Guideline Summary NGC-10885

Guideline Title

VA/DoD clinical practice guideline for the management of substance use disorders.

Bibliographic Source(s)

Management of Substance Use Disorders Work Group. VA/DoD clinical practice guideline for the management of substance use disorders. Version 3.0. Washington (DC): Department of Veterans Affairs, Department of Defense; 2015 Dec. 169 p. [327 references]

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: VA/DoD clinical practice guideline for management of substance use disorders (SUD). Washington (DC): Department of Veteran Affairs, Department of Defense; 2009 Aug. 158 p.

This guideline meets NGC's 2013 (revised) inclusion criteria.

FDA Warning/Regulatory Alert

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- March 22, 2016 – Opioid pain medicines ⬚: The U.S. Food and Drug Administration (FDA) is warning about several safety issues with the entire class of opioid pain medicines. These safety risks are potentially harmful interactions with numerous other medications, problems with the adrenal glands, and decreased sex hormone levels. They are requiring changes to the labels of all opioid drugs to warn about these risks.

Scope

Disease/Condition(s)

Substance use disorders (SUDs) including alcohol use disorder, opioid use disorder, cannabis use disorder, stimulant use disorder, and sedative/hypnotic use disorder

Guideline Category

Counseling

Evaluation

Management

Screening

Treatment

Clinical Specialty

Emergency Medicine

Family Practice

Internal Medicine

Psychiatry

Psychology

Intended Users

Advanced Practice Nurses

Health Care Providers

Nurses

Other

Pharmacists

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Social Workers

Substance Use Disorders Treatment Providers

Guideline Objective(s)

- To provide evidence-based recommendations to assist providers in managing or co-managing patients with substance use disorders (SUDs)
- To improve the patient's health and wellbeing by guiding health providers who are taking care of patients with SUD along the management pathways that are supported by evidence

- To promote early engagement and retention of patients with substance use conditions who can benefit from addiction-focused treatment

Target Population

Adult 18 years or older who have a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis of substance use disorder (SUD) with or without other health conditions or patients who have screened positive for unhealthy alcohol use based on Alcohol Use Disorders Identification Test-Consumption (AUDIT-C) criteria who are eligible for care in the Department of Veterans Affairs (VA) and Department of Defense (DoD) healthcare delivery systems (this population includes veterans as well as deployed and non-deployed active duty service members)

Note: This guideline does not provide recommendations for the management of SUD in children or adolescents.

Interventions and Practices Considered

1. Screening for unhealthy alcohol use annually using the three-item Alcohol Use Disorders Identification Test-Consumption (AUDIT-C) or Single Item Alcohol Screening Questionnaire (SASQ)
2. Brief alcohol intervention regarding alcohol-related risks and advice on limits for consumption
3. Determination of treatment setting
4. Treatment of alcohol use disorder
   - Pharmacotherapy (acamprosate, disulfiram, naltrexone, topiramate, gabapentin)
   - Psychosocial interventions (behavioral couples therapy for alcohol use disorder, cognitive behavioral therapy for substance use disorders (SUDs), community reinforcement approach, motivational enhancement therapy, 12-step facilitation)
5. Treatment of opioid use disorder
   - Pharmacotherapy (buprenorphine, naloxone, methadone, extended-release injectable naltrexone)
   - Individualizing choice of appropriate treatment setting (i.e., opioid treatment program or office-based)
   - Addiction-focused medical management alone or in conjunction with another psychosocial intervention
   - Psychosocial interventions with or without pharmacotherapy
6. Treatment of cannabis use disorder
   - Pharmacotherapy (no recommendation made)
   - Psychosocial interventions (cognitive behavioral therapy, motivational enhancement therapy, combined cognitive behavioral therapy/motivational enhancement therapy)
7. Treatment of stimulant use disorder
   - Pharmacotherapy (no recommendation made for or against)
   - Psychosocial interventions (cognitive behavioral therapy, recovery-focused behavioral therapy, general drug counseling, community reinforcement approach, contingency management in combination with one of the above)
8. Promoting group mutual help involvement (peer linkage, network support, 12-Step facilitation)
9. Treatment of co-occurring mental health conditions and psychosocial problems
10. Follow-up
    - Assessing response to treatment periodically and systematically, using standardized and valid instruments
    - Offering and encouraging ongoing systematic relapse prevention efforts or recovery support
    - Avoiding automatic discharge from care for patients who do not respond to treatment or who relapse
11. Assessment of stabilization and withdrawal
    - Using standardized measures to assess the severity of withdrawal symptoms such as Clinical Institute Withdrawal Assessment for Alcohol (revised version) (CIWA-Ar) for alcohol or Clinical Opiate Withdrawal Scale (COWS) for opioids
    - Inpatient medically supervised alcohol withdrawal management
    - Pharmacotherapy for managing alcohol withdrawal symptoms (benzodiazepines, carbamazepine, gabapentin, or valproic acid)
    - Avoiding withdrawal management alone for opioid use disorder
    - Pharmacotherapy for opioid withdrawal (methadone, buprenorphine, clonidine)
    - Sedative hypnotic use disorder stabilization and withdrawal (gradual taper of the original benzodiazepine, substitution of a longer acting benzodiazepine then gradual taper, substitution of phenobarbital for the addicting agent and gradual taper)

Major Outcomes Considered

- Consumption outcomes (e.g., alcohol consumption [drinks per day], opioid consumption, return to any/heavy drinking, drinking days, heavy drinking days, relapse/time to relapse, adherence with treatment or abstinence, retention/engagement in the treatment program, number lost to treatment [stability and engagement], duration of involvement in treatment, adverse events, morbidity and mortality, overdoses, hospitalization or readmission, emergency department utilization)
- Side effects of medications
- Recovery outcomes (e.g., days in the community, reduction in homelessness, decrease in encounters with criminal justice system, increase in employment)
- Functional status and quality of life outcomes (mental state, global functioning, social functioning, and quality of life and life satisfaction)
- Engagement outcomes (minimum number of outpatient visits and minimal length of stay in an inpatient setting)
- Health outcomes (e.g., accidents, injuries, mortality, healthcare utilization, functional status, quality of life)

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Searches of Unpublished Data

Description of Methods Used to Collect/Select the Evidence

Developing the Scope and Key Questions

The clinical practice guideline (CPG) Champions, along with the Work Group, were tasked with identifying Key Questions (KQs) to guide the systematic review (SR) of the literature on substance use disorders (SUDs). These questions, which were developed in consultation with the Lewin team, addressed clinical topics of the highest priority for the Department of Veterans Affairs (VA) and Department of Defense (DoD) populations. The KQs follow the population, intervention, comparison, outcome, timing and setting (PICOTS) framework for evidence questions, as established by the Agency for Healthcare Research and Quality (AHRQ). Table A‑1 in the original guideline provides a brief overview of the PICOTS typology.

