Clinical Practice Guideline (CPG)

Substance Use Disorders

SCOPE:

☒ Family Care ☒ PACE ☒ Partnership

AUDIENCE:

Interdisciplinary Team Staff (IDTS), Specialists, Clinicians, Providers

PURPOSE:

To provide best practice approach to Community Care Inc. Interdisciplinary team staff, physicians and other providers who care for our members.

Community care Clinical Practice Guidelines (CPG) are recommendations intended to guide an overall approach to care. Please see references for an in-depth review of the condition/disease.

Individual member factors, comorbidities, member preferences and member "goals of care" should be considered when making recommendations for an individual member.

Version: 1.0
Delivery: 06/14/2022
Owner: BH Director

Reviewer: SUD sub-group of BHRT, BH supervisor
Approver: Medical Director, Director of Clinical Services
Date Approved: 06/ /2022

Review Period in Years: 3
Next Review Date: 06/30/2025

CONTENTS:

1) Overview of (Disease/Condition)

Substance use disorders include cognitive, behavioral and physiological symptoms that can be identified in persons who continue to use substances despite problems in social, work and/or personal life caused by substance use. This behavior is relevant for many individuals. Continued substance use can result in impairment of control, impairment of social functioning, risky use, tolerance and withdrawal.

Screening for Substance Use Disorders (SUD), providing and/or coordinating treatment, includes a systematic approach to the recognition of the presence of Substance use Disorders

and guides the effective response. The goal is a person-centered response in order to achieve optimal treatment outcomes.
The professional making the diagnosis of a Substance Use Disorder, uses criteria, as specified by substance used, in the American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. The diagnosis and severity are determined by the number of criteria met as assessed by the appropriately licensed and credentialed professional.

- **Impaired control may be evidenced in several different ways**:
  - Using for longer periods of time than intended, or using larger amounts than intended;
  - Wanting to reduce use, yet being unsuccessful doing so;
  - Spending excessive time getting/using/recovering from the substance use;
  - Cravings that are so intense it is difficult to think about anything else.
- **Social impairment** is one type of substantial harm (or consequence) caused by the repeated use of a substance or an activity related to substance use.
  - A person may continue to use despite problems at work, school or with family/social obligations.
  - Interpersonal problems could include arguments with family members about the substance use or losing important friendships because of continued use.
  - Important and meaningful social and recreational activities may be given up or reduced because of substance use.
- **Risky use** is the failure to refrain from using the substance despite the harm it causes.
  - Using alcohol or other drugs while operating machinery or driving a car.
  - Continuing to use addictive substances when aware use is causing or worsening physical and psychological problems. For example, a person who continues to smoke cigarettes despite having a respiratory disorder such as asthma or COPD.
- **Pharmacological indicators**: Tolerance and withdrawal

2) Best Practice Standards

- Screen for Substance Use Disorders
  - **Screening Questions:**
    1. Is there a positive family history for substance use disorder? Yes/ No
       If yes, describe
    2. Does the person have a history of substance Use disorder? Yes/ No
       If yes, describe
    3. Does the person have easy access to alcohol or other substances? Yes/ No
       If the answer to either question 2 or 3 is YES, ask additional questions:

4. When was the last time this person consumed alcohol or other substances?
5. Where was alcohol or other substances consumed?
6. Note substance(s) used.
7. How long was the episode of substance use?

- **Screening Tools:**
  - CAGE
  - AUDIT
  - DAST

- Assessment and Diagnosis: The diagnosis and severity are determined by appropriately licensed and credentialed professionals.
- Initial response/treatment
  - Continued assessment, medical monitoring, and follow up are offered using a motivational approach
  - Lab tests should be ordered by primary care to establish a baseline, and monitored according to primary care protocols.
  - A baseline urine drug screen is recommended to be done with the person's permission and per primary care protocols.
  - If the person declines offers of assistance, document risk conversation, use a Motivational Interviewing approach, and use brief interventions, such as **FRAMES:**
    - **F**eedback regarding personal risk or impairment is given to the member following assessment of substance use patterns and associated problems.
    - **R**esponsibility for change is placed squarely and explicitly on the member (with respect for the member's right to make choices for himself/herself).
    - **A**dvice about changing (ask permission before giving advice) substance use-- reducing or stopping use-- is given to the member in a non-judgmental manner.
    - **M**enus of self-directed change options and treatment alternatives are offered to the member.
    - **E**mpathetic counselling utilizes warmth, respect, and understanding; listen more, talk less.
    - **S**elf-efficacy or optimistic empowerment is engendered in the member to encourage change.
  - Stay engaged

3) Prevention and Management of Acute Issues

- **Monitoring and follow up**
  - **Tolerance** occurs when a person needs to increase the amount of a substance to achieve the same desired effect. Stated differently, it is when someone experiences less

of an effect using the same amount. The "desired effect" might be to avoid withdrawal symptoms and/or to get “high.” Tolerance differs from person to person because people vary in their sensitivities to different substances. How quickly tolerance develops and the dose needed for tolerance to develop varies depending on the drug.

