DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
7700 ARLINGTON BOULEVARD
FALLS CHURCH, VA 22042

IN REPLY REFER TO
BUMEDINST 5353.4B
BUMED-M9
6 Jul 2015

BUMED INSTRUCTION 5353.4B

From: Chief, Bureau of Medicine and Surgery

Sub: STANDARDS FOR PROVISION OF SUBSTANCE RELATED DISORDER TREATMENT SERVICES

Ref: (a) MOU between the CNO and BUMED of 30 Jun 1995 (NOTAL)
(b) DoD Policy Memorandum on TRICARE Substance Abuse Treatment, HA Policy 97-029 of Feb 1997
(c) DoD Instruction 1010.4 of Feb 2014
(d) OPNAVINST 5350.4D
(e) Diagnostic and Statistical Manual of Mental Disorders, Current Edition
(f) American Society of Addiction Medicine, Patient Placement Criteria for Treatment of Substance Related Disorders, Current Edition
(g) The Joint Commission Standards Manual
(h) BUMEDINST 6320.66E
(i) Clinical Practice Guideline, VA/DoD Evidence Based Practice, Management of Substance Use Disorders
(j) American Psychiatric Association Practice Guidelines, Treatment of Patients with Substance Use Disorders, Second Edition

Encl: (1) Acronyms
(2) Levels of Care
(3) Patient Placement Dimensions and Adult Criteria: Crosswalk of Levels of Service
(4) Treatment Guidelines
(5) Definitions

1. Purpose. To update a uniform set of standards for the provision of substance related disorder treatment services within the Department of the Navy (DON). This is a complete revision and must be read in its entirety. Enclosure (1) is a list of acronyms used in this instruction.

2. Cancellation. BUMEDINST 5353.4A.

3. Scope. This instruction applies to all medical treatment facilities (MTF) and their subordinate hospitals and clinics.

4. Background. The memorandum of understanding (MOU) in reference (a) established the Chief, Bureau of Medicine and Surgery (BUMED) as responsible for management of the Navy Department program for substance related disorder treatment services, including management of the Navy Drug and Alcohol Counselor School and the Navy Preceptorship Program for drug and alcohol counselors.

5. Policy. This instruction implements policies outlined in reference (b) for the delivery of a comprehensive TRICARE substance related disorder treatment benefit within the Navy direct health system and aboard operational units. Enclosures (2) through (5) represent the scope of assessment and treatment services. Enclosure (5) defines terminology used in this instruction. Reference (c) provides information for implementing treatment services. Since assessment and treatment for substance use problems and substance related disorders impacts readiness, reference (d) contains administrative guidelines for active duty members. Diagnosis of substance abuse related disorders should follow reference (e). Reference (f) provides guidance for determining the intensity and duration of intervention. All treatment programs and services based on MTF shall meet The Joint Commission standards, reference (g). A licensed and privileged health care practitioner, as outlined in reference (h), will be responsible for all clinical services provided by the substance abuse program. References (i) and (j) provide guidance for the provision of substance abuse treatment. For administrative standardization, these services will be referred to as the Navy Substance Abuse Intervention and Treatment Program and the BUMED Assistant Deputy Chief for Health Care Operations is the program manager.

6. Responsibility

a. Commanding officers of Naval MTF providing assessment and treatment services for substance related disorders shall:

(1) Work in close coordination with the regional lead agent, as designated by the Assistant Secretary of Defense (Health Affairs), to develop an integrated plan for the delivery of substance abuse services to beneficiaries.

(2) Ensure assessment and treatment services meet the guidance in this instruction.

(3) Submit required patient census data to BUMED Substance Abuse Rehabilitation Program (SARP) Program Manager to assist in system resource allocation and program outcomes measurement.

b. Commanding Officer, Surface Warfare Medicine Institute, San Diego, CA shall:

(1) Be responsible for the Navy Drug and Alcohol Counselor School (NDACS) which, through intense, introductory training curriculum, prepares active duty personnel for a tour as a SARP and other Navy Alcohol and Drug Abuse Prevention NADAP training as directed by BUMED SARP Program Manager.

(2) Include Navy Alcohol and Drug Program Manager BUMED in the development of training requirements review inventory for NDACS curriculum.

(3) Manage contracts aimed at counselor training and development in consultation with the Navy Alcohol and Drug Program Manager.

(4) Administer the substance abuse counselor certification program.

c. Operational medical units providing assessment and treatment services for substance-related disorders are requested to adhere to these guidelines to the extent possible.

7. Records. Records created as a result of this instruction, regardless of media and format, shall be managed per SECNAV M-5210.1 of January 2012.

8. Reports. The patient census data report is assigned report control symbol MED 5353-5. This requirement is approved by Chief, BUMED for 3 years from the date of this instruction.

9. Forms. The following NAVMED forms are available at: https://navalforms.documentservices.dla.mil/web/public/forms at the "Forms tab," local reproduction is authorized.

(1) NAVMED 5353/18 (11-2014), Clinical Institute Withdrawal Assessment of Alcohol Scale.

(2) NAVMED 5353/19 (05-2015), Substance Abuse Rehabilitation Program Patient Census Data Report.

