DEFENSE CENTERS OF EXCELLENCE
For Psychological Health & Traumatic Brain Injury

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

Key Concepts for Providers

July 27, 2012

Audience: Providers in Defense Department and Veterans Administration Medical Treatment Facilities

DVBIC Defense and Veterans Brain Injury Center
DHCC Deployment Health Clinical Center
National Center for Telehealth & Technology

Key Training Objectives

To give primary care providers brief background information on the VA/DoD Clinical Practice Guideline for Management of Substance Use Disorder (SUD)

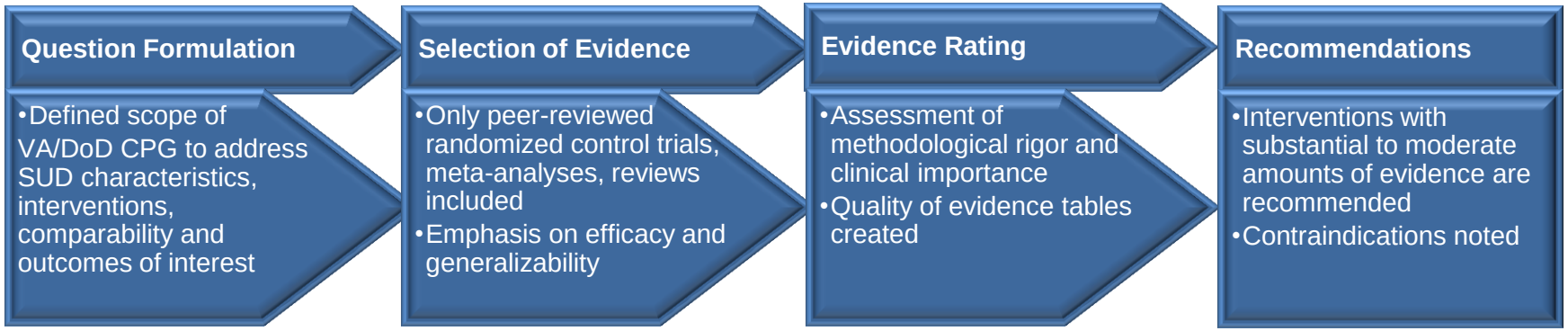
To provide primary care providers with an overview of how the tools in the SUD tool kit can be used to efficiently diagnose, assess and treat SUD

Substance Use Disorder CPG

A clinical practice guideline is defined by Veterans Affairs (VA) and the Defense Department (DoD) as:

- Recommendations for the performance or exclusion of specific procedures or services derived through a rigorous methodological approach that includes:
  - Determination of appropriate criteria such as effectiveness, efficacy, population benefit, or patient satisfaction
  - Literature review to determine the strength of the evidence in relation to these criteria

The CPG for SUD was developed using the following methodology:



Department of Veterans Affairs & Department of Defense (2008). *VA/DoD clinical practice guideline for substance use disorder.* (Version 2.0 – 2009) Washington, DC: The Management of SUD Working Group, The Office of Quality and Performance, VA & Quality Management Directorate, United States Army MEDCOM.
Retrieved from http://www.healthquality.va.gov/Substance_Use_Disorder_SUD.asp

VA/DoD Clinical Practice Guidelines

- Reduce current practice variation and provide facilities with a structured framework to help improve patient outcomes
- Provide evidence-based recommendations to assist providers and their patients in the decision-making process for patients with SUD
- Identify outcome measures to support the development of practice-based evidence that can ultimately be used to improve clinical guidelines

Department of Veterans Affairs & Department of Defense (2008). *VA/DoD clinical practice guideline for substance use disorder.* (Version 2.0 – 2009) Washington, DC: The Management of SUD Working Group, The Office of Quality and Performance, VA & Quality Management Directorate, United States Army MEDCOM.
Retrieved from http://www.healthquality.va.gov/Substance_Use_Disorder_SUD.asp

VA/DoD CPG for SUD

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

Department of Veterans Affairs & Department of Defense (2008). *VA/DoD clinical practice guideline for substance use disorder.* (Version 2.0 – 2009) Washington, DC: The Management of SUD Working Group, The Office of Quality and Performance, VA & Quality Management Directorate, United States Army MEDCOM.
Retrieved from http://www.healthquality.va.gov/Substance_Use_Disorder_SUD.asp

VA/DoD CPG for SUD

Describes the critical decision points and provides clear and comprehensive evidence-based recommendations incorporating current information and best practices

Provides guidelines for all aspects of care for SUD from screening and assessment to treatment, follow-up and monitoring

Includes a variety of reliable tools, questions and simple reference material giving primary care providers the resources they need to address their patients' mental health needs

Can be used in a stepwise fashion over the course of treatment or as a quick reference guide during or between appointments

Substance Use Disorders

SUD in the VA and DoD population

- In fiscal year 2007, over 375,000 VA patients had a substance use disorder diagnosis
- Nearly 500,000 additional patients had a nicotine dependence diagnosis in the absence of other substance use disorders

SUD in the DoD population

- The substantial negative consequences of alcohol use on the work performance, health and social relationships of military personnel have been a continuing concern assessed in DoD surveys
- In 2005, 8.1 percent of military personnel anonymously responding to a survey reported one or more serious consequences associated with alcohol use during the year, a decline from 9.6 percent in 2002
- Using AUDIT criteria, 2.9 percent of respondents were estimated to be highly likely to be dependent on alcohol in 2005

Department of Veterans Affairs & Department of Defense (2008). *VA/DoD clinical practice guideline for substance use disorder.* (Version 2.0 – 2009) Washington, DC: The Management of SUD Working Group, The Office of Quality and Performance, VA & Quality Management Directorate, United States Army MEDCOM. Retrieved from http://www.healthquality.va.gov/Substance_Use_Disorder_SUD.asp

SUD Tool Kit

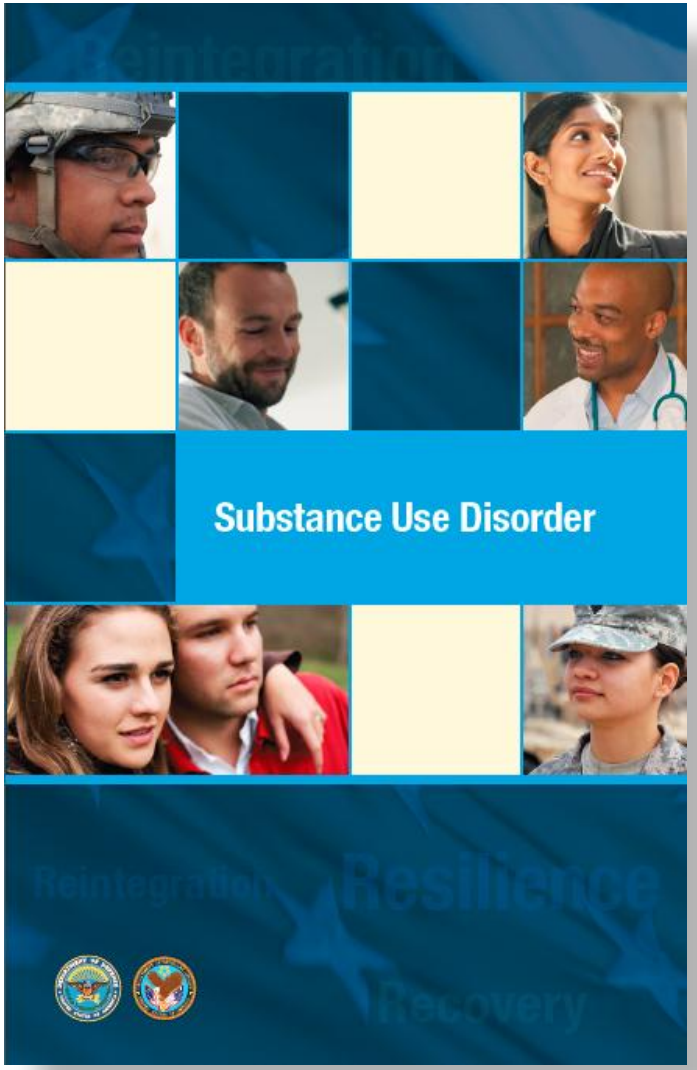
Provider Tool - SUD Pocket Guide

Patient Tool - “Medication-Assisted Treatment for Alcohol Dependence”

Family Tool - “Substance Abuse Affects Families”

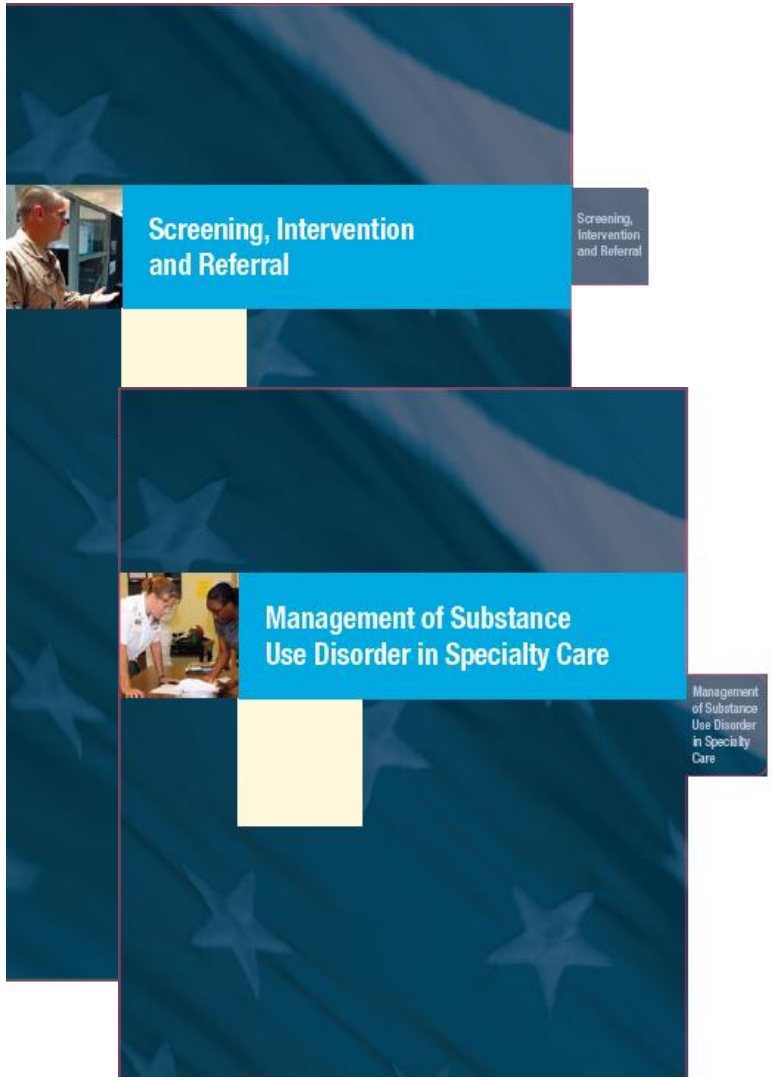
SUD Pocket Guide

- The SUD pocket guide is a clinical support tool summarized directly from VA/DoD CPG information and follows selected VA/DoD CPG algorithm modules
- Is a tabbed booklet for easy reference
- Provides easy to use, relevant and helpful clinical information



SUD Pocket Guide

- The tabbed sections are convenient and include topics such as:
  - Screening, intervention and referral
  - Management of substance use in specialty care
  - Stabilization and withdrawal management

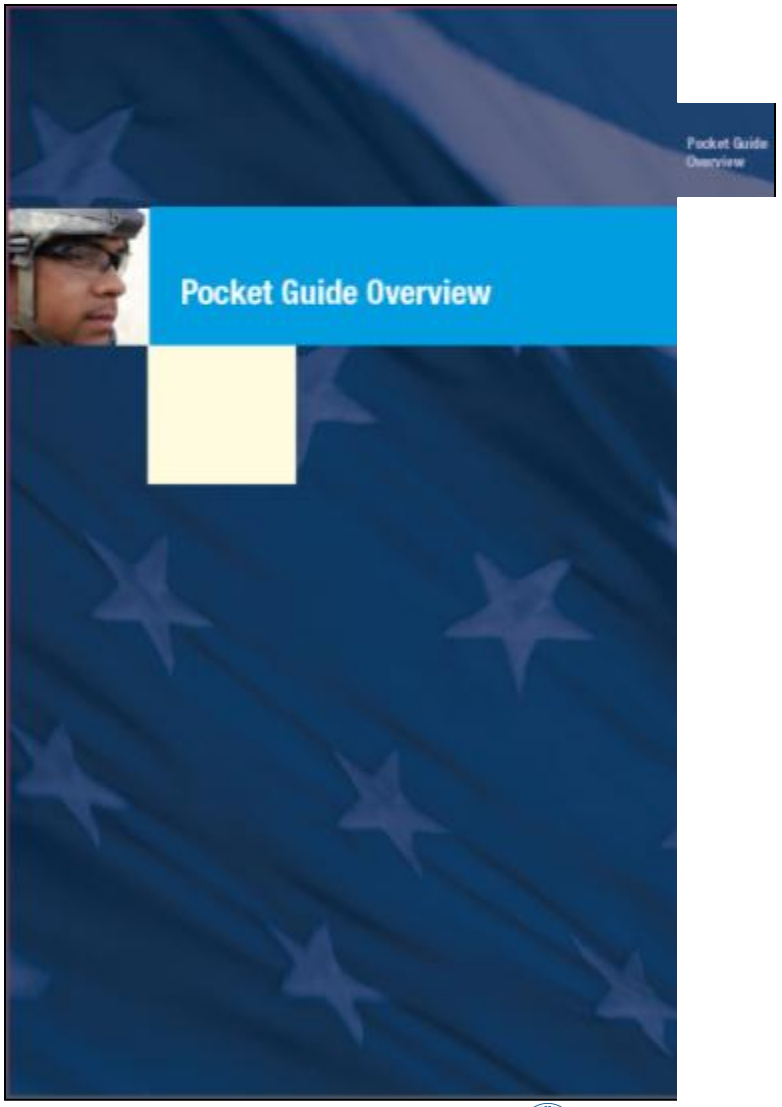


SUD Pocket Guide Topics

Tab	SUD Topics
Tab 1	Pocket Guide Overview
Tab 2	Screening, Intervention and Referral
Tab 3	Management of SUD in Specialty Care
Tab 4	Stabilization and Withdrawal Management
Tab 5	Symptoms of Intoxication and Withdrawal
Tab 6	Medication Tables
Tab 7	Patient and Family Education
Tab 8	ICD-9-CM Coding
Tab 9	Tools and Resources

