Defense Health Agency

ADMINISTRATIVE INSTRUCTION

NUMBER 6025.26
May 17, 2024

DAD-MA

SUBJECT: Management of Substance Use Disorder

References: See Enclosure 1.

1. PURPOSE. This Defense Health Agency-Administrative Instruction (DHA-AI), based on the authority of References (a) and (b) and in accordance with the guidance of References (c) through (y), establishes the Defense Health Agency's (DHA) procedures to assign responsibilities for alcohol and drug misuse identification, diagnosis, and treatment for Active-Duty service members and other eligible beneficiaries.

2. APPLICABILITY. This DHA-AI applies to the DHA Enterprise (components and activities under the authority, direction, and control of the DHA) to include assigned, attached, allotted, or detailed personnel. For the purpose of this instruction, Active Component (AC) and Reserve Component (RC) Service members (SM) currently on active duty for a period of more than 30 days, or who are on a Line of Duty Order for SUD clinical treatment will be referred to as Service members or ADSM and the term eligible beneficiary refers to those appropriately enrolled in either the direct care system or TRICARE private sector care.

3. POLICY IMPLEMENTATION. It is DHA's instruction, pursuant to References (a) through (y), to implement the use of standard operating procedures, evidence-based practices, and ongoing monitoring of patient outcomes in pursuit of continuous improvements in the treatment of substance misuse for all beneficiaries presenting for care at a military medical treatment facility (MTF).

4. CANCELED DOCUMENTS. This DHA-AI cancels DHA-PI 6025.15, "Management of Problematic Substance Use by DoD Personnel," of April 19, 2019.

5. RESPONSIBILITIES. See Enclosure 2.

6. PROCEDURES. See Enclosure 3.

7. PROPONENT AND WAIVERS. The proponent of this publication is the Deputy Assistant Director, Medical Affairs (DAD-MA). When Activities are unable to comply with this publication, the Activity may request a waiver that must include a justification, including an analysis of the risk associated with not granting the waiver. The Activity director or senior leader will submit the waiver request through their supervisory chain to the DAD-MA to determine if the waiver may be granted by the Director, DHA or their designee.

8. RELEASABILITY. **Cleared for public release.** This DHA-AI is available on the Internet from the Health.mil site at: https://health.mil/Reference-Center/Policies and is also available to authorized users from the DHA SharePoint site at: https://info.health.mil/cos/admin/pubs/DHA%20Publications%20Signed/Forms/AllItems.aspx.

9. EFFECTIVE DATE. This DHA-AI:

a. Is effective upon signature.

b. Will expire 10 years from the date of signature if it has not been reissued or cancelled before this date in accordance with Reference (c).

10. FORMS. The DD Form 3130, Consent for The Disclosure of Confidential Substance Use Information is available at: https://www.esd.whs.mil/directives/forms/.

11. SUMMARY OF CHANGES. This publication was transitioned from a DHA-PI to a DHA-AI, and all responsibilities for the MILDEPS were removed. This DHA-AI establishes and updates procedures for prevention, education, identification, and treatment of substance use disorders to include delineation of levels and locations of care, their relevance to retention and readiness along with aftercare and support for transitioning service members. This DHA-AI also addresses direct and TRICARE private sector care options and supports the direct care provision of care as the primary location for provision of services.

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TELITA CROSLAND
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Director

ENCLOSURE 1

REFERENCES

(a) DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs (ASD(HA))," September 30, 2013, as amended.
(b) DoD Directive 5136.13, "Defense Health Agency (DHA)," September 30, 2013, as amended
(c) DHA Procedural Instruction 5025.01, "Publication System," April 1, 2022
(d) DoD Instruction 1010.04, "Problematic Substance Use by DoD Personnel," February 20, 2014, as amended
(e) Code of Federal Regulations, Title 32, Part 199
(f) DoD Instruction 6490.08, "Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members," September 6, 2023
(g) Department of Veterans Affairs (VA)/DoD Clinical Practice Guidelines, "Management of Substance Use Disorder," 2021
(h) DHA Procedural Instruction 6040.07, "Medical Coding of the DoD Health Record," March 8, 2021
(i) The American Society of Addiction Medicine (ASAM) Criteria, current edition[1]
(j) American Psychiatric Association, "Diagnostic and Statistical Manual of Mental Health Disorders (DSM 5-TR)," current edition[2]
(k) DoD Instruction 4515.13, "Air Transportation Eligibility," January 22, 2016, as amended
(l) DoD Instruction 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)," July 26, 2023
(m) United States Code, Title 42, Section 290dd-2
(n) DoD Instruction 6025.18, "Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule Compliance in DoD Health Care Programs," March 13, 2019
(o) Code of Federal Regulations, Title 42, Part 2
(p) DoD Instruction 6010.23, "DoD and Department of Veterans Affairs Health Care Resource Sharing Program," February 3, 2022.
(q) DoD Instruction 5400.11, "DoD Privacy and Civil Liberties Program," January 29, 2019, as amended
(r) DoD 5400.11-R, "Department of Defense Privacy Program," May 14, 2007
(s) DHA Procedural Instruction 6490.01, "inTransition Program," May 23, 2017, as amended
(t) DHA Administrative Instruction 6490.01, "Behavioral Health System of Care," February 16, 2023
(u) Assistant Secretary of Defense (Health Affairs) Policy 11-005, "TRICARE Policy for Access to Care," February 23, 2011
(v) DHA Procedures Manual 6025.13, "Clinical Quality Management in the Military Health System," volumes 1-7 and implementation guidance, August 29, 2019.
(w) DHA Procedural Instruction 6490.02, "Behavioral Health (BH) Treatment and Outcomes Monitoring," July 12, 2018.