M. L. NATHAN

Distribution is electronic only via the Navy Medicine Web site at:
http://www.med.navy.mil/directives/Pages/default.aspx

ACRONYMS

ADSEP	Administrative Separation
AHLTA	Longitudinal Application
ASAM	American Society Addiction Medicine
BUMED	Bureau of Medicine and Surgery
CIWA-AR	Clinical Institute Withdrawal Assessment of Alcohol
DAPA	Drug and Alcohol Program Advisors
DoD	Department of Defense
DON	Department of the Navy
EAC	Executive Advisory Committee
IOP	Intensive Outpatient
MOU	Memorandum of Understanding
MTF	Medical Treatment Facilities
NADAP	Navy Alcohol and Drug Abuse Prevention
NDACS	Navy Drug and Alcohol Counselor School
PCM	Primary Care Provider
PPD	Purified Protein Derivative
PTSD	Posttraumatic Stress Disorder
SARP	Substance Abuse Rehabilitation Program
SOS	Secular Organization for Sobriety
UPC	Urinalysis Program Coordinator
VA	Veterans Affairs

LEVELS OF CARE

1. Levels of Care. Treatment programs shall adhere to the principals of a continuum of care model outlined in current edition of *The American Society of Addiction Medicine (ASAM) Patient Placement Criteria for the Treatment of Substance-Related Disorders,* reference (f). For convenience of describing different points of the continuum, ASAM has divided the continuum into sectors of five general levels of service.

a. Early Intervention. Level 0.5 is a program intended for individuals whose problems and risk factors appear to be related to substance use and who do not meet the diagnostic criteria for substance related disorders. Early intervention services are designed to explore and address problems or risk factors that appear to be related to substance use and to assist the individual in recognizing the harmful consequences of inappropriate substance use. The early intervention program may be a structured course with a set length and curriculum. The length of this program should be sufficient to accommodate the individual's ability to comprehend and use the information to avoid further substance use problems.

b. Outpatient. Level I program encompasses organized nonresidential services, which may be provided in a wide variety of settings. Addiction treatment personnel provide evaluation and treatment services to individuals diagnosed with substance related disorders. This level is for individuals diagnosed with a substance use disorder and who are able to meet treatment goals as outpatients with 9 hours of contact or less a week. Environmental and employment considerations may require that individuals who clinically need this level will receive treatment that is "condensed" or "front-loaded." For example, for any active duty patients, mission requirements will influence whether treatment will occur more often than 9 hours a week for the first 1 to 2 weeks. In such cases, the individual will be considered to be receiving outpatient treatment, as this matches his or her clinical level of functioning.

c. Intensive Outpatient. Level II program provides a structured day or evening program to individuals diagnosed with substance use disorders whose level of functioning requires more intense intervention than outpatient but does not require 24 hour supervision. As a general guideline, frequency of contact is usually in blocks of 4 or more hours, 3-5 times per week, up to a full day program. In this level, patients receive essential education and treatment components while being allowed to apply their newly acquired skills within "real world" environments. Programs have the capacity to arrange for medical and psychological consultation, and 24-hour crisis services (via hospital emergency departments). As a patient meets individual treatment goals, it is expected, where possible, the individual will move into a less intense intervention, i.e., outpatient services.

d. Clinically Monitored/Residential. Level III program is for patients who need a safe and stable living environment to develop sufficient recovery skills. They have been diagnosed with a substance use disorder and have been assessed using patient placement dimensions as requiring a structured 24 hour program. This program will be staffed 24 hours a day by designated

treatment personnel. Although medical services need to be readily available they are not required onsite. As a patient progress through treatment, where possible they will transition to a nonresidential program. Length of stay in a residential program is variable, depending on individual needs and response to treatment, but will generally not exceed 5 weeks.

e. Medically Managed. Level of care is an inpatient treatment for individuals requiring medical services for detoxification or other medical complications. When required, this level of service will be coordinated through MTF medical services.

f. Continuing Care. Patients diagnosed with Substance Dependence should be referred to Continuing Care services in the vicinity of their command. In most cases Continuing Care services will be available for 1 year following formal treatment but may vary based on the needs of the patient. Services shall include weekly group therapy sessions, quarterly patient reviews, self-help meeting participation, on-going ASAM assessments, and Navy MORE participation.

PATIENT PLACEMENT DIMENSIONS AND ADULT CRITERIA: CROSSWALK OF LEVELS OF SERVICE

1. Patient Placement Dimensions. The patient placement dimensions described in reference (f) provide the common foundation for defining admission, continuing stay, and discharge program criteria, as well as assessing level of functioning and problem areas for the individual. As such, assessment of a patient with these dimensions guides matching the individual with the most appropriate intervention intensity or level of care. The brief questions following each of the six dimensions will assist in assessing the severity of the patient's condition and the intensity of services required.

a. Acute Intoxication and/or Withdrawal Risk. Severe withdrawal risk is possible when there is a past history of withdrawal, the last drink was within 3 days (combined with a history of consistent heavy drinking), or there is a past history of hallucinations, tremulousness, or seizures with alcohol use and withdrawal. If immediate withdrawal risk is severe, the patient should be referred for detoxification evaluation before admission. Consider the following questions:

(1) What risk is associated with the patient's current level of intoxication?

(2) Is there significant risk of severe withdrawal symptoms, based on the patient's previous withdrawal history, amount, frequency, and recency of discontinuation of chemical use?

(3) Is the patient currently in withdrawal? To measure withdrawal, use the clinical institute withdrawal assessment in enclosure (2) or other objective instrument.

(4) Does the patient have the supports necessary to assist in ambulatory detoxification, if medically safe?

b. Biomedical Conditions and Complications. Severe biomedical complications are significant medical problems that have not been evaluated or current unstable medical problems such as hypertension, liver problems, chest pain, and diabetes. Members presenting severe biomedical conditions or complications need to be referred for evaluation before entry. Consider the following questions:

(1) Are there current physical illnesses, other than withdrawal, that need to be addressed or that may complicate treatment?

