients. For patients with major depressive disorders (MDD) or psychotic disorders, please refer to the sections in the VHA/DoD Clinical Practice Guideline for the Management of MDD in Adults and the VHA Clinical Practice Guideline For the Management of Persons with Psychoses. For a more specific module for management of psychiatric co-morbidity, refer to the VHA Clinical Practice Guideline For the Management of Persons with Psychoses.

While developing a care management plan, it is essential to recognize that this patient does not see abstinence as his or her immediate goal. The provider cannot expect the patient to meet goals the therapist would like to see accomplished, but that the patient sees as out of reach or undesirable at this time. The primary purpose is to engage the patient in the broader health care process and devise a plan that meets the patient's immediate goals. The plan must also spell out the treatment team's long-term expectation and use of appropriate services. This approach may result in reduction in substance use and associated problems, or it may result in a willingness to accept a referral to rehabilitation. In many respects, care management is similar to the approach used for most other chronic illnesses, such as diabetes mellitus, hypertension, or cancer. In fact, compliance with SUD treatment recommendations is generally comparable to that for many other chronic illnesses (McLellan et al., 1996).

EVIDENCE TABLE

	<b>Recommendations</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Apply care management approach and address substance use in all health care settings.	Kristensen et al., 1983 Willenbring et al., 1999	I	A

QE = Quality of Evidence; R = Recommendation (See Introduction)

**D. Reassess Progress Periodically**

OBJECTIVE

Provide opportunity to improve treatment effectiveness.

ANNOTATION

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

**E. Has Stable Remission Been Achieved?**

OBJECTIVE

Assess response to care management plan and appropriateness of other follow-up options.

ANNOTATION

**Assess progress toward current goals.**

Remission requires a period of at least 30 days without meeting full diagnostic criteria and is specified as *Early* (first 12 months) or *Sustained* (beyond 12 months) and *Partial* (some continued criteria met) versus *Full* (no criteria met) (APA, 1994).

**Consider follow-up with primary care provider if stable remission is achieved.**

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

**F. Follow-Up In Primary Care**

**OBJECTIVE**

Monitor substance use and encourage reduction or abstinence.

**ANNOTATION**

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

1. Look for spontaneous signs of use and ask the patient about their specific use and frequency of that use.
2. When possible, discuss other areas of concern in the patient’s life since these constitute collateral assessment and prognostic indicators.
3. Use biological assessments including the breathalyzer, urine toxicology, and BAL concurrently with the ongoing dialogue .
4. Encourage abstinence or reduced use consistent with the patient’s motivation and agreement.

**G. Educate About Substance Use, Associated Problems, And Prevention Of Relapse**

**OBJECTIVE**

Prevent the development of problematic alcohol or other drug use, abuse, and dependence (primary prevention) or resumption of problems following a period of remission.

**ANNOTATION**

1. Discuss the patient’s current use of alcohol and other drugs and address any potential problem areas, such as recent initiation of use, increase in use, and use to cope with stress.
2. Inform the patient about potential age- and gender-related problems, such as:
  - Abusive drinking or other drug use in the young adult
  - Alcohol and other drug use during pregnancy
  - Medication misuse or heavy drinking in the older adult
3. Convey openness to discuss any future concerns that may arise and encourage the patient to discuss them with you.
4. Periodically inquire about alcohol and drug use at future visits.

**EVIDENCE TABLE**

	<b>Recommendations</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Future monitoring of substance use.	Bradley et al., 1993 U. S. DHHS, 1995	III	B

QE = Quality of Evidence; R = Recommendation (See Introduction)

**H. Is Specialty Referral Indicated And Acceptable To The Patient?**

OBJECTIVE

Promote enhanced patient commitment to change and adherence to the planned treatment regimen.

ANNOTATION

Negotiate and set specific rehabilitation goals with the patient:

1. Establish treatment goals in the context of a negotiation between the treatment provider and the patient.
2. Review with the patient results of previous efforts at self-change and formal treatment experience, including reasons for treatment dropout.
3. Use motivational enhancement techniques when appropriate.
4. Consider bringing the addiction specialist into your office to assist with referral decision.
5. Regarding DoD active duty:
  - Referral to addictions specialty care for assessment is required for all active duty patients involved in an incident involving/suspected to involve substances (see Module A, Appendix A-2).
  - Should such patients refuse referral, notify the commanding officer so consideration can be given to either (a) order the patient to comply, (b) invoke administrative options (e.g., administrative separation from service), or (c) do nothing. This is the commander's decision, with input from the medical staff.

DISCUSSION

When both parties agree on what is to be accomplished and how this is to be done, the chances of achieving a favorable outcome are enhanced (Putnam et al., 1994; Sanches-Craig & Lei, 1986). Discussing treatment history and expectations can reduce reliance on previously ineffective treatment approaches and increase the likelihood of realistic goals for the current episode of care.

EVIDENCE TABLE

	<b>Recommendations</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Establish treatment goals through negotiation.	Heinssen et al., 1995 Miller, 1995 Miller & Rollnick, 1991 Sanchez-Craig & Lei, 1986 Sobell et al., 1992 Stark, 1992	II-1	A
2	Review prior treatment experience.	Stark, 1992	III	B

QE = Quality of Evidence; R = Recommendation (See Introduction)

**I. Provide Episodic Attention To Substance Use; Reassess Periodically**

OBJECTIVE

Encourage the patient to engage in ongoing care while addressing urgent concerns.

## ANNOTATION

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

Episodic attention to substance use may be accomplished by the following:

1. Provide crisis intervention, as needed.
2. At any contact initiated by the patient:
  - Assess current substance use.
  - Recommend that the patient accept ongoing care in the most appropriate setting.
3. Designate a single provider to coordinate care for patients who repeatedly present in crisis.
4. Consider involving supportive family members or significant others, if the patient agrees.
5. Initiate involuntary treatment procedures, if imminent threat to safety occurs (e.g., suicidal, violent, or unable to care for self).

## DISCUSSION

The approach to episodic care can be individualized and cover the areas that are of concern for that patient. All patients will require education and counseling on:

1. How to decrease the use or alter the route of administration in order to slow the progression of medical illness and decrease the risk to the public health.
2. Maximizing their present health and decreasing their own, and if appropriate, family members' suffering. For example, a patient who routinely comes to the emergency room for gastritis after a bout of drinking may require education on the issue of alcohol irritating the stomach and the eventual development of gastrointestinal (GI) bleeding and ulceration. In addition, an emergency treatment plan may need to be developed so that the patient is not admitted every time he or she comes to the emergency room (ER) with exacerbation of gastritis.
3. Understanding the issues of alcohol and family violence. The family should be furnished with an appropriate referral, if safety is an issue.
4. Brief motivational counseling to encourage the patient to accept more addiction-focused treatment in a specialized substance abuse treatment program, if necessary.

This is a pragmatic approach that delineates the management of a group of patients who present serious challenges to clinicians and agencies. The goals are to decrease morbidity, mortality, and inappropriate use of intensive services, while motivating the patient to accept addiction treatment or—at least—regular medical or psychiatric care. Although currently untested in rigorous studies, it is likely to be an improvement over a less systematic approach, with little if any added risk or expense.

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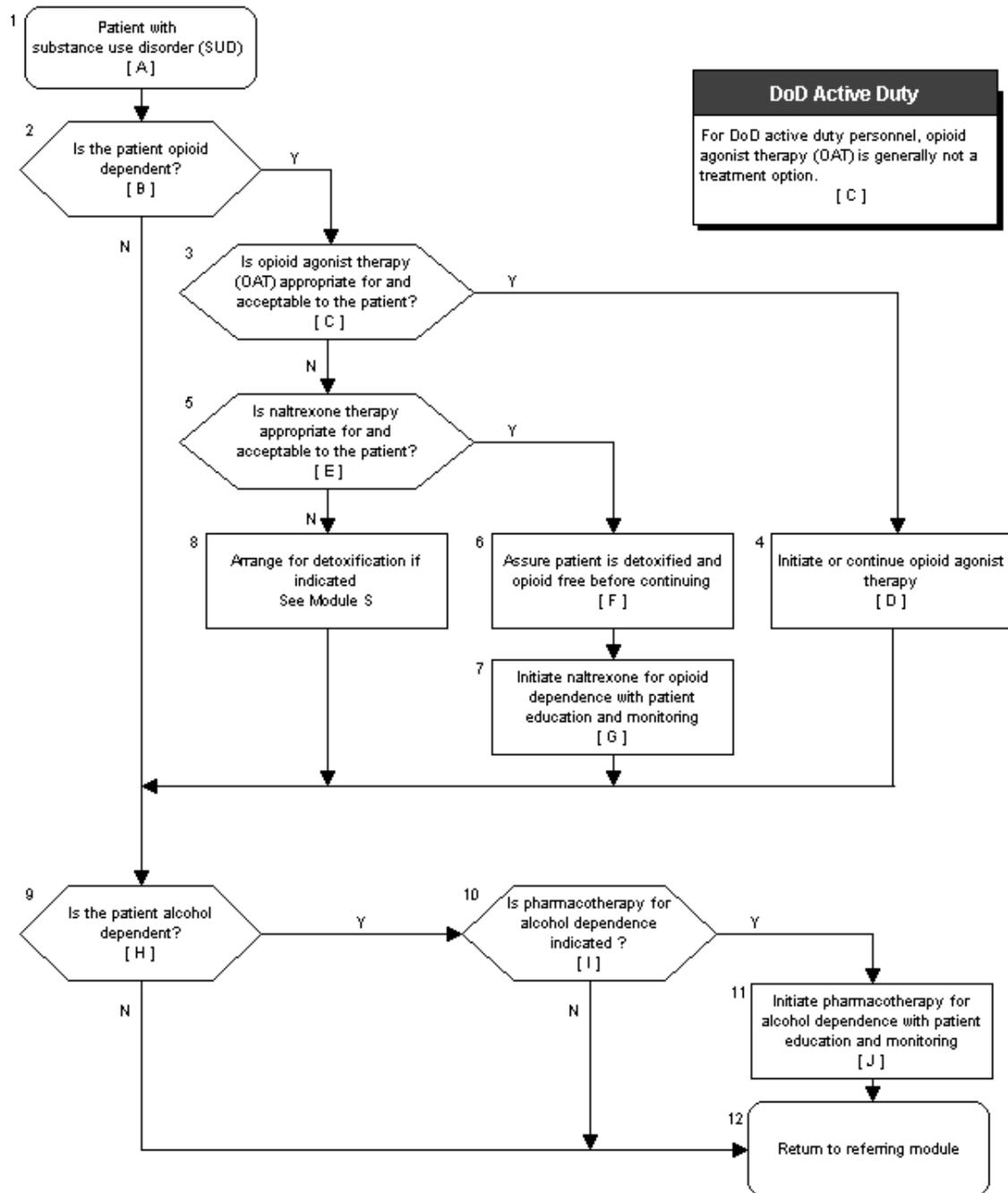
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VHA/DoD CLINICAL PRACTICE GUIDELINE FOR THE  
MANAGEMENT OF **SUBSTANCE USE DISORDERS**  
IN THE PRIMARY CARE SETTING

**MODULE P:**  
**ADDICTION-FOCUSED PHARMACOTHERAPY**

Version 1.0

**MANAGEMENT OF SUBSTANCE USE DISORDERS**  
**Module P: Addiction-Focused Pharmacotherapy**



## ANNOTATIONS

### A. Patient With Substance Use Disorder (SUD)

Patients managed within this module meet the criteria for substance abuse or dependence and are considered for addiction-focused pharmacotherapy.

### B. Is The Patient Opioid Dependent?

#### OBJECTIVE

Establish the patient's dependence on opioids.

#### ANNOTATION

See Module A: Assessment and Management in Primary Care, Annotation E.

### C. Is Opioid Agonist Therapy (OAT) Appropriate For And Acceptable To The Patient?

#### OBJECTIVE

Assure careful consideration of OAT as the first line treatment for opioid dependence. For DoD active duty, OAT is generally not a treatment option.

#### ANNOTATION

Opioid dependence is a cluster of cognitive, behavioral, and physiological symptoms characterized by repeated self-administration and usually results in opiate tolerance, withdrawal symptoms, and compulsive drug taking, despite negative consequences. While new federal regulatory language uses the term “opiate addiction,” the diagnostic term opioid dependence will be used here for consistency with the rest of the guideline. Dependence may occur with or without the physiological symptoms of tolerance and withdrawal. OAT for opioid dependence consists of administering an opioid agonist medication, such as methadone or levo-alpha-acetylmethadol (LAAM), in combination with a comprehensive range of medical, counseling, and rehabilitative services. By administering an opioid to prevent withdrawal, reduce craving, and reduce the effects of illicit opioids, the opioid dependent patient is able to focus more readily on recovery activities. When compared to detoxification attempts, OAT is more successful in achieving the long-term goal of reducing opioid use and the associated negative medical, legal, and social consequences.

Provide access to OAT for all opioid dependent patients, under appropriate medical supervision and with concurrent addiction-focused psychosocial treatment (See Module R: Assessment and Management in Specialty Care).

1. Consider methadone maintenance for its documented efficacy in reducing illicit opioid use, human immunodeficiency virus (HIV) risk behavior, and drug-related criminal behavior.
2. Consider LAAM, a long-acting, synthetic mu-agonist, a safe and effective alternative to methadone maintenance.
3. Consider the acceptability and feasibility of regular clinic attendance. Under Federal regulations of OAT programs, for the first 90 days of treatment the patient should attend clinic at least six days per week for methadone or three times per week for LAAM.
4. Refer to Table 1 for indications, contraindications, side effects, and drug interactions of methadone and LAAM.

**Table 1. Agonist Therapy for Opioid Dependence**

	<b>Opioid Agonists: Methadone and LAAM</b>
Indications	<ul style="list-style-type: none"> <li>▪ Opioid dependence <math>\geq</math> 1 year</li> <li>▪ 2 or more unsuccessful opioid detoxification episodes within a 12-month period</li> <li>▪ Relapse to opioid dependence within 2 years from OAT discharge</li> </ul>
Contraindications	<ul style="list-style-type: none"> <li>▪ Allergy to agent</li> <li>▪ Concurrent enrollment in another OAT</li> <li>▪ Significant liver failure</li> <li>▪ Use of opioid antagonists (e.g., naloxone, nalmefene, or naltrexone)</li> </ul>
Side Effects	<ul style="list-style-type: none"> <li>▪ Common: constipation</li> <li>▪ Less common: sexual dysfunction</li> </ul>
Drug Interactions	<ul style="list-style-type: none"> <li>▪ Drugs that reduce serum methadone level: phenytoin, carbamazepine, rifampin, barbiturate sedative-hypnotics, anti-virals involving CYP3A4 activity (including interferon and HIV protease inhibitors), ascorbic acid, and chronic ethanol use</li> <li>▪ Drugs that increase serum methadone level: cimetidine, ketoconazole, fluconazole, amitriptyline, diazepam, and fluvoxamine maleate</li> </ul>

## DISCUSSION

OAT is inaccurately considered by some providers to be a treatment of last recourse; however, evidence consistently shows that patients have better outcomes when maintained with an agonist than a placebo (Newman and Whitehall, 1979; Strain et al., 1993a; Strain et al., 1993b) or than when provided long-term detoxification (Sees et al., 2000). Discharge from OAT programs is generally followed by relapse and other adverse outcomes (Gerstein et al., 1994). Unless there are legal or other extenuating circumstances (such as active duty in DoD), OAT should be considered for any patient with a diagnosis of opioid dependence. For patients who previously relapsed, re-treatment should be a consideration. As part of the decision process, it is important to determine if appropriate agonist dosing was utilized and whether there were psychosocial barriers that could be better addressed upon re-attempting OAT.

Effective May 2001, the Substance Abuse and Mental Health Services Administration (SAMHSA), through its Center for Substance Abuse Treatment (CSAT), will regulate OAT programs as codified in 42 CFR Part 8 “Opioid Drugs in Maintenance and Detoxification of Opiate Addiction” ([http://www.samhsa.gov/news/click5\\_frame.html](http://www.samhsa.gov/news/click5_frame.html)). The new criteria for admission to OAT programs require that patients have been dependent on an opioid drug for at least 1 year prior to admission and that they provide voluntary informed consent to maintenance treatment. If considered clinically appropriate, the regulations provide exceptions to the requirement of a 1 year history of addiction for patients released from penal institutions within the prior 6 months, for pregnant patients, and for patients discharged from maintenance treatment within the prior 2 years.

The OAT program can provide short- or long-term detoxification and other services to patients not eligible for maintenance treatment; however, patients with 2 or more unsuccessful detoxification episodes within a 12-month period must be assessed by the OAT physician for other forms of treatment, as alternatives to detoxification.

The Drug Addiction Treatment Act of 2000 makes opioids available to the office practitioner, in Drug Enforcement Administration (DEA) Schedules III, IV, and V, with a Food and Drug Administration (FDA)-approved indication for the treatment of opioid dependence. At the time this guideline is written, no medications are approved for such use other than methadone and LAAM, both of which are DEA Schedule

II medications. However, it is anticipated that the FDA will approve in 2001 a partial mu-agonist, buprenorphine, for the treatment of opioid dependence; it is further anticipated that buprenorphine and/or a combination of buprenorphine/naloxone will fall within the guidelines of the Drug Addiction Treatment Act of 2000. Clinical practice guidelines and educational materials on the use of buprenorphine and buprenorphine/naloxone for the treatment of opioid dependence in office-based practice are being developed. More information is available at <http://www.samhsa.gov>.

EVIDENCE TABLE

	<b>Recommendations</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Consider OAT the first-line treatment for opioid dependence.	National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction, 1998 Sees et al., 2000	I	A
2	Methadone maintenance at adequate doses is efficacious in reducing opioid use.	Strain et al., 1993a Strain et al., 1993b Marsch, 1998 Johnson et al., 2000	I	A
3	LAAM maintenance at adequate doses is an effective alternative to methadone maintenance.	Eissenberg et al., 1997 Glanz et al., 1997	I	A

QE = Quality of Evidence; R = Recommendation (See Introduction)

**D. Initiate Or Continue Opioid Agonist Therapy (OAT)**

OBJECTIVE

Provide appropriate dosing and relapse monitoring to promote effective outcomes.