[1] This reference can be accessed at https://www.asam.org/asam-criteria/about-the-asam-criteria.
[2] This reference can be accessed at https://www.health.mil/Military-Health-Topics/MHS-Medical-Library.

(x) DHA AI 034, "Drug-Free Workplace Program," administratively reissued January 2015.
(y) DoD Manual 6025.18, "Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DOD Health Care Programs," March 13, 2019

ENCLOSURE 2

RESPONSIBILITIES

1. DIRECTOR, DHA. The Director, DHA will oversee implementation of this DHA-AI to confirm consistent application through the DHA enterprise.

2. ASSISTANT DIRECTOR, HEALTHCARE ADMINISTRATION. The Assistant Director, Healthcare Administration will establish priorities and policies for this DHA AI pursuant to Reference (b).

3. DAD-MA. The DAD-MA will:

a. Ensure dissemination and implementation of this DHA-AI throughout the DHA and provide guidance for the development and implementation of military medical treatment facility (MTF) clinical treatment programs, to include training, provider education, clinical integration, risk management and other comparable clinical activities.

b. Coordinate with the DoD Addictive Substance Misuse Advisory Committee (ASMAC) to assure DoD Component substance misuse program/treatment needs and goals are met according to Reference (d)

c. Coordinate with the DHA Behavioral Health Clinical Management Team (BHCMT) to ensure compliance with Reference (t).

4. DHA HEADQUARTERS CHIEF, BHCMT. The DHA Headquarters Chief BHCMT will:

a. Act as primary POC in providing DHA Behavioral Health System of Care (BHSOC) implementation and compliance guidance of all standardized SUD services and initiatives.

b. Ensure timely support of requests for information, briefings, and other requirements related to SUD clinical care delivery.

c. Provide consultation to Defense Health Network (DHN) BH leads, and through them, disseminate best practices for SUD clinical care delivery.

d. In collaboration with the DHN BH leads, offer consultation to ensure integrated, effective and efficient SUD clinical care for beneficiaries across DHNs.

5. BHCMT PROGRAM LEADS, DHA. BHCMT Program Leads will:

a. Provide status updates to the BHCMT Chief and advise on and oversee the DHA system-wide implementation of the substance use disorder clinical care (SUDCC) program.

b. Serve as the functional proponent for all DHA SUDCC programs within the BHSOC and provides oversight of guidance, procedures, training, technical support, and research for SUDCC programs.

c. Disseminate leading practices and improvement projects developed or identified by the DHA Clinical Communities.

6. DEFENSE HEALTH NETWORKS (DHNs). The Directors, DHNs will:

a. Implement and ensure MTF Directors are in compliance with DHA SUDCC standardization guidance and procedures for clinal operations as described in Enclosure 3 of this DHA-AI.

b. Coordinate with the DHA BHCMT Chief of SUDCC related complaints and inquiries.

c. Coordinate and collaborate with Service regional and major command BH leadership within area of operations to ensure unity of effort and maximal responsiveness to emerging SUDCC demands.

7. MTF DIRECTORS. The MTF Directors will:

a. Comply with instructions outlined in this DHA-AI.

b. Disseminate this DHA-AI to all MTF healthcare personnel and ensure that all providers follow the guidance and procedures in Enclosure 3 of this DHA-AI.

c. Confirm that MTF staff receive training on substance use disorder in accordance with Reference (d).

d. Ensure that all assigned SUDCC or MTF SUDCC-assigned BH technicians and alcohol and drug counselors (ADC) are allowed to accomplish the SUDCC mission as their primary responsibility in accordance with Reference (t)). For the purposes of this instruction, the terms BH technician and ADC will be used interchangeably.

8. MTF CHIEF, BEHAVIORAL HEALTH. The MTF Chief, BH will:

a. Under the authority of the MTF Director, coordinate services based on patient need.

b. Ensure SUD personnel, to include SUDCC or MTF SUDCC-assigned BH technicians and ADCs focus their work on activities consistent with this DHA AI. Depending on the size and scope of the MTF's Department of Behavioral Health (DBH) and demand for SUDCC and other DBH-related services, SUDCC providers and support staff may provide other DBH services, in accordance with (IAW) with their credentials and privileges. SUDCC providers will be integrated and co-located with Outpatient Behavioral Health (OBH) clinics, consistent with Reference (t). The MTF Chief of BH may use SUDCC providers to meet non-SUD clinical mission requirements, including triage, walk-in evaluations, and treatment of non-SUD patients, if, after SUD treatment demands are satisfied, there is excess capacity available to meet clinical mission demand as determined locally by the MTF Director in consultation with the MTF's Chief of BH. At no time can SUD demand be deferred to the TRICARE private sector network due to the lack of capacity at the MTF because SUD staff are performing non-SUD activities.

c. Identify an Addiction Medicine Champion, an appropriately credentialed and privileged physician, nurse practitioner, or prescribing psychologist, following guidelines set out in accordance with Reference (d) and Reference (v).

