

Alcohol Withdrawal Management Protocols for OASAS 820 Program A

In order to be eligible for alcohol withdrawal management at OASAS 820 treatment programs, the patient should either be having mild-to-moderate withdrawal (reflected by a CIWA-Ar of at least between 8 and 10) or be expected to have significant withdrawal based upon past medical history, amount and duration of alcohol use, and/or signs of withdrawal beginning while intoxicated/with a detectable blood alcohol content. In addition, the patient should not have acute medical or psychiatric problems that would make care within an OASAS 820 treatment program inadvisable due to safety concerns.

As evidence clearly supports the use of benzodiazepines for the treatment of alcohol withdrawal – and chlordiazepoxide appears superior to other benzodiazepines due to its longer half-life and self-tapering effect – this is the preferred drug for alcohol withdrawal management. However, if the patient has a history of liver cirrhosis or is over the age of 60, one may consider the use of lorazepam as it is mostly metabolized via Phase 2 conjugation as opposed to Phase 1 oxidation and may be a safer choice in specific situations.

The choice of alcohol withdrawal management protocols is a complex one, governed by the premise that the goal is to perform the safest and most comfortable withdrawal management possible. Both undermedication and overmedication are problematic. If a patient is undermedicated, particularly for alcohol withdrawal, one risks the possibility that the patient may progress to severe withdrawal and delirium tremens (which carries a mortality rate of about 5%). On the other hand, overmedication can lead to over-sedation, which can result in dangerous behavior as well as falls and other traumatic injuries.

Any protocol must be adjusted to the specific needs of the patient by the treating medical provider based upon an assessment of the degree of withdrawal, as well as the results of a thorough medical and psychiatric history and physical exam conducted by a member of the medical staff. Treatment protocol choices will be impacted by medical and psychiatric comorbidities such as diabetes, pregnancy, or anxiety; the amount and duration of alcohol and/or other sedatives used; or a history of alcohol withdrawal seizures, hospitalizations/intensive care admissions, and/or delirium tremens. Laboratory results may also suggest one approach as opposed to another (e.g., the use of lorazepam rather than chlordiazepoxide in patients with markedly abnormal hepatic laboratory tests).

These protocols must also take into account the type of treatment facility implementing them. As freestanding treatment facilities not located within a hospital, withdrawal management will only be initiated for those patients unlikely to require a higher level of care (e.g., those not requiring IV therapy and those with mild-to-moderate withdrawal symptoms unlikely to warrant admission to a hospital or intensive care during withdrawal management). According to a literature review performed by NCBI (<https://www.ncbi.nlm.nih.gov/pubmed/17323538>), the risk factors for severe withdrawal include a history of severe uncontrollable alcohol-withdrawal seizures or delirium tremens. Therefore, these patients should be excluded and referred to a hospital-based withdrawal management setting. Likewise, patients with moderate-to-severe alcohol withdrawal (as measured by the CIWA-Ar – a validated alcohol withdrawal scale – greater than 15) – or with any of the exclusionary criteria listed below – will be referred to a higher level of care (i.e., medically supervised or managed setting). In addition a LOCADTR

3.0 will be completed to document medical necessity for the level of care, as specified in other facility policies and protocols.

Exclusionary Criteria

Although OASAS 820 treatment programs have the ability to treat the majority of patients presenting to for withdrawal management and stabilization, physicians are on-site less than half the time during the week and not at all on weekends. Moreover, most facilities have little ability to handle acute or severe medical problems on-site and therefore must refer patients to the hospital for emergency care. Our goal is always to err on the side of safety, admitting for treatment only those patients most likely to receive benefit and least likely to experience complications that would require inpatient hospital admission. Our exclusionary criteria generally mirror those set out by the American Physician (Am Fam Physician 2005 1;71(3):495-502) and includes:

- 1) Coexisting acute or chronic illness requiring inpatient treatment (e.g., unstable angina, uncontrolled diabetes)
- 2) Current severe alcohol withdrawal (CIWA greater than 15), especially with signs of delirium
- 3) Pregnancy
- 4) History of severe uncontrolled alcohol withdrawal seizures
- 5) Unstable mental health problems and/or acutely increased suicide/self-harm or violence risk

Patients excluded from withdrawal management in the PROGRAM based upon the criteria above will be transported by ambulance to a local hospital for a medically managed withdrawal management and stabilization.