The Champions and evidence review team carried out several iterations of this process, each time narrowing the scope of the CPG and the literature review by prioritizing the topics of interest. Due to resource constraints, all developed KQs were not able to be included in the systematic evidence review. Thus, the Champions and Work Group determined which questions were of highest priority, and those were included in the review. Table A-2 in the original guideline contains the final set of KQs used to guide the SR for this CPG.

Conducting the Systematic Review

Extensive literature searches using the search terms and strategy included in Appendix H of the original guideline document identified 4,708 citations potentially addressing the KQs of interest to this evidence review. Of those, 2,100 were excluded upon title review for clearly not meeting inclusion criteria (e.g., not pertinent to the topic, not published in English, published prior to study inclusion publication date, not a full-length article). Overall, 2,608 abstracts were reviewed with 1,621 of those being excluded for the following reasons: not a SR or clinical study, did not address a KQ of interest to this review, did not enroll a population of interest, or published prior to November 2007. A total of 987 full-length articles were reviewed. Of those, 682 were excluded at a first pass review for the following: not addressing a KQ of interest, not enrolling the population of interest, not meeting inclusion criteria for clinical study or SR, not meeting inclusion criteria for any KQ, or being a duplicate. A total of 305 full-length articles were thought to address one or more KQs and were further reviewed. Of these, 184 were ultimately excluded. Reasons for their exclusion are presented in Figure A-1 of the original guideline document.

Overall, 135 studies (in 136 articles) addressed one or more of the KQs and were considered as evidence in this review. Table A-2 of the original guideline indicates the number of studies that addressed each of the questions.

Criteria for Study Inclusion/Exclusion

General Criteria

- Clinical studies or SRs published on or after November 1, 2007
- Studies must be published in English
- Publication must be a full clinical study or SR; abstracts alone were not included. Similarly, letters, editorials, and other publications that are not full-length, clinical studies were not accepted as evidence.
- Studies enrolled adults 18 years or older. In studies that mixed adults and children, at least 80% of the enrolled patients had to be 18 years or older.
- Studies must have enrolled a patient population where at least 80% of patients met the required diagnostic criteria.
- Studies of intervention outcomes must have followed patients for at least 12 weeks post-randomization unless otherwise noted (KQ 5, 6, 11, and 12 are exempt from this requirement).
- Studies that specifically focus on incarcerated substance use offenders or driving while intoxicated/driving under the influence offenders were excluded.

Pharmacotherapy/Non-pharmacologic Therapy for SUD (KQ 1-4, 6-10)

- Studies must have been randomized controlled trials (RCTs) or SRs of RCTs. In the absence of such evidence, prospective comparative studies will be reviewed.
- Randomized crossover trials were considered only if data from the first treatment period were reported separately.
- Studies must have enrolled ≥10 patients per treatment arm.

Criteria for Determining Appropriate Initial Intensity and Setting of Specialty Substance Use Care (KQ 5)

- Studies must have compared different criteria and enrolled ≥10 patients per treatment arm.

Literature Search Strategy

The following bibliographic databases were searched from 2007 through January 2015:

- The Cochrane Central Register of Controlled Trials (CENTRAL)
- The Cochrane Database of Methodology Reviews (Methodology Reviews)
- The Cochrane Database of Systematic Reviews (Cochrane Reviews)
- Database of Abstracts of Reviews of Effects
- EMBASE (Excerpta Medica)
- Health Technology Assessment Database (HTA)
- MEDLINE/PreMEDLINE
- PsycINFO
- PubMed (In-process and Publisher records)

The following gray literature sources were searched from 2007 through January 2015:

- AHRQ
- Healthcare Standards database
- National Guideline Clearinghouse (NGC)
- National Institute of Health and Clinical Excellence (NICE)
- TRIP database

Additional information on the search strategies, including topic-specific search terms and search strategies can be found in Appendix H of the original guideline document.

Number of Source Documents

Overall, 135 studies (in 136 articles) were included in the review. Table A-2 in the original guideline indicates the number of studies that addressed each of the questions.

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Quality of Evidence and Definitions*

| **High quality** — Further research is very unlikely to change confidence in the estimate of effect. |
| **Moderate quality** — Further research is likely to have an important impact on confidence in the estimate of effect and may change the estimate. |
| **Low quality** — Further research is very likely to have an important impact on confidence in the estimate of effect and is likely to change the estimate. |
| **Very low quality** — Any estimate of effect is very uncertain. |

*Guyatt, G. H., Oxman, A. D., Vist, G. E., Kunz, R., Falck-Ytter, Y., Alonso-Coello, P., Schünemann, H. J. & the GRADE Working Group. (2008). GRADE; An emerging consensus on rating quality of evidence and strength of recommendations. *BMJ, 336*, 924-926.

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Abstracting and Managing Data

For each study included in the review, the following study level details were abstracted: country, purpose, and quality rating. For previous systematic reviews, the search strategy used, study selection criteria, and overall information about the evidence base, including number of included studies and overall patients enrolled were reported. For all studies, reviewers abstracted data about characteristics of the included patients and interventions being assessed.

