

**PROGRAM C
CORE OUTPATIENT SUBSTANCE USE DISORDER TREATMENT
PRACTICE GUIDELINES
ANCILLARY WITHDRAWAL AND STABILIZATION**

Purpose:

To provide safe and effective medication management for symptom relief of abuse, mild to moderate withdrawal, or persistent withdrawal, in the outpatient substance use treatment setting. The goal, whenever possible, should be stabilization on maintenance medications.

Policy:

PROGRAM C substance use treatment programs certified by OASAS to provide treatment services may provide ancillary withdrawal services to those individuals requiring stabilization and/or withdrawal services due to a diagnosis of substance dependence, with the approval of NYS OASAS and in accordance with their DEA license.

Ancillary withdrawal and stabilization services will include pre-admission screening, a comprehensive assessment, recovery planning, medication administration or prescribing, medication management, aftercare planning, and referral / linkage with appropriate medical and counseling services consistent with the individual's stated desires as reflected in their recovery plan.

- A prescribing professional (physician, physician assistant, or nurse practitioner) as well as nursing and counselor staff will be readily available during hours when the ancillary withdrawal service is functioning.
- All patients will be provided with an emergency number through which they can reach a member of the program staff 24/7. Patients needing to be immediately seen during off-hours will be referred to the nearest PROGRAM C hospital emergency room or CPEP unit for assessment.

All substance use treatment programs have a quality assurance system in place to review incidents and untoward events as well as monitor key outcome indicators such as patient compliance and retention. Program based QA activities and data are then passed to the Behavioral Health QA and incident review process and ultimately to the larger hospital systems. Special indicators will be established and collected to monitor the flow of patients into ancillary withdrawal services, retention in the service, and program outcomes.

Procedures:

Admission Paths

Patients may access outpatient ancillary withdrawal services by:

1. Direct admission, including walking in
2. Transfer from an inpatient service
3. Referral from an outpatient substance use treatment or mental health treatment program
4. Referral from an emergency room
5. Referral from other medical / psychiatric service

Admission Criteria

- All admissions are to be voluntary in nature and individuals being admitted will be required to give their informed consent
- All individuals admitted must have a diagnosis of substance dependence which supports the medical necessity of treatment
- All individuals admitted must be:
 - Experiencing mild to moderate withdrawal as measured by standardized withdrawal evaluation instruments; OR
 - At risk of experiencing mild to moderate withdrawal as determined by a review of the individual's drug use and treatment history and clinical judgment; OR
 - Have been stabilized on an inpatient unit and then transferred to a lower level of care in accordance with need and long term treatment goals
- All individuals admitted must be determined to be free of acute medical and/or acute psychiatric comorbidities which may interfere with the treatment being provided. Pregnant women should be given priority admission. A readiness assessment and level of care determination will be completed at the time of application to establish the appropriateness of providing stabilization and withdrawal service on an ambulatory basis (including using the LOCADTR 3.0).

Exclusion criteria:

- Co-occurring medical conditions if that interferes with treatment
- History of previous delirium tremens or withdrawal seizures
- No capacity for informed consent
- Being actively suicidal/homicidal and/or psychotic symptoms that may interfere with treatment

Admission Process

All individuals requesting ancillary withdrawal services, with the exception of those requiring inpatient level of care, will be screened as per PROGRAM C's pre-admission screening process utilizing a Pre-Admission Assessment Form and a Pre-Admission Decision Form. This process will identify the reason the individual is seeking services, determine the severity of dependency and potential severity of withdrawal, review the individual's past treatment history, and determine whether the individual has any co-occurring disorders that may negatively impact treatment. This information will then be used to establish a diagnosis / medical necessity, determine the appropriate level of care, and ensure that the individual will be admitted in accordance with applicable admission criteria. A safety risk assessment will also be completed prior to admission.

- Individuals deemed appropriate for admission will sign an informed consent and be informed that admission is voluntary. 42 CFR Part 2 confidentiality regulations will also be explained and the individual will be provided a copy of the rules and responsibilities.

Patients will be scheduled for admission during regular program hours Monday through Friday. Patients being transferred from an inpatient withdrawal and stabilization unit may also be accepted if provider is on unit.