ANNOTATION

**Methadone**

For newly admitted patients, the initial dose of methadone should not exceed 30 mg and the total dose for the first day should not exceed 40 mg, without provider documentation that 40 mg did not suppress opioid withdrawal symptoms.

Under usual practices, a stable, target dose is greater than 60 mg/day and most patients will require considerably higher doses in order to achieve a pharmacological blockade of reinforcing effects of exogenously administered opioids. Effective May 2001, Federal regulations no longer require the OAT program physician to justify in the patient record doses > 100 mg/day.

**LAAM**

For newly admitted patients, the initial 48-hour dose of LAAM should not exceed 40 mg. After dose induction, a stable target dose is usually at least 50/50/70 mg administered on Monday/Wednesday/Friday and most patients will require considerably higher doses in order to achieve a pharmacological blockade of reinforcing effects of exogenously administered opioids. Friday doses are increased 40% to compensate for the 72-hour inter-dose interval. For patients on established doses of methadone, the relative potency of 48-hour LAAM doses is 1.2-1.3 times the daily methadone dose.

## Opioid Agonist Therapy

Providers should adjust opioid agonist doses to maintain a therapeutic range between signs/symptoms of overmedication (e.g., somnolence, miosis, itching, hypotension, and flushing) and opioid withdrawal (e.g., drug craving, anxiety, dysphoria, and irritability).

Deliver OAT in the context of a complete treatment program that includes counseling or psychotherapy (See Module R: Assessment and Management in Specialty Care).

- Methadone, combined with weekly counseling for at least four weeks after admission, followed by at least monthly counseling, has been shown to be more effective than methadone alone.
- Availability of more frequent counseling is associated with less illicit drug use.
- No specific form of psychosocial intervention has consistently been shown to be more or less efficacious.
- Programs with high-quality social services show better treatment retention.
- Programs must provide adequate urine toxicology for drugs of abuse, including a minimum of eight random tests per year, per patient.

## DISCUSSION

Effective May 2001, OAT programs must obtain accreditation from an accreditation body that has been approved by the Substance Abuse and Mental Health Services Administration (SAMHSA) (e.g., the Joint Commission of Accreditation on Healthcare Organizations [JCAHO] or the Commission on Accreditation of Rehabilitation Facilities [CARF]) or a state accreditation body, in order to be federally certified to dispense medications and provide treatment services.

To comply with Federal regulations to prevent diversion of opioid medication from legitimate treatment use (42 CFR 8), individual OAT programs have developed a variety of internal procedures with which the patient and provider must comply (e.g., random urine toxicology, policies for “take home” doses, and “call backs” to verify appropriate use of “take home” doses). Although each OAT program’s internal structure and guidelines vary, it would be prudent for the primary physician and/or other health care providers to discuss program rules and expectations with the OAT program physician so that patient care is appropriately coordinated.

OAT programs must provide full and reasonable access to adequate medical, counseling, vocational, educational, and other assessment and treatment services, either at the primary facility or through a documented agreement with other providers.

## EVIDENCE TABLE

	<b>Recommendations</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Methadone target dose is typically > 60 mg/day.	Strain et al., 1999 Preston et al., 2000	I	A
2	Methadone combined with regular counseling is more effective than methadone alone.	McLellan et al., 1993	I	A
3	Frequent counseling is associated with less illicit drug use.	Magura et al., 1999	II-2	A
4	High-quality social services show better treatment retention.	Condelli, 1993	I	A
5	LAAM target dose is typically at least 50/50/70 mg on Monday/Wednesday/Friday.	Jones et al., 1998 Eissenberg et al., 1997	I	A

QE = Quality of Evidence; R = Recommendation (See Introduction)

**E. Is Naltrexone Appropriate For And Acceptable To The Patient?**

OBJECTIVE

Identify patients who may benefit from naltrexone for opioid dependence.

ANNOTATION

1. Naltrexone has no positive psychoactive effects and is unpopular with many opioid dependent patients. However, some highly motivated patients can be successful using naltrexone therapy.
2. Subpopulations with better prognosis for response include:
  - Patients highly motivated for abstinence without obvious external pressure
  - Patients in the criminal justice system, with monitored administration
  - Health care workers with employment-related monitoring
3. Avoid an adverse opioid withdrawal reaction precipitated by naltrexone during lingering physiological dependence. Such reactions can result in extreme reluctance to trust treatment of any modality.
4. Consider OAT programs or long-term therapeutic community approaches for chronic opioid dependent patients.

**Table 2. Pharmacotherapy with Naltrexone for Opioid Dependence**

	<b>Naltrexone</b>
<b>Indications for Use</b>	Opioid dependence with: <ul style="list-style-type: none"> <li>▪ Ability to achieve at least 7-10 days of abstinence to rule out the need for detoxification</li> </ul> Note: Most effective when the patient is engaged in addiction-focused counseling with monitored administration
<b>Contraindications for Use</b>	<ul style="list-style-type: none"> <li>▪ Pregnancy</li> <li>▪ Opioid withdrawal</li> <li>▪ Opioid dependence, with use within past week</li> <li>▪ Medical condition requiring opioid medication</li> <li>▪ Severe hepatic dysfunction (i.e., transaminase levels &gt; 3 times normal, or liver failure)</li> <li>▪ Severe renal failure</li> <li>▪ Allergy to naltrexone</li> </ul>
<b>Side Effects</b>	<ul style="list-style-type: none"> <li>▪ Common: nausea (~10%)</li> <li>▪ Other: headache, dizziness, nervousness, fatigue, insomnia, vomiting, anxiety, and somnolence</li> </ul>
<b>Drug Interactions</b>	<ul style="list-style-type: none"> <li>▪ Opioid containing medications, including over-the-counter (OTC) preparations</li> <li>▪ Thioridazine</li> <li>▪ Oral hypoglycemics</li> </ul>

EVIDENCE TABLE

	<b>Recommendations</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Naltrexone should be used selectively for highly motivated patients.	O'Brien, 1996	III	A
2	Consider naltrexone, combined with monitored administration, for patients in the criminal justice system.	Cornish et al., 1997	I	B
3	Consider naltrexone for health care workers with employment-related monitoring.	Ling & Wesson, 1984	II-2	B

QE = Quality of Evidence; R = Recommendation (See Introduction)

**F. Assure Patient Is Detoxified And Opioid Free Before Continuing**

OBJECTIVE

Avoid precipitating an opioid withdrawal syndrome.

ANNOTATION

Consider pharmacologically assisted detoxification (see Module S: Stabilization, Annotation F), unless the patient successfully completed a naloxone challenge and/or has had at least 7-10 days of verified abstinence.

Two major problems with opioid detoxification have been identified:

- Extremely high relapse rates (Maddux & Desmond, 1992).
- Absence of standard detoxification protocols; therefore, individualized detoxification regimens are required, regardless of the detoxification agent involved.

There are several methods to resolve uncertainty about physiological dependence on opioids:

- Self-report
- Urine toxicology screening
- Medical record review
- Physical examination (e.g., stigmata of IV use or symptoms of opioid withdrawal)
- Intoxication

Confirming the physiological dependence can also be accomplished with a challenge using naloxone, a short acting narcotic antagonist, to elicit signs and symptoms of precipitated withdrawal (O'Brien, 1994). A naloxone challenge should be done selectively and with great care (e.g., by or in close consultation with a physician experienced in management of opioid withdrawal) since patients can rapidly experience serious opioid withdrawal.

- Give 0.2 - 0.4 mg of naloxone, subcutaneously or intravenously, and the precipitated withdrawal usually begins within minutes.
- Patients with low levels of opioid use may require up to a total dose of 0.8 mg of naloxone to precipitate withdrawal, given in increments of 0.2 mg every 30 minutes.
- Symptoms usually peak within 30 minutes and subside in 3-4 hours.
- An oral dose of 5 or 10 mg of methadone may attenuate the withdrawal.

**G. Initiate Naltrexone For Opioid Dependence With Patient Education And Monitoring**

OBJECTIVE

Provide appropriate dosing and relapse monitoring to promote effective outcomes.

ANNOTATION

Naltrexone has been shown to be safe and effective in blocking mu-opiate receptors and has been approved by the FDA for treatment of opioid dependence since 1983 (O'Brien & McKay, 1998; Kirchmayer, et al., 1999). Studies show safety and efficacy for up to several years of treatment at standard doses (refer to Table 3).

**Table 3. Pharmacotherapy Management with Naltrexone for Opioid Dependence (PDR, 1999)**

	<b>Naltrexone</b>
<b>Dosage</b>	<ul style="list-style-type: none"> <li>▪ 50 mg/day</li> </ul>
<b>Alternative Dosing Schedules</b>	<ul style="list-style-type: none"> <li>▪ 25 mg daily or twice a day (b.i.d.) with meals to reduce nausea, especially during the first week</li> <li>▪ Observed administration improves compliance. Full opioid blockage is produced with a schedule of 100 mg on Monday and Wednesday and 150 mg on Friday</li> </ul>
<b>Baseline Evaluation</b>	<ul style="list-style-type: none"> <li>▪ Transaminase levels</li> <li>▪ Urine toxicology</li> </ul>
<b>Patient Education</b>	<ul style="list-style-type: none"> <li>▪ Discuss compliance-enhancing procedures.</li> <li>▪ Negotiate commitment from the patient regarding monitored ingestion, if necessary.</li> <li>▪ Provide patients with wallet cards that indicate use of naltrexone.</li> </ul>
<b>Monitoring</b>	<ul style="list-style-type: none"> <li>▪ Monitor for opioid use at least weekly during early recovery, via urine toxicology.</li> <li>▪ Repeat transaminase levels monthly for the first 3 months and every 3 months thereafter.</li> <li>▪ Discontinue/reduce naltrexone, if transaminase levels rise significantly.</li> <li>▪ Reevaluate patient compliance and progress at least every 3 months and adjust the treatment plan as necessary.</li> <li>▪ Continue treatment for 12-24 months, if the patient maintains abstinence.</li> <li>▪ Consider reinstating naltrexone if the patient relapses to opioid use after discontinuation of naltrexone.</li> </ul>

**H. Is The Patient Alcohol Dependent?**

OBJECTIVE

Identify patients with alcohol dependence who should be considered for addiction-focused pharmacotherapy.

ANNOTATION

See Module A: Assessment and Management in Primary Care, Annotation E.

## I. Is Pharmacotherapy For Alcohol Dependence Indicated?

### OBJECTIVE

Identify patients who may benefit from pharmacotherapy.

### ANNOTATION

There are two medications currently approved for the treatment of alcohol dependence—naltrexone and disulfiram (refer to Table 4). Pharmacotherapy has been shown to be effective when combined with addiction-focused counseling. Efficacy in the absence of counseling is uncertain.

- Naltrexone, an opioid antagonist, should be routinely considered when treating alcohol dependence. It has been shown to significantly reduce the relapse rate during the first 12 weeks of treatment when combined with addiction counseling.
- Disulfiram should be considered more selectively. Monitored administration significantly improves compliance. When cocaine and alcohol dependence occur together (which they frequently do) use of disulfiram is associated with reductions in both cocaine and alcohol use. Disulfiram should only be used when abstinence is the goal.

**Table 4. Pharmacotherapy of Alcohol Dependence**

	<b>Naltrexone</b>	<b>Disulfiram</b>
<b>Indications for Use</b>	<p>Alcohol dependence with:</p> <ul style="list-style-type: none"> <li>▪ Ability to achieve at least 3-5 days of abstinence to rule out the need for detoxification</li> <li>▪ Drinking within the past 30 days and/or reports of craving</li> </ul> <p>Note: Most effective when the patient is engaged in addiction-focused counseling</p>	<p>Alcohol dependence with:</p> <ul style="list-style-type: none"> <li>▪ Abstinence &gt; 24 hours and BAL equal to 0</li> <li>▪ Combined cocaine and alcohol dependence</li> <li>▪ Failure of or contraindication to naltrexone</li> <li>▪ Previous response to disulfiram</li> <li>▪ Patient preference</li> <li>▪ Capacity to appreciate risks and benefits and to consent to treatment</li> </ul> <p>Note: Most effective with monitored administration (e.g., in clinic or with spouse or probation officer.)</p>
<b>Contraindications for Use</b>	<ul style="list-style-type: none"> <li>▪ Pregnancy</li> <li>▪ Opioid withdrawal</li> <li>▪ Opioid dependence with use within past week</li> <li>▪ Medical condition requiring opioid medication</li> <li>▪ Severe hepatic dysfunction (i.e., transaminase levels &gt; 3 times normal, or in liver failure)</li> <li>▪ Severe renal failure</li> <li>▪ Allergy to naltrexone</li> <li>▪ Need for alcohol detoxification</li> </ul>	<ul style="list-style-type: none"> <li>▪ Pregnancy</li> <li>▪ Severe cardiovascular, respiratory, or renal disease</li> <li>▪ Severe hepatic dysfunction (i.e., transaminase levels &gt; 3 times upper limit of normal or in liver failure)</li> <li>▪ Severe psychiatric disorders, especially psychotic and cognitive disorders and suicidal ideation</li> <li>▪ Poor impulse control</li> <li>▪ Previous disulfiram-ethanol reaction</li> <li>▪ Metronidazole or ketoconazole therapy, which already induce a similar reaction to alcohol</li> <li>▪ Allergy to disulfiram</li> </ul>

**Table 4. Pharmacotherapy of Alcohol Dependence (continued)**

<b>Side Effects</b>	<ul style="list-style-type: none"> <li>▪ Common: nausea (~10%)</li> <li>▪ Other: headache, dizziness, nervousness, fatigue, insomnia, vomiting, anxiety, and somnolence</li> </ul>	<ul style="list-style-type: none"> <li>▪ Common (usually mild and self-limiting): somnolence, metallic taste, and headache</li> <li>▪ Less common, but more serious: Hepatotoxicity, peripheral neuropathy, psychosis, and delirium</li> </ul>
<b>Drug Interactions</b>	<ul style="list-style-type: none"> <li>▪ Opioid containing medications, including OTC preparations</li> <li>▪ Thioridazine</li> <li>▪ Oral hypoglycemics</li> </ul> <p><i>Note: Does not alter ethanol absorption or metabolism or have major effects when combined.</i></p>	<ul style="list-style-type: none"> <li>▪ Alcohol containing medications, including OTC preparations</li> <li>▪ Severity of disulfiram-ethanol reaction varies considerably among patients and is generally dose-related, causing vasodilatation, flushing, hypotension, nausea, vomiting, dizziness, tachycardia, cardiac arrhythmias, myocardial infarction/stroke in susceptible patients, and even death from cardiac complications in older patients.</li> <li>▪ Drug-drug interactions may occur with phenytoin, warfarin, isoniazid, rifampin, diazepam, chlordiazepoxide, imipramine, desipramine, and oral hypoglycemic agents.</li> </ul>

EVIDENCE TABLE

	<b>Recommendations</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Consider naltrexone for alcohol dependence when combined with addiction counseling.	O'Malley et al., 1996 Volpicelli et al., 1992 CSAT, 1998 Anton et al., 1999 Garbutt et al., 1999	I	A
2	Monitored naltrexone administration significantly improves compliance.	Garbutt et al., 1999	II-1	A
3	Consider disulfiram for coexisting cocaine and alcohol dependence.	Carroll et al., 1998 McCance-Katz et al., 1998 George et al., 2000 Petrakis et al., 2000	I	B

QE = Quality of Evidence; R = Recommendation (See Introduction)

**J. Initiate Pharmacotherapy For Alcohol Dependence With Patient Education And Monitoring**

OBJECTIVE

Provide appropriate dosing and relapse monitoring to promote effective outcomes.

ANNOTATION

**Table 5. Pharmacotherapy Management For Alcohol Dependence (PDR, 1999)**

	<b>Naltrexone</b>	<b>Disulfiram</b>
<b>Dosage</b>	<ul style="list-style-type: none"> <li>▪ 50 mg/day up to 100 mg/day</li> </ul>	<ul style="list-style-type: none"> <li>▪ 250 mg/day</li> </ul>
<b>Alternative Dosing Schedules</b>	<ul style="list-style-type: none"> <li>▪ 25 mg daily or b.i.d. with meals to reduce nausea, especially during the first week</li> <li>▪ Full therapeutic effect is produced with a schedule of 100 mg on Monday and Wednesday and 150 mg on Friday</li> </ul>	<ul style="list-style-type: none"> <li>▪ Reduce dose to 125 mg to reduce side effects.</li> <li>▪ For monitored administration, consider giving 500 mg on Monday, Wednesday, and Friday.</li> <li>▪ If a patient taking 250 mg of disulfiram daily drinks alcohol and has no reaction, consider increasing dose to 500 mg daily.</li> </ul>
<b>Baseline Evaluation</b>	<ul style="list-style-type: none"> <li>▪ Transaminase levels</li> </ul>	<ul style="list-style-type: none"> <li>▪ Transaminase levels</li> <li>▪ Physical assessment</li> <li>▪ Psychiatric assessment</li> <li>▪ Electrocardiogram</li> <li>▪ Verify abstinence with breath or blood alcohol level.</li> </ul>
<b>Patient Education</b>	<ul style="list-style-type: none"> <li>▪ Discuss compliance-enhancing procedures.</li> <li>▪ If necessary, negotiate commitment from the patient regarding monitored ingestion.</li> <li>▪ Provide patients with wallet cards indicating use of naltrexone.</li> <li>▪ Note that side effects, if any, tend to occur early in treatment and can typically be resolved within 1-2 weeks with dose adjustment</li> </ul>	<ul style="list-style-type: none"> <li>▪ Instruct patients to avoid alcohol in food and beverages, including medications.</li> <li>▪ Provide patients with wallet cards that indicate the use of disulfiram.</li> <li>▪ Because of the risk of significant toxicity and limited evidence of effectiveness: <ul style="list-style-type: none"> <li>—Give careful consideration to risks and benefits.</li> <li>—Document informed consent discussion with the patient.</li> <li>—Obtain written informed consent for VA patients.</li> </ul> </li> </ul>
<b>Monitoring</b>	<ul style="list-style-type: none"> <li>▪ Repeat transaminase levels monthly for the first 3 months and then every 3 months thereafter.</li> <li>▪ Discontinue naltrexone if transaminase levels significantly rise.</li> <li>▪ Reevaluate patient compliance and progress at least every 3 months and adjust the treatment plan as necessary.</li> <li>▪ Continue treatment 3-12 months if the patient is making satisfactory progress towards treatment goals.</li> <li>▪ Consider reinstating naltrexone, if the patient relapses to harmful alcohol use after discontinuation of naltrexone.</li> <li>▪ Observed administration improves compliance.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Repeat transaminase levels monthly for the first 3 months and every 3 months thereafter.</li> <li>▪ Discontinue disulfiram if transaminase levels significantly rise.</li> <li>▪ Reevaluate the need for disulfiram at least every 3 months and discontinue use once stable abstinence is achieved or if patient adherence cannot be safely maintained.</li> </ul>

## DISCUSSION

There are several factors to consider regarding what, if any, pharmacotherapy to use for alcohol dependence. First, there must be some motivation on the part of the patient to achieve and maintain abstinence. Pharmacotherapy is unlikely to work if patients are not willing to make a commitment to recovery. Second, patients should generally be in some kind of counseling or psychotherapy. There are exceptions to this, for example, a patient who has been abstinent for some time and is involved in self-help groups, but requires pharmacotherapy to help maintain abstinence. Third, compliance-enhancing procedures must be integrated into the treatment plan (Volpicelli et al., 1997; Pettinati et al., 2000).