Assessing Individual Studies' Methodological Quality (i.e., Internal Validity or Risk of Bias)

As per the Department of Veteran Affairs/Department of Defense (VA/DoD) *Guidelines for Guidelines* document (see the "Availability of Companion Documents" field), risk-of-bias (or study quality) of individual studies and previous systematic reviews was assessed using the U.S. Preventive Services Task Force (USPSTF) method. Each study was assigned a rating of Good, Fair, or Poor based on sets of criteria that vary depending on study design. Detailed lists of criteria and definitions of Good, Fair, or Poor ratings for different study designs appear in Appendix VII of the USPSTF procedure manual 🗗.

Data Synthesis

The evidence review team used a narrative approach to synthesizing the evidence for all the Key Questions (KQs). As indicated in the VA/DoD *Guidelines for Guidelines* document, the first line of evidence was previous systematic reviews. For questions in which a previous review was available, individual studies that met this review's inclusion criteria were used to supplement or update the previous review. The reviewers considered whether subsequent evidence supports the conclusions reported in the previous review. For questions for which no previous review was available, the reviewers summarized the overall findings for the outcomes of interest of the studies that addressed a key question.

Assessing the Overall Quality of the Body of Evidence for an Outcome

The overall quality of the body of evidence supporting the findings for the outcomes of interest in this report was assessed using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system. The GRADE system primarily involves consideration of the following factors: overall study quality (or overall risk of bias or study limitations), consistency of evidence, directness of evidence, and precision of evidence. Given time and resources, other factors such as publication bias may also be considered.

The GRADE system rates the overall quality of the evidence as High, Moderate, Low, and Very Low (see the "Rating Scheme for the Strength of the Evidence" field). For instance, a body of evidence that consists of randomized controlled trials (RCTs) automatically starts with a rating of high quality. This rating can be downgraded if some of the RCTs have serious flaws such as lack of blinding of outcome assessors, not reporting concealment of allocation, or high dropout rate. Similarly, the quality can be downgraded or further downgraded if inconsistencies of findings are present or if there is a lack of precision surrounding an outcome's effect size. For more information on the GRADE system go to the GRADE working group Web site 🗗.

Assessing Applicability

When describing the evidence base addressing a KQ, the evidence review team discussed aspects of the included studies, such as characteristics of included patients and treatments being assessed that may make the overall findings of the studies more or less applicable to the population, treatments, or outcomes of interest to this review.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

The current document is an update to the 2009 Department of Veterans Affairs (VA)/Department of Defense (DoD) Clinical Practice Guideline (CPG) for the Management of Substance Use Disorders (SUDs). The methodology used in developing the 2015 CPG follows the *Guideline for Guidelines*, an internal document of the VA and DoD Evidence-Based Practice Working Group (EBPWG) (see the "Availability of Companion Documents" field). This document provides information regarding the process of developing guidelines, including the identification and assembly of the Guideline Champions (Champions) and other subject matter experts from within the VA and DoD, known as the Work Group, and ultimately, the development and submission of a new or updated SUD CPG.

The Champions and Work Group for this CPG were charged with developing evidence-based clinical practice recommendations and writing and publishing a guideline document to be used by providers within the VA/DoD healthcare systems. Specifically, the Champions and Work Group members for this guideline were responsible for identifying the key questions (s) of the most clinical relevance, importance, and interest for the management of patients with SUD. The Champions and the Work Group also provided direction on inclusion and exclusion criteria for the evidence review and assessed the level and quality of the evidence. The amount of new scientific evidence that had accumulated since the previous version of the CPG was also taken into consideration in the identification of the KQs. In addition, the Champions assisted in:

- Identifying appropriate disciplines of individuals to be included as part of the Work Group

- Directing and coordinating the Work Group

- Participating throughout the guideline development and review processes

The VA Office of Quality, Safety and Value, in collaboration with the Office of Evidence Based Practice, U.S. Army Medical Command, the proponent for CPGs for the DoD, identified three clinical leaders as Champions for the 2015 CPG.

The Lewin Team, including The Lewin Group, Duty First Consulting, ECRI Institute, and Sigma Health Consulting, LLC, was contracted by the VA and DoD to support the development of this CPG and conduct the evidence review. The first conference call was held in October 2014, with participation from the contracting officer's representative (COR), leaders from the VA Office of Quality, Safety and Value and the DoD Office of Evidence Based Practice, and the Champions. During this call, participants discussed the scope of the guideline initiative, the roles and responsibilities of the Champions, the project timeline, and the approach for developing and prioritizing specific research questions on which to base a systematic review (SR) about the management of SUD. The group also identified a list of clinical specialties and areas of expertise that are important and relevant to the management of SUD, from which Work Group members were recruited. The specialties and clinical areas of interest included: psychiatry, psychology, nursing, pharmacy, social work, primary care, family medicine, religious and spiritual services, bioethics, dietetics, pain, addiction psychiatry, addiction medicine, and substance use specialties.

The guideline development process for the 2015 CPG update consisted of the following steps:

1. Formulating and prioritizing evidence questions (KQs)

2. Conducting the SR

3. Convening a face-to-face meeting with the CPG Champions and Work Group members

4. Drafting and submitting a final CPG about the management of SUD to the VA/DoD EBPWG

Appendix A in the original guideline document provides a detailed description of each of these tasks.

Convening the Face-to-face Meeting

In consultation with the contracting officer's representative (COR), the Champions, and the Work Group, the Lewin Team convened a three and a half day face-to-face meeting of the CPG Champions and Work Group members on April 14-17, 2015. These experts were gathered to develop and draft the clinical recommendations for an update to the 2009 SUD CPG. Lewin presented findings from the evidence review of KQs 1-10 in order to facilitate and inform the process.

Under the direction of the Champions, the Work Group members were charged with interpreting the results of the evidence review, and asked to categorize and carry forward recommendations from the 2009 SUD CPG, modifying the recommendations as necessary. The members also developed new clinical practice recommendations not presented in the 2009 SUD CPG, based on the 2015 evidence review. The subject matter experts were divided into three smaller subgroups at this meeting.