SUD Pocket Guide

- Overview
- SUD basics
  - Conditions and disorders of unhealthy alcohol use
    - Risky users: women and men
    - Problem drinking
    - Risk of future physical, psychological or social harm increases with increasing levels of consumption
    - Short-term and long-term risks
  - DSM-IV-criteria:
    - Substance abuse
    - Dependence
    - Specifiers
  - CPG for SUD algorithms



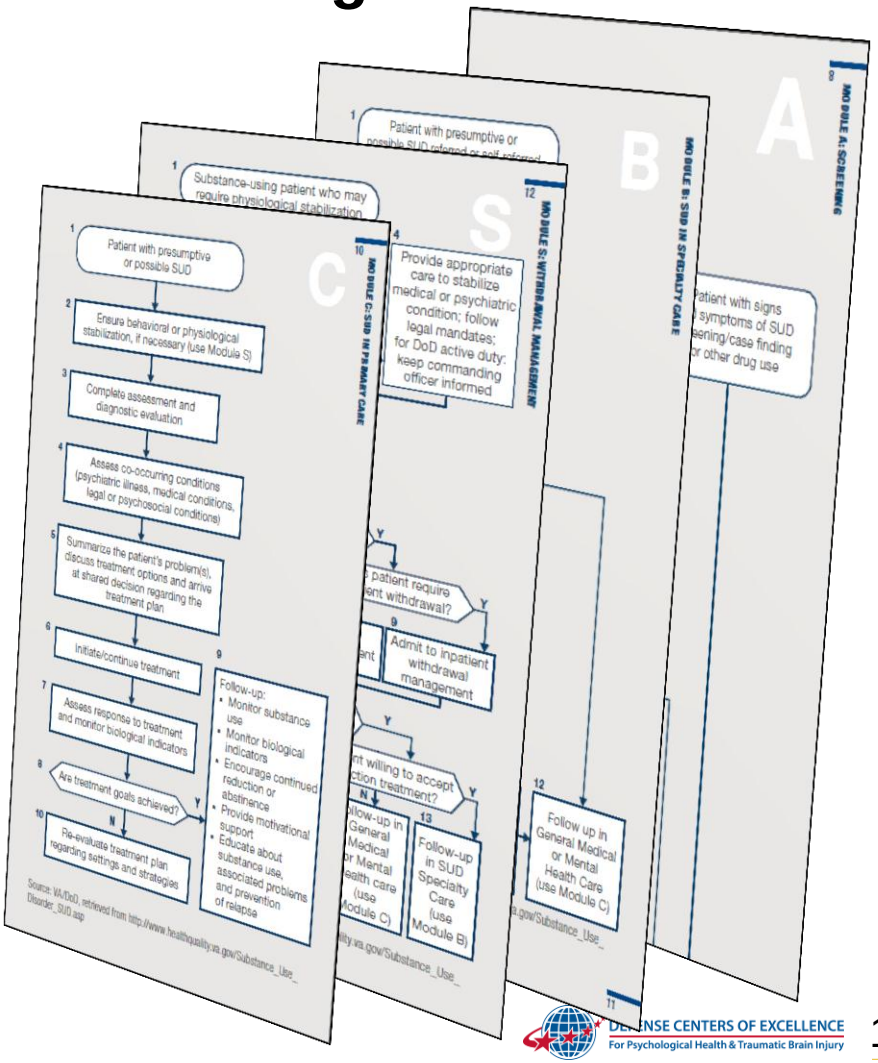
SUD Pocket Guide

DSM-IV-TR Criteria

DSM-IV-TR CRITERIA:

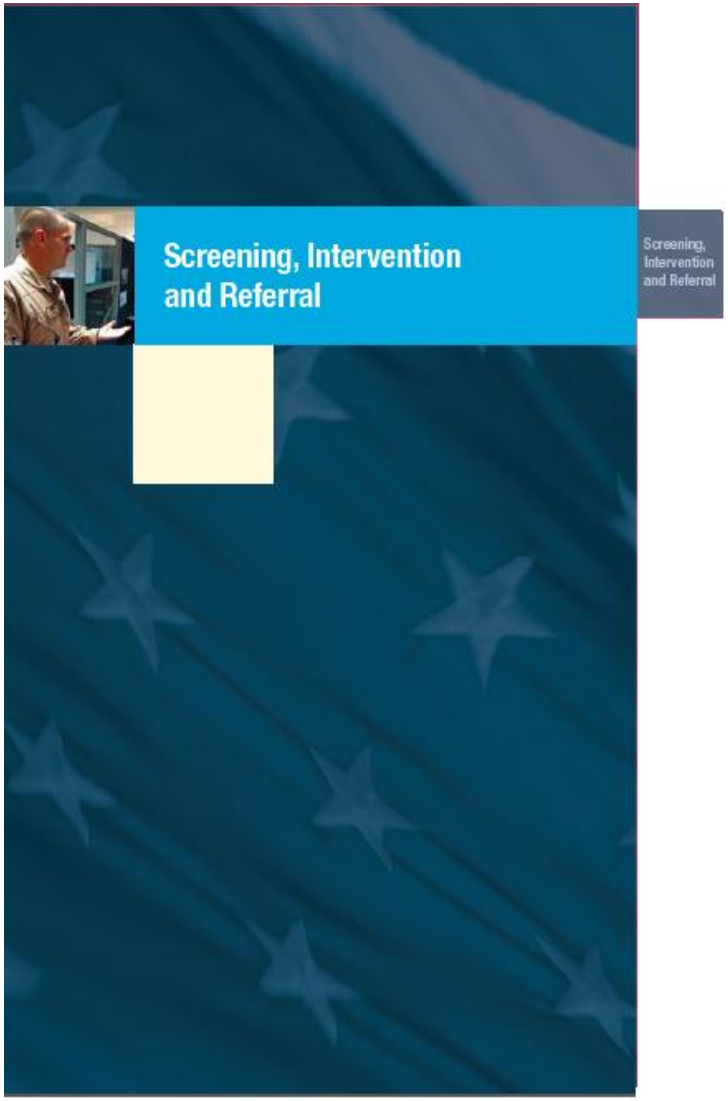
Substance Abuse	Substance Dependence
A maladaptive pattern of substance use, leading to clinically significant impairment or distress as manifested by one or more (abuse), three or more (dependence), of the following, at any time in the same 12-month period:	
▪ Failure to fulfill major role obligations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

Algorithms



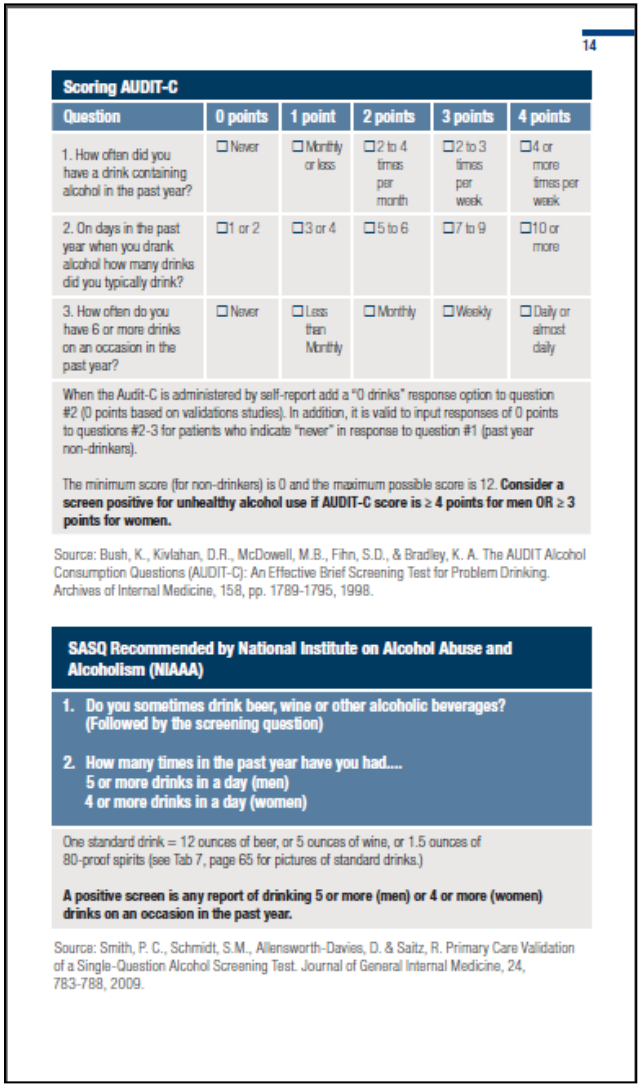
Screening, Intervention and Referral

- Screen annually
  - AUDIT-C, SASQ
- Assess current alcohol consumption
  - Contraindications to use
- Provide brief intervention
  - Characteristics, sample dialogue
- Follow up
- Relapse prevention,
  - Care management and referral
    Relapse/ongoing use, emergency referrals, non-emergency specialty care



Screening, Intervention and Referral

- Screen annually
  - AUDIT-C
    - Consists of three questions which can be administered by interview or self-report
  - SASQ
    - two questions which can be administered by interview or self-report
- Assess current alcohol consumption



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Scoring AUDIT-C

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

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

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

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

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

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

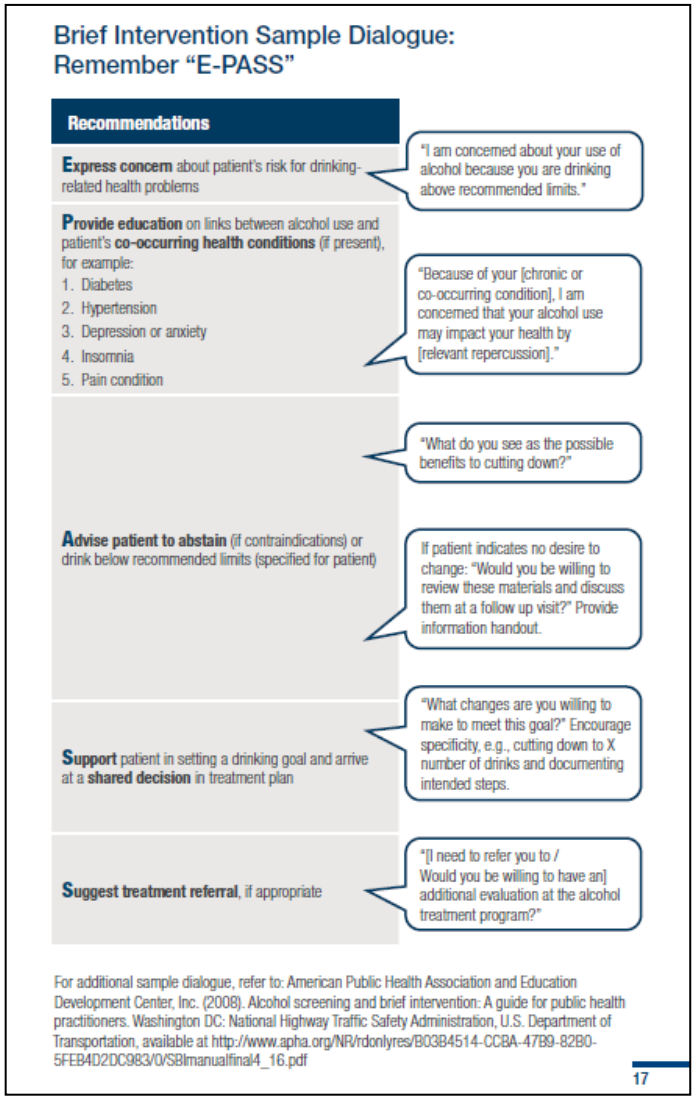
One standard drink = 12 ounces of beer, or 5 ounces of wine, or 1.5 ounces of 80-proof spirits (see Tab 7, page 65 for pictures of standard drinks.)