Of the two medications currently available, naltrexone has stronger evidence of efficacy, especially in the first three months of abstinence. It should be routinely considered for patients beginning alcoholism treatment. Naltrexone should also be considered whenever a patient is able to maintain some abstinence, but is having difficulty with slips or cravings. Nalmefene, a longer acting opioid antagonist, has been shown to have similar effects (Mason et al., 1999).

Disulfiram should be considered more selectively. Monitored administration significantly improves compliance. Disulfiram should be considered whenever a patient requests it or when some form of monitoring is available. In clinical practice, it is sometimes used to provide additional support during periods of high risk of relapse. Evidence for its efficacy in combined cocaine and alcohol dependence is relatively strong (Carroll et al., 1998; McCance-Katz et al., 1998; George et al., 2000; Petrakis et al., 2000).

Acamprosate is a drug of uncertain mechanism that has substantial empirical support in Europe for reducing drinking days. At the time this guideline is written, acamprosate is in the approval process for prescription in the United States (Garbutt et al., 1999; Sass et al., 1996).

Although this is changing, some self-help groups may urge the patient to discontinue all medications. Patients should be educated about this possibility (Rychtarik et al., 2000; Report from a group of physicians in Alcoholics Anonymous ([AA], 1984) and encouraged to continue taking their medications, if indicated. Providers should encourage patients to seek out self-help groups that are supportive of their recovery plan. It is important to monitor the patient's clinical condition regularly. If the patient's drinking has worsened or is unimproved from baseline, alternative pharmacotherapies should be considered (e.g., disulfiram or possibly a treatment for comorbid psychopathology). The counseling frequency might be increased or a significant other might be involved in the care plan. The setting for care might also need to be reevaluated (see Module R: Assessment and Management in Specialty Care).

## EVIDENCE TABLE

	<b>Recommendations</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Negotiate commitment regarding monitored ingestion of naltrexone.	Volpicelli et al., 1997 Pettinati et al., 2000	I	A

*QE = Quality of Evidence; R = Recommendation (See Introduction)*

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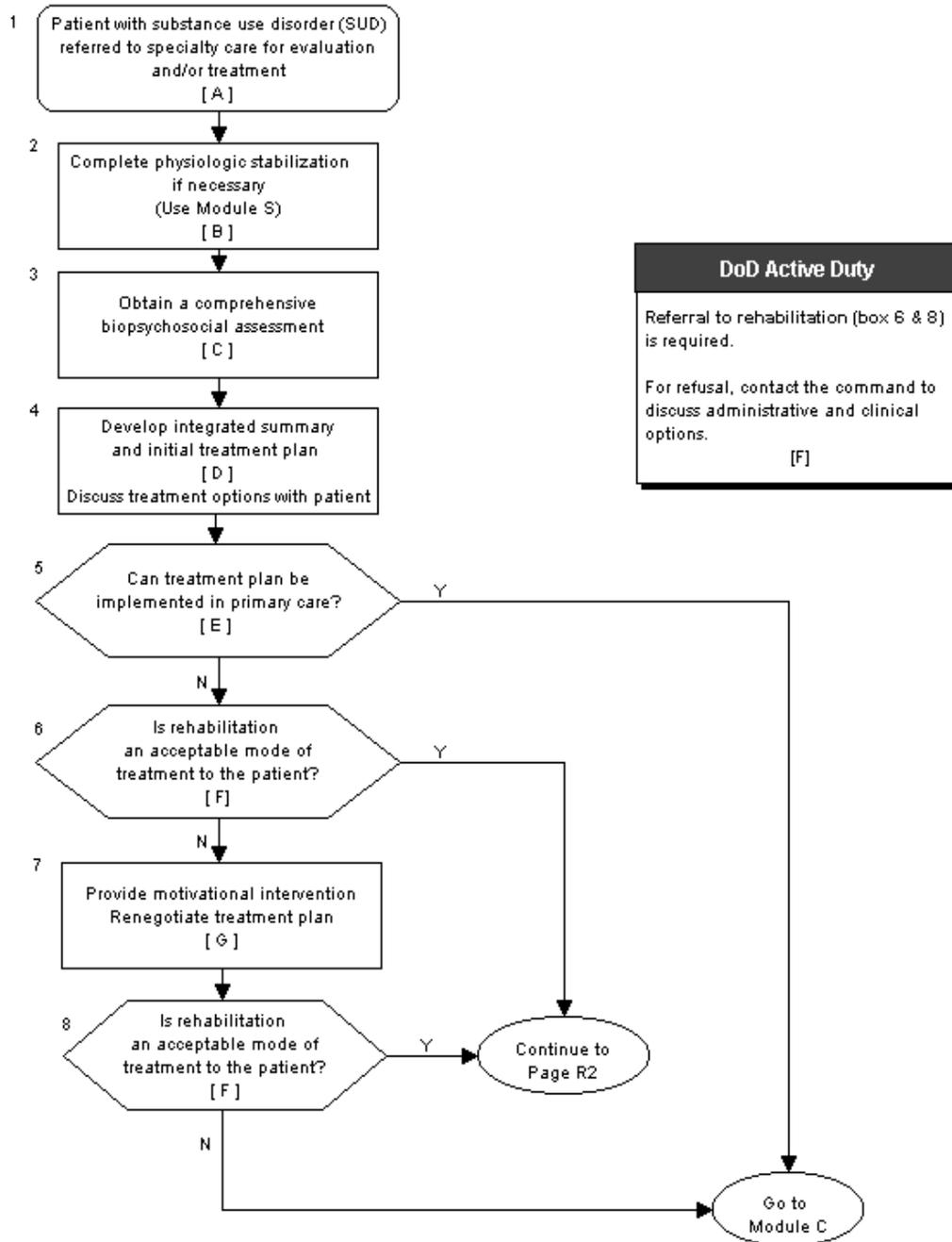
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VHA/D<sub>o</sub>D CLINICAL PRACTICE GUIDELINE FOR THE  
MANAGEMENT OF **SUBSTANCE USE DISORDERS**  
IN THE PRIMARY CARE SETTING

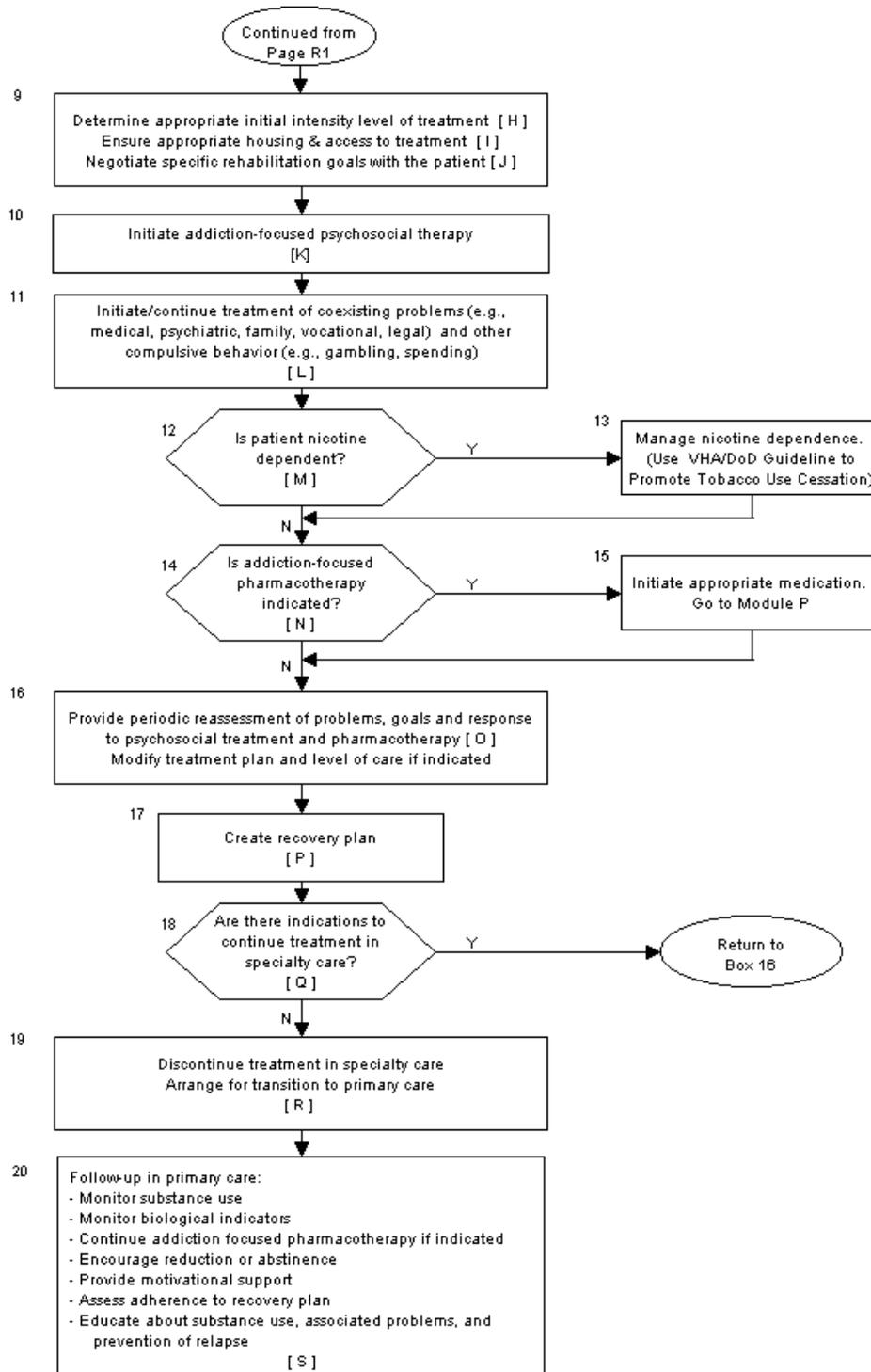
**MODULE R:**  
**ASSESSMENT AND MANAGEMENT**  
**IN SPECIALTY CARE**

Version 1.0

### MANAGEMENT OF SUBSTANCE USE DISORDERS Module R: Assessment and Management - Specialty Care



**MANAGEMENT OF SUBSTANCE USE DISORDERS**  
**Module R: Rehabilitation - Specialty Care**



## ANNOTATIONS

### A. Patient With Substance Use Disorder (SUD) Referred To Specialty Care For Evaluation And/Or Treatment

Patients may be referred to this module based on the following indications for treatment: hazardous substance use, substance abuse, substance dependence, risk of relapse, or mandated referral within the DoD. Patients identifying or willing to consider optimal or intermediate rehabilitation goals are appropriately managed using this module. Other patients may be ambivalent about rehabilitation goals and may benefit from more comprehensive assessment and discussion of treatment options. Finally, patients may be referred to a specialist for more extensive evaluation of substance use.

### B. Complete Physiologic Stabilization, If Necessary

#### OBJECTIVE

Assure patient safety and readiness to cooperate with further assessment.

#### ANNOTATION

Most patients managed within this module are not acutely intoxicated or in need of immediate physiological stabilization (see Module A: Assessment and Management in Primary Care) prior to initiating assessment and treatment planning. Others may have been stable at the time of referral, but require stabilization when they present for specialty care evaluation or treatment and should be managed using Module S: Stabilization.

### C. Obtain A Comprehensive Biopsychosocial Assessment

#### OBJECTIVE

Identify the patient's current problems, relevant history, and life context as a basis for the integrated summary and initial treatment plan.

#### ANNOTATION

Include the following 10 general categories in a comprehensive assessment of SUDs (ASAM, 1996; Senay, 1997; Strauss, 1995):

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

#### DISCUSSION

Assessment is the beginning of the therapeutic process. The clinician's empathic and non-judgmental interest during assessment can help the patient make sense of his or her condition, decrease the patient's sense of isolation, increase the likelihood of treatment adherence, and foster growth of the therapeutic

alliance. Conclusions from the assessment should be shared with the patient. The clinician's attitude and manner are important components of the assessment process. A nonjudgmental, respectful attitude that reflects genuine interest and empathy will facilitate rapport. Reliability and validity of the assessment will be affected by the degree of trust in the interviewer and by consideration of the degree to which the patient presents voluntarily or feels coerced. In determining reliability and validity of the assessment, the clinician should also recognize that recent substance use might affect the patient's presentation during the interview. Memory and cognitive deficits and impairment of judgment and mood, secondary to drug use, may be present. The clinician should monitor the patient's cognitive function and mental status during the assessment. If it is possible to gain permission from the patient to do so, consulting with collateral informants (e.g., spouse/partner, family, friends, and/or co-workers) will provide a useful adjunct to gathering information directly from the patient.

The guidelines do not exclusively endorse the use of any particular instrument as the basis for a comprehensive assessment. However, the Addiction Severity Index (ASI) (Fureman et al., 1990; McLellan et al., 1992) is a standardized, rater-administered interview that assesses seven functional domains considered important in an overall addiction evaluation: medical status, employment status, legal problems, family/social relations, drug use, alcohol use, and psychiatric status. A computerized narrative summary is available when interview responses are entered into VistA (the VA centralized computer system) and may serve as the basis for the initial treatment plan. Formal DSM-IV psychiatric diagnoses are derived from the clinical interview.

#### D. Develop Integrated Summary And Initial Treatment Plan

##### OBJECTIVE

Integrate assessment information from various sources, as a basis for formulating the diagnosis and treatment recommendations, followed by involvement of the patient in prioritizing problems and negotiating the initial treatment plan.

##### ANNOTATION

1. Consolidate and interpret the information obtained during the assessment process in a narrative form.
2. Include a diagnostic formulation.
3. Review comprehensive assessment and integrated summary, including past treatment response.
4. Incorporate an interdisciplinary perspective in presenting treatment recommendations.
5. Involve the patient in prioritizing problems to be addressed in the initial treatment plan.
6. Review the patient's motivational level and goals and match the patient needs with available programming (see Table 1).
7. Identify treatment options and discuss them with the patient.

**Table 1. Treatment Plan and Expected Outcomes**

Treatment Plan	Expected Outcomes
Rehabilitation with optimal goals	<ul style="list-style-type: none"> <li>▪ Complete and sustained remission of all SUDs</li> <li>▪ Resolution of, or significant improvement in, all coexisting biopsychosocial problems and health-related quality of life</li> </ul>
Rehabilitation with intermediate goals	<ul style="list-style-type: none"> <li>▪ Short- to intermediate-term remission of SUDs or partial remission of SUDs for a specified period of time</li> <li>▪ Resolution or improvement of at least some coexisting problems and health-related quality of life</li> </ul>

**Table 1. Treatment Plan and Expected Outcomes (continued)**

Treatment Plan	Expected Outcomes
Care Management	<ul style="list-style-type: none"> <li>▪ Engagement in the treatment process, which may continue for long periods of time or indefinitely</li> <li>▪ Continuity of care (case management)</li> <li>▪ Continuous enhancement of motivation to change</li> <li>▪ Availability of crisis intervention</li> <li>▪ Improvement in SUDs, even if temporary or partial</li> <li>▪ Improvement in coexisting medical, psychiatric, and social conditions</li> <li>▪ Improvement in quality of life</li> <li>▪ Reduction in the need for high-intensity health care services</li> <li>▪ Maintenance of progress</li> <li>▪ Reduction in the rate of illness progression</li> </ul>

## DISCUSSION

The integrated summary has also been referred to as the case formulation. The purpose of the integrated summary is to blend the disparate pieces of the assessment process into a more cohesive summarization. The summary needs to include biopsychosocial strengths and weaknesses that the patient brings to treatment. The summary also serves as a dynamic understanding of why the patient’s SUD evolved. The integrated summary serves as the foundation for the development of the treatment plan. Consistent with JCAHO standards, it is important that the information upon which the treatment plan is based appears within the assessment database and does not appear de novo in the integrated summary (JCAHO, 1999).

The integrated summary is intended to be interpretive in nature, providing more than a restatement of facts already present in the assessment. The clinician must use professional judgment to evaluate the information and discuss with the patient how his/her various strengths and problems interrelate to affect the treatment process. For example, patients may indicate that some problems, such as homelessness or ambivalence about change, may need to be addressed before others. Principles and techniques of Motivational Interviewing (Miller & Rollnick, 1991; Miller et al., 1992), rather than confrontation, can enhance treatment engagement and outcome (Bien et al., 1993; Miller, 2000). The integrated summary will typically reflect the results of an interdisciplinary team discussion; however, there may be local variations.