As the Work Group members drafted clinical practice recommendations, they also assigned a grade for each recommendation based on a modified GRADE and USPSTF methodology. Each recommendation was graded by assessing the quality of the overall evidence base, the associated benefits and harms, the variation in values and preferences, and other implications of the recommendation.

In addition to developing recommendations during the face-to-face meeting, the Work Group members also revised the 2009 SUD CPG algorithms to reflect the new and amended recommendations. They discussed the available evidence as well as changes in clinical practice since 2009, as necessary, to update the algorithms.

KQs 11 and 12 were developed following the face-to-face meeting, after the need to systematically review the evidence related to stabilization for withdrawal from alcohol and opioids was identified. For KQs 11 and 12, the process for developing and categorizing recommendations was adapted to be used in a teleconference format following the face-to-face meeting.

Grading Recommendations

The Champions and Work Group used the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system to assess the quality of the evidence base and assign a grade for the strength for each recommendation. The GRADE system uses the following four domains to assess the strength of each recommendation:

- Balance of desirable and undesirable outcomes
- Confidence in the quality of the evidence
- Values and preferences
- Other implications, as appropriate, e.g.:
  - Resource Use
  - Equity
  - Acceptability
  - Feasibility
  - Subgroup considerations

Table A-3 in the original guideline document ("Evidence to Recommendations Framework") was used by the Work Group to guide discussions on each domain.

Using this system, the Champions and Work Group determined the relative strength of each recommendation (Strong or Weak). A strong recommendation indicates that the Work Group is highly confident that desirable outcomes outweigh undesirable outcomes. If the Work Group is less confident of the balance between desirable and undesirable outcomes, they give a weak recommendation.

They also determined the direction of each recommendation (For or Against). Similarly, a recommendation for a therapy or preventive measure indicates that the desirable consequences outweigh the undesirable consequences. A recommendation against a therapy or preventive measure indicates that the undesirable consequences outweigh the desirable consequences (see the "Rating Scheme for the Strength of the Recommendation" field in this summary).

Reconciling 2009 Clinical Practice Guideline Recommendations

Evidence-based CPGs should be current, which typically requires revisions of previous guidelines based on new evidence, or as scheduled, subject to time-based expirations. For example, the U.S. Preventive Services Task Force (USPSTF) has a process for refining or otherwise updating its recommendations pertaining to preventive services. Further, the inclusion criteria for the National Guideline Clearinghouse (NGC) specify that a guideline must have been developed, reviewed, or revised within the past five years.

The SUD Guideline Work Group focused largely on developing new and updated recommendations based on the evidence review conducted for the priority areas addressed by the KQs. In addition to those new and updated recommendations, the Guideline Work Group considered, without complete review of the relevant evidence, the current applicability of other recommendations that were included in the previous 2009 SUD CPG, subject to evolving practice in today's environment.

A set of recommendation categories was adapted from those used by the National Institute for Health and Care Excellence (NICE). These categories, along with their corresponding definitions, were used to account for the various ways in which older recommendations could have been updated. In brief, the categories took into account whether or not the evidence that related to a recommendation was systematically reviewed, the degree to which the recommendation was modified, and the degree to which a recommendation is relevant in the current patient care environment and inside the scope of the CPG (see the "Rating Scheme for the Strength of the Recommendation" field). Additional information regarding these categories and their definitions can be found in Appendix A of the original guideline document.

The CPG Work Group recognized the need to accommodate the transition in evidence rating systems from the 2009 SUD CPG to the current CPG. In order to report the strength of all recommendations using a consistent format (i.e., the GRADE system) the CPG Work Group converted the USPSTF strengths of the recommendation accompanying the carryover recommendations from the 2009 guideline to the GRADE system. As such, the CPG Work Group considered the strength of the evidence cited for each recommendation in the 2009 SUD CPG as well as harms and benefits, values and preferences, and other implications, where possible. The CPG Work Group referred to the available evidence as summarized in the body of the 2009 SUD CPG and did not re-assess the evidence systematically. In some instances, peer-reviewed literature published since the 2009 SUD CPG was considered along with the evidence base used for that CPG.

Where such newer literature was considered when converting the strength of the recommendation from the USPSTF to the GRADE system, it is referenced in the discussion that follows the corresponding recommendation (see the original guideline document), as well as in Appendix D of the original guideline document.

The CPG Work Group recognizes that, while there are practical reasons for incorporating findings from a previous SR, previous recommendations, or recent peer-reviewed publications into an updated CPG, doing so does not involve an original, comprehensive SR and, therefore, may introduce bias.

Drafting and Submitting the Final Clinical Practice Guideline

Following the face-to-face meeting, the Champions and Work Group members were given writing assignments to craft discussion sections to support each of the new recommendations and/or to update discussion sections from the 2009 SUD CPG to support the amended "carried forward" recommendations. The Work Group also considered tables, appendices, and other sections from the 2009 SUD CPG for inclusion in the update. During this time, the Champions and Work Group also made additional revisions to the algorithms, as necessary.

Rating Scheme for the Strength of the Recommendations

The relative strength of the recommendation is based on a binary scale, "Strong" or "Weak." A strong recommendation indicates that the Work Group is highly confident that desirable outcomes outweigh undesirable outcomes. If the Work Group is less confident of the balance between desirable and undesirable outcomes, they present a weak recommendation.

Similarly, a recommendation for a therapy or preventive measure indicates that the desirable consequences outweigh the undesirable consequences. A recommendation against a therapy or preventive measure indicates that the undesirable consequences outweigh the desirable consequences.

Using these elements, the grade of each recommendation is presented as part of a continuum:

- **Strong For** (or "The Work Group recommends offering this option …")

- **Weak For** (or "The Work Group suggests offering this option …")

- **Weak Against** (or "The Work Group suggests not offering this option …")

- **Strong Against** (or "The Work Group recommends against offering this option …")

Note that weak (For or Against) recommendations may also be termed "Conditional," "Discretionary," or "Qualified." Recommendations may be conditional based upon patient values and preferences, the resources available, or the setting in which the intervention will be implemented. Recommendations may be at the discretion of the patient and clinician or they may be qualified with an explanation about the issues that would lead decisions to vary.

