

**SUMMARY**

**DECISION SUPPORT**

**PATIENT EDUCATION/SELF MANAGEMENT**

**GOALS**

- Reduce Substance Use Disorder (SUD) related morbidity and mortality.
- Equip patients with tools, techniques, and treatments necessary to successfully manage their addiction.
- Ensure continuity of care while incarcerated and when reintegrating into the community when leaving the California Department of Corrections and Rehabilitation (CDCR).

**ALERTS**

- If opioids are required for acute pain management, patients on methadone, buprenorphine/naloxone or naltrexone may require transfer to a triage and treatment area (TTA) or hospital, as medically indicated.
- Individuals leaving prison are at high risk for overdose-related harms, therefore everyone will be offered naloxone upon release.
- Pregnant patients with SUD/Opioid Use Disorder (OUD) require specialist management. (See [CCHCS Care Guide: MAT for OUD in Pregnancy](#))
- Recognizing signs of withdrawal and supporting relapse prevention is a shared responsibility with the entire treatment team. (See [CCHCS Care Guide: Intoxication and Withdrawal](#))

**SCREENING**

- The treatment team is multidisciplinary, and team members have unique roles and responsibilities in delivering major components of the program including screening, assessment, treatment, monitoring and transitional services (see [page 2](#)).
- The first question in the National Institute for Drug Abuse (NIDA) Modified ASSIST (NM-ASSIST) screens for SUD.
- Affirmative answers in the first question will trigger completion of questions two through eight, which will be referred to as “brief assessment”. (See assessment section below)
- For details see [page 4](#) and [Attachment A](#).

**ASSESSMENT**

- Assessment provides additional risk stratification using the NM-ASSIST and/or a multidimensional assessment developed by the American Society of Addiction Medicine (ASAM) that provides a common language for a holistic, biopsychosocial assessment that is used for service planning and treatment – known as the ASAM Criteria (see [page 4](#) and [page 9](#)).
- Motivational Interviewing techniques may assist with obtaining accurate assessments (see [page 6](#)).
- Diagnostic coding can be derived from 2 differing systems – DSM-5 and ICD-10 (see [page 8](#)).
- Primary Care Providers (PCP) will integrate SUD treatment into their overall patient care plans.

**TREATMENT**

Comprehensive treatment utilizes behavioral, pharmacologic and/or housing modalities to stabilize an individual. These treatment modalities may be utilized individually or in combination based on patient need and consent.

- Patients are responsible for their own recovery. The treatment team should work to provide all the evidence-based approaches that increase their chance at success.
- Behavioral treatment begins with motivational interviewing techniques and a therapeutic relationship with one’s care team and may include Cognitive Behavioral Intervention (CBI), Cognitive Behavioral Therapy (CBT) and peer support.
- Supportive Housing provides designated space where patients can be active participants in their own and each other’s recovery and where they share responsibility for therapeutic interactions among the community and staff. Studies find that participants in such therapeutic communities reduce substance abuse, criminal behavior, and mental health symptoms.
- Pharmacological treatment (MAT) is available for patients with OUD or Alcohol Use Disorder (AUD). If considered a candidate for MAT based on assessment findings, the patient will be started on MAT after signed consent.

**MONITORING**

- Follow-up appointments for patients on MAT are scheduled according to medication and duration of stability (see [page 16](#)).
- Urine drug screens (UDS) are used to monitor MAT adherence and performed randomly at defined intervals (see [page 18](#)).
- Annual labs and other diagnostic tests (e.g., EKG for patients on Methadone) should be done as recommended (see [page 16](#)).
- Follow-up appointments for patients with SUD, but not on MAT, will be based on other clinical conditions.
- Key performance indicators for institution and providers are included on the [ISUDT Dashboard](#).

**TRANSITION SERVICES**

- Transition services will be provided for those patients who are part of the ISUDT Program at the time of release in order to facilitate their ongoing treatment and recovery without interruption. See [page 20](#) for more details.
- A 30-day supply of medication (MAT) are dispensed at time of release. See [page 20](#).

Questions: [MAT@cdcr.ca.gov](mailto:MAT@cdcr.ca.gov)

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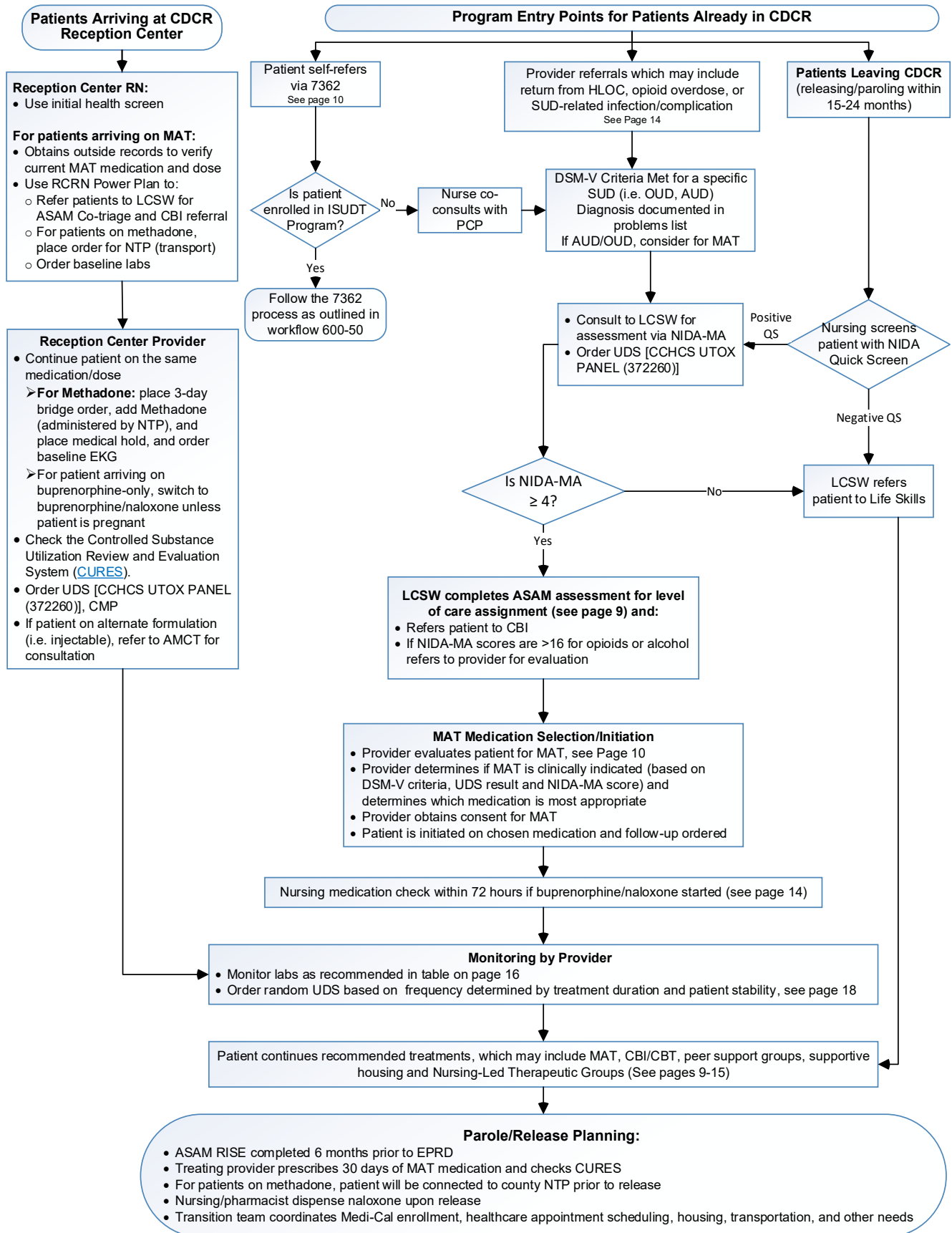
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*Information contained in the Care Guide is not a substitute for a health care professional's clinical judgment. Evaluation and treatment should be tailored to the individual patient and the clinical circumstances. Furthermore, using this information will not guarantee a specific outcome for each patient. Refer to "Disclaimer Regarding Care Guides" for further clarification: <https://cchcs.ca.gov/clinical-resources/>*

SUMMARY		DECISION SUPPORT		PATIENT EDUCATION / SELF-MANAGEMENT		
ISUDT PROGRAM						
Team Composition and Roles						
<p>The ISUDT Treatment team is multidisciplinary and composed of staff positions within California Correctional Health Care Services (CCHCS), the Division of Rehabilitative Programs (DRP) and the Division of Adult Institutions (DAI). Each team member has unique roles and responsibilities in delivering major components of the program including screening, assessment, treatment, and transitional services that support the patient. Sometimes the roles vary depending on where the patient is in their incarceration lifecycle. There are other staff who play important roles for patients; however, this table focuses on new positions and/or specific functions related to the ISUDT program.</p>				Population		
				EPRD 15 to 24	Already Here	Arrive on MAT
Team Member	Roles					
<b>Reception Center Registered Nurse (RN)</b>	<ul style="list-style-type: none"> <li>Initial health screening for patients that are new arrivals</li> <li>Release of information (CDCR 7385) to confirm medication/dosage</li> <li>If on MAT, notify Primary Care Team</li> <li>Referrals to Licensed Clinical Social Worker (LCSW) and AMCT</li> <li>For Methadone order Narcotic Treatment Program (NTP) (transport) see <a href="#">page 13</a></li> <li>Orders baseline labs per protocol</li> </ul>				X	X
<b>Primary Care Team Licensed Nursing Staff</b>	<ul style="list-style-type: none"> <li>Completes the NIDA Quick Screen, refers to Life Skills if negative</li> <li>If screen is positive, refers to LCSW for NIDA-Modified ASSIST</li> <li>Triage 7362</li> <li>SUD-related nursing patient care visits</li> <li>Co-consultations on SUD-related 7362 visits</li> </ul>		X	X		
<b>LVN Care Coordinators</b>	<ul style="list-style-type: none"> <li>Completes the post-induction medication checks (including COWS) at Basic institutions</li> </ul>		X	X		X
<b>Resource RN</b>	<ul style="list-style-type: none"> <li>Coordinates all transitions between Primary Care Teams (PCT), jails, counties, parole, and probation utilizing the ASAM Re-Entry Interview Script Enhancement (RISE) assessment completed by the LCSW.</li> </ul>		X	X		
<b>Supervisory Nurse</b>	<ul style="list-style-type: none"> <li>Oversees program components for Whole Person Care</li> </ul>		X	X		X
<b>Support Staff</b>	<ul style="list-style-type: none"> <li>Provides support to nursing staff in various programmatic roles</li> </ul>		X	X		X
<b>Licensed Clinical Social Workers (LCSW)</b>	<ul style="list-style-type: none"> <li>Assess patients with earliest possible release date (EPRD) of 15 to 24 months using ASAM</li> <li>Assess patients with SUD using NM-ASSIST and ASAM</li> <li>Assess patients arriving on MAT using ASAM</li> <li>Provide cognitive behavioral therapy (CBT)</li> </ul>		X	X		X
<b>Alcohol and Other Drug Counselors</b>	<ul style="list-style-type: none"> <li>Conducts group CBI sessions that help get to the root of addiction</li> <li>Helps provide insight into the patient's recovery while participating in CBI</li> </ul>		X	X		X
<b>Correctional Counselors (CC-III)</b>	<ul style="list-style-type: none"> <li>Case manage patients toward their goals in rehabilitation</li> <li>Assist with developing relapse-prevention plans</li> <li>Provide counseling, assign job skills training, and encourage education</li> </ul>		X	X		X
<b>Addiction Medicine Central Team (AMCT)</b>	<ul style="list-style-type: none"> <li>Provide consultation and technical support for PCP and Mental Health (MH) providers</li> <li>Review Alternative Agent Authorization (AAA) requests</li> </ul>		X	X		X
<b>Primary Care Providers (PCP)</b>	<ul style="list-style-type: none"> <li>Identify SUD-related complications, evaluate and initiate for MAT services</li> <li>Manage and monitor integrated SUD services as part of the Complete Care Model (CCM)</li> <li>Continue motivational interviewing to encourage initial and ongoing participation</li> <li>Discharge planning to include MAT Prescriptions</li> <li>Methadone bridge orders at reception and inter-facility transfers to ensure continuity of care</li> <li>Refer to LCSW for SUD assessment</li> <li>Consult with AMCT or institution Champion as needed</li> </ul>		X	X		X
<b>Pharmacists</b>	<ul style="list-style-type: none"> <li>Process and ensure appropriate MAT orders</li> <li>Assure prescriber X-waivers for buprenorphine orders</li> <li>Assists with medication reconciliation (transfers)</li> <li>Fills and dispenses 30-day medication supply upon release</li> <li>Arranges Naloxone on release via standing order</li> </ul>		X	X		X
<b>Dentists</b>	<ul style="list-style-type: none"> <li>Identify, evaluate and treat dental complications due to SUD</li> </ul>		X	X		X

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**SUBSTANCE USE DISORDER TREATMENT ALGORITHM**



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**PATIENT SCREENING**

**Screening and Assessment Tools**

For the purposes of evaluation and treatment in CDCR we will use the following definitions:

**Screening:** Screening is a process for evaluating the possible presence of a particular problem. The outcome is normally a simple yes or no. For this we will be using the first question on the NIDA Modified ASSIST (NM-ASSIST), which addresses the use of alcohol, prescription drugs for non-medical reasons, and illegal drugs within an individual’s lifetime.

**Brief Assessment:** Brief Assessment is a process for determining a diagnosis and risk severity. For this we will be using the full NM-ASSIST.

**Comprehensive Assessment:** Comprehensive Assessment is used for developing specific treatment recommendations and determining the appropriate level of care for those services to take place. Depending on the stage of program entry or nearing release from prison, we will be using the ASAM Co-Triage, ASAM Continuum, or the ASAM RISE.

**PATIENT ASSESSMENT**

Used For	Instrument	# of Items	Scoring
Screening for SUD	NIDA Modified Assist Screen (See Attachment A)	First question for substances used within lifetime	Any “Yes” responses, proceed to Brief Assessment
Assessment of Risk Related to Specific Substances	NIDA Modified Assist (See Attachment B)	8 questions repeated for 10 substances	Substance Involvement scores 0-3 = Lower Risk; 4-26 = Moderate Risk; ≥ 27 = High Risk
Multi-Dimensional Assessment for Service and Treatment Planning	ASAM Co-Triage	Assesses 6 major life areas impacting a patient’s Addiction/Recovery Used for treatment planning	Result specifies the “intensity” of treatment required for that particular patient
	ASAM RISE		
	ASAM Continuum		

**NIDA - Modified Assist (NM-ASSIST)**

- The NM-ASSIST guides clinicians through a series of questions to identify risky substance use in their patients by considering lifetime substance use and consequences related to more recent use.
- Scoring involves summed responses for questions 2-7 for each substance, yielding a substance involvement score.
- The patient’s risk level is based on their substance involvement score for each substance:
  - 0-3=lower risk
  - 4-26=moderate risk
  - ≥27= high risk

**ASAM Criteria - Comprehensive Multidimensional Assessment**

- The ASAM Criteria is an evidence-based comprehensive multidimensional assessment that provides a structured and common communication platform for service planning and treatment. The Criteria includes evaluation of 6 dimensions (listed on the next page) to provide a holistic, biopsychosocial assessment. Accomplished via computer interface, subsequent scoring helps to determine the level of care or intensity of Cognitive Behavioral Intervention (CBI) support one is assigned to.
- Patients can move between levels over time, depending on changes in their unique needs.
- In the community, there are 5 levels of care beginning with early intervention services and progressing to residential inpatient and medically managed intensive inpatient services.
- Since incarceration already provides for a type of residential service, CDCR adapted the level of care offerings to 3 levels: Education/Relapse Prevention (0.5), Outpatient Services (1.0), and Intensive Outpatient Services (2.1).
- The ASAM assessments are cloud-based tools that utilize an asymmetric branching algorithm to determine the proper questions to elucidate all six dimensions. It then provides a narrative report and level of care determination. CCHCS will be using three standardized versions of ASAM assessment: the Co-triage, Continuum and RISE.
  - The Co-triage is an initial assessment that determines provisional assignment for level of care
  - The Continuum is a comprehensive bio-psychosocial assessment that generates a level of care determination
  - The RISE is similar to the Continuum, with a revised script focused on re-entry preparation

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**PATIENT ASSESSMENT (CONT'D)**

ASAM Dimension	Considerations
<b>Dimension 1: Acute Intoxication and/ or Withdrawal Potential</b>	<ul style="list-style-type: none"> <li>• Are there current signs of withdrawal?</li> <li>• Is there significant risk of severe withdrawal symptoms or seizures based on the patient’s previous withdrawal history, amount, frequency, chronicity and recent discontinuation or significant reduction of alcohol or other drug use?</li> </ul>
<b>Dimension 2: Biomedical Conditions/ Complications</b>	<ul style="list-style-type: none"> <li>• Are there current physical illnesses, other than withdrawal, that need to be addressed or that may complicate treatment?</li> </ul>
<b>Dimension 3: Emotional/Behavioral/ Cognitive Conditions and Complications</b>	<ul style="list-style-type: none"> <li>• Are there current psychiatric illnesses or psychological, behavioral, emotional or cognitive problems that need to be addressed because they create risk or complicate treatment?</li> <li>• Is the patient able to manage the Activities of Daily Living (ADL)?</li> </ul>
<b>Dimension 4: Readiness to Change</b>	<ul style="list-style-type: none"> <li>• What is the individual's emotional and cognitive awareness of the need to change?</li> <li>• What is their level of commitment to and readiness for change?</li> <li>• What is or has been his or her degree of cooperation with treatment?</li> <li>• What is their awareness of the relationship of alcohol or other drug use to negative consequences?</li> </ul>
<b>Dimension 5: Relapse/Continued Use/ Continued Problem Potential</b>	<ul style="list-style-type: none"> <li>• Is the patient in immediate danger of continued alcohol/drug use or severe mental health distress?</li> <li>• Does the patient have any recognition of, understanding of, or skills to cope with their addictive or mental disorder in order to prevent relapse.</li> <li>• How aware is the patient of relapse triggers, ways to cope with cravings to use, and skills to control impulses to use or impulses to harm self or others?</li> </ul>
<b>Dimension 6: Recovery Environment</b>	<ul style="list-style-type: none"> <li>• Does the patient have supportive friendships, financial resources, or educational/vocational resources that can increase the likelihood of successful treatment?</li> </ul>

One important aspect of the ASAM Criteria is that it considers the whole patient, including all of their life areas, as well as all risks, needs, strengths, and goals. Guiding principles for how the ASAM Criteria are used to determine treatment services are listed here:

- Consider the whole person. A patient’s risks, needs, strengths and resources provide the basis for creating a treatment plan.
- Design treatment plans that are patient specific. Every treatment plan is based on the patient’s unique needs, and therefore may be different, or require a variety of types or intensities of care.
- Individualize treatment times. Treatment length depends on the patient’s progress and changing needs.
- “Failure” is not a treatment prerequisite. “Failure” from treatment is NOT a basis for determining correct level of care.
- Provide a spectrum of services. Levels of care are linked to one another, and patients can move among and between them based on their current needs.

