Substance Use Disorder (Sustained Remission)

[THIS MODULE ASSESSES SYMPTOMS OF SUBSTANCE USE DISORDER THAT WERE PRESENT > 12 MONTHS AGO. TO ASSESS CURRENT SUBSTANCE USE DISORDER, SEE THE SUBSTANCE USE DISORDER (CURRENT/EARLY REMISSION) MODULE.]

1. **Have you ever used recreational drugs or medications to get high or to change how you were feeling?** **A** ☒ **P**

   [IF CODING P, QUERY WHICH SUBSTANCES WERE USED AND DATE OF LAST USE]: Which substances have you used? How many times in a typical week did you use [substance]? When did you start using and how long did your use last?

   - ❑ [CANNABIS – E.G., POT/HERB/WEED/GRASS/GANJA, THC, HASHISH/RESIN, HASH OIL]

     Frequency: _____ x per day/week/month/year Date of last use: _____

   - ❑ [SEDATIVE, HYPNOTIC, OR ANXIOLYTIC – E.G., PRESCRIPTION SLEEPING MEDICATIONS AND PRESCRIPTION ANTIANXIETY MEDICATIONS, SUCH AS BENZODIAZEPINES, BENZODIAZEPINE-LIKE DRUGS (E.G., ZOLPIDEM, ZALEPLON), CARBAMATES (E.G., GLUTETHIMIDE, MEPROBAMATE), BARBITURATES (E.G., SECOBARBITAL), AND BARBITURATE-LIKE HYPNOTICS (E.G., GLUTETHIMIDE, METHAQUALONE)]

     Frequency: _____ x per day/week/month/year Date of last use: _____

   - ❑ [OPIOID – E.G., MORPHINE, HEROIN, OPIUM, CODEINE, DILAUDID, OXYCODONE, FENTANYL, HYDROMORPHONE]

     Frequency: _____ x per day/week/month/year Date of last use: _____

   - ❑ [STIMULANT – E.G., COCAINE, AMPHETAMINES, RITALIN, DEXEDRINE, METH/SPEED/CHALK, ICE/CRYSTAL/CRANK]

     Frequency: _____ x per day/week/month/year Date of last use: _____

   - ❑ [HALLUCINOGEN—PHENCYCLIDINE – E.G., PCP/ANGEL DUST/ROCKET FUEL, KETAMINE]

     Frequency: _____ x per day/week/month/year Date of last use: _____

   - ❑ [HALLUCINOGEN—OTHER – E.G., LSD/ACID, PSILOCYBIN, MESCALINE, DOM, MDMA/ECSTASY/MOLLY, DMT, SALVIA, MORNING GLORY SEEDS]

     [SPECIFY HALLUCINOGEN:] _____

     Frequency: _____ x per day/week/month/year Date of last use: _____

   - ❑ [INHALANT – E.G., GLUE, FUEL, PAINT, TOLUENE/SOLVENT]

     Frequency: _____ x per day/week/month/year Date of last use: _____

   - ❑ [CAFFEINE – E.G., COFFEE, TEA, CAFFEINATED SODA, ENERGY AIDS, OVER-THE-COUNTER ANALGESICS AND COLD REMEDIES, WEIGHT LOSS AIDS, CHOCOLATE]

     Frequency: _____ x per day/week/month/year Date of last use: _____

   - ❑ [TOBACCO – E.G., CIGARETTES, CHEWING TOBACCO, SMOKELESS TOBACCO, E-CIGARETTE]

     Frequency: _____ x per day/week/month/year Date of last use: _____

❑ [OTHER (OR UNKOWN) SUBSTANCE – E.G., ANABOLIC STEROIDS, NSAIDs, CORTISOL, ANTIHISTAMINES, NITROUS OXIDE, KAVA]

[SPECIFY SUBSTANCE:] _____

Frequency: _____ x per day/week/month/year Date of last use: _____

2. **During this period, did your substance use bother you or cause you any problems?** **A** **P**

[#2 IS CODED P AND/OR SUBSTANCE USE IS DEEMED CLINICALLY CONCERNING] **A** ☒ **P**

[NOTES:]

[LIST SUBSTANCES THAT ARE BOTHERSOME, CAUSE PROBLEMS, OR ARE DEEMED CLINICALLY CONCERNING. IF NOT KNOWN ASK :]

Which of the substances that you told me about cause problems for you?