(2) Are there chronic conditions that affect treatment?

c. Emotional and Behavioral Conditions or Complications. Patients with substance use problems or addiction often present varying degrees of emotional and behavioral difficulties. Negative emotional states, such as anxiety and depression, are frequently situational and are resolved with minimal intervention. However, in other cases the degree of instability associated

with these states may present immediate risks or obstacles to treatment and recovery. The more severe the emotional or behavioral problems are, the more intense the level of intervention. If the emotional problems are so severe as to preclude the patient's ability to work on substances abuse issues, referral to other mental health services may be required. It is acceptable to admit patients who are under mental health care or referred by mental health as long as their mental health condition is stable. If a patient presents an imminent danger to self or others, a mandatory mental health referral must be made. Consider the following questions:

(1) Are there current psychiatric/psychological problems that need to be addressed or which complicate treatment?

(2) Are there chronic conditions that affect treatment?

(3) Do any emotional or behavioral problems appear to be an expected part of addiction illness or do they appear to be autonomous?

(4) Is the patient diagnosed with PTSD, a Traumatic Brian Injury, or other mental health disorder that will interfere with therapeutic services?

d. Treatment Acceptance and Resistance. The patient's awareness of the problem, their admission of the consequences of the problem, and acceptance of the need for assistance are primary considerations in the treatment process. The level and nature of denial present will suggest the likelihood of continued attempts at controlled use and, therefore, the need for more intense, structured treatment. Also of concern is the distinction between internal versus external motivation, and the patient's willingness to commit to an ongoing treatment process. The more external the motivation and the weaker the willingness to commit, the more structured the intervention will need to be. For patients who are dependent, resistance and denial is to be expected throughout the recovery process. The treatment placement decision with this dimension should be made on the basis of degree and immediate consequences of the resistance and denial to the treatment process. Consider the following questions:

(1) Does the patient object to treatment?

(2) Does the patient feel coerced into coming to treatment?

(3) Does the patient appear to be complying with treatment only to avoid a negative consequence, or does he or she appear to be self-motivated?

e. Relapse Potential. Many factors contribute to the patient's difficulty in initiating and maintaining abstinence, including physiological and environmental concerns. This dimension describes these issues both in terms of immediate ability to abstain as well as the risk of return to active use. The intensity of service will depend on the patient's ability to interrupt impulsive and

self-defeating behaviors. Specific concerns in this area include such issues as the level of substance craving, the patient's recognition of internal and external relapse triggers, and history of past attempts to control or abstain. Consider the following questions:

(1) Is the patient in immediate danger of continued use?

(2) Does the patient have any recognition of, understanding of, or skills with which they can cope with their addiction problems to prevent continued use?

(3) What problems will potentially continue to distress the patient if they are not successfully engaged in treatment at this time?

(4) How aware is the patient of relapse triggers, ways to cope with cravings, and skills required to control impulses to continue use?

f. Recovery Environment. The patient's social and interpersonal network, including the atmosphere at their command, may support the recovery process or present major obstacles and stresses that may result in relapse. Consideration must be given to the patient's ability to successfully initiate recovery in his or her current environment. Family dysfunction and interaction with drinking or using peers are to be expected, but assessment must focus on the degree of these stresses and the patient's ability to maintain focus in treatment. In addition, the mobility and mission demands on the active duty population pose unique environmental constraints on providing treatment. This factor must be considered in evaluating the recovery environment. For example, if a patient would qualify on the other dimensions for intensive outpatient services, but the command's operational commitments cannot support attendance, the clinically monitored level should be recommended. Consider the following questions:

(1) Are there any family members, significant others, living situations, school, or working situations that pose a threat to treatment success?

(2) Does the patient have supportive friendships, financial resources, educational, or vocational resources that increase the likelihood of treatment success?

(3) Is the patient situated in a remote area, or are other environmental constraints such that less restrictive treatment services are not available?

2. Decisions to prescribe a level of service, and subsequent changes in intensity of intervention as treatment progresses, shall be based on how well the patient is meeting both immediate and long range treatment goals. This is especially important when the Interdisciplinary Treatment team is considering moving patients into a less structured outpatient level of care. The following tables present crosswalks which match generic assessments on each dimension with intensity of treatment intervention. These crosswalks are intended as a descriptive guide to aid in placing patients in the most appropriate level of care. The first table describes assessments expected upon entering the different levels of intervention. The second table describes assessments expected upon changing levels.

Entry Crosswalk Assessment on Dimension X Treatment Level

DIMENSION	EARLY INTERVENTION	OUTPATIENT SERVICES	INTENSIVE OUTPATIENT SERVICES	RESIDENTIAL
WITHDRAWAL	No/minimum risk.	No/minimum risk.	Minimum risk; No withdrawal that requires meds; No meds used to mask withdrawal.	Minimal risk; No withdrawal that requires meds; No meds used to mask withdrawal.
BIOMEDICAL	None to stable, non-interfering.	None to stable, non-interfering.	None to non-interfering. May be under current medical care.	None to non-interfering. May be under current medical care.
EMOTIONAL/ BEHAVIORAL	Able to comprehend and participate in activity. If problems, non-interfering.	Able to comprehend and participate in activity. If problems (anxiety, depression, guilt, etc.), non-interfering.	None to mild problems, and non-interfering.	None to moderate problems, not able to maintain stability over 72-hour period, i.e., distracted, negative emotions, anxiety, or other conditions requiring monitoring to support treatment goals.
TREATMENT ACCEPTANCE	Willing to participate.	Amenable to treatment; motivated to pursue treatment goals with support available through outpatient.	Willing to cooperate; able to acknowledge substance related problems. Requires monitoring and motivation strategies, but does not need 24-hour structured care.	Structural milieu required because patient attributes substance problems to others. Despite serious effects of addiction, patient does not relate problems to substance use. High resistance to treatment despite negative consequences.