Once it has been determined that the individual is appropriate for ancillary withdrawal the admission process will begin. This process will include:

- Completion of the Health Status / Functional Assessment
- Completion of the Medical Evaluation & Physical Exam
- Ordering or reviewing of labs, including
 1. Urine toxicology / breathalyzer
 2. Hepatitis B & C screening
 3. HIV screening
 4. PPD / chest x-ray (as per OASAS guidelines)
 5. Pregnancy test (women)
 6. Other lab work, (i.e. serum magnesium levels, EKG, PT/PTT, Comprehensive Chemistry Profile & LFT's, CBC differential & platelets) as clinically appropriate
- PMP check
- Offer of appropriate vaccines including Pneumovax, Influenza, and Hepatitis
- Assessment of overdose risk, provision of overdose risk reduction education, and offer of naloxone kit

For individuals being transferred from an inpatient or emergency service, their treatment record will be reviewed.

Once the above steps are completed, the Outpatient Admission / Initial Recovery Aftercare Plan will be completed for all individuals being admitted. As part of this process, a primary counselor will be assigned, initial orientation provided, an initial schedule and appointments set, and a preliminary treatment / aftercare plan established. The individual will then be started on the appropriate protocol.

Treatment Process

During the assessment and stabilization phase, a comprehensive assessment will be completed utilizing the Chemical History, Treatment & Use Profile), the Psychiatric Screen / Mental Status the Psycho-Social-Cultural Assessment and the Wellness & Behavioral Risk Assessment

Individuals being transferred from an inpatient withdrawal and stabilization unit may have recent assessments available for review by the ancillary withdrawal service.

Based on clinical assessment and patient preference, all patients will be initially assigned to one of three treatment tracks. This will be reassessed throughout the course of treatment with the goal of most patients entering long-term stabilization and maintenance.

1. Short Term Stabilization and Withdrawal Management

a. Target Population:

Individuals seeking short-term treatment to manage acute withdrawal symptoms and not interested in longer medication assisted treatment or counseling services

Individuals seeking induction onto medication assisted treatment with anticipated referral to or return to a community provider (i.e. PCP or General Psychiatrist)

b. Treatment Expectations:

Length of Treatment is anticipated to be 7-14 days

Individuals will generally be seen daily to monitor response to treatment and will be seen by medical staff during each program visit for medication management / monitoring to ensure a safe and comfortable withdrawal. This monitoring will include:

- Vital signs
- Completion of Withdrawal Assessment Instruments

- Toxicology testing in accordance with clinical judgment
 - Minimal expectation of participation in counseling services.
 - Assessments are to be completed during the second program visit.
2. Mid-Term Stabilization and Withdrawal Management
- a. Target Population:
Individuals seeking longer term assistance with management of acute withdrawal and assessed as likely to benefit from in a longer-term gradual taper
 - b. Treatment Expectations:
Length of Treatment anticipated to be greater than 14 days
Individuals may be seen daily or less frequently based on clinical assessment and will be seen by medical staff during each program visit for medication management / monitoring to ensure a safe and comfortable withdrawal. This monitoring will include:
 - Vital signs
 - Completion of Withdrawal Assessment Instruments
 - Toxicology testing in accordance with clinical judgment, but no less than weekly
 - Assessments are to be completed within the first 7 days of treatment.
3. Stabilization to Maintenance Medication Assisted Treatment
- a. Target Population: Individuals initiating medication assisted treatment with the goal of stabilizing on a maintenance dose and engagement in care
 - b. Treatment Expectations
Length of stay greater than 30 days
Participation in the outpatient treatment program as determined in the initial treatment plan
- The complete outpatient assessment process is to be followed and must be completed within 14 days of admission.

Any clinical signs of worsening symptoms will be reevaluated by a medical professional to assess for appropriate level of care.

Based on the comprehensive assessment, an Individualized Recovery Plan shall be established for each individual.

- The Outpatient Admission / Initial Recovery Aftercare Plan established upon admission will suffice for individuals admitted for rapid / short term withdrawal management. If additional issues are identified during the assessment process the plan is to be amended utilizing the Inpatient Initial Recovery / Aftercare Plan Update Form
- The Individualized Outpatient Recovery Plan, consisting of Part A Diagnosis/Issues/Action Plan Part B Educational Needs/Record Part C Initial Goal/Progress Measures and Part D Approvals is to be completed for all long term withdrawal management patients. This process is to be completed within 14 days of admission.

Withdrawal Management Process

In most cases the goal will be stabilization on maintenance medications. When clinically indicated and/or requested by the patient, medication will be provided in accordance with withdrawal management protocols which reflect best clinical judgment and expressed patient desires. See appendix for specific alcohol, buprenorphine and sedative protocols.