Alcohol Withdrawal Management Protocols

The dose of medication prescribed is dependent on several factors including, but not limited to, the following:

- 1) Patient's previous history with alcohol withdrawal
- 2) Amount and consistency of alcohol use
- 3) History of alcohol withdrawal seizures
- 4) Co-Occurring substance use disorders requiring withdrawal management (e.g., opioid use disorder, other sedative use)
- 5) Concurrent medical conditions
- 6) Medications currently taken by patient for medical and/or psychiatric conditions
- 7) Whether patient is on medication-assisted treatment, such as methadone, buprenorphine, or long-acting naltrexone injection
- 8) Co-Occurring psychiatric illness and if present – whether patient is stable or not as judged by a qualified mental health provider

Upon obtaining a history and performing a physical exam including vital signs, and completion of a CIWA-Ar, as well as ordering laboratory studies including but not limited to urine toxicology and blood alcohol content, the medical provider will decide on the appropriate alcohol withdrawal management regimen. It is important to note that while toxicology should be ordered immediately, providers should base initial withdrawal management on history and objective criteria such as the CIWA-Ar and vital signs, and not await laboratory or toxicology results before beginning treatment. Laboratory and toxicology studies are clinical tools providing additional information that can be used to adjust treatment as necessary.

CIWA-Ar scores will be done q-shift. If at any point the CIWA-Ar score is greater than 13, or if the CIWA-Ar score is rising or not improving despite medication treatment, the nurse will notify the medical provider for evaluation and consideration of a change in the management. If at any point the CIWA-Ar score is greater than 15, the patient will be transferred to a higher level of care. If a patient appears over-sedated or the blood pressure or pulse is low, the medical provider will be notified and the medication dose may be withheld at the discretion of the medical provider. Likewise, if the patient experiences changes in mental status from baseline or any other acute medical complication is suspected, the medical provider will be notified for consideration of transferring the patient to a higher level of care.

Chlordiazepoxide Withdrawal Management Regimen

Day 1-2:

Chlordiazepoxide 10-50mg every 4 hours but not to exceed Chlordiazepoxide 200mg over a 24-hour period. The medical provider may choose either a fixed dose or prn-based schedule (depending on vital signs and CIWA-Ar score). Patients requiring more medication than that will be transferred to a higher level of care

Day 3-4:

Chlordiazepoxide 10-25 mg every 4 – 8 hours based on patient symptomatology

Day 5-6

Chlordiazepoxide 10-25 mg every 8-12 hours based upon patient symptomatology

Lorazepam Withdrawal Management Regimen

Day 1-2:

Lorazepam 0.5 - 2mg every 4 hours but not to exceed Lorazepam 8 mg over a 24-hour period. The medical provider may choose either a fixed dose or prn based schedule (depending on vital signs and CIWA-Ar score). Patients requiring more medication than that will be transferred to a higher level of care.

Day 3-4:

Lorazepam 0.5 -1 mg every 4 – 8 hours based on patient symptomatology.

Day 5-6

Lorazepam 0.5-1 mg every 8-12 hours based upon patient symptomatology.

Ancillary Medications

- 1) All patients admitted for alcohol withdrawal management will be placed on Thiamine 100mg daily for the length of the withdrawal management to reduce the risk of Wernicke's encephalopathy.
- 2) As folic acid is poorly absorbed in many individuals with alcohol use disorder, all patients admitted for withdrawal management will receive folic acid daily.
- 3) Trazodone and/or hydroxyzine may be prescribed for insomnia at the medical provider's discretion
- 4) Ibuprofen or another non-steroidal anti-inflammatory medication may be prescribed for pain at the medical provider's discretion, though gastric protection with an H2 blocker or proton pump inhibitor should be strongly considered. Acetaminophen should be avoided in patients with alcohol use disorder due to risk of liver toxicity.
- 5) Patients with tobacco use disorder or nicotine dependence will be offered nicotine replacement therapy to prevent nicotine withdrawal while they are at the program and unable to use tobacco products, even if they are not willing to consider long-term tobacco cessation.

Medication-assisted Treatment

Medication-assisted treatment (MAT) for alcohol use disorder can be very helpful for many patients, is an evidence-based practice, and is under-utilized. Therefore, all patients will be routinely offering naltrexone and/or acamprosate and those agreeing will be started on their choice of MAT (as clinically appropriate) prior to discharge.