1. _____
2. _____
3. _____

	[SUBSTANCE 1:] _____	[SUBSTANCE 2:] _____	[SUBSTANCE 3:] _____
3. **During this period of problematic use:**			
3a. **On days that you used [substance], did you use a lot more than you planned to or for a longer period of time than intended?**	❒	❒	❒
3b. **Did you want to, or repeatedly try to, cut down or stop using [substance] but were unable to?**	❒	❒	❒
3c. **Did you spend a lot of time trying to get [substance], using it, or recovering from its effects?** On average, how many hours of your day (or week) are taken up with getting [substance], consuming it, or recovering from it?	❒	❒	❒
3d. **Did you experience strong urges or cravings to use [substance]?**	❒	❒	❒
3e. **Did your [substance] use repeatedly interfere with your duties at work, school, or home?**	❒	❒	❒

	[SUBSTANCE 1:] _____		[SUBSTANCE 2:] _____		[SUBSTANCE 3:] _____	
3f. **Did your [substance] use repeatedly cause you problems in social situations or in your relationships with other people?** [IF YES:] Did you continue to use despite these problems? [CHECK ONLY IF USE CONTINUED DESPITE PROBLEMS]		❒		❒		❒
3g. **Did you reduce or give up any of your usual activities because of your [substance] use?** Spending less time on hobbies because of your [substance] use? Spending less time with family or friends because of it?		❒		❒		❒
3h. **Did you use [substance] in situations that could have been dangerous or in which you could have been harmed?** Have you driven while high or not been able to remember how you got home? Engaged in risky behaviours, such as swimming or using machinery while high?		❒		❒		❒
3i. **Did your [substance] use repeatedly cause or worsen any medical or mental health problems?** [IF YES:] Did you continue to use despite these problems? [CHECK ONLY IF USE CONTINUED DESPITE PROBLEMS]		❒		❒		❒
3j. [TOLERANCE]: **Did you need to use greater amounts of [substance] to get the same effect as before, or did you get less of an effect when using the same amount of [substance]?**		❒		❒		❒
3k. [WITHDRAWAL]: **When you've reduced or stopped using [substance], did you experience any withdrawal symptoms** [ASSESS USING SUBSTANCE SPECIFIC WITHDRAWAL SYMPTOMS AT END OF MODULE] **or did you ever use alcohol or a substance to reduce or prevent withdrawal symptoms?**		❒		❒		❒
[AT LEAST TWO #3 ITEMS RELATED ARE CHECKED]	**A** ☒	**P**	**A** ☒	**P**	**A** ☒	**P**

[WITHDRAWAL SYMPTOMS (#3k) ARE NOT APPLICABLE TO PHENCYCLIDINE, OTHER HALLUCINOGENS, AND INHALANTS. DO NOT QUERY WITHDRAWAL FOR THESE SUBSTANCES.]

	[SUBSTANCE 1:] _____	[SUBSTANCE 2:] _____	[SUBSTANCE 3:] _____
[FOR PAST USE ONLY:]			
4. [NONE OF THE SYMPTOMS OF SUBSTANCE USE DISORDER HAVE BEEN PRESENT IN THE PAST 12 MONTHS (CRAVINGS MAY STILL BE PRESENT). IF NOT KNOWN ASK:] Have you engaged in problematic [substance] use or had any of the symptoms we just discussed in the past 12 months? Can you describe in what ways they have been problematic or which symptoms you've had in the past 12 months?	**A** **P**	**A** **P**	**A** **P**

[NOTES:]

		[SUBSTANCE 1:] _____	[SUBSTANCE 2:] _____	[SUBSTANCE 3:] _____
DIAGNOSTIC IMPRESSION: [SUBSTANCE] USE DISORDER, IN SUSTAINED REMISSION		**A** **S** **P** ☒	**A** **S** **P** ☒	**A** **S** **P** ☒
[PERIOD OF PAST USE:]		_____	_____	_____
[NAME OF SUBSTANCE SHOULD BE SPECIFIED IN THE DIAGNOSIS, E.G., METHAMPHETAMINE USE DISORDER, IN SUSTAINED REMISSION. IF MORE THAN ONE SUBSTANCE USE DISORDER IS PRESENT, ALL SHOULD BE DIAGNOSED.]				
	[SPECIFY:]			
SUBSTANCE IS NOT USED DUE TO BEING IN A CONTROLLED ENVIRONMENT (E.G., CARE FACILITY, PRISON). TO BE USED AS AN ADDITIONAL REMISSION SPECIFIER.	IN A CONTROLLED ENVIRONMENT	❒	❒	❒
	[SPECIFY:]			
TWO-THREE #3 ITEMS ARE CODED P	MILD	❒	❒	❒
FOUR-FIVE #3 ITEMS ARE CODED P	MODERATE	❒	❒	❒
≥ SIX #3 ITEMS ARE CODED P	SEVERE	❒	❒	❒

		[SUBSTANCE 1:] _____	[SUBSTANCE 2:] _____	[SUBSTANCE 3:] _____
RECEIVING MAINTENANCE THERAPY FOR SUBSTANCE USE DISORDER RELATED TO OPIOID USE	[SPECIFY:] ON MAINTENANCE THERAPY	❒	❒	❒
PANIC ATTACKS ARE PRESENT IN THE CONTEXT OF THIS DISORDER [NOTE: TO ASSESS SYMPTOMS OF A PANIC ATTACK, SEE PANIC ATTACK SPECIFIER AND PANIC DISORDER MODULE]	[SPECIFY:] WITH PANIC ATTACKS	❒	❒	❒

5. **How old were you when these symptoms first began?**	_____	_____	_____
6. **How old were you when these symptoms began to be a problem for you?**	_____	_____	_____
7. **On a scale from 0 to 10, 0 meaning not at all and 10 meaning extremely, how much are you bothered by your symptoms?**	_____	_____	_____

Substance Specific Withdrawal Symptoms

[WITHDRAWAL SYMPTOMS ARE NOT APPLICABLE TO PHENCYCLIDINE, OTHER HALLUCINOGENS, AND INHALANTS.]