Entry Crosswalk Assessment on Dimension X Treatment Level (continued)

DIMENSION	EARLY INTERVENTION	OUTPATIENT SERVICES	INTENSIVE OUTPATIENT SERVICES	RESIDENTIAL
RELAPSE POTENTIAL	Able to achieve program goals in educational setting.	Able to maintain treatment goals with support of outpatient program.	Able to maintain recovery goals with support and motivation provided in an outpatient setting.	High likelihood of substance use without close monitoring as indicated by lack of awareness of triggers, inability to postpone immediate gratification, etc.
RECOVERY ENVIRONMENT OPERATIONAL SCHEDULE	Supportive environment and skills to cope.	Patient can cope effectively with environment to work recovery goals.	Psychosocial environment is supportive enough for patient to work on recovery goals. Work schedule allows stable, consistent attendance, and timely entrance into tx.	Patient lives in environment in which tx unlikely to succeed, i.e., chaotic family, high level conflict, other members with active substance abuse. Patient performs job where continued substance use represents substantial imminent risk to self or others. Work schedule does not allow support timely, consistent tx. Distance between command and tx precludes participation in lower level of care.

Exit Cross Walk Assessment on Dimension X Treatment Level

DIMENSION	EARLY INTERVENTION	OUTPATIENT SERVICES	INTENSIVE OUTPATIENT SERVICES	RESIDENTIAL
WITHDRAWAL	Withdrawal risk requiring tx in another setting.	Withdrawal risk requiring treatment in another setting.	Withdrawal risk requiring treatment in another setting.	Withdrawal risk requiring treatment in another setting.
BIOMEDICAL	Problems arise requiring tx in another setting.	Problems arise requiring treatment in another setting.	Problems arise requiring treatment in another setting.	Problems arise requiring treatment in another setting.
EMOTIONAL/ BEHAVIORAL	Problems stable, non-interfering. Problems arise requiring tx in another setting.	Problems stable, non-interfering. Problems arise requiring tx in another setting.	Problems stable, non-interfering. Problems interfering with treatment, requiring treatment in another setting.	Problems no longer require 24-hour monitoring, stabilized and non-interfering with recovery plan. Problems identified are not responding to treatment and require another setting.
TREATMENT ACCEPTANCE	Satisfies program goals. Fails to attend, participate, or complete assignments.	Patient recognizes extent of substance problem. Patient understands consequences of continuing pattern. Patient applying essential knowledge and skill necessary to sustain treatment goals. Patient consistently failed treatment objects to degree that further progress unlikely.	Patient able to adhere to self-directed recovery plan; patient recognizes severity of problem and understands self-defeating relationship with substance; patient applying essential skills necessary to sustain sobriety through self help/continuing care. Patient consistently failed treatment objectives to degree that transfer to another setting indicated.	24-hour structure no longer needed; patient recognizes severity of problem; patient accepts and commits to specific plan for less intensive treatment. Patient consistently failed to achieve tx objectives to degree that further progress unlikely.

Exit Crosswalk Assessment on Dimension X Treatment Level (continued)

DIMENSION	EARLY INTERVENTION	OUTPATIENT SERVICES	INTENSIVE OUTPATIENT SERVICES	RESIDENTIAL
RELAPSE POTENTIAL	Satisfies program goals, develops alternative coping skills to prevent further alcohol related incidents.	Patient applying essential knowledge and skills to control/abstain from substance use. Increased craving, seeking behaviors require increased intensity treatment.	Patient has integrated, internalized skills for addressing craving and relapse issues. Patient having increased craving/using behaviors necessitating increased intensity treatment.	Patient capable of following and comprehending specific plan for continuing abstinence; risk of relapse outside of residential structure is low. Patient not committed to continued care, reached max benefits, non-amenable to treatment.
RECOVERY ENVIRONMENT/ OPERATIONAL SCHEDULE	Satisfies program goals, develops alternative sources of support.	Sufficient support for recovery to allow transfer to less intensive care. Patient unable to cope with recovery environment without more intensive treatment.	Patient has adequate social system support to use self directed treatment with low risk of relapse; patient functioning adequately in work, social, and primary relationships. Non-supportive or deteriorating social system or work schedule interferes, necessitating increased intensity treatment.	Problems in social/interpersonal environment responds to tx, allows transfer to lower intensity treatment. Patient developed coping skills needed to address current environmental obstacles.

TREATMENT GUIDELINES

1. Scope of Services. Services described in this instruction apply to all active duty and other TRICARE Prime beneficiaries seen within the Navy direct health care system. These services include screening, assessment, and treatment for alcohol and/or other drug abuse problems. The scope and limits of substance abuse treatment services for non-active duty individuals are governed by the TRICARE benefit. For current information, the local health care benefit agent should be contacted. Programs for adolescents between the ages of 13 and 17 are not covered under this instruction. Adult and adolescent programs shall be separate with adolescent programs staffed by personnel with skills and training in adolescent development and addiction treatment.

2. Treatment Philosophy. Substance use related problems and disorders are complex and multifaceted. Intervention is intended to motivate and precipitate changes through exposure to a variety of topics and experiences designed to assist individuals in evaluating and learning how to change their relationship with alcohol and other drugs. Engaging individuals in a timely manner and working collaboratively with them to develop individually tailored treatment plans are fundamental precepts for reaching positive treatment outcomes. Methods for improving access to care include the use of open ended counseling groups, regular interface with local commands, proactive case management, etc.

a. Patients will be treated in the least restrictive treatment environment that is appropriate to their therapeutic needs and circumstances. The intensity and setting of intervention will vary in relationship to individual patient needs and responses, and will be consistent with the guidelines of the current edition American Society of Addiction Medicine (ASAM) Patient Placement Criteria.

b. The length of time in treatment will vary depending on patient needs and responses to treatment. Emphasis is placed on eliminating unnecessary delays in placing patients into an appropriate level of care. Treatment programs will utilize evidence-based treatments consistent with Clinical Practice Guideline, Veterans Affairs/Department of Defense (VA/DoD) Evidence Based Practice, Management of Substance Use Disorders and the American Psychiatric Association Practice Guidelines, Treatment of Patients with Substance Use Disorders, Second Edition. Addiction-focused pharmacotherapy, such as naltrexone and/or acamprosate, will be routinely considered for patients with alcohol dependence. Medications should be offered in combined with addiction-focused counseling.