SUDs often follow a chronic, relapsing course, making individualized treatment more complicated (McLellan et al., 1996; O’Brien & McLellan, 1996). Treatment has not yet been well conceptualized for many patients who either have responded with minimal improvement to repeated rehabilitative treatments or are unable or unwilling to engage in rehabilitation efforts, but desire other services. Even when patients are unable and/or unwilling to participate in rehabilitation or show minimal benefit, there are opportunities to address SUDs in other care settings.

Care management approaches for SUDs are similar to management of other severe and persistent disorders for which no cure has been identified, such as bipolar disorder or diabetes mellitus (McLellan et al., 2000). Recent evidence suggests that approaches emphasizing engagement with the patient over long periods of time, case management, and integration of substance abuse treatment interventions with treatment for the coexisting conditions result in reduced substance use and associated complications (Drake & Mueser, 2000; Osher & Drake, 1996; U.S. DHHS, 1994; Willenbring et al., 1995; Willenbring & Olson, 1999). In the absence of serious co-morbidity or with appropriate specialist consultation, care management can be provided within a variety of clinical settings.

**E. Can Treatment Plan Be Implemented In Primary Care?**

OBJECTIVE

Identify the patient who does not require specialty care.

ANNOTATION

Consider the appropriateness of implementing the treatment plan in primary care, based on the following:

1. Review of the integrated summary and initial treatment plan.
2. Availability of a willing primary care provider with whom the patient has an ongoing clinical relationship.
3. Severity and chronicity of the SUD.
4. Active involvement with support for recovery in the community.
5. Prior treatment response.
6. Patient preference and likelihood of adherence.

Consider rehabilitation in specialty care for more complex clinical presentations, especially where problem severity is greater or patient motivation is less clear (Annotation F).

DISCUSSION

Different subtypes of patients referred for specialty assessment of SUDs might be appropriate for alternatives to rehabilitation in a specialty care setting, given the availability and willingness of a primary care provider to address and monitor their substance use as part of ongoing clinical care. For some patients the treatment plan might emphasize involvement in a previously effective self-help group, along with monitoring by the primary care provider.

**F. Is Rehabilitation An Acceptable Mode Of Treatment To The Patient?  
For DoD Active Duty, A Referral Is Required. For Refusal, Contact Command To Discuss  
Administrative and Clinical Options**

OBJECTIVE

Determine, along with the patient, the most appropriate treatment approach.

ANNOTATION

1. When acceptable to the patient, a specialty care rehabilitation plan is generally indicated.
2. Care management is likely to be a more acceptable and effective alternative when one of the following applies:
  - The patient refuses referral to rehabilitation, but continues to seek some services, especially medical and/or psychiatric services.
  - The patient has serious co-morbidity that precludes participation in available rehabilitation programs.
  - The patient has been engaged repeatedly in rehabilitation treatment with minimal progress toward optimal or intermediate rehabilitation goals.
3. Regarding DoD active duty patients:
  - DoD active duty refusing rehabilitation—contact command to discuss command directed treatment so consideration can be given to either (a) order the patient to comply, (b) invoke administrative options (e.g., administrative separation from service), or (c) do nothing. This is the commander's decision, with input from the medical staff.

## DISCUSSION

Even when patients refuse referral or are unable to participate in specialized addiction treatment, many are accepting of general medical or psychiatric care. Clinicians in multiple settings can deliver care management for patients with SUDs. The chronic illness approach is consistent with management approaches for many other disorders treated in medical and psychiatric settings (Drake & Mueser, 2000; McLellan et al., 2000; Willenbring & Olson, 1999).

### G. Provide Motivational Intervention Renegotiate Treatment Plan

#### OBJECTIVE

Clarify and/or increase patient commitment to change.  
Address barriers to, clarify, or promote patient readiness for rehabilitation goals.

#### ANNOTATION

1. Establish treatment goals in the context of a negotiation between the treatment provider and the patient.
2. Review with the patient results of previous efforts at self-change and formal treatment, including reasons for treatment dropout.
3. Use motivational enhancement techniques reflecting the FRAMES model (see Miller & Rollnick, 1991; Miller et al., 1992).
  - Feedback: Provide personalized feedback based on patient report of alcohol-related harm.
  - Responsibility: Emphasize patient responsibility and freedom of choice for changing behavior.
  - Advice: Provide clear and direct advice about the importance of change and availability of help.
  - Menu: Acknowledge and discuss alternative strategies for change.
  - Empathy: Maintain a patient-centered approach and accurately reflect patient statements and feelings.
  - Self-Efficacy: Emphasize the role of patient self-efficacy in their ability to make needed change and convey optimism in their potential to be successful.
4. Use empathic and non-judgmental (versus confrontational) therapist style.

#### EVIDENCE TABLE

	Recommendations	Sources of Evidence	QE	R
1	Use empathic and non-judgmental (versus confrontational) therapist style.	Hser, 1995 Miller et al., 1993 Najavits & Weiss, 1994	I	A

QE = Quality of Evidence; R = Recommendation (See Introduction)

### H. Determine Appropriate Initial Intensity Level Of Treatment

#### OBJECTIVE

Identify the appropriate level of initial treatment intensity that will help the patient achieve early remission and prevent relapse.

## ANNOTATION

No standard dose or modality of treatment has been found to be uniformly sufficient for recovery (Critts-Cristoph et al., 1999; Finney & Moos, 1998). The initial intensity of treatment should:

1. Complement recovery support in the patient's community (e.g., Alcoholics Anonymous) and/or facilitate development of community support.
2. Coordinate with intervention(s) for other biopsychosocial problems. Increasing the intensity of addiction-focused treatments may not improve outcomes as effectively as addressing identified concurrent problems.
3. Provide care in the least restrictive setting necessary for safety and effectiveness (ASAM, 1996).
4. Focus on promoting initial engagement and maintaining retention over time. This includes attention to appropriate housing and access to treatment, as addressed in Annotation I.
5. Consider multiple treatment contacts per week (including medication dispensing) for severely dependent patients in early recovery (ASAM, 1996).
6. For DoD active duty, command or operational concerns may be taken into consideration.

## DISCUSSION

Rehabilitation programs should provide individualized psychosocial therapy, often combined with pharmacotherapy, complementing the patient's recovery support in the community. As noted in Annotation K, addiction-focused treatment should proceed concurrently with intervention(s) for other biopsychosocial problems that may require careful coordination of adjunctive services of varying intensity.

Consistent with patient goals, addiction-focused treatment should be individualized in terms of intensity (session length and frequency), setting (inpatient, residential, partial hospital, and outpatient), duration (time from initial to final scheduled session), and modality or type of therapy (Finney & Moos, 1998; IOM, 1990).

The appropriateness of treatment intensity should be considered in terms of the least restrictive, least intensive level of care in which treatment goals can be effectively and safely achieved (ASAM, 1996). For example, treatment setting and intensity should be "unbundled" rather than requiring patients to be hospitalized in order to receive intensive addiction-focused services or treatment for concurrent biopsychosocial problems.

Considerable evidence shows that even brief interventions (i.e., one to four brief sessions) can be effective for many patients with alcohol dependence, particularly as early interventions for those with mild to moderate dependence severity (Finney & Moos, 1998; Wilk et al., 1997). Comparable findings have not been reported for brief intervention with other substance dependence (e.g., opioid and cocaine dependence), which typically require intensive treatment early in recovery (Critts-Cristoph & Siqueland, 1996).

Severely dependent patients typically may require multiple treatment contacts per week, in order to stabilize early remission. While the initial intensity of treatment is one factor, actual retention in treatment is the factor most consistently associated with successful treatment outcome (Critts-Cristoph & Siqueland, 1996; Gerstein & Harwood, 1990; Onken et al., 1997; Simpson et al., 1997). This suggests that for many patients following initial stabilization, it may be appropriate to provide a lower intensity of addiction-focused treatment extending over a longer duration (e.g., six months or more) (Finney & Moos, 1998). This longer duration presents opportunities to adjust the intensity of psychosocial interventions (e.g., frequency of group sessions), pharmacotherapy (e.g., dose amount and monitoring frequency), and community recovery support (e.g., Twelve-Step meeting attendance) consistent with treatment response over time.

EVIDENCE TABLE

	<b>Recommendations</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Complement recovery support in the patient's community (e.g., Alcoholics Anonymous) and/or facilitate development of community support.	Finney & Moos, 1998	II-2	A
2	Addressing identified concurrent problems improves outcomes.	Kraft et al., 1997 McLellan et al., 1998 Avants et al., 1999	I	A
3	Individualize treatment in terms of intensity, setting, duration, and modality.	Finney & Moos, 1998 IOM, 1990	III	A
4	Promote initial treatment engagement and retention.	Crits-Cristoph & Siqueland, 1996 Finney & Moos, 1998 Gerstein & Harwood, 1990 Onken et al., 1997	II-2	A

QE = Quality of Evidence; R = Recommendation (See Introduction)

**I. Ensure Appropriate Housing And Access To Treatment**

OBJECTIVE

Facilitate access to treatment and promote a supportive recovery environment.

ANNOTATION

The term "housing" is used generically as the residence of a patient while receiving treatment. It can involve the same setting within which treatment takes place or it can refer to a variety of living situations with varying degrees of supervision that are separate from the location of treatment services (refer to Table 2).

**Table 2. Housing Options**

<b>Types of Housing</b>	<b>Indications</b>	<b>Examples</b>
Intensive Medical Management or Monitoring	<ul style="list-style-type: none"> <li>▪ Medical or psychiatric instability requiring hospitalization (includes severe intoxication or withdrawal)</li> <li>▪ ASAM PPC-2* Levels III.7 and IV</li> </ul>	<ul style="list-style-type: none"> <li>▪ Inpatient medical bed section</li> <li>▪ Inpatient addiction/psychiatry bed section</li> </ul>
Professional Monitoring	<ul style="list-style-type: none"> <li>▪ Medical or psychiatric instability requiring 24-hour professional monitoring, but not of sufficient severity to require hospitalization</li> <li>▪ ASAM PPC-2 Levels III.3-III.5</li> </ul>	<ul style="list-style-type: none"> <li>▪ Social detoxification setting</li> <li>▪ VA Substance Abuse Residential Rehabilitation Treatment Programs (SARRTP) and VA Domiciliaries (if professional staff are present 24-hours/day)</li> </ul>

**Table 2. Housing Options (continued)**

Types of Housing	Indications	Examples
24-Hour Supervision	<ul style="list-style-type: none"> <li>▪ Mild to moderately severe psychiatric or medical conditions requiring some supervision that may be provided by paraprofessionals, volunteers, or patients in advanced stages of treatment</li> <li>▪ Demonstrated inability to remain abstinent in unsupervised setting or homeless</li> <li>▪ Lacking own social support system, such as family members willing and able to assist</li> <li>▪ ASAM PPC-2 Levels III.1-III.2</li> </ul>	<ul style="list-style-type: none"> <li>▪ Halfway houses</li> <li>▪ Sober houses or safe houses</li> <li>▪ Use of hospital bed space for lodging purposes (e.g., self-care wards in DoD &amp; lodger status in VA)</li> <li>▪ VA SARRTP and VA Domiciliaries (if staffed only by non-professionals at least part of the day or night)</li> </ul>
Non-Supervised Housing	<ul style="list-style-type: none"> <li>▪ Homeless</li> <li>▪ Lives at too great a distance to travel to outpatient program</li> <li>▪ Able to care for self, including use of medications</li> <li>▪ Able to remain abstinent in an unsupervised setting</li> <li>▪ ASAM PPC-2 Levels I, II.1, or II.3</li> </ul>	<ul style="list-style-type: none"> <li>▪ Patient's own home</li> <li>▪ Transitional living facility</li> <li>▪ Temporary housing provided on-site or in the community</li> </ul>

\*ASAM Patient Placement Criteria, 2<sup>nd</sup> Edition (ASAM, 1996)

**J. Negotiate Specific Rehabilitation Goals With The Patient**

**OBJECTIVE**

Specify the planned treatment regimen and promote patient adherence.

**ANNOTATION**

1. Negotiate treatment goals that specifically identify and address relapse risks.
2. Review with the patient results of previous efforts at self-change and formal treatment experience, including reasons for treatment dropout.
3. Use empathic and non-judgmental (versus confrontational) therapist style.

**DISCUSSION**

When both parties agree on what is to be accomplished and how this is to be done, the chances of achieving a good outcome are enhanced (Putnam, 1994; Sanchez-Craig & Lei, 1986). Discussing treatment history and expectations can reduce reliance on previously ineffective treatment approaches and prevent attempts to achieve goals likely unattainable during the current episode of care.

EVIDENCE TABLE

	<b>Recommendations</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Negotiate specific rehabilitation goals with the patient.	Heinssen et al., 1995 Miller, 1995 Miller & Rollnick, 1991 Sanchez-Craig & Lei, 1986 Sobell et al., 1992 Stark, 1992	II-1	A
2	Review previous treatment and efforts at self-change with patient.	Stark, 1992	III	B
3	Use empathic and non-judgmental (versus confrontational) therapist style.	Hser, 1995 Miller et al., 1993 Najavits & Weiss, 1994	I	A

QE = Quality of Evidence; R = Recommendation (See Introduction)

**K. Initiate Addiction-Focused Psychosocial Therapy**

OBJECTIVE

Initiate addiction-focused psychosocial treatment that will help the patient establish early remission and prevent relapse to substance use.

ANNOTATION

1. Indicate to the patient and significant others that treatment is more effective than no treatment.
2. Respect patient preference for the initial psychosocial intervention approach, since no single intervention has emerged as the treatment of choice.
3. Consider addiction-focused psychosocial interventions with the most consistent empirical support, several of which have been developed into published treatment manuals:
  - Behavioral marital therapy
  - Cognitive-behavioral coping skills training
  - Community reinforcement and other contingency-based approaches
  - Individual and group drug counseling
  - Motivational enhancement
  - Twelve-Step facilitation training
4. Emphasize that the most consistent predictor of successful outcome is retention in formal treatment or community support.
5. Promote active involvement in Twelve-Step programs (e.g., Alcoholics Anonymous and Narcotics Anonymous) that have been helpful to many and are widely available.
6. Use effective strategies for referral to mutual help programs in the community, addressing patient preferences and prior experiences.
  - Ask whether the patient has ever attended a self-help meeting.
  - Explore the patient's attitude and concerns about attending meetings.
  - Discuss the possible benefits.
  - Describe the range of meetings that are available.
  - Refer the patient to a specific meeting, at a specific time, date, and location.
  - Follow-up regarding meeting attendance and experience.

## DISCUSSION

Available qualitative and quantitative reviews consistently conclude that psychosocial treatment is more effective than no treatment (Gerstein & Harwood, 1990; IOM, 1990) and where indicated, pharmacotherapy with psychosocial treatment is more effective than pharmacotherapy alone (Carroll & Schottenfeld, 1997; Crits-Cristoph & Siqueland, 1996). However, of the many approaches empirically evaluated, no psychosocial treatment modality has emerged as the treatment of choice.

The most consistent evidence of effectiveness is found for modalities that prepare patients to prevent relapse in their everyday lives (Finney & Moos, 1998). The modalities consistently validated in clinical trials include motivational enhancement, social skills training, community reinforcement and other contingency-based approaches, and behavioral marital therapy (Carroll & Schottenfeld, 1997; Finney & Moos, 1998; Miller, 1995).

While no randomized clinical trial has compared the effectiveness of Alcoholics Anonymous *per se* with other treatments, treatment guided by Twelve-Step principles has shown outcome results comparable to those of cognitive-behavioral interventions (Humphreys, 1999; Ouimette et al., 1997; Project MATCH Research Group, 1997; Tonigan et al., 1996). In addition, Twelve Step meetings are the most widely available community support for recovery.

Therapist relational styles that are less confrontational and more empathic are associated with improved treatment outcome, independent of therapist training, therapeutic orientation, experience, or type of treatment (Hser, 1995; Najavits & Weiss, 1994).

## EVIDENCE TABLE

	<b>Recommendations</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Indicate to the patient that treatment is effective.	Gerstein & Harwood, 1990 IOM, 1990	I	A
2	Respect patient preference for the initial psychosocial intervention approach.	Carroll & Schottenfeld, 1997 Crits-Cristoph & Siqueland, 1996 Finney & Moos, 1998	I	A
3	Consider behavioral marital therapy.	Stanton & Shadish, 1997 O'Farrell, 1993	I	A
4	Consider cognitive-behavioral coping skills training.	Beck et al., 1993 Carroll, 1998 Kadden et al., 1992 Monti et al., 1989	I	A
5	Consider community reinforcement and other contingency-based approaches.	Budney & Higgins, 1998 Meyers & Smith, 1995 Silverman et al., 1996	I	A
6	Consider individual and group drug counseling.	Mercer & Woody, 1999	I	A
7	Consider motivational enhancement.	Miller et al., 1992	I	A
8	Consider Twelve-Step facilitation training.	Nowinski et al., 1992 Ouimette et al., 1997 Tonigan et al., 1996	I	A
9	Emphasize retention in formal treatment or community support.	Finney & Moos, 1998 Simpson, 1997	I	A
10	Promote active involvement in Twelve-Step programs.	Humphreys, 1999	II-2	A

QE = Quality of Evidence; R = Recommendation (See Introduction)

**L. Initiate/Continue Treatment Of Coexisting Problems (e.g., Medical, Psychiatric, Family, Vocational, And/Or Legal) And Other Compulsive Behavior (e.g., Gambling Or Spending)**

**OBJECTIVE**

Provide comprehensive individualized treatment that will improve clinical outcome and functional status.

**ANNOTATION**

1. Prioritize and address other coexisting biopsychosocial problems with services targeted to these areas, rather than increasing drug and alcohol counseling alone.
2. Treat concurrent psychiatric disorders consistent with VHA/DoD clinical practice guidelines (e.g., those for treating patients with Major Depressive Disorder or Psychoses) including concurrent pharmacotherapy.
3. Provide multiple services in the most accessible setting to promote engagement and coordination of care (Kraft et al., 1997).
4. Monitor and address deferred problems and emerging needs through ongoing treatment plan updates.
5. Coordinate care with other providers.

**DISCUSSION**

Treatment providers should identify psychiatric, medical, family/social, employment, and legal problems and evaluate the degree to which they are associated with the SUD. The ASI and other information from the biopsychosocial assessment (e.g., lab results, physical exam, mental status exam, and patient report) and integrated summary can be used to make this evaluation.