- Patients deemed unable to safely handle medications will have medications observed and will not be given prescriptions
 - At the discretion of the program, medication may be given to a member of the patient's immediate household for handling and control purposes.

Once begun, the detox process will be closely monitored through clinical observations by the treatment team, patient self-report, medical indicators, and minimum weekly toxicology testing. Positive toxicology results and objective physical indicators such as blood pressure, temperature, pulse, pupil size, tendon reflexes, fine muscle tremors, and bowel motility may be useful in determining and monitoring the response to lowered dosage levels. Patient self-reporting and subjective symptoms such as restlessness, irritability, sleep disorders; anxiety, depression and drug craving may ultimately have the most utility. Standardized and validated withdrawal scales will be used as appropriate to assist with evaluation. Thiamine and folic acid will be provided for all patients with alcohol use disorder.

Adjustments will be made to dosages and the detox schedule in accordance with the patient's response to dosage reductions in terms of reported cravings and discomfort, identified patient needs, and expressed desires. Adjustment of dosage levels is the responsibility of the program physician; however, as any number of bio-psycho-social factors may influence the tapering process, physicians are strongly encouraged to involve members of the treatment team in making decisions regarding further adjustments.

- Patients who are under-medicated may exhibit signs and symptoms of withdrawal, including dilation of pupils, yawning, sniffles, lacrimation, and chills. Patients may also report the presence of anxiety, insomnia, drug hunger and drug seeking behavior. In such cases, consideration should be given to increasing dosage levels at least temporarily. The use of clonidine and other adjuncts to address the symptoms of withdrawal may also be helpful.
- Patients may complain that their dose is not holding them. In such cases, care must be taken to appropriately identify whether this is related to detox or if other factors are coming into play. The ingestion of other substances, especially alcohol, or barbiturates and other sedative-hypnotics, may increase the metabolism of medications, as might licit drugs taken in response to medical conditions. Environmental changes and other stressors may also affect the metabolism rate of medications, and it may be appropriate to use counseling to identify and resolve causal factors prior to resorting to adjusting medication dosage levels. Consider modification of dosing level and frequency. Staff must be astute enough to recognize when patients who are reporting their dose is inadequate and /or that they are experiencing increased drug cravings are at risk of relapse.

Pharmacological supports may be utilized to reduce cravings and/or address problematic symptomology such as sleep disorders or anxiety which may accompany detox. As the detox process continues, patients should be made aware that their physical discomfort and anxiety will likely increase, and it is incumbent upon staff that patients are treated with ongoing concern, respect, sympathy, and support. In addition to the counseling issues indicated below, counseling should focus on assisting the patient with development of realistic expectations and offering alternative coping skills. Flexibility on the part of the program is essential, as is reassurance and sympathetic ear.

Typical problems faced by patients working on stabilization, and strategies for addressing them, include:

- Drug cravings which can be dealt with by avoiding triggers and high risk situations; utilizing relapse prevention techniques; and the use of stress reduction activities.

- Anxiety over getting off alcohol and drugs, to the point on occasion of a sense of doom, which can be alleviated by relaxation techniques.
- Emotional unsteadiness and sudden mood swings, which may require the temporary intervention of a mental health professional and the use of pharmacological supports.
- Impatience and lack of tolerance, which may require more education regarding the tapering process and assistance with managing stress.
- Withdrawal symptoms, which may not be as severe as heroin withdrawal but will last longer, should be brought to staff attention as they may require dosage adjustments, counseling, pharmacological or alternative interventions.

While in most cases, stabilization is preferred, if a patient requests tapering, during the final stages of tapering, the frequency of counseling should increase as necessary and appropriate and the focus should shift to the solidification of support systems and aftercare planning. Aftercare planning is to begin as soon as the patient begins the tapering process, but plans must be finalized and formal arrangements made as the patient nears attainment of abstinence.

- Patients should also be informed that protracted withdrawal symptoms could persist for 6 to 12 additional months and that medication assisted treatment such as oral naltrexone, long-acting injectable naltrexone (Vivitrol) and acamprosate may prove useful for addressing these.