(1) Early Intervention (IMPACT). Early Intervention treatment shall be developed as a 20-hour program. In developing this treatment program, each SARP should consider the needs of the commands it serves in determining the frequency of meetings and the total number of days required to complete the program. The actual length of time in early intervention for any individual patient will vary depending on patient needs and responses to treatment.

(2) Outpatient (Level I). Outpatient treatment shall be developed as a 64-hour program. Under no circumstances shall the typical length of outpatient treatment be less than 56 hours or greater than 72 hours. In developing this treatment program, each SARP should consider the needs of the commands it serves in determining the frequency of meetings and the total number of days required to complete the program. The actual length of time in outpatient treatment for any individual patient will vary depending on patient needs and responses to treatment.

(3) Intensive Outpatient (Level II). Intensive outpatient treatment shall be developed as a 120-hour program. Under no circumstances shall the typical length of intensive outpatient treatment be less than 112 hours or greater than 128 hours. In developing this treatment program, each SARP should consider the needs of the commands it serves in determining the frequency of meetings and the total number of days required to complete the program. The actual length of time in intensive outpatient treatment for any individual patient will vary depending on patient needs and responses to treatment.

(4) Clinically Monitored/Residential (Level III). Clinically monitored/residential treatment shall be developed as a 5-week program. Under no circumstances shall the typical length of clinically monitored/residential treatment be less than 5 weeks or greater than 5 weeks. In developing this treatment program, each SARP should consider the needs of the commands it serves in determining the frequency of meetings and the total number of days required to complete the program. The actual length of time in clinically monitored/residential treatment for any individual patient will vary depending on patient needs and responses to treatment.

(5) Continuing Care. Continuing care treatment shall be developed as a 12-month program. In developing this treatment program, each SARP should consider the needs of the commands it serves in determining the frequency of meetings and the total number of days required to complete the program. The actual length of time in continuing care treatment for any individual patient will vary depending on patient needs and responses to treatment.

c. Treatment for individuals diagnosed with substance dependence is based on clinical indicators that abstinence is necessary for recovery. Per reference (j), the evidence to date suggests that substance-dependent individuals who achieve sustained abstinence from the abused substance have the best long-term outcomes. A primary goal of treatment with this population is to set the foundation for developing an abstinent lifestyle. To this end, the precepts and network of self-help and support groups such as 12 Step Recovery Programs, Celebrate Recovery, SMART Recovery, Secular Organizations for Sobriety (SOS) and other abstinence based programs are a basic component of the abstinence based treatment program. Per reference (i), the preponderance of the evidence supports that support group participation is associated with improved addiction outcome compared to baseline. Joint Commission Standards assessments will address the religion and spiritual orientation of the individual served.

d. Treatment for individuals diagnosed with an alcohol abuse disorder may have goals and objectives focused on setting responsible limits on the use of alcohol when an abstinent lifestyle is not clinically indicated. Patients for whom this applies are expected to refrain from use of alcohol or other substances while in treatment, until there is an agreed upon strategy for resuming the use of alcohol. Active duty members in jobs or programs requiring abstinence as a condition of active duty status shall be counseled on the adverse consequences of continued use of alcohol.

e. Continuing Care services will be available to patients diagnosed with substance dependence or where clinically appropriate. Duration of Continuing Care will be a minimum of 1 year. Continuum of Care services will include enrollment in Navy MORE (My Ongoing Recovery Experience) Program for those determined to have a Substance Dependence Diagnosis.

3. Evaluation and Treatment Decisions

a. Individuals may refer themselves or be referred for evaluation and treatment services through different avenues. Active duty members who are involved in an alcohol related incident will be referred by their command for evaluation to determine the extent of a substance abuse problem. Individuals referred by another medical service (e.g., emergency services, primary care, mental health, etc.) will usually have an initial screening and/or clinical evaluation, which applies to the precipitating referral. It is the responsibility of the Substance Abuse Treatment Program to ensure these individuals are assessed to determine the existence and extent of substance abuse problems. This evaluation will include a clinical assessment, diagnosis, and recommended level of treatment.

b. Policy and procedures of confidentiality apply to all patients. However, the extent and limits of confidentiality, as it applies to active duty members, shall be addressed before beginning any evaluation. Informed consent will be obtained from all patients prior to substance abuse evaluation and treatment.

c. Brief screening tools such as the AUDIT C and the Single Item Alcohol Screening Questionnaire can aid in determining if further assessment is indicated. Health care providers such as physicians commonly use the CAGE Questionnaire if a brief screening indicates potential need for treatment, a comprehensive biopsychosocial assessment utilizing the current version of the Navy Clinical Package, to include a suicide risk assessment will be conducted in sufficient breadth and depth to develop diagnostic impressions and to recommend initial treatment placement using ASAM patient placement guidelines (see enclosure (3)). Patient data will be aggregated and analyzed both for the purposes of individual treatment planning and for program evaluation. Data collection instruments may include but are not limited to SOCRATES, Drinker Inventory of Consequences, Patient Health Questionnaire (9) for Depression, Post-Traumatic Stress Disorder (PTSD) Checklist – Military Version (PCL-M) and Zung Self-Rating Scale.