**TRAUMA-INFORMED CARE AND SUD**

To treat SUD appropriately, it is necessary to re-conceptualize the definition of “addiction.” Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual’s life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences. Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.

Many patients with SUD may not have had historical (pre-incarceration) access to or may have overtly avoided stigma-laden medical care. In fact, there is a high prevalence of adverse childhood experiences among patients with SUD. Therefore, assessment of a patient with SUD is best achieved in a trauma-informed care environment and over time in the context of establishing a therapeutic relationship.

A **trauma-informed approach** focuses on reducing the re-traumatization of traumatized individuals by the professionals who serve them.

- Understanding and recognizing the impact of trauma exposure is critical because frequently a person’s behavior – which is a normal reaction to unresolved trauma – is what causes them problems in many life areas.
- Every effort should be made to prevent further harm and re-traumatization, while creating opportunities for recovery/healing.
- Without understanding trauma, we are more likely to adopt behaviors and beliefs that are negative and unhealthy.
- Understanding trauma/stress allows health care staff to act compassionately and take well-informed steps toward wellness.

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**PATIENT ASSESSMENT - MOTIVATIONAL INTERVIEWING<sup>1</sup>**

Motivational Interviewing is a technique in which the provider becomes a helper in the change process and expresses acceptance of the patient. It is a way to interact with patients with any chronic disease, including SUD, that can help resolve the ambivalence that prevents patients from realizing their personal goals.

- Ambivalence about substance use (and change) is normal and constitutes an important motivational obstacle in recovery. Patients are often aware of the dangers of their use and want to stop, but at the same time do not want to stop – these feelings are natural, regardless of the patient’s stage of readiness.
- If a patient’s ambivalence is interpreted as denial or resistance, friction between the provider and the patient is likely to occur. Ambivalence can be resolved by working with the patient’s intrinsic motivations and values. The alliance between the provider and the patient is a collaborative partnership to which each individual brings important expertise.

**Five Principles of Motivational Interviewing**

Principle	Application to Practice
<b>1. Express Empathy</b> (through active listening)	<ul style="list-style-type: none"> <li>• Empathy communicates respect for and acceptance of patients and their feelings and encourages a non-judgmental, collaborative relationship.</li> <li>• Empathy is the foundation of a motivational counseling style.</li> </ul>
<b>2. Develop Discrepancy</b> (between the patient’s goals or values and their current behavior)	<ul style="list-style-type: none"> <li>• Developing awareness of consequences helps patients examine their behavior.</li> <li>• A discrepancy between present behavior and important goals motivates change.</li> </ul>
<b>3. Avoid Argument</b> (and direct confrontation)	<ul style="list-style-type: none"> <li>• Arguments with patients can rapidly turn into a power struggle and do not enhance motivation for beneficial change.</li> </ul>
<b>4. Roll With Resistance</b> (rather than opposing it directly)	<ul style="list-style-type: none"> <li>• Common types of resistance include arguing, interrupting, talking over or cutting off, denying, blaming, excusing, pessimism, or ignoring.</li> </ul>
<b>5. Support Self-Efficacy</b>	<ul style="list-style-type: none"> <li>• Many patients do not have a well-developed sense of self-efficacy which is often demonstrated in their inability to believe they can change.</li> <li>• Patient education can increase a patient’s sense of self-efficacy.</li> </ul>

**OARS Strategies**  
OARS is an acronym that represents 4 interaction strategies for Motivational Interviewing. OARS strategies can be used to propel patients through the change process by eliciting self-motivational statements, or *change talk*. The OARS strategies are:

**OARS Strategies**

<b>Open Questions</b>	<p>Encourage the patient to answer with more than “yes” and “no” answers. Building rapport between the provider and the patient can facilitate open communication and sharing of information. Open-ended questions may seem more time-consuming, but can actually be more efficient because they elicit more reliable and complete information and, when skillfully managed, do not have to lead to lengthy discussions.</p> <ul style="list-style-type: none"> <li>• <i>“Tell me about your family.”</i></li> </ul>
<b>Affirmation</b>	<p>Affirmation through statements of empathy and support of past accomplishments and strengths in order to anchor patients to their strengths and resources as they address problem behaviors. Affirmations help patients feel more comfortable, forthcoming, and open to feedback. Affirmations can be brief but powerful in building a therapeutic alliance.</p> <ul style="list-style-type: none"> <li>• <i>“This meeting brought out a lot of painful feelings. Thank you for staying through it.”</i></li> </ul>
<b>Reflective Listening</b>	<p>Reflections are restatements of a patient’s words or guesses at what a patient means. Providers who reflect are, in essence, acting as mirrors for patients to hear back what they have said. Hearing someone repeat back to you what you are saying may increase insight and self-reflection. Reflections are not meant to be directive, but to allow patients to elaborate on their concerns.</p> <ul style="list-style-type: none"> <li>• <i>“What I hear you saying is you want to quit, but your cell mate is making it hard for you.”</i></li> </ul>
<b>Summary Reflections</b>	<p>Summarizing is simply a set of reflections gathered together and presented to the patient. Summaries help patients and families organize their experiences. Summarization brings closure and consensus to what has been discussed and sets the stage for next steps. A summary statement often ends with a question.</p> <ul style="list-style-type: none"> <li>• <i>“What you’ve said is important and I want to make sure I have it right……”</i></li> </ul>

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**PATIENT ASSESSMENT - HISTORY AND PHYSICAL EXAM**

Healthcare Providers will evaluate patients prior to initiating MAT.

**Initial Evaluation History will include, but is not limited to, identifying and documenting the following:**

- The patient’s primary substance(s) of choice
- When substance use first began, first use of each substance, pattern of use of each substance
- The patient’s current level of cravings
- History of past or current MH conditions and current level of stress, anxiety or depression
- History of past or current trauma (the patient may not want to discuss at the first visit; if not, wait until trust is developed)
- History of prior substance use treatment
- The patient’s current motivation for sobriety
- The patient’s family history regarding substance use
- Prior screening for Tuberculosis (TB), Hepatitis A (HAV), Hepatitis B (HBV), Hepatitis C (HCV), Human Immunodeficiency Virus (HIV), and Syphilis (RPR) (if screening is not done - order)

Providers must check CURES if:

- Controlled medication has been ordered within 12 months of incarceration
- Controlled medication is prescribed at time of release/parole

**Physical Exam:** Focus on signs of substance use or complications of substance use:

System	Areas of Substance Use Focus
General Observation	Level of interaction, pale or flushed, lethargic or active, agitated or calm, cooperative or combative, abnormal movements
Head, Eyes, Ears, Nose & Throat (HEENT)	Pupil size, yellow sclera, conjunctivitis, rhinorrhea, rhinitis, excoriation or perforation of nasal septum, epistaxis, sinusitis, hoarseness or laryngitis, poor dentition, gum disease, dental abscesses
Skin	Abscesses, rashes, cellulitis, thrombosed veins, jaundice, scars, track marks, pock marks
Heart	Murmurs, arrhythmias
Respiratory	Dyspnea, rales, hemoptysis
Musculoskeletal/Extremities	Pitting edema, broken bones, traumatic amputations, burns on fingers
Gastrointestinal	Hepatomegaly, hernias, hematemesis
Other	Evidence of acute intoxication or withdrawal, e.g., slurred speech, unsteady gait or impaired balance/coordination, bizarre or atypical behavior, changes in level of arousal (agitation or sedation)

**PATIENT ASSESSMENT - DIAGNOSTIC TESTS**

Prior to initiating MAT, screening for TB, HBV, HCV, Hepatitis A, HIV, and Syphilis is done along with Comprehensive Metabolic Panel (CMP), UDS, and Urine beta-hCG (for women), and EKG (for Methadone). See table on [page 16](#) for more details.

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**PATIENT ASSESSMENT - DIAGNOSIS**

Making a diagnosis requires a thorough evaluation and often includes assessment by multiple care team members. There are two different coding systems used for diagnosing SUD - DSM-5 and ICD-10. Either are acceptable to use. Each are further described below.

**SUD Diagnosis—DSM-5**

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) provides criteria that can be used to diagnose SUD and its severity.

The DSM-5 has shifted from the use of the term "addiction" to "substance use disorders" and has integrated the concepts of substance abuse and substance dependence into the diagnosis of SUD.

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li>• Inhalant-related disorders</li> <li>• Tobacco-related disorders</li> <li>• Other, or unknown, substance-related disorders</li> <li>• Caffeine-related disorders</li> <li>• Hallucinogen-related disorders</li> </ul> | <ul style="list-style-type: none"> <li>• Alcohol-related disorders</li> <li>• Opioid-related disorders</li> <li>• Cannabis-related disorders</li> <li>• Sedative, hypnotic, or anxiolytic-related disorders</li> <li>• Stimulant-related disorders</li> </ul> |
|---|---|

The DSM-5 separates SUD into different categories, based on the substance being abused. The DSM-5 defines SUD as: "A problematic pattern of alcohol and drug use leading to clinically significant impairment or distress, as manifested by **at least two of the following**, occurring within a 12-month period".<sup>9</sup> The criteria have been divided based on how they manifest in behavior.

Loss of Control	Adverse Consequences	Physical Dependence
<ul style="list-style-type: none"> <li>• Taking larger amounts or for longer than intended</li> <li>• Wanting to cut down or quit but unable to</li> <li>• Increasing time getting, using, and recovering from use of the substance</li> <li>• Craving</li> <li>• Recurrent use in hazardous situations</li> </ul>	<ul style="list-style-type: none"> <li>• Failure to carry out obligations at work, school or home</li> <li>• Continued use despite social and/or interpersonal problems</li> <li>• Stopping or reducing other important activities</li> <li>• Use despite medical or psychological consequences</li> </ul>	<ul style="list-style-type: none"> <li>• Tolerance</li> <li>• Withdrawal</li> </ul>

The number of criteria a person demonstrates defines the severity of the substance use disorder.

# of criteria present:	2-3	4-5	≥ 6
Severity of SUD:	Mild	Moderate	Severe

- Each specific substance is addressed as a separate disorder (i.e. AUD, OUD), though most of the criteria are the same for each substance.
- It is important to note that the DSM-5 also provides criteria for diagnosis of Substance Intoxication, Substance Withdrawal, and Substance Induced Disorders. These can be found in DSM-5 (see [Intoxication and Withdrawal Care Guide](#)).

**SUD Diagnosis—ICD-10**

Documenting a specific diagnosis is important for subsequent treatment planning. Diagnostic ICD-10 master code numbers for specific drug(s) of use are listed here. The relevant ICD-10 code(s) can be selected using IMO box in the Electronic Health Record System (EHRS) and should be entered into the Diagnosis section of EHRS and transferred to the Problem List:

• Alcohol (F10)	• Sedative, hypnotic or anxiolytic (F13)	• Hallucinogens (F16)
• Opioids (F11)	• Cocaine (F14)	• Inhalants (F17)
• Cannabis (F12)	• Other stimulant (F15)	• Other psychoactive substance (F19)

Healthcare Providers will identify and document the patient's Substance Use Disorders in EHRS Diagnosis and move to Problem List after completing an assessment. Can search IMO for terms below (see examples of ICD-10 shown).

Opioid abuse	F11.10	Alcohol Abuse	F10.10
Opioid dependence	F11.20	Alcohol Dependence	F10.20



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**TREATMENT OVERVIEW**

Treatment for SUD may include a combination of many components, including behavioral interventions, pharmacologic interventions, and supportive housing. Each of these components of treatment can be used in tandem with other modalities or be used independently. For example, a patient may be on MAT and in supportive housing, and determine that they would like to discontinue MAT, without any impact to their eligibility for supportive housing. Similarly a patient on MAT who determines they are not ready for supportive housing can continue MAT.

**BEHAVIORAL INTERVENTIONS**

**Cognitive Behavioral Interventions (CBI)/Cognitive Behavioral Therapy (CBT)**

DRP provides CBI across a spectrum of topics relevant to SUD. CBI enhances skills and coping strategies used in navigating high-risk situations that commonly precipitate relapse, teaching participants to:

- Improve emotional regulation
- Identify and resolve interpersonal conflict difficulties
- Avoid high risk situations such as going to areas likely to be associated with exposure to drugs/alcohol

These psychosocial interventions seek to teach participants to identify and change unhelpful thoughts, beliefs and attitudes (cognitive distortions) and behaviors that often contribute to substance use.

DRP uses a set of standardized evidence-based SUD curriculum at all institutions so that patients transferring to another institution will continue their CBI program with minimal interruption.

Life skills education and relapse prevention (lowest ASAM score) CBI is less SUD-focused and covers broad topics such as parenting and anger management.

In order to communicate the assessment findings with the counselors in the DRP, the Medical Classification Chrono (MCC) is used to transmit the level of care assignment associated with the ASAM score. The corresponding range of hours of contact for CBI is shown under “CBI Intensity” in the table below.

ASAM Score	MCC Code	Level of Care	CBI/ CBT Intensity
≥ 2.1	T1	Intensive Outpatient	10 hours of service weekly
1.0	T2	Outpatient Services	6 hours of service weekly
.5	T3	Life Skills (Education/Relapse Prevention)	Non-SUD related CBI; brief intervention via classes/groups 6 hrs/week

The range of needs for cognitive behavioral interventions for the incarcerated population is broad and delivering group and/or individual therapy contact hours achieves a higher level of care when delivered by licensed clinical therapists. AOD counselors are involved with delivering the basic intervention hours for outpatient level of care and LCSWs provide additional contact hours of processing groups, using the Seeking Safety curriculum to achieve a more intensive outpatient level of care.

SUD participants with less than 14-months to serve are offered 90-days of packet programming using manualized curriculum focused on SUD and anger management. They will also receive a monthly check-in with an AOD Counselor.

Participants not showing improvement in CBIs for SUD are referred to an ISUDT LCSW for further assessment and may be appropriate for more intensive services. This may include LCSW led CBT groups to address trauma and/or substance use using standardized trauma informed therapy curriculum.

**Nursing Led Therapeutic Groups**

The CCHCS Nursing Led Therapeutic Groups (NLTG) Program was developed in compliance with the Patient Education Policy. NLTGs are structured and standardized to encourage and promote social skills, life skills, behaviors, and coping mechanisms to improve inmate patient health and wellness outcomes while incarcerated and upon release. These groups are offered to all level of care patients including General Population (GP).

Nursing Led Therapeutic Program offer groups on disease processes, substance use disorders, positive health behaviors, health improvement, and therapeutic interventions. These groups intend to improve the patients’ overall quality of life and health status to improve self-management methods, and encourage active participation in their disease management and prevention.

The patients can be referred by Interdisciplinary Treatment Teams (IDTTs), ISUDT staff, PCPs or can sign up of their own accord, when groups are offered by nursing staff. NLTGs provide hour for hour Rehabilitation Achievement Credit (RAC) for the patient attendees. These groups provides patient education on signs, symptoms, health risks, social and physical impact, treatment and prevention on various substance use disorders. HQ MH Nursing continues to expand this program to all institutions. Each institution works with their executive leadership and offer groups based on the needs of the patient population and staff availability.