Please see other relevant policies and protocols for how discharge and transition to continued community care will be managed in each OASAS 820 program.

Opioid Withdrawal Management Protocols for OASAS 820 Program A

In order to be eligible for opioid withdrawal management and/or stabilization at OASAS 820 treatment programs, the patient should either be having mild-to-moderate withdrawal (as reflected by a COWS of between 8 and 23) or be expected to have significant withdrawal based upon past medical history and amount and duration of opioid use. In addition, they should not have acute medical or psychiatric problems that would make care within an 820 treatment program inadvisable due to safety concerns.

For patients with opioid use disorder (OUD) and in opioid withdrawal, transition to and stabilization on medication-assisted treatment (MAT) rather than tapering withdrawal management medications is the safest and most evidence-based standard of care. Not only does MAT increase rates of continued follow-up in the community and enhance chances for recovery, but the risk of overdose death is high after detoxification from opioids, and MAT is protective. Stabilization on MAT is therefore considered routine practice, with rare exceptions for patient refusal or significant contraindications. Since it is more challenging and time-consuming to transition from methadone to other MAT options, protocols should generally begin with using buprenorphine to treat symptoms of opioid withdrawal, followed by presenting MAT options to patients once they are comfortable (i.e., remaining on buprenorphine, transitioning to methadone, or transitioning to long-acting naltrexone injection). When a program has the ability to perform a methadone induction (e.g., has an OTP as part of program, has an appropriate agreement with a nearby opioid treatment program), protocols can include starting with methadone as an option for appropriate patients. For patients who choose long-acting naltrexone injection upon admission, protocols can include an opioid-free withdrawal management option prior to naltrexone induction. To accommodate patients who refuse all MAT options once comfortable on buprenorphine, protocols can include a buprenorphine taper option, though discharging patients without any MAT should be the exception.

This protocol must take into account the specific attributes of the PROGRAM and its proximity to a hospital. As a freestanding treatment program that is not located within a hospital, only those patients unlikely to require a higher level of care will be accepted for treatment (i.e., those not requiring IV therapy and those with mild-or-moderate withdrawal symptoms unlikely to warrant admission to a hospital during withdrawal management). Patients who present with severe opioid withdrawal (as measured by a COWS of greater than 23) – or have any of the exclusionary criteria listed below – will be referred to a higher level of care as they are likely to require IV hydration and correction of electrolyte imbalances.

Exclusionary Criteria

Although OASAS 820 treatment programs have the ability to treat the majority of patients presenting to for withdrawal management and stabilization, physicians are on-site less than half the time during the week and not at all on weekends. Moreover, most facilities have little ability to handle acute or severe medical problems on-site and therefore must refer patients to the hospital for emergency care. Our goal is always to err on the side of safety, admitting for treatment only those patients most likely to receive benefit and least likely to experience complications that would require inpatient hospital admission. Our exclusionary criteria generally mirror those set out by the American Physician (Am Fam Physician 2005 1;71(3):495-502) and includes:

- 1) Coexisting acute or chronic illness requiring inpatient treatment (e.g., unstable angina, uncontrolled diabetes)
- 2) Current severe opioid withdrawal (COWS greater than 23)
- 3) Concurrent moderate-to-severe alcohol or benzodiazepine withdrawal (i.e., CIWA-Ar greater than 15)
- 4) Pregnancy
- 5) History of uncontrolled seizure disorder or severe uncontrolled seizure history with withdrawal
- 6) Unstable mental health problems and/or acutely increased suicide/self-harm or violence risk

Patients excluded from withdrawal management services based upon the criteria above will be transported by ambulance to a local hospital.

Opioid Withdrawal Management Protocol

The choice and dose of medication prescribed is dependent on several factors including, but not limited to, the following:

- 1) Patient's previous history with opioid detoxification (e.g., intractable vomiting)
- 2) Amount and consistency of opioid use
- 3) Co-Occurring Substance Use Disorders requiring withdrawal management (e.g., alcohol use disorder)
- 4) Concurrent medical conditions (e.g., chronic pain or a history of respiratory compromise)
- 5) Medications currently taken by patient for medical or psychiatric conditions
- 6) Whether patient is currently in an Opioid Treatment Program (i.e., on methadone)
- 7) Patient interest in ongoing MAT for OUD

The two most widely prescribed medications for opioid withdrawal are buprenorphine and methadone. As a partial agonist at the mu opioid receptor, buprenorphine is generally safer as it has a ceiling effect that makes overdose unlikely. However, buprenorphine can lead to precipitated withdrawal if a full agonist opioid is still present in the blood. This can be particularly problematic if a patient is using a non-prescribed opioid, such as heroin, as it may contain impurities that include such long-acting opioids as methadone.