When problems are identified, and their severity and relationship to the SUD determined, the provider and treatment team should then address the optimal timing and setting of interventions (e.g., whether the patient needs immediate or delayed referral to a specialized program for a chronic co-morbid psychiatric condition, family therapy, or vocational rehabilitation). When unavailable through the primary treatment team, patients may need referral to other clinics in order to access needed services, such as primary medical care or psychiatric evaluation, housing placement, family counseling, and/or vocational training. Providing these services in a single setting (one-stop service) may be more effective than usual procedures (Umbricht-Schneiter et al., 1994). Other facilities will need to develop referral resources and feedback mechanisms. Either way, ongoing communication and coordination between service providers is essential to quality care.

In addition to the standard addiction-focused services, programs should address psychiatric, medical, family/social, employment, legal, or other problems that exist in association with the SUD. Treatment services directed toward these additional problems, when they exist, are associated with improvement, while problems show little improvement if services are not provided.

**EVIDENCE TABLE**

	<b>Recommendations</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Treat concurrent psychiatric disorders, including concurrent pharmacotherapy.	Mason et al., 1996 Nunes et al., 1995 Nunes et al., 1998 U. S. DHHS, 1994	I	A
2	Target specific services to address other coexisting biopsychosocial problems.	McLellan et al., 1993 McLellan et al., 1994 McLellan et al., 1998	I	A

QE = Quality of Evidence; R = Recommendation (See Introduction)

**M. Is Patient Nicotine Dependent?**

OBJECTIVE

Identify patients with nicotine dependence for which cessation treatment may be effective.

ANNOTATION

1. Nearly all daily nicotine users are nicotine dependent (See Module A, Annotation E, for the DSM-IV dependence criteria [305.1]).
2. Offer and recommend smoking cessation treatment to every patient who is dependent on nicotine. Use the VHA/DoD Clinical Practice Guideline To Promote Tobacco Use Cessation in the Primary Care Setting.
3. Identification and treatment of co-morbid nicotine dependence may improve recovery rates of other SUDs.

DISCUSSION

Nicotine and alcohol interact in the brain, each drug possibly affecting vulnerability to dependence on the other (Schiffman & Balabanis, 1995). Initial studies suggest that recovery rates from non-nicotine SUDs are significantly improved in patients who reduce their nicotine usage prior to discharge from structure rehabilitation settings, versus those nicotine addicts who do not effect any reductions in their nicotine use (Frosch, et al., 2000). Consequently, some researchers postulate that treating both addictions simultaneously might be an effective, even essential, way to help reduce dependence on both (NIAAA, 2000).

**N. Is Addiction-Focused Pharmacotherapy Indicated?**

OBJECTIVE

Consider appropriateness of addiction-focused pharmacotherapy for all patients.

ANNOTATION

1. Consider addiction-focused pharmacotherapy for opioid dependence and/or alcohol dependence as part of a comprehensive treatment plan including addiction-focused psychosocial treatment and pharmacotherapy for co-existing psychiatric conditions (O'Brien & McKay, 1998).
2. Evaluate indications for pharmacotherapy in all patients with opioid and alcohol dependence (see Tables 3 and 4).

**Table 3. Indications for Using Naltrexone and Disulfiram for Alcohol Dependence**

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

**Table 4. Indications for Using Naltrexone and Opioid Agonists for Opioid Dependence**

Naltrexone	Opioid Agonists: Methadone and LAAM
<p>Opioid dependence with:</p> <ul style="list-style-type: none"> <li>▪ Ability to achieve at least 7-10 days of abstinence to rule out the need for detoxification</li> <li>▪ Most effective when the patient is engaged in addiction-focused counseling with monitored administration</li> </ul>	<ul style="list-style-type: none"> <li>▪ Opioid dependence <math>\geq</math> 1 year</li> <li>▪ Two or more unsuccessful opioid detoxification episodes within a 12-month period</li> <li>▪ Relapse to opioid dependence within 2 years from OAT discharge</li> </ul>

Please refer to Module P: Addiction-Focused Pharmacotherapy for contraindications and regimen guidelines.

#### DISCUSSION

Naltrexone is indicated in the treatment of alcohol dependence and for the blockade of the effects of exogenously administered opioids. Naltrexone has been shown to reduce drinking and may be particularly effective in preventing full-blown relapses in patients who are alcohol dependent and return to drinking after achieving abstinence (O'Brien & McLellan, 1996; O'Brien & McKay, 1998; Schuckit, 1996; Volpicelli et al., 1997). Predictors of positive responses have included high levels of alcohol craving at treatment admission, poorer cognitive functioning, and more somatic complaints. The most consistent predictor of treatment response is better adherence to the treatment protocol and medication regimen.

There continue to be questions concerning the efficacy of disulfiram use for alcohol dependence. Some studies show little efficacy for maintaining complete abstinence at one year (Fuller & Roth, 1979; Fuller et al., 1986, Smith et al., 1998). Other studies show treatment improvement, especially for highly motivated patients whose disulfiram administration is supervised (Azrin et al., 1982; Chick et al., 1992). Because of the medical risks of a disulfiram-ethanol reaction (DER) and the risks of disulfiram use itself, disulfiram is generally not considered in a patient who has never received treatment for their alcoholism. In addition, disulfiram is only appropriate for alcoholics who seek abstinence as their treatment goal. Disulfiram use should be considered if there is a history of relapse (especially multiple relapses) or if the patient has a past history of successful abstinence while using disulfiram. Some studies suggest that middle-aged alcohol dependent males with social stability (defined as living with someone or being employed) may be the best candidates (Fuller, 1995).

Naltrexone has been shown safe and effective in blocking opiate receptors and has been FDA approved for treatment of opioid dependence since 1983. It is unpopular among many opioid dependent patients, and few programs encourage chronic opioid addicts to try it (see Module P, Annotation E).

New pharmacotherapies for these and other substance use disorders are under investigation (e.g., acamprosate for alcohol dependence and buprenorphine for opioid dependence) and should be considered pending efficacy data and FDA approval.

#### **O. Provide Periodic Reassessment Of Problems, Goals, And Response To Psychosocial Treatment And Pharmacotherapy**

##### OBJECTIVE

Periodically reassess response to treatment, change in treatment goals, or other indications for change in the treatment plan.

## ANNOTATION

1. Reassess and document clinical response throughout the course of treatment:
  - Daily in the acute inpatient setting, including reevaluation of the continued need for that level of care.
  - At least weekly in the residential setting, including reevaluation of the continued need for that level of care.
  - In the outpatient setting:
    - Within the first 10-14 days for a new episode of care
    - After the first 90 days of continuing care
    - At least annually for long-term care
2. For patients receiving pharmacotherapy with disulfiram or naltrexone, transaminase levels should be reassessed monthly for the first 3 months and then every 3 months thereafter (see Module P, Annotation J).
3. Modify treatment plans individually based on changes in a patient’s clinical and psychosocial condition rather than imposing uniform treatment plans (ASAM, 1996)
4. Indications to change treatment intensity or provide adjunctive treatments may include:
  - Relapse based on self-report or urine toxicology
  - Increased risk of relapse (e.g., craving or personal loss)
  - Emergence or exacerbation of comorbid medical and psychiatric conditions
  - Suboptimal response to medication
  - Emergence of medication side effects
5. Discuss relapse as a signal to reevaluate the treatment plan rather than evidence that the patient cannot succeed or was not sufficiently motivated (Miller & Rollnick, 1991).
6. Target services to identified problems (e.g., psychiatric, medical, family/social, legal, vocational, and housing) that increase the risk of relapse, rather than increasing drug and alcohol counseling alone (McLellan et al., 1997).
7. Consider care management for patients with persistently sub-optimal response, rather than routinely intensifying rehabilitation or discharging (See Module C: Care Management).
8. Consider reduced treatment intensity or discontinuing some treatment components based on:
  - Full, sustained remission
  - Greater involvement in community support
  - Improvements in other associated problem areas
9. Coordinate follow-up with the patient's primary medical or behavioral health provider during transitions to less intensive levels of care in order to reinforce progress and improve monitoring of relapse risks.

## EVIDENCE TABLE

	<b>Recommendations</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Modify treatment plans based on changes in a patient’s clinical and psychosocial condition.	ASAM, 1996	III	A
2	Discuss relapse as a signal to reevaluate the treatment plan.	Miller & Rollnick, 1991 Marlatt & Gordon, 1985	III	A
3	Target services to identified problems that increase the risk of relapse.	McLellan et al., 1997	I	A

QE = Quality of Evidence; R = Recommendation (See Introduction)

## P. Create Recovery Plan

### OBJECTIVE

Maximize the patient's chances for achieving his/her rehabilitation goals by summarizing, simplifying, and solidifying key recovery ingredients.

### ANNOTATION

Summarize on paper "the basic things I need to do to meet my rehabilitation goals," including the following:

1. Information on treatment appointments and mutual help meetings to attend
2. Recognizing relapse warning signs and triggers and appropriate coping responses
3. Maintaining contact with recovery support network

As part of discharge instructions, provide this to the patient to facilitate compliance with aftercare plans.

### DISCUSSION

A Recovery Plan (Tri-Service Addiction Recovery Center (TRISARC), 1998) is a mutual effort between the patient and treatment team to crystallize those aspects of aftercare that are essential to being successful in recovery. Recovery Plans can be personalized to the individual patient's needs or the treatment team's discretion. However, some basic areas to be considered include the following descriptive (rather than prescriptive) list:

1. A listing of the names, dates, and times of *follow-up meetings*. For example: 12 Step (or non-12 Step) support meetings the patient will be attending after rehabilitation (including the frequency of attendance); first name and phone number of sponsor(s); aftercare and other medical appointment dates, times and locations as well as phone numbers/addresses (and provider's names, if known).
2. A summarization of the primary issues the patient has been working on during rehabilitation treatment and the specific methods the patient intends to use towards resolution of these issues.
3. The patient's personally identified (with the help of their sponsor, rehabilitation counselor, etc.) relapse warning signs and triggers, and the respective countering coping skills planned (Gorski & Miller, 1986).
4. A listing of individuals within the patient's identified recovery support network (Galanter, 1997) (other than sponsors and providers) along with some description regarding the role of each in the patient's recovery.

Relapse warning signs are those behaviors manifested by the patient that often precede a lapse or relapse (Talbot et al., 1998). Examples may include behaviors such as defensiveness with one's sponsor or support network, impulsive behavior, failing to plan one's days out ahead of time, or irregular eating habits. While not specifically predictive of a relapse, they are nevertheless suggestive and important to monitor. Both the patient and her/his support group may benefit from such knowledge. While combinations of relapse warning signs are unique to each individual, various texts on recovery offer common examples (Gorski & Miller, 1986).

As opposed to warning signs, relapse triggers are those items in the patient's everyday internal or external environment that may place her/him at increased risk of imminent relapse (e.g., spouse conflict, occupational stressors, depressed affect, and episodes of rage).

**Q. Are There Indications To Continue Treatment In Specialty Care?**

OBJECTIVE

Optimize the duration of formal addiction-focused treatment consistent with the establishment of recovery support in the patient's community.

ANNOTATION

1. Use the patient's progress in attaining recovery goals to guide treatment continuation, rather than uniform treatment plans.
2. Uniform length or intensity of care.
3. Consider patient report of craving and other subjective indications of relapse risk.
4. Emphasize the increased risk of relapse in early recovery and the importance of follow-up, until the patient establishes full-sustained remission (i.e., no dependence criteria met for 12 months).

DISCUSSION

In general, longer lengths of time in treatment correlate with better outcomes for more severely dependent patients (Gerstein & Harwood, 1990; Mattson et al., 1998). Monitoring of the patient's response to treatment should inform decisions regarding continuation until recovery support in the patient's daily life is adequately established.

When no further addiction-focused treatment visits are scheduled, patients should be scheduled for follow-up with their primary medical or behavioral health care provider for relapse monitoring and ongoing management of coexisting medical and/or psychiatric conditions.

**R. Discontinue Treatment In Specialty Care; Arrange For Transition To Primary Care**

OBJECTIVE

Provide appropriate continuity of care to follow up with primary medical or behavioral health care provider.

ANNOTATION

Discuss the impact of changes in substance use on other medical and psychiatric conditions and identify relapse risks for future monitoring. Arrange for continued monitoring of substance use and co-morbid conditions either in addiction specialty care or by the patient's primary medical or behavioral health care provider.

1. Schedule primary care follow-up within 90 days to reinforce recovery progress during the post-discharge period of highest risk for relapse (McLellan et al., 1996).
2. Encourage patients to re-contact addiction-focused treatment providers for additional help as needed in preventing or promptly interrupting relapse.
3. For DoD active duty patients, addiction-focused treatment follow-up may be mandated for a period of 6-12 months from the time of initial referral (this may be referred to as "aftercare" in the DoD community).

## DISCUSSION

Relapse rates in substance use disorders are comparable to those reported for other chronic medical disorders that require behavioral compliance (e.g., hypertension, asthma, and diabetes) (McLellan et al., 2000). Given the risks of relapse even with successful treatment, primary providers should ask about and discuss with patients any relapses or warning signs during ongoing follow-up.

### **S. Follow-up In Primary Care**

#### OBJECTIVE

Assure continuity of care with primary provider and promote abstinence or reduced use.

#### ANNOTATION

Communicate the follow-up plan to the primary provider, including:

1. Monitor signs of use and ask the patient about specific quantity and frequency of use.
2. Monitor other biological indicators that may improve with abstinence (e.g., transaminase levels or hypertension).
3. Assess adherence to recovery plan.
4. Coordinate continued addiction-focused pharmacotherapy, if indicated.
5. Provide motivational support.
6. Discuss other areas of concern in the patient's life that may be prognostic indicators.
7. Encourage abstinence or reduced use that is consistent with patient's motivation and agreement.

## Module R References

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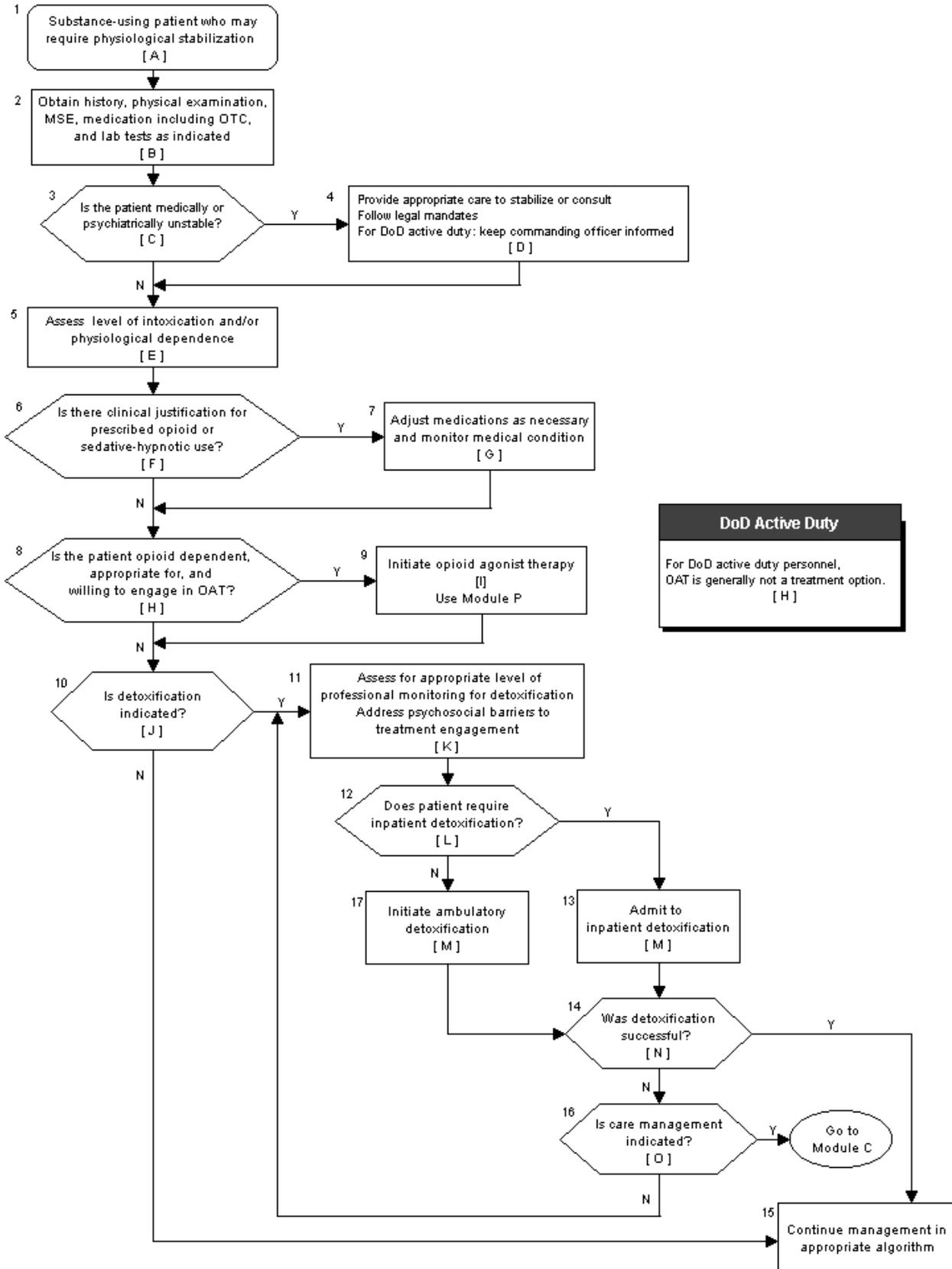
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VHA/D<sub>o</sub>D CLINICAL PRACTICE GUIDELINE FOR THE  
MANAGEMENT OF **SUBSTANCE USE DISORDERS**  
IN THE PRIMARY CARE SETTING

**MODULE S:  
STABILIZATION**

Version 1.0

**MANAGEMENT OF SUBSTANCE USE DISORDERS**  
**Module S: Stabilization**



## ANNOTATIONS

### A. Substance-Using Patient Who May Require Physiological Stabilization

This module addresses the management of patients who are physiologically dependent on alcohol or other sedative-hypnotics or opioids and at risk of withdrawal symptoms, or for whom the provider is uncertain about the level of withdrawal risk and seeks further evaluation.