SUMMARY	DECISION SUPPORT	PATIENT EDUCATION / SELF-MANAGEMENT
<b>BEHAVIORAL INTERVENTIONS (CONT'D)</b>		
<b>CBI Placement and Waitlist Prioritization</b>		
<ul style="list-style-type: none"> <li>• Priority placement onto waitlists for Outpatient/Intensive Outpatient CBI is based on:               <ul style="list-style-type: none"> <li>• High risk medical, prioritized by release date, includes:                   <ul style="list-style-type: none"> <li>• History of overdose</li> <li>• SUD-related hospitalization</li> <li>• 7362 submission requesting assistance with SUD</li> <li>• Pregnant with SUD</li> </ul> </li> <li>• On MAT, prioritized by release date</li> <li>• 15-24 months to release EPRD and BPH CPED, prioritized by release date.</li> </ul> </li> <li>• Prioritization of placement onto Life Skills Waitlist (CB2)</li> <li>• Patients serving a life sentence without parole are ineligible for reserved slots for CBI.</li> </ul>		
<b><u>Those at Fire Camp</u></b>		
<ul style="list-style-type: none"> <li>• Patients transferred to a camp, will be placed on a separate waitlist that keeps their original referral date and LOC.</li> </ul>		
<b><u>Short-term Restricted Housing, Long-term Restricted Housing, Ad Seg, or PIP</u></b>		
<ul style="list-style-type: none"> <li>• Those who are assessed and placed on a waitlist, and then moved to Short-term Restricted Housing, Long-term Restricted Housing, Ad Seg, or PIP, will be placed on a separate wait list that keeps their original referral date and LOC. If they are referred back to general population, they will be placed back into the main list, based on original referral date, and if determined to be the same LOC. If new LOC is determined, they will be placed on the waitlist of the new LOC.</li> </ul>		
<b>Aftercare</b>		
<p>Formalized aftercare is available utilizing the SMART Recovery InsideOut curriculum. In these groups, Peer Mentors support and facilitate others' recovery. Behavioral specialists provide ongoing support and training for peer mentors earning preceptor hours towards certification, and participate in case management for complex patients. Less formal aftercare is also available for those who wish to participate in inmate leisure time activity groups (ILTAG) such as alcoholics or narcotics anonymous among others.</p>		
<b>Peer Support Groups</b>		
<p>Peer support groups are another behavioral treatment option. They support a patient's recovery by:</p> <ul style="list-style-type: none"> <li>• Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse.</li> <li>• Focusing on ongoing relationships and support networks in combination with improving coping strategies.</li> </ul> <p>Peer support groups are available as Inmate Leisure Time Activity Groups (ILTAGs) within all institutions. ILTAGs will vary by institution, but every institution will offer at least two. The process for a patient to request to join an ILTAG is as follows:</p> <ul style="list-style-type: none"> <li>• The patient completes a CDCR 22, Inmate/Parolee Request for Interview, Item, or Service and submits the form to the Community Resource Office for processing.</li> <li>• If accepted into the group, the patient will receive a ducat indicating time, date, and place for the group.</li> </ul> <p>Examples of peer support groups that may be available are White Bison, Alcoholics Anonymous, and Celebrate Recovery.</p>		
<b>Peer Mentors</b>		
<p>Patients who complete CBI programming can apply to become a peer mentor who serves as a sponsor for others in recovery. They can begin this process by contacting their Community Partnership Manager. The process for becoming a peer mentor is outlined below:</p> <ul style="list-style-type: none"> <li>• Candidate Recruitment &amp; Selection</li> <li>• Participates in 18-week CBI Intensive Outpatient Program (18 weeks)</li> <li>• Study Preparation &amp; skill Building (80-hours)</li> <li>• Formal Classroom Education (350 hours)</li> <li>• Supervised Practicum Training (255 hours)</li> <li>• Prepare and Sit for Written Exam</li> <li>• Supervised Internship (Between 2080 &amp; 3000 hours)</li> <li>• Complete Internship Hours/Receive Certification</li> <li>• On-Going Work Experience/Continuing Education/Certification Advancement</li> </ul> <p>Once hours are completed and an individual is certified they can lead the peer support groups, support with creation of a therapeutic community in supportive housing units.</p>		

<b>SUMMARY</b>	<b>DECISION SUPPORT</b>	<b>PATIENT EDUCATION / SELF-MANAGEMENT</b>
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**SUPPORTIVE HOUSING<sup>2</sup>**

Supportive housing units are a key treatment modality. While participation in supportive housing is voluntary, due to its known benefits, ISUDT program participants should be encouraged to participate in supportive housing therapeutic communities. The central philosophy for designated supportive housing units is that it creates a space where patients can be active participants in their own and each other’s recovery; and the responsibility for the daily running of the community is shared among patients and staff. Studies find that therapeutic community participants show decreased substance abuse, criminal behavior, and mental health symptoms.

- Supportive housing units will be available at all institutions.
- Patients assigned to supportive housing are those identified as being at high risk due to environmental factors.

Oversight in supportive housing units will be provided by custody officers specifically trained in ISUDT support.

**TREATMENT- PHARMACOLOGIC<sup>3, 4, 5</sup>**

**Medication Assisted Treatment (MAT): Selecting a MAT Agent for OUD<sup>6</sup>**

Selection of the appropriate agent involves consideration of patient laboratory results, history and preferences which are generally considered/discussed at the time of consent and initiation. These may include:

- Danger of overdose or possible harm to the patient (consider the patient’s substance use history)
- Efficacy of MAT agent in limiting or eliminating problematic substance use
- Treatment retention and adherence
- Availability of chosen agent upon parole/release (relevant during pre-release stages; community acceptance may differ)
- Patient’s preferences, past treatment history, and historical and current substance use patterns. Reviewing previous documentation may provide valuable information.
- Patient’s concurrent medical and/or mental health conditions

While similarly effective, the two types of drugs (agonist and antagonist) have stark differences which are outlined below:

	<b>AGONISTS (Buprenorphine &amp; Methadone)</b>	<b>ANTAGONIST (Naltrexone)</b>
<b>Action</b>	Activate opioid receptors Maintain physical dependence on opioids	Competitive antagonist at opiate receptor; [At high concentrations, an opiate can displace Naltrexone]
<b>Initiation</b>	While the patient is still dependent or detoxifying	Only after full detoxification to avoid withdrawal
<b>Prescribing Restrictions</b>	X-waiver (Buprenorphine) Licensed NTP (Methadone)	None; all providers may prescribe, may be dispensed KOP when appropriate (stable in recovery)
<b>Side effects</b> (see pgs. 22-26)	Lower extremity swelling, urinary hesitancy, constipation, sedation	Nausea, abdominal cramps/pain, anxiety, chills, possible precipitated withdrawal
<b>Cautions</b>	Drug-drug interactions with QT prolongation	Avoid in patients with advanced liver disease (F3-4) or renal impairment (CrCl , 30 ml/min)
<b>Advantages</b>	Comorbid pain control (See page 21)	No diversion, no dependence, lower stigma in some settings. No euphoric effects
<b>Discontinuation</b>	Associated with withdrawal symptoms	No withdrawal
<b>Abuse potential</b>	Medium to High	None

Before considering which agent to use, providers should review the results of the patient’s NIDA-MA and UDS. If either of these results are not yet available, provider should confirm that they were ordered and/or completed.

In considering the three agents for OUD:

- **Naltrexone**, an opioid antagonist, requires that the patient detoxify from opiates (typically 7 days) before beginning Naltrexone; this is commonly called the “detox hurdle.” Because Naltrexone is an antagonist, it does not curb cravings as much as agonists and may not be suitable for those with a long history of OUD. Consequently, Naltrexone may be best for those who are highly motivated to abstain from all opioids and would prefer not to use an agonist. Naltrexone should be considered the first-line agent for those who already have established a period of sobriety.
- **Methadone**, a full opioid agonist, allows a transition from opioid use to medication maintenance without detoxification. Methadone is often used in patients physiologically dependent on opioids for greater than 2 years. The administration of methadone for OUD is monitored and administered under the regulations of a licensed NTP.
- **Buprenorphine**, a partial opioid agonist, is permitted to be prescribed in physician offices significantly increasing access. Under the Drug Addiction Treatment Act of 2000 (DATA 2000), qualified physicians and advanced practice providers with an X-waiver can offer buprenorphine for opioid dependency. Generally induction may occur at least 12-24 hours after the last use of heroin or other short-acting opioids, or 24-72 hours after the last use of a long-acting opioid, such as methadone. If timing is uncertain, a Clinical Opiate Withdrawal Scale (COWS) can be done, and induction started when the score is 6-10. It is important to note that buprenorphine can bring on acute withdrawal for patents who are not in the early stages of withdrawal and who have other opioids in their bloodstream. However, complete detoxification is not a requirement. As a controlled substance (C-III), new start orders require re-evaluation within 7 days prior to renewal/continuation. This is often accompanied with assistance/consultation with nursing staff.

<b>SUMMARY</b>	<b>DECISION SUPPORT</b>	<b>PATIENT EDUCATION / SELF-MANAGEMENT</b>
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**TREATMENT- PHARMACOLOGIC** <sup>3, 4, 5</sup>

**Medication Assisted Treatment (MAT): Selecting a MAT Agent for AUD**<sup>6</sup>

For the treatment of AUD, it has been found that acamprosate and naltrexone have similar rates for retention and positive patient outcomes.

- Acamprosate is associated with higher rates of abstinence.
- When outcomes of heavy drinking and craving are combined, naltrexone is statistically superior to acamprosate.
- Naltrexone should be considered for patients with *both* AUD and OUD since it is effective in treating both disorders.
- Other considerations for choosing a MAT agent for AUD are summarized below:

Medication	Doses/Day	Patients with Liver Disease	Patients with Renal Disease
Acamprosate	3 doses	Safe Use	CrCl <30 contraindication; CrCl 30-50 reduce dose
Naltrexone (oral)	1 dose	Avoid in advanced liver disease	CrCl <30 contraindication

**Medication Administration**

- When prescribing a MAT medication, providers should carefully consider administration time. This is needed to avoid overburdening any one administration time (AM, noon, PM or HS). This should be done by discussing with the patient their current schedule which may include a job or other program elements. For patients already on MAT medication that are being considered for a new administration time, please discuss with the patient prior to switching.
  - ⇒ Additionally, in consideration of pill line burden, patients prescribed medications that are eligible to be administered KOP (including acamprosate and naltrexone) that are being delivered NA or DOT should be considered for transition to KOP administration
  - ⇒ Once daily dosing is standard. Because of this, be mindful of dosage prescribed to ensure it is viable with two strips.
- Suboxone is given as a sublingual film. Nursing will instruct the patient to place the Suboxone film under the tongue in a parallel direction and close mouth.
- No more than two films may be given at one time. If two films are needed, place one film under the right side of the tongue and the other under the left side of the tongue. Do not let the films touch.
- Observing the medications entering the mouth shall satisfy the verification requirement noted in the medications NA/DOT policy. If the medication enters the mouth and the nurse provides counseling for 30 seconds or more to initiate adherence to the oral mucosa, the nurse does not need to perform a mouth check.
- Nursing will communicate to the Suboxone prescriber of any misuse or refusal of the Suboxone film by sending a message in Cerner and copying the Resource RN or local ISUDT team (please note this is not the HQ AM message pool).

**MAT Agents Offered in CDCR**

CCHCS offers four medications approved by the Federal Drug Administration (FDA) for MAT for OUD and AUD. The AMCT or Institution Addiction Medicine Champion will evaluate and initiate MAT when deemed appropriate. Consent for MAT will be obtained using the [CDCR 7240](#) (see attachment D). Available MAT medications on CCHCS formulary are summarized below.

Medication	For	Use Criteria
<b>Acamprosate</b> <i>(NA/DOT or KOP after stable)</i>	AUD	<ul style="list-style-type: none"> <li>• Recommended starting dose is 666 mg TID</li> <li>• Recommended maximum dose is 666 mg TID</li> <li>• No contraindications or hypersensitivity to acamprosate</li> <li>• Contraindication or intolerance to Naltrexone or inadequate response at 100 mg/day</li> <li>• Patient/provider preference</li> <li>• Acamprosate contraindicated in severe renal impairment (CrCl ≤ 30 mL/min)</li> </ul>
<b>Buprenorphine/Naloxone (Suboxone) sublingual films</b> <i>(NA/DOT-SL)</i>  <i>Opioid partial agonist</i>	OUD	<ul style="list-style-type: none"> <li>• Recommended outpatient starting dose 8 mg daily</li> <li>• Recommended maximum dose 24 mg daily</li> <li>• No contraindications or hypersensitivity to buprenorphine/naloxone</li> <li>• If a patient arrives on buprenorphine-only formulation, switch to combination buprenorphine/naloxone, unless contraindicated by pregnancy</li> <li>• <i>An X-waiver is required to prescribe buprenorphine (except for a 3-day bridge order when needed to continue a patient on established treatment)</i></li> <li>• As a controlled substance (C-III), new start orders require re-evaluation within 7 days</li> </ul>
<b>Naltrexone Oral</b> <i>(NA/DOT or KOP after stable)</i>  <i>Opioid Antagonist</i>	AUD OUD	<ul style="list-style-type: none"> <li>• Recommended starting dose is 50 mg daily</li> <li>• Recommended maximum dose is 100mg per day for oral naltrexone</li> <li>• No contraindications or hypersensitivity to naltrexone</li> <li>• No opioid use within 7 days (depending on last opioid agent used)</li> <li>• No opioid withdrawal symptoms</li> <li>• No acute hepatitis or liver failure</li> <li>• Avoid if CrCl &lt; 30 ml/min</li> </ul>

*Table is continued on following page*

<b>SUMMARY</b>	<b>DECISION SUPPORT</b>	<b>PATIENT EDUCATION / SELF-MANAGEMENT</b>
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**TREATMENT- PHARMACOLOGIC <sup>3, 4, 5</sup> (CONT'D)**

**MAT Agents Offered in CDCR (Cont'd)**

Medication	For	Use Criteria
<b>Restricted Use</b> Requires submission of AAA Form	<b>Methadone (NA/DOT - crush &amp; float)</b> Opioid Agonist	<ul style="list-style-type: none"> <li>•Dosing is managed by NTP (contracted with CDCR)</li> <li>•No contraindications or hypersensitivity to methadone</li> <li>•Continue if the patient arrived on methadone for OUD (3-day bridge)</li> <li>•Preference for methadone over buprenorphine based on a patient's prior good result using methadone, or the need for a more structured delivery system</li> <li>•<i>Methadone for MAT can only be prescribed through a federally licensed NTP (except for a 3-day bridge order when needed while arranging treatment via NTP).</i></li> <li>•<b>New starts require AAA form submission.</b></li> </ul>
	<b>Buprenorphine/naloxone injection (NA)</b>	AUD OUD <ul style="list-style-type: none"> <li>•The patient is on sublingual buprenorphine therapy for more than 7 days <i>and</i></li> <li>•Patient is unable to manage daily dosing with oral formulations upon release</li> <li>•<i>An X-waiver is required to prescribe buprenorphine</i></li> </ul>
	<b>Naltrexone Injection (NA)</b>	AUD OUD <ul style="list-style-type: none"> <li>•The patient is on oral naltrexone therapy and is within 3 months of release <i>and</i></li> <li>•Patient is unable to manage daily dosing with KOP medication <i>and</i></li> <li>•Patient is considered at high risk for overdose</li> </ul>

**Alternative Agent Authorization (AAA) Form**

- The AAA form provides a pathway for consideration of alternative MAT agents or formulations, such as methadone, topiramate, injectable buprenorphine/naloxone or injectable naltrexone.
- This form is filled out by a provider for approval by the AMCT and is found in the ad-hoc section in Cerner.

**Patients Requiring Bridge Orders While Treatment Continuity Arranged**

During reception, or at times of transfer (e.g., patients transferring to another facility, out-to-court return, etc.), patients may need bridge orders for MAT medications in order to facilitate uninterrupted continuity of care. All providers are expected to provide bridge orders regardless of their X-waiver status per [21 CFR 1306.07\(b\)](#).

Use the **MAT Reception Center (Provider) PowerPlan** to leverage built-in decision support.

When placing any MAT order for OUD or AUD, be sure to include the ICD-10 F11.20 (Opioid Dependence) or F10.20 (Alcohol Dependence) in the "diagnosis" section of the medication order.

The provider must check [CURES](#) if controlled medication is ordered within 12 months of incarceration or at the time of parole.

- Look for any prior prescriptions of controlled substances and document in EHRS. (Scan report into EHRS)
- This is required by law and may be audited by the Department of Justice

Here are steps to take to provide bridge orders based on specific medication:

**Methadone:**

- Place 3-day bridge order for methadone (same dose as on arrival)
- Place "Methadone NTP (Administered by NTP) order" for internal drug-drug interaction checking
- Place Medical Hold
- Ensure the patient has an NTP transport order that initiates daily transport to a local NTP within 4 days (Reception RN orders).

**Buprenorphine/naloxone:**

- X-waived PCP - Place 30-day order (same dose as on arrival; use combination product on formulary unless the patient is pregnant)

**Naltrexone and Acamprosate:**

- Place 30-day order at current dose

In addition to medication bridge orders, also place orders for:

- CCHCS UTOX PANEL (372260)

The Reception RN will order CMP, Baseline EKG if on Methadone, and Consult to LCSW for ASAM assessment

**Patients Arriving on Alternative Agents (Methadone, Sublocade, Vivitrol)**

These patients should be referred to the AMCT for consultation and formulation adjustments as needed.