d. Evaluating the presence and potential risk of withdrawal is a fundamental concern in ensuring patient safety. To that end, in addition to the complete history, every attempt will be made to obtain as accurate a picture as possible about the patient's recent alcohol and other substance use, including obtaining information from family and coworkers whenever possible. All counselors and providers involved in the program will be skilled in identifying the signs and symptoms of withdrawal and activation of the local emergency system.

e. Individuals diagnosed with a substance use disorder and referred to treatment (outpatient, intensive outpatient, or residential) must have a current physical examination (within 30 days) before or upon entry into treatment. The purpose of the evaluation is to assess the medical impact of the substance abuse, prescribe medical regimen as indicated, and medically clear the individual for treatment. Medical assessment should include review for both direct and indirect impact of substance abuse, and should, at a minimum, include a general chemistry panel to include review of electrolytes, Complete Blood Count (CBC), Comprehensive Metabolic Panel, Hepatic Function Panel, and Drugs of Abuse screen. If not drawn within the past year, human immunodeficiency virus and Purified Protein Derivative (PPD) should also be done. A provider may request additional tests based on the patient's history and clinical presentation. The patient's Primary Care Provider (PCM) or assigned medical officer will be responsible for ordering and reviewing the required physical examination.

f. Patients initially entering the intensive outpatient (IOP) and residential levels are assumed to have a more intense history, and are potentially at higher risk for withdrawal. These patients should be evaluated for withdrawal risk using the Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA-AR) or equivalent objective instrument. For residential patients evaluation should be conducted 4 times per 24-hour period for minimum of 72 hours or as clinically indicated. The structure of IOP programs will shape timing and frequency of withdrawal evaluations. Additionally, screening tests for current use of alcohol and other drugs may be needed to provide the staff with accurate information for treatment. These screening tests include breathalyzers, quantitative enzyme diagnostics, blood alcohol levels, and urine drug/toxicology screens. To ensure patient safety and to monitor progress on treatment goals, alcohol and drug screens will be used as indicated on admission (smell of alcohol, symptoms of drug use, or withdrawal), and randomly throughout the course of treatment.

g. Working collaboratively with patients, individualized treatment plans will be developed describing primary problems, goals of treatment, and treatment objectives designed to meet those goals. Problems should be conceptualized within the framework of the ASAM placement criteria using the access and completion crosswalks as guides to ensure appropriate level of intervention (see enclosure (3)). The interdisciplinary treatment team will routinely review all treatment plans while the patient is in treatment, documenting the review and all updates and modifications. Treatment plans will be developed for all patients diagnosed with a substance related disorder. Individuals identified as at risk and attending early intervention (IMPACT) do not require treatment plans.

h. Reference (d) describes readiness implications of substance abuse which lead to potential employment consequences for active duty members in treatment. For active duty individuals, "treatment noncompliance" may lead to administrative separation from the Navy. Lack of compliance or failure to improve is defined as a patient's inability or unwillingness to achieve the goals and objectives of the individualized treatment plan. A clearly defined list of expectations must be included in the individualized treatment plan signed by the patient and referred to throughout the course of treatment.

(1) Resistance or ambivalence to treatment can be demonstrated in behaviors having moderate to severe negative impact on treatment outcomes. Missed appointments, refusal to sign contracts, failure to complete homework assignments, failure to make progress on the agreed upon treatment plan, and failure to attend self-help groups are examples of minimal participation that typically can be satisfactorily resolved with one-on-one or group therapeutic interventions and/or through revisions to the treatment plan. Unsuccessful attempts to address this resistance therapeutically may result in treatment failure (therapeutic discharge).

(2) A positive therapeutic milieu can be developed to recognize that substance use during treatment may be symptomatic of the patient's addictive process which may occur at any level of care. The commanding officer or his or her Substance Abuse Representative, DAPA must be notified of substance use in treatment. The interdisciplinary treatment team may consider a transition to a higher level of care, change in treatment planning, or when a patient's progress is impeded beyond reconciliation, therapeutic discharge. Therapeutic discharge will also be considered if an individual's actions place the recovery of other Service members at risk. Case management and utilization review, in combination with clinical judgment will assist in determining if therapeutic discharge is in the best interest of the patient. In these situations a summary of care will reflect the steps taken to intervene before treatment termination. Active duty members will be returned to their commands. Per the OPNAVINST 5350.4D, members discharged from treatment as treatment failures are to be processed for administrative separation. It is the responsibility of commanding officers to determine whether the member has a potential for further useful service and submit a waiver to BUPERS to retain the member in the military.

4. Program Staff and Organization

a. Shore based substance abuse treatment services may be delivered through free-standing clinics of military MTFs, departments within MTFs, as a component of a mental health unit, or as a component of a primary care unit. Shipboard substance abuse treatment services will be provided through the medical departments. The organizational alignment of the SARP within the MTF/medical department will depend on the amount of program resources and structure of the MTF/medical department. A licensed health care practitioner, as recognized in reference (h), is responsible for all clinical services provided within this program. All SARP Directors will submit a quarterly report (NAVMED 5353/19 (05-2015), Substance Abuse Rehabilitation Program Patient Census Data Report.) to the BUMED Program Manager to assist in system resource allocation. The quarterly report is due no later than 10 working days after the end of the quarter.

