Substance Use Disorder
&
Intoxication and Withdrawal
Care Guide

January 2026

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

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/

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SUMMARY

GOALS

- ✓ Reduce Substance Use Disorder (SUD) related morbidity and mortality.
- ✓ Prompt disease recognition and Medication Assisted Treatment (MAT) prescription.
- ✓ Recognize signs of intoxication and withdrawal and provide MAT when needed.
- ✓ 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 upon leaving the California Department of Corrections and Rehabilitation (CDCR).

ALERTS

- If opioids are required for acute pain management, patients on MAT may require consultation with the Addiction Medicine Central Team (AMCT).
- Individuals with Opioid Use Disorder (OUD) are at high risk for overdose-related harms, therefore everyone will be offered naloxone during incarceration and upon release.
- Patients that choose to discontinue MAT are at high risk for SUD-related complications and death.
- Patients with an overdose should immediately be referred to a provider for evaluation and treatment.
- Intoxication signs such as respiratory depression, unstable vital signs, altered level of consciousness, risk for sympathetic storm should be referred to a Higher Level of Care (HLOC).
- Patients presenting with altered level of consciousness typical of intoxication should also be checked for possible coinciding injury that can complicate their presentation
- Pregnant patients with SUD/OUD require AMCT management. (See MAT for OUD In Pregnant Patients).
- Recognizing signs of withdrawal and supporting relapse prevention is a shared responsibility with the entire treatment team. Team members have unique roles and responsibilities outlined here.

SCREENING

- The National Institute for Drug Abuse (NIDA) Quick Screen (QS) is a tool used to screen for SUD. The NIDA QS has four questions to address alcohol, tobacco, prescription drugs and illegal drugs. A positive result on the NIDA QS triggers referral for a Behavioral Health assessment.

ASSESSMENT

- Assessment using the NIDA Modified Assist (MA) provides substance involvement risk scores for 10 different substances. An affirmative answer to the first question for each substance triggers completion of questions two through eight, (see page 9 and Attachment B).
- A multidimensional biopsychosocial assessment developed by the American Society of Addiction Medicine (ASAM) is conducted to determine level of care and treatment recommendations (see page 9).
- Motivational Interviewing techniques assist with obtaining accurate assessments, engaging the patient, and strengthening the therapeutic relationship (see page 10); all team members are encouraged to utilize these techniques.
- Medical assessments apply diagnostic coding derived from 2 differing systems – Diagnostic and Statistical Manual (DSM-5) and International Classification of Diseases (ICD-10) (see page 12). The MAT PowerForm and Addiction Medicine Note Template support assessment and documentation.
- Primary Care Providers (PCP) will integrate ongoing periodic assessment and relapse prevention into patient care plans.

TREATMENT

- Comprehensive treatment utilizes behavioral, pharmacologic and/or housing modalities to stabilize an individual. These treatment modalities may be used individually or in combination based on patient need and consent.
- Patients are participants in their own recovery. The treatment team should work to provide all the evidence-based approaches that increase their chance of success.
- Treatment begins with motivational interviewing techniques and development of a relationship with one's care team and may include Cognitive Behavioral Interventions (CBI) and Cognitive Behavioral Therapy (CBT).
- Nursing Led Therapeutic groups, as well as various peer support services, are available and vary by institution.
- MAT is available for patients with OUD or Alcohol Use Disorder (AUD). MAT candidates will need to sign an informed consent.

MONITORING

- Follow-up appointments for patients on MAT are scheduled every 90 days or sooner according to medication, duration of stability, and risk profile.
- Follow-up appointments for patients with SUD are essential to monitor this chronic disease, even if the patient is not prescribed MAT (see page 31).
- Urine drug screens (UDS) are used to monitor MAT adherence and are performed randomly at defined intervals (see page 34).
- Annual labs and other diagnostic tests (e.g., Electrocardiogram (EKG) for patients on Methadone) should be done as recommended (see page 31).
- Key performance indicators for institution and providers are included on the Integrated Substance Use Disorder Treatment (ISUDT) Dashboard.
- Patients with possible overdose events in which naloxone was administered can be found here and should be considered for initiation of treatment if not already prescribed MAT, dose maximization if prescribed MAT, or additional support as indicated.

ENHANCED PRE-RELEASE AND TRANSITION SERVICES

- Transition services are provided for all releasing patients in order to facilitate ongoing treatment and recovery without interruption. See page 37 for more details.
- MAT medication (if applicable) and naloxone are dispensed to the patient at time of release.

ISUDT Program – A Multidisciplinary, Trauma-Informed Approach

Treatment - Trauma-Informed Care and SUD

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. Many patients with SUD may not have had historical (pre-incarceration) access to or may have overtly avoided stigma-laden medical care. 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 patients 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.
- Without understanding trauma, negative and unhealthy behaviors and beliefs tend to propagate.
- Understanding trauma/stress encourages staff to act compassionately to support their own and other's wellness, prevent further harm and re-traumatization, while creating opportunities for recovery/healing.

The Addictionary® may be useful in identifying language that is not stigmatizing.

Institution Management – ISUDT Steering Committee

The integrated nature of the ISUDT Program requires collaboration across many program areas. Institutional success requires a multidisciplinary team of leaders meeting monthly in the ISUDT Steering Committee to review local program performance against statewide goals, identify and troubleshoot program barriers, and elevate issues as necessary to their local reporting structure. Steering Committee membership includes the Warden or Chief Deputy Warden, the institution Chief Executive Officer, Chief Nurse Executive, Chief Medical Executive, Chief of Mental Health and Chief/Supervising Psychiatrist, the Supervising Dentist, the ISUDT Supervising Registered Nurse II, the Prison Industry Authority Administrator or lead manager, Correctional Counselor IIIs, and a supervisory level ISUDT Ambassador.

Performance for each program goal is reported through the ISUDT Dashboard, which is updated daily and should be reviewed at each monthly Steering Committee meeting, along with other information about program performance, such as observations from ISUDT Ambassadors and other institution staff. Using performance information, the Steering Committee provides support and direction to different program areas as they implement ISUDT services, coordinating and managing change across the institution.

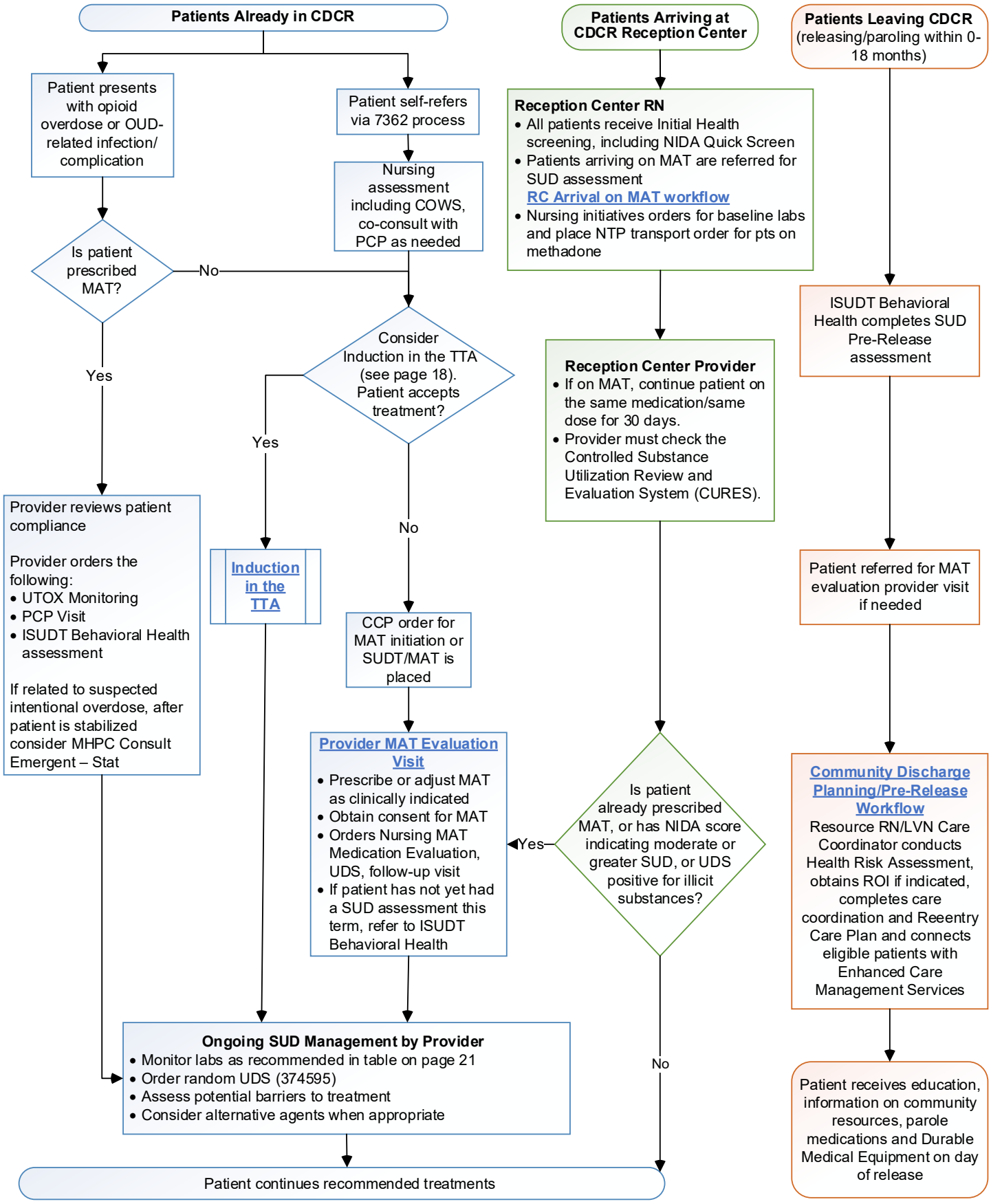
Multidisciplinary Team

The 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. Population segments are defined as those who arrive to CDCR on MAT, those who are already in CDCR, and those who are within 2 years of their earliest possible release date (EPRD). Many staff play important roles in patient care and program support; this table focuses on specific positions and/or functions related to the ISUDT Program.

TEAM MEMBER AND ROLES	
RECEPTION CENTER REGISTERED NURSE (RN)	• Initial health screening for patients that are new arrivals including NIDA Quick Screen for all patients arriving who are not prescribed MAT. • CDCR 7385, Authorization for Release of information Protected Health Information, to confirm medication/dosage • For methadone order Narcotic Treatment Program (NTP) (transport) (see page 16) • Refers to ISUDT Behavioral Health and addiction medicine provider as indicated • Orders baseline labs using the Receiving & Release PowerPlan
PRIMARY CARE TEAM LICENSED NURSING STAFF	• Completes the NIDA Quick Screen. If positive, refers to ISUDT Behavioral Health for SUD assessment. • Access to care via 7362 processes: triage, address patient needs, co-consultation/refer as needed • Administers monthly long-acting injectable MAT agents • Helps coordinate transitions between Primary Care Teams (PCT) • SUD-related nursing patient care and/or co-consultation with provider
RN CARE MANAGER/LICENSED VOCATIONAL NURSE (LVN) CARE COORDINATORS	• Completes the MAT Medication Evaluation after new MAT initiations or dose changes
LVN/PSYCHIATRIC TECHNICIAN (PT) (MEDICATION ADMINISTRATION)	• Administers medications and document patient medication line behaviors
RESOURCE RN PRE-RELEASE CARE COORDINATOR	• Coordinates transitions between jails, counties, parole, and probation; provides warm handoffs as appropriate • Connects CalAIM eligible patients with Enhanced Care Management services • Develops discharge plan and provides patient with education, community resource information, and documentation with appointments, medications, etc. at time of release
RESOURCE SUPERVISING REGISTERED NURSE II	• Oversees institutional ISUDT, outcome metrics, assists facilitation of steering committee meetings, collaborates with multiple disciplines to coordinate care upon release.
ADMINISTRATIVE SUPPORT STAFF	• Provides support to various ISUDT programmatic roles
ISUDT BEHAVIORAL HEALTH TEAM	• Assesses patients with SUD using NIDA-MA and ASAM suite of tools. Assessment outcome recommends CBI level. • Provides CBT to address SUD and trauma care coordination • Collaborates with the MH team as clinically indicated
PSYCHIATRIST	• Identifies SUD-related complications, and refer to primary care team for further assessment • Collaborates with Care Team for complex patients
MH PRIMARY CLINICIAN	• Offers psychotherapeutic approaches to encourage ISUDT participation • Educates patients about ISUDT program, and discuss possible referral in routine or specially scheduled IDTT
LABORATORY TECHNICIANS	• Collects and processes UDS samples
ALCOHOL AND OTHER DRUG (AOD) COUNSELORS	• Facilitates CBI classes to help patients develop healthy coping skills, improve emotional regulation, & manage unhelpful thoughts, beliefs, attitudes (cognitive distortions), & behaviors
CORRECTIONAL COUNSELORS (CC-III)	• Case manages patients toward their goals in rehabilitation, including managing CBI assignment • Assigns job skills training and encourage education
ADDICTION MEDICINE CENTRAL TEAM (AMCT)	• Provides consultation and technical support via encounters and AMCT Hotline (916) 478-8610 • Consults on patients referred by PCP, to determine appropriate interventions, which may include alternative MAT agents, dose adjustments, CBT • Manages patients on alternative MAT agents (injectable buprenorphine, Vivitrol®, methadone)
PRIMARY CARE PROVIDERS (PCP)	• Identifies SUD-related complications, evaluates for and initiates MAT services • Manages and monitors integrated SUD services as part of the Complete Care Model (CCM) • Uses motivational interviewing to encourage initial and ongoing participation • Provides MAT prescriptions upon release • Methadone bridge orders at reception and inter-facility transfers to ensure continuity of care • Refers to ISUDT Behavioral Health for SUD assessment, follow-up appointment, or CBT assessment • Consults with AMCT as needed • Collaborates with MH team as clinically indicated
PHARMACISTS	• Reviews and verify appropriate MAT orders • Assists with medication reconciliation (transfers) • Fills and dispenses MAT (30-day) and other medication supply upon release • Arranges naloxone on release via standing order
DENTISTS	• Evaluates, educates and treats patients with dental complications due to SUD

SUBSTANCE USE DISORDER TREATMENT SUMMARY ALGORITHM

The following is a summary of how patients get connected to ISUDT services. More detailed workflows are maintained here



ISUDT Order Guidance

The following table provides guidance on when each order type should be used, to support the multidisciplinary team in identifying the proper interventions.

ISUDT Orders and Use Cases			
Category	Order Name	Purpose	Use Case
ISUDT Behavioral Health (BH) Assessment	Consult to ISUDT Behavioral Health 30	Initial assessment following positive screening for SUD helps determine initial treatment needs	• **For patients with EPRD > 18 months,** following positive NIDA Quick Screen • Only needed one time per incarceration term
	Follow-up ISUDT Behavioral Health 60	Evaluate patients who are worsening or not improving in treatment, to determine if they might be appropriate for Cognitive Behavioral Therapy	• Patients worsening or not improving while in treatment, with EPRD > 18 months ○ Can be seen via SUD-related complications occurring while on Tx, including new or recurring Hepatitis C (HCV), SUD-related HLOC send outs, naloxone administration event
	Pre-Release ASAM Assessment 60	For patients incoming with < 18 months EPRD, serves as initial assessment following positive screening for SUD and to determine treatment needs while in custody, including possible CBT Determines treatment needs for patients paroling/releasing, to help connect them to treatment in the community	• **For patients with EPRD < 18 months,** following positive NIDA QS • **Patients with EPRD < 18 months** who are worsening or not improving while in treatment • All patients releasing within 18 months
Provider MAT Evaluation	Medical Chronic Care (CCP) Follow-up 60, "SUDT/MAT Initial Evaluation"	Following positive assessment by ISUDT BH, or when patient has objective signs of SUD (new or recurrent HCV, SUD-related HLOC send out, naloxone administration event)	• Ordered by ISUDT BH clinician following assessment that indicates likely SUD • Ordered by Nursing after co-consult with the PCP, ideally after rapid induction
	Consult to Addiction Medicine Central Team 60	For patients with complex SUD care needs, including those with worsening SUD and chronic pain or cooccurring MH disease Consultation for patients following AMCT Hotline discussion with PCP	• Order placed by PCP for patient needing consultation • Placed by PCP after discussion with AMCT via Hotline
Nursing MAT Medication Evaluation	Follow Up RN 10 (MAT Medication Evaluation)	Following MAT initiation or after medication changes, to determine medication tolerance and dose effectiveness **For use at Intermediate institutions**	• Ordered by providers • Within 72 hours for outpatient, within 24 hours for inpatient, or upon consultation with Primary Care Team
	Follow Up LVN 10 (MAT Medication Evaluation)	Following MAT initiation or after medication changes, to determine medication tolerance and dose effectiveness **For use at Basic institutions**	• Ordered by providers • Within 72 hours for outpatient, within 24 hours for inpatient, or upon consultation with Primary Care Team
Urine Drug Screening	Screening UDS (374594)	Smallest number of substances tested, with the quickest turnaround time	• Ordered in preparation for an initial evaluation
	Monitoring UDS (383403)	Most commonly used UDS order, with more detail than the Screening panel; results in about 3 days	• Ordered for most follow-up appointments to monitor disease progress and encourage conversation with patients
	Comprehensive UDS (373993)	Used rarely, with a long turnaround time, and includes comprehensive testing of mental health (MH) medications	• Ordered for monitoring of patients that exhibit severe, unstable co-occurring disorders

PATIENT SCREENING & ASSESSMENT

Patient Screening – NIDA QS

- Screening for SUD is accomplished using the NIDA Quick Screen (See Attachment A) which asks about use of alcohol, tobacco products, prescription drugs for non-medical reasons, and illegal drugs within an individual's lifetime.
- Any affirmative answers trigger a referral for behavioral health assessment to explore the risk related to specific substances, and eligibility for medication and/or psychoeducational treatment. An exception is an affirmative answer to only marijuana use (not synthetic), where further assessment will *not* be triggered.
- Screening is routinely done at the time of reception and is also applied periodically depending on an individual's clinical circumstance or proximity to release from prison.

Behavioral Health Assessment – NIDA Modified Assist (NIDA-MA)

- The NIDA- Modified Assist (See Attachment B) guides clinicians through a series of 8 questions repeated for 10 substances to identify risky substance use in their patients by considering lifetime substance use and consequences related to more recent use.
- The patient's risk level is based on their Substance Involvement (SI) score for each substance:

0-3=lower risk	4-26=moderate risk	≥27= high risk

- Triggers a referral for MAT Evaluation when SI score is greater than 16 for alcohol or opioids, or based on assessor's clinical discretion.
- SI scores are utilized by the assessing clinician to refer patients to CBI programming. DRP then assigns patients to CBI programming based on their prioritization matrix. Inquiries about CBI classes should be directed to Correctional Counselor I.