SUMMARY	DECISION SUPPORT	PATIENT EDUCATION / SELF-MANAGEMENT
<b>TREATMENT - PHARMACOLOGIC (CONT'D)</b>		
<b>Referrals from the Field</b>		
<p><b>All patients will be eligible for assessment and treatment within the ISUDT program (including MAT when appropriate).</b></p> <ul style="list-style-type: none"> <li>• When patients are identified with a history of opioid overdose and/or known SUD-related complications such as endocarditis, osteomyelitis, poor oral health, or cellulitis related to IV drug use, refer the patients to LCSW for assessment using the “Consult to LCSW” order, with “SUD Related Complications” selected under <i>reason for consult</i>.</li> <li>• Additionally, patients who are identified as having an OUD-related complication, as noted above, should have an order for CCHCS UTOX PANEL (372260), with ASAP selected under <i>collection priority</i>, and should be considered for MAT.</li> <li>• For patients returning from HLOC, consider if the transfer was due to SUD-related complications, such as overdose, skin infections, trauma, and refer accordingly.</li> <li>• For patients presenting for HIV/HCV treatment and/or recurrent viremia, refer for SUD evaluation and treatment as appropriate.</li> <li>• For patients with significant co-occurring disorders including major depression disorder or other mental illness, it is important to collaborate with MH providers and coordinate care.</li> <li>• Patients transferring to acute care MH beds (PIP) already on MAT are continued on MAT without interruption unless patient’s condition requires adjustment via collaboration with MH provider.</li> <li>• New admissions to acute care MH beds generally are not considered candidates for MAT initiation until their condition is stabilized.</li> </ul>		
<b>Rapid Induction</b>		
<ul style="list-style-type: none"> <li>• For patients that present in active opioid withdrawal (COWS <math>\geq 8</math>), providers should consider a rapid induction. For more information on rapid induction including the workflow, see <a href="#">CCHCS Care Guide: Intoxication and Withdrawal</a>.</li> <li>• Communication should be made to the Addiction Medicine Team via the HQ Addiction Services Provider Message Pool</li> <li>• Rapid induction does not replace an initial Addiction Medicine evaluation and a consultation order is needed.</li> </ul>		
<b>Post Induction Evaluations with RN or LVN</b>		
<p>Following MAT initiation providers should schedule a post-induction evaluation with nursing within 3 days. This evaluation includes a COWS and medication check to assess for any adverse effects.</p> <ul style="list-style-type: none"> <li>• Intermediate Institutions have the PCRN evaluate the patient</li> <li>• Basic institutions have the LVN Care Coordinator evaluate the patient</li> <li>• In the order be sure to enter: <ul style="list-style-type: none"> <li>⇒ Reason for Follow-up: Post-Induction COWS</li> <li>⇒ Timeframe: within 72 hours</li> <li>⇒ Within special instructions provider should indicate who results should be messaged to</li> </ul> </li> </ul>		
<b>Opioid Overdose Risk &amp; Prevention Counseling<sup>5</sup></b>		
<p>Patients with OUD <u>all have an increased risk of overdose</u> if they are abstinent from or significantly reduce their use of opioids due to their loss of physiologic tolerance.</p> <p><b>Additional Overdose Risk with Naltrexone:</b> Patients on Naltrexone (opioid antagonist) are at risk of sudden overdose if taking opioids while on Naltrexone.</p> <ul style="list-style-type: none"> <li>• Naltrexone blocks the opioid receptor initially, and the patient gets no effect from the opioid taken. However, if more opioids are taken, the opioids can overcome the blockade and result in <b>respiratory arrest, circulatory collapse and death</b></li> <li>• It is imperative to educate patients who are on naltrexone that using opioids is risky and can result in death; if on injectable naltrexone, the blockade effect can last up to 30 days from their last injection.</li> </ul> <p>Tell <b>all</b> patients:</p> <ul style="list-style-type: none"> <li>• Sobriety from opioids results in a loss of tolerance and use of “usual” amount of opioids may result in death.</li> <li>• Do not use opioids with other depressants (alcohol or benzodiazepines).</li> <li>• Do not use multiple doses of opioids in a short duration of time and if using, do not use alone.</li> <li>• After release from prison, have naloxone available.</li> </ul>		

SUMMARY	DECISION SUPPORT	PATIENT EDUCATION / SELF-MANAGEMENT
<b>TREATMENT - PHARMACOLOGIC (CONT'D)</b>		
<b>Overview on Switching MAT Medications<sup>5</sup></b>		
<p><b>Switching medications will be done by the AMCT or Institution Addiction Medicine Champion.</b></p> <p>General considerations:</p> <ul style="list-style-type: none"> <li>• Unless there is a strong indication to switch medications, patients already established on a specific therapy should be continued on that therapy.</li> <li>• Changes in medication formulation may be necessary to conform with CCHCS formulary restrictions. For example, a patient who enters CDCR on MAT using buprenorphine/naloxone tablets will be transitioned to sublingual (SL) films.</li> <li>• Switching MAT agents for the treatment of OUD may be appropriate if the patient experiences intolerable side effects or is not successful in attaining or maintaining treatment goals through the current agent.</li> </ul> <p>Below are some general concepts for some common transitions:</p>		
<b>Methadone to Buprenorphine</b>		
<ul style="list-style-type: none"> <li>• Patient switching from methadone to buprenorphine should be on low doses of methadone prior to switching medications.</li> <li>• Patients on daily doses of 30-40 mg or less generally tolerate transition to buprenorphine with minimal discomfort, whereas patients on higher doses of methadone may experience significant discomfort with switching medications.</li> </ul>		
<b>Buprenorphine to Methadone</b>		
<ul style="list-style-type: none"> <li>• Switching from buprenorphine to methadone, there is no required delay since the addition of a full <math>\mu</math>-opioid agonist to a partial agonist does not typically result in any type of adverse reaction.</li> <li>• Arrangements to transition the patient to an NTP will be necessary and is only done by the AMCT.</li> <li>• During the transition, if buprenorphine is tapered, close monitoring is recommended.</li> </ul>		
<b>Naltrexone to Buprenorphine (Methadone would be done by NTP)</b>		
<ul style="list-style-type: none"> <li>• Switching from an antagonist to an agonist is generally less complicated because there is no physical dependence associated with antagonist therapy so there no possibility of precipitated withdrawal.</li> <li>• Before switching, assure that naltrexone is no longer in the patient's system (about 1 day for oral naltrexone or 30 days for extended release injectable naltrexone).</li> <li>• Because of the absence of physical dependence on opioids, initial doses of buprenorphine (or NTP prescribed methadone) should be low.</li> </ul>		
<b>Buprenorphine or Methadone to Naltrexone</b>		
<ul style="list-style-type: none"> <li>• Switching from an agonist or partial agonist to an antagonist can be complex.</li> <li>• The agonist or partial agonist should be weaned off no faster than 10% per 48 hours.</li> <li>• Clonidine can be used to help with symptoms at doses of 0.1 mg TID PRN.</li> <li>• Naltrexone can be started 7-10 days after cessation of buprenorphine.</li> <li>• Naltrexone can be started 10-14 days after cessation of methadone.</li> </ul>		
<b>Overview on MAT Medication Discontinuation/Tapering</b>		
<p>General considerations:</p> <ul style="list-style-type: none"> <li>• If the patient decides they no longer want to continue taking MAT or there is a medical indication for discontinuing MAT, tapering off of their medication needs to be done instead of abrupt discontinuation (except naltrexone and acamprosate). In the case of refusal, the treating provider will get a signed <b>CDCR 7225, Refusal of Examination and/or Treatment</b> form (<a href="#">see attachment E</a>). Tapering of MAT medications should be guided by the AMCT if the prescribing provider has any questions about how to taper a MAT therapeutic.</li> <li>• <b>Naltrexone:</b> no need to taper, may just discontinue medication (warn the patient of overdose risk if returning to opioid use due to loss of tolerance while abstinent and warn those on injectable naltrexone that medication will remain in their system for 30 days – see below).</li> <li>• <b>Acamprosate:</b> no need to taper, may just discontinue medication.</li> <li>• <b>Methadone:</b> tapering is challenging and is generally directed by a licensed NTP.</li> <li>• <b>Buprenorphine:</b> tapering is generally safely accomplished by reducing the total dose by 10-15% weekly and monitoring for withdrawal until complete discontinuation. Slower taper at lower doses may be necessary.</li> </ul>		

SUMMARY	DECISION SUPPORT	PATIENT EDUCATION / SELF-MANAGEMENT
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**MONITORING FOR PATIENTS ON MAT**

**Follow-up Visits Overview**

SUD is a chronic disease and will be a lifelong concern for the patient. Whole Person Care requires the patient's PCT and Mental Health team to be aware of their SUD diagnoses and all aspects of their SUD treatment plan. All PCT members and MH providers should encourage the patient to engage with their treatment by using Motivational Enhancement and Motivational Interviewing techniques (See the Substance Abuse and Mental Health Services Administration's [SAMHSA] [Empowering Change: Motivational Interviewing](#)).

**The provider will monitor patients on MAT medication.**

During follow-up appointments, the provider will:

- Obtain interim history and document any complaints or concerns
- Review patient chart notes since last visit, which may indicate need for a higher level of care
- Focus physical exam on individual patient history
- Review Medication Administration Record (MAR): MAT medication, administration route, and current dose and adherence
- Review and document UDS results (per monitoring guidelines, see pages [18-19](#))
- Order interim diagnostic tests as needed (see table below)
- Document:
  - Cravings/urges to use substance(s) as 0 to 10 [0= no cravings]
  - Motivation to continue on MAT as 0 to 10 [0= no motivation to stay on MAT]
  - Mood (PHQ-2/PHQ-9)
  - Patient's group and/or programming participation
  - Any identified relapse risk factors (e.g., recent bad news, poor self care, avoiding peer support groups (see [page 17](#)))
- Schedule follow-up visit according to level of stability:
  - Follow-up visits should be scheduled more frequently during initial dosage titration (i.e., every few days to a week) upwards toward every 3 months once stable if on a controlled substance.
  - If patient remains stable with no adverse medication effects, no cravings, no significant relapse risk factors, and acceptable participation in other SUDT plan components **and** UDS is consistent with treatment:
    - Schedule f/u appointment within 3 months if on controlled substance and as indicated if not on controlled med
    - Order random UDS (frequency per table on [page 18](#))
    - Follow-up may vary if not on controlled medication (consider other medical conditions).
    - If the patient wishes to discontinue MAT a signed refusal will be obtained (see [page 15](#)).

MAT Medication	Diagnostic Test	Annual	PRN
Acamprosate	Comprehensive Metabolic Panel (CMP)	✓	✓
Buprenorphine	Screening for HAV, HBV, HCV, HIV, RPR	✓	✓
Naltrexone	Random UDS (see next page for frequency based on stage of care)		✓
Methadone	Urine beta-hCG for women		✓
Methadone	EKG	✓	✓*

\*Consider repeat EKG with dose changes and with the addition of any medication that may affect QT interval



SUMMARY	DECISION SUPPORT	PATIENT EDUCATION / SELF-MANAGEMENT
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**MONITORING FOR PATIENTS ON MAT - (CONT'D)**

**Recovery Concepts**

The following concepts are important to monitoring and following-up with patients in the ISUDT program:

**Recovery:** a process of sustained action that addresses the biological, psychological, social, and spiritual disturbances inherent in SUDs. This effort is in the direction of a consistent pursuit of abstinence, addressing impairment in behavioral control, dealing with cravings, recognizing problems in one’s behaviors and interpersonal relationships, and dealing more effectively with emotional responses. Recovery actions lead to reversal of negative, self-defeating thoughts and behaviors, allowing healing of relationships with self and others. [ASAM]

**Sobriety:** the quality of being serious about recovery, engaged in treatment, and focused on one’s well-being. *It does not simply mean abstinence from drugs or alcohol.* One person’s definition of sobriety may not be the same as another’s and there are no definitive guidelines for how sobriety is achieved.

**Cravings:** Cravings are a state of intense focus on acquiring and using a substance to achieve a desired effect.

- Cravings are subjective and individualized, and vary in duration and intensity.
- Cravings and triggers drive people with SUD to keep using despite adverse impacts to their health, relationships and lives.
- Specific triggers should be explored if a once-stable patient starts complaining of unmanageable cravings.

**Triggers:** Triggers include people, places and things that a person associates with substance use that may spark potential relapse.

- The four categories of triggers include pattern, social, emotional and withdrawal:
  - ⇒ Patterns are situations that incite recollections of substance use. (i.e. time of day, location, seasonal events)
  - ⇒ Social triggers are a person or group associated with drug use.
  - ⇒ Emotional triggers associated with drug use may stem from a wide range of emotions such as celebrating happiness or self-medicating for sadness and anxiety.
  - ⇒ Withdrawal triggers are biological responses to the lack of a substance in a person’s body.

**Addressing Cravings and Triggers**

- Cravings and triggers need to be identified before a person can properly respond to them.
- Coping mechanisms to overcome cravings and triggers include avoidance, staying busy with healthy behaviors, remember that cravings end and journaling.
- Do not overly rely on medication to address cravings.

**Relapse:** a process in which an individual who has established abstinence or sobriety experiences recurrence of signs and symptoms of active addiction, often including resumption of the pathological pursuit of reward and/or relief through the use of substances and other behaviors.

When relapse occurs, there is often disengagement from recovery activities. Relapse can be triggered by:

- Rewarding substances and behaviors
- Environmental cues to use
- Emotional stressors that trigger heightened activity in brain stress circuits

**Note:** Relapse is part of the chronic disease process and should not be interpreted as a failure in treatment. Recognizing warning signs of relapse can help with taking proactive steps to interrupt, prevent or consider referral for more intensive or specialized services. **Anyone may detect relapse.** If a patient reports a relapse, manage your response - there is likely need for more help in treatment. We are here to help guide patients toward recovery, which is not a static phase, but something that will be continuously managed over time.

**Be aware of the warning signs of a potential relapse and offer support and education to the patient on relapse and overdose prevention (See Patient Education pages 29-32)**

Warning Signs of Potential Relapse	Strategies to Prevent Relapse
<ul style="list-style-type: none"> <li>• Hunger, anger, lonely or tired (HALT)</li> <li>• Avoidance of peer support groups</li> <li>• Practicing poor self care, poor eating and sleeping</li> <li>• Romanticizing/glorifying people, places and things that are associated with past use</li> <li>• Minimizing consequences of continued use</li> <li>• Disclosure of any bad news (i.e., death of a family member, divorce, increase in sentencing, other sources of grief)</li> </ul>	<ul style="list-style-type: none"> <li>• Avoid people, places &amp; activities associated with drug use</li> <li>• Develop pleasurable and rewarding alternatives to drug use (hobbies)</li> <li>• Join a peer support group that can help celebrate the process of sobriety and offer accountability</li> <li>• Report safety concerns/ request housing change if needed</li> <li>• Mindfulness activities (i.e., breathing, relaxation, stress reduction, guided meditation)</li> </ul>

<b>SUMMARY</b>	<b>DECISION SUPPORT</b>	<b>PATIENT EDUCATION / SELF-MANAGEMENT</b>
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**MONITORING FOR PATIENTS ON MAT - (CONT'D)**

**Urine Drug Screening<sup>8</sup>**

The **CCHCS Urine Drug Screen** (CCHCS UTOX PANEL 372260) is a clinical tool to help providers monitor the disease and keep the patient safe. It is not intended to determine punitive measures. The test provides both screening and quantitative confirmatory results for about 60 drugs and related metabolites (See [Attachment C](#)).

- In general, random drug testing is a strong deterrent to drug use as it is intended to be conducted on an unannounced basis.
- **Varying the timing for UDS** within the given frequency parameters is recommended:

**UDS Frequency to Monitor MAT**

Stage of Care	<b>&lt;30 days</b>	<b>31-90 days</b>	<b>91 days-2 years</b>
<b>UDS Performance Frequency At Least Every:</b>	2 weeks (Random 1-2 wks)	4 weeks (Random 2-4 wks)	6 weeks (Random 4-6 wks)

- Patient should NOT be told when test is to be done.
- If relapse occurs after an abstinence period, reset stage of care to <30 days with more frequent monitoring.
- If UDS consistent with therapy >2 years on controlled medication, continue random testing at least every 3 months.
- For questions on UDS testing or interpretation contact the AMCT
- Many factors including state of hydration, other medications, genetics, patient’s age, gender and urinary pH can affect the rate of excretion of parent drug and metabolites
- Under no circumstance are the UDS results to be shared with custody staff.

**Sample Validity:** In order to appropriately treat the patient, the provider needs to know the UDS results are valid. Urine samples can be altered in the following ways:

- Adding a substance so that it appears to have been ingested (adulterant)
- Diluting with water to decrease chances of detecting substances present
- Providing a sample produced earlier or by another person

The ISUDT program has implemented new collection policy and procedures to mitigate some or all of these concerns. Note the usual pH of urine is 4.5-8, normal creatinine in urine is >20 mg/dl, the normal Specific Gravity >1.002-1.030 and temperature between 90-100 F within 4 minutes.

For proper interpretation of UDS results, it is important to reconcile with the medication administration record (MAR) based on date of UDS collection for compliance taking medication, noting any refusals. In addition, providers should know:

- MAT medication prescribed and relevant metabolites (See [Attachment C](#))
- All medications prescribed to the patient and important metabolites, if any.
- Opioid metabolism if unexpected opioid metabolites (See [page 19](#))
- Alcohol and other substances of abuse metabolites and detection time (See [Attachment C](#))
- Engage the patient regarding results (see [page 19](#))

**Tips for Monitoring MAT Medications:** Look for presence of prescribed medication and expected metabolites:

Medication	Metabolites	Detection	Comments
Acamprosate	Acamprosate	1-3 days	Acamprosate is active in parent form
Buprenorphine	Buprenorphine, Norbuprenorphine	1-3 days	Buprenorphine is metabolized to norbuprenorphine. Typically one would expect to see Norbup >Bup in the UDS.
Methadone	Methadone EDDP	1-3 days	EDDP is an inactive metabolite that would be expected in the urine of a patient taking methadone.
Naltrexone	Naltrexone, 6-Beta-naltrexol	1-3 days	Naltrexone is metabolized to 6-Beta-naltrexol, an active metabolite which has a much longer half-life than the parent drug.

**Patient letters** are to be sent to patients following receipt of UDS results. When these letters are sent, they should be non-specific and not contain actual UDS results, out of respect for patient’s protected health information.

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**MONITORING FOR PATIENTS ON MAT - (CONT'D)**

**Urine Drug Screening Interpretation<sup>8</sup>**

**Language for UDS results:** it is not acceptable to call a UDS result “clean” or “dirty.” Instead UDS results are said to be “consistent with treatment” (expected) or “not consistent with treatment” (unexpected).

**UDS results described as consistent with treatment** should demonstrate both ingestion of prescribed medications *and* the absence of non-prescribed or illicit substances.

**There are two common scenarios where results are NOT consistent with treatment that cause concern in interpretation:**

- **Expected drug NOT found:** provider must look at the entire clinical picture to determine if the patient was: 1) not taking the drug, 2) taking a lower dose than instructed, or 3) taking the drug properly but the results were negative due to factors such as extremely diluted urine, unexpected rapid metabolism etc.
- **Unexpected drug found:** if a drug not prescribed to the patient is found, the entire clinical picture must be taken into consideration to determine if the patient was 1) taking the non-prescribed drug, 2) has a false positive result (can be seen commonly with screening, but confirmatory tests done make this much less likely) or 3) if the drug is simply a metabolite of a prescribed drug (as applicable).