d. Maximize the coordination of care between SUD treatment and other forms of mental health care to include direct care SUD clinical care between the provider and the assigned Addiction Medicine Champion or their designee in accordance with Reference (d).

e. Confirm the MTF has established processes to assess the readiness of those ADSM who may be deferred to TRICARE private sector BH care. The processes will vary depending on the resources and capabilities available; each MTF's staff needs to best meet the readiness requirements of their empaneled SM population. Readiness monitoring activities include having the MTF's Director of Clinical Services re-evaluate the care of those SMs referred to the private sector, review of clear and legible reports from the treating private sector care BH provider, periodic health assessments, or monitoring of TRICARE private sector care utilization reports to identify SMs with duty limiting diagnoses (Reference (u)). This will also include implementation of the right of first refusal for all TRICARE private sector care referrals.

f. Develop and present to the MTF director recommendations for programming that would recapture care to the MTF, as appropriate, to include, but not limited to, outpatient, intensive outpatient programs, partial hospitalization programs (PHP), and residential treatment facilities, based on documented need, a business case analysis, and the availability of funding and staffing.

g. Confirm the monitoring, reporting, and annual evaluation of the MTF's SUDCC program as follows:

(1) Monitoring. Compliance with annual screening using the Alcohol Use Disorders Identification Test, Alcohol-Consumption Questions – (AUDIT-C). Monitoring information is derived from the Behavioral Health Data Platform IAW Reference (w)

(2) Measures. AUDIT-C and Behavioral Health Data Platform measures will serve as

internal control mechanisms related to policy implementation: percent of patient encounters across the DHA in compliance with annual AUDIT-C screening requirement. Then the annual screening rates and trends can be calculated (by the same measure and measurement period) and identified for reporting in all subsequent years.

(3) Annual Evaluation of Measures. By practice, when the AUDIT-C is administered, screening data is entered at that encounter using the electronic health record (EHR) management system.

9. THE MTF ADDICTION MEDICINE CHAMPION. The MTF Addiction Medicine Champion as identified in paragraph 8 (c) will:

a. Facilitate the training of MTF staff on substance use disorders in accordance with Reference (d).

b. Be available for or facilitate colleague clinical consultation and case-based teaching for prescribing medication-assisted treatment, outpatient alcohol withdrawal management, and other aspects of addiction care.

10. PRIMARY CARE AND OTHER HEALTHCARE PROVIDERS. Primary Care and Other Healthcare Providers will:

a. Be responsible for identifying and referring any patient who is involved in healthcare whose performance may be impaired by misuse of alcohol or other non-substance-related addictive disorders to the MTFs SUD program. One critical aspect of the SUD evaluation process is early identification. Identification can occur when healthcare providers identify substance misuse during routine or emergency medical treatment. If a healthcare provider notes substance misuse during routine or emergency medical screening of a beneficiary, the healthcare provider will recommend/refer the individual for a SUD evaluation. Refer to Reference (f) regarding the criteria for notification to command in instances where a service member does not self-refer.

b. As appropriate, refer healthcare providers to the Impaired Healthcare Provider Program (IHPP), as outlined in Reference (v).

ENCLOSURE 3

PROCEDURES

1. OVERVIEW. The DoD recognizes SUDs as treatable and potentially preventable. This DHA-AI provides general guidance on SUD levels of care, implementation of Reference (g), and evidence-based treatment and treatment outcomes. This guidance applies to all DHA beneficiaries. Patients who are not ADSMs will be triaged and may be referred to a provider in the TRICARE private sector care network. While the focus of the MTFs' SUDCC direct care system is supporting the ADSM, the full scope of DHA's SUD services are available to all eligible beneficiaries. While self-referral is preferred, commanders and supervisors at all levels are also responsible for identifying SMs at risk for a SUD, referring them for screening and evaluation, and actively supporting prevention, intervention, and treatment.

2. SUBSTANCE USE PREVENTION AND EARLY INTERVENTION. Substance use prevention and early intervention (level 0.5) activities are not classified as clinical treatment and provide information intended to prevent or reduce substance misuse. Universal approaches to prevention and early intervention activities aim to reduce community level substance use trends. In collaboration with local prevention services, personnel at MTFs should implement universal strategies based on the emergent need of the MTF's patient population or address trending substance misuse topics. Targeted activities provide all DoD personnel prevention education, including those who have been identified as misusing substances, but who do not meet the criteria for having a SUD, with information intended to reduce substance misuse. The goals of prevention and early intervention are to:

a. Foster the recognition of substance misuse and its harmful effects.

b. Encourage early identification of individuals engaged in substance misuse through comprehensive prevention strategies and education.

c. Support personnel who self–refer, were referred by their command, or who have misused substances, but do not meet the diagnostic criteria for having an SUD will receive education and prevention services from local substance use disorder prevention personnel.