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

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

Screening, Intervention and Referral

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



Brief Intervention Sample Dialogue: Remember "E-PASS"

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

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

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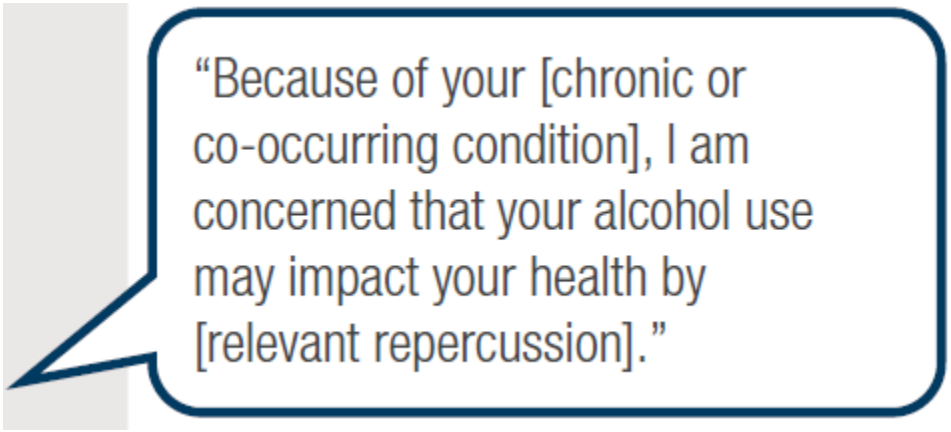
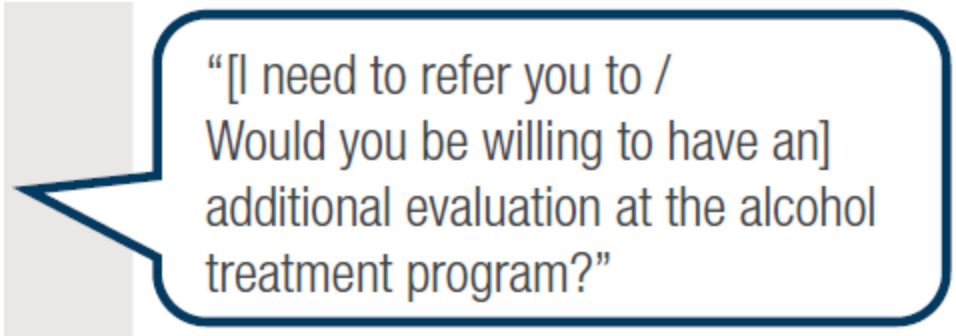
Screening, Intervention and Referral

- Provide brief intervention
  - Sample dialogue





Screening, Brief Intervention and Referral Treatment (SBIRT) – An Additional Screening Tool

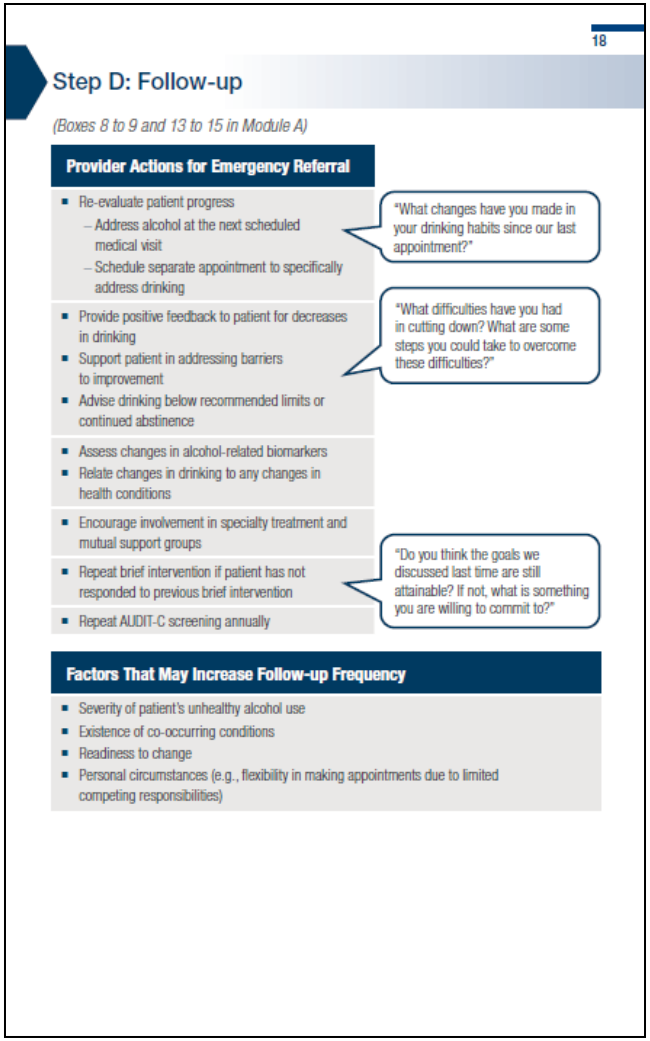
- **S**creening
- **B**rief **I**ntervention
- **R**eferral **T**reatment

- SBIRT is a system-level approach to identify and treat people with drinking problems

- The primary goal is to identify those who are at moderate or high risk for psycho-social or health care problems related to their substance use choices

Screening, Intervention and Referral

- Follow Up
  - Provider actions for emergency referral
  - Factors that may increase follow-up frequency



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Step D: Follow-up

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

Provider Actions for Emergency Referral

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

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

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

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

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

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

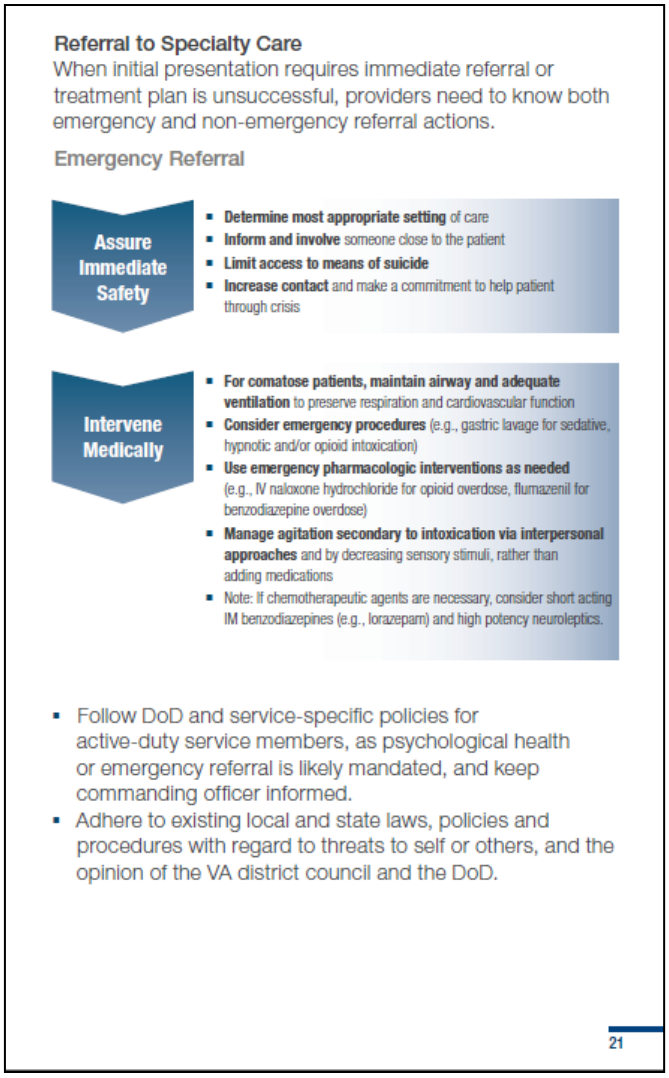
- Repeat AUDIT-C screening annually

Factors That May Increase Follow-up Frequency

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

Screening, Intervention and Referral

- Additional topics include
  - Relapse prevention
  - Care management and referral
  - Relapse/ongoing use
  - Emergency referrals and non-emergency specialty care



Referral to Specialty Care

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

Emergency Referral

Assure Immediate Safety

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

Intervene Medically

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

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

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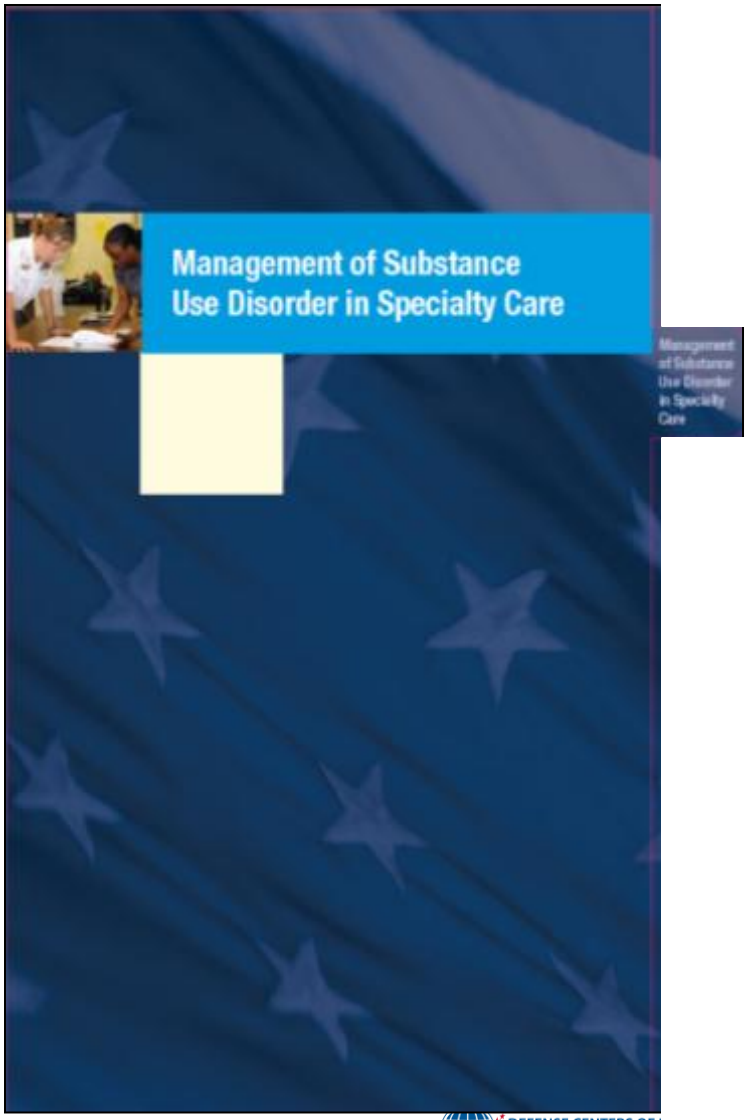
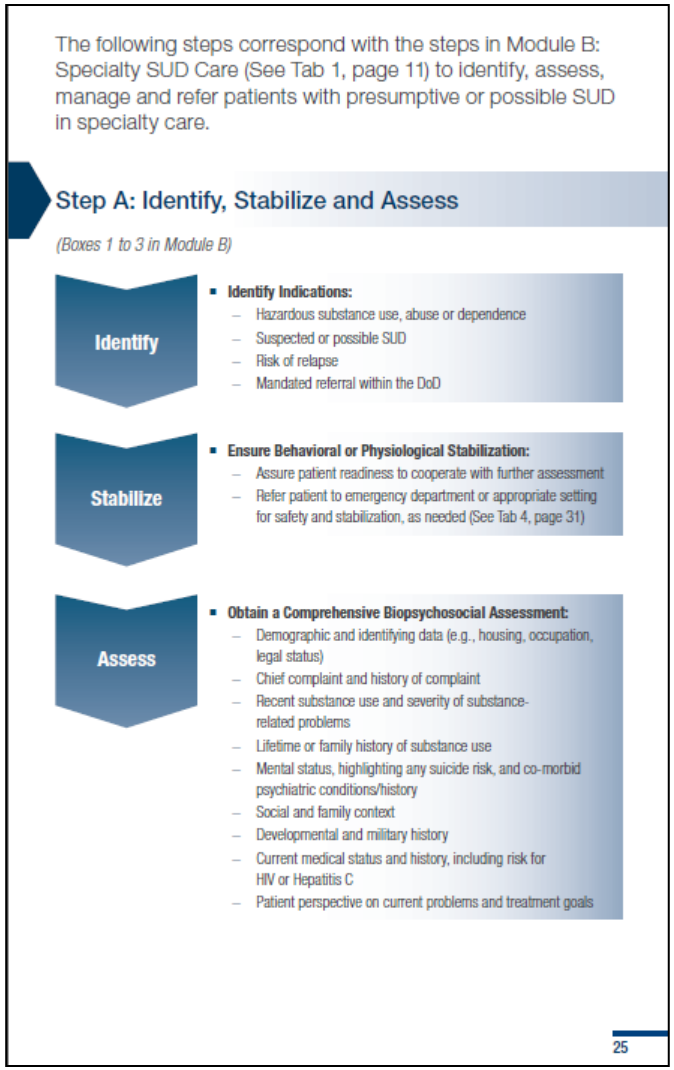
Management of SUD in Specialty Care

- Identify, stabilize and assess
- Diagnose and develop treatment plan
- Initiate addiction focused interventions
- Address recovery environment, manage co-occurring conditions and monitor
- Reinforce and follow-up for relapse prevention
- Develop aftercare/recovery plan
- Re-evaluate treatment plan



Management of SUD in Specialty Care

- **Identify, stabilize and assess**
  - **Identify-** Indications**:**
    - Hazardous substance use, abuse or dependence
    - Suspected or possible SUD
    - Risk of relapse
    - Mandated referral within the Defense Department
  - **Stabilize-** Ensure behavioral or physiological stabilization:
    - Assure patient readiness to cooperate with further assessment
    - Refer patient to emergency department or appropriate setting for safety and stabilization as needed
  - **Assess-** Obtain comprehensive biopsychosocial assessment:
    - Demographic and identifying data
    - Chief complaint/history of complaint
    - Recent substance use and severity of substance related problems
    - Lifetime or family history of substance use
    - Mental status, highlighting any suicide risk and co-morbid psychiatric conditions/history
    - Social and family context
    - Developmental and military history
    - Current medical status and history, including risk for HIV/Hepatitis C
    - Patient perspective on current problems and treatment goals


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

Step A: Identify, Stabilize and Assess

(Boxes 1 to 3 in Module B)