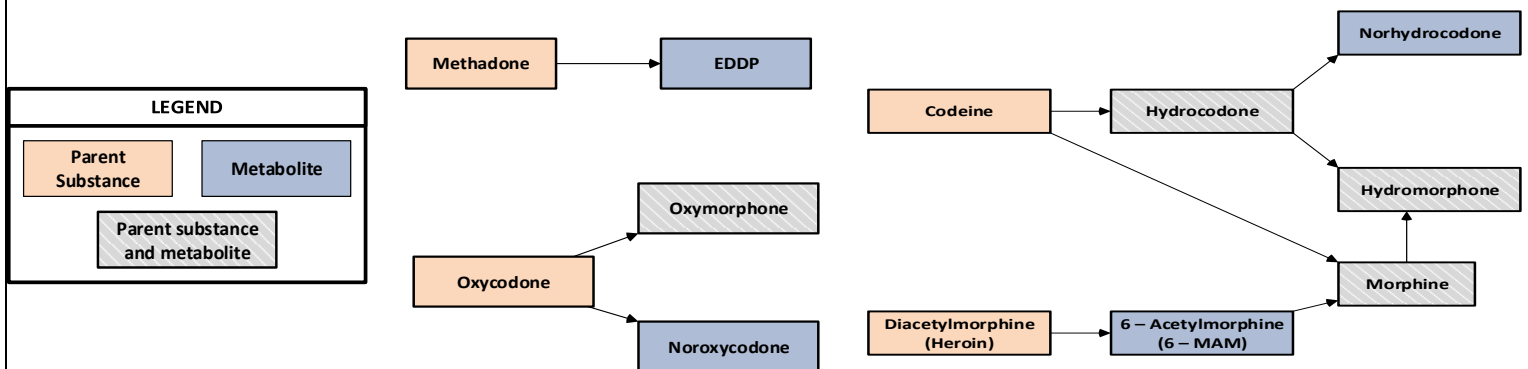
**What to do with results NOT consistent with treatment:**

- Have a conversation with the patient
- Consider supportive housing—discuss triggers with your patient, including those linked to housing such as a cellmate who continues to use
- Consider identifying and treating a co-occurring use disorder
- Consider a referral to mental health for co-occurring disorder
- Review elements of the therapeutic agreement
- Consider repeating the UDS
- Consider modifications to therapy as needed:
  - ⇒ Review the medication dose
  - ⇒ Refer to LCSW for re-evaluation of intensity of CBI/CBT
  - ⇒ Increase frequency of clinic visits
  - ⇒ Increase frequency of random UDS testing

**Do not over-interpret the UDS:** It is tempting to utilize concentrations of substances in the urine to infer compliance with ingestion of the drug. To do so, one must have the dose delivered at the same time multiple days in a row, give a urine sample at the same time of the day, have the same hydration level and many other factors. Given the variations in a myriad of factors, is it not recommended that the urine concentrations of medication be used for interpretation of compliance.

**Know How Opioids Metabolize:** when interpreting the results of a UDS, it is important to know how opioids metabolize so that you can determine whether the identified substance is an expected metabolite of the prescribed medication, or represents an unexpected drug which was not prescribed to the patient. See **Attachment C** for compounds and metabolites tested for in CCHCS UDS.

**Opioid Metabolic Pathways:** understanding the metabolism of opioid agents, both prescribed and illicit, is important in the interpretation of UDS results. For example, if a patient were on methadone and the UDS showed methadone, EDDP and 6-MAM it would be clear from these metabolism flow maps that 6-MAM cannot be a metabolic product of methadone and that the patient has likely ingested heroin in addition to the prescribed methadone.



SUMMARY	DECISION SUPPORT	PATIENT EDUCATION / SELF-MANAGEMENT
<b>TRANSITION SERVICES</b>		
<b>Inter-facility Transfers</b>		
<p>In order to transfer patient orders from a sending institution to a receiving institution, providers are encouraged to utilize the <a href="#">Cross Encounter Reconciliation (CER)</a> tool within Cerner.</p>		
<p>When utilizing the CER <u>it is critical to enter compliance dates consistent with the original orders.</u></p>		
<p>In addition, for patients on methadone who transfer to another institution, a medical hold is placed until care coordination can be arranged between the institutions.</p>		
<b>Patients Leaving CDCR<sup>9</sup></b>		
<p>People leaving prison are at significantly higher risk of dying of an overdose compared with age/sex controls in the general population. Therefore, the population leaving CDCR will be a focus of careful screening, assessment and treatment initiation.</p>		
<p>The Whole Person Care Transition Services Team comprised of Nursing, other CCHCS staff and CDCR partners, collaborates with community stakeholders in all 58 counties in California to arrange treatment continuity as patients prepare for release back into their community. This care coordination is collaborated through a routine pre-release coordination meeting consisting of the institution resource team, mental health pre-release coordinators, Transitional Case Management Program benefit workers, and parole service associates. The interdisciplinary Transition Services Team discuss patients' health and social needs to obtain the appropriate services upon release. Services arranged may include, but are not limited to:</p>		
<ul style="list-style-type: none"> <li>• Enrollment and activation of Medi-Cal benefits</li> <li>• Scheduling health care appointments, including connecting patients on methadone to community NTP</li> <li>• Obtaining housing</li> <li>• Arranging transportation to and from appointments</li> <li>• Engaging family &amp; peer support</li> <li>• Assisting with employment and/or education resources as needed</li> <li>• Providing a release packet that includes community resources with their contact information such as substance use, mental health, local county and city resources, free Internet and cell phones</li> <li>• Offering naloxone to all patients as they release</li> <li>• Educating patients on the use of naloxone and overdose prevention             <ul style="list-style-type: none"> <li>• Key points to make in educating patients during their pre-release planning:                 <ul style="list-style-type: none"> <li>⇒Periods of sobriety from opioids results in a loss of tolerance</li> <li>⇒Use of the same amount of opioids previously used or multiple doses over a short duration may result in death</li> <li>⇒Combining use of opioids with other agents such as alcohol or sedatives is deadly</li> </ul> </li> </ul> </li> </ul>		
<p>Patients on MAT will have additional requirements to assure continuity of medication delivery such as:</p>		
<ul style="list-style-type: none"> <li>• Patients receiving methadone via an NTP will be transitioned to an NTP in their community upon release.</li> <li>• Patients receiving buprenorphine, naltrexone, or acamprosate will be provided with a 30-day supply of their MAT medication</li> <li>• Provider must consult CURES when any controlled medications are prescribed at the time of parole or release, because these prescriptions will be dispensed to the patient and reported to CURES. Checking CURES protects the provider in the event of an audit against the dispensed medication at time of discharge.</li> <li>• Patients who are placed on injectable naltrexone within 3 months of release will be provided a medical alert card.</li> </ul>		
<b>Board of Parole Hearings</b>		
<p>In order to consider whether a patient is safe to reintegrate into the community, the Board of Parole Hearings has access to documents including the patient's medical records. Careful objective documentation regarding a patient's participation in the ISUDT Program and engagement in their sobriety is important to the Board's consideration.</p>		

SUMMARY	DECISION SUPPORT	PATIENT EDUCATION / SELF-MANAGEMENT
<b>SPECIAL CIRCUMSTANCES</b>		
<b>Managing Patients with Acute Pain While on MAT</b>		
<p>Advanced planning for patients on MAT who are scheduled for elective procedures is best.</p> <ul style="list-style-type: none"> <li>• Treatment of acute post-operative pain in patients on buprenorphine maintenance includes continuing the patient's baseline dosing to avoid increased pain and/or withdrawal.</li> <li>• Total daily doses of buprenorphine may have to be increased post-operatively for up to 7 days for pain control and may be split to optimize analgesia (e.g., 24 mg/day changed to 8 mg every 8 hours).</li> <li>• If further pain control is needed, utilize multimodal pain management with non-opioids (see <a href="#">CCHCS Care Guide: Pain Management Part 2—Therapy—Non-Opioid</a>).</li> <li>• Consider use of local and regional anesthesia as needed.</li> <li>• If opioids are needed for breakthrough pain, standard dosing protocols should initially be utilized with careful monitoring and the understanding that patients with a history of OUD may require higher than usual doses due to cross-tolerance and increased pain sensitivity.</li> <li>• Patient Controlled Analgesias (PCA) without a basal component may be considered in addition to a patient's buprenorphine if pain is not adequately captured. If a PCA is utilized, discontinue oral PRN opioids.</li> <li>• The buprenorphine/naloxone provider should be contacted pre- and post-procedure to assist in ongoing assessment, support and pain management</li> <li>• Patient should be scheduled to be seen by their buprenorphine/naloxone prescriber within one week post-procedure</li> </ul> <p>In order to overcome the pharmacologic blockade on extended-release injectable naltrexone, extremely high doses of opioids are required to achieve adequate analgesia. This could lead to accidental overdose, <b>respiratory depression and death</b>. Non-opioid analgesics are recommended whenever possible. Regional nerve blocks and dissociative analgesics such as ketamine may be considered. Generally, transfer to a higher level of care is necessary to manage the patient in a setting that offers a full range of cardiopulmonary monitoring and ventilator support if necessary.</p> <p>Patients with oral pain should be referred for dental consultation.</p> <p>Co-consultation with the AMCT and a Pain Specialist should occur with any of these scenarios.</p>		
<b>Co-Occurring Mental Illnesses and SUD<sup>7</sup></b>		
<p>Psychiatric illness and substance use have a complex and bidirectional relationship. It is estimated that about half of those who experience a mental illness during their lives will also experience SUD.</p> <ul style="list-style-type: none"> <li>• Some begin to experience MH issues first, experiment with drugs and alcohol to "self-medicate" and develop an SUD.</li> <li>• Others may first develop an SUD that triggers the onset of symptoms that may have otherwise remained dormant.</li> <li>• Self-medication to treat psychiatric symptoms, exacerbations of psychiatric symptomatology during periods of intoxication and withdrawal, and substance-facilitated elevations in suicide and violence risk are some examples of issues that need to be considered for effective substance use and psychiatric treatment.</li> </ul> <p>Patients with co-occurring MH illness and SUD should have collaborative care coordinated by Medical and MH providers, as Integrated treatment for both SUD and co-occurring MH illness is more effective than treating them separately.</p> <p>When depression is identified through conversation with patient or through PHQ-2/PHQ-9, patient should be referred to MH.</p>		
<b><u>MAT In the Inpatient Setting</u></b>		
<p>As clinically indicated, the integration of MAT treatment decisions into the overall psychiatric treatment plan is encouraged.</p> <p>Patients transferring to a psychiatric inpatient unit already on MAT should be continued on MAT without interruption unless the patient's treatment requires adjustment via collaboration with the treating psychiatrist.</p>		
<p>There are three primary mental health inpatient levels of care within CDCR:</p> <ul style="list-style-type: none"> <li>• Mental Health Crisis Bed (MHCB) - acute crisis stabilization (hospitalization length of days to weeks)</li> <li>• PIP Acute (Acute Psychiatric Program - APP) - longer term crisis stabilization (hospitalization length of weeks to months)</li> <li>• PIP Intermediate (Intermediate Care Facility - ICF) - long term inpatient care for patients who cannot function in outpatient settings but not requiring acute crisis stabilization (hospitalization length of months to years)</li> </ul>		
<p>In many cases, it may be preferable to initiate MAT within the longer-term PIP programs, rather than during the shorter-term crisis stabilization treatment settings (e.g., MHCB), although treatment determinations should be coordinated by the treatment team as noted above.</p>		

SUMMARY	DECISION SUPPORT	PATIENT EDUCATION / SELF-MANAGEMENT
<b>SPECIAL CIRCUMSTANCES (CONT'D)</b>		
<b>Reports of Noncompliance</b>		
<p>When report of potential medication misuse and/or noncompliance with other aspects of care are received, these generally should not trigger a report to custody. The following steps shall be taken by health care staff:</p> <ul style="list-style-type: none"> <li>• <u>For all reported cases of misuse, providers should have a conversation with the patient and conduct their own inquiry</u></li> <li>• Meet with the patient to explore potential triggers or reasons for reported behaviors</li> <li>• Review the patient's MAR and UDS to determine if they are consistent</li> <li>• Consider next steps including therapeutic adjustments as necessary, which may include: <ul style="list-style-type: none"> <li>⇒ Supportive housing to remove some potential triggers</li> <li>⇒ Medication agent, dose, and timing of treatment</li> </ul> </li> <li>• If additional guidance is needed, consider Care Team Enhance Conferences (CTEC) or other resources</li> <li>• Consider the use of alternative MAT agent such as an injectable through submission of a MAT AAA form (see Page 13)</li> <li>• Report systemic issues to your local ISUDT Steering Committee</li> <li>• Document the outcome of the above in a progress note in EHRS</li> </ul>		
<b>Common Scenarios</b>		
<p>Some common scenarios in treatment that may need to be addressed include:</p> <ul style="list-style-type: none"> <li>• Behavior issues at the pill line: have a conversation with the patient and ensure documentation regarding the correct manner of taking the strip</li> <li>• No buprenorphine/norbuprenorphine in UDS: reconcile with the MAR and ensure that the patient has been presenting to pill line to take the medication. Consider other substances found in the urine to determine if the urine truly belongs to the patient</li> <li>• Patient wants to stop suboxone due to yard politics: remember that these patients have a high risk of overdose, consider KOP naltrexone. In addition, have the patient sign an informed refusal</li> <li>• Patient refuses to participate in CBI or supportive housing: these programs, while helpful in establishing sobriety and recovery, are NOT mandatory for MAT medication. We do not stop MAT due to refusal of these other treatment components.</li> </ul>		
<b>RESOURCES</b>		
<ul style="list-style-type: none"> <li>• The institution Addiction Medicine Champion is the first line for questions that arise while managing patients on MAT.</li> <li>• The Addiction Medicine Central Team is available for questions unresolved by champion outreach.</li> <li>• For patient specific questions or concerns, use the <b>HQ Addiction Services Provider Message Pool</b> in EHRS.</li> <li>• For programmatic questions, contact the MAT Mailbox at <a href="mailto:MAT@cdcr.ca.gov">MAT@cdcr.ca.gov</a>.</li> <li>• Additional resources are available in the <a href="#">Provider Resource Library</a>, including materials related to Motivational Interviewing,</li> </ul>		

SUMMARY	DECISION SUPPORT	PATIENT EDUCATION / SELF-MANAGEMENT	
<b>MEDICATION TABLES</b>			
<b>Acamprosate</b>			
MEDICATION	DOSING*	ADVERSE EFFECTS/ INTERACTIONS*	COMMENTS*
<p><b>Acamprosate</b></p> <p><b>Delayed Release Tablet:</b> <b>333 mg</b></p> <p><b>\$\$\$\$</b></p>	<p>Usual dose: 666 mg orally three times daily for AUD</p> <p>Maintain treatment even if the patient relapses.</p> <p><u>Renal Impairment:</u> CrCl &gt;50 mL/min: No dosage adjustment necessary</p> <p>CrCl 30—50 mL/min: Starting dose of 333 mg orally three times daily is recommended</p> <p>CrCl ≤30 mL/min: Contraindicated</p>	<p><u>Adverse effects:</u></p> <ul style="list-style-type: none"> <li>• Major: Suicidality 2.4% (vs. 0.8% on placebo during the first year in clinical trials),</li> <li>• Common: Diarrhea (16%)</li> <li>• Other: Anxiety, asthenia, depression, insomnia, flatulence, nausea, pruritus, pain, dizziness</li> </ul> <p><u>Drug interactions:</u></p> <ul style="list-style-type: none"> <li>• Antidepressants: Weight changes more common than with either medication alone</li> </ul>	<p><u>Contraindications:</u></p> <ul style="list-style-type: none"> <li>• Hypersensitivity to acamprosate or any component of the product</li> <li>• Severe renal insufficiency (CrCl ≤30 mL/min)</li> </ul> <p><u>Use with caution in:</u></p> <ul style="list-style-type: none"> <li>• Moderate renal impairment (CrCl 30-50 mL/min)</li> <li>• Depression</li> <li>• Suicidal ideation/attempts</li> <li>• Sulfite hypersensitivity</li> <li>• Elderly</li> <li>• Pregnancy (Category C)</li> <li>• Breastfeeding</li> </ul> <p>Safe to use for patients with liver disease</p>

**Bold = Formulary**

\*See prescribing information for complete description of dosing, adverse effects, drug interactions, precautions and contraindications

The cost scale \$-\$\$\$\$ represents the relative cost of acquisition of medication only. Frequency and complexity of medication administration (institution workload, effect on adherence) should be considered when determining overall cost-effectiveness of treatment.