<u>Recommendation Categories and Definitions</u>

For use in the 2015 substance use disorders (SUDs) clinical practice guideline (SUD CPG), a set of recommendation categories was adapted from those used by the United Kingdom National Institute for Health and Care Excellence (NICE). These categories, along with their corresponding definitions, were used to account for the various ways in which recommendations could have been updated from the 2009 SUD CPG.

Evidence Reviewed*	Recommendation Category*	Definition*
Reviewed	New-added	New recommendation following review of the evidence
	New-replaced	Recommendation from previous CPG that has been carried over to the updated CPG that has been changed following review of the evidence
	Not changed	Recommendation from previous CPG that has been carried forward to the updated CPG where the evidence has been reviewed but the recommendation is not changed
	Amended	Recommendation from the previous CPG that has been carried forward to the updated CPG where the evidence has been reviewed and a minor amendment has been made
	Deleted	Recommendation from the previous CPG that has been removed based on review of the evidence
Not reviewed	Not changed	Recommendation from previous CPG that has been carried forward to the updated CPG, but for which the evidence has not been reviewed
	Amended	Recommendation from the previous CPG that has been carried forward to the updated CPG where the evidence has not been reviewed and a minor amendment has been made
	Deleted	Recommendation from the previous CPG that has been removed because it was deemed out of scope for the updated CPG

*Adapted from the NICE guideline manual (2012) and Garcia et al. (2014).

Abbreviation: CPG: clinical practice guideline

Cost Analysis

Published cost analyses were reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

After developing the initial draft of the updated clinical practice guideline (CPG), an iterative review process was used to solicit feedback on and make revisions to the CPG. Once they were developed, the first two drafts of the CPG were posted on a wiki Web site for a period of 14 to 20 business days for internal review and comment by the Work Group. All feedback submitted during each review period was reviewed and discussed by the Work Group and appropriate revisions were made to the CPG.

Draft 3 of the CPG was made available for peer review and comment. This process is described in the section "Peer Review Process" in the original guideline document. After revisions were made based on the feedback received during the peer review and comment period, the Champions presented the CPG to the Evidence-Based Practice Working Group (EBPWG) for their approval. Changes were made based on feedback from the EBPWG and the guideline was finalized.

The final 2015 SUD CPG was submitted to the EBPWG in December 2015.

Recommendations

Major Recommendations

Note from the Department of Veterans Affairs and the Department of Defense (VA/DoD) and the National Guideline Clearinghouse (NGC): The recommendations for the management of substance use disorders (SUD) are organized into 2 modules with accompanying algorithms (Screening and Treatment [Module A] and Stabilization [Module B]). The recommendations are presented below. See the original guideline document for the algorithms and evidence table associated with selected recommendations, including level and quality of evidence, strength of recommendation, and supporting evidence citations.

The strength of recommendation grading (**Strong For**, **Weak For**, **Strong Against**, **Weak Against**) and recommendation categories (**Reviewed**, **Not reviewed**, **New-added**, **New-replaced**, **Not changed**, **Amended**, **Deleted**) are defined at the end of the "Major Recommendations" field.

Screening

1. For patients in general medical and mental healthcare settings, the Work Group recommends screening for unhealthy alcohol use annually using the three-item Alcohol Use Disorders Identification Test-Consumption (AUDIT-C) or Single Item Alcohol Screening Questionnaire (SASQ). (**Strong For; Not reviewed, Amended**)

Brief Alcohol Intervention

2. For patients without documented alcohol use disorder who screen positive for unhealthy alcohol use, the Work Group recommends providing a single initial brief intervention regarding alcohol-related risks and advice to abstain or drink within nationally established age and gender-specific limits for daily and weekly consumption. (**Strong For; Reviewed, New-replaced**)

Determination of Treatment Setting

3. For patients with a diagnosis of a SUD, the Work Group suggests offering referral for specialty SUD care based on willingness to engage in specialty treatment. (**Weak For; Not reviewed, Amended**)

4. For patients with SUDs, there is insufficient evidence to recommend for or against using a standardized assessment that would determine initial intensity and setting of SUD care rather than the clinical judgment of trained providers. (**N/A; Reviewed, New-replaced**)

Treatment

Alcohol Use Disorder

Pharmacotherapy

5. For patients with moderate-severe alcohol use disorder, the Work Group recommends offering one of the following medications:

- Acamprosate
- Disulfiram
- Naltrexone- oral or extended release
- Topiramate

(**Strong For; Reviewed, New-replaced**)

6. For patients with moderate-severe alcohol use disorder for whom first-line pharmacotherapy is contraindicated or ineffective, the Work Group suggests offering gabapentin. (**Weak For; Reviewed, New-replaced**)

Psychosocial Interventions

7. For patients with alcohol use disorder the Work Group recommends offering one or more of the following interventions considering patient preference and provider training/competence:
   - Behavioral couples therapy for alcohol use disorder
   - Cognitive behavioral therapy for SUD
   - Community reinforcement approach
   - Motivational enhancement therapy
   - 12-Step facilitation

   (**Strong For; Reviewed, New-replaced**)

Opioid Use Disorder

Pharmacotherapy

8. For patients with opioid use disorder, the Work Group recommends offering one of the following medications considering patient preferences
   - Buprenorphine/naloxone
   - Methadone in an opioid treatment program

   (**Strong For; Reviewed, New-replaced**)

9. In pregnant women with opioid use disorder for whom buprenorphine is selected, the Work Group suggests offering buprenorphine alone (i.e., without naloxone) considering patient preferences. (**Weak For; Reviewed, New-added**)

10. For patients with opioid use disorder for whom buprenorphine is indicated, the Work Group recommends individualizing choice of appropriate treatment setting (i.e., opioid treatment program or office-based) considering patient preferences. (**Strong For; Reviewed, New-replaced**)

11. For patients with opioid use disorder for whom opioid agonist treatment is contraindicated, unacceptable, unavailable, or discontinued and who have established abstinence for a sufficient period of time (see narrative in the original guideline document), the Work Group recommends offering
    - Extended-release injectable naltrexone (**Strong For; Reviewed, New-replaced**)