In the event of a slip or relapse, counseling and/or pharmacologic interventions will be provided. Program medical staff will evaluate the patient for symptoms of withdrawal, assess the level of care, adjust the detoxification schedule as necessary, and consider other pharmacological alternatives. Counselors will review the triggers and response of the patient. The tapering process will also be carefully reviewed in cases where an increase in secondary abuse is noted.

- Opioid dependent patients opting to end their attempt to detox may be built back to a maintenance dose

In addition to the actual detox process, programs will provide a range of supportive services. These services will include education, individual and group counseling, adjunct therapies, supportive activities, and referrals as appropriate.

Education

Basic education will be provided to all patients and include, among other topics:

- The tapering process, including signs and symptoms of withdrawal, relapse warning signs, and methods for coping with the effects of tapering through psycho-social interventions and alternative therapies.
- Overdose prevention
- Harm reduction strategies for high risk behaviors
- Relapse prevention, focused on identifying and avoiding triggers, as well as teaching and reinforcing relapse prevention techniques and effective responses to high risk situations.
- Relaxation and stress reduction techniques and strategies.

Available Services

All patients will have access to basic counseling services which will include:

- Comprehensive Assessment / Staging
- Recovery Planning
- Care management and coordination
- Proactive follow-up of missed visits
- Assistance with development and utilization of support systems
- Aftercare Planning

A variety of supportive services will be available and patients will be encouraged to avail themselves of these opportunities. Adjunct services include:

- Vocational services
- HIV / HCV testing and follow-up care
- Linkage to / coordination of care for co-occurring medical and/or mental health needs

Adjunct counseling services, may address, among other topics:

- Issues surrounding tapering and cravings
- Exploration of sources of anxiety and methods for relief
- Emotional stability
- Patience and anger management
- Reinforcement of lifestyle skills
- Support of self-sufficiency and employment

Aftercare Arrangements/Discharge

All patients will be assessed for aftercare planning needs throughout their course of treatment. Aftercare will be arranged in collaboration with the patient and natural supports of their choosing. At time of discharge an aftercare plan will be provided that is based on patient's strengths, preferences, and goals.

This plan will:

- Provide appropriate arrangements for follow-up counseling and medical care
- Provide a listing of self-help meetings and other community supports
- Prescribe medications as appropriate for post withdrawal symptoms
- Naloxone Kit-in-hand or prescription for one as well as education upon discharge

Documentation Requirements

All medical records will include all pre-admission screening documentation, admission documentation, a comprehensive assessment, a recovery plan, and an aftercare plan. Progress notes will also document individual visits and progress in treatment.

Admission note shall include withdrawal symptoms, medication prescribed, schedule for monitoring visits and other withdrawal symptoms, behavioral issues, as well as the signature, date and time of the admitting physician.

Before any take home medication, including prescriptions, is provided, the physician must document in a note that it has been reasonably determined that the individual has the capacity for medication compliance / safe handling.

All services provided must be in accordance with ancillary withdrawal practice guidelines, the recovery plan established for each individual, and APG documentation requirements.