<b>SUMMARY</b>	<b>DECISION SUPPORT</b>	<b>PATIENT EDUCATION / SELF-MANAGEMENT</b>
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**MEDICATION TABLES CONT'D**

**Buprenorphine/Naloxone**

MEDICATION	DOSING*	ADVERSE EFFECTS/ INTERACTIONS*	COMMENTS*
<p><b>Buprenorphine/ Naloxone (Suboxone®)</b>  <b>Sublingual Films:</b>  <b>2 mg/0.5 mg</b>  <b>4 mg/1 mg</b>  <b>8 mg/2 mg</b>  <b>12 mg/3 mg</b>  <b>\$\$\$ - \$\$\$</b></p> <p><b>Buprenorphine (plain)</b>  <b>[Limited use for pregnancy only]</b>  <b>Sublingual Tablets:</b>  <b>2 mg, 8 mg</b>  <b>\$\$\$ - \$\$\$</b></p> <p><b>RESTRICTED USE</b>  <b>Injection, ER (Sublocade®)</b>  <b>300 mg/mL</b>  <b>\$\$\$\$</b></p>	<p><u>Sublingual Films:</u>                      Induction therapy for patients dependent on opioids:</p> <ul style="list-style-type: none"> <li>• Induction is generally initiated after objective signs of moderate withdrawal appear and at least 6 hours following the last opioid dose.</li> <li>• Day 1: Initial, buprenorphine/naloxone 2 mg/ 0.5 mg – 4 mg/ 1 mg SL with incremental increase to a maximum dose of 8 mg. Checking COWS between doses administered every 1-2 hours may guide medication titration (i.e., additional doses for COWS≥6; end titration once COWS≤5).</li> <li>• Continue daily at established dose for 1 week. Re-evaluate at/within 7-days.</li> <li>• At 1 week follow-up, if symptoms not optimized, may increase the dose in 2/0.5 mg - 4mg/ 1 mg SL increments up to 16 mg/ 4 mg SL or higher if necessary. To be effective, dose should be sufficient to enable patients to discontinue illicit opioid use.</li> <li>• Maximum dose: Doses above 24 mg/6 mg SL daily have not demonstrated a clinical advantage.</li> <li>• Patients should be seen frequently at the beginning of treatment until they are determined to be stable.</li> <li>• <u>Pregnancy:</u> Do NOT use the combined formulation (buprenorphine/naloxone); use the single ingredient buprenorphine SL tablets. Pregnant patients require specialist management. See <a href="#">CCHCS MAT for OUD in Pregnancy Care Guide</a> for details.</li> </ul> <p><b>RESTRICTED USE</b>  <b>IM Injection, Extended Release:</b>  <b>For patients who have been stabilized on SL buprenorphine for a minimum of 7 days and are releasing from prison within 3 months.</b></p> <p><b>Recommended dose: 300 mg SQ once monthly for the first 2 months, followed by 100 mg once monthly with a minimum of 26 days between doses. Based on clinical response, maintenance dose may be increased to 300 mg once monthly if benefits outweigh the risks</b></p> <ul style="list-style-type: none"> <li>• <b>Serious harm or death can occur if given IV</b></li> <li>• <b>SQ Injection - Use not recommended in moderate to severe hepatic impairment (Child Pugh B or C)</b></li> </ul>	<p><u>Adverse effects:</u></p> <ul style="list-style-type: none"> <li>• <b>Major:</b> Addiction, abuse, misuse, lethargy, respiratory and CNS depression- avoid combining with other depressants, hypersensitivity reactions, elevation of cerebrospinal fluid pressure - caution in patients with head injury, elevation of intracholedochal pressure - caution in patients with biliary tract dysfunction, adrenal insufficiency</li> <li>• <b>Common:</b> Headache, dizziness, nausea, constipation, opioid withdrawal</li> <li>• <b>Other:</b> Neonatal Opioid Withdrawal Syndrome, hepatic events, orthostatic hypotension</li> <li>• May impair ability to drive or operate machinery</li> <li>• May obscure diagnosis and clinical course of an acute abdominal condition</li> </ul> <p><u>Drug Interactions:</u></p> <ul style="list-style-type: none"> <li>• CNS depressants - to include benzodiazepines and muscle relaxants, and other opioids</li> <li>• Inhibitors of CYP3A4 - can increase plasma concentrations of buprenorphine</li> <li>• Inducers of CYP3A4 - can decrease plasma concentrations of buprenorphine</li> <li>• Serotonergic Drugs- serotonin syndrome</li> <li>• MAOIs- may cause serotonin syndrome, recommend to be off MAOIs x 14 days prior to initiation</li> <li>• Diuretics - opioids may reduce efficacy of diuretics</li> <li>• Anticholinergic Drugs - increases risk of urinary retention and constipation</li> <li>• Antiretrovirals                             <ul style="list-style-type: none"> <li>⇒ NNRTIs – may act as CYP3A4 inducer</li> <li>⇒ PIs – may act as CYP3A4 inhibitor</li> </ul> </li> </ul>	<p><u>Contraindications:</u></p> <ul style="list-style-type: none"> <li>• Hypersensitivity to drug/class</li> <li>• Avoid abrupt withdrawal</li> </ul> <p><u>Use with caution in:</u></p> <ul style="list-style-type: none"> <li>• Elderly or debilitated patients</li> <li>• Pulmonary impairment</li> <li>• CNS depression</li> <li>• Concurrent CNS depressant use including alcohol</li> <li>• Hepatic impairment, moderate or severe (Child Pugh class B/C)</li> <li>• Delirium tremens</li> <li>• Toxic psychosis</li> <li>• ICP increase</li> <li>• Head injury</li> <li>• Hypothyroidism or myxedema</li> <li>• Electrolyte abnormalities</li> <li>• QT prolongation or a family history of QT prolongation</li> <li>• History of Torsades de pointes</li> <li>• Ventricular arrhythmias</li> <li>• Bradycardia</li> <li>• Recent MI</li> <li>• CHF</li> <li>• Acute abdomen</li> <li>• Biliary surgery or disease</li> <li>• Adrenal insufficiency</li> <li>• Prostatic hypertrophy</li> <li>• Urethral stricture</li> <li>• Kyphoscoliosis</li> </ul> <p>• Consider reducing starting and titration dose by 50% in severe hepatic impairment (Child Pugh C).</p>

**Bold = Formulary**

\*See prescribing information for complete description of dosing, adverse effects, drug interactions, precautions and contraindications

The cost scale \$-\$\$\$\$ represents the relative cost of acquisition of medication only. Frequency and complexity of medication administration (institution workload, effect on adherence) should be considered when determining overall cost-effectiveness of treatment.



SUMMARY	DECISION SUPPORT	PATIENT EDUCATION / SELF-MANAGEMENT	
<b>MEDICATION TABLES CONT'D</b>			
<b>Methadone</b>			
MEDICATION	DOSING*	ADVERSE EFFECTS/ INTERACTIONS*	COMMENTS*
<p><b>Methadone (Dolophine®)</b></p> <p>for OUD can only be given in a federally licensed facility and must be given as a solution. This is achieved by dissolving tablets in a designated volume of water</p> <p><b>Tablet: 5 mg, 10 mg</b></p> <p>CCHCS providers will order up to 3-days of methadone therapy in order to continue newly arrived patients on Methadone for OUD.</p> <p>Arrangements must be made for the patient to be seen at nearby NTP by day 4.</p> <p>\$</p>	<ul style="list-style-type: none"> <li>• <u>Typical dose:</u> 60-120 mg orally daily for maintenance</li> <li>• <u>Max effect:</u> Achieved in 7 days</li> <li>• <u>Severe renal (CrCl &lt;10 mL/min) and severe hepatic (Child Pugh Class C) impairment:</u> Dose adjustments recommended; monitor for signs of respiratory and CNS depression</li> </ul> <p><b>Note: All dose adjustments done by the Federal NTP prescribing provider</b></p>	<p><u>Adverse effects:</u></p> <ul style="list-style-type: none"> <li>• <u>Major:</u> Addiction, abuse, misuse, QT prolongation/sudden death, respiratory depression, hypotension</li> <li>• <u>Common:</u> Nausea, vomiting, constipation, dizziness, sedation, sweating, weight gain</li> <li>• <u>Other:</u> Seizures, increased cholesterol/triglycerides</li> <li>• May impair ability to drive or operate machinery</li> <li>• May obscure diagnosis of an acute abdominal condition</li> </ul> <p><u>Drug Interactions:</u></p> <ul style="list-style-type: none"> <li>• Azole antifungals</li> <li>• Antiarrhythmic</li> <li>• Benzodiazepines</li> <li>• Antipsychotics</li> <li>• Cimetidine</li> <li>• Cyclobenzaprine</li> <li>• Macrolides</li> <li>• Fluoroquinolones</li> <li>• SSRIs</li> <li>• TCAs</li> <li>• Pentamidine</li> <li>• Some HIV Meds</li> <li>• Rifampin</li> <li>• Carbamazepine</li> <li>• Risperidone</li> <li>• Phenobarbital</li> <li>• Phenytoin</li> </ul>	<p><b>Statements from the FDA regarding methadone:</b></p> <p>Prescribers of methadone should be familiar with methadone's toxicities and unique pharmacokinetic properties. Methadone dose should be slowly titrated.</p> <p><b>Boxed warnings:</b> Life-threatening respiratory depression- monitor for respiratory depression especially during initiation or following dose increases.</p> <ul style="list-style-type: none"> <li>• Life-threatening QT prolongation - closely monitor patients for changes in cardiac rhythm during initiation and titration</li> </ul> <p><u>Contraindications:</u></p> <ul style="list-style-type: none"> <li>• Hypersensitivity to methadone or any component of the product</li> <li>• Significant respiratory disorder, acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment, paralytic ileus</li> </ul> <p><u>Precautions:</u></p> <ul style="list-style-type: none"> <li>• Use caution in patients with chronic pulmonary disease, cardiac disease, urethral stricture, concurrent use with CNS depressants, pregnancy, hepatic or renal insufficiency, elderly</li> </ul> <p><u>Monitoring:</u></p> <ul style="list-style-type: none"> <li>• Obtain ECG at baseline, 1 month and annually due to QT prolongation. (Increase ECG monitoring if patient receiving &gt;100 mg/day or if unexplained syncope or seizure occurs while on methadone):</li> <li>• If QTC is &gt;450 ms but &lt;500 ms, consider risk vs. benefit - monitor more frequently</li> <li>• If QTC is &gt;500 ms, consider alternative therapy (buprenorphine or naltrexone), dose reduction, or elimination of contributing factors (e.g., other medications)</li> </ul>

**Bold = Formulary**

\*See prescribing information for complete description of dosing, adverse effects, drug interactions, precautions and contraindications

The cost scale \$-\$\$\$\$\$ represents the relative cost of acquisition of medication only. Frequency and complexity of medication administration (institution workload, effect on adherence) should be considered when determining overall cost-effectiveness of treatment.



<b>SUMMARY</b>	<b>DECISION SUPPORT</b>	<b>PATIENT EDUCATION / SELF-MANAGEMENT</b>
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**MEDICATION TABLES CONT'D**

**Topiramate**

MEDICATION	DOSING*	ADVERSE EFFECTS/INTERACTIONS*	COMMENTS*
<p>Topiramate Oral tablets</p> <p>Tablet: 25 mg, 50 mg, 100 mg</p> <p>\$</p> <p><b>RESTRICTED USE—requires submission of a MAT AAA Form for consideration</b></p>	<p><u>Dosage and Administration:</u> Initial dose—Dose adjusts weekly when initiating topiramate. Week 1—25 mg Q daily Week 2—25 mg BID Week 3—50 mg BID Week 4—75 mg BID Week 5 and ongoing—100 mg BID</p> <p><u>Maximum recommended dose:</u> 300 mg daily</p>	<p><b>Adverse effects:</b></p> <ul style="list-style-type: none"> <li>• Major: anorexia, epilepsy, speech disorders/related speech problems, serious skin reaction, kidney stones</li> <li>• Common: paresthesia, weight loss, fatigue, dizziness, somnolence, nervousness, fever, migraine, drowsiness, dysmenorrhea, mastalgia, nystagmus,</li> <li>• Other: psychomotor slowing, abnormal vision, oligohidrosis, hyperthermia, acute myopia, secondary angle closure glaucoma, metabolic acidosis, suicidal behavior and ideation, cognitive/neuropsychiatric adverse reactions, hyperammonemia and encephalopathy, hypothermia with concomitant valproic acid</li> </ul> <p><b>Drug Interactions:</b></p> <ul style="list-style-type: none"> <li>⇒ Oral contraceptives: decreased contraceptive efficacy and increased breakthrough bleeding, especially at doses greater than 200 mg/day</li> <li>⇒ Monitor lithium levels if lithium is used with high-dose topiramate</li> </ul>	<p><b>Contraindications:</b></p> <ul style="list-style-type: none"> <li>• Patients with known allergies or sensitivity to Topiramate</li> </ul> <p><b>Use with caution in:</b></p> <ul style="list-style-type: none"> <li>• Women who are pregnant or breastfeeding</li> <li>• Patients with reduced renal function</li> <li>• 1 - 24 months experience increased risk on infection</li> <li>• Patients with history of kidney stones</li> </ul> <p><b>Pregnancy:</b> Topiramate can cause fetal harm when administered to a pregnant woman. When administered to an infant in utero, this medication has shown to cause cleft lip and/or cleft palate and being small for gestational age.</p>

**Bold = Formulary**

\*See prescribing information for complete description of dosing, adverse effects, drug interactions, precautions and contraindications

The cost scale \$-\$\$\$\$\$ represents the relative cost of acquisition of medication only. Frequency and complexity of medication administration (institution workload, effect on adherence) should be considered when determining overall cost-effectiveness of treatment.

## SUMMARY

## DECISION SUPPORT

## PATIENT EDUCATION / SELF-MANAGEMENT

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<b>SUMMARY</b>	<b>DECISION SUPPORT</b>	<b>PATIENT EDUCATION/SELF MANAGEMENT</b>
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## PATIENT EDUCATION/SELF-MANAGEMENT OPIOID USE DISORDER (OUD)

### WHAT IS OPIOID USE DISORDER?

Opioid Use Disorder (OUD) is a treatable disease that can be caused by frequent opioid use. It is also known as opioid addiction.

- Addiction is a chronic disease. No one knows exactly why some people get addicted and some people do not. Your genes are a part of it. Often addiction runs in families.
- Lifestyle and your surroundings can put someone at higher risk of becoming addicted.
- Addiction cannot be cured, however it can be managed with counseling, medication, and support from family and friends.
- Recovery takes a lifetime of commitment, one day at a time.



Symptoms include:

- Strong cravings for opioids
- Feeling unable to stop or reduce opioid use
- Having work, school, legal, or family problems caused by your opioid use
- Needing more opioids to get the same effect
- Feeling sick after stopping or lowering use

### WHAT ARE THE COMPLICATIONS CAUSED BY OPIOID USE DISORDER?

**Short-term**

- Sedation
- Paranoia
- Nausea
- Risky behaviors
- Death from accident or overdose due to stopping breathing



**Longer-term**

- Constipation
- Depression
- Insomnia
- Decreases in testosterone
- Osteoporosis
- HIV & Hepatitis C
- Cirrhosis (liver failure)
- Brain damage from decreased breathing



### HOW IS IT TREATED?

OUD can be treated with a combination of counseling and therapeutic methods as well as medication, which may be appropriate for some cases. The support of family and friends can also be critical to the success of treatment. Medication Assisted Treatment may help to reduce cravings, or to manage withdrawal symptoms.



Cognitive Behavioral Intervention (CBI) may help you learn to:

- Move away from doing things that are harmful to you
- Change addictive thoughts into healthy thoughts
- Make healthy decisions
- Handle setbacks and stress
- Deal with feelings such as depression or low self-esteem
- Recognize the cues and habits that lead to opioid use



**SUMMARY**

**DECISION SUPPORT**

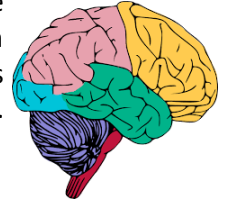
**PATIENT EDUCATION/SELF MANAGEMENT**

**PATIENT EDUCATION/SELF-MANAGEMENT**

**ALCOHOL USE DISORDER (AUD)**

**ALCOHOL USE DISORDER: WHAT IS IT?**

Alcohol Use Disorder (AUD) is a chronic disease, similar to diabetes, hypertension and asthma. No one knows exactly why some people get addicted and some people do not. Your genes are a part of it. Often addiction runs in families. AUD is related to the large consumption of alcohol resulting in chemical changes in the brain. There are no known cures, but the disease can be treated with counseling and detoxification. Medications may be appropriate in some cases, and may help in reducing the desire to drink.



**WHAT COMPLICATIONS ARE CAUSED BY ALCOHOL USE DISORDER?**

AUD causes complications for a person’s health and for their personal lives. The health impacts include a strong desire to drink, tiredness, dizziness, upset stomach, dehydration, liver problems, weakened immune system and vomiting. A person with AUD might also engage in risky behaviors or place themselves in dangerous situations as a result of drinking alcohol, or become sick for long periods of time due to overdrinking.

AUD can also hurt a person’s relationships. Often the desire to drink can outweigh the desire to engage in other social behaviors such as time with family or friends. In more severe instances, it may also impact a person’s ability to take care of their responsibilities, including their job, and/or contribute to bad decisions that can result in legal trouble.

**CONSEQUENCES OF ALCOHOL USE**

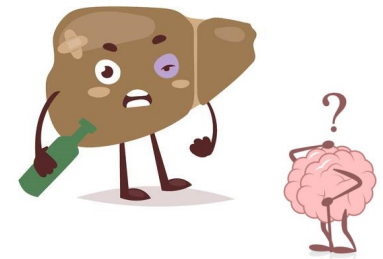
**Short-term**

- Sedation
- Slurred speech
- Emotional changes
- Lower body temperature
- Heartburn, nausea, vomiting
- Loss of bowel or bladder control
- Decreased number of hours of sleep
- Risky behaviors
- Blackouts
- Death from accident or alcohol poisoning



**Longer-term**

- Weight gain
- High blood pressure
- Depression
- Gastritis
- Pancreatitis
- Anemia
- Cirrhosis (liver failure)
- Decreased sexual performance
- Death of brain cells leading to memory problems and loss of balance
- Increased risk of cancers of the mouth, esophagus, stomach and bladder



**HOW IS ALCOHOL USE DISORDER TREATED?**

AUD can be treated with a combination of counseling and therapeutic methods as well as medication, which may be appropriate for some cases. The support of family and friends can also be important to the success of treatment.

Medication assisted treatment may help to reduce cravings, or to manage withdrawal symptoms.



CBI may help you learn to:

- Move away from doing things that are harmful to you.
- Change addictive thoughts into healthy thoughts.
- Make healthy decisions.
- Deal with feelings such as depression or low self-esteem.
- Recognize the cues and habits that lead to alcohol use.
- Handle setbacks and stress.

<b>SUMMARY</b>	<b>DECISION SUPPORT</b>	<b>PATIENT EDUCATION/Self MANAGEMENT</b>
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## PATIENT EDUCATION/Self-MANAGEMENT RELAPSE PREVENTION

### WHAT IS A RELAPSE?

Relapse occurs when someone who suffers from a disease has a setback in their progress of recovery. Often this means that a person goes back to habits and use patterns that are similar to what they engaged in before beginning treatment. With some substance use disorders, relapses can be dangerous and even life-threatening.



A relapse does not mean that a person has failed out of treatment or that they are unable to successfully continue in recovery. It is a momentary setback, but is not an event that necessarily undoes the progress that has been achieved.

### SIGNS AND RISKS OF RELAPSE

Relapses are generally a gradual process with distinct stages. If the warning signs are noticed, the process may be prevented.

**Signs and Risks of Relapse:**

- Hungry, Angry, Lonely or Tired (HALT)
- Bottled-up emotions
- Avoidance of support groups
- Poor self care, poor eating and sleeping habits
- Not addressing strong cravings
- Romanticizing/glorifying people, places and things that are associated with past use
- Minimizing the consequences of continued use



### STRATEGIES FOR PREVENTING RELAPSE

- Avoid people, places and activities that are associated with the substances.
- Develop pleasurable and rewarding alternatives to drug use .
- Join a peer support group that can help celebrate the steps of sobriety taken and offer accountability.
- Build a solid support network of friends, family, etc.
- If you begin to think about returning to drug use, speak with your health care team right away.



<b>SUMMARY</b>	<b>DECISION SUPPORT</b>	<b>PATIENT EDUCATION/Self MANAGEMENT</b>
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## PATIENT EDUCATION/Self-MANAGEMENT OVERDOSE PREVENTION

### WHAT IS AN OVERDOSE?

Overdose happens when a toxic amount of a drug, or combination of drugs overwhelms the body. People can overdose on lots of things including alcohol, Tylenol, opioids or a mixture of drugs.