12. There is insufficient evidence to recommend for or against oral naltrexone for treatment of opioid use disorder. (**N/A; Reviewed, New-replaced**)

13. At initiation of office-based buprenorphine, the Work Group recommends addiction-focused medical management (see narrative in the original guideline document) alone or in conjunction with another psychosocial intervention. (**Strong For; Reviewed, New-replaced**)

Psychosocial Interventions with or without Pharmacotherapy

14. For patients in office-based buprenorphine treatment, there is insufficient evidence to recommend for or against any specific psychosocial interventions in addition to addiction-focused medical management. Choice of psychosocial intervention should be made considering patient preferences and provider training/competence. (**N/A; Reviewed, New-replaced**)

15. In opioid treatment program settings, the Work Group suggest offering individual counseling and/or contingency management, considering patient preferences and provider training/competence. (**Weak For; Reviewed, New-replaced**)

16. For patients with opioid use disorder for whom opioid use disorder pharmacotherapy is contraindicated, unacceptable or unavailable, there is insufficient evidence to recommend for or against any specific psychosocial interventions. (**N/A; Reviewed, New-replaced**)

Cannabis Use Disorder

Pharmacotherapy

17. There is insufficient evidence to recommend for or against the use of pharmacotherapy in the treatment of cannabis use disorder. (**N/A; Reviewed, New-added**)

Psychosocial Interventions

18. For patients with cannabis use disorder, the Work Group recommends offering one of the following interventions as initial treatment considering patient preference and provider training/competence:
    - Cognitive behavioral therapy
    - Motivational enhancement therapy
    - Combined cognitive behavioral therapy/motivational enhancement therapy

    (**Strong For; Reviewed, New-replaced**)

Stimulant Use Disorder

Pharmacotherapy

19. There is insufficient evidence to recommend for or against the use of any pharmacotherapy for the treatment of cocaine use disorder or methamphetamine use disorder. (**N/A; Reviewed, New-added**)

Psychosocial Interventions

20. For patients with stimulant use disorder, the Work Group recommends offering one or more of the following interventions as initial treatment considering patient preference and provider training/competence:
    - Cognitive behavioral therapy
    - Recovery-focused behavioral therapy
      - General drug counseling
      - Community reinforcement approach
    - Contingency management in combination with one of the above

(**Strong For; Reviewed, New-replaced**)

Promoting Group Mutual Help Involvement

21. For patients with SUDs in early recovery or following relapse, the Work Group recommends promoting active involvement in group mutual help programs using one of the following systematic approaches considering patient preference and provider training/competence:

- Peer linkage

- Network support

- 12-Step Facilitation

(**Strong For; Reviewed, New-replaced**)

Co-occurring Mental Health Conditions and Psychosocial Problems

22. Among patients in early recovery from SUDs or following relapse, the Work Group suggests prioritizing other needs through shared decision making (e.g., related to other mental health conditions, housing, supportive recovery environment, employment, or related recovery-relevant factors) among identified biopsychosocial problems and arranging services to address them. (**Weak For; Not Reviewed, Amended**)

Follow-up

23. The Work Group suggests assessing response to treatment periodically and systematically, using standardized and valid instrument(s) whenever possible. Indicators of treatment response include ongoing substance use, craving, side effects of medication, emerging symptoms, etc. (**Weak For; Reviewed, New-replaced**)

24. For patients who have initiated an intensive phase of outpatient or residential treatment, the Work Group recommends offering and encouraging ongoing systematic relapse prevention efforts or recovery support individualized on the basis of treatment response. (**Strong For; Not reviewed, Amended**)

25. For patients in SUDs specialty care, the Work Group recommends against automatic discharge from care for patients who do not respond to treatment or who relapse. (**Strong Against; Not reviewed, Amended**)

Stabilization and Withdrawal

Assessment

26. For patients with alcohol or opioid use disorder in early abstinence, the Work Group suggests using standardized measures to assess the severity of withdrawal symptoms such as Clinical Institute Withdrawal Assessment for Alcohol (revised version) (CIWA-Ar) for alcohol or Clinical Opiate Withdrawal Scale (COWS) for opioids. (**Weak For; Not reviewed, Amended**)

27. The Work Group recommends inpatient medically supervised alcohol withdrawal management for patients with any of the following conditions:

- History of delirium tremens or withdrawal seizures

- Inability to tolerate oral medication

- Co-occurring medical conditions that would pose serious risk for ambulatory withdrawal management (e.g., severe coronary artery disease, congestive heart failure, liver cirrhosis)

- Severe alcohol withdrawal (i.e., CIWA-Ar score ≥20)

- Risk of withdrawal from other substances in addition to alcohol (e.g., sedative hypnotics)

(**Strong For; Reviewed, Amended**)

28. The Work Group suggests inpatient medically supervised withdrawal for patients with symptoms of at least moderate alcohol withdrawal (i.e., CIWA-Ar score ≥10) and any of the following conditions:

- Recurrent unsuccessful attempts at ambulatory withdrawal management

- Reasonable likelihood that the patient will not complete ambulatory withdrawal management (e.g., due to homelessness)

- Active psychosis or severe cognitive impairment

- Medical conditions that could make ambulatory withdrawal management problematic (e.g., pregnancy, nephrotic syndrome, cardiovascular disease, lack of medical support system)

(**Weak For; Reviewed, Amended**)

Alcohol Use Disorder Stabilization and Withdrawal

29. The Work Group recommends using one of the following pharmacotherapy strategies for managing alcohol withdrawal symptoms:

- A predetermined fixed medication tapering schedule with additional medication as needed

- Symptom-triggered therapy where patients are given medication only when signs or symptoms of withdrawal occur (e.g., as needed dosing)

(**Strong For; Not reviewed, Amended**)

30. For treatment of moderate to severe alcohol withdrawal, the Work Group recommends using benzodiazepines with adequate monitoring because of documented efficacy and high margin of safety. (**Strong For; Reviewed, Amended**)