Identify

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

Stabilize

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

Assess

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

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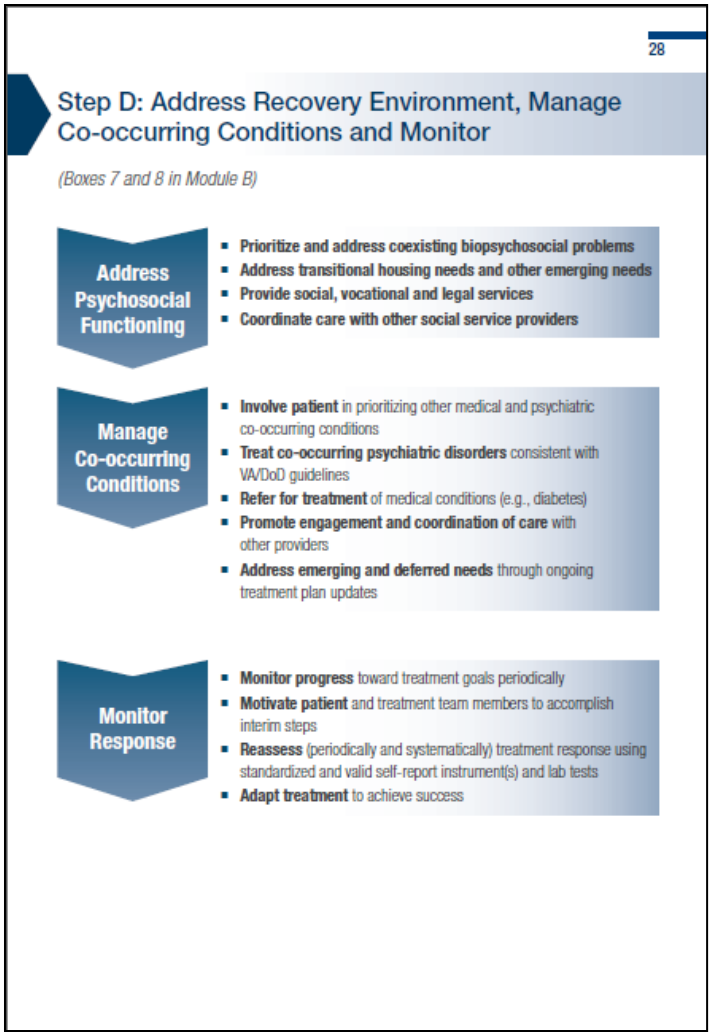
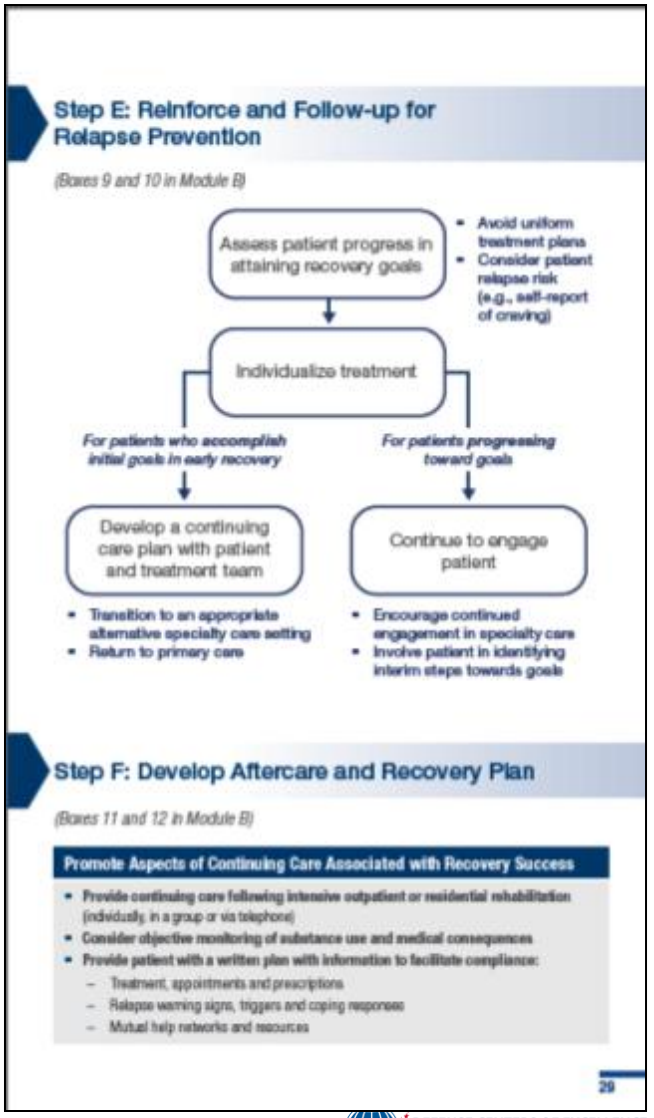
Management of SUD in Specialty Care

- Diagnose and develop treatment plan
- If indicated, initiate addiction focused interventions
- Address recovery environment, manage co-occurring conditions and monitor response



Management of SUD in Specialty Care

- Reinforce and follow-up for relapse prevention
- Develop aftercare/recovery plan
- Re-evaluate treatment plan



Step E: Reinforce and Follow-up for Relapse Prevention

(Boxes 9 and 10 in Module B)

Assess patient progress in attaining recovery goals

- Avoid uniform treatment plans
- Consider patient relapse risk (e.g., self-report of craving)

Individualize treatment

For patients who accomplish initial goals in early recovery

Develop a continuing care plan with patient and treatment team

- Transition to an appropriate alternative specialty care setting
- Return to primary care

For patients progressing toward goals

Continue to engage patient

- Encourage continued engagement in specialty care
- Involve patient in identifying interim steps towards goals

Step F: Develop Aftercare and Recovery Plan

(Boxes 11 and 12 in Module B)

Promote Aspects of Continuing Care Associated with Recovery Success

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

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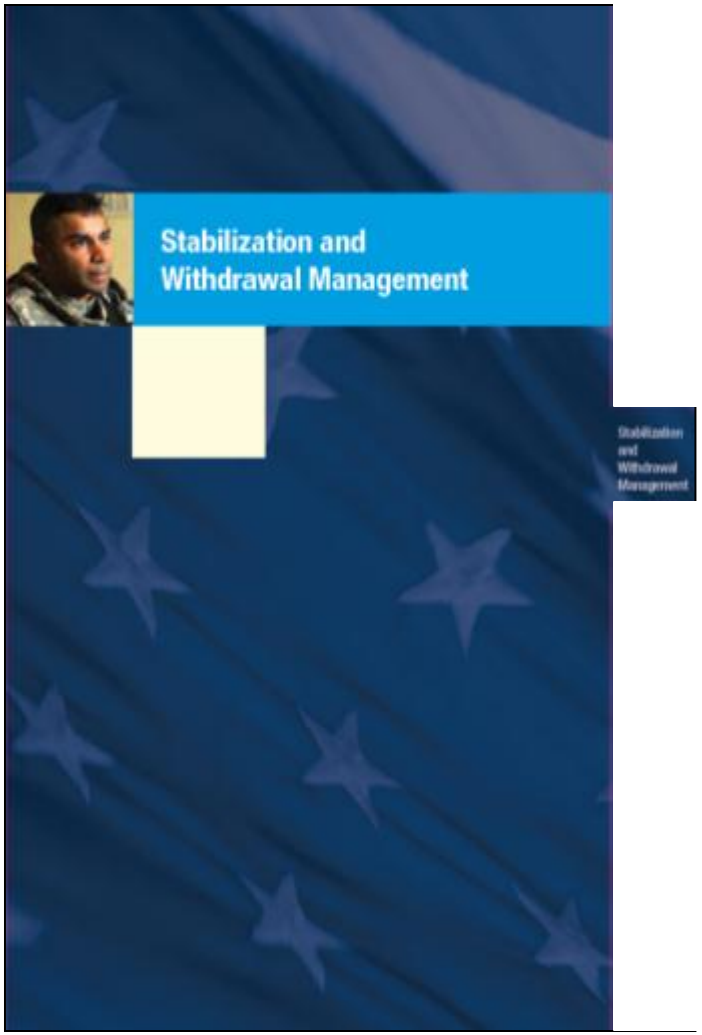
Stabilization and Withdrawal Management

- Obtain history, exams, medication and laboratory tests
- Assess for immediate crisis or intoxication and stabilize
- Determine physiological dependence level and withdrawal risk
  - Using the CIWA-Ar, COWS
- Assess withdrawal management need and appropriate setting of care
- Manage withdrawal
- Assess need for care management



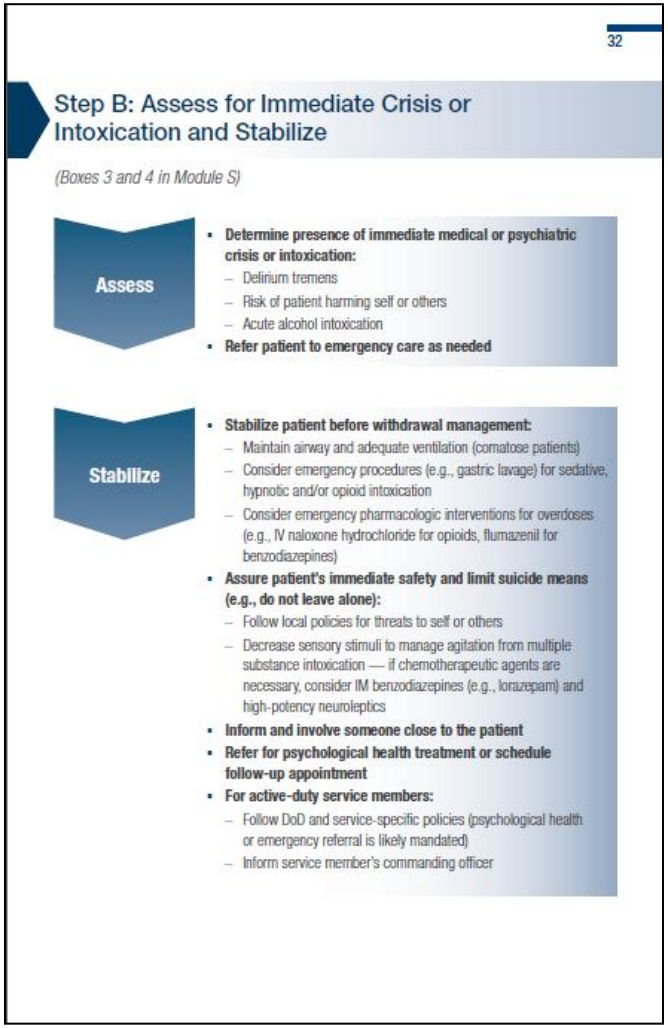
Stabilization and Withdrawal Management

- Obtain history, exams, medication and laboratory tests

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

(Boxes 1 and 2 in Module S)

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



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Step B: Assess for Immediate Crisis or Intoxication and Stabilize

(Boxes 3 and 4 in Module S)

Assess

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

Stabilize

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

- Assess for immediate crisis or intoxication and stabilize

Stabilization and Withdrawal Management

- Determine physiological dependence level and withdrawal risk
  - Using the CIWA-Ar, COWS
- Assess withdrawal management need and appropriate setting of care
- Manage withdrawal
- Assess need for care management

CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT OF ALCOHOL (CIWA-Ar)

Patient:_____

Date:_____

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

Pulse or heart rate, taken for one minute:_____

Blood pressure:_____

NAUSEA AND VOMITING – Ask "Do you feel sick to your stomach? Have you vomited?" Observation.
0 no nausea and no vomiting
1 mild nausea with no vomiting
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves and vomiting

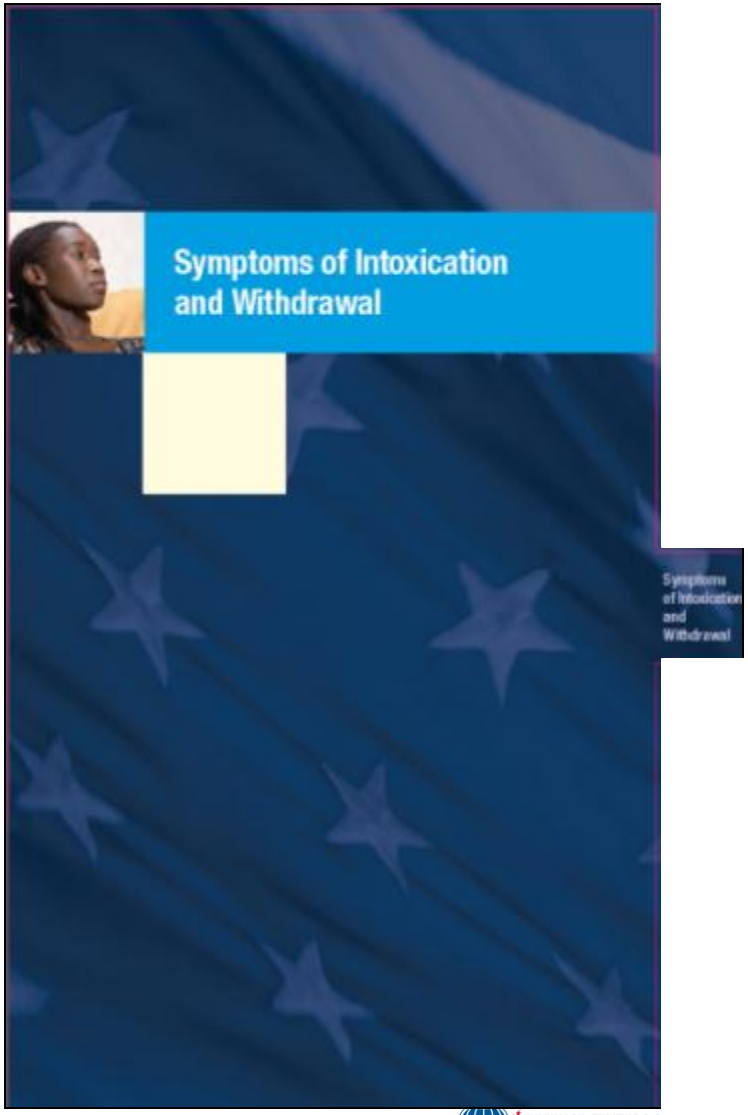
TACTILE DISTURBANCES – Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.
0 none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning or numbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

TREMOR – Arms extended and fingers spread apart. Observation.
0 no tremor
1 not visible, but can be felt fingertip to fingertip
2
3
4 moderate, with patient's arms extended
5
6
7 severe, even with arms not extended

AUDITORY DISTURBANCES – Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.
0 not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