*Opioid* overdoses happen when there are so many opioids or a combination of opioids and other drugs in the body that breathing decreases or even stops and this can result in death.

Heroin, prescription opioids (like Oxycontin, Fentanyl, Morphine, Vicodin, Percocet, etc.) and other *downers* such as alcohol and benzodiazepines (like Xanax, Klonopin, Valium, Ativan, etc.) are very dangerous when taken together since they all affect the body’s central nervous system which slows breathing, blood pressure, and heart rate, and can reduce body temperature resulting in death.

In a *stimulant* overdose drugs like *speed*, *cocaine*, and *ecstasy* raise the heart rate, blood pressure, and body temperature, and speed up breathing. This can lead to a seizure, stroke, heart attack or death.

### RISKS FOR OVERDOSE

Anyone who uses opioids can experience an overdose, but certain factors may increase risk including, but not limited to:

- Combining opioids with alcohol or certain other drugs
- Taking high daily dosages of prescription opioids
- Taking more opioids than prescribed
- Taking illicit or illegal opioids, like heroin or illicitly-manufactured fentanyl, that could possibly contain unknown or harmful substances
- Certain medical conditions, such as sleep apnea, or reduced kidney or liver function make overdose more likely
- Age greater than 65 years old



### SIGNS OF OVERDOSE

<ul style="list-style-type: none"> <li>• Slow and difficult breathing</li> <li>• Fingernails and lips turning blue or purple</li> <li>• Very small “pinpoint” pupils</li> <li>• Slow heartbeat and/or low blood pressure</li> <li>• Cold, clammy skin</li> </ul>	<ul style="list-style-type: none"> <li>• Frequent vomiting</li> <li>• Extreme sleepiness or unable to wake up</li> <li>• Dizziness and confusion</li> </ul>
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### STRATEGIES FOR PREVENTING OVERDOSE

- ⇒ Start at a lower dose or do a test shot if you haven’t used in a while (because in the hospital, jail, or detox) because your body is not used to the same amount as before.
- ⇒ Don’t use alone (no one can help you).
- ⇒ Don’t mix drugs like benzos, alcohol and opioids (like heroin).





<b>RESUMEN</b>	<b>APOYO PARA TOMAR DECISIONES</b>	<b>EDUCACIÓN PARA EL PACIENTE/CONTROL PERSONAL DEL CASO</b>
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## EDUCACIÓN PARA EL PACIENTE/CONTROL PERSONAL DEL CASO TRASTORNO POR CONSUMO DE OPIOIDES (TCO)

### ¿QUÉ ES EL TRASTORNO POR CONSUMO DE OPIOIDES?

El Trastorno por Consumo de Opioides (TCO) es una enfermedad tratable que puede ser causada por el uso frecuente de opioides. También se conoce como adicción a los opioides.

- La adicción es una enfermedad crónica. No se sabe con exactitud por qué algunas personas se vuelven adictas y otras no, pero los genes son un factor determinante y por ello a menudo la adicción se hereda en las familias.
- El estilo de vida y el entorno pueden poner a alguien en mayor riesgo de volverse adicto.
- La adicción no se puede curar, sin embargo, se puede controlar con asesoría, medicamentos y apoyo de familiares y amigos.
- La recuperación requiere toda una vida de compromiso, un día a la vez.



#### Los síntomas incluyen:

- Antojos fuertes de consumir opioides
- Sentirse incapaz de detener o reducir el uso de opioides
- Tener problemas laborales, escolares, legales o familiares a causa del uso de opioides
- Necesitar más opioides para obtener el mismo efecto
- Sentirse enfermo después de dejar o disminuir el consumo

### ¿CUÁLES SON LAS COMPLICACIONES QUE CAUSA EL TRASTORNO POR CONSUMO DE OPIOIDES?

**A corto plazo**

- Sedación
- Paranoia
- Náuseas
- Comportamientos arriesgados
- Muerte por accidente o sobredosis debido a la suspensión de la respiración



**A largo plazo**

- Estreñimiento
- Depresión
- Insomnio
- Disminución de la testosterona
- Osteoporosis
- VIH y hepatitis C
- Cirrosis (fallo del hígado)
- Daño cerebral debido a la disminución de la respiración



### ¿CÓMO SE TRATA?

El Trastorno por Consumo de Opioides se puede tratar con una combinación de asesoría y métodos terapéuticos, así como con medicamentos, los cuales pueden ser apropiados para algunos casos. El apoyo de la familia y los amigos también puede ser importante para el éxito del tratamiento.



El tratamiento asistido con medicamentos puede ayudar a reducir la necesidad de consumir o a controlar los síntomas de abstinencia.

Las intervenciones cognitivas conductuales pueden ayudarle a:

- Alejarse de situaciones que sean peligrosas para usted
- Cambiar pensamientos adictivos por otros saludables
- Tomar decisiones saludables
- Manejar las complicaciones y el estrés
- Lidar con sentimientos de depresión o baja autoestima
- Reconocer los impulsos y hábitos que conducen al consumo de opioides

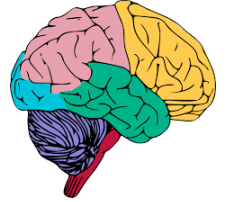


<b>RESUMEN</b>	<b>APOYO PARA TOMAR DECISIONES</b>	<b>EDUCACIÓN PARA EL PACIENTE/CONTROL PERSONAL DEL CASO</b>
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## EDUCACIÓN PARA EL PACIENTE/CONTROL PERSONAL DEL CASO TRASTORNO POR CONSUMO DE ALCOHOL (TCA)

### TRASTORNO POR CONSUMO DE ALCOHOL: ¿QUÉ ES?

El Trastorno por Consumo de Alcohol (TCA) es una enfermedad crónica similar a la diabetes, la hipertensión y el asma. No se sabe con exactitud por qué algunas personas se vuelven adictas y otras no, pero los genes son un factor determinante y por ello a menudo la adicción se hereda en las familias. El Trastorno por Consumo de Alcohol esta relacionado con un elevado consumo de alcohol que provoca cambios químicos en el cerebro.



No se conoce ninguna cura, pero la enfermedad se puede tratar mediante la asesoría y la desintoxicación. Los medicamentos pueden ser apropiados en algunos casos y pueden ayudar a reducir el deseo de beber.

### ¿CUÁLES SON LAS COMPLICACIONES QUE CAUSA EL TRASTORNO POR CONSUMO DE ALCOHOL?


El Trastorno por Consumo de Alcohol causa complicaciones para la salud y la vida de una persona. Los impactos en la salud incluyen un fuerte deseo de beber, cansancio, mareos, malestar estomacal, deshidratación, problemas hepáticos, debilidad del sistema inmunológico y vómitos. Una persona con este trastorno también puede tener comportamientos arriesgados o involucrarse en situaciones peligrosas al beber alcohol, o enfermarse por largos periodos debido al exceso de bebida.

Este Trastorno por Consumo de Alcohol puede dañar las relaciones de una persona. A menudo, el deseo de beber puede superar el deseo de participar en otras actividades sociales como pasar tiempo con la familia o amigos. En casos más graves, también puede afectar la capacidad de una persona para asumir sus responsabilidades, incluido su trabajo, y/o contribuir a malas decisiones que pueden resultar en problemas legales.

### CONSECUENCIAS DEL USO DEL ALCOHOL

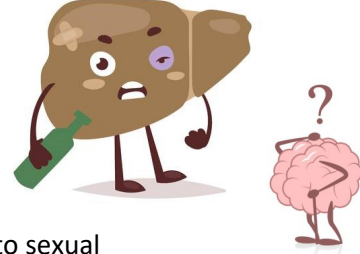
**A corto plazo**

- Sedación
- Dificultad para hablar
- Cambios emocionales
- Menor temperatura corporal
- Acidez estomacal, náuseas, vómitos
- Pérdida del control de los intestinos o de la vejiga
- Disminución del número de horas de sueño
- Comportamientos arriesgados
- Pérdida del conocimiento
- Muerte por accidente o intoxicación por alcohol



**A largo plazo**

- Aumento de peso
- Presión sanguínea alta
- Depresión
- Gastritis
- Pancreatitis
- Anemia
- Cirrosis (fallo del hígado)
- Disminución del rendimiento sexual
- Muerte de las células cerebrales que ocasiona problemas de memoria y pérdida del equilibrio
- Aumento del riesgo de cáncer de boca, esófago, estómago y vejiga



### ¿CÓMO SE TRATA EL TRASTORNO POR CONSUMO DE ALCOHOL?

El Trastorno por Consumo de Alcohol se puede tratar con una combinación de asesoría y métodos terapéuticos, así como con medicamentos, los cuales pueden ser apropiados para algunos casos.

El apoyo de la familia y los amigos también es importante para el éxito del tratamiento.

El tratamiento asistido con medicamentos puede ayudar a reducir el deseo de consumir o a controlar los síntomas de abstinencia.



Las intervenciones cognitivas conductuales pueden ayudarle a:

- Alejarse de situaciones que sean peligrosas para usted.
- Cambiar pensamientos adictivos por otros saludables.
- Tomar decisiones saludables.
- Manejar las complicaciones y el estrés.
- Lidiar con sentimientos de depresión o baja autoestima.
- Reconocer los impulsos y hábitos que conducen al consumo de alcohol.

RESUMEN

APOYO PARA TOMAR DECISIONES

EDUCACIÓN PARA EL PACIENTE/CONTROL PERSONAL DEL CASO

## EDUCACIÓN PARA EL PACIENTE/CONTROL PERSONAL DEL CASO PREVENCIÓN DE SOBREDOSIS

### ¿QUÉ ES UNA SOBREDOSIS?

La sobredosis ocurre cuando una cantidad tóxica de un medicamento o una combinación de medicamentos agobia al cuerpo. Las personas pueden sufrir una sobredosis de diversas sustancias, incluyendo alcohol, Tylenol, opioides o una mezcla de drogas.

Las sobredosis por *opioides* ocurren cuando hay tantos opioides o una combinación de opioides y otras drogas en el cuerpo que la respiración disminuye o incluso se detiene y esto puede resultar en la muerte.

La heroína, los opioides recetados (como Oxycontin, Fentanyl, Morphine, Vicodin, Percocet) y otros sedantes como el alcohol y las benzodiazepinas (como Xanax, Klonopin, Valium, Ativan) son una combinación muy peligrosa cuando se toman juntas. Todos estos medicamentos afectan al sistema nervioso central del cuerpo, lo que disminuye la respiración, la presión arterial y la frecuencia cardíaca y, a su vez, reduce la temperatura corporal resultando en la muerte.

En una sobredosis de estimulantes, las drogas como la anfetamina, la cocaína y el éxtasis aumentan la frecuencia cardíaca, la presión arterial y la temperatura corporal y aceleran la respiración, lo que puede causar a una convulsión, un derrame cerebral, un ataque cardíaco o la muerte.

### RIESGO DE SOBREDOSIS

Cualquier persona que consuma opioides puede tener una sobredosis, pero algunos factores pueden aumentar el riesgo, lo cual incluye, entre otros:

- Combinación de opioides con alcohol u otras drogas
- Tomar altas dosis diarias de los opioides recetados
- Tomar más opioides de los recetados
- Tomar opioides ilícitos o ilegales, como la heroína o el fentanyl fabricado de forma ilegal, que podrían contener sustancias desconocidas o nocivas
- Ciertas condiciones médicas como la apnea del sueño, o reducción de la función renal o hepática
- Edad superior a 65 años



### SIGNOS DE UNA SOBREDOSIS

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>• Respiración lenta y difícil</li> <li>• Las uñas y los labios se tornan azules o morados</li> <li>• Pupilas muy pequeñas, como puntos</li> <li>• Latidos cardíacos lentos y/o presión arterial baja</li> </ul> | <ul style="list-style-type: none"> <li>• Vómitos frecuentes</li> <li>• Somnolencia extrema o incapacidad para despertarse</li> <li>• Mareos y confusión</li> </ul> |
|--|--|

### ESTRATEGIAS PARA PREVENIR UNA SOBREDOSIS

- ⇒ Comience con una dosis más baja o aplique una inyección de prueba si no la ha usado por un tiempo (ha estado en el hospital, en la cárcel o en un centro de desintoxicación), porque su cuerpo no está acostumbrado a la misma cantidad que antes.
- ⇒ No lo use si esta solo (nadie puede ayudarlo).
- ⇒ No mezcle drogas como benzodiazepinas, alcohol y opioides (como la heroína).

**DETENGAMOS**  
LAS  
SOBREDOSIS

RESUMEN

APOYO PARA TOMAR DECISIONES

EDUCACIÓN PARA EL PACIENTE/CONTROL PERSONAL DEL CASO

**EDUCACIÓN PARA EL PACIENTE/CONTROL PERSONAL DEL CASO  
PREVENCIÓN DE RECAÍDA**

**¿QUÉ ES UNA RECAÍDA?**

Una recaída ocurre cuando una persona que sufre de una enfermedad experimenta un retroceso en el progreso de su recuperación, lo que en general significa que la persona repite los hábitos y patrones que tenía antes de comenzar el tratamiento. Con algunos trastornos por uso de sustancias, las recaídas pueden ser peligrosas e incluso poner en peligro la vida.



Una recaída no significa que una persona haya suspendido el tratamiento o que no pueda continuar con éxito su recuperación. Es un retroceso momentáneo, pero no es un acontecimiento que necesariamente anule el progreso que se ha logrado a través del proceso de recuperación.

**SIGNOS Y RIESGOS DE UNA RECAÍDA**

Las recaídas son por lo general un proceso gradual con varias etapas. Si se observan los signos de alerta, se puede evitar el proceso.

**Signos y riesgos de una recaída:**

- Hambre, ira, aislamiento, cansancio
- Emociones reprimidas
- Evitar grupos de apoyo
- Cuidado personal, alimentación y hábitos de sueño deficientes
- No abordar los antojos fuertes
- Romantizar o glorificar a las personas, lugares y cosas que se asocian con el consumo en el pasado
- Minimizar las consecuencias del consumo continuo
- Planear cómo volver a un comportamiento anterior poco saludable, como volver a consumir drogas

**ESTRATEGIAS PARA PREVENIR UNA RECAÍDA**

- Evitar personas, lugares y actividades que estén asociados con las sustancias.
- Desarrollar alternativas placenteras y gratificantes para evitar el consumo de drogas.
- Unirse a un grupo de apoyo de compañeros que ayude a celebrar los pasos que se den hacia la sobriedad y que ofrezca responsabilidad.
- Construir una red de apoyo sólida con familiares, amigos, etc.
- Si comienza a pensar en volver a consumir drogas, hable con su elenco tratante médico de inmediato.

**PREVENCIÓN DE RECAÍDAS**



## Attachment A

### NIDA Quick Screen V1.0<sup>8</sup>

*(Health care staff completes with patient)*

*Please use paper forms only if EHR is down and ensure information is entered into patient’s health record when EHR is back online. (See Adhoc Folder)*

Name: \_\_\_\_\_ Sex: ( ) F ( ) M Age: \_\_\_\_\_

Interviewer: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

#### Introduction (Please read to the patient)

Hi, I’m \_\_\_\_\_, nice to meet you. If it’s okay with you, I’d like to ask you a few questions that will help me give you better medical care. The questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we’ll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed. I’ll also ask you about illicit or illegal drug use—but only to better diagnose and treat you.

**Instructions:** For each substance, mark in the appropriate column. For example, if the patient has used cocaine monthly in the past year, put a mark in the “Monthly” column in the “illegal drug” row.

NIDA Quick Screen Question:	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
<b>In the past year, how often have you used the following?</b>					
<b>Alcohol</b> For men, 5 or more drinks a day For women, 4 or more drinks a day					
<b>Tobacco Products</b>					
<b>Prescription Drugs for Non-Medical Reasons</b>					
<b>Illegal Drugs</b>					

If the patient says “Never” for all drugs in the Quick Screen, reinforce abstinence. **Screening is complete.**

If the patient answers indicated **one or more days of heavy drinking**, the patient is an at-risk drinker. Please see the NIAAA website “[How to Help Patients Who Drink Too Much: A Clinical Approach](#)” for more information.

If the patient says “Yes” to use of tobacco: Any current tobacco use places a patient at risk. Advise all tobacco users to quit. For more information on smoking cessation, please see “[Helping Smokers Quit: A Guide for Clinicians](#)”.

If the patient says “YES” to the use of illegal drugs or prescription drugs for non-medical reasons, proceed to Question 1 of the NIDA-Modified Assist (See Attachment B).

<sup>1</sup> This guide is designed to assist clinicians serving adult patients in screening for drug use. The NIDA Quick Screen was adapted from the single-question screen for drug use in primary care by Saitz et al. (available at <http://archinte.ama-assn.org/cgi/reprint/170/13/1155>) and the National Institute on Alcohol Abuse and Alcoholism’s screening question on heavy drinking days (available at [http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians\\_guide.htm](http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm)). The NIDA-modified ASSIST was adapted from the World Health Organization (WHO) Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), Version 3.0, developed and published by WHO (available at [http://www.who.int/substance\\_abuse/activities/assist\\_v3\\_english.pdf](http://www.who.int/substance_abuse/activities/assist_v3_english.pdf)).

# CCHCS Care Guide: Substance Use Disorder

Health care staff completes with patient

Please use paper forms only if EHRS is down and ensure information is entered into patient's health record when EHRS is back online. (See Adhoc Folder)

## Attachment B

### NIDA-Modified ASSIST V2.0<sup>9</sup>

**Question 1 of 8, NIDA-Modified ASSIST**

Yes

No

**In your LIFETIME, which of the following substances have you ever used?**

*\*Note for physicians: for prescription medications, please report nonmedical use only*

a. Cannabis (marijuana, pot, hash, etc.)		
b. Cocaine (coke, crack, etc.)		
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)		
d. Methamphetamine (speed, crystal meth, ice, etc.)		
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)		
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHC, etc.)		
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)		
h. Street opioids (heroin, opium, etc.)		
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)		
j. Other- specify:		

•The patient *should not* indicate **"NO"** for all drugs in Question 1. If they do, remind them that their answers in the Quick Screen indicated they used an illegal or prescription drug for nonmedical reasons within the past year and then **repeat Question 1**.