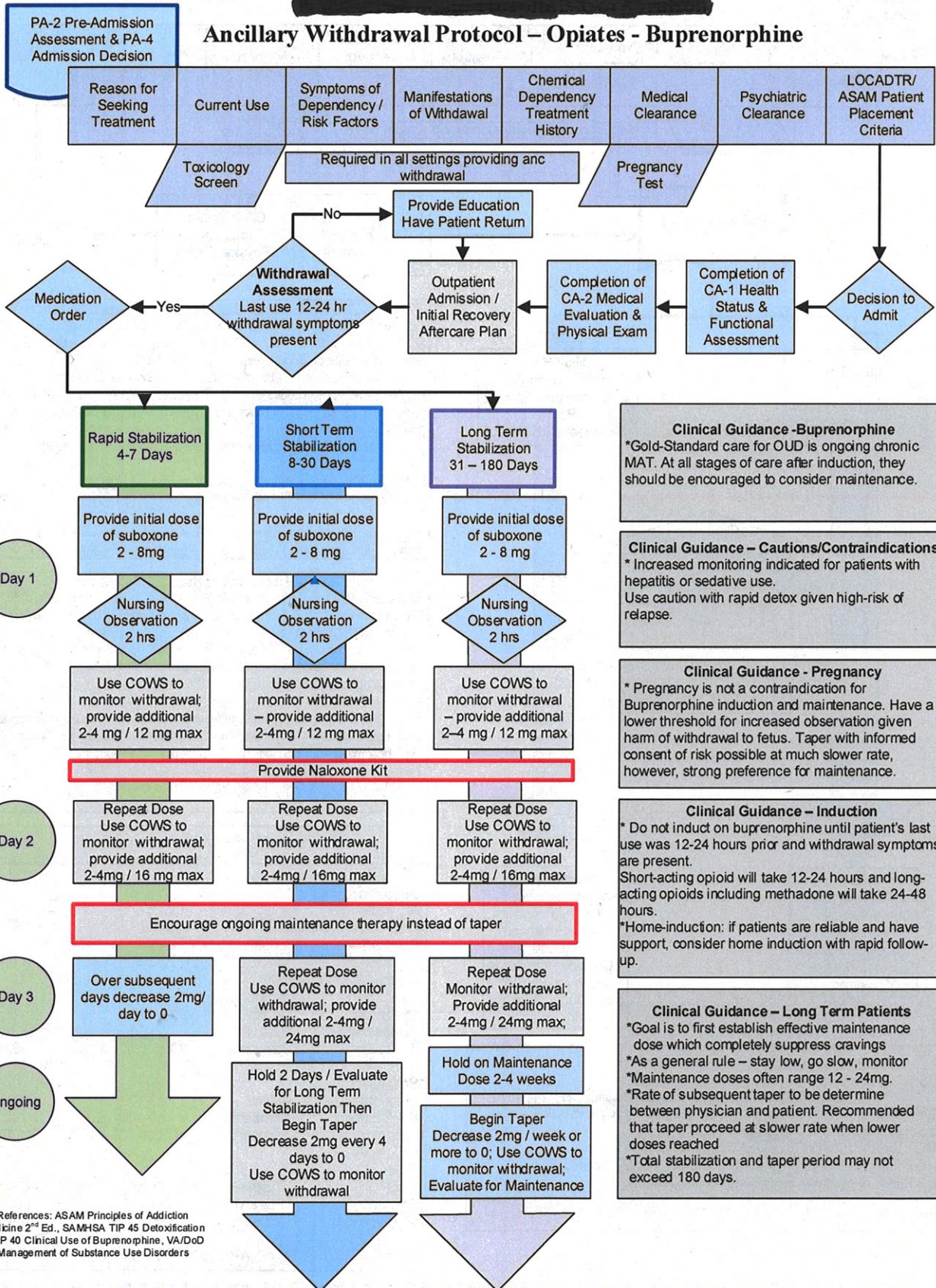
Outcome Measurement / Quality Assurance

Programs certified for ancillary withdrawal services will collect, aggregate and monitor data related to operational issues, outcome measures and quality assurance. These data elements and outcome measures will include:

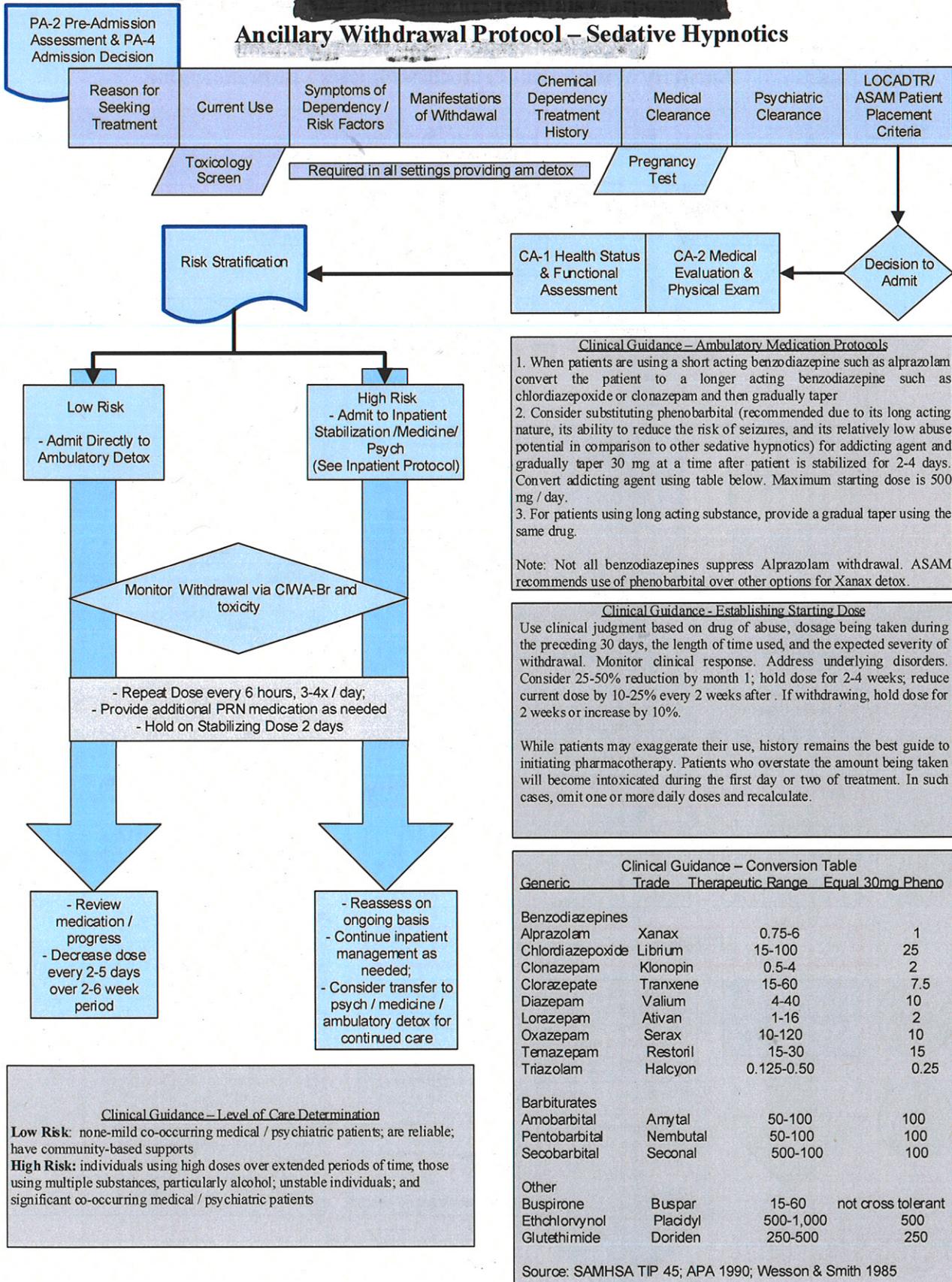
- Primary Problematic Substance
- Referral Source
- Type of Detox (Rapid, Short Term, Long Term)
- Patients leaving AMA / lost to contact
- Rate of Completion
- Continuation in Aftercare Services
- Standardized outcome measures (compliant with TJC requirements)

Appendix

Ancillary Withdrawal Protocol – Opiates - Buprenorphine

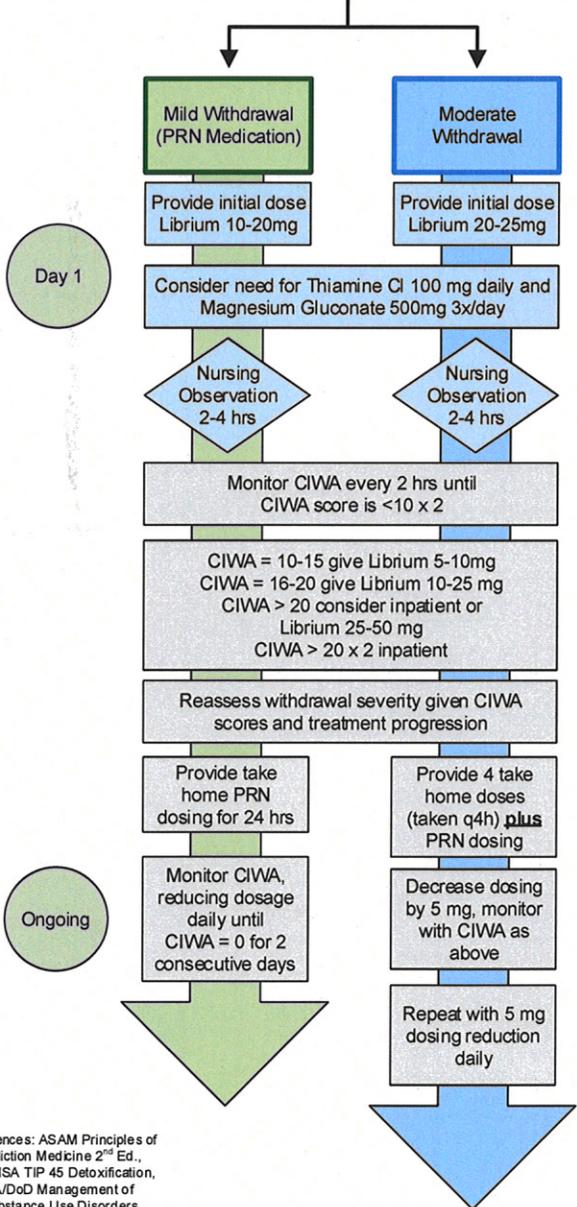
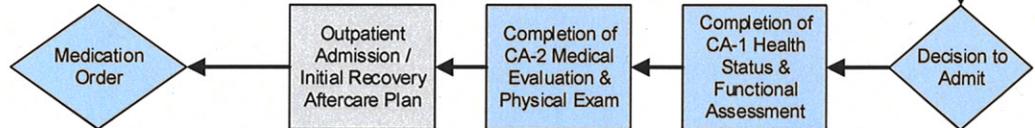
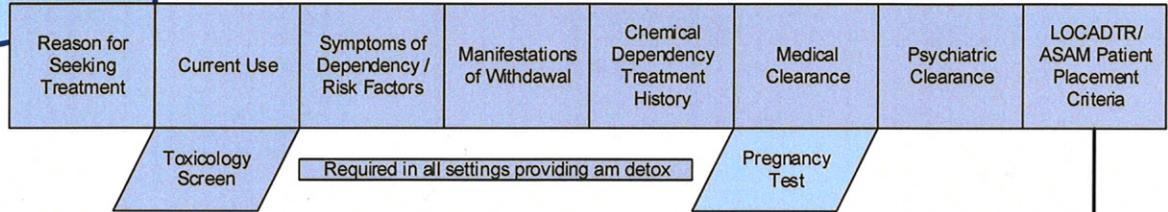