31. For managing mild to moderate alcohol withdrawal in patients for whom risks of benzodiazepines outweigh benefits (e.g., inadequate monitoring available, abuse liability, or allergy/adverse reactions), the Work Group suggests considering carbamazepine, gabapentin, or valproic acid as an alternative. (**Weak For; Reviewed, New-replaced**)

32. The Work Group recommends against using alcohol as an agent for medically supervised withdrawal. (**Strong Against; Not reviewed, Amended**)

Opioid Use Disorder Stabilization and Withdrawal

33. For patients not yet stabilized from opioid use disorder, the Work Group recommends against withdrawal management alone due to high risk of relapse and overdose (see Recommendations 8 and 11 above). (**Strong Against; Reviewed, New-replaced**)

34. Among patients with opioid use disorder for whom maintenance agonist treatment is contraindicated, unacceptable, or unavailable, the Work Group recommends using a methadone (in Opioid Treatment Program only) or buprenorphine taper for opioid withdrawal management (see Recommendation 11). (**Strong For; Reviewed, New-replaced**)

35. For patients with opioid use disorder for whom methadone and buprenorphine are contraindicated, unacceptable, or unavailable, the Work Group recommends offering clonidine as a second-line agent for opioid withdrawal management (see Recommendation 11). (**Strong For; Reviewed, New-replaced**)

Sedative Hypnotic Use Disorder Stabilization and Withdrawal

36. For patients in need of withdrawal management for sedative hypnotics, the Work Group suggests one of the following:

- Gradually taper the original benzodiazepine

- Substitute a longer acting benzodiazepine then taper gradually

- Substitute phenobarbital for the addicting agent and taper gradually

(**Weak For; Not reviewed, Amended**)

Definitions

Strength of Recommendations

The relative strength of the recommendation is based on a binary scale, "Strong" or "Weak." A strong recommendation indicates that the Work Group is highly confident that desirable outcomes outweigh undesirable outcomes. If the Work Group is less confident of the balance between desirable and undesirable outcomes, they present a weak recommendation.

Similarly, a recommendation for a therapy or preventive measure indicates that the desirable consequences outweigh the undesirable consequences. A recommendation against a therapy or preventive measure indicates that the undesirable consequences outweigh the desirable consequences.

The grade of each recommendation is presented as part of a continuum:

- **Strong For** (or "The guideline panel recommends offering this option …")
- **Weak For** (or "The guideline panel suggests offering this option …")
- **Weak Against** (or "The guideline panel suggests not offering this option …")
- **Strong Against** (or "The guideline panel recommends against offering this option …")

Note that weak (For or Against) recommendations may also be termed "Conditional," "Discretionary," or "Qualified." Recommendations may be conditional based upon patient values and preferences, the resources available, or the setting in which the intervention will be implemented. Recommendations may be at the discretion of the patient and clinician or they may be qualified with an explanation about the issues that would lead decisions to vary.

Recommendation Categories and Definitions

For use in the 2015 SUDs clinical practice guideline (SUD CPG), a set of recommendation categories was adapted from those used by the United Kingdom National Institute for Health and Care Excellence (NICE). These categories, along with their corresponding definitions, were used to account for the various ways in which recommendations could have been updated from the 2009 SUD CPG.

Evidence Reviewed*	Recommendation Category*	Definition*
Reviewed	New-added	New recommendation following review of the evidence
	New-replaced	Recommendation from previous CPG that has been carried over to the updated CPG that has been changed following review of the evidence
	Not changed	Recommendation from previous CPG that has been carried forward to the updated CPG where the evidence has been reviewed but the recommendation is not changed
	Amended	Recommendation from the previous CPG that has been carried forward to the updated CPG where the evidence has been reviewed and a minor amendment has been made
	Deleted	Recommendation from the previous CPG that has been removed based on review of the evidence
Not reviewed	Not changed	Recommendation from previous CPG that has been carried forward to the updated CPG, but for which the evidence has not been reviewed
	Amended	Recommendation from the previous CPG that has been carried forward to the updated CPG where the evidence has not been reviewed and a minor amendment has been made
	Deleted	Recommendation from the previous CPG that has been removed because it was deemed out of scope for the updated CPG

*Adapted from the NICE guideline manual (2012) and Garcia et al. (2014).

Abbreviation: CPG: clinical practice guideline

Clinical Algorithm(s)

The following algorithms are provided in the original guideline document:

- Module A: screening and treatment
- Module B: stabilization

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

Table A-2 in the original guideline document indicates the number and type of studies that addressed each of the key questions and the relevant recommendations associated with each question. The evidence base consists primarily of systematic reviews and randomized controlled trials.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- When properly executed, patient-centered care (PCC) may decrease patient anxiety, increase trust in clinicians, and improve treatment adherence. Improved patient-clinician communication through PCC can be used to convey openness to discuss any future concerns.
- Although there was insufficient evidence to make a recommendation for or against measurement-based care in either primary or specialty care settings for improving consumption and health outcomes, there are a number of benefits to consider which include:
- Patient accountability ("No one will know" is a common trigger for relapse)
- Continual feedback and monitoring of treatment response
- Compliance with accrediting expectations of outcome evaluation

Refer to the "Discussion" sections in the original guideline document for benefits of specific interventions.

Potential Harms

- Refer to Table B-1 in the original guideline for warnings/precautions, adverse effects, and drug interactions of naltrexone oral and injectable, acamprosate, disulfiram, topiramate, and gabapentin for alcohol use disorder.
- Refer to Table B-2 in the original guideline for warnings/precautions, adverse effects, and drug interactions of methadone, buprenorphine/naloxone or buprenorphine, and injectable naltrexone for opioid use disorder.

Contraindications

Contraindications

Refer to Tables B-1 and B-2 in the original guideline for contraindications to medications used in management of alcohol and substance use disorders (SUDs).