•If the patient answers **"Yes"** to any of the drugs, proceed to **Question 2** of the NIDA-Modified ASSIST.

**Question 2 of 8, NIDA-Modified ASSIST**

**2. In the past three months, how often have you used the substances you mentioned (first drug, second drug, etc.)?**

Never      Once or twice      Monthly      Weekly      Daily or Almost Daily

	Never	Once or twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
b. Cocaine (coke, crack, etc.)	0	2	3	4	6
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	2	3	4	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	2	3	4	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	2	3	4	6
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHC, etc.)	0	2	3	4	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	2	3	4	6
h. Street opioids (heroin, opium, etc.)	0	2	3	4	6
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	2	3	4	6
j. Other- specify: Alcohol	0	2	3	4	6

• For patients who report **"Never"** having used any drugs in the past 3 months: **Go to Questions 6-8**.

• For any recent **illicit or nonmedical prescription drug use**, go to **Question 3**

# CCHCS Care Guide: Substance Use Disorder

## Attachment B

### NIDA-Modified ASSIST V2.0

**3. In the past three months, how often have you had a strong desire or urge to use (first drug, second drug, etc.)?**

	Never	Once or twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
b. Cocaine (coke, crack, etc.)	0	3	4	5	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	4	5	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	4	5	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	4	5	6
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHC, etc.)	0	3	4	5	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	4	5	6
h. Street opioids (heroin, opium, etc.)	0	3	4	5	6
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	4	5	6
j. Other- specify:	0	3	4	5	6

**4. In the past three months, how often has your use of (first drug, second drug, etc.) led to health, social, legal, or financial problems?**

	Never	Once or twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
b. Cocaine (coke, crack, etc.)	0	4	5	6	7
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	4	5	6	7
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	4	5	6	7
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	4	5	6	7
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHC, etc.)	0	4	5	6	7
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	4	5	6	7
h. Street opioids (heroin, opium, etc.)	0	4	5	6	7
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	4	5	6	7
j. Other - specify:	0	4	5	6	7

# CCHCS Care Guide: Substance Use Disorder

## Attachment B

### NIDA-Modified ASSIST V2.0

**5. During the past three months, how often have you failed to do what was normally expected of you because of your use of (first drug, second drug, etc.)?**

	Never	Once or twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
b. Cocaine (coke, crack, etc.)	0	5	6	7	8
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	5	6	7	8
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	5	6	7	8
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	5	6	7	8
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHC, etc.)	0	5	6	7	8
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	5	6	7	8
h. Street opioids (heroin, opium, etc.)	0	5	6	7	8
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	5	6	7	8
j. Other- specify:	0	5	6	7	8

**Instructions:** Ask Questions 6 & 7 for all substances **ever used** (e.g., those endorsed in the Question 1).

**6. Has a friend or relative or anyone else ever expressed concern about your use of (first drug, second drug, etc.)?**

	No, Never	Yes, but not in the past 3 months	Yes, in the past 3 months
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	6
b. Cocaine (coke, crack, etc.)	0	3	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	6
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	0	3	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	6
h. Street opioids (heroin, opium, etc.)	0	3	6
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	6
j. Other- specify:	0	3	6



## Attachment B

### NIDA-Modified ASSIST V2.0

7. Have you ever tried and failed to control, cut down or stop using (first drug, second drug, etc.)?	No, Never	Yes, but not in the past 3 months	Yes, in the past 3 months
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	6
b. Cocaine (coke, crack, etc.)	0	3	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	6
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	0	3	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	6
h. Street opioids (heroin, opium, etc.)	0	3	6
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	6
j. Other- specify:	0	3	6

**Instructions:** Ask Question 8 if the patient endorses any drug that might be injected, including those that might be listed in the other category (e.g., steroids). Circle appropriate response.

8. Have you ever used any drug by injection (NONMEDICAL USE ONLY)?	No, Never	Yes, but not in the past 3 months	Yes, in the past 3 months
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- Recommend to patients reporting any prior or current intravenous drug use that they get tested for HIV and Hepatitis B/C.
- If the patient reports using a drug by injection in the past three months, ask about their pattern of injecting during this period to determine their risk levels and the best course of intervention.
  - If the patient responds that they inject once weekly or less OR fewer than 3 days in a row, provide a brief intervention including a discussion of the risks associated with injecting.
  - If the patient responds that they inject more than once per week OR 3 or more days in a row, refer for further assessment.

**Note:** Recommend to patients reporting any current use of alcohol or illicit drugs that they get tested for HIV and other sexually transmitted diseases.

### Scoring the full NIDA-Modified ASSIST:

**Instructions:** For each substance (labeled a-j) add up the scores for questions 2-7 above. This is the Substance Involvement (SI) score. Do not include the results from either the Q1 or Q8 (above) in your SI scores.

### Use the resultant Substance Involvement (SI) Score to identify patient's risk level.

To determine patient's risk level based on their SI score, see the table below:

Level of risk associated with different Substance Involvement Score ranges for Illicit or nonmedical prescription drug use	
0-3	Lower Risk
4-26	Moderate Risk
27+	High Risk

October 2021

**URINE DRUG SCREEN MONITORING: METABOLITES AND DETECTION TIME**

When interpreting the results of a UDS, it is important to know how substances metabolize to determine whether the identified substance is an expected metabolite of the prescribed medication or is an unexpected substance.

**Monitoring MAT – Expected Results on UDS and Confirmatory Testing**

Substance Class	Medication/Substance Tested	Metabolites*	Detection Time
<b>MAT Agents</b>	Acamprosate	Acamprosate	1-3 days
	Buprenorphine	Buprenorphine, Norbuprenorphine	1-3 days
	Methadone	Methadone, EDDP	1-3 days
	Naltrexone	Naltrexone, 6-Beta-Naltrexol	1-3 days
<b>Alcohol</b>	Alcohol	Ethyl Glucuronide, Ethyl Sulfate	Up to 80 hours
<b>Opiates</b>	Codeine (Tylenol #3)	Codeine, Morphine, Hydrocodone	1-3 days
	Hydrocodone (Vicodin)	Hydrocodone, Hydromorphone, Norhydrocodone, Codeine	1-3 days
	Hydromorphone (Dilaudid)	Morphine, Hydrocodone, Hydromorphone	1-3 days
	Morphine (MS Contin)	Morphine, Hydromorphone, Codeine	1-3 days
<b>Opioids</b>	Fentanyl (Duragesic)	Fentanyl, Norfentanyl	1-3 days
	Meperidine (Demerol)	Meperidine, Normeperidine	1-3 days
	Oxycodone (Oxycontin)	Oxycodone, Noroxycodone, Oxymorphone	1-3 days
	Oxymorphone (Opana)	Oxycodone, Noroxycodone, Oxymorphone	1-3 days
	Tapentadol (Nucyncta)	Tapentadol, Nortapentadol	1-3 days
	Tramadol (Ultram)	Tramadol, Desmethyiltramadol	1-3 days
<b>Illicit Substances</b>	Cocaine	Benzoyllecgonine	1-3 days
	Heroin	6-Monoacetylmorphine (6-MAM)	1-3 days
	MDMA	MDA, MDMA	1-2 days
	Phencyclidine (PCP)	Phencyclidine	1-3 days
	THC	Marijuana Metabolite	1-3 days ≥30 days if chronic use
<b>Amphetamines</b>	Amphetamine (Adderall)	Amphetamine	1-3 days
	Methamphetamine	Methamphetamine, Amphetamine	1-3 days
<b>Stimulants</b>	Methylphenidate (Ritalin)	Ritalinic Acid	1-3 days
	Phentermine (Adipex-P)	Amphetamine	2-4 days
<b>Antipsychotics</b>	Olanzapine (Zyprexa)	Olanzapine	1-3 days
	Chlorpromazine (Thorazine)	Chlorpromazine	1-3 days
	Quetiapine (Seroquel)	Quetiapine	1-3 days

Adapted from *Quest Diagnostics Prescription Drug Monitoring Reference Guide* <sup>13</sup>

\*Parent substance is listed if no metabolite is detectable by UDS.

**URINE DRUG SCREEN MONITORING: METABOLITES AND DETECTION TIME (CONT)****Monitoring MAT – Expected Results on UDS and Confirmatory Testing**

Substance Class	Medication/Substance Tested For	Metabolites*	Detection Time
Antidepressants	Bupropion (Wellbutrin)	Bupropion	1-3 days
	Buspar	Buspar, 5-Hydroxy-Buspirone, 1-Pyrimidinylpiperazine	1-3 days
	Duloxetine (Cymbalta)	Duloxetine	1-3 days
	Mirtazapine (Remeron)	Remeron	1-3 days
	Trazodone	Trazodone, 1-(3-Chlorophenyl) Piperazine	1-3 days
	Venlafaxine (Effexor)	Venlafaxine	1-3 days
Antiepileptics	Oxcarbazepine	Oxcarbazepine, 10-OH-Carbazepine	1-3 days
	Topiramate	Topiramate	1-3 days
	Gabapentin (Neurontin)	Gabapentin	1-3 days
	Pregabalin (Lyrica)	Pregabalin	1-3 days
Benzodiazepines	Alprazolam (Xanax) **	Alpha-Hydroxyalprazolam	1-3 days
	Clonazepam (Klonopin) **	Aminoclonazepam	>3 days
	Diazepam (Valium)	Oxazepam, Temazepam, Nordiazepam	>3 days
	Lorazepam (Ativan)	Lorazepam	1-3 days
	Oxazepam (Serax)	Oxazepam, Temazepam, Nordiazepam	1-3 days
	Temazepam (Restoril)	Temazepam, Oxazepam, Nordiazepam	1-3 days
Muscle Relaxants	Carisoprodol (Soma)	Meprobamate	1-3 days
	Cyclobenzaprine (Flexeril)	Norcyclobenzaprine	1-3 days
	Methocarbamol	Unhydrolyzed Carbamates	1-3 days
Tricyclic Antidepressants	Amitriptyline (Elavil)	Amitriptyline, Nortriptyline	1-3 days
	Desipramine (Norpramin)	Desipramine	1-3 days
	Imipramine (Tofranil)	Imipramine	1-3 days
	Nortriptyline (Pamelor)	Nortriptyline	1-3 days
Other	Diphenhydramine	Diphenylmethoxyacetic Acid	1-3 days
	Eszopiclone (Lunesta)	(S)-Zopiclone-N-Oxide	1-3 days
	Hydroxyzine	Hydroxyzine, Cetirizine	1-3 days
	Ketamine	Ketamine, Norketamine	1-3 days
	Pseudoephedrine	Pseudoephedrine	1-3 days
	Zaleplon (Sonata)	Aldehyde Oxidase	1-3 days
	Zolpidem (Ambien)	Zolpidem	1-3 days
Zopiclone (Zimovane)	Zopiclone	1-3 days	

\*Parent substance is listed if no metabolite is detectable by UDS.

\*\*May be difficult to detect by UDS, as substance is predominantly excreted by other means

**INFORMED CONSENT FOR MEDICATION ASSISTED TREATMENT (MAT) - CDCR 7240**

STATE OF CALIFORNIA

DEPARTMENT OF CORRECTIONS AND REHABILITATION

**INFORMED CONSENT FOR MEDICATION ASSISTED TREATMENT (MAT)  
FOR SUBSTANCE-USE DISORDER (SUD)  
CDCR 7240 (Rev. 07/20)**

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**I consent to allowing \_\_\_\_\_ (provider's name) to prescribe Medication-Assisted Treatment (MAT) as part of my Substance-Use Disorder (SUD) Treatment Plan.**

**I understand that MAT has risks including:**

- **Side Effects.** Such as dizziness, itching, sleepiness, nausea, slowed breathing, constipation, among others.
- **Risk of an Overdose.** Especially if used with other medications, alcohol, or illegal drugs. This can cause death.
- **Physical Dependence.** If medication is suddenly stopped, it could lead to withdrawal symptoms (flu like symptoms: nausea, diarrhea, aches, sweats, chills, irritability, tremors, and confusion), which are uncomfortable, but not life-threatening.

**I understand there are rules for the use of MAT including:**

- I will engage in other treatments for my disorder, including counseling as ordered by my provider.
- I will attend all follow-up appointments and do all ordered labs tests (urine, blood, or EKG).
- I must tell the provider any and all effects I have from this medication.
- I will not share this medication with others or take it other than as prescribed.
- I will keep a positive relationship with my provider and understand that I may need to renew this consent annually and/or upon transfer of care.
- I will not drink alcohol or take substances not prescribed to me by my medical provider.
- If I am sent out to a hospital or for an outside specialty visit, I am responsible for letting health care staff know that I am on MAT, unless I am incapacitated.
- I will notify my health care provider if I believe I may be pregnant.
- I will notify my health care provider when I need birth control.

**My provider may adjust MAT dosage or switch agents depending on my response to treatment.**

**I understand that if I violate this agreement in any way, my provider may alter treatment and certain therapeutics may be disallowed.**

Examples of violations are, but are not limited to:

- Not cooperating with my treatment program, including attending scheduled clinic appointments.
- Suspicion of hoarding/cheeking which may also result in the search of my housing unit.
- Sharing medication with other people or taking it in ways other than prescribed.
- Refusing any urine or blood screenings.
- Using any illegal drugs (methamphetamine, cocaine, marijuana or others).

**My signature below indicates that I have reviewed the above with my provider, and understand the terms of this agreement. I also authorize my provider to notify custody if any circumstance related to this treatment causes concerns for my safety or that of others.**

Patient Name (print): \_\_\_\_\_ Patient Signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Provider Name (print): \_\_\_\_\_ Provider Signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_

<p><b>1. Disability Code:</b>  <input type="checkbox"/> TABE score ≤ 4.0  <input type="checkbox"/> DPH <input type="checkbox"/> DPV <input type="checkbox"/> LD  <input type="checkbox"/> DPS <input type="checkbox"/> DNH  <input type="checkbox"/> DDP  <input type="checkbox"/> Not Applicable</p>	<p><b>2. Accommodation:</b>  <input type="checkbox"/> Additional time  <input type="checkbox"/> Equipment <input type="checkbox"/> SLI  <input type="checkbox"/> Louder <input type="checkbox"/> Slower  <input type="checkbox"/> Basic <input type="checkbox"/> Transcribe  <input type="checkbox"/> Other*</p>	<p><b>3. Effective Communication:</b>  <input type="checkbox"/> Patient asked questions  <input type="checkbox"/> Patient summed information  <b>Please check one:</b>  <input type="checkbox"/> Not reached* <input type="checkbox"/> Reached  *See chrono/notes</p>	<p>CDCR #: _____  Last Name: _____  First Name: _____ M.I. _____  DOB: _____</p>
<p><b>4. Comments:</b> _____</p>			

*Unauthorized collection, creation, use, disclosure, modification or destruction of personally identifiable information and/or protected health information may subject individuals to civil liability under applicable federal and state law*

**REFUSAL OF EXAMINATION AND/OR TREATMENT—CDCR 7225**

STATE OF CALIFORNIA  
**REFUSAL OF EXAMINATION AND/OR TREATMENT**  
 CDCR 7225 (Rev. 03/19)

DEPARTMENT OF CORRECTIONS AND REHABILITATION  
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REFUSAL OF EXAMINATION AND / OR TREATMENT		
PATIENT NAME (TYPE OR PRINT CLEARLY)	CDCR NUMBER	INSTITUTION

Having been fully informed of the risks and possible consequences involved in refusal of the examination and/or treatment in the manner and time prescribed for me, I nevertheless refuse to accept such examination and/or treatment. I agree to hold the Department of Corrections and Rehabilitation, the staff of the medical department and the institution free of any responsibility for injury or complications that may result from my refusal of this examination and/or treatment, specifically: Describe the examination and/or treatment refused as well as the risks and benefit of the intervention:

-The medical treatment/assessment I am refusing is for evaluation of opioid use disorder and possible treatment with medication.

-I may or may not have been diagnosed with opioid use disorder prior to this appointment but understand that by refusing treatment I will not be diagnosed in any fashion at this appointment.

**-The diagnosis of opioid use disorder that remains untreated is associated with a significant increase in the risk of infection, disability and death.** I also understand that the benefit of the offered treatment (medication assisted treatment i.e. MAT) considerably decreases my risk of infection, disability and death but I am currently refusing such treatment.

-I also understand that **I will not be penalized for this decision** and, should my circumstances change or I reconsider this decision, I may reach out to the SUDT and request re-consultation.

PATIENT SIGNATURE	DATE	<input type="checkbox"/> PATIENT REFUSES TO SIGN	DATE
<b>WITNESS</b>			
NAME OF WITNESS (PRINT/TYPE)		NAME OF WITNESS (PRINT/TYPE)	
WITNESS SIGNATURE	DATE	WITNESS SIGNATURE	DATE

<p><b>1. Disability Code:</b>  <input type="checkbox"/> TABE score ≤ 4.0  <input type="checkbox"/> DPH <input type="checkbox"/> DPV <input type="checkbox"/> LD  <input type="checkbox"/> DPS <input type="checkbox"/> DNH  <input type="checkbox"/> DDP  <input type="checkbox"/> Not Applicable</p>	<p><b>2. Accommodation:</b>  <input type="checkbox"/> Additional time  <input type="checkbox"/> Equipment <input type="checkbox"/> SLI  <input type="checkbox"/> Louder <input type="checkbox"/> Slower  <input type="checkbox"/> Basic <input type="checkbox"/> Transcribe  <input type="checkbox"/> Other*</p>	<p><b>3. Effective Communication:</b>  <input type="checkbox"/> Patient asked questions  <input type="checkbox"/> Patient summed information  <b>Please check one:</b>  <input type="checkbox"/> Not reached* <input type="checkbox"/> Reached                  *See chrono/notes</p>	CDCR #: Last Name: First Name: DOB:	MI:
<p><b>4. Comments:</b>                  _____</p>				