Behavioral Health Assessment - ASAM Criteria

- The ASAM Criteria is an evidence-based multidimensional evaluation that considers 6 dimensions (detailed in Appendix 2) to provide a biopsychosocial assessment and recommend a level of care.
- Patients can move between levels over time, depending on changes in their unique needs.
- CDCR offers 3 levels of care: Education/Relapse Prevention (0.5), Outpatient Services (1.0), and Intensive Outpatient Services (2.1).
- A recommendation of Opioid Treatment Program (OTP) or clinician judgement will trigger referral for a MAT evaluation.
- CCHCS uses three standardized versions of ASAM assessment: the Co-Triage, Continuum and Re-Entry Interview Script Enhancement (RISE).
  - The ASAM Co-Triage is an initial assessment that determines provisional assignment for level of care and CBI.
  - The Continuum generates a level of care determination for patients that require more intensive treatment while in custody.
  - The RISE is a version of the Continuum focused on community re-entry and release planning, completed within 18 months of release.

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.
- Individualize treatment. Treatment length depends on the patient's progress and changing needs.
- 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.

Motivational Interviewing [1]

Motivational Interviewing (MI) is a technique in which the interviewer 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. This technique can help resolve patient ambivalence about lifestyle changes favoring improved health and wellbeing.

- 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 – this discordant tension is normal, regardless of the patient's stage of readiness.
- If a patient's ambivalence is interpreted as denial or resistance, friction between provider and patient may occur.
- Ambivalence can be resolved by working with the patient's intrinsic motivations and values.
- MI facilitates a therapeutic collaborative partnership where everyone brings important expertise.

PRINCIPLE	APPLICATION TO PRACTICE
1. Express Empathy	· Empathy communicates respect for and acceptance of patients and their feelings and encourages a non-judgmental, collaborative relationship. · Empathy, through active listening, is the foundation of a motivational counseling style.
2. Develop Discrepancy	· Developing awareness of consequences helps patients examine their behavior. · A discrepancy between present behavior and important goals motivates change.
3. Avoid Argument	· Arguments and confrontations with patients can rapidly turn into a power struggle and creates barriers to a therapeutic alliance and accessing motivation for beneficial change.
4. Roll With Resistance	· Common types of resistance include arguing, interrupting, talking over or cutting off, denying, blaming, excusing, pessimism, or ignoring.
5. Support Self-Efficacy	· Many patients do not have a well-developed sense of self-efficacy which is often demonstrated in their inability to believe they can change. · Patient education can increase a patient's sense of self-efficacy.

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	
Open Questions	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. ➢ *"Tell me about your family."*
Affirmation	Affirmation through statements of empathy and support of past accomplishments and strengths 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. ➢ *"This meeting brought out a lot of painful feelings. Thank you for staying through it."*
Reflective Listening	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. ➢ *"What I hear you saying is you want to quit, but your cell mate is making it hard for you."*
Summary Reflections	Summarizing is simply a set of reflections gathered 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 often ends with a question. ➢ *"What you've said is important and I want to make sure I have it right…"*

PROVIDER ASSESSMENT – INITIAL MAT EVALUATION

An initial evaluation for MAT should not be delayed while waiting for a Behavioral Health assessment.

Use of the MAT PowerForm and Addiction Medicine Note Template guide providers through inclusion of these key elements and is captured by the ISUDT dashboard.

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

- Primary substance(s) of choice, when substance use began, and pattern of use of each substance
- The patient's current level of cravings, and motivation for sobriety
- The number of DSM-V criteria defines the severity of substance use disorder

# of screening Criteria Present	2-3	4-5	≥ 6
Severity of SUD	Mild	Moderate	Severe

- The 11 criteria are divided based on behavioral manifestations:

LOSS OF CONTROL	ADVERSE CONSEQUENCES	PHYSICAL DEPENDENCE
• Taking larger amounts or for longer than intended • Wanting to cut down or quit but unable to • Increased time getting, using, and recovering from use of the substance • Craving • Recurrent use in hazardous situations	• Failure to carry out obligations at work, school or home • Continued use despite social and/or interpersonal problems • Stopping or reducing other important activities • Use despite medical or psychological consequences	• Tolerance • Withdrawal

- History of past or current MH conditions and current level of stress, anxiety or depression
- History of past or current trauma (may defer exploring until trust is developed)
- Prior screening for Tuberculosis (TB), Hepatitis A (HAV), Hepatitis B (HBV), HCV, Human Immunodeficiency Virus (HIV) including current partner status, and syphilis (to be ordered if not already completed)
  - For patients with documented intravenous drug use, with partner of unknown or unreliable HIV status, consider ordering *Consult to STI Prevention (high priority)* for pre-exposure prophylaxis (PrEP) discussion and education.
- Other social and family history
- For co-occurring disorders including major depressive disorder or other mental illness, it is important to collaborate with MH providers and coordinate care.
- Patients transferring to any inpatient mental health setting already on MAT are continued on MAT without interruption unless patient's condition requires adjustment via collaboration with MH provider.
- New admissions to inpatient MH settings generally are not considered candidates for MAT initiation until condition is stabilized.
- Documentation of any SUD-related complications which include, but are not limited to:
  - Return from a HLOC due to overdose, skin and soft tissue infections, etc.
  - Endocarditis, cellulitis related to IV drug use
  - Poor oral health due to drug use
  - HCV infection or reinfection
  - Naloxone administration with recorded improvement
  - UDS positive for fentanyl, heroin or unprescribed buprenorphine
- For any SUD-related complication, consider Consult to ISUDT Behavioral Health for SUD-Related Complications
- For suspected intentional overdoses, consider Mental Health Primary Clinician (MHPC) Consult Emergent – STAT

The ISUDT Dashboard includes indications for many of the high-risk events noted above and can be used by care teams to identify patients that should be connected to SUD treatment.

Per HCDOM 3.5.9 Controlled Substances, providers must check and document the Controlled Substance Utilization Review and Evaluation System (CURES) if:

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

If CURES contains information on prescribed controlled medicine, print report and scan into EHRS.

Physical Exam: Focus on signs of substance use or complications of substance use, including intoxication or withdrawal (refer to table below):

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	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)

Diagnostic testing: Comprehensive Metabolic Panel (CMP), Urine beta-hCG (for persons with a uterus of childbearing age), and EKG (for methadone) should be ordered. See table on page 31 for more details on recurrent frequency. A urine drug test should also be ordered. Generally, the screening panel is used initially. See page 34 for guidance on selecting the appropriate panel.

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 in the Electronic Health Records 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)

Health care 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

Nursing MAT Medication Evaluation

Following MAT initiation or significant dose change, providers should order a nursing follow-up for *MAT Medication Evaluation*. This two-page electronic evaluation includes a Clinical Opioid Withdrawal Scale (COWS) and medication check to assess for any adverse effects, both pages need completion to ensure proper communication with the prescriber.

- Intermediate Institutions have the PCRN evaluate the patient (order Follow Up RN 10)
- Basic institutions have the LVN Care Coordinator evaluate the patient (order Follow Up LVN 10)
- For inpatient settings, have the inpatient RN evaluate the patient (order MAT Medication Evaluation [Inpatient Only])
- For these orders:
  - Indicate the Reason for Follow-up as *MAT Medication Evaluation.*
  - Timeframe: within 72 hours for outpatient, within 24 hours for inpatient
  - Special instructions should indicate to whom the results should be messaged

Signs and Symptoms of Intoxication and Withdrawal [2]

Proper identification and treatment of intoxication and withdrawal can help form trust and opens lines of communication between the patient and provider and serve as the entry point for a patient into long term treatment of SUD.

- Identification and treatment of intoxication can lead to appropriate management of withdrawal phenomenon and can provide an avenue for entry into treatment for an underlying SUD.
- Detoxification should be thought of as one component of a comprehensive treatment strategy, and is not meant to be a standalone treatment.
- It is important to distinguish detoxification from SUD treatment, which involves a constellation of ongoing therapies intended to promote recovery for patients with SUD.

The primary goals in recognizing and treating intoxication and withdrawal are safe clinical stabilization and prevention of morbidity and mortality related to an underlying SUD. These events often create an opportunity to engage with patients and connect them to longer-term management of their SUD, including consideration of MAT.

Utilize a systematic and consistent approach to evaluation and management.
Presentation depends upon:

- Substance ingested, smoked, snorted, or injected.
- Whether ingestion involves a single substance or a combination of substances (such as both heroin and methamphetamine). Many illicit substances in the correctional environment may contain more than one substance. The patient may not be aware of all ingested substances.
- Acute vs. chronic use.
- Other medications the patient may be taking, including both prescribed and non-prescribed.
- Comorbid conditions.

Note that intoxication states vary based on substances used and may mimic other psychiatric and medical conditions.
Urine toxicology screens (374594) can provide valuable information for treatment (results available in 1-2 days).

Note that patients with substance intoxication (particularly stimulants) may have increased agitation and risk for violent behavior.

The first step is stabilizing patient and airway, then determine whether signs and symptoms warrant transfer to a HLOC, or if the patient can be successfully treated within the institution in a Triage and Treatment Area (TTA) or inpatient medical bed.

The identification of withdrawal or intoxication should begin with the collection of pertinent patient information including patient history, physical examination, and laboratory screening.

Use intoxication diagnostic codes – search under intoxication and select for the specific substance(s) used.
The signs and symptoms of intoxication and withdrawal differ by the specific type of substance used. This Care Guide covers intoxication and withdrawal from opioids, alcohol, stimulants, and sedative-hypnotics.

Substance	Acute Intoxication	Withdrawal Syndrome
Alcohol	• Eyes: nystagmus • Cardiovascular: hypotension, tachycardia • Psychological: disinhibited behavior, euphoria, moodvariability • Neurological: slurred speech, incoordination, unsteady gait,memory impairment, seizure, stupor, coma • Lab abnormalities: hypoglycemia, hypokalemia, hyperlactatemia, hypomagnesemia, hypocalcemia,hypophosphatemia	• Physical: nausea, vomiting, headache,tremors, seizure, paroxysmal sweats, tachycardia, hypertension, pyrexia • Psychological: anxiety, agitation, audio disturbances, tactile disturbances, visual hallucinations • Can use the Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar) scale to measure severity of withdrawal
Opioids	• Eyes: pupils constricted • Cardiopulmonary: respiratory depression, hypoxia, apnea, hypotension, pulmonary edema • Neurological: reflexes diminished to absent, stupor or coma • Other: hypothermia, constipation	• Physical: pupils dilated, pulse rapid, gooseflesh, abdominal cramps, muscle jerks, "flu" syndrome, vomiting, diarrhea,tremulousness, yawning • Psychological: anxiety • Can use the COWS assessment to measure severity of withdrawal
Stimulants	• Eyes: pupils dilated and reactive • Cardiovascular: elevated blood pressure and heart rate, cardiac arrhythmias, chest pain, tachycardia, palpitations, ruptured aneurysm, cardiogenic shock • Psychological: change from baseline mental status, paranoia, hallucinations, impulsivity • Neurological: hyperactive reflexes, tremors, hyperactivity,convulsions, coma, psychosis, agitation • Other: nausea, vomiting, temperature elevated, respiration shallow, hyperventilation, dry mouth, sweating, headache, bruxism, exacerbation of asthma, diuresis, myoglobinuria	• Physical: muscular aches, abdominal pain, chills,tremors, voracious hunger, prolonged sleep, lack of energy, exhaustion • Psychological: anxiety, profound depression, sometimes suicidal
Sedative-Hypnotics	• Eyes: pupils in mid position and fixed (but dilated in severe poisoning), nystagmus • Cardiopulmonary: respiratory depression, hypotension • Psychological: confusion, delirium • Neurological: depressed reflexes, drowsiness or coma, ataxia, slurred speech, convulsions or hyper-irritability, serious poisoning rare with benzodiazepines alone	• Physical: tremulousness, insomnia, sweating, fever, clonic blink reflex, cardiovascular collapse, convulsions, shock, headache, anorexia, palpitations,elevated vital signs, GI upset, muscle aches, hypothermia • Psychological: anxiety, agitation, delirium,hallucinations, disorientation, perceptual hyperacusis, depression, psychosis, decreased concentration, panic

OPIOIDS – ASSESSMENT & TREATMENT

Assessment of Opioid Intoxication [5]

- The clinical presentation of opioid intoxication can often be confounded by multiple substance ingestions.
- Given the high prevalence in the correctional setting, opioid intoxication should be considered in altered mental status.
- Typical signs in addition to unresponsiveness include respiratory depression, pinpoint pupils, and cyanosis.
- Look for other evidence of opioid use such as needle tracks.
- Diagnostic tests should target other causes for altered consciousness such as hypoglycemia, trauma, and electrolyte abnormalities.
- A UDS (374594) and EKG should be obtained.

For pregnant patients, consult an Obstetrician and see MAT for OUD in Pregnant Patients.

Assessment of Opioid Withdrawal [5, 6]

- Opioid withdrawal can be extremely unpleasant but generally it is not fatal. However, patients with other existing conditions such as advanced age, HIV, or coronary artery disease may be prone to life-threatening complications.
- Short-acting opioids such as heroin and oxycodone may generate withdrawal symptoms within 12 hours of last opioid use, whereas, long-acting opioids such as MSContin or fentanyl may generate symptoms within 24 hours of last use. With methadone, symptoms may emerge within 30-72 hours of last exposure and may last up to 10 days.
- Precipitated opioid withdrawal occurs when a patient who is physically dependent on opioids is administered an opioid antagonist such as naloxone or naltrexone, or an opioid partial agonist such as buprenorphine. Signs and symptoms of precipitated withdrawal are similar except that the time course is more rapid, and symptoms may be much more severe.

Withdrawal symptoms may mimic other common presentations of gastroenteritis, flu symptoms, etc., so reviewers should be cautious to consider the patient's entire clinical picture, especially reported last use.
In combination with the clinical picture, the tool used to assess the severity of opioid withdrawal is the COWS.

Characteristics of the COWS:

- Measures eleven signs and symptoms with a score of 0-5, with higher numbers representing greater severity
- Total score gives an objective measure of the severity of withdrawal that can be tracked over time
- Can be used to measure readiness for and response to treatment

OVERVIEW OF THE COWS		
SIGNS AND SYMPTOMS EXAMINED		
• Yawning • Rhinorrhea and/or lacrimation • Piloerection • Perspiration	• Tremor • Mydriasis (dilated pupils) • Pulse rate • Anxiety or irritability	• Restlessness • Nausea and/or vomiting • Bone or joint aches
SCORES AND CORRESPONDING SEVERITY OF WITHDRAWAL		
SCORES	*WITHDRAWAL SEVERITY*	*INDUCTION*
5+	Mild to severe	Transfer to TTA or consider induction in clinic (See page 18 for Induction in TTA)

Regardless of COWS score, patients in withdrawal should be considered for transfer to TTA or MAT initiation in clinic.

Primary treatment of opioid withdrawal is initiation on MAT, detailed here. With any questions, contact the AMCT Hotline at (916) 478-8610.

Medication Assisted Treatment (MAT): Selecting a MAT Agent for OUD[4]

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

- SUD related complications (HLOC send outs, HCV infection, overdose, endocarditis, cellulitis, skin and soft tissue infection [SSTI], etc.)
- Efficacy of MAT agent in limiting or eliminating problematic substance use
- Treatment retention and adherence
- Availability of chosen agent upon parole/release
- History of substance use patterns and treatment
- Patient's concurrent medical and/or mental health conditions

If UDS or SUD assessment results are not yet available, provider should confirm that they were ordered and/or completed. **For patients with objective signs of SUD, i.e., withdrawals, recent resuscitation with naloxone, SUD-related hospitalization, initiation of treatment can occur without a UDS or Behavioral Health assessment.**

In considering the three agents for OUD:

- ***Buprenorphine*** is a partial opioid agonist. In CCHCS, buprenorphine is generally prescribed in the combination buprenorphine-naloxone. Induction ideally occurs 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. This is to avoid potential acute withdrawal. Advise patient that it is best to be in mild withdrawal when initiating buprenorphine.
  As a controlled (C-III) substance, new start orders require re-evaluation within 7 days prior to renewal/continuation. This can be accomplished through a Nursing MAT Medication Evaluation (see page 12).
- ***Methadone***, a full opioid agonist, allows a transition from illicit opioid use to medication maintenance without detoxification (no need to be in withdrawal prior to initiating). Methadone is prescribed to patients diagnosed with OUD using a once-daily dose schedule. The administration of methadone for OUD is monitored and administered under the regulations of a licensed NTP. Indications for methadone are uncommon and it is a restricted agent. Please submit a Consult to Addiction Medicine Central Team 60 for consideration of all alternative agents, including methadone.
- ***Naltrexone***, an opioid antagonist, requires that the patient detoxify from opiates (typically 7 days) before beginning; 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.

Consideration for Alternative MAT Agents

- Use of any agent other than sublingual buprenorphine, acamprosate, and oral naltrexone for treatment of SUD requires prior approval by the AMCT. Place a *Consult to AMCT 60* for consideration.
- The AMCT provider will consult with patient and determine if an alternative agent is indicated, and if there are other treatment recommendations (e.g., CBT). Following the Consult, the AMCT provider will complete encounter documentation including treatment recommendations, and forward their note to the PCP.
- If the patient is found to be suitable for an alternative MAT agent, the AMCT will assume management of SUD treatment for the patient while they are prescribed the alternative agent.
- Some scenarios that may be appropriate for consideration of an alternative MAT agent include:
  - Patient with worsening SUD with chronic pain
  - Patient with worsening SUD with cooccurring mental health disease
  - Polysubstance use disorder
  - SUD related complications including overdoses, SSTI

Orders to Ensure Treatment Continuity

During reception, patients on methadone will need bridge orders to facilitate uninterrupted continuity of care. All providers are expected to provide such orders per 21 CFR 1306.07(b).

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

Per HCDOM 3.5.9, DEA Schedule II-V Controlled Substances, 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 orders based on specific medication:

Buprenorphine/naloxone:

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

Methadone:

- Consult to AMCT – same day.
- 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).
- Baseline EKG.

Injectable Naltrexone

- Consult to AMCT – 14 days
- Place 30-day order of oral naltrexone

Injectable Buprenorphine:

- Consult to AMCT – 14 days.
- If last injectable buprenorphine dose was given at least 28 days ago, order 16 mg sublingual buprenorphine/naloxone starting next day.
- If last injectable buprenorphine dose was given less than 28 days ago, order 16 mg sublingual buprenorphine/naloxone starting 28 days after the last injection.
- For transfers between institutions - AMCT Hotline provider will be messaged via the HQ Addiction Services Provider Message Pool regarding the transfer. The AMCT will place the patient on 16 mg SL strips of Suboxone starting 28 days from their last injection of Sublocade®. An AMCT follow-up order will be placed with a 14-day compliance.