3. LEVELS OF CLINICAL CARE.

a. Not all levels of clinical care are offered at all MTFs. All beneficiaries will be afforded access to services at the nearest MTF location (as clinically appropriate and as availability allows). If services are not available at an MTF, use of VA and/or community-based services is supported, along with the use of the TRICARE private sector network. The substance misuse treatment/care will include withdrawal management, medical treatment, and transition counseling, if indicated, within the appropriate level of care facility.

b. The level of substance use intervention/treatment is based upon the severity of the individual's symptoms related to the SUD, as well as a variety of environmental factors and other criteria. For a person diagnosed with a SUD, treatment may consist of individual, group, and/or family counseling, outpatient services (Level 1), intensive outpatient/partial hospitalization services (Level 2), residential services (Level 3) and medically managed intensive inpatient services (Level 4). Modalities are structured within the scope of individualized, short-term treatment. A level of care placement recommendation is based upon ASAM criteria regarding the severity of impairment. The current edition of the ASAM Criteria Continuum of Care has removed level 0.5 and modified level 1 to "Long-Term Remission Monitoring" moving outpatient clinical treatment to Level 1.5. Levels defined below:

(1) Level 1.5 - outpatient care: encompasses organized, non-residential services, typically a combination of individual and group therapy modalities, which may be delivered in a wide variety of settings. Treatment personnel provide professionally directed evaluation, treatment, and recovery services. Such services are provided in regularly scheduled sessions and follow a defined set of policies and procedures or medical protocols. Higher levels of care should be considered based on clinical presentation and patient progress or lack of progress.

(2) Level 2 - intensive outpatient care/partial hospitalization services:

(a) Level 2.1 - intensive outpatient care: provide a combination of individual and group care covering essential education and treatment components while allowing patients to apply newly acquired skills within "real world" environments. Programs have the capacity to arrange for medical and psychiatric consultation, psychopharmacological consultation, medication management, and 24-hour crisis services. Programs are a combination of individual and group care delivered a minimum of nine hours per week and typically last up to a maximum of six weeks. Should longer than six weeks of care be required, a higher level of care should be considered.

(b) Level 2.5 – High-Intensity Outpatient (HIOP): (previously named PHP) provides a combination of group and individual care delivered a minimum of 20 hours per week. These programs offer the most intensive treatment available at the outpatient level. HIOP emphasize education and therapeutic elements, skill building, and application of skills in "real world" environments. HIOP programs have the capacity to arrange for medical and psychiatric consultation, psychopharmacological consultation, medication management, and 24- hour crisis services. The typical course of HIOP is up to a maximum of four weeks. Should longer than four weeks of partial hospital care be clinically indicated, a higher level of care will be considered.

(3) Level 3 - clinically managed/medically managed residential treatment: residential inpatient treatment is an organized, interdisciplinary, clinical service in which qualified healthcare professionals provide medically monitored assessment, evaluation and treatment, 24 hours a day, seven days a week. The defining characteristic of Level 3 programs is the intensity of care can vary based on the individual's needs and provide a safe and stable living environment to support development of their recovery skills. Such living environments may be housed in the same facility where treatment services are provided, or they may be housed in a separate facility

affiliated with the treatment provider. The typical course of residential treatment is up to a maximum of six weeks, or as clinically indicated.

(4) Level 4 - medically managed intensive inpatient services: this level of care offers 24-hour nursing care and daily physician care for severe, medically unstable symptoms. Full resources of general acute medical, detoxification, and psychiatric care available.

(5) Aftercare (recovery support services): following completion of a treatment program at or above Level 1, beneficiaries will be encouraged to continue treatment at a lower level of care (also referred to as "step-down care") or other recommended aftercare services, which may include web and smartphone-based recovery resources, telehealth, coaching, community, and peer-based recovery support resources. Aftercare may also refer to other forms of care that may not meet coding criteria or definitions. The typical course of aftercare is 12 months. This service is important to maintain early recovery gains made during a recent phase of SUD acute care. ASAM Criteria dimensions in the Fourth Edition adds a 6th dimension: Person-Centered Considerations (considering barriers to care, including social determinants of health, patient preferences, and need for motivational enhancement), to aftercare.

4. METHODS OF IDENTIFICATION AND REFERRAL. The SUD treatment process reflects a logical approach that can be applied to solving challenges (e.g., interpersonal and work relationships, housing) in any area. Solving these challenges begins with preliminary identification of the general issues followed by a more detailed determination of the specifics. All healthcare providers are responsible for identifying and referring any patient who is involved in healthcare whose performance may be impaired by misuse of alcohol or other non-substance-related addictive disorders to the MTFs SUD clinical program and IHPP, as appropriate, as outlined in Reference (v). Those referred to the IHPP will be managed in accordance with applicable guidance contained in Reference (v). One critical aspect of the SUD evaluation process is early identification. Identification can occur through a variety of methods:

a. Voluntary/self-referral. Individuals are encouraged to refer themselves for evaluation and treatment services. Command notification is not required for service members who self-refer for substance misuse education services, evaluation, or routine outpatient treatment unless command notification requirements are met in accordance with Reference (f).

b. Commander/supervisor identification occurs when a commander or supervisor observes, suspects, or otherwise becomes aware of an individual whose job performance, interpersonal relationships, physical or mental readiness, or health appears to be affected adversely by suspected substance misuse, to include alcohol or substance-related incidents.

c. Medical identification can occur when healthcare providers identify substance misuse during routine or emergency medical treatment. If a healthcare provider notes substance misuse during routine or emergency medical screening of a beneficiary, the healthcare provider will recommend/refer the individual for a SUD evaluation. Refer to Reference (f) regarding the criteria for notification to command in instances where a service member does not self-refer.