Methadone does not have a ceiling effect – making it potentially more likely to result in overdose (it can cause significant respiratory depression) – but it does not cause precipitated withdrawal. At higher doses it may also interact with various psychiatric medications (mostly antipsychotics), especially in patients with long QT intervals on ECG and in rare cases can cause Torsade De Pointes, a cardiac arrhythmia that can be fatal

As with any other medication, the PROGRAM medical provider will need to weigh the benefits and risks of each approach and discuss their recommendations with the patient. For example, buprenorphine is often an easier-to-implement choice as one does not have to wait for the methadone to “wash out” to start maintenance therapy. On the other hand, if a patient was using street methadone as their drug of choice, methadone may be more appropriate as an initial choice, as one does not have to worry about precipitating withdrawal.

Upon obtaining a history and performing a physical exam the medical provider will decide on the appropriate opioid withdrawal management regimen. Although the PROGRAM medical providers should tailor the specifics of the protocols below to the needs of an individual patient, these protocols are typical examples for opioid withdrawal management.

Buprenorphine Withdrawal Management

Generally, a combined buprenorphine/naloxone sublingual product should be used (e.g., brand: Suboxone), as this mitigates diversion risk. However, in certain cases (e.g., pregnancy, documented naloxone allergy), buprenorphine-alone (e.g., brand: Subutex) can be used. When to begin buprenorphine induction depends upon a number of factors including:

- 1) Type of opioid patient has been using (i.e., long vs. short-acting). This can be based upon patient self-report and confirmed to some extent by the initial toxicology testing performed at intake.
- 2) Withdrawal Symptoms – Ideally the patient should be in the early stages of opioid withdrawal (COWS greater than 8) when the first dose of buprenorphine is administered.

As a rule, waiting 16-24 hours after a patient's last use of opioids should avoid inducing precipitated withdrawal when buprenorphine is started. However, buprenorphine can be started earlier based on withdrawal symptoms and clinical judgment.

COWS scores will be done q shift. If at any point the COWS score is greater than 23 the patient will be transferred to a higher level of care. If a patient appears over-sedated or blood pressure or pulse is low, the opioid medication dose may be withheld at the discretion of the medical provider. Likewise, if the patient experiences changes in mental status from baseline they will be transferred to a higher level of care.

Once the COWS score reaches at least 8:

1. Give buprenorphine 2-4mg sublingually
2. Re-assess COWS in 1-2 hours.
3. If significant withdrawal signs/symptoms still present, give buprenorphine 2-4mg sublingually.
4. Repeat steps 2 and 3 every 1-2 hours until patient is no longer experiencing significant withdrawal, patient begins to experience side effects of buprenorphine (e.g., sedation, dizziness, low blood pressure), or maximum dose for day 1 of 16mg is reached.
5. On day 2, assess whether withdrawal signs/symptoms are well -controlled. If so, give total buprenorphine dose for day 1 as maintenance dose. If not, give total dose for day 1 + 2-4mg additional dose and assess COWS in 3-4 hours. If significant withdrawal signs/symptoms still present, give additional 2-4mg.
6. Repeat step 5 until patient is no longer experiencing significant withdrawal, patient begins to experience side effects of buprenorphine (e.g., sedation, dizziness, low blood pressure), or maximum dose for day 2 of 24mg is reached.
7. On day 3, give total buprenorphine dose for day 2 as maintenance dose. *For most patients, withdrawal and craving should be well-controlled by 16mg of buprenorphine daily, though some will need as much as 24mg. It is rare that patients will need higher doses than 24mg, but medical providers will use clinical judgment over time to assess whether some patients need doses higher than 24mg to manage cravings, up to a maximum daily dose of 32mg.