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

- CCHCS UTOX PANEL (383403)
- CMP
- ISUDT Behavioral Health assessment

MAT Initiation for OUD [7, 8]

- The MAT PowerForm is a decision-support tool that standardizes and ensures the coverage of essential elements typically captured in an addiction medicine encounter and is used for initiation and all follow-up visits. Use of the PowerForm supports providers in ensuring all data is documented including:
  - Diagnosis if DSM-5 criteria are met
  - PHQ 2/9 results
- Additionally, utilizing the Addiction Medicine Note Template will auto-populate the following elements to support a provider in decision making:
  - NIDA MA/Co-Triage results
  - HLOC-related data
  - Documentation of SUD-related complications such as endocarditis, HCV
  - Record of any naloxone improvement events
- Consider the patient's current medications and any potential interactions, i.e., central nervous system (CNS) depressants such as anti-epileptics and antipsychotics.
- Additional items to consider are covered within ISUDT Didactic Training Series which can be found **here**.
- When starting a patient on a MAT agent, switching a patient to a new MAT agent, or assuming care of a patient on MAT, a new CDCR 7240, *Informed Consent for Medication Assisted Treatment for Substance Use Disorder* should be completed.
- For details on each MAT agent including starting dose, maximum recommended dose and contraindications, see page 23.
- Be mindful of efficient dosing for sublingual buprenorphine, e.g., 16 mg should be accomplished with two 8 mg strips rather than a 12 mg and 4 mg strip. In addition, dosing once daily is recommended.
- If patient enters buprenorphine-induced precipitated withdrawal, send patient to the TTA.
- Provider should order a MAT Medication Evaluation with Nursing, detailed in the section below.
- Some patients have difficulty with standard induction with buprenorphine due to regular use of fentanyl and struggle with precipitated withdrawal symptoms. Consider contacting the AMCT Hotline for assistance.
- **Patients who present in opioid withdrawal, were recently resuscitated following an overdose with naloxone, or are returning from a hospitalization for a SUD-related complication**, should be evaluated in the TTA and considered for MAT initiation. This evaluation should consider other causes of altered mental status such as delirium, organ failure, or other complicating factors. Refer to the Buprenorphine/Naloxone Rapid Induction Workflow.
  - In cases of suspected intentional overdose, provider should consider ordering MHPC Consult Emergent – STAT, to rule out suicidal ideation.
  - If induction with buprenorphine is not immediately available or patient refuses treatment, consider:
    - Informing patient of the risks of subsequent relapse and death.
    - Medications for anxiety, nausea, diarrhea, etc.
    - Recommending a self-help group. Patient initiates process through submission of a CDCR 2016, Inmate Activity Group Program Request.
    - Informing patients of peer support specialist services.
    - Arranging for follow-up within 90 days with a CCP order.

MAT for OUD – Administration Guidance

- When prescribing 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 (i.e., job and other programming) and considering consolidation with other medication administration. For patients already on MAT medication that are being considered for a new administration time, please discuss with the patient prior to switching.
- Care teams and institution leadership are also encouraged to review the Medication Line Distribution Power BI and Medication Line Distribution Improvement toolkit.
- Additionally, in consideration of medication line burden, patients prescribed medications that are eligible to be administered as Keep-on-Person (KOP) (including acamprosate and naltrexone) that are being delivered NA or DOT should be considered for transition to KOP administration.
- Once daily dosing Suboxone is standard.
- 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.
- Suboxone dosing should be accomplished efficiently and with no more than two films, e.g., 16 mg should be prescribed as two 8 mg films, and 18 mg should be avoided as it would require three films.
- 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.
- Medication administration should respect patient privacy and confidentiality.
- 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 patient education or instruction for 30 seconds to initiate adherence to the oral mucosa, the nurse does not need to perform a mouth check.
- Nursing will communicate to the prescriber of any misuse or refusal of the Suboxone film by documenting with a nonadherence message in the Medication Administration Wizard (MAW).

Opioid-induced Constipation (OIC)

Opioids can cause constipation. Best practices to maintaining bowel function include strategies for prevention, self-care and prescribed stimulant or an osmotic laxative when needed. OIC is estimated to affect 40-60% of noncancer patients taking opioids. Patients with OIC have a higher number of hospital admissions and longer inpatient stays compared to their peers without OIC.

Be aware of patients taking other constipating drugs such as tricyclic antidepressants and who have other risk factors such as immobility, dehydration, or metabolic abnormalities (e.g., hypercalcemia) that make them more prone to developing constipation.

Recommendations:

- Encourage lifestyle interventions such as increased fluid, fiber intake, physical activity and mobility within patient limits.
- Note that patients on Medication Assisted Treatment (MAT) can have constipation from etiologies other than OIC and may need to be addressed accordingly.
- Have a low threshold for starting prophylactic laxatives (e.g., Miralax® and/or Senna) in patients with any possible contributing factors including chronic constipation.[4]
- If additional support is needed, consider the following medications:

Medication	Type	Dose
Polyethylene glycol 3350 (PEG-3350) (Miralax®) Bottle	Osmotic	• Starting dose: 17 g QD • Maximum dose: 17 g BID • Action onset: 1-4 days **PACKET IS FOR IN-PATIENT USE ONLY**
Bisacodyl (Dulcolax®) Tablet: 5 mg	Stimulant laxative	• Starting dose: 5 mg QHS • Maximum dose: 15 mg BID • Action onset: 6-10 hours
Sennosides 8.6mg	Stimulant laxative	• Starting dose: 8.6 mg QHS • Maximum dose: 17.2 mg BID • Action onset: 6-12 hours

Managing Patients with Acute Pain While on MAT for OUD

Advanced planning for patients on MAT who are scheduled for elective procedures is best.

- Continuation of MAT medication such as buprenorphine is recommended during the perioperative period.
- **Total daily doses of buprenorphine may have to be increased post-operatively <u>for no longer than 7 days</u> for pain control and may be split to optimize analgesia (e.g., 24 mg/day changed to 8 mg every 8 hours).**
- If further pain control is needed, utilize multimodal pain management with non-opioids (see CCHCS Care Guide: Pain Management).
- Consider non-opioid analgesia as needed for breakthrough pain.
- 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.
- The PCP should be contacted pre– and post-procedure to assist in ongoing assessment, support and pain management.
- Methadone for OUD compared to chronic pain management is prescribed differently and has different treatment parameters. Therefore, methadone through an NTP to address OUD **and** chronic pain is not indicated.

Patients with oral pain should be referred for dental consultation.

Managing Patients with Chronic Pain While on MAT

- The formulation of buprenorphine-naloxone used in treatment of OUD is not intended for the use of chronic pain.
- Non-opioid analgesia is recommended.

Assessment of chronic pain is complex, and should include a complete history, physical, and appropriate objective studies. For guidance on the assessment and treatment of chronic pain, refer to the CCHCS Care Guide: Pain Management.

ALCOHOL – ASSESSMENT & TREATMENT

Overview of Alcohol Withdrawal[9]

- Alcohol withdrawal can be fatal. Risk stratification is necessary to determine if a patient requires hospitalization.
- Patients at a high risk for severe alcohol withdrawal include the following:
  - History of delirium tremens
  - Advanced age
  - Co-occurring chronic diseases
  - History of sustained drinking, or presence of significant withdrawal despite Blood Alcohol Content
- Uncomplicated alcohol withdrawal is generally completed within five days.
- Be aware that symptoms generally progress in severity over time, with mild symptoms first, seizures generally between 6 and 48 hours of alcohol cessation, hallucinations between 12 to 48 hours, and delirium tremens after 48 hours.
- There is a great deal of overlap and variability in the presentation of these symptoms.

Assessment of Alcohol Withdrawal with the CIWA-Ar

- The primary tool used to assess the severity of alcohol withdrawal as well as the response to therapy is the CIWA-Ar.
  - Completed in approximately 5 minutes.
  - Measures ten signs and symptoms and assigns them a score of 1-7 (with exception of orientation, which is scored 1-4). Higher numbers represent greater severity.
  - Total score gives an objective measure for the severity of alcohol withdrawal.
  - The CIWA-Ar PowerForm provides direction that patients showing mild to severe withdrawal be referred to the TTA.
- Available as a PowerForm within the EHRS.

SIGNS AND SYMPTOMS OF ALCOHOL WITHDRAWAL EXAMINED		
• Nausea/Vomiting	• Orientation/Clouding of sensorium	• Visual disturbances
• Tremor	• Anxiety	• Tactile disturbances
• Paroxysmal sweats	• Agitation	• Auditory disturbances
• Headache/fullness in head		

SCORES AND CORRESPONDING SEVERITY OF WITHDRAWAL	
Score	**Withdrawal Severity**
0 to 9 points	Very mild withdrawal
10 to 15 points	Mild withdrawal
16 to 20 points	Modest withdrawal
21 to 67 points	Severe withdrawal

Treatment of Alcohol Withdrawal [9, 10]

Alcohol withdrawal severity often increases after repeated withdrawal episodes. This is known as the kindling phenomenon and suggests that even patients who experience only mild withdrawal should be treated aggressively to reduce the severity of withdrawal symptoms in subsequent episodes. Kindling also may contribute to a patient's relapse risk and to alcohol-related brain damage and cognitive impairment.

Patients who should be considered for transfer to the hospital include those who:

- Show severe withdrawal symptoms (CIWA-Ar score of 21 or greater)
- Are actively seizing or at risk for seizures (i.e., history of withdrawal seizures, seizure disorder) or exhibit delirium tremens
- Exhibit Wernicke encephalopathy characterized by confusion, lethargy, inattentiveness, impaired memory, vision changes, ophthalmoplegia, and ataxia. Left untreated, Wernicke Encephalopathy can progress to Korsakoff psychosis, which is a permanent condition characterized by impaired memory formation, hallucinations, and confabulation
- Have concomitant medical or psychiatric co-morbidities including pregnancy

Administration of thiamine and lorazepam should be considered while transfer to a hospital is arranged.

For patients appropriate for outpatient treatment of their alcohol withdrawal, treatments to consider include:

- Oral thiamine. This should be done before administering glucose.
- Benzodiazepines are the treatment of choice to both treat symptoms and raise the seizure threshold.
- If the CIWA-Ar score is >8-10, lorazepam should be administered.
- Repeat the CIWA-Ar an hour after each dose is administered to determine if medication should be continued.

Individuals in alcohol withdrawal often develop fluid imbalances, electrolyte abnormalities, vitamin deficiencies and hypoglycemia. Careful attention to these issues can prevent significant medical complications. Treatment may require the use of intravenous fluids, glucose (after appropriate thiamine replacement), and electrolytes.

Assessment of Alcohol Intoxication

- Patients experiencing severe alcohol intoxication should be considered for transfer to a HLOC. As alcohol consumption increases and becomes persistent, both clinical presentation and blood alcohol level (BAL) may be poorly correlated and unreliable predictors of intoxication.
- As tolerance develops, more alcohol consumption is needed to achieve the same neurotransmitter effect, and the BAL will be higher with fewer signs and symptoms.
- Presentation may be altered with co-ingestion of other substances that may antagonize or augment the effects of alcohol.
- To measure a patient's alcohol level, serum measurements provide the most accurate results.
- Breath analysis offers more rapid results but may return slightly lower alcohol concentrations.

Blood Alcohol Level and Associated Clinical Presentation

BLOOD ALCOHOL LEVEL	CLINICAL SIGNS AND SYMPTOMS
0.01 – 0.05 g/dl 10 - 50 mg/dl	Mild euphoria, decreased inhibitions, diminished attention and judgement
0.05 – 0.10 g/dl 50 – 100 mg/dl	Euphoria, sedation, impaired coordination, decreased sensory responses to stimuli, decreased judgement
0.15 – 0.30 g/dl 150 – 300 mg/dl	Confusion, disorientation, impaired balance, slurred speech
0.25 – 0.40 g/dl 250 – 400 mg/dl	Sleep or stupor, marked muscular incoordination, markedly decreased response to stimuli, incontinence
0.40 – 0.50 g/dl 400 – 500 mg/dl	Coma, hypothermia, respiratory and circulatory failure, possible death

Treatment of Alcohol Intoxication [9, 10]

- Treatment for isolated and mild acute alcohol intoxication is primarily supportive and rarely requires medical intervention.
- In the correctional setting, other causes for altered mental status, such as trauma or other drug use, should be carefully considered.
- For moderate - severe symptoms of alcohol intoxication (hypotension, tachycardia, fever, hypothermia, hypoxia, hypoglycemia, seizure, and need for parenteral medication), consider need to transfer to a HLOC for aggressive supportive care that includes:
  - IV fluids for evidence of volume depletion or hypotension
  - Preparation to protect the airway with intubation and ventilation as necessary
- Activated charcoal and gastric lavage are generally not helpful because of the rapid rate of absorption of ethanol from the gastrointestinal tract.
- All patients with suspected alcohol intoxication should be treated with thiamine. Be mindful that the CCHCS formulary includes oral thiamine (vitamin B1), but intravenous thiamine is not readily available.
- Thiamine before glucose
- A glucose infusion for hypoglycemia should not be started until after thiamine is delivered to avoid precipitating Wernicke's encephalopathy. Wernicke's encephalopathy is characterized by altered gait, numb extremities, and nystagmus. In addition, if Korsakoff psychosis is also present, confusion, hallucinations, and confabulation can occur. This can progress to coma and death if untreated.

Continued Treatment and Monitoring after Alcohol Intoxication

- Patients who present with alcohol intoxication or withdrawal should be assessed for alcohol use disorder (AUD) and offered treatment for this chronic condition. UDS (383403) should be ordered and *Consult to Behavioral Health* should be placed. If deemed high risk, place order for *Consult to Addiction Medicine Central Team 60*.
- Patients may have other vitamin deficiencies and should receive a daily multivitamin, folic acid 1 mg daily, and thiamine 100 mg daily for one month after the intoxication/withdrawal episode; consider longer term treatment if indicated.[4]
- Refer to the treatment algorithm on page 7 and the pathway noting "Patient presents with opioid overdose or SUD-related infection/complication".

Medication Assisted Treatment (MAT): Selecting a MAT Agent for AUD[4]

For treatment of AUD, acamprosate and naltrexone are found to have similar rates for retention and positive 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
Topiramate	1-2 doses	Yes; recommend close monitoring of liver function	Use with caution CRCL<70 decrease dose 50%

MAT Agent Summary

MEDICATION		FOR	USE CRITERIA
ACAMPROSATE (NA/DOT or KOP after stable)		**AUD**	• Recommended starting and maximum dose is 666 mg TID • No contraindications or hypersensitivity to acamprosate • Contraindication or intolerance to naltrexone or inadequate response at 100 mg/day • Patient/provider preference • Acamprosate contraindicated severe renal impairment (CrCl ≤ 30 mL/min)
BUPRENORPHINE/NALOXONE (SUBOXONE) SUBLINGUAL FILMS (NA/DOT-SL) Opioid partial agonist		**OUD**	• Partial agonist, with tight binding to opioid receptors that reduces cravings and blocks other opioids from activating receptors • Can be initiated when patients are in withdrawal • **Recommended outpatient starting dose 12-16 mg daily** • Recommended maximum dose 24 mg daily • No contraindications or hypersensitivity to buprenorphine/naloxone • If patient arrives on buprenorphine-only formulation, whether injectable or tablet, switch patient to buprenorphine/naloxone sublingual formulation, unless patient is pregnant • As a controlled substance (C-III), new start orders require re-evaluation within 7 days. This re-evaluation can be accomplished with a 72-hour Nursing visit as described on page 12
NALTREXONE ORAL (NA/DOT or KOP after stable) Opioid Antagonist		**AUD** **OUD**	• Antagonist, should only be started after full detoxification (no opioid use in past 7 days) to avoid precipitated withdrawal • Recommended starting dose is 50 mg daily • Recommended maximum dose is 100 mg per day for oral naltrexone • No contraindications or hypersensitivity to naltrexone • No acute hepatitis or liver failure • Avoid if CrCl < 30 ml/min
RESTRICTED USE – REQUIRES REVIEW AND APPROVAL BY AMCT	**METHADONE** (NA/DOT - crush & float) Opioid Agonist	**OUD**	• Dosing is managed by NTP (contracted with CDCR) • No contraindications or hypersensitivity to methadone • Continue if the patient arrived on methadone for OUD (3-day bridge) • Dosing is once daily for OUD • 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).
	BUPRENORPHINE INJECTION (NA)	**OUD**	• The patient is on sublingual buprenorphine therapy for more than 7 days and • Patient is unable to manage daily dosing with oral formulations • Patients nearing release
	NALTREXONE INJECTION (NA)	**AUD** **OUD**	• Patient is unable to manage daily dosing with KOP medication • Patient is considered at high risk for overdose
	TOPIRAMATE (NA/DOT)	**AUD**	• Recommended starting dose is 25 mg daily • Use with caution in pregnant persons or those who are breastfeeding, and patients with reduced renal function or history of kidney stones • No contraindications or hypersensitivity to topiramate

As there are no Food and Drug Administration (FDA) approved medications for the treatment of stimulant use disorder at this time, CCHCS does not recommend MAT for stimulant use disorder. CBT is the recommended treatment.

Overview of Switching MAT Medications[4]

General considerations:

- Medication changes should be considered on a case-by-case basis. For consideration of switching a patient to an alternative MAT agent such as methadone, injectable buprenorphine, or injectable naltrexone, place an order for *Consult to Addiction Medicine Central Team 60.*
- Changes in medication formulation may be necessary to conform to CCHCS formulary restrictions. For example, a patient who enters CDCR on MAT using buprenorphine tablets or injections will be transitioned to films.
- Switching MAT agents for the treatment of OUD may be appropriate if there are documented intolerable side effects or patient is not successful in attaining or maintaining treatment goals using the current agent.

Methadone to Buprenorphine

- Patients switching from methadone to buprenorphine should be on low doses of methadone prior to switching medications.
- 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.

Buprenorphine to Methadone

- Arrangement to transition the patient to an institution with access to an NTP will be necessary.
- CTEC forum is required to initiate methadone and to discern treatment barriers and goals.

Naltrexone to Buprenorphine or Methadone (Methadone provided by NTP)

- Switching from an antagonist to an agonist is generally less complicated because there is no physical dependence associated with antagonist therapy so there is no possibility of precipitated withdrawal.
- 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).

Buprenorphine or Methadone to Naltrexone

- Switching from an agonist or partial agonist to an antagonist can be complex.
- The agonist or partial agonist should be weaned off no faster than 10% per 48 hours.
- Medications for symptom management are found on page 25.
- Naltrexone can start 7-10 days after cessation of sublingual buprenorphine, and 10-14 days after cessation of methadone.
- Please call the AMCT Hotline for guidance if you consider switching a patient from injectable buprenorphine to naltrexone.

Overview of MAT Medication Discontinuation/Tapering

- Patients who discontinue MAT have a higher risk of all-cause mortality, including overdose.
- If a patient requests MAT discontinuation, providers should explore reasoning and counsel the patient on risks.
- Providers should consider tapering/discontinuation of MAT if over a 6 month period:
  - Patient is adherent with taking MAT (>80% administration on MAR) but does not have expected MAT metabolites in their UDS repeatedly
    or
  - Patient fails to provide a valid UDS specimen
- The patient should be followed based on guidance here even if MAT is discontinued. Patients should be seen sooner if they are identified as having SUD related complications (e.g., overdose, skin and soft tissue infections, new HCV infection or reinfection).
- In the case of refusal, the treating provider will get a signed CDCR 7225, Refusal of Examination and/or Treatment form (see attachment E). If the patient decides they no longer want to continue taking MAT or there is a medical indication for discontinuing MAT, adjust medications as noted below:
- **Naltrexone**: no need to taper, may discontinue medication (warn patient of overdose risk if returning to opioid use due to loss of tolerance while abstinent and warn those on Vivitrol that medication will remain in their system for 30 days – see below).
- **Acamprosate**: no need to taper, may discontinue medication.
- **Methadone**: tapering is challenging and is generally directed by a licensed NTP, along with AMCT oversight.
- **Sublingual Buprenorphine:** 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.