Symptoms of Intoxication and Withdrawal

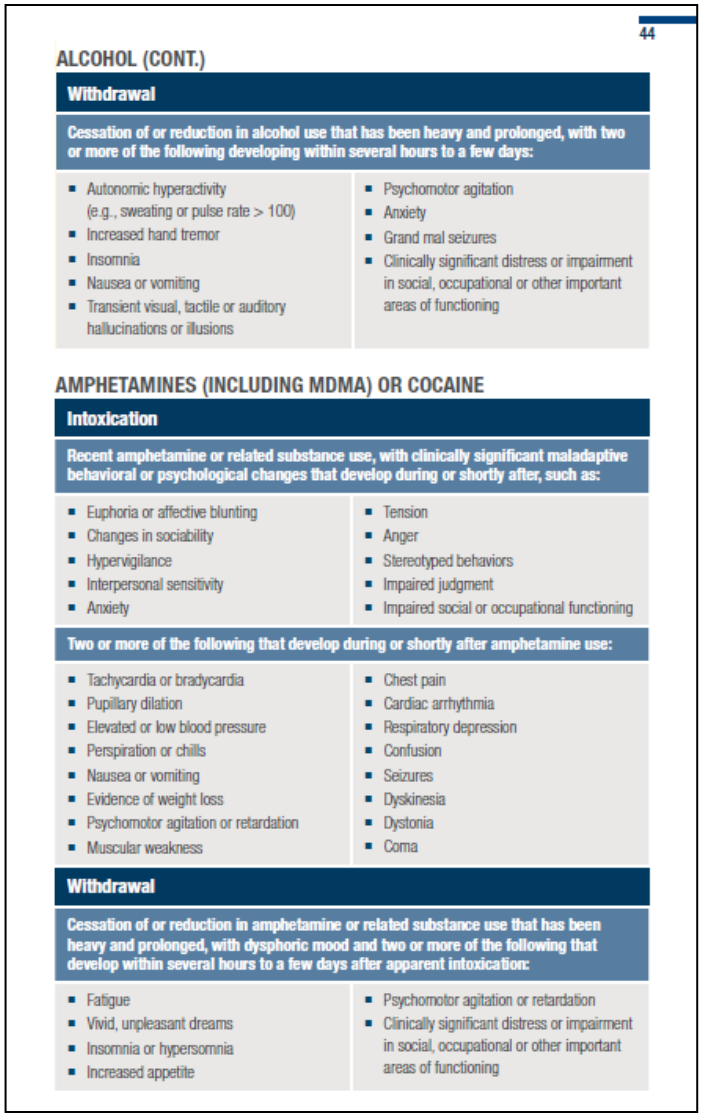
- DSM-IV-TR symptoms of intoxication and withdrawal criteria for:
  - Alcohol
  - Amphetamines
  - Cannabis
  - Dextromethorphan (DXM)
  - Hallucinogens
  - Inhalants
  - Opioids
  - Phencyclidine
  - Sedatives, hypnotics, anxiolytics



Symptoms of Intoxication and Withdrawal

Specific symptoms of intoxication and withdrawal from:

- Alcohol
- Amphetamines
- Cannabis
- Dextromethorphan (DXM)
- Hallucinogens
- Inhalants
- Opioids
- Phencyclidine
- Sedatives, hypnotics, anxiolytics



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ALCOHOL (CONT.)

Withdrawal

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

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

AMPHETAMINES (INCLUDING MDMA) OR COCAINE

Intoxication

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

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

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

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

Withdrawal

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

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

Review

Question:	Answers:
1. What are the three items that make up the SUD tool kit?	1. SUD pocket guide, patient tool, family tool
2. Which tab contains the DSM-IV-TR criteria?	2. Tab 1
3. Name the four recommended assessment tools?	3. AUDIT-C, SASQ, CIWA-ar, COWS

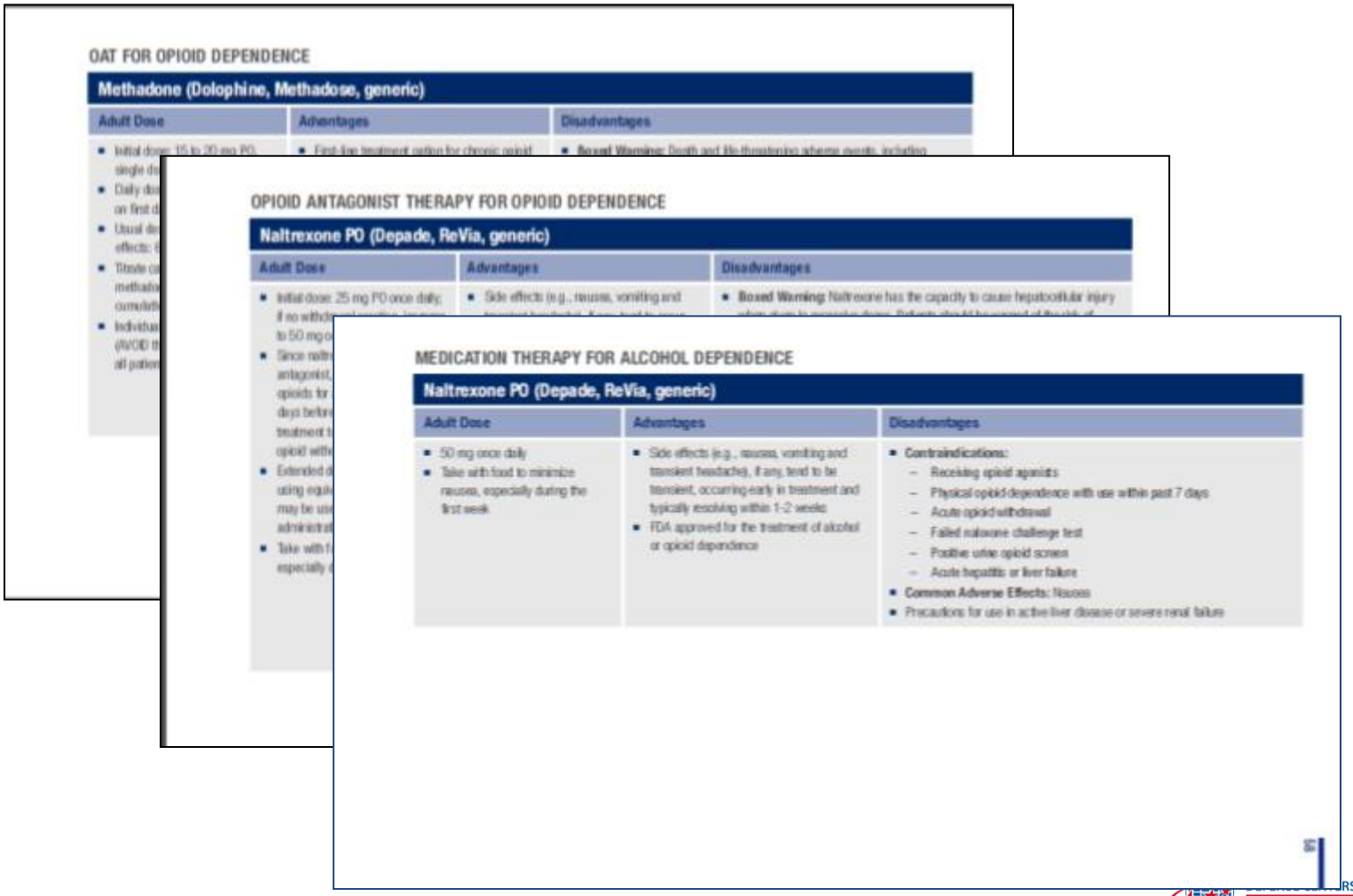
Medication Tables

- Medications used in the management of SUD
  - Opioid agonist therapy
  - Opioid antagonist therapy
  - Medication therapy for alcohol dependence

- (See also “Medication-Assisted Treatment For Alcohol Dependence” patient tool)

Medication Tables

Medications used in the management of SUD: Opioid agonist therapy, opioid antagonist therapy, medication therapy for alcohol dependence



OAT FOR OPIOID DEPENDENCE

Methadone (Dolophine, Methadose, generic)

Adult Dose	Advantages	Disadvantages
• Initial dose: 15 to 20 mg PO, single do	• First-line treatment option for chronic opioid	• **Boxed Warning:** Death and life-threatening adverse events, including
• Daily do on first d		
• Usual do effects: t		
• Titrate u methadu cumulati		
• Individua (AVOID t all patien		

OPIOID ANTAGONIST THERAPY FOR OPIOID DEPENDENCE

Naltrexone PO (Depade, ReVia, generic)

Adult Dose	Advantages	Disadvantages
• Initial dose: 25 mg PO once daily; if no withdr to 50 mg o	• Side effects (e.g., nausea, vomiting and transient headache, if any, tend to be	• **Boxed Warning:** Naltrexone has the capacity to cause hepatocellular injury
• Since naltr antagonist, opioids for days before treatment t opioid with		
• Extended d using equi may be us administrat		
• Take with f especially		

MEDICATION THERAPY FOR ALCOHOL DEPENDENCE

Naltrexone PO (Depade, ReVia, generic)

Adult Dose	Advantages	Disadvantages
• 50 mg once daily • Take with food to minimize nausea, especially during the first week	• Side effects (e.g., nausea, vomiting and transient headache), if any, tend to be transient, occurring early in treatment and typically resolving within 1-2 weeks • FDA approved for the treatment of alcohol or opioid dependence	• **Contraindications:** – Receiving opioid agonists – Physical opioid dependence with use within past 7 days – Acute opioid withdrawal – Failed naloxone challenge test – Positive urine opioid screen – Acute hepatitis or liver failure • **Common Adverse Effects:** Nausea • Precautions for use in active liver disease or severe renal failure

Medication Tables

OAT FOR OPIOID DEPENDENCE

Methadone (Dolophine, Methadose, generic)

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

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Medication Tables

OPIOID ANTAGONIST THERAPY FOR OPIOID DEPENDENCE (cont.)

Naltrexone PO

Drug Interactions

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

General Information

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

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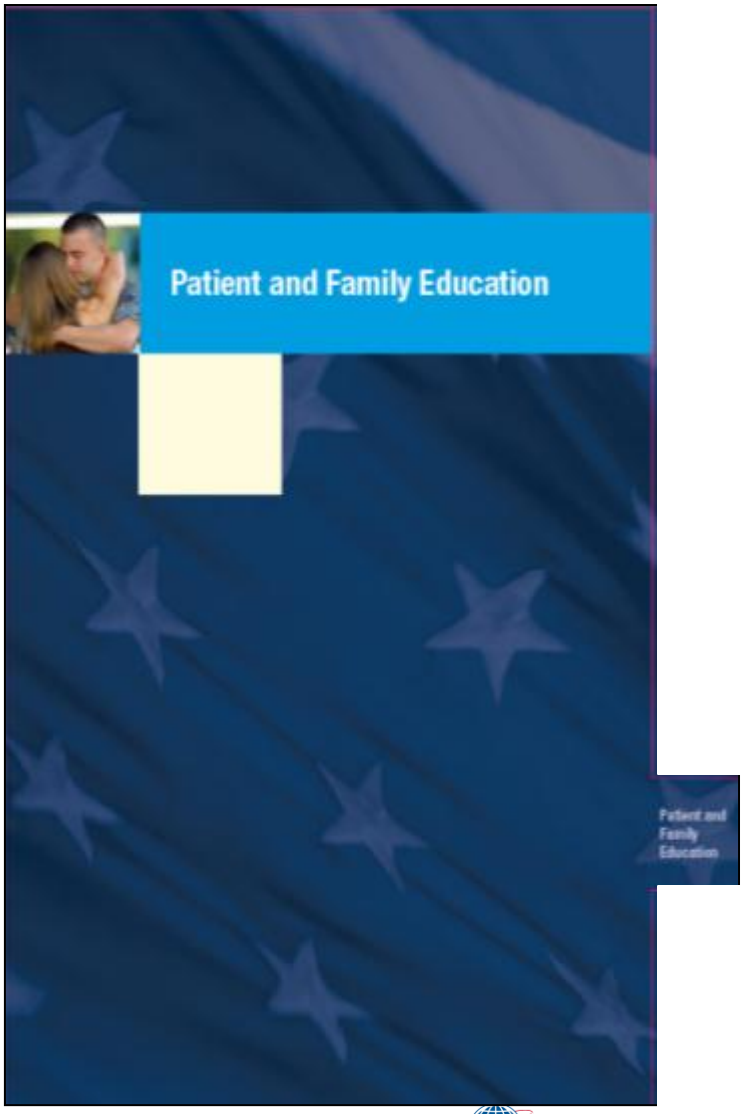
SUD Patient and Family Education

- Topics include
  - What counts as a drink?
  - Which group are you in?
  - Recommended daily and weekly drinking limits
  - What's "at risk" or "heavy" drinking?
  - Effects of high risk drinking
  - Why are women's risk limits different from men's?
  - What are symptoms of an alcohol use disorder?
  - Importance of family member intervention and support
  - Reassure and refer your loved one
  - Referral resources



SUD Patient and Family Education

What counts as a drink?

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

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

Which group are you in? Recommended daily and weekly drinking limits

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WHICH GROUP ARE YOU IN?