5. ALCOHOL USE SCREENING IN PRIMARY CARE.

a. Annual adult screening for alcohol misuse for beneficiaries enrolled in the MTF for primary care is an essential component of identifying and educating personnel who may be at risk for developing problems related to their alcohol use.

b. Alcohol use screening in primary care has goals of:

(1) Promoting health and readiness through the early identification of alcohol misuse, utilizing all educational components and resources available at the time.

(2) Providing early opportunities for MTF healthcare providers to intervene with beneficiaries who are at-risk for an alcohol use disorder, as clinically indicated.

c. Screening for at-risk alcohol use in adults will be performed at least annually in primary care settings as recommended in Reference (g) utilizing AUDIT-C as the primary tool, while also utilizing all other skills provider has received training.

d. All licensed independent practitioners (LIP), including BH personnel assigned to primary care settings, will receive annual education and training on:

(1) Current trends and practices in the identification, assessment, and referral of personnel at risk for substance use related problems, including interpretation and use of the alcohol screening instrument AUDIT-C.

(2) Intervention strategies that are consistent with risk level determinations made from screenings that incorporate the AUDIT-C or other assessments" " in accordance with Reference (d).

e. Primary care providers will screen or monitor beneficiaries for signs and symptoms of substance use disorders other than alcohol use disorder.

f. Providers will inquire further about screening results that indicate a need for further assessment and take appropriate actions, as clinically indicated. Actions may include patient education about substance misuse, health risks, and recommended alcohol consumption guidelines, as well as the use of evidence-based intervention and referral models (e.g., Screening Brief Intervention and Referral to Treatment), and referral to BH or SUD clinical treatment personnel for further assessment, as indicated by Reference (g).

g. Medical encounters that include the screening and, when necessary, brief interventions will be coded in accordance with Reference (h).

6. EVALUATION FOR TREATMENT SERVICES.

a. Eligible beneficiaries may self-refer for evaluation and treatment services, be referred by a non-medical provider from such entities as Marine and Family Counseling Services, Army Community Services, Fleet and Family Services, and Military and Family Readiness Centers or be referred by a medical/BH provider. Beneficiaries referred with a primary presenting problem of substance misuse will receive an assessment in accordance with established TRICARE access to care standards (see Reference (u)). In accordance with Reference (u), initial treatment to evaluate new or reemergent BH needs (to include substance use disorder) is considered primary care and will result in an evaluation by a provider who is credentialed or specifically privileged to perform BH assessments. A civilian employee presenting with a SUD who does not meet eligibility for MTF care will be referred to the DHA Employee Assistance Program and offered other appropriate resources IAW Reference (x).

b. In accordance with Reference (u): A new BH condition or exacerbation of a previously diagnosed condition for which intervention is required but is not urgent will comply with routine care requirements; eligible beneficiaries must be offered an appointment to visit a LIP or BH technician under the supervision of a LIP within 7 calendar days. Following the initial BH assessment, referrals for additional care will be provided within the access standard for specialty care, which is 4 weeks (28 calendar days), unless the referring provider determines more urgent care is needed.

c. All Service members who are identified by a commanding officer/supervisor or another medical service (e.g., emergency services, primary care, BH), as suspected or exhibiting signs of substance misuse, will be referred without exception for a SUD evaluation. Service members requiring acute detoxification or immediate medical care will be transported to the emergency department by ambulance, if needed, and the command is to be called immediately if not present. In accordance with Reference (u), such Service members will be assessed as soon as medically appropriate or no later than seven (7) business days from discharge from an acute setting for detoxification.

d. Service members who are referred by their command for a SUD-related incident (e.g., positive drug test, driving under the influence, altercation involving substances) to an MTF will receive an assessment no later than seven (7) business days from the date referral is received, in accordance with Reference (u).

e. Matching personnel to the most appropriate level of care in accordance with Reference (i) requires a thorough biopsychosocial diagnostic assessment using criteria for SUDs as defined in the current Reference (j).

f. Evaluation. A biopsychosocial evaluation of personnel being considered for treatment is essential to prescribing the appropriate level of care. The evaluation will assess:

(1) Level of acute intoxication and withdrawal potential.

(2) Medical conditions and complications, including a history of past and current medical conditions that may complicate treatment or contribute to the patient's condition.

(3) Additional medical or psychological conditions that are either diagnosable or sub-clinical that complicate treatment or require separate medical treatment.

(4) Readiness to change, including resistance to treatment and willingness to accept the current diagnosis and treatment strategy.

(5) Risk of relapse continued use or continued problem potential, to include risk of harm to self or others and any additional risks associated with delayed treatment.

(6) The nature of the recovery environment, such as family members, significant others, and living situations that pose a threat and/or provide support to the patient's safety, the safety of others, or their treatment.

g. The evaluation will also educate the beneficiary on the limits of confidentiality and required notification of commanders per Reference (f) (as appropriate), evaluation and treatment processes, limited use policy (limiting the use of SUD information), providing additional levels of confidentiality for SUD records, References (r) and (d), and information about SUD services.

h. Baseline Laboratory Evaluation. Initial baseline laboratory evaluation, including biomarkers, should be ordered by supporting medical providers, typically a psychiatrist/nurse practitioner involved in the patient's SUD treatment. Clinical indications for baseline laboratory evaluation may include, but will not be limited to, beneficiaries who report having physical health symptoms, or who are receiving medical treatment for a physical condition. A baseline laboratory evaluation may be obtained through MTF or comparable civilian medical laboratory services facility. Medical providers will refer to Reference (g) for recommended baseline and follow up laboratory evaluations. This will support treatment and better characterize patterns of substance use, recurrent use, and relapse. Routine testing can also support abstinence-based recovery efforts.

i. Medical laboratory testing for identification and monitoring of problematic substance use will be performed by an appropriately accredited and registered clinical laboratory and handled using medical toxicology/laboratory practices. Random testing may be administered at the local level using approved testing kits.