Patients Returning from HLOC with an AUD/OUD-related Complication

When patients return from higher level of care (HLOC) and are evaluated by the TTA RN, the TTA RN should review if the hospitalization was due to SUD related complications by using the SUD-related tab in the Offsite/Hospital Return PowerForm.

The patient's PCP should consider:

- If the patient started on MAT while at the hospital, continue MAT.
- If the patient has not started on MAT while at HLOC, *and* is not currently prescribed MAT, consider starting MAT.
- If the patient has been compliant with MAT, consider MAT dose increase.
- If the patient is noncompliant with MAT, utilize motivational interviewing to address any barriers and consider alternative agent if appropriate.
- Order the following:
  - CCHCS UTOX Monitoring – 383403
  - TTA Follow Up (20/40) – 5 days
  - MHPC Consult Emergent – STAT (to assess for suicidal ideation) if there is a suspected intentional overdose
  - Behavioral Health Order (see table here)

Assessment & Treatment for Intoxication & Withdrawal States Due to Other Substances

Goals of Withdrawal Management

- Evaluation and safe withdrawal from the substance(s) used
- Stabilization and provision of treatment that is humane and thus protects the patient's dignity
- Foster the patient's readiness for entry into treatment for SUD

Onset, duration, and intensity of withdrawal are variable and influenced by:

- Specific agent used and agent's half-life
- Duration of use and degree of neuroadaptation

Pharmacologic Management of Withdrawal

There are two general strategies for pharmacologic management of withdrawal; either or both may be used to manage withdrawal syndromes effectively:

- Suppressing withdrawal through use of a cross-tolerant medication.
  - A longer-acting medication typically is used to provide a milder, controlled withdrawal.
  - Examples include use of methadone for opioid detoxification and lorazepam for alcohol detoxification.
- Reducing signs and symptoms of withdrawal through alteration of another neuropharmacological process.
  - Medications that are not cross-tolerant are used to treat specific signs and symptoms of withdrawal.

OVERVIEW OF SYMPTOMATIC TREATMENTS USED IN INTOXICATION & WITHDRAWAL TREATMENT [9, 12, 13]

Use of the following medications for temporary symptomatic treatment should be time-limited to 7 days or less.

SIGN OR SYMPTOM	MEDICATION	TYPICAL DOSES
Anxiety, Irritability, Restlessness	Hydroxyzine Pamoate (Vistaril®)	25 to 100 mg orally every 6 to 8 hours as needed
Seizures	Lorazepam (Ativan®)	2 mg IV, PO, IM initial, with repeated dosing for clinical response
Abdominal Cramping	Dicyclomine (Bentyl®)	20 mg 4 times per day
Diarrhea	Loperamide (Imodium®)	4 mg orally for first dose, followed by 2 mg orally after each loose stool. Maximum of 16 mg/day
Nausea/Vomiting	Ondansetron (Zofran®)	4 to 8 mg orally three times daily
Gastrointestinal (GI) Upset	Aluminum Hydroxide/Magnesium Hydroxide/Simethicone (Maalox®, Mylanta®)	Regular Strength:10 to 20 mL or 2 to 4 tablets orally 4 times daily Maximum Strength: 10 to 20 mL orally twice daily
Muscle Aches, Joint Pain, Headache	Acetaminophen (Tylenol®)	650 to 1000 mg orally every 4 to 6 hours. Max dose: 4000 mg in a 24-hour period from all sources
	Ibuprofen (Advil®, Motrin®)	400 mg orally every 4 to 6 hours as needed
	Naproxen (Naprosyn®)	500 mg initial, followed by 500 mg every 12 hours or 250 mg every 6-8 hours

Refer to medication tables for additional details

Assessment of Stimulant Withdrawal[11, 12]

Symptoms of stimulant withdrawal include both those that are self-limited and will generally dissipate within 1 to 2 weeks without treatment, as well as symptoms that may linger over the longer term.

- Depression
- Anxiety
- Fatigue/anergia
- Difficulty concentrating
- Anhedonia
- Intense drug craving
- Return of appetite
- Hypersomnolence
- Increased dreaming/REM sleep

Treatment of Stimulant Withdrawal [12]

Treatment of stimulant withdrawal is primarily symptomatic support. See table on page 25 for overview. Supportive treatments of stimulant withdrawal include:

- Rest, exercise, healthy diet
- Education on the risks of overdose and relapse

Monitoring following Stimulant Withdrawal [12]

Patients withdrawing from stimulants should be monitored closely for:

- Depression/suicidality
- Prolonged QTc intervals—an EKG is recommended to monitor for cardiac complications
- Seizures

Assessment of Stimulant Intoxication[12]

- High rates of stimulant use have been documented in persons involved with the criminal justice system.
- Stimulants share the same range of psychological and physiological effects, while differing in potency and pharmacokinetic characteristics.
- The initial intoxication effects of stimulants include increased energy and alertness, elation, euphoria, decreased need for sleep, and decreased appetite.
- With high doses of stimulants or continued use, stimulant intoxication usually progresses to unwanted effects such as anxiety, irritability, hypervigilance, suspiciousness, impaired judgement, stereotyped behavior, and psychotic symptoms such as hallucinations and bouts of paranoia.
  - *NOTE: Psychosis associated with stimulant intoxication is often misdiagnosed as schizophrenia.*

Severe symptoms of stimulant intoxication that may indicate transfer to a HLOC:

- Hyperpyrexia (excessively high fever)
- Severe hypertension
- Convulsions
- Cardiovascular collapse
- Chest pain

Clinical evaluation should include a drug history and UDS to confirm stimulant intoxication and rule out other potential medical conditions (hyperthyroidism, hypoglycemia) or neuropsychiatric conditions (panic or bipolar affective disorder, schizophrenia). For a list of signs and symptoms of stimulants withdrawal, refer to the table on page 14.

Treatment of Stimulant Intoxication [12]

For severe intoxication, agitation, psychosis, often involving cardiovascular instability, refer to a higher level of care.

The initial treatment approach for mild to moderate stimulant intoxication should be non-pharmacologic such as:

- Placing the patient in a quiet environment with limited stimuli
- Explain procedures clearly, confidently, and calmly to keep the patient oriented to reality (or help reorient to reality)
- Avoid physical restraints to control agitation unless necessary
- Supportive therapies such as hydration

Pharmacologic treatment may be considered for severe toxicity including:

- Benzodiazepines for acute cardiovascular and CNS toxicity
- Calcium channel blockers (cardiac arrhythmia)

Assessment for Synthetic Cannabinoid Use

- Synthetic cannabinoids, known as "K2" and "Spice" have emerged as a concerning public health threat. This drug is comprised of several hundred chemicals that are ever-changing. The usual manner of producing this drug is by spraying synthetic cannabinoid onto plant material of some sort and dried for smoking or oral ingestion. These are sold in retail stores as herbal incense, potpourri or herbal smoking blends.
- Should not be confused with natural occurring marijuana plant; these drugs are collection of numerous laboratory chemicals that interact with the cannabinoid receptor in the brain to mimic marijuana and induce a marijuana-like high.
- More potent than marijuana and induce nausea, emesis, tachycardia, hypertension, agitation, and "excited delirium". Severe symptoms can include cardiac arrythmias, myocardial infarction, psychosis, respiratory depression, hyperthermia, etc.
- Due to the constantly changing components of this drug, lab testing for this substance is unrewarding and only tests for some specific cannabinoid compounds are thus not recommended currently.
- If testing is necessary for treatment planning, use of the Novel Psychoactive Substances Panel may be appropriate.

Treatment of Synthetic Cannabinoid Intoxication

- Treatment of mild to moderate intoxication is largely supportive: decrease stimulation, reassurance and benzodiazepines.
- Severe intoxication can be life threatening. Hyperthermia, rhabdomyolysis, seizures, acute coronary syndrome, etc. can occur and sending to a higher level of care is recommended.
- Linking this patient with a Substance use assessment and addiction medicine evaluation is imperative.

Assessment of CNS Depressant Intoxication [13]

- Common CNS depressants include:
  - Sedative-hypnotics
  - Gabapentinoids (e.g., gabapentin, pregabalin)
  - Central alpha agonists (e.g., clonidine)
- The signs and symptoms of CNS depressant intoxication are like those of alcohol intoxication. Characterized by physiologic depression and drowsiness, severe intoxication can lead to respiratory depression, coma, and death, especially when used in combination with opioids.
- Combining multiple CNS depressants with different mechanisms of action leads to a higher rate of morbidity and mortality. Consequently, to the extent possible, assessing active substance(s) in the patient's system will help to determine risks.
- Acute toxicity of CNS depressants should prompt consideration for transfer to the hospital if there are signs of:
  - Delirium with hallucinations
  - Changes in consciousness, coma
  - Autonomic instability
  - Respiratory depression

Treatment of CNS Depressant Intoxication [13]

- Consider higher level of care for severe intoxication.
- Because sedative-hypnotic intoxication causes respiratory depression, the focus of managing overdose or severe intoxication while arranging transfer to the hospital is on maintaining the airway and respiratory support.

Assessment of CNS Depressant Withdrawal[13]

- A clinically significant withdrawal syndrome is likely to occur after discontinuation of a high-dose CNS depressant previously used for 2 to 3 months or a low-dose CNS depressant previously used for 4 to 6 months.
- Withdrawal symptoms can occur sooner and are influenced by three main factors:
  - Dose
  - Duration of use
  - Duration of drug action
- Withdrawal symptoms for CNS depressants are similar to those seen in alcohol withdrawal though timing may vary:
  - Symptoms generally begin within 12 to 24 hours and peak within 1-3 days for agents with short half-lives.
  - For longer-acting agents, symptoms may begin later and not peak until 4 to 7 days after discontinuation and may be protracted.
- For signs and symptoms that may present during withdrawal from CNS depressants, please refer to the table on page 13.

Treatment of CNS Depressant Withdrawal [13]

- The most supported approach to treating CNS depressant withdrawal is using a tightly controlled taper of the medication over a long period of time.
- This strategy can be managed within the outpatient setting and minimizes withdrawal symptoms.
- Referral to ISUDT Behavioral Health should be considered for evaluation and comprehensive treatment planning for underlying SUD.
- Multidisciplinary care coordination is recommended for tapered dosing.

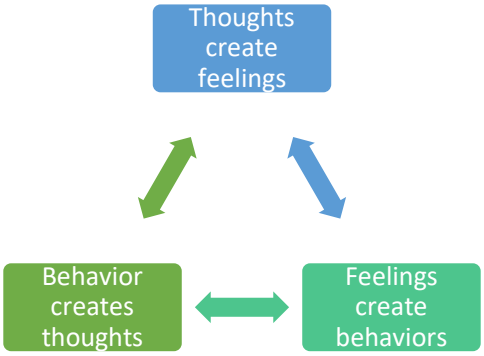
TREATMENT – BEHAVIORAL INTERVENTIONS

Within CCHCS, two primary methods of behavioral interventions are used to support patients with SUD:

Behavioral Intervention	*Administered by:*	*Topics/Curriculum*	*How to Access*
Cognitive Behavioral Therapy (CBT)	ISUDT Behavioral Health Social Workers and therapists	Intended for patients not improving or worsening in their treatment. Uses *Seeking Safety* curriculum to target a patient's specific cognitive thought patterns and triggers.	PCP orders *Follow-Up ISUDT Behavioral Health 60*, patient will then be assessed to determine if CBT is appropriate If patient EPRD < 18 months, use *SUD Pre-Release ASAM Assessment 60* order
Cognitive Behavioral Interventions (CBI)	DRP	Coping skills, emotional regulation, resolving conflicts, anger management, parenting	Automatically assigned after SUD assessment

Cognitive Behavioral Therapy (CBT)

- For patients needing a higher LOC (intensive outpatient services), licensed therapists engage in providing CBT to address substance use using a standardized trauma informed therapy curriculum. *Seeking Safety* is an evidence-based curriculum that increases safety by addressing substance use and trauma in a structured, clinical environment.
- Patients who are not showing improvement or worsening in treatment can be referred to ISUDT Behavioral Health therapists for further assessment and treatment.
  - For patients with EPRD 18 months or greater, order *Follow-up ISUDT Behavioral Health 60*
  - For patients with EPRD ≤ 18 months, order *SUD Pre-Release ASAM Assessment 60*
- Supports patients in developing coping skills, including stress reduction techniques such as muscle relaxation
- CBT challenges negative thoughts and feelings and helps patients learn to develop new constructive thoughts and behavior patterns.



Cognitive Behavioral Interventions (CBI) Overview

- DRP provides CBI across a spectrum of topics relevant to SUD. The Medical Classification Chrono (MCC) is used to transmit the level of care assignment associated with the ASAM score to the counselors in the DRP:

ASAM SCORE	MCC CODE	LEVEL OF CARE (LOC)
.5	T3	Life Skills (Education/Relapse Prevention)
1.0	T2	Outpatient Services
2.0	T1	Intensive Outpatient Services

- DRP uses MCC codes T4 to indicate one has completed CBI, and T5 to indicate one has not completed CBI and/or has been removed from the waitlist.
- CBI enhances skills and coping strategies used to improve emotional regulation and identify/resolve interpersonal conflicts. Avoidance of environments linked to exposure to drugs/alcohol is also key. CBI seeks to teach participants how to identify and change unhelpful thoughts, beliefs, and attitudes (cognitive distortions).
- CBI participation is offered to patients with an EPRD of 15-24 months, and attendance is mandatory for the duration of their assigned CBI program. Patients who are indeterminately sentenced will be assessed for appropriateness for CBI when they are 15-24 months from a Board of Parole Hearing (BPH).
- While helpful in establishing sobriety and recovery, CBI is not mandatory for MAT medication. We do not stop MAT due to refusal of these other treatment components.

Support Groups/Inmate Leisure Time Activity Groups (ILTAG)

Support groups (such as Alcoholics Anonymous, Narcotics Anonymous, White Bison) support a patient's recovery by:

- Helping patients become and stay engaged in the recovery process and reduce the likelihood of relapse through shared understanding, respect, and mutual empowerment.
- Focusing on ongoing relationships and support networks in combination with improving coping strategies.

Support groups are available as 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:

- The patient completes a CDCR 2016, Inmate Activity Group Program Request and submits the form to the Community Resource Office for processing.
- If accepted into the group, the patient will receive a ducat indicating time, date, and place for the group.

Peer Support Specialists Program

The Peer Support Specialist Program (PSSP) is designed to provide mentorship, guidance, and coaching to incarcerated individuals within our system. Peer Support Specialists (PSS) incorporate evidence-based tools that support recovery, mental health and wellness and life skills. Peer Support Specialists utilize their lived experiences, motivational interviewing, strength identification and goal setting to assist peers with their recovery journey.

- PSSs are individuals with lived experience of recovery from substance use and/or mental health challenges who are trained to provide support to others on their recovery journey.
- PSSs complement clinical services by offering hope, empathy and guidance rooted in personal experience.
- PSSs reduce fear, shame and stigma associated with substance use disorder treatments by sharing lived experiences, modeling recovery, using person-centered language, and normalizing seeking SUD treatment as a sign of strength rather than weakness.

PSS are peer advocates and guide their peers through many aspects of the recovery process including assisting with identifying readiness to begin the recovery journey and offer support with creating recovery plans, as well as providing education on the harmful effects of substance use. They can coach peers through identifying triggers that can lead to drug use or relapses and teach techniques to manage those triggers. PSS can assist in identifying causes of stress and offer guidance to manage emotions through crisis, including mentorship through life-changing events. As part of the recovery journey, they are available to help with skills to rebuild and maintain healthy relationships with family members, peers, and staff. Except for mandatory reporting requirements, all interactions with the PSS are kept confidential and private; patient rights will always be respected.

Attending peer led groups or reaching out to a Peer Support Specialist are highly encouraged. Sign-up sheets for groups or meetings with a PSS are in respective housing units. More information regarding the PSSP and all services they may offer is available on the patient's tablet.

For more information on this program, providers can visit the Peer Support Specialist Program SharePoint.

Nursing Led Therapeutic Groups

Nursing Led Therapeutic Groups (NLTG) Program is structured to encourage and promote social skills, life skills, behaviors, and coping mechanisms to improve patient health and wellness outcomes while incarcerated and upon release. Nursing Led Therapeutic Program offers groups on disease processes, the signs, symptoms, and health risks of substance use disorders, positive health behaviors, health improvement, and therapeutic interventions.

Patients can be referred to by Interdisciplinary Treatment Teams (IDTTs), ISUDT staff, PCPs, or can self-refer by submitting a CDCR 2016, Inmate Activity Group Program Request. NLTGs provide hour-for- hour Rehabilitation Achievement Credit (RAC) for the patient attendees.

Supportive Housing[14]

- While participation in supportive housing is voluntary, due to its known benefits, ISUDT program participants should be encouraged to participate in supportive housing. Supportive housing is open to patients who are currently participating or have previously participated in the ISUDT Program, or who have expressed interest in rehabilitation and recovery activities.
- 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.

MONITORING

Follow-up Visits for Patients with SUD - Overview

SUD is a chronic disease and will be a lifelong concern for the patient. Whole Person Care requires the patient's PCT and MH team to be aware of their SUD diagnoses and all aspects of their SUD treatment plan. Follow up for SUD is necessary even if the patient is not on MAT, to provide sufficient monitoring of this chronic disease, and because patients with SUD who are not on MAT are particularly vulnerable to SUD-related complications. Reviewing their risk profile (overdoses, cellulitis, CDCR 7362 submissions, HCV status, etc.) should be done continuously and patients scheduled for visits as clinically appropriate.

All PCT members should encourage the patient to engage with their treatment by using Motivational Interviewing techniques. (See also the Substance Abuse and Mental Health Services Administration's [SAMHSA] Using Motivational Interviewing in Substance Use Disorder Treatment.)

Preparation for a Follow-up Visit

- Completion of the MAT PowerForm is required at each visit. Use of the PowerForm and Addiction Medicine Note templates will guide providers in review of the items below that are pertinent to ongoing SUD care:
  - Patient chart notes since last visit, including prior addiction medicine notes, CDCR 7362s submitted, hospital send outs, etc., which may indicate need for a higher intensity of SUD care including greater frequency of follow-up visits and UDS.
  - UDS results since the last AM visit (per monitoring guidelines, see page 34). Note for any CNS depressants e.g., alcohol, unprescribed gabapentinoids.
  - Medication Administration Record (MAR) since last AM visit: MAT medication, administration route, and current dose and adherence. In addition, providers should monitor for drug interactions (anti-epileptics, antipsychotics, antiarrhythmic, antibiotics, etc.).

During the Follow-up Visit

- Obtain interim history and document any complaints or concerns
- Focused physical exam
- Ensure medication is ordered in your name, and refill as needed
- Schedule follow-up visit and random UDS according to duration of treatment and clinical need:

Clinical Scenario	UDS Frequency	Follow-up Visit Frequency
Newly started on MAT	14-30 days	14-30 days
OUD on MAT*	90 days	90 days
OUD not on MAT, UDS results have evidence of illicit substance use or patient is not adherent with providing UDS, or patient has other SUD-related complications	90 days	90 days
OUD not on MAT, adherent with UDS submission every 90 days, UDSs are free of illicit drug use, with no SUD-related complications	90 days	180 days

* If the patient is showing signs of poor disease management i.e., missed medication doses, relapses, lack of attendance of assigned CBT, etc., follow-up and UDS frequency should be increased until patient shows signs of improved disease management.