Once patients are stabilized on a maintenance dose and are comfortable in terms of withdrawal signs/symptoms and cravings, the medical provider and the clinical team should use a shared decision-making approach to engage the patient in a discussion about what MAT option is best for the patient at that time, i.e., remaining on buprenorphine, transitioning to methadone, or transitioning to long-acting naltrexone injection. Patients can also choose to taper off MAT, though patients choosing this option should be educated about the risks of this approach, including but not limited to overdose.

For patients who decide to taper off buprenorphine for any reason (i.e., they refuse MAT; they request methadone induction; they request long-acting naltrexone induction), the following buprenorphine taper protocol can be used, after slowly tapering to 8-12mg:

Day 1 – Buprenorphine 8-12 mg sublingually

Day 2 – Buprenorphine 8 mg sublingually

Day 3 – Buprenorphine 6 mg sublingually

Day 4 – Buprenorphine 4 mg sublingually

Day 5 – Buprenorphine 2 mg sublingually

Day 6 – No buprenorphine

Methadone Withdrawal Management

For PROGRAMs that are able to use methadone for withdrawal management due to their certification and/or a relationship with a community OTP, a medical provider may use methadone as the initial withdrawal management medication for opioid use disorder. When to begin methadone induction depends upon a number of factors including:

- 1) Type of opioid patient is using (long vs. short-acting). This can be based upon patient self-report and confirmed to some extent by the initial point-of-care drug testing performed at intake.
- 2) Withdrawal Symptoms – Methadone can treat withdrawal symptoms, though the patient does not need to be in withdrawal when the first dose of methadone is administered.
- 3) As a rule, waiting 16-24 hours after a patient's last use of opioids should avoid over-sedation when methadone is started.
- 4) Methadone 10-20mg should be given on induction, depending on the severity of withdrawal, the amount of recent opioid use, and other factors such as medical comorbidities that would necessitate a lower initial dose. After 2 hours, the patient should be re-assessed for signs/symptoms of opioid withdrawal and side effects of methadone (e.g., sedation, dizziness, low blood pressure), and an additional 5-10mg of methadone can be given. It should be noted, however, that the maximum dose on the first day should be methadone 30mg daily to avoid inducing over-sedation or respiratory depression, unless patient has documentation that they have been receiving a higher dose of methadone daily from an OTP. In addition, if the patient appears over-sedated, if the blood pressure is less than 90/60, or the pulse is less than 55, the dose of methadone will be held until the patient's condition normalizes.
- 5) On day 2, the patient will be re-assessed and the methadone dose can be increased as tolerated and necessary to control withdrawal symptoms in 5-10mg increments. However, the maximum does for day 2 should not exceed 40mg of methadone.
- 6) For patient who choose to be stabilized on methadone maintenance as MAT, dose titrations above 40mg will be managed at/by an OTP.

For patients tapering off of methadone, the following is the suggested methadone taper protocol. Although the PROGRAM medical provider may tailor the specifics of the protocol below to the needs of

an individual patient, this fixed dose protocol is a typical of approach to opioid withdrawal management using methadone.

Day 1 – Methadone 30 mg orally in 2 divided doses

Day 2 –Methadone 25 mg orally

Day 3 – Methadone 20 mg orally

Day 4 – Methadone 15 mg orally

Day 5 – Methadone 10 mg orally

Day 6 – Methadone 5 mg orally

Non-opioid Withdrawal Management

Some individuals may choose and be appropriate for induction on long-acting naltrexone injection on initial presentation. These individuals will need to be opioid-free for 7-10 days to avoid risk of protracted opioid withdrawal, and up to 14 days for long-acting opioids (e.g., methadone). Others may request opioid-free withdrawal management for other reasons. For these individuals, aggressive use of ancillary withdrawal medications – often with standing orders – is often necessary to ensure patient comfort and retention in care. See below for ancillary medications.

Ancillary Medications

When treating withdrawal for opioid use disorder, ancillary medications are often indicated to provide symptomatic relief. Several of these are listed below, but others may be utilized as appropriate by PROGRAM medical providers as indicated.

Multiple symptoms – Clonidine (with hold parameters for blood pressure and pulse, maximum daily dose = 1-1.2mg)

For insomnia – Trazodone, hydroxyzine, mirtazapine, clonazepam*

For Nausea and Vomiting – Ondansetron, metoclopramide

For Abdominal Cramps – Metoclopramide, dicyclomine

Diarrhea – Bismuth subsalicylate, loperamide

Headaches – Ibuprofen, acetaminophen

Anxiety – Gabapentin, hydroxyzine, mirtazapine, clonazepam*

Nicotine withdrawal – Patients with tobacco use disorder or nicotine dependence will be offered nicotine replacement therapy to prevent nicotine withdrawal while they are at the program and unable to use tobacco products, even if they are not willing to consider long-term tobacco cessation.