7. SUD TREATMENT.

a. SUD treatments address and seek to alleviate factors and issues that cause individuals to develop alcohol or other substance-misusing behaviors and/or become dependent on or addicted to drugs and/or alcohol. SUD treatment will be patient-centered, using a multi-disciplinary integrated team approach to provide a full continuum of evidence-based behavioral and pharmacological therapies to treat SUD and comorbid BH disorders.

b. Psychosocial aspects of treatment:

(1) Treatment planning will be assessed continually and modified, as necessary, to

confirm that the plan meets the patient's changing needs. At a minimum, the treatment plan will be updated every six months.

(2) Individual and/or group counseling and other evidence-based behavioral therapies are critical components of effective treatment. As part of a comprehensive treatment program, per Reference (g), providers should encourage patients to attend and participate in community mutual-help groups.

(3) Aftercare coordination begins at entry into a program, utilizing all available unit, command, family, and community resources. Any individual who has engaged in SUD clinical care may benefit from additional or extended aftercare services that are not customarily provided by an MTF.

(a) Aftercare takes many forms. For example, there are many long term, evidence-based aftercare/long-term recovery programs, held both in person and on-line as well as via a smart phone application that are based on a long-established 12-step model.

(b) Aftercare can and should be provided in modalities that can be easily accessed as ease of access is a key component to participation and increases potential for successful recovery. Aftercare can be provided in person, via a web-based virtual platform, telephonically, and via web-based applications on phones and tablets with internet access.

c. Pharmacotherapies:

(1) In addition to the psychosocial treatments provided in SUD treatment, those receiving SUD treatment at an MTF will be evaluated, if clinically indicated, for appropriate adjunctive pharmacotherapy, as part of a comprehensive treatment plan.

(2) Long-term drug replacement therapies may be made available in accordance with Reference (g).

8. COMMAND, SUPERVISOR, AND FAMILY INVOLVEMENT IN CARE.

a. Command or Supervisor Involvement. The treatment staff will involve the commander/commanding officer or supervisor for Service members in the individual's treatment program and encourage engagement in their recovery support whenever necessary in accordance with References (d) and (f).

(1) It is the responsibility of the SUD clinic staff to confer with the command to determine if a referral for evaluation should be made when a commander/supervisor suspects that substance misuse is related to adverse impact on individual job performance, interpersonal relations, physical or mental readiness, or health.

(2) Commanders/commanding officers/supervisors who refer personnel for evaluation will be informed of information as permitted by References (d) (f) and (y).

b. Family Involvement. When appropriate, family involvement should be encouraged and authorization from the patient obtained. Initial patient assessment must include family data and an initial plan for family involvement in treatment and recovery support, which must be made known to the patient before entry into treatment. Lack of participation by family members will not preclude treatment for personnel affected with an SUD. Based on the guidelines contained in Reference (k), when a family member's presence is necessary to the patient's health and welfare, personnel may coordinate a nonmedical attendant IAW Reference (k).

9. TREATMENT PROGRAM STAFFING AND TRAINING. Individual provider credentials and qualifications will be carefully evaluated before allowing involvement in patient care in accordance with References (l) and (v).

a. Staffing levels are determined by a risk-adjusted staffing model based on population and utilization needs with the goal of providing 85 percent of the care in MTFs.

b. Staff members must be under the supervision of personnel qualified to evaluate their clinical performance in accordance with References (l) and (v).

c. A LIP who is privileged as a BH provider, must be responsible for all care provided by the alcohol and drug counselor (ADC), a non-privileged BH technician and, in addition to the required "eyes on" supervision (a minimum of two hours per month, which can be provided either in-person or virtually when the LIP is geographically remote), the LIP will provide sufficient additional supervision and direction of care to confirm the quality of services (consistent with References (l) and (v)).

d. Certified ADCs must practice within the scope of the Substance Abuse and Mental Health Services Administration addiction treatment standards and/or the four domains as specified by the International Certification and Reciprocity Consortium for ADCs, and as directed by a privileged healthcare provider to be able to maintain this certification.

e. The initial assessment, any changes to the treatment plan, or crisis intervention requires "eyes on" supervision of the ADC by a healthcare provider who possesses both a valid license and is a fully privileged BH provider at the MTF where services are being delivered. In treatment situations, "eyes on" supervision must be provided by observation of direct patient contact and review of the patient's EHR and other appropriate treatment records. All supervision must be documented in the EHR.

f. A SUD diagnosis can only be made by a LIP.

10. QUALITY ASSURANCE.

a. MTF SUD treatment services must adhere to the DHA medical quality assurance standards related to the credentialing and privileging of providers, risk management, reporting of

adverse medical events, and performance measurement and improvement in accordance with References (l) and all aspects of (v).

b. MTF SUD treatment services must maintain accreditation by an accrediting organization approved by the Director, DHA, in accordance with Reference (l) and volume 5 of Reference (v).