- Order interim diagnostic tests as needed (see table below)

MAT MEDICATION	DIAGNOSTICS TEST	ANNUAL	PRN
All MAT Medications	CMP	X	X
	Screening including HAV, HBV, HCV, HIV, RPR	X	X
	Random UDS (every 90 days, or more frequent if clinically indicated)		X
	Urine beta-hCG for persons with a uterus of childbearing age		X
Methadone Only	EKG* *(in addition to items noted above)* *Consider repeat EKG with dose changes and with the addition of any medication that may affect QT interval*	X	X

Documenting Addiction Medicine Encounters

- Providers use the MAT PowerForm at each ducated encounter (including for refused appointments). The MAT PowerForm is a decision-support tool that leads providers through the essential elements typically captured in addiction medicine encounters, ensuring they are addressed at each visit. Additionally, use of the MAT PowerForm will pre-populate many elements of the Addiction Medicine Follow-up Note template.
- Providers should utilize the Addiction Medicine Follow-up Note template, which will prompt providers to include the critical elements in their discussion with the patient:
  - Motivation to continue MAT as 0 to 10 *[0= no motivation to stay on MAT]*
  - Cravings/urges to use substance(s) as 0 to 10 [0= no cravings]
  - Mood (PHQ-2/PHQ-9)
  - Any identified relapse risk factors (e.g., recent bad news, poor self-care, avoiding peer support groups [see page 32])
  - Most recent infectious disease laboratory results (HBV/HCV/HIV/RPR status)
  - Missed MAT medication doses per the MAR, non-adherence notifications in the MAW, recent CDCR 7362 submissions by the patient, and recent appointment or lab refusals.

Recovery and Sobriety

Recovery: a process related to stopping or reducing use of an addictive substance, while making other changes to improve overall health and wellbeing.
Sobriety: being 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.

Sustained Remission

Sustained Remission: a period of at least 12 months without meeting any criteria for the disorder, except for a strong desire or urge to use the substance.
This is evidenced by regular use of the MAT PowerForm illustrating disease control reflected by DSM-V criteria, *and* regular UDSs consistent with treatment over a 12-month period.

Relapse, Cravings & Triggers

Relapse: a process in which an individual who has established abstinence or sobriety experiences recurrence of signs and symptoms of active addiction. Relapses are part of the chronic disease process and should not be interpreted as 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, such as CBT or increased provider visit frequency. **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. Warning signs include:

- Resumption of the pathological pursuit of reward using illicit or unprescribed substances
- Avoidance of peer support groups, CBI/CBT and other rehabilitative activities
- Refusal of medications and other health care appointments

Note that relapses are not the same as sustained non-compliance with elements of treatment. Sustained non-compliance can present as a patient failing to provide multiple UDSs, or a patient who demonstrates regular recorded medication administrations in the MAR but whose UDS results show no MAT metabolites. See page 24 for more information.

Cravings: Cravings are a state of intense focus on acquiring and using a substance to achieve a desired effect. Unmanaged cravings are a warning sign for potential relapse.

- Cravings are subjective and individualized, vary in duration and intensity, and may impact patient's 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 substances that may spark potential relapse. The four categories of triggers are:

- **Patterns** are situations that incite recollections of substance use (e.g., time of day, location, seasonal events).
- **Social** triggers are people or groups associated with drug use.
- **Emotional** triggers may stem from a wide range of emotions such as happiness or self-medicating for sadness and anxiety.
- **Withdrawal** triggers are biological responses to the lack of a substance in a person's body.

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)

WARNING SIGNS OF POTENTIAL RELAPSE	STRATEGIES TO PREVENT RELAPSE
• Hunger, Anger, Loneliness or Tiredness (HALT) • Avoidance of peer support groups • Practicing poor self-care, poor eating and sleeping • Romanticizing/glorifying people, places and things that are associated with past use • Minimizing consequences of continued use • Disclosure of any bad news (e.g., death of a family member, divorce, increase in sentencing, BPH denial, other sources of grief) • Refusing medications & premature termination of treatment	• Avoid people, places & activities associated with drug use • Develop pleasurable and rewarding alternatives to drug use (hobbies) • Join a peer support group that can help celebrate the process of sobriety and offer accountability • Report safety concerns/ request housing change if needed • Mindfulness activities (e.g., breathing, relaxation, stress reduction, guided meditation)

Addressing Cravings, Triggers and Signs of Relapse

- 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, remembering cravings end, and journaling.
- Do not overly rely on medication to address cravings.

Opioid Overdose Risk & Prevention Counseling[5, 14]

Patients with OUD all have an increased risk of overdose if they stop MAT.

Tell all patients:

- Sobriety from opioids results in a loss of tolerance and use of "usual" amount of opioids may result in death.
- Do not use opioids with other CNS depressants (alcohol or benzodiazepines).
- Do not use multiple doses of opioids in a short duration of time and if using, do not use alone.
- ALL illicit drugs should be considered as tainted with fentanyl, despite what patients are told and report to staff.
- Naloxone is available to patients without a prescription. See local operating procedures at your institution for guidance.
- All patients receive keep-on-person naloxone upon parole/release.

Additional Overdose Risk with Naltrexone: Patients on naltrexone (opioid antagonist) are at risk of sudden overdose if taking opioids while on naltrexone because opioids can overcome the blockade and result in **respiratory arrest, circulatory collapse and death.**

- 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.

Urine Drug Screening [15]

The CCHCS Urine Drug Screen is a clinical tool to help providers monitor the disease, adherence to treatment, and to keep the patient safe. It is not intended to determine punitive measures. (See **Attachment C**).

- CCHCS uses UDS as a clinical tool to identify those at risk and for chronic disease monitoring. UDS is not intended to result in punitive measures. Under no circumstance are the UDS results to be shared with custody staff.
- In general, random drug testing is a strong deterrent to drug use and is intended to be conducted on an unannounced basis. To support the use of ***random*** drug testing, UDS orders should be varied within the frequency parameters, and should never occur with a standing (i.e., q4 wks.) frequency.
- Urine drug screening should be conducted every 90 days, or sooner if clinically indicated.
- Most substances are detectable in urine for about 3 days after use.
- Every UDS result should be discussed with the patient and interpretation placed in the note. Compliant results provide an opportunity for providers to encourage the patient's progress, and noncompliant results offer opportunity to discuss any obstacles the patient is facing.
- The various UDS orders that are used are summarized below. Frequency of UDS and follow-up visit should be based on observations of most recent UDS results and clinical judgement, e.g., if patient is frequently missing MAT administrations, or UDS shows illicit substances, provider should increase frequency of UDS and follow-up visits.

TEST TYPE & ORDER NUMBER	SCREENING 374594	MONITORING 383403	COMPREHENSIVE 373993
SCENARIO FOR USE	Used in preparation for a Consultation.	The test most used for routine follow-up.	Rarely used. Used when a patient has severe, unstable, or co-occurring disorders that require a broader panel, or when psychotropic drugs are also monitored.
TURNAROUND TIME	Most rapid, 1-2 days	3 days	Longest turnaround time 5-7 days
COLLECTION PRIORITY	ASAP	Timed Study	Timed Study
COLLECTION TIME	2359	2359	2359
NOTES	Auto-fires from a NIDA-MA Assessment from ISUDT Behavioral Health, if appropriate.	Will not include MH medications. Positive screening assay for opiates and/or fentanyl reflexes to confirmatory testing.	Includes testing of MH medications.
Patients on Dialysis **- Use serum test 91360. This test is not for confirmatory testing following urine results, as most substances have a short detection window for serum testing**			

- Patients should NOT be told when tests are to be done.
- If relapse occurs after an abstinence period, consider increasing test frequency.
- If patient is in sustained remission (see page 32), continue random testing at least every 3 months.
- 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.

UDS Sample Validity: To appropriately treat the patient, the provider needs to know the UDS results are valid. Normally, urine has a pH of 4.5-8, Creatinine >20 mg/dl, Specific Gravity >1.002-1.030, and temperature between 90-100 Fahrenheit within 4 minutes. 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

For proper interpretation of UDS results, it is important to reconcile with the 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
- Alcohol and other substances of abuse metabolites and detection time
- Engage the patient regarding results
- For assistance interpreting UDS results, please contact the AMCT Hotline (916-478-8610) or call a Quest Diagnostics Toxicology Specialist by calling 1-877-40-RX TOX (1-877-407-9689).

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. Levels are unreliable to correlate with dose.
Methadone	Methadone	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.
Topiramate	Topiramate	1-3 days	Topiramate is active in parent form.

Patient letters are auto generated and sent to patients following endorsement of UDS results.

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 substance NOT found:** Provider should look at the entire clinical picture to determine if the patient was: 1) not taking the medication or 2) taking the medication properly but the results were negative due to factors such as extremely diluted urine, unexpected rapid metabolism etc.
  - Situations in which a patient may be taking their medication but return a negative result for buprenorphine/norbuprenorphine due to trace amounts of analytes below the cutoff for the qualitative test, rendering a negative result:
    - Injectable buprenorphine
    - Low dose sublingual buprenorphine (< 4 mg)
- **Unexpected substance found:** If a medication not prescribed to the patient is found, the entire clinical picture should 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 can validate) or 3) if the drug is simply a metabolite of a prescribed drug (as applicable).

What to do with results NOT consistent with treatment or if the patient is frequently not providing urine specimens for testing especially in the context of consistently being administered suboxone in the medication line.

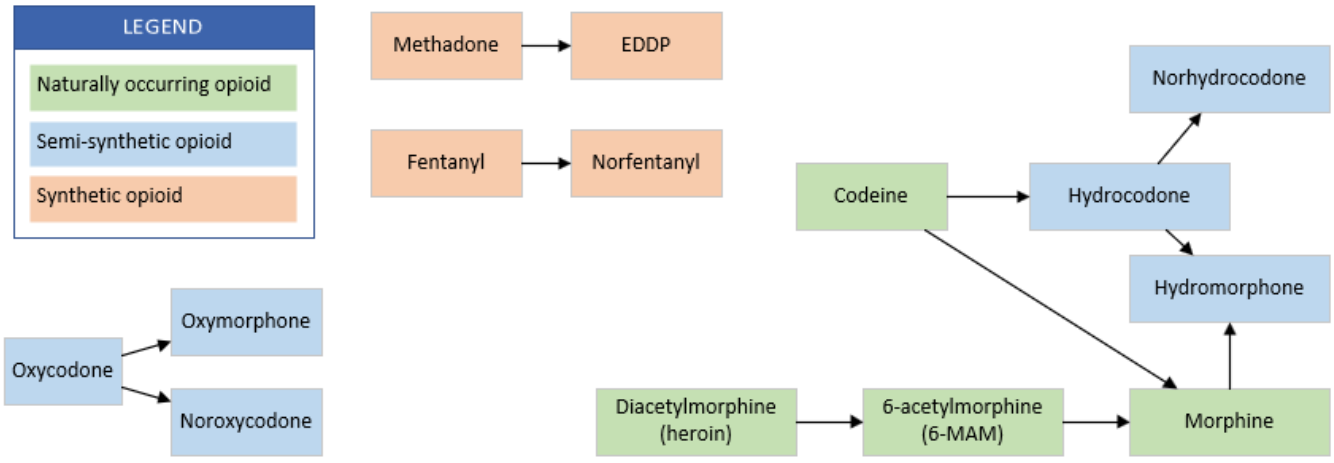
- Have a conversation with the patient
- Consider a change in housing—discuss triggers with your patient, including those linked to housing such as a cellmate who continues to use
- Consider identifying and treating any co-occurring conditions; consider a referral to MH and collaboration as needed
- Correlate the results with the patient presentation. If results seem inconsistent with presentation, consider reordering UDS and documenting
- No MAT agent or metabolite present in UDS: reconcile with the MAR and ensure that the patient has been presenting to medication line to take the medication
- Consider other substances found in the urine to determine if the urine truly belongs to the patient.
- Review elements of the therapeutic agreement
- Consider repeating the UDS
- Consider modifications to therapy as needed:
  - Review the medication dose or consider alternative agents as clinically appropriate
  - Refer to ISUDT Behavioral Health for re-evaluation and consideration for CBT
  - Increase frequency of clinic visits and/or random UDS testing
  - Discontinue treatment on a tapering schedule as appropriate

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 should have the dose delivered at the same time multiple days in a row, give a urine sample at the same time of the day, and have the same hydration level and many other factors. Given the variations in a myriad of factors, it is not recommended that the urine concentrations of medication be used for interpretation of compliance.

Reports of Non-adherence: If you receive notifications of patient non-adherence or non-compliance during medication administration, see page 40.

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.



ENHANCED PRE-RELEASE AND TRANSITION SERVICES

Inter-facility Transfers

In order to transfer patient orders from a sending institution to a receiving institution, providers are encouraged to utilize the Cross Encounter Reconciliation (CER) tool within EHRS.
When utilizing the reconciliation tool, it is critical to enter compliance dates consistent with the original orders.
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.

Patients Leaving CDCR[16]

People leaving prison are at significantly higher risk of dying of an overdose.
The Whole Person Care Transition Services Team collaborates with community stakeholders to arrange treatment as patients prepare for release back into their community.
Services provided to patients leaving CDCR may include, but are not limited to:

- Enrollment and activation of Medi-Cal benefits
- Enhanced Care Management Services
- Scheduling health care appointments
- Housing resources
- Arranging transportation to and from appointments
- Engaging family & peer support
- Assisting with employment/education resources
- Providing a release packet that includes community resources
- Offering naloxone to each patient upon release, along with education on its use

For concerns regarding this process, or a specific patient's pre-release plans, please contact the Resource Team.

Provision of MAT for Patients Paroling/Releasing

Patients on MAT will have additional requirements to assure continuity of medication delivery such as:

- Patients receiving methadone via an NTP will be transitioned to an NTP in their community upon release.
- Patients receiving buprenorphine (both sublingual and injectable) will be provided with a 30-day supply of sublingual buprenorphine, and patients receiving oral acamprosate or naltrexone will be provided with a 60-day supply.
  - Patients on injectable buprenorphine are switched to films to more easily coordinate with community resources. They will have a new order placed for a 30-day supply of sublingual buprenorphine/naloxone, to start 28 days after their last injection.
- Patients placed on injectable naltrexone within 3 months of release will be provided with a medical alert card.
- All dispensed controlled medications are reported to CURES.

SPECIAL CIRCUMSTANCES

Co-Occurring Mental Illnesses and SUD

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.

- Some experience MH issues first, experiment with drugs and alcohol to "self-medicate" and develop an SUD.
- Others may first develop an SUD that triggers the onset of symptoms that may have otherwise remained dormant.
- 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.

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.
When previously undiagnosed or unaddressed mental health symptoms are identified through conversation or screening assessments, patient should be referred to MH.

MAT In the Inpatient Setting

The PCP should consider the initiation or continuation of MAT for patients in the inpatient setting as clinically appropriate. 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.
There are three primary mental health inpatient levels of care within CDCR:

- Mental Health Crisis Bed (MHCB) - acute crisis stabilization (generally up to 10 days)
- PIP Acute (Acute Psychiatric Program - APP) - longer term inpatient mental health treatment
- PIP Intermediate (Intermediate Care Facility - ICF) - longer term inpatient treatment beyond that provided in the acute setting

It is often 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.

MAT for OUD In Pregnant Patients [17, 18, 19]

Introduction: OUD in Pregnancy

The prevalence of OUD in pregnancy has escalated in recent years, paralleling the epidemic observed in the general population. The increased prevalence of opioid use during pregnancy has led to an upsurge in neonatal abstinence syndrome (NAS) [also known as Neonatal Opioid Withdrawal Syndrome (NOWS)]; however, it is important to remember that NAS is an expected and treatable condition that has not been found to have any significant effect on cognitive development.

In CCHCS, pregnant patients on MAT are managed by the AMCT. The AMCT Hotline should be called promptly after a Consult to Addiction Medicine Central Team order is placed to connect a pregnant patient with SUD to the AMCT. MAT improves adherence to prenatal care and addiction treatment programs and has been shown to reduce the risk of pregnancy complications. It is the recommended course of therapy for pregnant women with OUD.
There may be a select group of women who make an informed decision to discontinue MAT. Regardless of the decision regarding MAT continuation, it is critical that the patient receives long-term follow-up and support to prevent relapse, which can pose grave risks both to mother and child.
Benefits of MAT for pregnant patients with OUD include:

- Stabilizes drug level over the course of the day and prevents opioid withdrawal symptoms
- Reduces the risk of relapse and its associated consequences including risk of infectious diseases
- Improves adherence to prenatal care, addiction treatment programs, and preparation for delivery
- Decreases risk of miscarriage, decreases preterm labor, and improves birthweight
- Reduces maternal mortality and severe morbidity

Management of Pregnant Patients on MAT

Typically, patients enter CDCR from jail with their pregnancy recognized and already on MAT therapy.

Management of a pregnant patient with OUD on MAT requires a collaborative approach between Nursing, Primary Care Provider, AMCT, designated SW, MH, Pharmacist, and Correctional Counselors.

CCHCS OB Provider	Responsible for all medical and prenatal care needs throughout pregnancy and coordinate with other disciplines as needed.
Community High-Risk OB	Should be consulted for complicated pregnancies (i.e., women with a history of complicated pregnancies in the past, chronic health conditions, and for women who develop unexpected problems during their pregnancy).
Mental Health	Should be consulted if patient presents any signs of peripartum mental health symptoms and/or underlying mental illness.
AMCT	Follows the patient through pregnancy and postpartum period at least monthly to assure uninterrupted MAT provision. In the case of methadone, coordination with a local NTP will be arranged.
Designated Social Worker	Reviews placement options for the child, and provides information regarding the Community Prison Mother Program. If the patient is interested, she is referred to their Correctional Counselor I to determine eligibility. The designated SW may also assist with transition planning in cases where the pregnant woman is released.

Typical interval for CCHCS OB Provider follow-up visits during pregnancy are as follows:

Gestation (weeks)	Minimum Follow-up Frequency
4-28	Monthly
28-36	Every 2 weeks
36-40	Weekly

Follow-up frequency may be increased as needed. In addition to routine prenatal care, it is important to:

- Maintain ongoing assessment for signs or symptoms of acute withdrawal using COWS,
- Assess for changes in psychosocial needs, and
- Repeat UDS monitoring. UDS should be done at least every 90 days and more often as indicated.

Any signs of deficient fetal growth may call for antenatal testing. If necessary, such testing should be performed at least 4-6 hours after the last opioid agonist treatment dose to reduce false positive rates.

Labor and Delivery

Communication is critical when preparing to transfer the patient to the hospital for labor and delivery to ensure:

- **Uninterrupted continuation of either buprenorphine or methadone at the current dose.**
- Appropriate planning for pain management such as utilizing epidural analgesia, as well as oral and injectable acetaminophen and nonsteroidal anti-inflammatory drugs (NSAIDS), and/or short acting opioid medication.
- Appropriate consultations should be made with Community High-Risk OB and Addiction Medicine Providers as needed.