### B. Obtain History, Physical Examination, Mental Status Examination (MSE), Medication Including Over-The Counter (OTC), And Lab Tests As Indicated

*Note: An assessment may already have been obtained as part of the patient's initial assessment.*

#### OBJECTIVE

Obtain clinical background information on the patient.

#### ANNOTATION

1. Interview the patient and other collateral informants, where appropriate, about medical history and use of prescription and non-prescription medications before initiating extensive diagnostic testing.
2. Note any history of recent head trauma.
3. Order laboratory tests selectively, aiming to detect potential medical causes for the presenting symptoms, where indicated by:
  - Specific symptoms found on the medical review of systems
  - Evidence of unusual symptom profiles
  - History of atypical illness course
4. Screen for cognitive status, particularly in the elderly patient.
  - Consider a standardized instrument, such as Folstein's Mini-Mental State Examination (MMSE) (Folstein et al., 1975) using age and education-adjusted cut-off scores (Crum et al., 1993).
  - Consider using a standardized procedure, such as the Neurobehavioral Cognitive Status Exam (Kiernan et al., 1987), if the mental status screening is positive.

### C. Is The Patient Medically Or Psychiatrically Unstable?

#### OBJECTIVE

Identify the patient who needs to be stabilized before continuing in the algorithm.

#### ANNOTATION

Patients with problems that require emergency care or urgent action should not be further managed in this algorithm. Emergency or urgent actions include unstable medical problems (e.g., acute trauma, myocardial infarction, and stroke) or unstable psychiatric problems (e.g., delirium and imminent risk of harm to self and/or others).

### **Delirium (APA, 1994)**

Delirium can be identified through the following:

1. Disturbance of consciousness (e.g., reduced clarity of awareness of the environment with reduced ability to focus, sustain, or shift attention).
2. A change in cognition (such as memory deficit, disorientation, or language disturbance) or the development of a perceptual disturbance that is not accounted for by a preexisting, established, or evolving dementia.
3. The disturbance develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day.
4. There is evidence from the history, physical examination, or laboratory findings that:
  - Illness is characterized by an atypical course.
  - Disturbances are caused by the direct physiological consequences of a general medical condition.
  - Symptoms developed during substance intoxication or medication use are etiologically related to the disturbance.
  - Symptoms are developed during or following a withdrawal syndrome.
  - Delirium has more than one etiology (e.g., a general medical condition plus intoxication or a medication side effect).

### **Risk of harm to self or others**

1. If suicidal ideation is present, the imminent risk increases with one or more of the following risk factors:
  - Prior suicide attempt and lethality of prior acts
  - Level of intent and formulation of plan
  - Greater preoccupation (e.g., frequency, intensity, and duration of thoughts)
  - Availability of lethal means for suicide (e.g., firearms or pills)
  - Family history of completed suicide
  - Presence of active mental illness (e.g., severe depression or psychosis)
  - Presence of substance abuse
  - Current negative life events (e.g., loss in personal relationship)
  - Feelings of hopelessness or helplessness
2. Consider the patient's history of violent acts as an increased risk for violence toward self or others.
3. Offer mental health counseling to patients with evidence of suicidal, assaultive, or homicidal ideation.
4. Arrange voluntary or involuntary emergency psychiatric treatment and possibly hospitalization for patients with definite intent to harm self or others, particularly those with a plan and the available means.

### **Serious psychiatric instability**

Obtain immediate mental health consultation if other psychiatric symptoms (e.g., acute psychosis) significantly interfere with further assessment and require immediate psychiatric treatment before continuing assessment.

EVIDENCE TABLE

	<b>Recommendations</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Assess imminent risk for suicide.	U. S. PSTF, 1996	II-2	A
2	Note increased risk for violence.	Hasting & Hamberger, 1997 Thienhaus & Piasecki, 1998	III	A
3	Offer counseling to patients at risk.	Hirschfield & Russell, 1997 U. S. PSTF, 1996	III	A
4	Arrange emergency treatment or possible hospitalization.	APA, 1993 CSAT, 1995 U. S. DHHS, 1993 & 1995 U. S. PSTF, 1996 VA Task Force, n/d.	III	A

QE = Quality of Evidence; R = Recommendation (See Introduction)

**D. Provide Appropriate Care To Stabilize Or Consult  
Follow Legal Mandates  
For DoD Active Duty: Keep Commanding Officer Informed**

OBJECTIVE

Provide services to stabilize the patient's condition.

ANNOTATION

1. Implement suicide or high-risk protocols, as needed.
2. Review local policies and procedures with regard to threats to self or others. These policies reflect local and state laws and the opinion of the VA District Council and the DoD. Primary care, mental health, and administrative staff must be familiar with these policies and procedures.
3. For DoD active duty: follow service-specific mandates, as mental health/emergency referral is likely mandated.

**E. Assess Level Of Intoxication And/Or Physiological Dependence**

OBJECTIVE

Obtain the necessary data to guide the patient's detoxification process.

ANNOTATION

Indications for stabilization include intoxication or risk of withdrawal:

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

**Table 1. Signs and Symptoms of Intoxication (APA, 1994)**

Types of Intoxication	Signs and Symptoms
Alcohol and Sedative-Hypnotics	<ul style="list-style-type: none"> <li>▪ Slurred speech</li> <li>▪ Incoordination</li> <li>▪ Unsteady gait</li> <li>▪ Nystagmus</li> <li>▪ Impairment in attention or memory</li> <li>▪ Stupor or coma</li> </ul>
Cocaine or Amphetamine	<ul style="list-style-type: none"> <li>▪ Tachycardia or bradycardia</li> <li>▪ Pupillary dilation</li> <li>▪ Elevated or lowered blood pressure</li> <li>▪ Perspiration or chills</li> <li>▪ Nausea or vomiting</li> <li>▪ Psychomotor agitation or retardation</li> <li>▪ Muscular weakness, respiratory depression, or chest pain</li> <li>▪ Confusion, seizures, dyskinesias, dystonias, or coma</li> </ul>
Opiate	<ul style="list-style-type: none"> <li>▪ Pupillary constriction (or dilation due to anoxia from overdose)</li> <li>▪ Drowsiness or coma</li> <li>▪ Slurred speech</li> <li>▪ Impairment in attention or memory</li> <li>▪ Shallow and slow respiration or apnea</li> </ul> <p><i>Note: Acute opiate intoxication can present as a medical emergency with unconsciousness, apnea, and pinpoint pupils.</i></p>

**Symptoms of withdrawal from sedative-hypnotics or alcohol**

1. Signs and symptoms of withdrawal from sedative-hypnotics or alcohol include two or more of the following, developing within several hours to a few days after cessation or reduction in heavy and prolonged use:
  - Autonomic hyperactivity (e.g., diaphoresis, tachycardia, and elevated blood pressure)
  - Increased hand tremor
  - Insomnia
  - Nausea and vomiting
  - Transient visual, tactile, or auditory hallucinations or illusions
  - Delirium tremens (DTs)
  - Psychomotor agitation
  - Anxiety
  - Irritability
  - Grand mal seizures
2. The potential for a withdrawal syndrome can be gauged only imprecisely by asking the patient the pattern, type, and quantity of recent and past substance use.
3. Consider standardized measures to assess the severity of withdrawal symptoms. The Clinical Institute Withdrawal Assessment for Alcohol-Revised (CIWA-Ar) has good reliability and validity for assessing severity of withdrawal symptoms from alcohol (see Appendix A-1).
4. CIWA-Ar has 10 provider ratings. Interpret total scores as follows:
  - Minimal or absent withdrawal:  $\leq 9$
  - Mild to moderate withdrawal: 10-19
  - Severe withdrawal:  $\geq 20$

**Symptoms of opioid withdrawal**

1. The opioid withdrawal syndrome can be protracted with intense symptoms, though the syndrome itself poses virtually no risk of mortality. However, there is significant mortality risk from overdose

for those who relapse following unsuccessful detoxification attempts, as a result of loss of opioid tolerance.

2. Signs and symptoms of opioid withdrawal include any or all of the following, which may develop at a time appropriate for the ingested opioid (e.g., within 6-12 hours after the last dose of a short acting opioid, such as heroin, or 36-48 hours after the last dose of a long acting opioid, such as methadone):
  - Craving for opioids
  - Restlessness or irritability
  - Nausea or abdominal cramps
  - Increased sensitivity to pain
  - Muscle aches
  - Dysphoric mood
  - Insomnia or anxiety
  - Pupillary dilation
  - Sweating
  - Piloerection (i.e., gooseflesh)
  - Tachycardia
  - Vomiting or diarrhea
  - Increased blood pressure
  - Yawning
  - Lacrimation

#### **Physiological dependence**

1. Determine the presence of tolerance or withdrawal, as documented in DSM-IV diagnostic criteria.
2. Tolerance is identified by either of the following:
  - A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
  - Markedly diminished effect with continued use of the same amount of the substance.
3. Withdrawal is identified by either of the following:
  - The characteristic withdrawal syndrome for the substance (refer to DSM-IV for further details).
  - The same (or a closely-related) substance is taken to relieve or avoid withdrawal symptoms.
4. Evaluate patients using multiple substances (e.g., opioids and sedative-hypnotics) for risk of withdrawal from each substance.

#### **DISCUSSION**

Recent intake of a substance can be assessed from the history, physical examination (e.g., alcohol on the breath), or toxicological analysis of urine or blood. The specific clinical picture in substance intoxication depends on the substance(s) used, the duration of use at that dose, tolerance, time since last dose, expectations of effects, and the environment or setting of use.

DSM-IV (APA, 1994) substance intoxication is:

- The development of a reversible substance-specific syndrome due to recent ingestion of (or exposure to) a substance. Note: Different substances may produce similar or identical syndromes.
- Clinically significant maladaptive behavioral or psychological changes that are due to the effect of the substance on the central nervous system (e.g., belligerence, mood lability, cognitive impairment, impaired judgment, and impaired social or occupational functioning) and develop during or shortly after use of the substance.

Note: The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

EVIDENCE TABLE

	<b>Recommendations</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Consider using standardized assessment of withdrawal symptoms.	Sullivan et al., 1989 Gossop, 1990 Zilm & Sellers, 1978	II-2	A

QE = Quality of Evidence; R = Recommendation (See Introduction)

**F. Is There Clinical Justification For Prescribed Opioid Or Sedative-Hypnotic Use?**

OBJECTIVE

Clarify the underlying clinical condition being managed through opioid or sedative-hypnotic use.

ANNOTATION

1. Distinguish patients with legitimate pain and/or anxiety disorders who develop physiological tolerance during long-term use of prescribed medications, from those with markers of "addict behavior" (e.g., seeking medications for other than pain, seeking prescriptions from multiple providers, increasing the dose without consultation, frequent "losses" of medications, intoxication, or buying medication on the street).
2. Evaluate opioid dependent patients for severe acute or chronic physical pain that may require appropriate short-acting opioid agonist medication, in addition to the medication needed to prevent opioid withdrawal symptoms (see also [www.asam.org/ppol/opioids.htm](http://www.asam.org/ppol/opioids.htm) for American Society of Addiction Medicine policy statement).
3. Consider patients with a history of substance use disorders (SUDs) to be at elevated risk of receiving inadequate therapy for pain or anxiety.
4. Prescribe opioid analgesic medication (in cases of severe pain disorders) or sedative-hypnotic medication (in cases of severe anxiety or seizure disorders), when medically indicated, even if the patient has a history of SUD and provided that the patient's medical condition is:
  - Diagnosed correctly, including physical examination, review of past records, and appropriate consultation
  - Acute enough to justify the use of opioid analgesics
  - Documented in the clinical record
5. Consult with an addiction specialist, if uncertain whether to prescribe an opioid analgesic or sedative-hypnotic medication to a substance dependent patient with a current or historical SUD.

EVIDENCE TABLE

	<b>Recommendations</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Distinguish opioid addiction from opioid dependence.	Portenoy, 1994 American Geriatrics Society Panel, 1998	III	A
2	Consider patients with SUDs to be at elevated risk of receiving inadequate pain therapy.	Portenoy et al., 1997 Savage, 1999	III	B

QE = Quality of Evidence; R = Recommendation (See Introduction)

**G. Adjust Medications As Necessary And Monitor Medical Condition**

OBJECTIVE

Assure appropriate symptom management and safety monitoring for medically indicated opioid or sedative-hypnotic prescription.

ANNOTATION

1. Consider prescribing a higher medication dose for adequate symptom relief of physiologically tolerant, non-addicted patients.
2. Set reasonable behavioral and dosing limits and increase monitoring when pharmacologically treating pain or anxiety in patients with a history of substance dependence.
  - Prescribe medication on a fixed schedule, rather than as needed (PRN).
  - Use long-acting medication (such as sustained-release morphine or diazepam), rather than short acting medication (such as oxycodone/acetamenophen or alprazolam).
  - Limit prescription medication to what is needed until the next appointment.
  - Follow the patient weekly or biweekly, at least at the beginning of therapy.
  - Write out the prescription as you would a check, to prevent alteration.
3. Consider using written contracts for patients receiving opioids or sedative-hypnotics long term, and monitor their conditions carefully, with relatively frequent visits, urine drug screens, and use of collateral informants.
4. Discontinue prescription (with detoxification, if necessary) and refer to a SUD specialist, if abuse of opioid or sedative-hypnotic medications occurs.

EVIDENCE TABLE

	<b>Recommendations</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Consider prescribing a higher opioid dose for adequate pain relief of physiologically tolerant, non-addicted patients.	Portenoy, 1994 Portenoy et al., 1997	III	B
2	Set reasonable behavioral and dosing limits and increase monitoring when pharmacologically treating pain or anxiety in patients with substance dependence.	Portenoy, 1994 Portenoy et al., 1997 Scimeca et al., 2000 Longo et al., 2000	III	A

QE = Quality of Evidence; R = Recommendation (See Introduction)

**H. Is The Patient Opioid Dependent, Appropriate For, And Willing To Engage In Opioid Agonist Therapy (OAT)?**

OBJECTIVE

Assure careful consideration of OAT as the first line treatment for opioid dependence. For DoD active duty, OAT is generally not a treatment option.

ANNOTATION

Opioid dependence is a cluster of cognitive, behavioral, and physiological symptoms characterized by repeated self-administration and usually results in opiate tolerance, withdrawal symptoms, and compulsive drug taking, despite negative consequences. While new Federal regulatory language uses the term “opiate addiction,” the diagnostic term “opioid dependence” will be used here for consistency with the rest of the guideline. Dependence may occur with or without the physiological symptoms of tolerance and withdrawal. OAT for opioid dependence consists of administering an opioid agonist medication, such as

methadone or levo-alpha-acetylmethadol (LAAM), in combination with a comprehensive range of medical, counseling, and rehabilitative services. By administering an opioid to prevent withdrawal, reduce craving, and reduce the effects of illicit opioids, the opioid dependent patient is able to focus more readily on recovery activities. When compared to detoxification attempts, OAT is more successful in achieving the long-term goal of reducing opioid use and associated negative medical, legal, and social consequences.

Provide access to OAT for all opioid dependent patients, under appropriate medical supervision and with concurrent addiction-focused psychosocial treatment (See Module R: Assessment and Management in Specialty Care).

1. Consider methadone maintenance for its documented efficacy in reducing illicit opioid use, HIV risk behavior, and drug-related criminal behavior.
2. Consider LAAM, a long-acting, synthetic mu-agonist, a safe and effective alternative to methadone maintenance.
3. Consider the acceptability and feasibility of regular clinic attendance. Under Federal regulations of OAT programs, for the first 90 days of treatment the patient should attend clinic at least six days per week for methadone or three times per week for LAAM.
4. Refer to Table 2 for indications, contraindications, side effects, and drug interactions of methadone and LAAM.

**Table 2. Agonist Therapy for Opioid Dependence**

	<b>Opioid Agonists: Methadone and LAAM</b>
Indications	<ul style="list-style-type: none"> <li>▪ Opioid dependence <math>\geq</math> 1 year</li> <li>▪ Two or more unsuccessful opioid detoxification episodes within a 12 month period</li> <li>▪ Relapse to opioid dependence within 2 years from OAT discharge</li> </ul>
Contraindications	<ul style="list-style-type: none"> <li>▪ Allergy to agent</li> <li>▪ Concurrent enrollment in another OAT</li> <li>▪ Significant liver failure</li> <li>▪ Use of opioid antagonists (e.g., naloxone, nalmefene, or naltrexone)</li> </ul>
Side Effects	<ul style="list-style-type: none"> <li>▪ Common: constipation</li> <li>▪ Less common: sexual dysfunction</li> </ul>
Drug Interactions	<ul style="list-style-type: none"> <li>▪ Drugs that reduce serum methadone level: phenytoin, carbamazepine, rifampin, barbiturate sedative-hypnotics, some anti-virals, ascorbic acid, and chronic ethanol use</li> <li>▪ Drugs that increase serum methadone level: cimetidine, ketoconazole, fluconazole, amitriptyline, diazepam, and fluvoxamine maleate</li> </ul>

## DISCUSSION

OAT is inaccurately considered by some providers to be a treatment of last recourse; however, evidence consistently shows that patients have better outcomes when maintained with an agonist than a placebo (Newman and Whitehall, 1979; Strain et al., 1993a; Strain et al., 1993b) or than when provided long-term detoxification (Sees et al., 2000). Discharge from OAT programs is generally followed by relapse and other adverse outcomes (Gerstein et al., 1994; Magura & Rosenblum, in press). Unless there are legal or other extenuating circumstances, (such as active duty in DoD), OAT should be considered for any patient with a diagnosis of opioid addiction. For patients who previously relapsed, re-treatment should be a consideration. As part of the decision process, it is important to determine if appropriate agonist dosing was utilized and whether there were psychosocial barriers that could be better addressed upon re-attempting OAT.