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

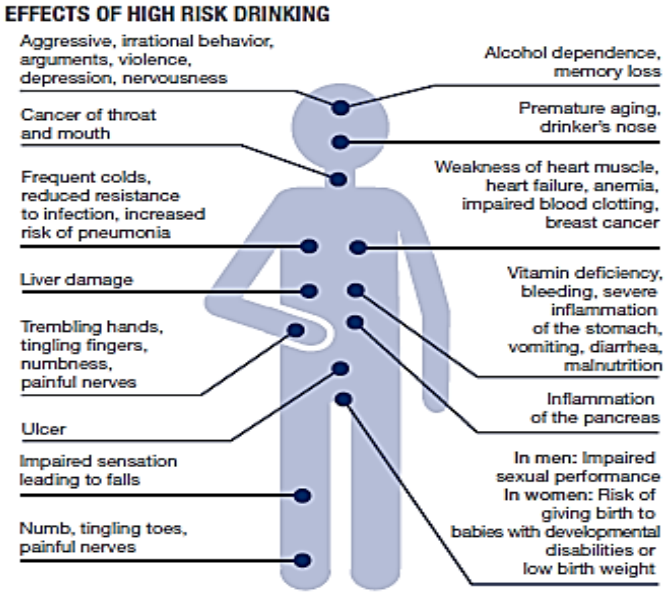
Source: National Institute on Alcohol Abuse and Alcoholism, retrieved from http://pubs.niaaa.nih.gov/publications/RethinkingDrinking/Rethinking_Drinking.pdf

RECOMMENDED DAILY AND WEEKLY DRINKING LIMITS FOR MEN AND WOMEN

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

SUD Patient and Family Education

Effects of High Risk Drinking



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

Why are women's risk limits different from men's?
Research shows that women have alcohol-related problems at lower drinking levels than men because:

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

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SUD Patient and Family Education

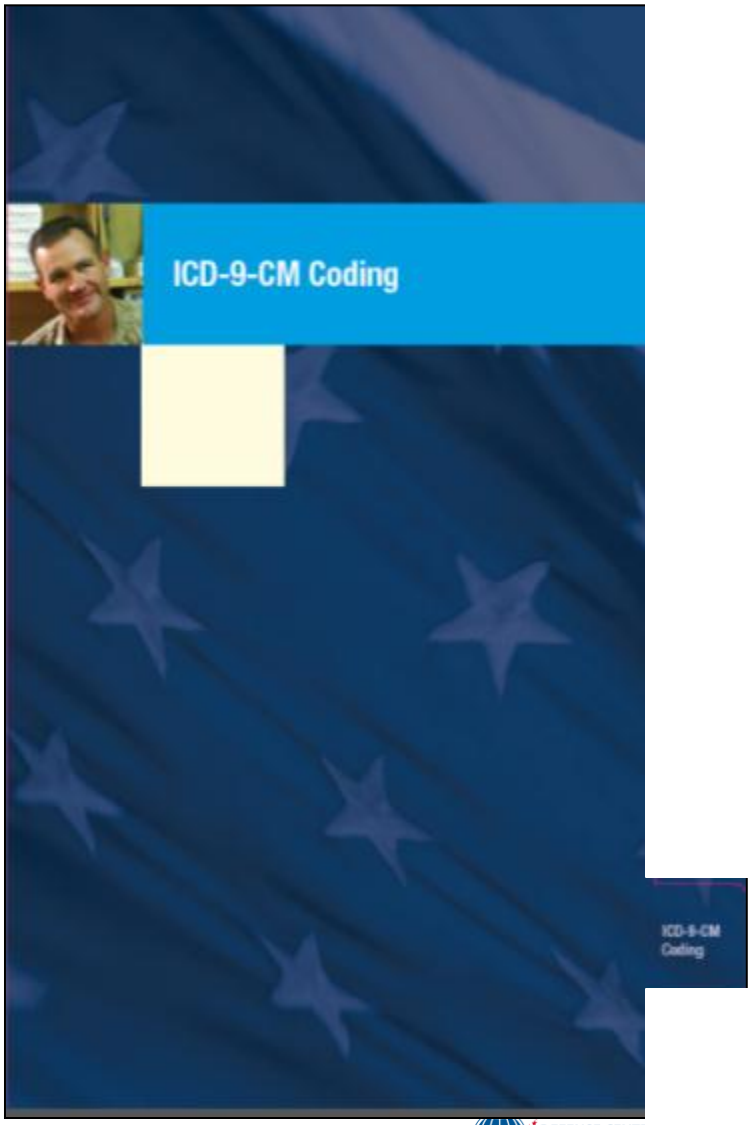
Importance of family member intervention and support

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

Remember the Seven C's	
I didn't	Cause it
I can't	Cure it
I can't	Control it
I can take better	Care of myself by… Communicating my feelings
Making healthy	Choices… Celebrating myself

SUD ICD-9-CM Coding Guidance

- Commonly used coding for SUD
  - Special screening for mental disorders and developmental handicaps
  - 291-292 series codes
  - 303-305 series codes



SUD ICD-9-CM Coding Guidance

- Commonly used coding
  - Special screening for mental disorders and developmental handicaps
    - V79.1 alcoholism
  - 291-292 series codes
    - 291 alcohol-induced mental disorders
    - 292 drug-induced mental disorders
  - 303-305 series codes
    - 303 alcohol dependence syndrome
    - 304 drug dependence
    - 305 non-dependent use of drugs

Special Screening for Mental Disorders and Developmental Handicaps

Series Code	Description
V79.1	Alcoholism

291–292 Series Codes

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

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

303–305 Series Codes

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

SUD Tools and Resources

- Tools
- VA/DoD resources
- Additional SUD-related military resources
- Additional SUD-related civilian resources
- Community resources

SUD Tools and Resources

- Tools
  - AUDIT-C
  - SASQ

Scoring AUDIT-C

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

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

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

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

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

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

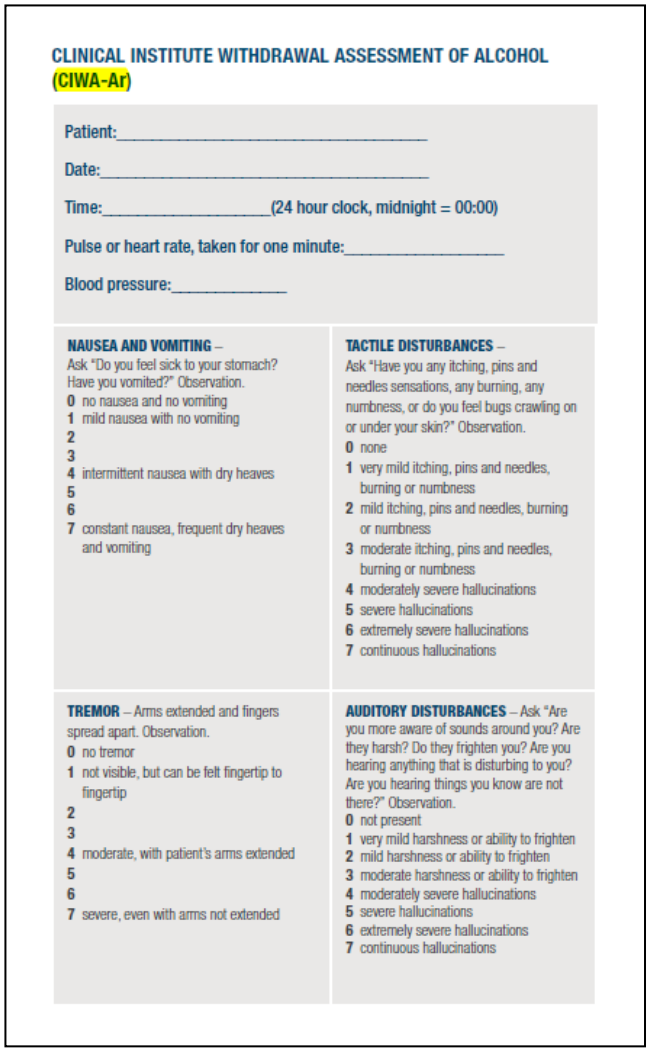
One standard drink = 12 ounces of beer, or 5 ounces of wine, or 1.5 ounces of 80-proof spirits (see Tab 7, page 65 for pictures of standard drinks.)

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

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

SUD Tools and Resources

- Tools
  - CIWA-Ar
  - COWS



CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT OF ALCOHOL (CIWA-Ar)

Patient:_____

Date:_____

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

Pulse or heart rate, taken for one minute:_____

Blood pressure:_____

NAUSEA AND VOMITING – Ask "Do you feel sick to your stomach? Have you vomited?" Observation.
0 no nausea and no vomiting
1 mild nausea with no vomiting
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves and vomiting

TACTILE DISTURBANCES – Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.
0 none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning or numbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

TREMOR – Arms extended and fingers spread apart. Observation.
0 no tremor
1 not visible, but can be felt fingertip to fingertip
2
3
4 moderate, with patient's arms extended
5
6
7 severe, even with arms not extended

AUDITORY DISTURBANCES – Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.
0 not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
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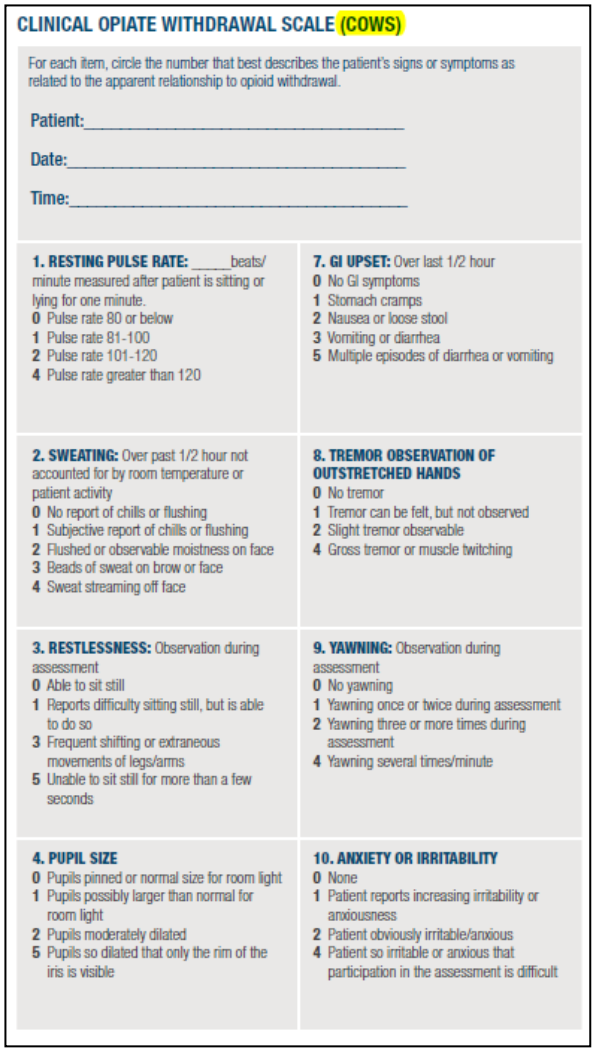


CLINICAL OPIATE WITHDRAWAL SCALE (COWS)

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

Patient:_____

Date:_____

Time:_____

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

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

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

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

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

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

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

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

SUD Tools and Resources

VA/DoD Resources

- The full VA/DoD SUD guideline can be accessed at:

www.healthquality.va.gov/

https://www.qmo.amedd.army.mil/substance%20abuse/substance.htm

SUD Tools and Resources

VA/DoD Resources

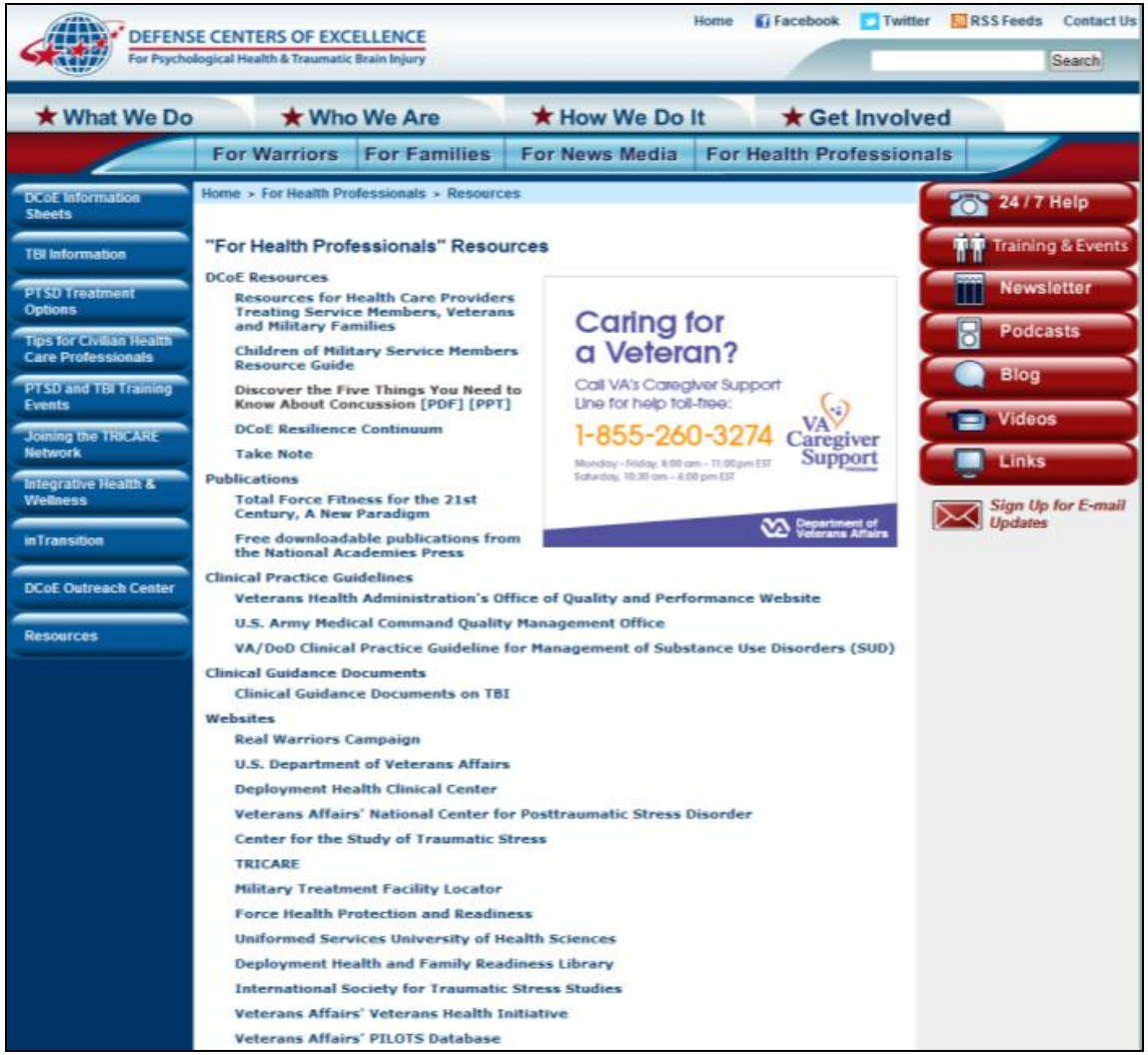
- Updated VA/DoD CPGs for additional psychological health disorders, including bipolar disorder, major depressive disorder and posttraumatic stress, can also be accessed at these sites:

www.healthquality.va.gov/

https://www.qmo.amedd.army.mil/pguide.htm

SUD Tools and Resources

- **Additional SUD-Related Military Resources**



www.dcoe.health.mil/ForHealthPros/Resources.aspx

SUD Tools and Resources

- **Additional SUD-Related Military Resources**

www.oefoif.va.gov/substanceabuseprograms.asp

SUD Tools and Resources

- **Additional SUD-Related Military Resources**

http://acsap.army.mil/sso/pages/index.jsp

SUD Tools and Resources

Additional SUD-Related Civilian and Community Resources

Agencies

- National Institute on Alcohol Abuse and Alcoholism (NIAAA)
- National Institute on Drug Abuse (NIDA)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