Postpartum Period

- Postpartum time frame typically ranges from delivery to six weeks.
- Upon the patients' return from delivery, the patient will resume care with both the Primary Care Provider and the AMCT.
- Monitoring signs and symptoms of intoxication or withdrawal during the postpartum period is important since as fluid shifts and volume of distribution change, and medication doses may need to be adjusted.
- Breastfeeding is recommended in persons who are stable on their opioid agonist, not using illicit drugs, and have no other contraindication such as HIV infection. Only trace amounts of opioid agonists are found in breast milk.
- Individuals who wish to discontinue breastfeeding are advised to gradually wean the infant from breast milk to prevent sudden withdrawal in the infant.
- If the patient has access to future family visits, discuss postpartum contraception options.
- Monitor the patient for postpartum depression.
- Maintain 'PREGNANCY' designation in the MCC for at least six weeks post-partum to continue bottom bunk assignment and other restrictions.
- MAT is continued by the Addiction Medicine Provider, as clinically appropriate.

Postpartum Monitoring

- Close monitoring is important to the health and safety of both the mother and baby.
- The frequency of UDS monitoring for adherence to therapy and continued illicit drug use varies by phase of treatment and signs/symptoms of OUD withdrawal. Therefore, UDS frequency is recommended at least every 90 days and more often as clinically indicated (e.g., during dose adjustments).
- An EKG should be performed at baseline within the first month of initiating methadone and annually to monitor QT Prolongation.

Reports of Noncompliance

When reports of potential medication misuse and/or noncompliance with other aspects of care are received, these should not trigger a report to custody. The following steps should be taken by health care staff:

- For reported cases of misuse, providers should have a conversation with the patient and conduct their own assessment, considering the following:
  - Potential triggers or reasons for reported behaviors
  - Review the patient's MAR and UDS to determine if they are consistent
  - Document the outcome of the above in a progress note in EHRS
  - Therapeutic adjustments, such as dose, timing, change in MAT agent or discontinuation may be considered based on patient engagement and provider judgement.
- Report systemic issues to your local ISUDT Steering Committee
- If additional guidance is needed, call the AMCT Hotline, or consider CTEC or other resources
- It is important to differentiate between intermittent relapse (while prescribed treatment) vs. sustained non-compliance demonstrated by failure to complete UDS testing or completed UDS results with MAT metabolites absent despite regular recorded medication administrations on the MAR (see page 24).

RESOURCES

- The AMCT Hotline is staffed by an AMCT member available to primary care providers and other care team members to respond to questions regarding health care for patients with SUD.
- The Hotline can be reached at **916-478-8610, Monday-Friday, 7AM-3PM.**
- For programmatic questions such as questions about the workflows, contact the MAT Mailbox at MAT@cdcr.ca.gov.
- Additional resources are available here, including recordings of ISUDT trainings and materials related to Motivational Interviewing, Trauma-Informed Care, and opioid pharmacology.

CTEC Referrals

- For patients with complex co-occurring diagnoses, CTEC are available to assist in developing a comprehensive care plan.
- CTEC aims to gather representatives from a variety of disciplines to coordinate in optimizing a patient's care plan.
- Providers can request a CTEC by filling out the CTEC Request Form found here and submitting it to the Complex Care Team at CCHCSComplexCare@cdcr.ca.gov.
- Some examples of when a provider may wish to utilize CTEC are outlined in the *Special Circumstances* section.

PRIVACY & CONFIDENTIALITY

Medical Records

Treatment records created by CCHCS providers based on their own patient encounter(s) are not covered by Part 2. However, SUD records previously received from a Part 2 program (i.e., a community NTP) are segmented in the EHRS to ensure that records created by CCHCS providers will not become subject to Part 2. Consent to disclose any Part 2 records requires a signed patient consent specifying the circumstances for disclosure.

- Medical records are kept confidential, governed by the rules according to HIPAA.
- NTP records are governed by 42 CFR part 2 and are kept separate in the medical record.
- Appropriate signed release of information needs to be obtained to gain access to or share Part 2 records.
- Exceptions to maintaining confidentiality of Part 2 records are under the following circumstances:
  - Medical Emergency
  - Purposes of research, audit, or program evaluation
  - Court order

Board of Parole Hearings

A parole suitability hearing is a hearing conducted by the BPH to determine if an incarcerated person should be released from prison. Such a hearing is often a very stressful and significant event for incarcerated people, victims, victims' family members, correctional staff, and the community. The Board is dedicated to protecting public safety, treating all people who participate in a parole hearing with respect and dignity, applying the law in an unbiased manner, and protecting the rights of incarcerated people and victims.

The Board conducts parole suitability hearings for a variety of incarcerated persons who are sentenced to lengthy prison terms, once they have served a certain amount of time, including individuals who:

- Are sentenced to life with the possibility of parole.
- Are sentenced to life with the possibility of parole for a nonviolent offense under an alternative sentencing scheme, such as the state's Three Strikes Law.
- Were under the age of 26 at the time of their offense, who served a minimum of 15, 20, or 25 years of continuous incarceration, and who are eligible for a youth offender hearing.
- Are age 50 or older, who have served 20 years of continuous incarceration, and who are eligible for the state's elderly parole program.

To consider whether a patient is safe to reintegrate into the community, the BPH has access to all documents and custodial file information inclusive of 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. It is important to make patients aware that their medical record is accessible to the BPH and that their engagement in their sobriety and programming is looked upon favorably by the Board.

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APPENDIX 1: ASAM CRITERIA DIMENSIONS

ASAM DIMENSION	CONSIDERATIONS
Dimension 1: Acute Intoxication and/or Withdrawal Potential	· Are there current signs of withdrawal? · 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?
Dimension 2: Biomedical Conditions/Complications	· Are there current physical illnesses, other than withdrawal, that need to be addressed or that may complicate treatment?
Dimension 3: Emotional/Behavioral/ Cognitive Conditions and Complications	· Are there current psychiatric illnesses or psychological, behavioral, emotional, or cognitive problems that need to be addressed because they create risk or complicate treatment? · Is the patient able to manage the Activities of Daily Living?
Dimension 4: Readiness to Change	· What is the individual's emotional and cognitive awareness of the need to change? · What is their level of commitment to and readiness for change? · What is or has been his or her degree of cooperation with treatment? · What is their awareness of the relationship of alcohol or other drug use to negative consequences?
Dimension 5: Relapse/Continued Use/ Continued Problem Potential	· Is the patient in immediate danger of continued alcohol/drug use or severe mental health distress? · Does the patient have any recognition of, understanding of, or skills to cope with their addictive or mental disorder in order to prevent relapse? · 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?
Dimension 6: Recovery Environment	· Does the patient have supportive friendships, financial resources, or educational/vocational resources that can increase the likelihood of successful treatment?

MEDICATION TABLES

Acamprosate

MEDICATION	DOSING*	ADVERSE EFFECTS*/INTERACTIONS
Acamprosate **Delayed Release Tablet**: 333mg $$$$	• Usual dose: 666 mg orally three times daily for AUD • Maintain treatment even if the patient relapses **Renal Impairment:** • CrCl >50 mL/min: No dosage adjustment necessary • CrCl 30—50 mL/min: Starting dose of 333 mg orally three times daily is recommended • CrCl ≤30 mL/min: Contraindicated	• Adverse effects: Major: Suicidality 2.4% (vs. 0.8% on placebo during the first year in clinical trials), • Common: Diarrhea (16%) • Other: Anxiety, asthenia, depression, insomnia, flatulence, nausea, pruritus, pain, dizziness • Drug interactions: Antidepressants: Weight changes more common than with either medication alone

ADDITIONAL NOTES

- **Contraindications:** Hypersensitivity to acamprosate or any component of the product; Severe renal insufficiency (CrCl ≤30 mL/min)
- **Use with caution in:** Moderate renal impairment (CrCl 30-50 mL/min); Depression; Suicidal ideation/attempts; Sulfite hypersensitivity; Elderly; Pregnancy (Category C); Breastfeeding
- Safe to use for patients with liver disease

Buprenorphine

MEDICATION	DOSING*	ADVERSE EFFECTS*/INTERACTIONS
Buprenorphine/ Naloxone (Suboxone®) Sublingual Films: 2 mg/0.5 mg 4 mg/1 mg 8 mg/2 mg 12 mg/3 mg $$$ - $$$$ **Buprenorphine (plain) [Limited use for pregnancy only] Sublingual Tablets:** 2 mg, 8 mg $$$-$$$$	• **Sublingual Films:** Induction therapy for patients dependent on opioids: • Induction is generally initiated after objective signs of moderate withdrawal appear and at least 6 hours following the last opioid dose. • Please refer to SUD Care Guide for guidance on initial dosing for standard and rapid inductions. • Re-evaluation should be accomplished through a Nursing MAT Medication Evaluation. • At 1 week follow-up, if symptoms not optimized, may increase the dose in 2 mg/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. • Maximum dose: Doses above 24 mg/6 mg SL daily have not demonstrated a clinical advantage. • Patients should be seen frequently at the beginning of treatment until they are determined to be stable. • **Pregnancy:** May use the single ingredient buprenorphine SL tablets. Pregnant patients require specialist management. See *MAT for OUD in Pregnant Patients* for details.	• Adverse effects: Dependency, 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 • Common: Headache, dizziness, nausea, constipation, opioid withdrawal • Other: Neonatal Opioid Withdrawal Syndrome, hepatic events, orthostatic hypotension • May impair ability to drive or operate machinery • May obscure diagnosis and clinical course of an acute abdominal condition • May cause dental complications including tooth decay, cavities, etc. • Drug Interactions: CNS depressants - to include benzodiazepines and muscle relaxants, and other opioids • Inhibitors of CYP3A4 - can increase plasma concentrations of buprenorphine • Inducers of CYP3A4 - can decrease plasma concentrations of buprenorphine • Serotonergic Drugs- serotonin syndrome • MAOIs- may cause serotonin syndrome, recommend to be off MAOIs x 14 days prior to initiation • Diuretics - opioids may reduce efficacy of diuretics • Anticholinergic Drugs - increases risk of urinary retention and constipation • Antiretrovirals • NNRTIs – may act as CYP3A4 inducer • PIs – may act as CYP3A4 inhibitor
RESTRICTED USE (Only managed by AMCT) **Sublocade® Buprenorphine Injection** 100 mg, 300 mg **Brixadi® Buprenorphine Injection** 8 mg, 16 mg, 24 mg, 32 mg, 64 mg, 96 mg, 128 mg $$$$$	RESTRICTED USE • **SQ Injection, Extended Release:** For patients who have been stabilized on SL buprenorphine for a minimum of 7 days. • Recommended dose (Sublocade®): 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 • Recommended dose (Brixadi): 128 mg SQ once monthly • Serious harm or death can occur if given IV • Injection site reactions can occur • SQ Injection - Use not recommended in moderate to severe hepatic impairment (Child Pugh B or C)	

ADDITIONAL NOTES

- Contraindications: Hypersensitivity to drug/class
- Avoid abrupt withdrawal
- Use with caution in: Elderly or debilitated patients; Pulmonary impairment; CNS depression; Concurrent CNS depressant use including alcohol
- Hepatic impairment, moderate or severe (Child Pugh class B/C); Delirium tremens; Toxic psychosis; ICP increase; Head injury; Hypothyroidism or myxedema, Electrolyte abnormalities, QT prolongation or a family history of QT prolongation; History of Torsades de pointes; Ventricular arrhythmias; Bradycardia; Recent MI; CHF; Acute abdomen; Biliary surgery or disease; Adrenal insufficiency; Prostatic hypertrophy; Urethral stricture; Kyphoscoliosis
- Consider reducing starting and titration dose by 50% in severe hepatic impairment (Child Pugh C).

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.

Methadone

MEDICATION	DOSING*	ADVERSE EFFECTS*/INTERACTIONS
RESTRICTED USE **Methadone (Dolophine®)** for OUD can only be given in a federally licensed facility and should be given as a solution. This is achieved by dissolving tablets in a designated volume of water **Tablet:** 5 mg, 10 mg $ CCHCS providers will order up to 3 days of methadone therapy in order to continue newly arrived patients on Methadone for OUD. Arrangements should be made for the patient to be seen at nearby NTP by day 4.	• Typical dose: 60-120 mg orally daily for maintenance • Severe renal (CrCl <10 mL/min) and severe hepatic (Child Pugh Class C) impairment: Dose adjustments recommended; monitor for signs of respiratory and CNS depression • Note: All dose adjustments done by the Federal NTP prescribing provider	• Major: Addiction, abuse, misuse, QT prolongation/sudden death, respiratory depression, hypotension • Common: Nausea, vomiting, constipation, dizziness, sedation, sweating, weight gain • Other: Seizures, increased cholesterol/triglycerides; may impair ability to drive or operate machinery; may obscure diagnosis of an acute abdominal condition • Drug Interactions: Azole antifungals, Antiarrhythmic, Benzodiazepines, Antipsychotics, Cimetidine, Cyclobenzaprine, Macrolides, Fluoroquinolones, SSRIs, TCAs, Pentamidine, some HIV Meds, Rifampin, Carbamazepine, Risperidone, Phenobarbital, Phenytoin

ADDITIONAL NOTES

- Statements from the FDA regarding methadone: Prescribers of methadone should be familiar with methadone's toxicities and unique pharmacokinetic properties. Methadone dose should be slowly titrated.
- Boxed warnings: Life-threatening respiratory depression- monitor for respiratory depression especially during initiation or following dose increases.
- Life-threatening QT prolongation - closely monitor patients for changes in cardiac rhythm during initiation and titration.
- Contraindications: Hypersensitivity to methadone or any component of the product.
- Precautions: Use caution in patients with chronic pulmonary disease, cardiac disease, urethral stricture, concurrent use with CNS depressants, pregnancy, hepatic or renal insufficiency, elderly.
- Monitoring: Obtain ECG at baseline, 1 month and annually due to QT prolongation. (Increase ECG monitoring if patient receiving >100 mg/day or if unexplained syncope or seizure occurs while on methadone):
- If QTC is >450 ms but <500 ms, consider risk vs. benefit - monitor more frequently.
- If QTC is >500 ms, consider alternative therapy (buprenorphine or naltrexone), dose reduction, or elimination of contributing factors (e.g., other medications).

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.

Naltrexone

MEDICATION	DOSING*	ADVERSE EFFECTS*/INTERACTIONS
Naltrexone Oral Tablet 50 mg $$-$$$	• Oral dosing: Usual dose: 50 mg orally once daily. For patients on KOP naltrexone, a dose of 25 mg daily may improve tolerance. May increase dose to 100 mg once daily after 1 month if no benefit from 50 mg/day. • If using for AUD, consider changing to acamprosate if no benefit from 100 mg/day after 1 month. • Patients should be opioid free (including tramadol) prior to initiating therapy for at least 7 days (opioid-free duration should be 5-7 half lives of last used opioid). • Hepatic impairment: Naltrexone undergoes significant liver metabolism. Use with caution due to risk of accumulating higher naltrexone plasma levels. • Renal impairment: Do not use if CrCl <30	• Adverse effects (oral and injection): • Major: Eosinophilic pneumonia (injection only) • Common: Nausea, injection site reactions, precipitated withdrawal, abdominal cramps, abdominal pain, arthralgia, myalgia, chills, rash • Other: Headache, anxiety, sedation, dizziness, fatigue, insomnia, vomiting, diarrhea, transient asymptomatic elevated liver enzymes, depression, suicidal ideation, pain, anorexia, cramps, nasopharyngitis • Drug interactions: Opioid-containing medications (Contraindicated) • Thioridazine (increased lethargy and somnolence) Disulfiram—use of two potentially hepatoxic meds is not recommended unless the probable benefits outweigh the known risks • Additional considerations on depression, suicidal ideation and liver function abnormalities: • 0-15% of oral naltrexone treated patients and 0-17% of placebo treated patients developed depression. New onset suicide attempt/ideation in 0-1% of oral naltrexone treated patients and 0-3% of placebo treated patients. • Depression related events resulting in discontinuation of medication occurred in 1% of patients treated with injectable naltrexone and 0% of patients treated with placebo. • Suicidal ideation, suicide attempt, suicide occurred in 1% of injectable naltrexone treated patients and 0% of placebo patients. • 7 to 13% of patients treated with injectable naltrexone have increases in LFTs (depending on which LFT you are evaluating) compared to 2-6% of patients treated with placebo. • The evidence that identified oral naltrexone as a hepatotoxin was not obtained in studies involving its use at the doses recommended for opioid blockade, or for treatment of alcohol dependence but at 300 mg/daily.
RESTRICTED USE **Naltrexone Extended Release Injectable Solution** (Vivitrol®) 380 mg/vial $$$$$	**RESTRICTED USE** • Injectable dosing: Usual dose: 380 mg 1x q 28 days by deep intramuscular injection • The patient will be provided a medical alert device (e.g., bracelet/card) upon release • **Criteria for Injection:** 1. Willingness to receive injections 2. Difficulty adhering to an oral regimen 3. High risk of accidental overdose 4. Not a candidate for agonist therapy	

ADDITIONAL NOTES

- Contraindications: Receiving opioid agonists, Physiologic opioid dependence, Acute opioid withdrawal, Positive opioid screen, Hypersensitivity to naltrexone or any component of the product including the diluent used in the injection, Acute hepatitis or liver failure, Inadequate muscle mass for injection, Pregnancy, Renal impairment
- Warnings/Precautions: Vulnerability to opioid overdose due to loss of tolerance, Precipitated opioid withdrawal
- Use in patients with evidence of less severe liver disease, or a history of recent liver disease should be carefully considered in light of its hepatotoxic potential
- No cases of hepatic failure due to oral naltrexone administration have ever been reported
- A large proportion of patients had abnormal LFTs at baseline, further supporting the conclusion that the abnormalities observed are not attributable to oral naltrexone
- The risk of suicide is known to be increased in patients with substance abuse with or without concomitant depression
- Patients with a uterus of child bearing age, Excreted in breast milk
- Reference: package insert
- Caution injection use in patients with thrombocytopenia or coagulopathy

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.

Topiramate

MEDICATION	DOSING*	ADVERSE EFFECTS*/INTERACTIONS
Topiramate **Oral tablets** **Tablet: 25 mg, 50 mg, 100 mg** **$** **RESTRICTED USE— requires review and approval by the AMCT**	• Dosage and Administration: 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 • Maximum recommended dose: 300 mg daily	• Major: anorexia, epilepsy, speech disorders/related speech problems, serious skin reaction, kidney stones • Common: paresthesia, weight loss, fatigue, dizziness, somnolence, nervousness, fever, migraine, drowsiness, dysmenorrhea, mastalgia, nystagmus • 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 • Drug Interactions: Oral contraceptives: decreased contraceptive efficacy and increased breakthrough bleeding, especially at doses greater than 200 mg/day • Monitor lithium levels if lithium is used with high-dose topiramate

ADDITIONAL NOTES

- Contraindications: Patients with known allergies or sensitivity to topiramate
- Use with caution in: Patients with a uterus who are pregnant or breastfeeding, Patients with reduced renal function, 1 - 24 months experience increased risk of infection, Patients with history of kidney stones
- Pregnancy: Topiramate can cause fetal harm when administered to a pregnant persons. 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.