Effective May 2001, the Substance Abuse and Mental Health Services Administration (SAMHSA), through its Center for Substance Abuse Treatment (CSAT), will regulate OAT programs as codified in 42 CFR Part 8 “Opioid Drugs in Maintenance and Detoxification of Opiate Addiction” ([http://www.samhsa.gov/news/click5\\_frame.html](http://www.samhsa.gov/news/click5_frame.html)). The new criteria for admission to OAT programs require that patients have been addicted to an opioid drug for at least 1 year prior to admission and that they provide voluntary informed consent to maintenance treatment. If considered clinically appropriate, the regulations provide exceptions to the requirement of a 1 year history of addiction for patients released from penal institutions within the prior 6 months, for pregnant patients, and for patients discharged from maintenance treatment within the prior 2 years.

The OAT program can provide short- or long-term detoxification and other services to patients not eligible for maintenance treatment; however, patients with 2 or more unsuccessful detoxification episodes within a 12-month period must be assessed by the OAT physician for other forms of treatment.

The Drug Addiction Treatment Act of 2000 makes opioids available to the office practitioner, in DEA Schedules III, IV, and V, with an FDA-approved indication for the treatment of opioid dependence. At the time this guideline is written, no medications are approved for such use other than methadone and LAAM, both of which are DEA Schedule II medications. However, it is anticipated that the FDA will approve in 2001 a partial mu-agonist, buprenorphine, for the treatment of opioid dependence; it is further anticipated that buprenorphine and/or a combination of buprenorphine/naloxone will fall within the guidelines of the Drug Addiction Treatment Act of 2000. Clinical practice guidelines and education material on the use of buprenorphine and buprenorphine/naloxone in office-based practice for the treatment of opioid dependence are being developed. More information is available at <http://www.samhsa.gov>.

#### EVIDENCE TABLE

	<b>Recommendations</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Consider OAT the first line treatment for opioid dependence.	National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction, 1998 Sees et al., 2000	I	A
2	Methadone maintenance, at adequate doses, is efficacious in reducing opioid use.	Strain et al., 1993a Strain et al., 1993b Marsch, 1998 Johnson, 2000	I	A
3	LAAM maintenance, at adequate doses, is an effective alternative to methadone maintenance.	Eissenberg et al., 1997 Glanz et al., 1997	I	A

QE = Quality of Evidence; R = Recommendation (See Introduction)

### I. Initiate Opioid Agonist Therapy (OAT)

#### OBJECTIVE

Provide appropriate dosing and relapse monitoring to promote effective outcomes.

#### ANNOTATION

##### **Methadone**

For newly-admitted patients, the initial dose of methadone should not exceed 30 mg, and the total dose for the first day should not exceed 40 mg, without provider documentation that 40 mg did not suppress opiate withdrawal symptoms.

Under usual practices, a stable target dose is greater than 60 mg/day and most patients will require considerably higher doses in order to achieve a pharmacological blockade of reinforcing effects of exogenously administered opioids. Effective May 2001, Federal regulations will no longer require the OAT program physician to justify in the patient record doses > 100 mg/day.

### **LAAM**

For newly admitted patients, the initial 48-hour dose of LAAM should not exceed 40 mg. After dose induction, a stable target dose is usually at least 50/50/70 mg administered on Monday/Wednesday/Friday and most patients will require considerably higher doses in order to achieve a pharmacological blockade of reinforcing effects of exogenously administered opioids. Friday doses are increased 40% to compensate for the 72-hour inter-dose interval. For patients on established doses of methadone, the relative potency of 48-hour LAAM doses is 1.2-1.3 times the daily methadone dose.

### **Opioid Agonist Therapy**

Providers should adjust opioid agonist doses to maintain a therapeutic range between signs/symptoms of overmedication (e.g., somnolence, miosis, itching, hypotension, and flushing) and opioid withdrawal (e.g., drug craving, anxiety, dysphoria, and irritability).

Deliver OAT in the context of a complete treatment program that includes counseling or psychotherapy (See Module R: Assessment and Management in Specialty Care).

- Methadone, combined with weekly counseling for at least four weeks after admission, followed by at least monthly counseling, has been shown to be more effective than methadone alone.
- Availability of more frequent counseling is associated with less illicit drug use.
- No specific form of psychosocial intervention has consistently been shown to be more or less efficacious.
- Programs with high-quality social services show better treatment retention.
- Programs must provide adequate urine toxicology for drugs of abuse, including a minimum of eight random tests per year per patient.

### **DISCUSSION**

Effective May 2001, OAT programs must obtain accreditation from an accreditation body that has been approved by the SAMHSA (e.g., JCAHO or CARF) or a state accreditation body, in order to be Federally certified to dispense medications and provide treatment services.

To comply with Federal regulations to prevent diversion of opioid medication from legitimate treatment use (42 CFR 8), individual OAT programs have developed a variety of internal procedures with which the patient and provider must comply (e.g., random urine toxicology, policies for “take home” doses, and “call backs” to verify appropriate use of “take home” doses). Although each OAT program's internal structure and guidelines vary, it would be prudent for the primary physician and/or other health care providers to discuss program rules and expectations with the OAT program physician, so that patient care is appropriately coordinated.

OAT programs must provide full and reasonable access to adequate medical, counseling, vocational, educational, and other assessment and treatment services, either at the primary facility or through a documented agreement with other providers.

EVIDENCE TABLE

	<b>Recommendations</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Methadone target dose is typically > 60 mg/day.	Strain et al., 1999 Preston et al., 2000	I	A
2	Methadone, combined with regular counseling, is more effective than methadone alone.	McLellan et al., 1993	I	A
3	Frequent counseling is associated with less illicit drug use.	Magura et al., 1999	II-2	A
4	High-quality social services show better treatment retention.	Condelli, 1993	I	A
5	LAAM target dose is typically at least 50/50/70 mg on Monday/Wednesday/Friday.	Jones et al., 1998 Eissenberg et al., 1997	I	A

QE = Quality of Evidence; R = Recommendation (See Introduction)

**J. Is Detoxification Indicated?**

OBJECTIVE

Identify patients who need detoxification from alcohol, sedative-hypnotics, or opioids.

ANNOTATION

Detoxification is an essential initial gateway in preparing many patients for additional treatment. Pharmacological detoxification is warranted only for alcohol, sedative-hypnotics, and opioids. For nicotine dependence, refer to the VHA/DoD Clinical Practice Guideline To Promote Tobacco Use Cessation in the Primary Care Setting. Other drugs of abuse do not require pharmacological management for withdrawal.

**Indications for detoxification from alcohol or sedative-hypnotics**

1. Medical monitoring of detoxification should be provided for dependence on central nervous system (CNS) depressants, due to the potential severity of untreated withdrawal in severely dependent persons.
2. Mild withdrawal symptoms that are not accompanied by complicating comorbidities may not require pharmacological management and may respond sufficiently to generalized support, reassurance, and frequent monitoring (APA, 1995).
3. Detoxification from sedative-hypnotics is indicated when there is physical dependence in the absence of clinical indications for ongoing treatment (e.g., anxiety or panic disorder) or when accompanied by “addict behavior” (e.g., prescriptions from multiple providers, patient escalating doses without provider consultation, or buying medications on the street).

**Indications for opioid detoxification**

1. It is difficult to identify opioid addicted patients with good prognosis for successful opioid detoxification; however, the following are relative indications:
  - Briefer and less severe addiction history that does not meet regulatory criteria for opioid agonist treatment (see Annotation H)
  - Active commitment to an abstinence-oriented recovery program (e.g., monitored naltrexone, mutual help program involvement, and therapeutic community participation)
2. Detoxification is contraindicated for individuals with two or more unsuccessful detoxification episodes within a 12-month period. Such patients must be assessed by an opioid treatment program physician for alternatives to detoxification.

## DISCUSSION

Detoxification from CNS depressants is not a complete treatment for substance dependence, although it can prepare patients for a comprehensive treatment strategy. Simpson and Sells (1990) showed that patients in methadone maintenance, therapeutic community, or outpatient drug-free counseling had better outcomes than did patients who either did not follow-up after an intake assessment or received only detoxification without follow-up treatment. Even among highly motivated patients who are clinically and psychosocially stable over several years (Magura & Rosenblum, in press), few achieve extended full remission after leaving treatment and many experience adverse outcomes such as death, incarceration, and HIV infection.

If a patient is physiologically dependent on sedative-hypnotics that are not being prescribed as part of an appropriate ongoing treatment regimen for underlying pathology (e.g., anxiety and seizure disorders), careful monitoring during detoxification is indicated. While withdrawal symptoms are present or likely to emerge in a patient with moderate to severe physiologic dependence, detoxification in many cases can be safely accomplished without pharmacological management of withdrawal symptoms.

## EVIDENCE TABLE

	<b>Recommendations</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Mild withdrawal symptoms that are not accompanied by complicating comorbidities may respond sufficiently to generalized support, reassurance, and frequent monitoring.	APA, 1995	II-2	D

*QE = Quality of Evidence; R = Recommendation (See Introduction)*

### **K. Assess For Appropriate Level Of Professional Monitoring For Detoxification Address Psychosocial Barriers to Treatment Engagement**

#### OBJECTIVE

Ensure safety during detoxification in the least restrictive environment and promote long-term successful recovery.

#### ANNOTATION

Determine appropriate level of care, based on:

1. Severity of current and past withdrawal symptoms (e.g., use of CIWA-Ar for alcohol or the Short Opiate Withdrawal Scale (SOWS) or Clinical Institute Narcotics Assessment (CINA) for opioids).
2. Severity of comorbid conditions.
3. Patient's treatment acceptance and potential to complete detoxification.
4. Recovery environment and other ASAM criteria (see Web site: <http://www.asam.org>).

#### DISCUSSION

This guideline endorses ASAM's (1996) recommendation to consider the following primary patient dimensions in making a decision about appropriate level of care:

1. Acute intoxication and/or withdrawal potential, especially history of withdrawal seizures
2. Biomedical conditions and complications
3. Emotional/behavioral conditions and complications including:
  - Psychiatric conditions
  - Psychological or emotional/behavioral complications of known or unknown origin
  - Poor impulse control

- Change in mental status
  - Transient neuropsychiatric complications
4. Treatment acceptance/resistance
  5. Relapse/continued use potential
  6. Recovery/living environment

Standardized assessments, such as the CIWA-Ar, SOWS, or CINA scales, may be used in addition to monitoring vital sign status and evidence of severe withdrawal by history. The patient’s potential to complete detoxification should also be evaluated to determine the appropriate setting for stabilization.

EVIDENCE TABLE

	<b>Recommendations</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Determine appropriate level of care.	ASAM, 1996	III	A
2	Use standardized assessment of withdrawal symptoms.	Sullivan et al., 1989 Gossop, 1990 Zilm & Sellers, 1978	II	A

QE = Quality of Evidence; R = Recommendation (See Introduction)

**L. Does Patient Require Inpatient Detoxification?**

OBJECTIVE

Identify the appropriate setting for safe and effective withdrawal management.

ANNOTATION

1. Ambulatory detoxification has the potential advantages of:
  - Facilitating continuity of care in the outpatient setting
  - Reducing disruption to the patient's life
  - Lowering costs in the outpatient setting
2. While no definitive standard exists for setting up an ambulatory detoxification protocol, there should be systematic assessment and consistent monitoring.
3. Inpatient detoxification allows closer monitoring of withdrawal symptoms and higher likelihood of completing the detoxification protocol.
  - There are fewer logistic medical and legal concerns (e.g., arranging for patient transportation, driving during the course of detoxification, and the ability to give informed consent).
  - While patients are more likely to complete the inpatient detoxification protocol, long-term outcomes do not indicate a difference between inpatient and outpatient detoxification programs.
4. Consider the following indications for inpatient detoxification:
  - Current symptoms of moderate to severe alcohol withdrawal (e.g., CIWA-Ar score  $\geq 10$ )
  - History of DTs or withdrawal seizures
  - Inability to tolerate oral medication
  - Imminent risk of harm to self or others
  - Recurrent unsuccessful attempts at ambulatory detoxification
  - Reasonable likelihood that the patient will not complete ambulatory detoxification (e.g., due to homelessness)
  - Active psychosis or severe cognitive impairment
5. Because medical complications and withdrawal severity are often the reasons for an inpatient detoxification admission, inpatient programs should provide adequate, on-site medical staffing in order to ensure patient safety during detoxification.

## DISCUSSION

Compared to ambulatory detoxification settings, inpatient detoxifications can often be done more rapidly since access to alcohol and drugs is restricted. Detoxification monitoring, performed while a patient is in a clinically managed residential setting (e.g., some VA Substance Abuse Residential Rehabilitation Treatment Programs [SARRTP]), is considered ambulatory.

## EVIDENCE TABLE

	<b>Recommendations</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Indications for inpatient detoxification.	ASAM, 1996	III	A

QE = Quality of Evidence; R = Recommendation (See Introduction)

### **M. Admit To Inpatient Detoxification Initiate Ambulatory Detoxification**

#### OBJECTIVE

Provide a safe withdrawal from alcohol or sedative-hypnotics and prepare the patient for ongoing addiction treatment.

#### ANNOTATION

##### **Alcohol detoxification**

Facilities should develop local alcohol detoxification pathways, taking into consideration the following principles:

1. Use either of the following two acceptable pharmacotherapy strategies for managing alcohol withdrawal symptoms:
  - Symptom-triggered therapy, where patients are given medication only when signs or symptoms of withdrawal appear (e.g., PRN dosing).
  - A predetermined fixed medication dose, with gradual tapering over several days.
2. Consider standardized assessments, such as the CIWA-Ar scale for alcohol withdrawal, to guide dosing decisions (e.g., if and when to dose).
3. Consider the following empirically validated procedures for ambulatory alcohol detoxification monitoring as safe and effective alternatives to inpatient approaches:
  - Medical or nursing staff should assess the patient in person, either daily or every other day (patient contact may be made by telephone on other days), to include:
    - Patient report of any alcohol use the previous day
    - Reported medication intake compared to the medication dispensed the previous day
    - Tremor, restlessness, and previous night's sleep
    - Skin (e.g., color and turgor)
  - Urine toxicology or a breathalyzer test of BAC should be completed.
  - The patient should be medically cleared before initiating or continuing outpatient detoxification, if the daily screening is positive for any one of the following:
    - Blood sugar  $\geq$  400 or positive anion gap
    - History of recent hematemesis or other GI bleeding disorder
    - Bilirubin  $\geq$  3.0
    - Creatinine  $\geq$  2.0
    - Systolic blood pressure  $\geq$  180 or diastolic blood pressure  $\geq$  110
    - Unstable angina
    - Temperature  $\geq$  101 degrees
    - BAC  $\geq$  0.08 on two outpatient visits

4. For the treatment of alcohol withdrawal, use benzodiazepines over non-benzodiazepine sedative-hypnotics because of documented efficacy, decreased abuse potential, and a greater margin of safety. Benzodiazepines are the drug of choice because they reduce withdrawal severity, incidence of delirium, and seizures. All benzodiazepines appear to be effective.
5. For geriatric patients, start with lower doses of benzodiazepines than for younger adults.
6. For managing alcohol withdrawal, carbamazepine can be used as an effective alternative to benzodiazepines.
7. Other agents, such as beta-blockers, dilantin, and clonidine, are generally not considered as appropriate monotherapy for alcohol withdrawal, but may be considered in conjunction with benzodiazepines in certain patients.
8. During and after detoxification, emphasis should be placed on engagement in ongoing addiction treatment.

### **Sedative-hypnotics detoxification (e.g., benzodiazepines)**

There are three general treatment strategies for patients withdrawing from other sedative-hypnotic medications at doses above the therapeutic range, for a month or more:

1. Substitute phenobarbital for the addicting agent and taper gradually.
  - The average daily sedative-hypnotic dose is converted to a phenobarbital equivalent and divided into 3 doses per day for 2 days. Detailed information on phenobarbital equivalencies for sedative hypnotics can be found in Goodman and Gilman's *The Pharmacological Basis of Therapeutics-Ninth Edition (1996)*.
  - Phenobarbital dose should be reduced by 30 mg per day, beginning on day 3.
2. For patients on a shorter acting benzodiazepine, substitute a longer acting benzodiazepine (e.g., chlordiazepoxide) and taper 10% per day, over 1 to 2 weeks.
3. Gradually decrease the dosage of the long-acting substance the patient is currently taking.

### **Opioid detoxification**

1. Focus treatment of opioid withdrawal on facilitating entrance into comprehensive long-term treatment, as well as alleviating acute symptoms.
2. The preferred method of opioid detoxification remains short-term substitution therapy with methadone:
  - Use initial doses sufficient to suppress signs and symptoms of withdrawal, usually 30-40 mg/day.
  - Set the length of the taper period based on the treatment setting and goal of the detoxification. Dose decreases of more than 5 mg/day are generally poorly tolerated.
3. Detoxification can usually be accomplished in 4-7 days in an inpatient setting, to quickly achieve opioid abstinence prior to treatment in a drug-free setting.
4. Longer taper periods should be used in the outpatient setting to minimize patient discomfort and maximize chances of success.
5. A period of 21 days is generally sufficient for short-term outpatient detoxification in the most stable and motivated individual. However, many patients presenting for treatment have very chaotic lives and should receive OAT for a period of extended stabilization, before they can realistically hope to maintain a drug-free lifestyle. Frequently, long-term detoxification occurs in the setting of an OAT program. Longer-term detoxification protocols frequently allow for a 21-day or 180-day detoxification.
6. The 180-day stabilization/detoxification regimen, done within an OAT program, should be considered to work on patients' early recovery problems, while stabilized on a relatively low dose (50-60 mg/day) of methadone. Stabilization is followed by short-term detoxification from methadone and transition to a drug-free rehabilitation program (for details refer to Table 3).
7. Clonidine, an alpha-adrenergic agonist, can be considered as an effective alternative for inpatient opioid detoxification; however, outpatient success is much lower.

