Substance Use Disorder: VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorder (2021)

About the Guideline

- In 2015, Veterans Affairs (VA) and Department of Defense (DoD) published a clinical practice guideline (CPG) for the management of substance use disorders (SUD) based on evidence reviewed from November 2007 through January 2015. In 2021, the fourth update of the guideline was published based on updated literature.
- The guideline is a set of recommendations for evaluating, treating, and managing the individual needs of patients with SUD in the VA and DoD with the goal of early engagement and retention of patients who can benefit from addiction-focused treatment.
- The guideline is not intended to serve as a standard of care.
- The guideline work group consisted of five clinical champions as well as experts representing dietitians, emergency medicine, family medicine, internal medicine, nursing, pain management, pharmacology, psychiatry, psychology, and social work.

Key Clinical Considerations

Become familiar with the recommendations and best-practice statements provided in this guideline.

Screening and Alcohol Intervention

- Periodic screening for unhealthy alcohol use is recommended for patients in general medical and mental healthcare settings using the three-item Alcohol Use Disorders Identification Test Consumption (AUDIT-C) or the Single Item Alcohol Screening Questionnaire (SASQ).
- A single, initial brief intervention regarding alcohol-related risks and advising the patient to abstain or to remain within established limits for daily and weekly alcohol consumption is suggested for patients without documented alcohol use disorder, or for those who screen positive for unhealthy alcohol use.
- There is no recommendation for or against screening for drug use disorders in primary care to facilitate enrollment in treatment.

Treatment Setting

- There is no recommendation for or against using a standardized assessment that would determine the initial intensity and setting of substance use disorder care for patients with SUD.

Stabilization and Withdrawal

<u>Alcohol Use Disorder</u>

- Benzodiazepines with adequate monitoring are recommended for the treatment of moderate to severe alcohol withdrawal.
- CarBAMazepine, gabapentin, or valproic acid is suggested as an alternative to benzodiazepines for managing mild to moderate alcohol withdrawal in patients when the risks of benzodiazepine treatment outweigh the benefits.

<u>Opioid Use Disorder</u>

- Due to the high risk of relapse and overdose, withdrawal management without planned ongoing pharmacotherapy treatment is not recommended.

- Buprenorphine/naloxone (in any setting), or methadone or buprenorphine/naloxone (in inpatient or accredited opioid treatment programs), is suggested for patients for whom opioid withdrawal management is indicated.
- CloNIDine or lofexidine is indicated as a second-line agent for opioid withdrawal management when methadone and buprenorphine are contraindicated, unacceptable, or unavailable.

Sedative Hypnotic Use Disorder

- Gradual tapering of benzodiazepines for patients in need of withdrawal management is recommended.
- There is no recommendation for or against the use of adjunctive medications for the treatment of benzodiazepine withdrawal.

Treatment

Alcohol Use Disorder

- For patients with moderate to severe alcohol use disorder:
  - Naltrexone (oral or extended release) or topiramate is recommended as first-line pharmacotherapy.
  - Acamprosate or disulfiram is suggested.
  - Gabapentin is suggested when first-line pharmacotherapy is contraindicated or considered an ineffective intervention.
- The following psychosocial interventions are suggested, with consideration for availability and patient preference:
  - Cognitive behavioral therapy
  - Behavioral couples therapy
  - Motivational enhancement therapy
  - Community reinforcement approach
  - 12-step facilitation

Opioid Use Disorder

- For patients with opioid use disorder
  - Buprenorphine/naloxone (in any setting) or methadone or buprenorphine/naloxone (through an accredited opioid treatment program) is recommended.
  - Extended-release naltrexone IM is suggested.
  - There is no recommendation for or against any one FDA-approved formulation or route of delivery of buprenorphine over another.
  - There is no recommendation for or against oral naltrexone.
  - There is no recommendation for or against any specific psychosocial intervention in addition to addiction-focused medical management.
  - There is no recommendation for or against any specific psychosocial intervention for patients when opioid use disorder pharmacotherapy is contraindicated, unacceptable, or unavailable.

Cannabis Use Disorder

- There is no recommendation for or against the use of pharmacotherapy in the treatment of cannabis use disorder.

  - Motivational enhancement therapy, cognitive behavioral therapy, or a combination of both therapies is suggested.
  - A brief intervention (i.e., 60 minutes or less) is not recommended.

Stimulant Use Disorder

- There is no recommendation for or against the use of any pharmacotherapy for the treatment of cocaine use disorder or amphetamine/methamphetamine use disorder.
- One or more of the following psychosocial interventions is recommended as initial treatment for cocaine use disorder, considering patient preference and availability:
  - Cognitive behavioral therapy
  - Recovery-focused behavioral therapy
  - Contingency management in combination with another behavioral intervention
- Contingency management as initial treatment in combination with another behavioral intervention is suggested for patients with amphetamine/methamphetamine use disorder, with consideration for patient preference and availability.

Group Mutual Help Involvement

- For patients with alcohol use disorder in early recovery or following relapse:
  - Promoting active involvement in group programs such as network support, peer linkage, or 12-step facilitation is recommended, considering patient preference and availability.
- For patients with drug use disorders in early recovery or following relapse:
  - Promoting active involvement in group mutual help programs such as peer linkage or 12-step facilitation is suggested, considering patient preference and availability.

Mindfulness-Based Therapies

- There is no recommendation for or against the use of mindfulness-based therapies for the treatment of SUD.

Telehealth

- Technology-based interventions (i.e., automated text/voice messaging, smartphone apps) in addition to usual care are suggested for alcohol use disorder.
- Structured telephone-based care, as an adjunct to usual care, is suggested for SUD.
- There is no recommendation for or against the use of telemedicine-delivered treatment, either alone or in combination with usual care, for SUD.
- There is no recommendation for or against the use of computer-delivered behavioral treatments, either alone or in combination with usual care, for SUD.

Reference

Department of Veterans Affairs/Department of Defense. (2021). *VA/DoD clinical practice guideline for the management of substance use disorders*. https://www.healthquality.va.gov/guidelines/MH/sud/VADoDSUDCPG.pdf