Overdose Reversal

SYMPTOMS	MEDICATION	DOSING*	ADVERSE EFFECTS*/INTERACTIONS
Opioid Intoxication	**Naloxone** (Narcan®) Nasal spray: 4 mg/spray $$$ - $$$$$ Solution for Injection: 0.4 mg/mL - 1 mL $ - $$$$	• Nasal Spray: 1 spray (4 mg) by intranasal administration. Use a new nasal spray for subsequent doses and administer into alternating nostrils. May repeat dose every 2 to 3 minutes as needed if the desired response is not attained or if the patient relapses into respiratory depression • Solution for Injection: 0.4 to 2 mg IV, repeat every 2 to 3 minutes as needed; if no response after 10 mg, reconsider diagnosis of opioid toxicity; may administer IM or subcutaneously if IV route is unavailable • Hepatic Dosing: Use with caution; naloxone is metabolized by the liver. No dosage adjustments provided in manufacturer's labeling • Renal Dosing: Specific guidelines not available; appears no adjustment needed	• Acute withdrawal symptoms - aches, fever, sweating, runny nose, sneezing, piloerection, yawning, weakness, shivering or trembling, nervousness, restlessness or irritability, diarrhea, nausea or vomiting, abdominal cramps, increased blood pressure, tachycardia Additional adverse effects associated with the Nasal Spray - dental pain, constipation, muscle spasms, musculoskeletal pain, headache, nasal dryness, nasal edema, nasal congestion, nasal irritation, rhinalgia, nasal inflammation, xeroderma • Drug Interactions: Opiate agonists, opiate antagonists, mixed opiate agonists/antagonists, cobicistat

ADDITIONAL NOTES

- Contraindications: hypersensitivity to naloxone or any component of the formulation
- Use with caution in the following: patients with a known hypersensitivity to nalmefene or naltrexone, cardiovascular disease, seizures, known or physical dependence on opioids, pregnancy, breast-feeding

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.

ATTACHMENT A - NIDA QUICK SCREEN

NIDA Quick Screen V1.0[8]

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

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).

[1] 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 OMS - ASSIST V3*). 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* NIDA-Modified ASSIST (NM ASSIST): Clinician's Screening Tool for Drug Use in General Medical Settings | SAMHSA.*)*

ATTACHMENT B – NIDA-MODIFIED ASSIST

NIDA-Modified ASSIST V2.0[9]

Questions 1 through 8, NIDA-Modified ASSIST

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

**Note for physicians: for prescription medications, please report nonmedical use only*	**Yes**	**No**
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: Alcohol		

- 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.

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**
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**

National Institute on Drug Abuse. National Institute on Drug Abuse (NIDA) Modified Assist Automated Version. https://www.drugabuse.gov/nmassist/.

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: Alcohol	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: Alcohol	0	4	5	6	7

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: Alcohol	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: Alcohol	0	3	6

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: Alcohol	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**

- 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.
  - o 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.
  - o 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

ATTACHMENT C – URINE DRUG SCREEN MONITORING: METABOLITES & 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. Below is a note of which substances are tested across our UDS panels, the detection time of various metabolites, and which UDS panels it appears on, including note if there is confirmatory testing.

Monitoring MAT – Expected Results on UDS and Confirmatory Testing

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

Adapted from *Quest Diagnostics Prescription Drug Monitoring Reference Guide* [13]

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

‡ Legend for UDS Panel inclusion:

M=Monitoring panel (383403)	S=Screening panel (374594)
M+= Monitoring panel, includes confirmatory testing	C=Comprehensive panel (373993) – all items include confirmatory testing

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

*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

‡ Legend for UDS Panel inclusion:

M=Monitoring panel (383403)	S=Screening panel (374594)
M+= Monitoring panel, includes confirmatory testing	C=Comprehensive panel (373993) – all items include confirmatory testing

ATTACHMENT D – CDCR 7240 INFORMED CONSENT FOR MAT FOR SUD

STATE OF CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION

INFORMED CONSENT FOR MEDICATION ASSISTED TREATMENT (MAT) FOR SUBSTANCE USE DISORDER (SUD)

CDCR 7240 (Rev. 09/24) Page 1 of 1

Introduction: We would like to offer you medication that is effective treatment for people with Substance Use Disorder (SUD). Before you decide to take the medication, it is important to understand how it works, its benefits, its risks, and other options. Please read this form carefully and feel free to ask any questions you may have. This medication is used in combination with counseling and behavioral therapies to treat people with SUD.

Benefits of Starting and Continuing Treatment: Medication Assisted Treatment (MAT) especially for Opioid Use Disorder (OUD) can help people:

- Control cravings and withdrawal symptoms
- Stop using opioids and avoid overdose
- Stay in treatment programs once started
- Function well enough to find and keep a job
- Lower risk of contracting diseases like HIV or HCV
- More effectively focus on recovery

Risks of Treatment: Depending on the MAT agent used, risks may include, but are not limited to:

- **Side Effects** such as headache, fatigue, dizziness, injection site reaction, confusion, blurry vision, nausea, constipation. Risk of dental problems that may increase dental erosion if not attentive to oral health care.
- **Risk of Overdose and Death.** Especially if used with other sedating medications, alcohol, or illegal drugs, OR with skipping or refusing doses.
- **Dependence.** The risk of dependence is higher for patients who suffer from mental health disorders or SUD (or both). If medication is suddenly stopped, you may be at increased risk for withdrawal symptoms, including nausea, diarrhea, aches, sweats, chills, irritability, tremors, and confusion.
- **Injection Site Reactions.** Skin changes associated with injections can include a visible bump, itchiness, or irritation.

Risks of Stopping or Reducing Doses of Medications to Treat OUD: According to scientific studies, medications containing Methadone or Buprenorphine can reduce the risk of overdose and death from opioids like fentanyl. Stopping or reducing the dose of these medications can increase your risks of relapse, overdose and other complications related to untreated or undertreated OUD.

I consent to allowing_____ (my provider) to prescribe MAT as part of my SUD Treatment Plan. I understand that my MAT agent selected is:

- ☐ **Daily Sublingual Suboxone® (Buprenorphine/Naloxone)**
- ☐ **Monthly Injection Sublocade® (Buprenorphine)**
- ☐ **Monthly Injection Vivitrol® (Naltrexone)**
- ☐ **Daily Oral Naltrexone**
- ☐ **Daily Oral Acamprosate**
- ☐ **Daily Oral Methadone**
- ☐ **Daily Oral Topiramate**

I understand there are conditions for being prescribed MAT including:

- I will engage in other treatments for my disorder, including SUD counseling as ordered by my provider.
- I will attend all follow-up appointments and complete all ordered or at random lab tests (urine, blood, or EKG).
- I will tell the provider all effects I have from this medication.
- I will not share this medication with others or take it other than as prescribed.
- I will not drink alcohol or take illegal substances or medications that are not prescribed for me .
- I am responsible for letting health care staff know that I am on MAT unless I am incapacitated.
- If I receive an injection, I will not rub or massage the injection site, or try to remove the medication afterward.
- I will notify my health care provider if I believe I may be pregnant or need birth control.
- **If I do not adhere to this agreement, my provider may alter treatment and follow-up frequency**.

Treatment Alternatives: Other treatment options available for SUD include counseling and support groups such as Narcotics Anonymous (NA) or Alcoholics Anonymous (AA). These alternatives can support recovery but usually are in addition to MAT and often do not replace the need for medications. Your health care provider can help you explore these additional options.

Voluntary Participation: Your decision to accept MAT does not affect your access to other medical care. Abrupt discontinuation carries risks as outlined above. Please discuss your decision to discontinue treatment with your provider.

Signing below indicates that I have reviewed the above and understand this agreement. I 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: _____

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

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

Distribution: Original - Patient Chart; Copy - Patient

ATTACHMENT E – CDCR 7225 REFUSAL OF EXAMINATION AND/OR TREATMENT

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

DEPARTMENT OF CORRECTIONS AND REHABILITATION

PAGE 1 OF 1

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	☐ PATIENT REFUSES TO SIGN	DATE
WITNESS			
NAME OF WITNESS (PRINT/TYPE)		NAME OF WITNESS (PRINT/TYPE)	
WITNESS SIGNATURE	DATE	WITNESS SIGNATURE	DATE

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

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.

ATTACHMENT F – CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT OF ALCOHOL SCALE, REVISED (CIWA-AR)[12]

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

Patient's Name: _____ **Date and Time: _____** *(24 hr. midnight = 00:00)*

Pulse or heart rate, taken for one minute: _____ **Blood Pressure: _____**

Nausea and vomiting- Ask: "Do you feel sick to your stomach?Have you vomited?" Observation.	**Tremor-** Arms extended and fingers spread apart. Observation.
0- no nausea and no vomiting	0- no tremor
1- mild nausea and no vomiting	1- not visible, but can be felt fingertip to fingertip
2-	2-
3-	3-
4- intermittent nausea with dry heaves	4- moderate, with patient's arms extended
5-	5-
6-	6-
7- constant nausea, frequent dry heaves and vomiting	7- severe, even with arms not extended
Anxiety-Ask: "Do you feel nervous?" Observation.	**Agitation-** Observation.
0- no anxiety, at ease	0- normal activity
1- mildly anxious	1- somewhat more than normal activity
2-	2-
3-	3-
4- moderately anxious, or guarded, so anxiety is inferred	4- moderately fidgety and restless
5-	5-
6-	6-
7- equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions	7- paces back and forth during most of the interview, or constantly thrashes about
Paroxysmal Sweats-Observation.	**Orientation and clouding of the sensorium-** Ask "What day isthis? Where are you? Who am I?"
0- no sweat visible	0- oriented and can do serial additions
1- barely perceptible sweating, palms moist	1- cannot do serial additions or is uncertain about date
2-	2- disoriented for date by no more than 2 calendar days
3-	3- disoriented for date by more than 2 calendar days
4- beads of sweat obvious on forehead	4- disoriented in place/or person
5-	
6-	
7- drenching sweats	
Tactile Disturbances- Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.	**Auditory disturbances-** Ask "Are you more aware of soundsaround you? Are they harsh? Do they frighten you? Are youhearing anything that is disturbing to you? Are you hearing things that are not there?" Observation.
0- none	0- not present
1- very mild itching, pins and needles, burning, or numbness	1- very mild harshness or ability to frighten
2- mild itching, pins and needles, burning or numbness	2- mild harshness or ability to frighten
3- moderate itching, pins and needles, burning or numbness	3- moderate harshness or ability to frighten
4- moderately severe hallucinations	4- moderately severe hallucinations
5- severe hallucinations	5- severe hallucinations
6- extremely severe hallucinations	6- extremely severe hallucinations
7- continuous hallucinations	7- continuous hallucinations or muscle twitching is difficult

Visual disturbances- Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things that you know are not there?" Observation	**Headache, fullness in the head -** Ask "Does your head feel different? Does it feel like there is a band around your head?"Do not rate for dizziness or lightheadedness. Otherwise, rate severity.
0- not present 1- very mild sensitivity 2- mild sensitivity 3- moderate sensitivity 4- moderately severe hallucinations 5- severe hallucinations 6- extremely severe hallucinations 7- continuous hallucinations	0- not present 1- very mild 2- mild 3-moderate 4- moderately severe 5-severe 6- very severe 7-extremely severe
	Total CIWA-Ar Score: _____ **Rater's Initials:** _____ *Maximum Possible Score 67*

Sullivan, J.T. et. al., Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar). British Journal of Addiction. https://umem.org/files/uploads/1104212257_CIWA-Ar.pdf

ATTACHMENT G – CLINICAL OPIATE WITHDRAWAL SCALE (COWS)[13]

Patient's Name:_____ **Date and Time:**_____

Reason for this assessment: _____

Resting Pulse Rate: beats/min *Measured after patient is sitting or lying for 1 minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset:** *Over last ½ hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *Over past ½ hour not accounted for byroom temperature or patient activity* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor**: *Observation of outstretched hands* 0 no tremor 1 tremor can be felt, but not observed2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness: *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	**Yawning**: *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil Size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris isvisible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint Aches: *If patient was having pain previously, only the additional component attributedto opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unableto sit still because of discomfort	**Gooseflesh Skin** 0 skin is smooth 3 piloerection of skin can be felt or hairs standing up on arms 5 prominent piloerection
Runny nose or tearing: *Not accounted for by coldsymptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes2 nose running or tearing 4 nose constantly running or tears streaming downcheeks	**Total Score:**_____ *The total score is the sum of all 11 items* **Initial of person completing assessment:** _____

Score 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

Modified from: Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). J Psychoactive Drugs, 35(2), 253–9.

PATIENT EDUCATION

OPIOID USE DISORDER (OUD)

WHAT IS OPIOID USE DISORDER?

Opioid Use Disorder (OUD) is a chronic condition, like diabetes and high blood pressure, caused by frequent opioid use. It is often referred to as opioid addiction. Risk factors include genetics, lifestyle, and environment.

While there is no cure for OUD, it can be managed through counseling, medication, and support from loved ones.

Recovery is a lifelong commitment, one day at a time.

Symptoms include:

- Strong opioid cravings
- Inability to stop/reduce use
- Problems at work, school, or with family
- Needing more opioids for the same effect
- Withdrawal sickness

WHAT ARE THE COMPLICATIONS CAUSED BY OPIOID USE DISORDER?

Short-term	Longer-term
• Sedation • Paranoia • Nausea • Risky behaviors • Death from accident or overdose	• Constipation • Depression • Insomnia • Decreases in testosterone • Osteoporosis • HIV & Hepatitis C • Cirrhosis (liver failure) • Brain damage

HOW IS IT TREATED?

Treatment typically involves counseling, medication, and support from family and friends.

- Medication-Assisted Treatment (MAT) helps manage cravings and withdrawal.
- Cognitive Behavioral Intervention (CBI) and Cognitive Behavioral Therapy (CBT) help in avoiding harmful behaviors, transforming thoughts, making decisions, and coping with stress.
- Support from loved ones and peer support groups can play a vital role in recovery.

Some MAT medications may impact your dental health. Talk to your dentist about any concerns.

PATIENT EDUCATION

ALCOHOL USE DISORDER (AUD)

ALCOHOL USE DISORDER: WHAT IS IT?

Alcohol Use Disorder (AUD) is a chronic condition, like diabetes and high blood pressure. Genetics can play a role, with addiction running in families. AUD involves drinking too much alcohol consumption, affecting brain function. While there is no complete cure, individuals can manage it through therapy, detox programs, and sometimes medication.

WHAT COMPLICATIONS ARE CAUSED BY ALCOHOL USE DISORDER?

AUD can lead to health issues such as a strong urge to drink, fatigue, dizziness, gastrointestinal problems, liver damage, and a weakened immune system. It may also result in risky behaviors and dangerous situations, prolonging illness.

Additionally, AUD negatively impacts personal relationships. The desire to drink can lead to loneliness and isolation and hinder responsibilities, sometimes leading to legal issues.

CONSEQUENCES OF ALCOHOL USE

<u>Short-term</u>

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

<u>Longer-term</u>

- 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, Medication Assisted Treatment (MAT), and Cognitive Behavioral Intervention (CBI) to manage cravings, change thoughts, and handle stress. Support from family and peer groups is vital.

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

PATIENT EDUCATION

RELAPSE PREVENTION

WHAT IS A RELAPSE?

- Relapse is a temporary setback in recovery where someone returns to harmful habits.
- It doesn't mean failure but should be addressed quickly as it can be risky and potentially life-threatening.
- A relapse does not mean treatment failure or an inability to recover; it is temporary and does not erase prior progress.

SIGNS AND RISKS OF RELAPSE

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

Signs and Risks of Relapse:

- Hungry, Angry, Lonely or Tired (HALT)
- Avoidance of peer support groups
- Poor self-care, poor eating and sleeping habits
- Not addressing strong cravings
- Planning how to return to unhealthy behavior, such as drug use

STRATEGIES FOR PREVENTING RELAPSE

- Avoid triggers (people, places, activities that are associated with drug use)
- Build a support network
- Invest in new rewarding activities as an alternative to drug use (writing, working out, reading, etc.)
- Join peer groups and contact healthcare providers when struggling

OVERDOSE PREVENTION

WHAT IS AN OVERDOSE?

An overdose occurs when a toxic amount of a drug, or combination of drugs, overwhelms the body.

Opioid overdoses slow or stop breathing, potentially causing death. Combining opioids (e.g., heroin, Oxycontin, Fentanyl) with alcohol, benzodiazepines(e.g., Xanax, Valium) or antiepileptic drugs is particularly dangerous.

Stimulant overdoses (e.g., cocaine, ecstasy) raise heart rate, blood pressure, and body temperature, potentially causing seizures, strokes, heart attacks, or death.

RISKS FOR OVERDOSE

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

- Mixing opioids with alcohol or other drugs.
- Taking high doses, illegal opioids or fentanyl.
- Certain health conditions (e.g., sleep apnea, liver or kidney issues).
- Loss of tolerance after a period of sobriety.
- Age greater than 65 years old

Often, overdoses occur when an opioid or other drug is laced with an unexpected substance like fentanyl. Because of this, avoiding all illicit drugs is the best method for avoiding overdose.

SIGNS OF AN OVERDOSE

- Slow or difficult breathing
- Blue lips or fingernails
- Pinpoint pupils
- Cold, clammy skin
- Extreme drowsiness or confusion

STRATEGIES FOR PREVENTING OVERDOSE

- Start at a lower dose or do a test shot if you haven't used in a while, 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 antiepileptic drugs (like gabapentin, pregabalin, oxcarbazepine), alcohol, and opioids (like heroin).
- Keep naloxone nearby if at risk of opioid overdose. Naloxone is available at your institution, ask your health care team how to access.

PATIENT EDUCATION

INTOXICATION AND WITHDRAWAL

WHAT IS INTOXICATION?	WHAT IS WITHDRAWAL?
Intoxication occurs when a person consumes a large amount of a substance, impacting their mood and abilities. It can range from mild effects like drowsiness and slurred speech to severe outcomes such as vomiting, blackouts, and even unconsciousness, which can be life-threatening. Continued use may indicate a Substance Use Disorder (SUD), leading to serious physical harm, including brain injury. For more information on SUD and treatment options, consult your healthcare provider.	Withdrawal happens when someone dependent on a substance stops or reduces use, causing physical and mental symptoms as the body adjusts.
SIGNS AND RISKS OF INTOXICATION	**SIGNS AND RISKS WITHDRAWAL**
Slow breathing (opioids, alcohol, and benzodiazepines), slurred speech (alcohol), rapid heartbeat (stimulants), drowsiness (opioids, alcohol, and benzodiazepines). • Risks: Overdose, respiratory depression, seizures, or death.	Sweating, vomiting, and insomnia (opioids); tremors and seizures (alcohol); fatigue and depression (stimulants); anxiety and seizures (benzodiazepines). • Risks: Seizures, mental disturbance and shakiness (alcohol), cardiac issues, or mental health crises.
Both intoxication and withdrawal can be life-threatening. Seek medical care.	

PREVENTION STRATEGIES

Long-term treatment can help prevent the difficult symptoms of intoxication and withdrawal.

Individuals with intoxication and withdrawal may suffer from a Substance Use Disorder (SUD) and should seek help to reduce substance use and cravings.

HOW ARE INTOXICATION AND WITHDRAWAL TREATED?

Ready to deal with your substance use disorder? Decide to make a change.