Mutual-Help Groups

- Alcoholics Anonymous (www.aa.org) 212-870-3400
- Secular Organizations for Sobriety
- (www.cfiwest.org/sos/index.htm) 323-666-4295

Groups for Family and Friends

- Al-Anon/Alateen (www.al-anon.alateen.org) 888-425-2666 for meetings
- Adult Children of Alcoholics (www.adultchildren.org) 310-534-1815

Medical and Non-Medical Addiction Specialists

- American Academy of Addiction Psychiatry (www.aaap.org) 401-524-3076
- American Psychological Association (http://apa.org) 800-964-2000
- American Society of Addiction Medicine (www.asam.org) 301-656-3920
- The Association for Addiction Professionals (www.naadac.org) 800-548-0497
- National Association of Social Workers (www.socialworkers.org or www.helpstartshere.org) 202-408-8600

Suicide Hotline

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

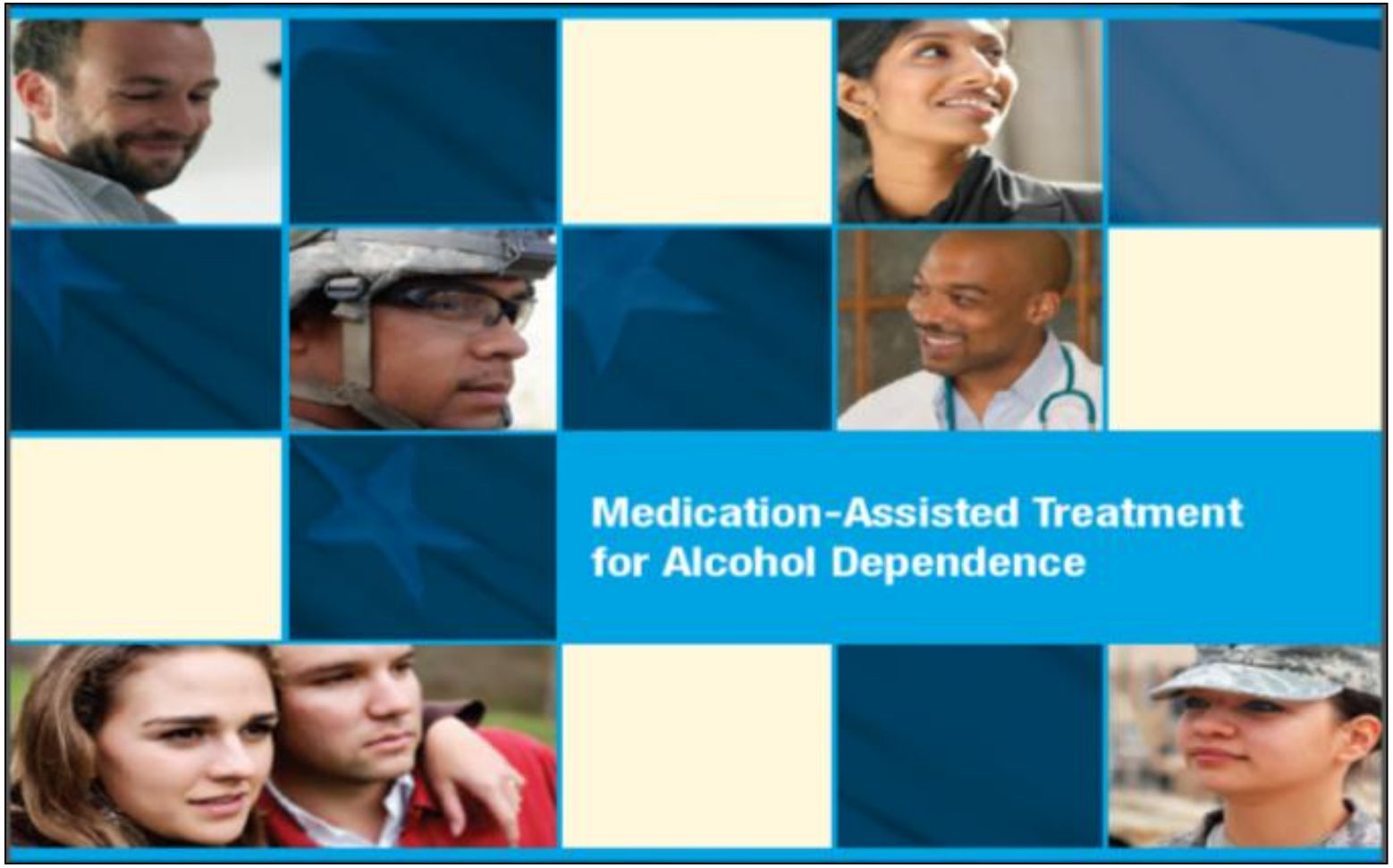
Treatment Facilities

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

Review

Question:	Answers:
1. On which tab does the audience switch from provider to the patient?	1. Tab 7: Patient and Family Education
2. Where can I find med tables and ICD-9-CM diagnostic criteria?	2. Tabs 6: Medication Tables and 8: ICD-9CM Codes
3. Where can I find all four assessment tools together?	3. Tab 9: Tools and Resources

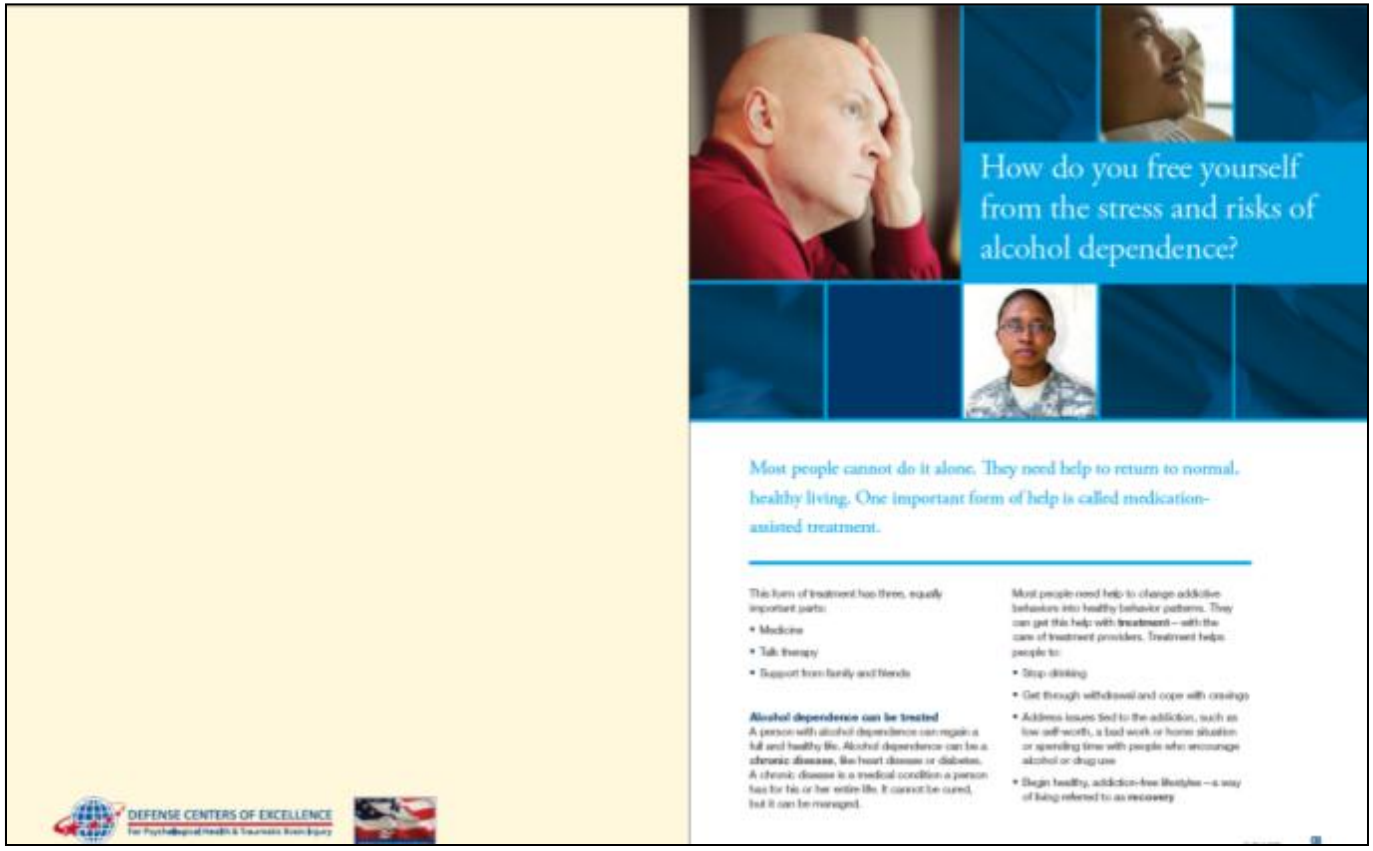
SUD Patient Education Booklet



SUD Patient Education Booklet

Topics include:

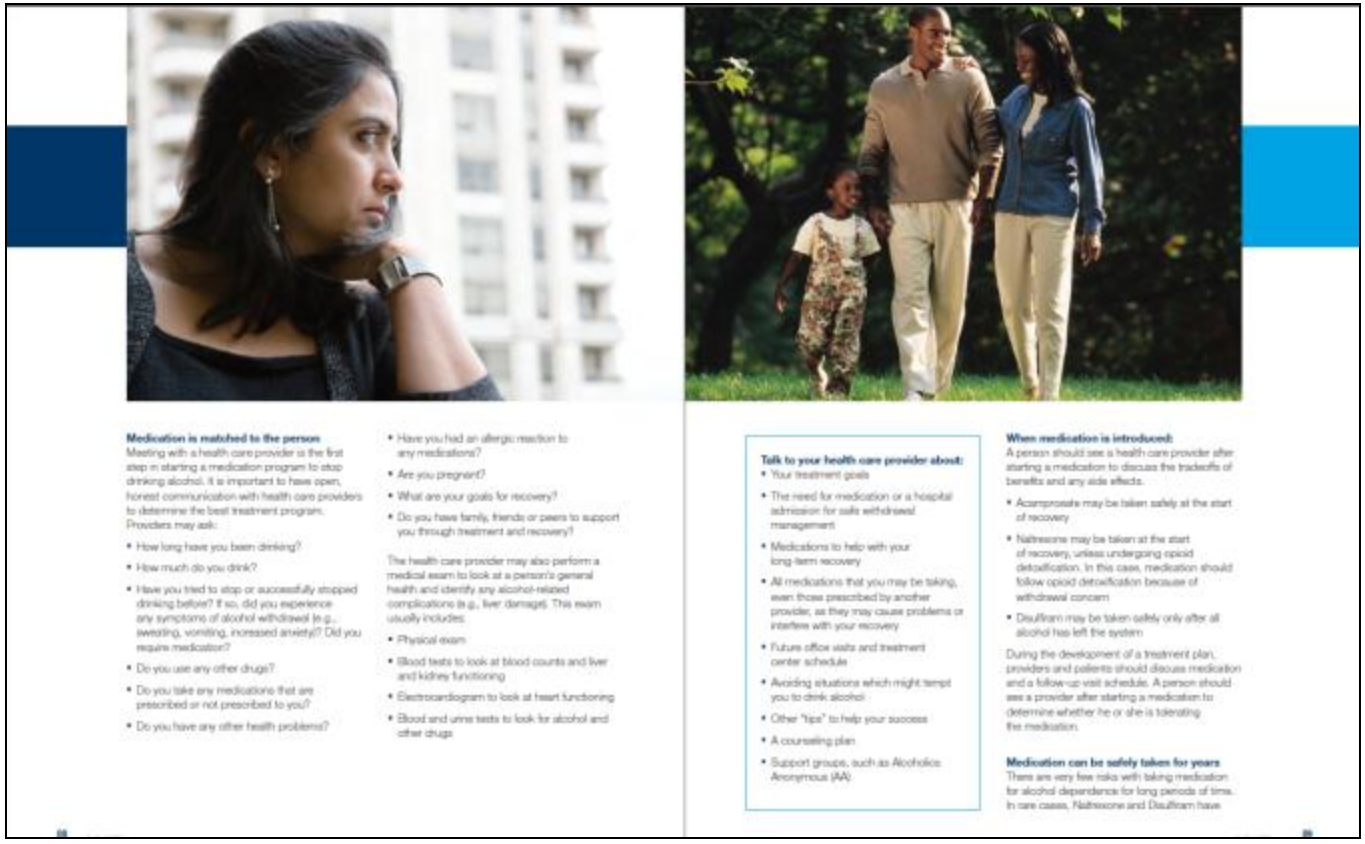
- Alcohol dependence can be treated



SUD Patient Education Booklet

Topics include:

- Treatment may include medication



Medication is matched to the person
Meeting with a health care provider is the first step in starting a medication program to stop drinking alcohol. It is important to have open, honest communication with health care providers to determine the best treatment program. Providers may ask:

- How long have you been drinking?
- How much do you drink?
- Have you tried to stop or successfully stopped drinking before? If so, did you experience any symptoms of alcohol withdrawal (e.g., sweating, vomiting, increased anxiety)? Did you require medication?
- Do you use any other drugs?
- Do you take any medications that are prescribed or not prescribed to you?
- Do you have any other health problems?
- Have you had an allergic reaction to any medications?
- Are you pregnant?
- What are your goals for recovery?
- Do you have family, friends or peers to support you through treatment and recovery?