11. DOCUMENTATION, CONFIDENTIALITY, CONSENT FOR TREATMENT AND RELEASE OF INFORMATION.

a. Documentation. The DHA EHR will be used to document care, including all SUD treatment, regardless of the level of care provided. All clinical contacts will be documented, as soon as possible, no later than 72 business hours following the encounter.

b. Confidentiality. Confidentiality is respected and maintained at all times. The limitations of confidentiality in accordance with relevant regulations (See References (d), (f), (o), , (q), (r), (t), and (y)) should be clearly stated at the initial meeting with the patient. The patient completes the most currently utilized MTF's limits of confidentiality and consent for treatment forms prior to being seen. Any paper forms will be scanned into the EHR. Providers will review the limited use policy with Service members and annotate within the EHR that this policy was discussed with the patient.

c. Consent for Release of Information. Special rules for alcohol and drug misuse program patient records are outlined in References (d), (m), (n), and (y). Covered entities will comply with the special rules protecting the confidentiality of alcohol and drug misuse patient records in federally assisted alcohol and drug misuse programs, as detailed in References (d), (m), (n), (o), and (y). Without the patient's consent, covered alcohol and drug misuse patient records may only be used or disclosed if the requirements of both regulations are met.

12. CULTURALLY SENSITIVE CARE. The military is a distinct group with its own unique laws, communities, disciplines, and rites of initiation; manners of dress, address, and grooming; standards of physical fitness; and systems of hierarchy and group organization. Given this cultural consideration, the importance of groups and group identity within quality SUD care, and the requirements of readiness and close coordination with command, care should be maintained within the MTFs when clinically available and appropriate.

13. RESOURCE SHARING. The DHA, in concert with the VA, shares resources in accordance with Reference (p), when beneficial and feasible. Service members in transition between facilities, services, or from the DoD healthcare system to the VA healthcare system or the TRICARE private sector will have a transition plan addressing continuity of care and coordination among providers. This should be reviewed throughout the transition process, and there should be clarity about who is the lead clinician to confirm continuity of care.

a. Residential VA Treatment. When mutually agreeable and authorized by law and

regulation, the DHA may choose to use VA residential programs for service members and authorized beneficiaries via a support agreement between the DoD and specific VA facilities.

b. Treatment for Service Members Who Are Being Discharged. Service members who are to be discharged for an SUD may be referred for treatment to a VA facility, if eligible, when mutually agreed upon by the DHA and the VA facility. In accordance with References (q), (r), and (p), the VA facility will be provided appropriate records, such as a copy of the service member's Military Service record and the nature of the service member's discharge. The service member must be informed of this opportunity for treatment. Service members who are evaluated as not having potential for further Military Service, if discharged, are to be evaluated by a physician, physician assistant, and/or nurse practitioner, provided with appropriate care and referred to a VA facility for further services in accordance with the provisions of References (e) and (s), should the service member choose this option.

(1) The Service member is also to be advised of resources outside of the VA system should there not be a VA in their community offering SUD care or if they should choose to access care through their local community.

(2) All Service members being separated have the opportunity to utilize the DHA's "inTransition program" (Reference (s)).

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

ADC	Alcohol and Drug Counselor
ASAM	American Society of Addiction Medicine
ASMAC	Addictive Substance Misuse Advisory Committee
AUDIT-C	Alcohol Use Disorders Identification Test, Alcohol-Consumption Questions
BH	behavioral health
DBH	Department of Behavioral Health
DHA	Defense Health Agency
DHA-AI	Defense Health Agency-Administrative Instruction
DoD	Department of Defense
EHR	Electronic Health Record
HIOP	High-Intensity Outpatient
IAW	In accordance with
LIP	licensed independent provider
MA	Medical Affairs
MILDEP	Military Department
MTF	Military medical treatment facility
PHP	partial hospitalization programs
SUD	substance use disorder
SUDCC	substance use disorder clinical care
VA	Department of Veterans Affairs

PART II. DEFINITIONS

aftercare. Provides support for patients in early or sustained remission, usually in an individual or group settings via telehealth, web and smartphone applications, and can include both MTF, community, and peer-based recovery resources.

alcohol misuse. The consumption of alcohol in daily or weekly amounts greater than those

defined as safe by the U.S. Preventive Task Force. Drinking at levels above the recommended amounts places an individual at greater risk for illness, injury, or social or legal problems.

ASMAC. As defined in Reference (d).

AUDIT-C. The AUDIT-C is a three-item alcohol screening that can help identify persons who are hazardous drinkers or have active alcohol use disorders (including alcohol misuse or dependence). The AUDIT-C is a modified version of the ten question AUDIT instrument.

beneficiary. As defined in References (e) and (u).

commander. Any commissioned officer who exercises command authority over a Service member. The term includes a military member designated to carry out any activity of a commander.

Detoxification. As defined in Reference (d).

documentation. The DoD EHR or other approved EHR system used to document care, including all SUD treatment, regardless of the level of care provided. All clinical contacts involving SUD will be documented no later than 72 hours following the encounter.