CDCR/CCHCS has an Integrated Substance Use Disorder Treatment (ISUDT) Program. Start your recovery by completing a CDCR 7362 form. We're here to help you with your assessment appointment and necessary treatment.

Treatments are personalized and may include Cognitive Behavioral Therapy, medications, and ongoing support to prevent relapse and maintain sobriety, both in CDCR and upon returning to the community.

The hardest part of recovery is admitting you have a problem and choosing to change.

PATIENT EDUCATION

INJECTABLE BUPRENORPHINE

What is injectable buprenorphine?

Injectable buprenorphine is a medication for adults with opioid addiction.
It is administered by a nurse every 28 days to manage withdrawal symptoms and reduce opioid cravings.

Tell your provider if any of the following applies before starting injectable buprenorphine:

· Breathing or lung problems
· Problems with passing urine
· Liver, gallbladder and/or kidney problems
· A head or brain injury
· Thyroid gland problems
· Pregnancy or breastfeeding

Before you Begin Treatment with Injectable Buprenorphine:

· You need to use sublingual buprenorphine under your tongue for at least 7 days before starting injectable buprenorphine. This will help manage withdrawal symptoms.
· Ensure your follow-up appointment is set.
· Ask your doctor any questions regarding this medication.

How does it work?

· Injectable buprenorphine is injected under the skin, forming a depot
· The depot releases medicine throughout the month.
· You will need to return monthly to get your dose. If you miss your dose, tell your health care team right away.
· Injectable buprenorphine is given in two dose sizes:
  - Starting Dose
  - Monthly dose

More Details about the Injection

· The depot may be seen or felt as a small bump under the skin.
· The injection site will be alternated each month.
· As the medicine goes into your body, the bump starts to shrink.
· Avoid removing the depot. Do not touch the injection area. Keep belts or waistbands from rubbing against the injection site.

When to Contact Your Provider:

If you have any of these symptoms, contact your healthcare provider right away.

· Shaking
· Sweating more than normal
· Feeling hot or cold more than normal
· Runny nose
· Watery eyes
· Goose bumps
· Diarrhea
· Vomiting
· Muscle aches
· Redness and pain at injection site

Long-term use of opioids, benzodiazepines, alcohol, and other drugs can cause serious side effects. Inform your doctor about all medications you're taking before getting a prescription for injectable buprenorphine.

PATIENT EDUCATION

MAT FOR OUD DURING PREGNANCY

WHAT ARE THE RISKS OF OUD DURING PREGNANCY?

OUD during pregnancy poses serious risks for you and your baby, including:
· Fetal growth problems
· Preterm birth
· Stillbirth/death

Overdosing on the drug can cause fainting, slow breathing, or even death. If you're on Medication-Assisted Treatment (MAT), continue your medication for your safety and your baby's. Stopping MAT can be harmful and increases risks.

HOW DOES OPIOID USE DURING PREGNANCY AFFECT A NEWBORN?

When a baby is born to a mother who used opioids during pregnancy, the baby may show withdrawal signs, a condition known as neonatal abstinence syndrome (NAS), which can last from days to months.
Symptoms of NAS include:
· Shaking and tremors
· Poor feeding or sucking
· Inconsolable crying
· Fever
· Diarrhea
· Vomiting
· Sleep problems

NAS is a treatable condition that typically doesn't affect growth and development. Avoid smoking, alcohol, and illegal drugs, as they can worsen NAS in your baby.

CAN I BREASTFEED WHILE ON MAT?

A small amount of MAT medication enters breastmilk, allowing mothers on buprenorphine or methadone to breastfeed. Breastfeeding provides health benefits and can reduce the severity or duration of NAS.

COMMUNITY PRISON MOTHER PROGRAM

The Community Prison Mother Program enables pregnant individuals and mothers with young children to live together in a separate facility, focusing on family connections, parenting education, and addressing substance use challenges.

If you want to join this program, talk to your health care team.

EDUCACIÓN DEL PACIENTE

TRASTORNO POR USO DE OPIODES(OUD)

¿QUÉ ES EL TRASTORNO POR USO DE OPIODES?

El Trastorno por Uso de Opioides (OUD, por sus siglas en inglés) es una condición crónica, similar a la diabetes y a la presión arterial alta, causada por el uso frecuente de opioides. A menudo se le llama adicción a los opioides. Los factores de riesgo incluyen la genética, el estilo de vida y el entorno.

No existe una cura definitiva para el OUD, pero puede manejarse mediante consejería, medicamentos y apoyo de seres queridos.

La recuperación es un compromiso de por vida, un día a la vez.

Síntomas incluyen:

- Fuerte deseo o ansiedad por consumir opioides
- Incapacidad para detener o reducir el consumo
- Problemas en el trabajo, escuela o con la familia
- Necesidad de más opioides para obtener el mismo efecto
- Síntomas de abstinencia

¿CUÁLES SON LAS COMPLICACIONES CAUSADAS POR EL TRASTORNO POR CONSUMO DE OPIOIDES?

A corto plazo:

- Sedación
- Paranoia
- Náuseas
- Conductas de riesgo
- Muerte por accidente o sobredosis

A largo plazo:

- Estreñimiento
- Depresión
- Insomnio
- Disminución de testosterona
- Osteoporosis
- VIH y Hepatitis C
- Cirrosis (insuficiencia hepática)
- Daño cerebral

¿CÓMO SE TRATA?

El tratamiento normalmente incluye consejería, medicamentos y apoyo de amigos y familia.

- El Tratamiento Asistido con Medicamentos (MAT, por sus siglas en inglés) ayuda a controlar los antojos y la abstinencia.
- La Intervención Cognitivo Conductual (CBI) y la Terapia Cognitivo Conductual (CBT) ayudan a evitar conductas dañinas, cambiar pensamientos, tomar decisiones y manejar el estrés.
- El apoyo de seres queridos y grupos de apoyo puede ser vital.

Algunos medicamentos MAT pueden afectar la salud dental. Hable con su dentista si tiene dudas.

EDUCACIÓN DEL PACIENTE

TRASTORNO POR USO DE ALCOHOL(AUD)

¿QUÉ ES EL TRASTORNO POR USO DE ALCOHOL?

El Trastorno por Uso de Alcohol (AUD, por sus siglas en inglés) es una condición crónica, similar a la diabetes y la presión arterial alta. La genética puede influir, ya que la adicción puede presentarse en familias. El AUD implica beber demasiado alcohol, lo que afecta el funcionamiento del cerebro. Aunque no tiene cura total, puede manejarse con terapia, programas de desintoxicación y a veces medicamentos.

¿CUALES SON LAS COMPLICACIONES CAUSADAS POR EL TRASTORNO POR CONSUMO DE ALCOHOL?

Puede causar problemas de salud como fuerte deseo de beber, fatiga, mareos, problemas gastrointestinales, daño hepático y un sistema inmunológico debilitado. También puede llevar a comportamientos riesgosos, situaciones peligrosas y problemas legales.

Afecta negativamente las relaciones personales, causando aislamiento y dificultades para cumplir responsabilidades.

CONSECUENCIAS DEL ALCOHOL

A corto plazo:

- Sedación
- Habla arrastrada
- Cambios emocionales
- Temperatura corporal baja
- Acidez, náuseas, vómitos
- Pérdida del control de esfínteres
- Disminución del sueño
- Conductas de riesgo
- "Blackouts" o lagunas mentales
- Muerte por accidente o intoxicación alcohólica

A largo plazo:

- Aumento de peso
- Presión arterial alta
- Depresión
- Gastritis
- Pancreatitis
- Anemia
- Cirrosis
- Disminución del rendimiento sexual
- Muerte de células cerebrales (problemas de memoria y equilibrio)
- Mayor riesgo de cáncer (boca, esófago, estómago y vejiga)

¿CÓMO SE TRATA EL TRASTORNO POR USO DE ALCOHOL?

El AUD puede tratarse mediante consejería, Tratamiento Asistido con Medicamentos (MAT) y la Intervención Cognitivo Conductual (CBI) para manejar antojos, cambiar pensamientos y enfrentar el estrés. El apoyo de la familia y de los grupos de pares es vital.

La CBI ayuda a:

- Alejarse de conductas dañinas
- Cambiar pensamientos adictivos por pensamientos saludables
- Tomar decisiones saludables
- Manejar sentimientos como depresión o baja autoestima
- Reconocer señales que llevan al consumo de alcohol
- Afrontar recaídas y estrés

EDUCACIÓN DEL PACIENTE

PREVENCIÓN DE RECAÍDAS

¿QUE ES UNA RECAÍDA?

- Una recaída es un contratiempo temporal durante la recuperación, cuando la persona vuelve a hábitos dañinos.
- No significa fracaso, pero debe abordarse de inmediato porque puede ser peligrosa o mortal.
- Una recaída no significa fracaso del tratamiento ni una incapacidad para recuperarse; es temporal no borra el progreso previo.

SIGNOS Y RIESGOS DE RECAÍDA

Las recaídas suelen ser un proceso gradual con etapas distintas. Si se notan las señales de advertencia, la recaída puede prevenirse. Señales y riesgos de recaída:

- Hambre, Enojo, Soledad o Cansancio (HALT por sus siglas en inglés)
- Evitar grupos de apoyo
- Poca atención al autocuidado, mala alimentación, y falta de sueño
- No abordar antojos fuertes
- Planear volver al consumo

ESTRATEGIAS PARA PREVENIR RECAÍDAS

- Evitar desencadenantes (personas, lugares, actividades relacionadas con el uso)
- Construir una red de apoyo
- Invertir en nuevas actividades gratificantes como alternative al consumo de drogas como (leer, escribir, hacer ejercicio)
- Unirse a grupos de apoyo y buscar ayuda médica cuando sea necesario

PREVENCIÓN DE SOBREDOSIS

¿QUÉ ES UNA SOBREDOSIS?

Una sobredosis ocurre cuando una cantidad toxica de una droga, o la combinación de varias drogas, sobrecarga el cuerpo.
Las sobredosis de opioides ralentizan o detienen la respiración, potencialmente causando la muerte.
Combinar opioides (p. ej., heroína, oxicodona, fentanilo) con alcohol, benzodiacepinas o antiepilépticos (p. ej., alprazolam, diazepam) es especialmente peligroso.
Las sobredosis de estimulantes (p. ej., cocaína, éxtasis) aumentan la frecuencia cardíaca, la presión arterial y la temperatura corporal, potencialmente causando convulsiones, accidentes cerebrovasculares, infartos o la muerte.

FACTORES DE RIESGO

Cualquier persona que use opioides puede experimentar una sobredosis, pero ciertos factores pueden aumentar el riesgo, incluyendo, entre otros:

- Mezclar opioides con alcohol u otras drogas.
- Tomar dosis altas, opioides ilegales o fentanilo.
- Ciertas condiciones de salud (p. ej., apnea del sueño, problemas de hígado o riñón).
- Pérdida de tolerancia después de un período de sobriedad.
- Edad mayor de 65 años.

A menudo, las sobredosis ocurren cuando un opioide u otra droga está mezclada con una sustancia inesperada como el fentanilo. Debido a esto, evitar todas las drogas ilícitas es el mejor método para prevenir una sobredosis.

SIGNOS DE SOBREDOSIS

- Respiración lenta o difícil
- Labios o uñas azules
- Pupilas muy pequeñas
- Piel fría y húmeda
- Somnolencia extrema o confusión

ESTRATEGIAS PARA PREVENIR LA SOBREDOSIS

- Comienza con una dosis más baja o haz una prueba si no has usado en un tiempo, porque tu cuerpo no está acostumbrado a la misma cantidad de antes.
- No uses solo (nadie puede ayudarte).
- No mezcles drogas como medicamentos antiepilépticos (como gabapentina, pregabalina, oxcarbazepina), alcohol y opioides (como la heroína).
- Mantén naloxona cerca si estás en riesgo de sobredosis por opioides. La naloxona está disponible en tu
- institución, pregunta a tu equipo de salud cómo acceder a ella.

EDUCACIÓN DEL PACIENTE

INTOXICACIÓN Y ABSTINENCIA

¿QUE ES LA TOXICACIÓN?	¿QUÉ ES LA ABSTINENCIA?
La intoxicación ocurre cuando una persona consume una gran cantidad de una sustancia, afectando su estado de ánimo y sus capacidades. Puede variar desde efectos leves, como somnolencia y dificultad para hablar, hasta consecuencias graves, como vómitos, pérdida de la memoria temporal e incluso pérdida del conocimiento, lo cual puede poner en peligro la vida. El uso continuo puede indicar un Trastorno por Consumo de Sustancias (SUD, por sus siglas en inglés), que puede causar daños físicos graves, incluida una lesión cerebral. Para más información sobre el SUD y las opciones de tratamiento, consulte a su proveedor de atención médica.	Ocurre cuando una persona dependiente reduce o deja el consumo, causando síntomas físicos y mentales.
SEÑALES Y RIESGOS DE INTOXICACIÓN	**SEÑALES Y RIESGOS DE ABSTINENCIA**
Respiración lenta (opioides, alcohol y benzodiacepinas), habla arrastrada (alcohol), ritmo cardíaco rápido (estimulantes), somnolencia (opioides, alcohol y benzodiacepinas). • Riesgos: Sobredosis, depresión respiratoria, convulsiones o muerte.	Sudoración, vómitos e insomnio (opioides); temblores y convulsiones (alcohol); fatiga y depresión (estimulantes); ansiedad y convulsiones (benzodiacepinas). • Riesgos: Convulsiones, delirium tremens (alcohol), problemas cardíacos o crisis de salud mental.

Ambas pueden ser mortales. Busque atención médica.

ESTRATEGIAS DE PREVENCIÓN

El tratamiento a largo plazo puede ayudar a prevenir los síntomas difíciles de la intoxicación y la abstinencia.

Las personas que presentan intoxicación y abstinencia pueden sufrir de un Trastorno por Consumo de Sustancias (SUD, por sus siglas en inglés) y deben buscar ayuda para reducir el uso de sustancias y los antojos.

¿CÓMO SE TRATAN LA INTOXICACIÓN Y LA ABSTINENCIA?

¿Listo para enfrentar su trastorno por consumo de sustancias? Decida hacer un cambio.

CDCR/CCHCS cuenta con un Programa Integrado de Tratamiento para el Trastorno por Consumo de Sustancias (ISUDT). Comience su recuperación completando el formulario CDCR 7362. Estamos aquí para ayudarle con su cita de evaluación y el tratamiento necesario.

Los tratamientos son personalizados e incluyen Terapia Cognitivo-Conductual, medicamentos y apoyo continuo para prevenir recaídas y mantener la sobriedad, tanto dentro de CDCR como al regresar a la comunidad.

La parte más difícil de la recuperación es admitir que tiene un problema y decidir cambiar.

EDUCACIÓN DEL PACIENTE

BUPRENORFINA INYECTABLE

¿Qué es la buprenorfina inyectable?

La buprenorfina inyectable es un medicamento para adultos con adicción a los opioides. Se administra por una enfermera cada 28 días para controlar los síntomas de abstinencia y reducir los antojos de opioides.

Informe a su proveedor si alguna de las siguientes situaciones aplica antes de comenzar con buprenorfina inyectable:

· Problemas respiratorios o pulmonares
· Problemas para orinar
· Problemas del hígado, vesícula biliar y/o riñones
· Lesión en la cabeza o el cerebro
· Problemas de la glándula tiroides
· Embarazo o lactancia

Antes de comenzar el tratamiento con buprenorfina inyectable:

· Necesita usar buprenorfina sublingual debajo de la lengua durante al menos 7 días antes de comenzar con buprenorfina inyectable. Esto ayudará a manejar los síntomas de abstinencia.
· Asegúrese de tener programada su cita de seguimiento.
· Haga cualquier pregunta a su médico sobre este medicamento.

¿Cómo funciona?

· La buprenorfina inyectable se administra bajo la piel, formando un depósito.
· El depósito libera el medicamento durante todo el mes.
· Necesitará regresar mensualmente para recibir su dosis. Si omite su dosis, informe a su equipo de atención médica de inmediato.
· La buprenorfina inyectable se administra en dos tamaños de dosis:
  - Dosis inicial
  - Dosis mensual

Más detalles sobre la inyección

· El depósito puede verse o sentirse como un pequeño bulto bajo la piel.
· El sitio de la inyección se alternará cada mes.
· A medida que el medicamento entra en su cuerpo, el bulto comienza a disminuir.
· Evite retirar el depósito. No toque el área de la inyección. Evite que los cinturones o la pretina de la ropa rocen el sitio de la inyección.

Cuándo contactar a su proveedor:

Si presenta alguno de estos síntomas, comuníquese con su proveedor de atención médica de inmediato.

· Temblor
· Sudoración excesiva
· Sentirse más caliente o más frío de lo normal
· Moqueo nasal
· Lágrimas en los ojos
· Piel de gallina
· Diarrea
· Vómitos
· Dolores musculares
· Enrojecimiento y dolor en el lugar de la inyección

El uso prolongado de opioides, benzodiacepinas, alcohol y otras drogas puede causar efectos secundarios graves. Informe a su médico sobre todos los medicamentos que está tomando antes de recibir una receta para buprenorfina inyectable.

EDUCACIÓN DEL PACIENTE

TRATAMIENTO CON MAT PARA OUD DURANTE EL EMBARAZO

¿CUÁLES SON LOS RIESGOS DEL OUD DURANTE EL EMBARAZO?

El OUD durante el embarazo representa riesgos graves para usted y su bebé, que incluyen:

· Problemas de crecimiento fetal
· Nacimiento prematuro
· Muerte fetal/Muerte

Una sobredosis del medicamento puede causar desmayos, respiración lenta o incluso la muerte. Si estás en Tratamiento Asistido con Medicación (TAM), continúa con tu medicación por tu seguridad y la de tu bebé. Suspender el TAM puede ser perjudicial y aumentar los riesgos.

¿CÓMO AFECTA EL USO DE OPIOIDES DURANTE EL EMBARAZO A UN RECIÉN NACIDO?

Cuando un bebé nace de una madre que usó opioides durante el embarazo, el bebé puede mostrar signos de abstinencia, una condición conocida como síndrome de abstinencia neonatal (SAN), que puede durar desde días hasta meses.
Los síntomas del SAN incluyen:

· Temblor y sacudidas
· Dificultad para alimentarse o succionar
· Llanto inconsolable
· Fiebre
· Diarrea
· Vómitos
· Problemas de sueño

SAN es una condición tratable que normalmente no afecta el crecimiento y el desarrollo. Evite fumar, consumir alcohol y drogas ilegales, ya que pueden empeorar el SAN en su bebé.

¿PUEDO AMAMANTAR MIENTRAS ESTOY EN MAT?

Una pequeña cantidad de medicamento MAT pasa a la leche materna, lo que permite que las madres que toman buprenorfina o metadona amamanten. La lactancia materna proporciona beneficios para la salud y puede reducir la gravedad o duración del SAN.

PROGRAMA COMUNITARIO DE MADRES EN PRISIÓN

El Programa de Madres en Prisión Comunitaria permite que personas embarazadas y madres con hijos pequeños vivan juntas en una instalación separada, enfocándose en los lazos familiares, la educación en crianza y en abordar los desafíos relacionados con el uso de sustancias.

Si deseas unirte a este programa, habla con tu equipo de atención médica.