b. Navy Drug and Alcohol Counselors are involved in the direct provision of clinical services. Consideration should be given in the assignment of collateral duties in order to have minimal impact on the counselors' availability to provide substance abuse care. The unique training and development of counselor interns need consistent and repeated reinforcement in order to become effective and competent certified drug and alcohol counselors. Therefore the importance of completing the internship process and impact on quality of patient care should be considered before counselors are pulled from the SARP clinic to fill other positions or collateral duties or deploy. Counselors should not be in positions where their involvement can be perceived as a conflict of interest, (i.e., disciplinary review board). Where practical based upon manning, involvement in command collateral duties that do not provide perception of a conflict or impact patient care should be encouraged.

c. Navy Drug and Alcohol Counselors attached to SARPs will not be utilized as a DAPA, UPC, or in the collection of non-medical urine samples. This is a conflict of interest and damaging to the overall impact of the NADAP program.

d. Substance abuse rehabilitation programs will deliver services commensurate with staffing and resources. The minimum program will consist of providing screenings and assessments, early intervention services, and continuing care for individuals returning from more intense interventions. Individuals requiring services verified as not available through appropriate Utilization Managers representing the MTF will be referred to an appropriate military or civilian facility.

e. The program may be staffed by active duty drug and alcohol counselors, civilian counselors with State or U.S. Navy certification, mental health professionals, nurses, and physicians. All providers of care will meet profession specific credentialing and privileging requirements. Individuals in a training status will be supervised by licensed practitioners or certified clinical supervisors/preceptors as appropriate. Recognizing the unique nature of substance abuse and addictions, providers of care shall be trained in the assessment and treatment of addictive disorders and should attend appropriate professional development conferences and workshops to maintain current knowledge in this field. Funding for continuing education and training is the responsibility of the local command. Recognizing the biopsychosocial and spiritual nature of addiction treatment, and also the diversity of patient needs, a multidisciplinary approach to treatment is essential. As most programs cannot support a full time multidisciplinary staff dedicated solely to substance abuse, this approach can be accomplished through having multiple professions present at treatment team case reviews and through referral to other programs as needed (e.g., Fleet and Family Service Centers, Chaplain services, etc.).

f. An Executive Advisory Committee reporting to and providing input to the BUMED Program Manager will be established. The purpose of the Executive Advisory Committee for Navy Drug and Alcohol Programs is to identify priority issues and initiate best practices,

and to make collaborative recommendations to Navy Alcohol and Drug Program Manager. The Executive Advisory Committee assists the Navy Alcohol and Drug Program Manager in developing policy, guidelines, implementation instructions, education plans, measures of success, and feedback/measurement mechanisms. The committee establishes work groups to address significant processes across Navy Substance Abuse programs. These work groups will consist of committee members and/or middle managers who have "ownership" of a process. These work groups may be permanently established to ensure continuous improvement or may disband once they provide the committee with the data necessary for continuous improvement efforts.

(1) Membership. EAC core membership shall consist of SARP Directors or their representatives from: Norfolk, San Diego, Jacksonville, and Camp Lejeune. Two additional members will be drawn from the balance of the SARPs. Ad Hoc Members and NDACS representative(s) will be appointed as determined by the needs of the committee. Other members-at-large may be appointed at the discretion of the BUMED Program Manager and the EAC. Members attend committee meetings regularly, provide support for projects and commit the necessary resources to any project (inclusive of people and technology) and advise EAC where changes to strategy might impact projects. Members who miss 2 consecutive meetings without giving sufficient cause are considered withdrawn from the Committee, subject to review by the Advisory Committee.

(2) Chair. Chair will serve for 1 fiscal year. Core members will serve at the discretion of the Navy Alcohol and Drug Program Manager, At large members will serve for 3 fiscal years or if active duty, until transferred. The Chair of the committee shall convene and preside at the meetings of the Advisory Committee, set its agenda, coordinate its work, and, as appropriate to deal with particular subject matter, establish subcommittees of the Advisory Committee that shall consist of members of the Advisory Committee (or their designees), and such other full-time or permanent part-time officers or employees of the Federal Government as the Chair and/or Committee may designate.

(3) Roles and Responsibilities. The EAC assists the Navy Alcohol and Drug Program Manager in developing policy, guidelines, strategies for implementation, education plans, measures of success, and feedback/measurement mechanisms. The EAC establishes work groups to address significant processes across Navy Substance Abuse programs. These work groups will consist of EAC members and/or middle managers who have "ownership" of a process. These work groups may be permanently established to ensure continuous improvement or may disband once they provide the EAC with the data necessary for continuous improvement efforts. The EAC will assist the Navy Alcohol and Drug Program Manager in developing and reviewing policy proposals, as requested by the Chair with intent and purpose of facilitating and enhancing decision-making by the Advisory Committee. The EAC will obtain feedback about treatment programs for the purpose of improving the provision of services. The EAC will select

the sites and dates for future meetings and develop and review agenda items for EAC meetings. The EAC will meet as minimum of twice per fiscal year. The Advisory Committee shall coordinate, to the maximum extent practicable, guidance to be issued by SARP Department Heads to ensure an integrated approach to treatment.

(4) Meetings and Decision Making. The EAC will meet as needed at the invitation of the Drug and Alcohol Program Manager and EAC Chair. With case-by-case approval of the Chair, an Executive Committee member may send a surrogate to a meeting. A status report on the work of the EAC will be a standing agenda item. Meetings will be called by the Naval Alcohol and Drug Program Manager and can also be held by video conference, teleconference or electronic mail.

(5) Support. The Drug and Alcohol Program office will provide staff support to the EAC.

(6) Approval. This Charter will remain in effect until amended or replaced.