*Benzodiazepines should generally not be started for patients with opioid use disorder in the program, especially for patients on opioid agonist medications. However, for patients with psychiatric and/or withdrawal-related symptoms that are not adequately controlled with primary withdrawal management medications, as well as patients undergoing non-opioid withdrawal management (e.g., prior to long-acting naltrexone induction), temporary benzodiazepine use can help to keep patients comfortable and retain them in care. Benzodiazepines should be tapered to discontinuation prior to discharge whenever possible.

Care Transition Planning

Please see other relevant policies and protocols for how discharge and transition to continued community care will be managed in each OASAS 820 program.

All patients with opioid use disorder – as well as other substance use disorders such as cocaine/stimulant use disorder – will be provided with overdose prevention education and a naloxone kit prior to discharge.

Benzodiazepine Withdrawal Management Protocols for OASAS 820 Program A

Benzodiazepines, of which alprazolam (brand: Xanax) is the most prevalently (and potentially the most dangerous) misused drug, are central nervous system depressants. Once tolerance has developed, there is a significant probability for a potentially life-threatening withdrawal syndrome should the drug be abruptly stopped.

It is important to realize that the time-frame of withdrawal corresponds to the half-life of the drug, with shorter half-life drugs (e.g., alprazolam) resulting in peak (and often more severe) withdrawal symptoms after about 5 days of abstinence while with clonazepam, such symptoms can take up to 3 weeks to develop. This “lag time” between discontinuing medication and withdrawal symptoms is important to keep in mind when monitoring patients over time for withdrawal symptoms.

The safest approach to detoxification from benzodiazepines is to prevent significant withdrawal symptoms from occurring, rather than wait for them to develop and “chase” the symptoms. As with alcohol withdrawal, the greatest concerns are delirium tremens and withdrawal seizures, outcomes that can generally be successfully avoided if a slow and controlled taper is used.

In OASAS 820 treatment programs, it is recommended to use the CIWA-B to determine whether a patient is appropriate for our level of care, though the CIWA-Ar can also be utilized given the similarities between alcohol and benzodiazepine withdrawal. It is recommended to only consider managing patients with mild or moderate withdrawal. Due to the risk of delirium, withdrawal seizures and other complications, those with scores indicating severe or very severe withdrawal will be sent for treatment at a hospital offering medically managed withdrawal management.

The choice of benzodiazepine withdrawal management protocols is a complex one, governed by the premise that the goal is to perform the safest and most comfortable withdrawal management possible. Both undermedication and overmedication are problematic. If a patient is undermedicated, one risks the possibility that the patient may progress to severe withdrawal and/or seizures. On the other hand, overmedication can lead to over-sedation, which can result in dangerous behavior as well as falls and other traumatic injuries.

Any protocol must be adjusted to the specific needs of the patient based upon an assessment of the degree of withdrawal, as well as the results of a thorough medical and psychiatric history and physical exam conducted by an experienced member of the medical staff. Treatment protocol choices will be impacted by medical and psychiatric comorbidities such as diabetes, anxiety, or a history of withdrawal seizures. Laboratory results may also suggest one approach as opposed to another (e.g., significant electrolyte abnormalities may increase the risk of complications and such patients should undergo treatment in a hospital-based treatment program).

For 820 treatment programs, with limited on-site medical staff, both patient selection and the protocols employed must work given our scope of practice. As freestanding treatment centers that are not located within a hospital, it is recommended that OASAS 820 treatment programs perform ancillary withdrawal management only with those patients unlikely to require a higher level of care (e.g., those not requiring IV therapy and those with mild or moderate withdrawal symptoms unlikely to warrant

admission to a hospital and/or ICU during withdrawal management). In addition a LOCADTR 3.0 will be completed to document medical necessity for the level of care, as specified in other facility policies and protocols.