**Table 3. Example Methadone Dosing Schedules for Withdrawal From Illicit Opioids**

<b>Day(s) in Treatment</b>	<b>21-Day Schedule Dose (mg)</b>	<b>90-Day Schedule Dose (mg)</b>	<b>180-Day Schedule Dose (mg)</b>
1	30	30	30
2	20	40	40
3	30	50	50
4 – 6	25	60	60
7 – 10	20	60	60
11 – 13	15	60	60
14 – 17	10	60	60
18 – 21	5	55	60
22 – 28		50	60
29 – 35		45	55
36 – 42		40	50
43 – 49		35	45
50 – 56		30	40
57 – 63		25	40
64 – 70		20	35
71 – 77		15	35
78 – 84		10	30
85 – 90		5	30
91 – 100			25
101 – 110			25
111 – 120			20
121 – 130			20
131 – 140			15
141 – 150			15
151 – 160			10
161 – 170			10
171 - 180			5

*(Adapted from Strain & Stitzer, 1999)*

## DISCUSSION

Alternative detoxification methods have been sought, due to concern that tapering regimens using opioid agonists prolong the problem by prescribing an addictive medication. Many of the symptoms of opioid withdrawal (e.g., diaphoresis, hyperactivity and irritability) appear to be mediated by over-activity in the sympathetic nervous system. This resulted in trials that attempted to depress the over-activity and ameliorate the withdrawal syndrome, using adrenergic agents, such as clonidine and lofexidine, that are without abuse potential (Gold et al., 1978; Gold et al., 1980).

Clonidine, an alpha-adrenergic agonist with inhibitory action primarily at the locus ceruleus, is effective in decreasing the signs and symptoms of opioid withdrawal in inpatient populations. Inpatient studies reported an 80-90% success rate in detoxifying patients from methadone or heroin, while outpatient studies have reported success rates as low as 30-35% (Cornish et al., 1998).

The problems identified in outpatient clonidine detoxification include easier access to heroin and other opioids, lethargy, insomnia, dizziness, and over-sedation. All of these problems are more easily managed in the inpatient setting.

EVIDENCE TABLE

	<b>Recommendations</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Use symptom-triggered therapy or gradual dose tapering over several days for alcohol withdrawal management.	Hayashida et al., 1989 Mayo-Smith, 1997 Saitz et al., 1994 APA, 1995 CSAT, 1995	I	A
2	Consider ambulatory alcohol detoxification, when indicated.	Hayashida et al., 1989	I	B
3	Use benzodiazepines over non-benzodiazepine sedative-hypnotics for alcohol withdrawal management.	Mayo-Smith, 1997	I	A
4	For managing alcohol withdrawal, carbamazepine can be used as an effective alternative to benzodiazepines.	Malcolm et al., 1989	II	B
5	Gradually decrease the dosage of the sedative-hypnotic or substitute phenobarbital for the addicting agent and taper gradually.	CSAT, 1995 Smith & Wesson, 1994	III	A
6	During opioid detoxification, facilitate engagement in comprehensive long-term treatment.	Simpson & Sells, 1990 Magura & Rosenblum, in press	II-2	A
7	Use short-term agonist substitution therapy for opioid detoxification.	Strain & Stitzer, 1999	III	A

QE = Quality of Evidence; R = Recommendation (See Introduction)

**N. Was Detoxification Successful?**

OBJECTIVE

Identify patients in need of additional detoxification or stabilization before proceeding with further evaluation or treatment.

ANNOTATION

According to Mattick & Hall (1996), detoxification is successful to the degree the patient:

- Is physiologically stable
- Avoids hazardous medical consequences of withdrawal
- Experiences minimal discomfort
- Reports being treated with respect for his or her dignity
- Completes the detoxification protocol (e.g., no longer requires medication for withdrawal symptom management)
- Engages in continuing care for SUD

**O. Is Care Management Indicated?**

OBJECTIVE

Identify patients with SUDs who can benefit from implementation of a care management plan.

## ANNOTATION

If detoxification is unsuccessful, consider one of the following:

1. A more intensive level of care for detoxification (e.g., inpatient) [Return to Box 11].
2. Care Management, if detoxification is not indicated or acceptable to the patient [see Module C].

For some patients, repeated detoxification episodes may have a cumulative motivating effect in preparation for ongoing treatment.

## Module S References

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**PARTICIPANT LIST**

Version 1.0

## PARTICIPANT LIST

Carolyn Barrett-Ballinger, MA  
Clinical Operations  
Bureau of Medicine and Surgery  
2300 E St., NW  
Washington, DC 20372  
202-762-3109  
202-762-3109 (fax)  
[csbarrett-ballinger@us.med.navy.mil](mailto:csbarrett-ballinger@us.med.navy.mil)

Stuart Bokser, MSW  
Clinical Director  
Ft. Monmouth, Building 864  
Ft. Monmouth, NJ 07703  
732-532-2415  
732-532-6429 (fax)  
[stu.bokser@na.amedd.army.mil](mailto:stu.bokser@na.amedd.army.mil)

Sandra Brake, ACSW  
Acting Director of Social Work  
VHA Headquarters  
810 Vermont Avenue  
Washington, DC 20920  
202-273-8549  
202-273-8385 (fax)  
[brake.sandra@vhaco.gov](mailto:brake.sandra@vhaco.gov)

Peter Durand, LTC, MC, USAF  
AFMOA/SGOC  
110 Luke Ave, Room 405  
Bolling AFB, DC 20332  
202-767-4169  
202-404-4043 (fax)  
[peter.durand@usafsg.bolling.af.mil](mailto:peter.durand@usafsg.bolling.af.mil)

Noreen Durkin, MSN  
Associate QM Coordinator  
James A. Haley VAMC  
13000 Bruce B. Downs Blvd.  
Tampa, FL 33612  
813-972-2000, ext. 7156  
813-979-3693 (fax)  
[noreen.durkin@med.va.gov](mailto:noreen.durkin@med.va.gov)

Joanne Fertig, PhD  
Psychologist  
Treatment Research Branch  
Division of Clinical & Prevention Research  
National Institute on Alcohol Abuse and  
Alcoholism  
6000 Executive Blvd.  
Bethesda, MD 20892  
301-443-0635  
301-443-8772 (fax)

Rosalie Fishman, RN, MSN, CPHQ  
Clinical Coordinator  
Birch & Davis Holdings, Inc.  
8905 Fairview Road  
Silver Spring, MD 20910  
301-650-0218  
301-650-0398 (fax)  
[rfishman@birchdavis.com](mailto:rfishman@birchdavis.com)

Roger W. Hartman  
Health Policy Analyst  
OASD (HA)/TMA  
Skyline 5, Suite 810  
511 Leesburg Pike  
Falls Church, VA 22041  
703-681-0064  
703-681-6037 (fax)  
[roger.hartman@tma.osd.mil](mailto:roger.hartman@tma.osd.mil)

Verna Hightower  
Birch & Davis Holdings, Inc.  
8905 Fairview Road  
Silver Spring, MD 20910  
301-650-0357  
301-650-0398 (fax)  
[vhightower@birchdavis.com](mailto:vhightower@birchdavis.com)

Ken Hoffman, COL, MC, USA  
Medical Director  
Military and Veterans Health Coordinating  
Board, and  
Persian Gulf Veterans Coordinating Board  
810 Vermont Ave., NW (13H)  
Washington, DC 20420  
202-273-9895  
202-273-9912 (fax)  
[kenneth.hoffman@mail.va.gov](mailto:kenneth.hoffman@mail.va.gov)

Vern Hunter, EdM  
Clinical Director  
Community Counseling Center  
MEDDAC  
515 Sternberg Ave  
Ft. Eustis, VA 23604  
(757) 314-7557  
(757) 314-7678 (fax)  
[vern.hunter@na.amedd.army.mil](mailto:vern.hunter@na.amedd.army.mil)

## PARTICIPANT LIST

Sarah Ingersoll  
Field Operations Director  
Birch & Davis Holdings, Inc.  
8905 Fairview Road  
Silver Spring, MD 20910  
301-650-0218  
301-650-0398 (fax)  
[singersoll@birchdavis.com](mailto:singersoll@birchdavis.com)

David Jones, LTC, MC USA  
Chief, Internal Medicine Service  
Walter Reed Army Medical Center  
6900 Georgia Ave.  
Washington, DC 20307  
202-782-5580  
202-782-5036 (fax)  
[david.jones.2@amedd.army.mil](mailto:david.jones.2@amedd.army.mil)

Arthur Kaufman, MD  
Medical Director  
Birch & Davis Holdings, Inc.  
8905 Fairview Road  
Silver Spring, MD 20910  
301-650-0268  
301-650-0398 (fax)  
[akaufman@birchdavis.com](mailto:akaufman@birchdavis.com)

Daniel Kivlahan, PhD  
Director, VA Center of Excellence in Substance  
Abuse Treatment and Education  
VA Puget Sound  
Associate Professor, Department of Psychiatry  
and Behavioral Sciences, University of  
Washington  
1660 S. Columbian Way  
Seattle, WA 98108  
206-768-5483  
206-764-2293 (fax)  
[daniel.kivlahan@med.va.gov](mailto:daniel.kivlahan@med.va.gov)

George Kolodner, MD  
Kolmac Clinic – Suite #2  
1003 Spring Street  
Silver Spring, MD 20910  
301-589-0255  
301-589-0291 (fax)  
[gkolodner@aol.com](mailto:gkolodner@aol.com)

Joanne Marko, SLP, MS  
Senior Consultant  
Birch & Davis Holdings, Inc.  
8905 Fairview Road  
Silver Spring, MD 20910  
301-650-0269  
301-650-0398 (fax)  
[jmarko@birchdavis.com](mailto:jmarko@birchdavis.com)

Laura F. McNicholas, MD, PhD  
Director, VA Center of Excellence in Substance  
Abuse Treatment and Education  
Philadelphia VAMC 7E (116)  
University & Woodland Avenues  
Philadelphia, PA 19104  
215-823-6085  
215-823-5919 (fax)  
[mcnicholas@research.trc.upenn.edu](mailto:mcnicholas@research.trc.upenn.edu)

Charles Miller, MD  
Medical Coordinator, AMEDD  
Clinical Practice Guideline  
USA Medcom MCHO-CL-C  
2050 Worth Road, Suite 102  
Fort Sam Houston, TX 78234  
210-221-7109  
210-221-6896 (fax)  
[charles.miller@cen.amedd.army.mil](mailto:charles.miller@cen.amedd.army.mil)

Shannon Miller, MD, CMRO  
MAJ, USAF, MC  
Chief, Triservice Addiction Recovery Center  
Malcolm Grow USAF Medical Center  
1050 W. Perimeter Rd, Ste. B4-23  
89MDOS/SGOHA  
Andrews AFB, MD 20762  
240-857-8227  
240-857-8367 (fax)  
[shannon.miller@mgmc.af.mil](mailto:shannon.miller@mgmc.af.mil)

Charlotte A. Mullican, MPH  
Health Scientist Administrator  
Agency for Health Care & Research Quality  
6010 Executive Blvd., Suite 336  
Rockville, MD 20852  
301-594-0382  
301-594-3211 (fax)  
[cmullica@ahrq.gov](mailto:cmullica@ahrq.gov)

## PARTICIPANT LIST

Robert B. Murphy, CAPT, MC, USN  
Executive Assistant, DoD Prevention, Safety  
and Health Promotion Council  
QuIC Substance Abuse Task Force  
110 Luke Ave, Suite 405  
Bolling AFB, DC 20332  
202-404-8089  
202-404-8098 (fax)  
[robert.murphy@usafsg.bolling.af.mil](mailto:robert.murphy@usafsg.bolling.af.mil)

Tina Russ, PhD, CPT, BSC, USAF  
Health Psychology Consultant, OPHSA  
2602 Doolittle Rd. Building 804  
AFMOA/SGOH  
Brooks AFB, TX 78235  
210-536-4322  
210-536-6290 (fax)  
[tina.russ@ophsa.brooks.af.mil](mailto:tina.russ@ophsa.brooks.af.mil)

Wendy Smith, PhD  
Health Services Research Program  
NIAAA  
600 Executive Blvd.  
Suite 505  
Bethesda, MD 20892  
301-443-8771  
301-443-8774 (fax)  
[wsmith@willco.niaaa.nih.gov](mailto:wsmith@willco.niaaa.nih.gov)

Janet Spinks, RN, MS, CPHQ  
Senior Consultant  
Birch & Davis Holdings, Inc.  
8905 Fairview Road  
Silver Spring, MD 20910  
301-650-0285  
301-650-0398 (fax)  
[jspinks@birchdavis.com](mailto:jspinks@birchdavis.com)

Frances Stewart, CAPT, MC, USN  
Program Director  
Patient Advocacy/Medical Ethics  
Office of the ASD  
Five Skyline Place, Suite 601  
5111 Leesburg Pike  
Falls Church, VA 22041  
703-681-1703, ext. 5214  
703-681-3658 (fax)  
[frances.stewart@ha.osd.mil](mailto:frances.stewart@ha.osd.mil)

Richard Suchinsky, MD  
Associate Chief for Addictive Disorders  
Department of Veterans Affairs  
810 Vermont Avenue, NW  
Washington, DC 20420  
202-273-8437  
202-273-9069 (fax)  
[ruchard.suchinsky@hg.va.gov](mailto:ruchard.suchinsky@hg.va.gov)

Oded Susskind, MPH  
P. O. Box 112  
Brookline, MA 02146  
617-232-3558  
617-713-4431 (fax)  
[oded@tiac.net](mailto:oded@tiac.net)

Debby Walder, RN, MSN  
Performance Management Facilitator  
Department of Veterans Affairs  
810 Vermont Avenue, NW  
Washington, DC 20420  
202-273-8336  
202-273-9030 (fax)  
[debby.walder@mail.va.gov](mailto:debby.walder@mail.va.gov)

Christine D. Winslow  
Program Development Coordinator  
Birch & Davis Holdings, Inc.  
3 Skyline Place, Suite 600  
5201 Leesburg Pike  
Falls Church, VA 22041  
703-998-4981  
703-820-7363 (fax)  
[cwinslow@birchdavis.com](mailto:cwinslow@birchdavis.com)

Mark Willenbring, MD  
Medical Director, Addictive Disorders Section  
VA Medical Center (116A)  
Associate Professor, Department of Psychiatry,  
University of Minnesota  
One Veterans Drive  
Minneapolis, MN 55417  
612-725-2000, x3967  
612-725-2292 (fax)  
[vhaminwillem@med.va.gov](mailto:vhaminwillem@med.va.gov)

Russ Wolf, MD, MPH  
Chief Medical Officer  
Boston VAMC  
130 Marshall Rd  
Lowell, MA 01852  
978-671-9000  
978-671-9149 (fax)  
[frwolf@boston.va.gov](mailto:frwolf@boston.va.gov)

VHA/D<sub>o</sub>D CLINICAL PRACTICE GUIDELINE FOR THE  
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**ACRONYM LIST**

Version 1.0

## ACRONYM LIST

<b>AA</b>	Alcoholics Anonymous
<b>ADAPT</b>	Alcohol and Drug Abuse Prevention and Treatment
<b>AHCPR</b>	Agency for Health Care Policy and Research (now known as the Agency for Health Care Quality and Research)
<b>AIDS</b>	Acquired immunodeficiency syndrome
<b>APA</b>	American Psychiatric Association
<b>ASAP</b>	Army's Substance Abuse and Prevention program
<b>ASI</b>	Addiction Severity Index
<b>ASAM</b>	American Society of Addiction Medicine
<b>AUDIT</b>	Alcohol Use Disorders Screening Test
<b>BAC</b>	Blood alcohol concentration
<b>BAL</b>	Blood alcohol level
<b>b.i.d.</b>	Twice a day
<b>CAGE</b>	Alcohol abuse/dependence screening instrument
<b>CARF</b>	Commission on Accreditation of Rehabilitation Facilities
<b>CCT</b>	Clinical controlled trials
<b>CINA</b>	Clinical Institute Narcotics Assessment
<b>CIWA-Ar</b>	Clinical Institute Withdrawal Assessment for Alcohol – Revised
<b>CNS</b>	Central nervous system
<b>CPG</b>	Clinical practice guideline
<b>CSAT</b>	Center for Substance Abuse Treatment
<b>DAST</b>	Drug Abuse/Dependence Screener
<b>DEA</b>	Drug Enforcement Administration
<b>DER</b>	Disulfiram ethanol reaction
<b>DHHS</b>	U.S. Department of Health and Human Services
<b>DoD</b>	Department of Defense
<b>DSM-IV</b>	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
<b>DT</b>	Delirium tremens
<b>FDA</b>	U.S. Food and Drug Administration
<b>GGT</b>	Gamma glutamic transferase
<b>GI</b>	Gastrointestinal
<b>HIV</b>	Human immunodeficiency virus
<b>IOM</b>	Institute of Medicine
<b>JCAHO</b>	Joint Commission of Accreditation on Healthcare Organizations
<b>LAAM</b>	Levomethadyl acetate hydrochloride

## ACRONYM LIST

<b>MCV</b>	Mean corpuscular volume
<b>MDD</b>	Major depressive disorder
<b>MMSE</b>	Folstein's Mini-Mental State Examination
<b>MSE</b>	Mental Status Examination
<b>NIAAA</b>	National Institute on Alcohol Abuse and Alcoholism
<b>OAT</b>	Opioid agonist therapy
<b>OTC</b>	Over-the-counter
<b>PPC</b>	Patient placement criteria
<b>PRN</b>	As needed
<b>QE</b>	Quality of evidence
<b>RCTs</b>	Random controlled trials
<b>SACC</b>	Substance Abuse Counseling Center
<b>SAMHSA</b>	Substance Abuse and Mental Health Services Administration
<b>SARRTP</b>	VA Substance Abuse Residential Rehabilitation Treatment Programs
<b>SOWS</b>	Short Opiate Withdrawal Scale
<b>SR</b>	Strength of recommendation
<b>SUD</b>	Substance use disorder
<b>TICS</b>	Two-Item Conjoint Screen
<b>TRISARC</b>	Tri-Service Addiction Recovery Center
<b>U. S. DHHS</b>	United States Department of Health and Human Services
<b>U. S. PSTF</b>	United States Preventive Services Task Forces
<b>VHA</b>	Veterans Health Administration
<b>VA</b>	Veterans Administration
<b>VistA</b>	VA centralized computer system

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