5. Records

a. To ensure continuity of care, patients' diagnoses, treatment recommendations, progress notes, and summaries of care must be entered into the patients' Armed Forces Health Longitudinal Application (AHLTA) or current DoD electronic health record notes, primary or secondary medical record, and if necessary, a copy entered into the secondary record per reference (b). Entries in the primary record will note the date when the secondary record is opened, the date when closed, and the location of this secondary record. The rehab information entered in AHLTA or current DoD electronic health record should be marked sensitive/place "under the glass" so it is not wrongfully accessed or given to a command.

b. Readiness and deployment factors for active duty members require information and regular communication between the treatment program and the member's command regarding treatment progress. A summary of care will be completed, regardless of length of stay, anytime an individual has been engaged in treatment, completed treatment, or when transferred from one facility to another. Patients being treated for alcohol dependence will be transitioned to continuing care following an initially more intensive phase of treatment. For these patients, a summary of care, including recommended services to enhance recovery, will be completed at the time of transition. This summary will include at minimum:

(1) A recommendation that the member abstain from the consumption of alcohol.

(2) A recommendation that the member participate in regular follow-up sessions with their command DAPA.

(3) A recommendation that the member participate in support group meetings.

(4) A recommendation that the member participate in a formal Continuing Care group at their servicing SARP.

(5) A recommendation for continued participation in the Navy MORE program. The patient, DAPA, and the commanding officer of active duty patients will be provided copies of the summary of care as they are developed.

c. Individuals and their commanding officers will receive documentation of completion for early intervention programs.

d. The command DAPA is a source of support to the active duty member as he or she transitions through treatment back into the command. The DAPA may refer to the summary of care for developing a command monitoring program.

DEFINITIONS

The definitions used in this instruction correspond to references and enclosures of this instruction and are intended for the clinical and administrative management of the substance abuse treatment program.

1. Assessment. Assessment is an ongoing process of gathering information about patients' strengths, weaknesses, problems, and needs. This information is evaluated and integrated into treatment recommendations and plans. A diagnosis is based on data gathered in an initial assessment.

2. At Risk. Describes an individual that has had some difficulties related to substance use, but who does not meet the diagnostic criteria of substance use disorder. Usually individuals identified as being "at risk" will be referred to a focused, early intervention, educationally based program such as IMPACT.

3. Biopsychosocial Interview. Substance abuse affects all aspects of an individual's life. Therefore, a comprehensive interview includes investigation of such areas as biology (physical consequences associated with use of alcohol and other drugs, other physical illnesses, etc.), emotions, attitudes, behavior (psychology), and relationships (sociology).

4. Case Management. Case management is the clinical and administrative support and coordination of therapeutic services that make up the treatment plan and facilitate a positive outcome.

5. Continuum of Care. A full range of services encompassing initial assessment, early intervention, variety of outpatient services, 24-hour clinical management, and 24-hour medical management. It assumes that patients move smoothly within the continuum, with intensity of intervention, varying as the needs change.

6. Drug and Alcohol Program Advisor (DAPA). Collateral duty defined within OPNAVINST 5350.4D, is responsible to commanding officer. Acts as liaison between command and treatment program for referral and command treatment support issues.

7. IMPACT. A structured, educationally based early intervention counseling program aimed at increasing the personal awareness of at risk individuals.

8. Intake. The administrative and assessment procedures upon entering a treatment program. It typically follows an initial diagnostic assessment that has recommended a treatment intervention.

9. Lapse and Relapse. Lapse and relapse are not unusual when treating addicted individuals. Every effort should be made to formulate a strategy for intervening with a patient who is experiencing difficulty in making progress in treatment or maintaining a recovery program. Discharge from treatment is a last resort when all other avenues for reconciliation have been exhausted.

10. Least Restrictive Environment. Treating in the least restrictive environment is the principle that individuals are treated in the most appropriate and therapeutic setting that is no more restrictive than required to assist them in meeting the goals of the treatment plan.

11. Levels of Care or Service. Services ranging from early intervention through outpatient services to medically managed intensive inpatient care. The intensity or level of intervention individuals receive is guided by admission, continued stay and discharge criteria. These criteria are based on a thorough assessment using the patient placement criteria.

12. Interdisciplinary Treatment Team. Characterized by a variety of disciplines, as available, (e.g., Chaplain, Psychiatrist, Psychologist, LCSW, Substance Abuse Counselor, Case Manager, Recreation Therapist, etc.) that participate in the assessment, planning, implementation and/or review of a patient's care. The intent of an interdisciplinary treatment team is the coordination and provision of multifaceted care to those that have been impacted by substance abuse.

13. Orientation. Presenting to the patient the general nature and goals of the program; mutual expectations; program rules governing conduct; and patient rights.

14. Screening. The process by which an individual is determined appropriate and eligible for admission to a particular program. Screening may include the use of short, commonly used questions or surveys such as the CAGE or AUDIT to assist in determining if the individual has a substance related disorder.

15. Setting. Clinical environment such as hospital, doctor's office, clinic, counseling center, classroom, etc., that meets accreditation standards for delivery of services.

16. Substance Related Disorders. For the purpose of this document, substance related disorders refers to an ailment related to the taking of a drug of abuse (including alcohol) that meets the diagnostic criteria for substance use disorder as outlined in the Diagnostic and Statistical Manual. Impairment or disability can manifest in the areas of either mental or physical functioning, or both.

17. Summary of Care. Identifies patient diagnosis, treatment, summary of care progress notes and any comments regarding continuing care. For active duty members, summaries are completed and provided to the patient and his or her command at the end of treatment and whenever the member is transferred from one treatment facility to another.

18. Treatment Plan. The treatment plan is the identification and prioritization of problems needing resolution. Working together, the patient and the counselor establish immediate and long-term goals; and decide on the treatment methods and resources to be used. The goals of treatment will be consistent with the dimensions of the patient placement criteria, allowing the use of the generic admission, continued stay, and discharge criteria as a guide for best level of treatment intervention. Treatment plans will be reviewed and updated regularly.