Exclusionary Criteria

Although we have the ability to manage withdrawal in many of the patients presenting to OASAS 820 treatment facilities, our goal is always to err on the side of safety, admitting for treatment only those patients most likely to receive benefit and least likely to experience complications that would require inpatient hospital admission. Our exclusionary criteria include:

- 1) Coexisting acute or chronic illness requiring inpatient treatment (e.g., unstable angina, uncontrolled diabetes)
- 2) Current severe withdrawal (CIWA-Ar greater than 15 or CIWA B greater than 40), especially with delirium
- 3) Pregnancy
- 4) History of severe uncontrolled withdrawal seizures
- 5) Unstable mental health problems and/or increased suicide/self-harm or violence risk
- 6) Polysubstance Use and Withdrawal – For example, a patient withdrawing from opioids and benzodiazepines would often not be a good candidate for ancillary withdrawal management due to the risk of respiratory or neurological compromise while trying to arrive at stabilizing doses of medication. On the other hand, a patient requiring withdrawal from benzodiazepines who also uses cocaine or cannabis could be considered for withdrawal management, as the withdrawal syndrome from such drugs is not life-threatening.

Patients excluded from withdrawal management at an OASAS 820 treatment program based upon the criteria above will be transported by ambulance to a local hospital.

Benzodiazepine 2-week Withdrawal Management Protocol

The best approach is benzodiazepine withdrawal management is to perform a slow taper. Although one can take months to taper this class of drug, generally a 2-week taper is sufficient to ensure patient comfort and safety. A typical approach to benzodiazepine taper is shown below although actual doses and schedules will vary at the discretion of the prescribing medical provider.

- 1) The patient's current dose of benzodiazepines is converted to an equivalent dose of diazepam or clonazepam, both long-acting benzodiazepines, by utilizing a benzodiazepine equivalents chart such as this (<http://emedicine.medscape.com/article/2172250-overview?pa=GdeGibEF2GyYQvMHil378qhsCYTXDw%2Byriw76iyNml2wAHGSu3%2Fid%2F0QWaC6REx8VrJxKJt4DRD8mxYr6kYfOw%3D%3D>)

For example, if a patient is taking alprazolam 8 mg/day, the equivalent dosage of diazepam would be 40-60 mg/day or clonazepam 4 mg/day. Although both diazepam and clonazepam are effective, clonazepam may be a better choice in most cases as its side-effect profile is somewhat better than diazepam (which can cause more disorientation due to active metabolites). However, in cases where the risk of seizure is higher (based upon patient history, or the amount and duration of benzodiazepine use), one may use diazepam as there is more evidence supporting its use in this regard. The recommended starting dose is 70% of the dose the patient has been using with a maximum of clonazepam 4 mg/day or diazepam 60 mg/day. Doses will be adjusted as needed for agitation or over-sedation.

- 2) On Day 1 and 2, the dose of clonazepam or diazepam calculated above will be given in 3 divided doses. In the example cited,

Day 1/Day 2 – Clonazepam 1 mg 3x/day or Diazepam 10 mg 4x/day

Day 3/Day 4 - Clonazepam 2.5 mg/day (in 3 divided doses) or Diazepam 25 mg/day (in 3 divided doses)

Day 5/Day 6 - Clonazepam 2 mg/day (in 3 divided doses) or Diazepam 20 mg/day (in 3 divided doses)

Day 7/Day 8 - Clonazepam 1.5 mg/day (in 3 divided doses) or Diazepam 15 mg/day (in 3 divided doses)

Day 9/Day 10 - Clonazepam 1 mg/day (in 2 divided doses) or Diazepam 10 mg/day (in 2 divided doses)

Day 11/Day 12 - Clonazepam .5 mg/day or Diazepam 5 mg/day

Day 13/Day 14 - Clonazepam .25 mg/day or Diazepam 2 mg/day

The above is just a suggested protocol. It is up to the discretion of the medical team to make adjustments in medication dosages depending upon both the objective and subjective symptoms exhibited by the patient.

Although this approach results in fairly good treatment of physical withdrawal symptoms (e.g., increased heart rate or blood pressure), psychiatric symptoms such as insomnia or anxiety (often with panic attacks) may recur as the taper continues. Therefore, it will likely be necessary to aggressively treat psychiatric symptoms with ancillary agents, such as mirtazapine, trazodone, gabapentin, propranolol, etc.

Please see other relevant policies and protocols for how discharge and transition to continued community care will be managed in each OASAS 820 program.