Ancillary Withdrawal Protocol – Sedative Hypnotics



Ancillary Withdrawal Protocol – Alcohol

PA-2 Pre-Admission Assessment & PA-4 Admission Decision



Clinical Guidance – Withdrawal Risk

- * Withdrawal highly individualized. Up to 90% of patients do not progress beyond mild symptoms which typically peak 24-36 hours. In mild cases patients may experience visual, auditory, tactile distortions of perception but sensorium otherwise clear and insight retained
- * In more severe cases misperceptions may develop into visual, auditory or tactile hallucinations, insight may be lost.

Clinical Guidance – Medication

- * CIWA-Ar scores under 10 indicate minimal withdrawal, need for non-pharmacological therapy and monitoring. CIWA-Ar scores between 10-19 indicate mild to moderate withdrawal, need for medication.
- * Medication should be provided to those with history prior seizures and/or significant co-occurring medical conditions,
- * Exercise caution with patients using alcohol and sedative-hypnotics. Tolerance to benzodiazepines may require adjustment of dosage.

Clinical Guidance – Librium Alternatives

Can substitute 2 mg Ativan or 10 mg Valium for 25 mg Librium

Clinical Guidance – Withdrawal Seizures

- * In some instances, withdrawal symptoms can worsen and progress into grand mal seizures or severe life-threatening delirium.
- * Withdrawal seizures usually begin 8- 24 hrs after last drink, correspond to peak withdrawal induced EEG abnormalities, and may occur before BAL returns to 0. Most are generalized major motor seizures and may occur singly or in bursts over a period of one to six hours.
- * Risk of withdrawal seizures increased in patients with prior seizures
- * Concurrent withdrawal from other sedative-hypnotic drugs and repeated episodes of alcohol withdrawal may also increase the risk.

Clinical Guidance – DTs

- * In a small percentage of patients, manifestations may worsen and progress into life threatening delirium, delirium tremens (DTs), which can appear 72 – 96 hours after the last drink.
- * DTs are considered a medical emergency requiring immediate attention. DTs are marked by pronounced signs of withdrawal including tachycardia, tremor, diaphoresis, fever, global confusion, disorientation, separate psychic reality, hallucinations with no insight, increased psychomotor activity, and severe disruption of sleep
- * Consider need for transfer to alternative levels of inpatient care.

Clinical Guidance – Aftercare

Consider use of Naltrexone / Vivitrol / Acamprosate

References: ASAM Principles of Addiction Medicine 2nd Ed., SAMHSA TIP 45 Detoxification, VA/DoD Management of Substance Use Disorders

[REDACTED]