Qualifying Statements

Qualifying Statements

- The Department of Veterans Affairs (VA) and the Department of Defense (DoD) guidelines are based upon the best information available at the time of publication. They are designed to provide information and assist decision-making. They are not intended to define a standard of care and should not be construed as one. Neither should they be interpreted as prescribing an exclusive course of management.

- This Clinical Practice Guideline (CPG) is based on a systematic review of both clinical and epidemiological evidence. Developed by a panel of multidisciplinary experts, it provides a clear explanation of the logical relationships between various care options and health outcomes while rating both the quality of the evidence and the strength of the recommendation.

- Variations in practice will inevitably and appropriately occur when providers take into account the needs of individual patients, available resources, and limitations unique to an institution or type of practice. Every healthcare professional making use of these guidelines is responsible for evaluating the appropriateness of applying them in the setting of any particular clinical situation.

- These guidelines are not intended to represent TRICARE policy. Further, inclusion of recommendations for specific testing and/or therapeutic interventions within these guidelines does not guarantee coverage of civilian sector care. Additional information on current TRICARE benefits may be found at www.tricare.mil or by contacting your regional TRICARE Managed Care Support Contractor.

Implementation of the Guideline

Description of Implementation Strategy

Implementation

This clinical practice guideline (CPG) and algorithms are designed to be adapted by individual healthcare providers with consideration of local needs and resources. The algorithms serve as a tool to prompt providers to consider key decision points in the course of an episode of care.

Although this CPG represents the recommended practice on the date of its publication, medical practice is evolving and this evolution requires continuous updating based on published information. New technology and more research will improve patient care in the future. The CPG can assist in identifying priority areas for research and to inform optimal allocation of resources. Future studies examining the results of CPG implementation may lead to the development of new evidence particularly relevant to clinical practice.

Implementation Tools

Clinical Algorithm

Patient Resources

Pocket Guide/Reference Cards

Quick Reference Guides/Physician Guides

Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Management of Substance Use Disorders Work Group. VA/DoD clinical practice guideline for the management of substance use disorders. Version 3.0. Washington (DC): Department of Veterans Affairs, Department of Defense; 2015 Dec. 169 p. [327 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2015 Dec

Guideline Developer(s)

Department of Defense - Federal Government Agency [U.S.]

Department of Veterans Affairs - Federal Government Agency [U.S.]

Source(s) of Funding

United States Government

Guideline Committee

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Financial Disclosures/Conflicts of Interest

At the start of this guideline development process and at other key points throughout, the project team was required to submit disclosure statements to reveal any areas of potential conflict of interest (COI) in the past 12 months. Verbal affirmations of no COI were used as necessary during meetings throughout the guideline development process. The project team was also subject to random Web-based surveillance (e.g., ProPublica). Disclosed industry related COIs are listed in Appendix G of the original guideline document.

If a project team member reported a COI (actual or potential), then it was reported to the Office of Evidence Based Practice. It was also discussed with the Substance Use Disorders Clinical Practice Guideline (SUD CPG) Work Group in tandem with their review of the evidence and development of recommendations. The Office of Evidence Based Practice and the SUD CPG Work Group determined whether or not action, such as restricting participation and/or voting on sections related to the conflict or removal from the Work Group, was necessary. If it was deemed necessary, action was taken by the co-chairs and Office of Evidence Based Practice, based on the level and extent of involvement, to mitigate the COI.

Several Work Group members disclosed relationships and/or affiliations which had the potential to introduce bias into the guideline. Based on the level and extent of involvement, no individuals were removed from the Work Group. In order to mitigate the risk of bias while maximizing the contributions of those with expertise in a specific area of SUD treatment, co-chairs asked Work Group members to disclose relevant relationships during related guideline development discussions. Members with potential COIs contributed to the discussions related to their particular areas of expertise as well as the overarching guideline document in order to ensure differing viewpoints and experiences were adequately represented.

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: VA/DoD clinical practice guideline for management of substance use disorders (SUD). Washington (DC): Department of Veteran Affairs, Department of Defense; 2009 Aug. 158 p.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Available from the Department of Veterans Affairs (VA) Web site .

Availability of Companion Documents

The following are available:

- VA/DoD clinical practice guideline for the management of substance use disorders. Clinician summary. Washington (DC): Department of Veterans Affairs, Department of Defense; 2015 Dec. 31 p. Available from the Department of Veterans Affairs (VA) Web site .
- VA/DoD clinical practice guideline for the management of substance use disorders. Screening and treatment pocket card. Washington (DC): Department of Veterans Affairs, Department of Defense; 2015 Dec. 12 p. Available from the VA Web site .
- VA/DoD clinical practice guideline for the management of substance use disorders. Stabilization pocket card. Washington (DC): Department of Veterans Affairs, Department of Defense; 2015 Dec. 6 p. Available from the VA Web site .
- Guideline for guidelines. Washington (DC): Department of Veterans Affairs; 2013 Apr 10. Available from the VA Web site .
- Putting clinical practice guidelines to work in VHA. Washington (DC): Department of Veterans Affairs. 64 p. Available from the VA Web site .

In addition, a pharmacotherapy table and descriptions of psychosocial interventions are available in the appendices of the original guideline document .

Patient Resources

The following are available:

- VA/DoD clinical practice guideline for the management of substance use disorders. Patient guide. Washington (DC): Department of Veterans Affairs, Department of Defense; 2015 Dec. 7 p. Available from the Department of Veterans Affairs (VA) Web site .
- Substance abuse affects families. Patient brochure. Washington (DC): Department of Veterans Affairs, Department of Defense. 2 p. Available from the VA Web site .
- Medication-assisted treatment for alcohol dependence. Patient brochure. Washington (DC): Department of Veterans Affairs, Department of Defense. 12 p. Available from the VA Web site .

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

This NGC summary was completed by ECRI on August 9, 2002. The information was verified by the guideline developer on September 25, 2002. This summary was updated by ECRI Institute on June 23, 2010. This summary was updated by ECRI Institute on July 10, 2013 following the U.S. Food and Drug Administration advisory on Valproate. This summary was updated again by ECRI Institute on May 4, 2016. The information was not verified by the guideline developer.

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