The health care provider may also perform a medical exam to look at a person's general health and identify any alcohol-related complications (e.g., liver damage). This exam usually includes:

- Physical exam
- Blood tests to look at blood counts and liver and kidney functioning
- Electrocardiogram to look at heart functioning
- Blood and urine tests to look for alcohol and other drugs

Talk to your health care provider about:

- Your treatment goals
- The need for medication or a hospital admission for safe withdrawal management
- Medications to help with your long-term recovery
- All medications that you may be taking, even those prescribed by another provider, as they may cause problems or interfere with your recovery
- Future office visits and treatment center schedule
- Avoiding situations which might tempt you to drink alcohol
- Other "tips" to help your success
- A counseling plan
- Support groups, such as Alcoholics Anonymous (AA)

When medication is introduced:
A person should see a health care provider after starting a medication to discuss the tradeoffs of benefits and any side effects.

- Acamprosate may be taken safely at the start of recovery
- Naltrexone may be taken at the start of recovery, unless undergoing opioid detoxification. In this case, medication should follow opioid detoxification because of withdrawal concern
- Disulfiram may be taken safely only after all alcohol has left the system

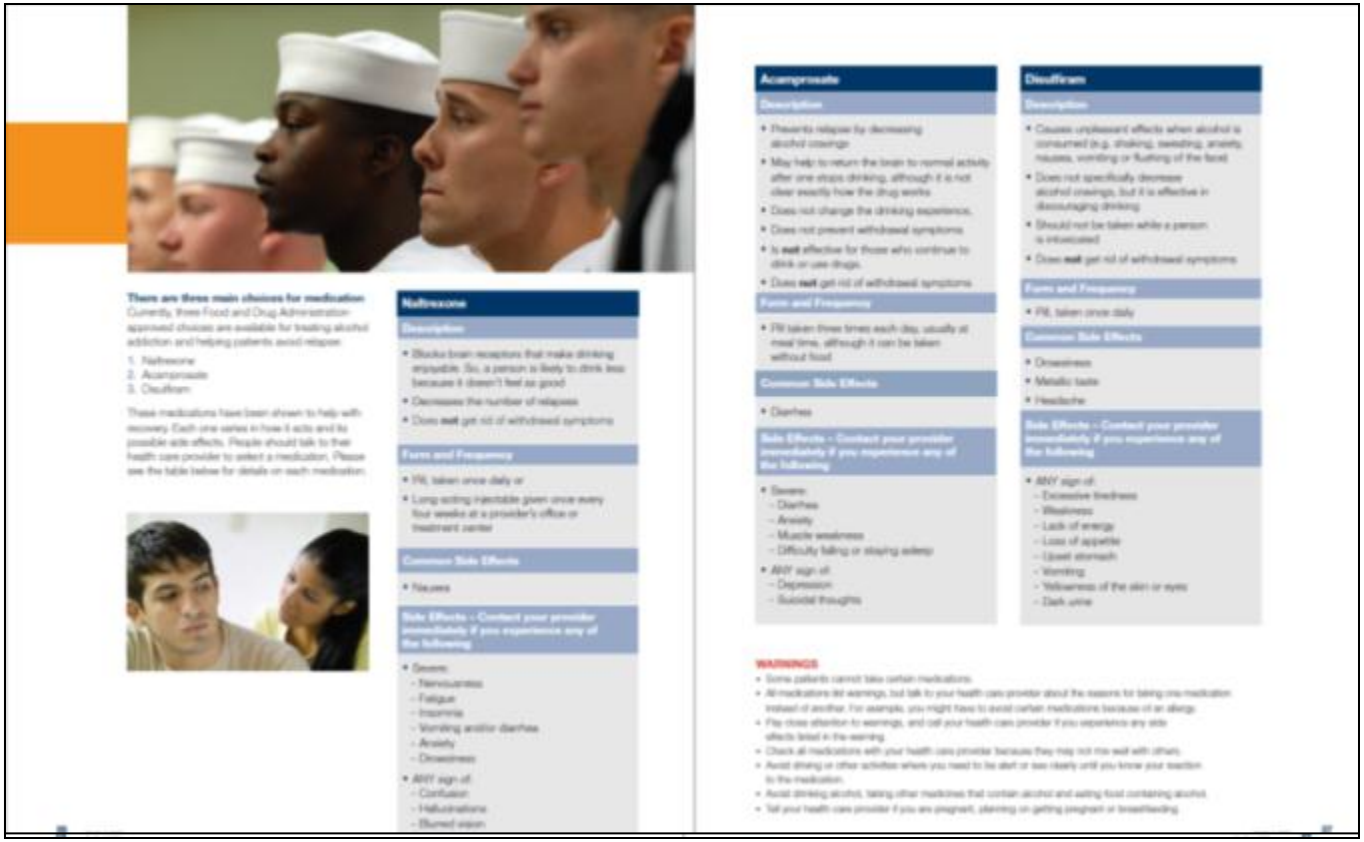
During the development of a treatment plan, providers and patients should discuss medication and a follow-up visit schedule. A person should see a provider after starting a medication to determine whether he or she is tolerating the medication.

Medication can be safely taken for years
There are very few risks with taking medication for alcohol dependence for long periods of time. In rare cases, Naltrexone and Disulfiram have

SUD Patient Education Booklet

Topics include:

- There are three main choices for medication



SUD "Substance Abuse Affects Families" Brochure

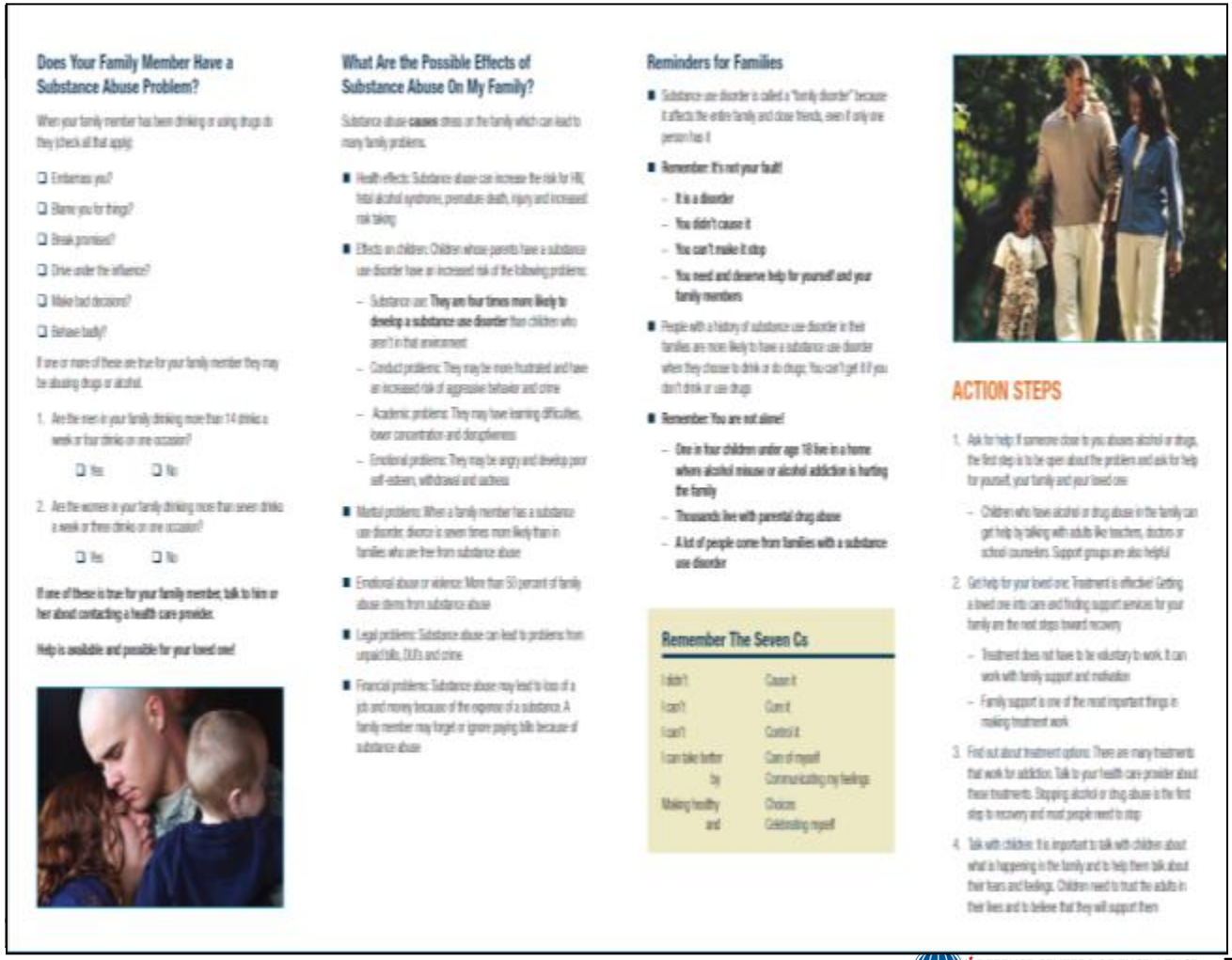
Topics include:

- Facts on substance abuse
- Does your family have a substance abuse problem?

SUD "Substance Abuse Affects Families" Brochure

Topics include:

- Facts on substance abuse
- Does your family have a substance abuse problem?
- What are the possible effects of substance abuse on my family?
- Reminders for families
- Action steps



Does Your Family Member Have a Substance Abuse Problem?

When your family member has been drinking or using drugs do they (check all that apply)

- ❑ Embarrass you?
- ❑ Blame you for things?
- ❑ Break promises?
- ❑ Drive under the influence?
- ❑ Make bad decisions?
- ❑ Behave badly?

If one or more of these are true for your family member they may be abusing drugs or alcohol.

1. Are the men in your family drinking more than 14 drinks a week or four drinks on one occasion?
   ❑ Yes ❑ No
2. Are the women in your family drinking more than seven drinks a week or three drinks on one occasion?
   ❑ Yes ❑ No

If one of these is true for your family member, talk to him or her about contacting a health care provider.

Help is available and possible for your loved one!

What Are the Possible Effects of Substance Abuse On My Family?

Substance abuse **causes** stress on the family which can lead to many family problems.

- Health effects: Substance abuse can increase the risk for HIV, fetal alcohol syndrome, premature death, injury and increased risk taking
- Effects on children: Children whose parents have a substance use disorder have an increased risk of the following problems:
  - Substance use: **They are four times more likely to develop a substance use disorder** than children who aren't in that environment
  - Conduct problems: They may be more frustrated and have an increased risk of aggressive behavior and crime
  - Academic problems: They may have learning difficulties, lower concentration and disruptiveness
  - Emotional problems: They may be angry and develop poor self-esteem, withdrawal and sadness
- Marital problems: When a family member has a substance use disorder, divorce is seven times more likely than in families who are free from substance abuse
- Emotional abuse or violence: More than 50 percent of family abuse stems from substance abuse
- Legal problems: Substance abuse can lead to problems from unpaid bills, DUI's and crime
- Financial problems: Substance abuse may lead to loss of a job and money because of the expense of a substance. A family member may forget or ignore paying bills because of substance abuse

Reminders for Families

- Substance use disorder is called a "family disorder" because it affects the entire family and close friends, even if only one person has it
- **Remember: It's not your fault!**
  - **It is a disorder**
  - **You didn't cause it**
  - **You can't make it stop**
  - **You need and deserve help for yourself and your family members**
- People with a history of substance use disorder in their families are more likely to have a substance use disorder when they choose to drink or do drugs. You can't get it if you don't drink or use drugs
- **Remember: You are not alone!**
  - **One in four children under age 18 live in a home where alcohol misuse or alcohol addiction is hurting the family**
  - **Thousands live with parental drug abuse**
  - **A lot of people come from families with a substance use disorder**

Remember The Seven Cs

I didn't	Cause it
I can't	Cure it
I can't	Control it
I can take better	Care of myself
by	Communicating my feelings
Making healthy	Choices
and	Celebrating myself

ACTION STEPS

1. Ask for help: If someone close to you abuses alcohol or drugs, the first step is to be open about the problem and ask for help for yourself, your family and your loved one
   - Children who have alcohol or drug abuse in the family can get help by talking with adults like teachers, doctors or school counselors. Support groups are also helpful
2. Get help for your loved one: Treatment is effective! Getting a loved one into care and finding support services for your family are the next steps toward recovery
   - Treatment does not have to be voluntary to work. It can work with family support and motivation
   - Family support is one of the most important things in making treatment work
3. Find out about treatment options: There are many treatments that work for addiction. Talk to your health care provider about these treatments. Stopping alcohol or drug abuse is the first step to recovery and most people need to stop
4. Talk with children: It is important to talk with children about what is happening in the family and to help them talk about their fears and feelings. Children need to trust the adults in their lives and to believe that they will support them

Conclusion

- We briefly reviewed the development of the VA/DoD Clinical Practice Guideline for Management of SUD
- We covered the contents of the SUD tool kit
  - SUD pocket guide tabbed booklet
  - Patient tools: patient education booklet and family brochure
- We described the benefits of utilizing these tools
  - Decreased practice variation
  - Improved patient outcomes
  - Effective decision-making
  - Decreased risk

References

- Department of Veterans Affairs & Department of Defense (2008). *VA/DoD clinical practice guideline for substance use disorder.* (Version 2.0 – 2009) Washington, DC: The Management of SUD Working Group, The Office of Quality and Performance, VA & Quality Management Directorate, United States Army MEDCOM. Retrieved from www.healthquality.va.gov/Substance_Use_Disorder_SUD.asp