DoD personnel. As defined by Reference (d).

drug. As defined by Reference (d).

drug misuse. The use of substance(s) with the intent to alter one's mental physiological state (e.g., to alter one's mood, emotion, or state of consciousness). May include medications, illicit drugs, or use of a commercial product outside its intended purpose (such as inhalants or synthetic cannabinoids).

early intervention. Services that explore and address any problems or risk factors that appear to be related to use of alcohol, tobacco, and/or other drugs and addictive behaviors and that may help an individual to recognize the harmful consequences of high-risk use or behavior. Such individuals may not appear to meet the diagnostic criteria for substance misuse or addictive disorder but require early intervention for education and further assessment.

"eyes on" supervision. Direct contact by the LIP with the patient of sufficient length and interaction to validate the assessment and recommendation. Can be provided via telehealth when LIP is geographically remote.

high-intensity outpatient care (HIOP). A treatment setting capable of providing an interdisciplinary program of medically monitored therapeutic services, to include management of withdrawal symptoms, as medically indicated. Services may include day, evening, night, and weekend treatment programs which employ an integrated, comprehensive, and complementary schedule of recognized treatment approaches. HIOP is a time-limited, ambulatory, active treatment program that offers therapeutically intensive, coordinated, and structured clinical

services within a stable therapeutic environment. High-intensity outpatient care is an appropriate setting for crisis stabilization, treatment of partially stabilized mental disorders, to include substance use disorders, and a transition from an inpatient program when medically necessary.

illicit drug. As defined in Reference (d).

inpatient treatment. Treatment provided in a hospital or other authorized institution for bed occupancy for purposes of receiving necessary medical care for the active medical treatment of the acute phases of substance withdrawal (detoxification), for stabilization and for treatment of medical complications for SUD, with the reasonable expectation that the patient will remain in the institution at least 24 hours, and with the registration and assignment of an inpatient number or designation. If the patient has been received at the hospital, but death occurs before the actual admission occurs, an inpatient admission exists as if the patient had lived and had been formally admitted.

intensive outpatient program. A treatment setting capable of providing an organized day or evening program that includes assessment, treatment, case management and rehabilitation for individuals not requiring 24-hour care for mental disorders, to include SUDs, as appropriate for the individual patient. Treatment is a minimum of 9 hours (or more) of treatment per week. Intensive outpatient programs are diverse and flexible with respect to the spectrum, intensity, and duration of settings in which services are delivered. The program structure is regularly scheduled, individualized, and shares monitoring and support with the patient's family and support system.

license. As defined in Reference (v).

LIP. Defined in Reference (v).

medically managed treatment. As defined in Reference (d).

medically monitored treatment. As defined in Reference (d).

mutual-help group. Mutual support groups and self-help programs that can be implemented online or in a community setting. They are generally peer facilitated and include 12-step programs such as alcoholics anonymous, narcotics anonymous, and gamblers anonymous. Mutual-help groups can offer their insight and encouragement during recovery.

outpatient treatment. Non-residential treatment delivered in an outpatient setting, typically 9 or less contact hours per week, in which treatment staff provide professionally directed evaluations and treatment for substance-related, addictive, and/or BH disorders.

pharmacotherapy. The treatment of disease with prescribed medication.

prescription drug misuse. Taking a medication in a manner or dose other than prescribed; taking someone else's prescription, even if for a legitimate medical compliant such as pain; or taking a medication to feel euphoria (i.e., to get high).

prevention programs. Activities designed to influence participants to avoid substance misuse or to encourage individuals to seek early assistance.

privileged healthcare provider. An individual who possesses appropriate credentials and is granted authorized clinical privileges to diagnose, initiate, alter, or terminate regimens of healthcare within defined scope of practice.

substance misuse. The use of any substance in a manner that puts the user at risk of failing in their responsibilities to mission or family, or that is considered unlawful by regulation, policy, or law. This includes substance use those results in negative consequences to the health and/or well-being of the user or others; or meets the criteria for an SUD.

psychoeducation. The use of information or training that is intended to increase awareness or improve skills of persons with a psychological health need.

recovery support. Social support services, linkages to and coordination among allied service providers, and a full range of human services that facilitate recovery and wellness contributing to an improved quality of life.

rehabilitation. The process of restoring a person who is impaired by the use of alcohol or other drugs to an effective functioning level.

relapse. The resumption of a pattern of substance misuse in an individual seeking abstinence.

residential inpatient treatment. Residential treatment that provides medically monitored, interdisciplinary addiction-focused treatment. Qualified professionals provide 24-hour, 7 days-per week medically monitored assessment, evaluation, and treatment.

substance or drug misuse. The use of any substance with or without a prescription with the primary goal to alter one's mental state (i.e., to alter mood, emotion, or state of consciousness), outside of its medically prescribed purpose. May include medications, illicit drugs, or use of a commercial product outside its intended purpose (over the counter products, inhalants or synthetic cannabinoids).

SUD. As defined by Reference (j).

supervision. The process of reviewing, observing, and accepting responsibility for assigned personnel. The types of supervision are:

a. indirect. The supervisor performs retrospective review of selected records. Criteria used for review relate to quality of care, quality of documentation, and the authorized scope of practice.

b. direct. The supervisor is involved in the decision-making process.

c. verbal. The supervisor is contacted by phone or informal consultation before implementing or changing a regimen of care.

treatment personnel. As defined by Reference (d).

voluntary self-referral. The process of seeking information about or obtaining an appointment for SUD screening, evaluation, or treatment initiated by a Service member without being ordered or directed by a commander or supervisor.