- **Withdrawal** is the body's response to the abrupt cessation of a drug, once the body has developed a tolerance to it. Although withdrawal is very unpleasant, it does not usually require medical assistance.
  However, withdrawal from some drugs can be fatal. ***Consultation with a medical professional is required if the member is attempting to stop drug or alcohol use after a period of heavy and continuous use, in order to ensure that stopping drug or alcohol use is as safe and comfortable as possible.***
- If a member is experiencing withdrawal symptoms at the time they are being evaluated for treatment, diagnosis of both substance use and substance withdrawal should be sought.
- **Potential indicators of a substance use disorder**:
  - High tolerance
  - Job/school/interpersonal problems
  - Blackouts
  - Legal problems
  - Sneaking substances
  - Morning use
  - Preoccupation with drug of choice
  - Solitary use
  - Hurried ingestion
  - Aggressive behavior/violent outbursts
  - Hiding and minimizing
  - Lack of empathy
  - Loss of control
  - Weight loss/gain, change in appetite
  - Alibis and excuses
  - Restlessness, hyper verbal
  - Concern by others
  - Health problems
  - Change in patterns/behaviors

- **Treatment settings-Options for supports and interventions:**

  - Consultation with BH Specialist, SUD credentialed specialist.
  - Risk conversation/agreement with the member utilizing the Motivational Interviewing approach which is collaborative, compassionate, and meets the member where they are in the “stages of change”.
  - Harm Reduction approach if member is pre-contemplative in terms of considering change/treatment. A Harm Reduction approach means using whatever you can to

reduce risk or harm; negotiating ways for the member to reduce harm or risk while they are still engaging in the substance use.
    - Formal assessment with credentialed provider can be requested based on the results of screening
    - Continued assessment, medical monitoring, and follow up are offered to the member
- Relapse or recurrence means resumption of old behaviors. When this happens, identify the trigger for relapse or recurrence, reassess motivation and barriers, and collaboratively plan stronger coping strategies.

4) Process for Interdisciplinary Team Staff (IDTS)

- Review screening questions and /or use screening tools at initial, and at each MCP review assessment.
- Interventions are guided by Motivational Interviewing principles, and include member-relevant information/handouts related to substance use and health care goals.
- Collaborate with BH and SUD specialists in provision of verbal information, written materials, and treatment resource options that reflect member's position in the "stages of change" continuum.
- Use motivational interviewing techniques to explore barriers to change, member understanding of risks of continued use, and member readiness to explore the options and benefits of treatment.
- The member-centered plan of care includes member goals, treatment resources, and a customized list of interventions, when appropriate and agreed upon by the member and caregiver or legal decision maker, utilizing a shared decision making process.
- Referral and treatment options include:
    - Individual Therapy
    - Group Therapy
    - Psychiatry
    - Anti-craving medication
    - Nutritional Therapy
    - Recreational Therapy
    - Laboratory testing
    - Substance Use Disorder Treatment
    - Detoxification
    - Transportation to approved, community based substance use disorder treatment/support
    - Community based self-help support groups
- Collaborate with Primary Care Provider (PCP): ordering and monitoring of laboratory testing. Laboratory testing may include liver function testing, drug screens, and blood levels

of therapeutic pharmacology when indicated. Laboratory testing may be ordered when needed to determine whether member outcomes are met.

5) Quality Assurance Monitoring

- Community care monitors quality of care provided to all its members via Internal file review, target audits, risk reports, HEDIS data, Acumen data, electronic health record guideline reports, Clinical Dashboards and feedback from providers.
- Community care recognizes that Clinical Practice Guidelines are intended to assist in decision-making and may not apply to all members or circumstances, and complete compliance is not expected for all guidelines.

6) References

1. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013.

2. Treatment Improvement Protocols (TIPs) from the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Substance Abuse Treatment (CSAT) U.S. Department of Health and Human Services

3. Addressing Alcohol and Other Drug Problems in the Partnership Program: A Self-Study Manual and Best Practices Guideline, Ann Pooler, RN, PhD, Center for Excellence in Long-Term Care University of Wisconsin-Madison School of Nursing for the Wisconsin Department of Health and Family Services; Robert Wood Johnson Foundation Grant #041075 October 2003

4. Overview of the ASAM Patient Placement Criteria, Second Edition Revised (ASAM PPC-2R) June 9, 2005

5. NIAAA: National Institute on Alcohol Abuse and Alcoholism: http://www.niaaa.nih.gov/

6. SAMHSA- HRSA Center for Integrated Health Solutions (current) Screening

https://www.integration.samhsa.gov/clinical-practice/sbirt/screening

7. A. Tom Horvath, Ph.D., ABPP, Kaushik Misra, Ph.D., Amy K. Epner, Ph.D., and Galen Morgan Cooper, Ph.D. (Aug 26, 2013 Updated Apr 25, 2016)

https://www.mentalhelp.net/contributors/horvarth/

8. DiClemente, C. C. & Scott, C. W. (1997) Stages of change: Interactions with treatment Compliance and Involvement, NIDA Res Monogr, 165, 131-56