[CANNABIS – E.G., POT/HERB/WEED/GRASS/GANJA, THC, HASHISH/RESIN, HASH OIL:]

In the week after you stopped using [substance], did you start to experience:

- ❑ Irritability, anger, or aggression
- ❑ Anxiety or nervousness
- ❑ Difficulty with sleep or upsetting dreams
- ❑ Decreased appetite or weight loss
- ❑ Restlessness
- ❑ Depressed mood
- ❑ Stomach pain, shakiness or tremors, sweating, fever, chills, or headaches that cause you significant discomfort

[CANNABIS WITHDRAWAL: AT LEAST THREE ITEMS ARE CHECKED] **A** **P**

[SEDATIVE, HYPNOTIC, OR ANXIOLYTIC – E.G., PRESCRIPTION SLEEPING MEDICATIONS AND PRESCRIPTION ANTIANXIETY MEDICATIONS, SUCH AS BENZODIAZEPINES, BENZODIAZEPINE-LIKE DRUGS (E.G., ZOLPIDEM, ZALEPLON), CARBAMATES (E.G., GLUTETHIMIDE, MEPROBAMATE), BARBITURATES (E.G., SECOBARBITAL), AND BARBITURATE-LIKE HYPNOTICS (E.G., GLUTETHIMIDE, METHAQUALONE):]

In the hours or days after you stopped using [substance], did you start to experience:

- ❑ Sweating, or increased heart rate
- ❑ Shaky hands
- ❑ Difficulty sleeping
- ❑ Nausea or vomiting
- ❑ Seeing or hearing things that others didn't perceive, or feeling strange physical sensations
- ❑ Agitation or restlessness
- ❑ Anxiety
- ❑ Seizures

[SEDATIVE, HYPNOTIC, OR ANXIOLYTIC WITHDRAWAL: AT LEAST TWO ITEMS ARE CHECKED] **A** **P**

[OPIOID – E.G., MORPHINE, HEROIN, OPIUM, CODEINE, DILAUDID, OXYCODONE, FENTANYL, HYDROMORPHONE:]

In the minutes or days after you stopped using [substance], did you start to experience:

- ❑ Depressed mood
- ❑ Nausea or vomiting
- ❑ Achy muscles (e.g., back and legs)
- ❑ Watery eyes or runny nose
- ❑ Dilated pupils, goose bumps or hairs standing on end, or sweating
- ❑ Diarrhea
- ❑ Yawning
- ❑ Fever
- ❑ Difficulty with sleep

[OPIOID WITHDRAWAL: AT LEAST THREE ITEMS ARE CHECKED] **A** **P**

[STIMULANT – E.G., COCAINE, AMPHETAMINES, RITALIN, DEXEDRINE, METH/SPEED/CHALK, ICE/CRYSTAL/CRANK:]

In the hours or days after you stopped using [substance], did you start to experience:

- ❑ Fatigue
- ❑ Vivid nightmares
- ❑ Difficulty sleeping or oversleeping
- ❑ Increased appetite
  Feeling slowed down or agitated/restless

[STIMULANT WITHDRAWAL: AT LEAST TWO ITEMS ARE CHECKED] **A** **P**

[CAFFEINE – E.G., COFFEE, TEA, CAFFEINATED SODA, ENERGY AIDS, OVER-THE-COUNTER ANALGESICS AND COLD REMEDIES, WEIGHT LOSS AIDS, CHOCOLATE:]

Within 24 hours after you stopped using [substance], did you start to experience:

- ❑ Headache
- ❑ Fatigue or drowsiness
- ❑ Depressed mood or irritability
- ❑ Concentration difficulties
- ❑ Feeling flu-like (e.g., nauseous, vomiting, achy muscles)

[CAFFEINE WITHDRAWAL: AT LEAST THREE ITEMS ARE CHECKED] **A** **P**

[TOBACCO – E.G., CIGARETTES, CHEWING TOBACCO, SMOKELESS TOBACCO, E-CIGARETTE:]

Within 24 hours after you stopped using [substance], did you start to experience:

- ❑ Irritability or anger
- ❑ Anxiety
- ❑ Concentration difficulties
- ❑ Increased appetite
- ❑ Feeling agitated/restless
- ❑ Depressed mood
- ❑ Difficulty with sleep

[TOBACCO WITHDRAWAL: AT LEAST FOUR ITEMS ARE CHECKED] **A** **P**