CCHCS Care Guide: Substance Use Disorder

SUMMARY | DECISION SUPPORT | PATIENT EDUCATION/SELF MANAGEMENT

GOALS

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

ALERTS

- If opioids are required for acute pain management, patients on methadone, buprenorphine/naloxone or naltrexone may require transfer to a triage and treatment area (TTA) or hospital, as medically indicated.
- Individuals leaving prison are at high risk for overdose-related harms, therefore everyone will be offered naloxone upon release.
- Pregnant patients with SUD/Opioid Use Disorder (OUD) require specialist management. (See Appendix 1: MAT for OUD in Pregnant Patients)
- Recognizing signs of withdrawal and supporting relapse prevention is a shared responsibility with the entire treatment team. (See CCHCS Care Guide: Intoxication and Withdrawal)

SCREENING

- The treatment team is multidisciplinary, and team members have unique roles and responsibilities in delivering major components of the program including screening, assessment, treatment, monitoring and transitional services (see page 2).
- The National Institute for Drug Abuse (NIDA) Quick Screen (QS) is used to screen for SUD. The NIDA QS has four questions to address alcohol, tobacco, prescription drugs and illegal drugs. A positive affirmation on the NIDA QS triggers referral for 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 triggers completion of questions two through eight, (see page 5 and Attachment B).
- A multidimensional biopsychosocial assessment developed by the American Society of Addiction Medicine (ASAM) is conducted to develop specific level of care and treatment recommendations (see page 5).
- Motivational Interviewing techniques assist with obtaining accurate assessments, engaging the patient, and strengthening the therapeutic relationship (see page 7). (http://healtheknowledge.org/course/view.php?id=190)
- Diagnostic coding can be derived from 2 differing systems – DSM-5 and ICD-10 (see page 9).
- 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 responsible for their own recovery. The treatment team should work to provide all the evidence-based approaches that increase their chance of success.
- Behavioral intervention 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, are available and vary by institution.
- Supportive Housing is designated safe and secure environment at each institution where residents can engage in independent living and where the social milieu promotes recovery, eliminates the stigma of addiction, and supports rehabilitation.
- Medication Assisted Treatment (MAT) is available for patients with OUD or Alcohol Use Disorder (AUD). If considered a candidate for MAT based on assessment findings, MAT will be initiated after completion of a signed informed consent.

MONITORING

- Follow-up appointments for patients on MAT are scheduled according to medication and duration of stability. Follow-up appointments for patients with SUD is essential to monitor the disease, even if the patient is not on MAT (see page 17).
- Urine drug screens (UDS) are used to monitor MAT adherence and performed randomly at defined intervals (see page 19).
- Annual labs and other diagnostic tests (e.g., EKG for patients on Methadone) should be done as recommended (see page 17).
- Key performance indicators for institution and providers are included on the ISUDT Dashboard.

ENHANCED PRE-RELEASE AND TRANSITION SERVICES

- Transition services are provided for all releasing patients in order to facilitate their ongoing treatment and recovery without interruption. See page 22 for more details.
- MAT medication (if applicable) and naloxone are dispensed to the patient at time of release. See page 22.

Questions: MAT@cdcr.ca.gov

TABLE OF CONTENTS

ISUDT PROGRAM

Team Composition and Roles

The ISUDT Treatment team is multidisciplinary and composed of staff positions within California Correctional Health Care Services (CCHCS), the Division of Rehabilitative Programs (DRP) and the Division of Adult Institutions (DAI). Each team member has unique roles and responsibilities in delivering major components of the program including screening, assessment, treatment, and transitional services that support the patient. Roles sometimes vary depending on where the patient is in their incarceration lifecycle. 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 planned 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	Roles	Population: EPRD 0 to 24 Months	Population: Already Here	Population: Arrive on MAT
Reception Center Registered Nurse (RN)	•Initial health screening for patients that are new arrivals			X
	•Release of information (CDCR 7385) to confirm medication/dosage			X
	•If on MAT, notify Primary Care Team			X
	•For methadone order Narcotic Treatment Program (NTP) (transport) (see page 14)			X
	•Referrals to Licensed Clinical Social Worker (LCSW) and addiction medicine provider			X
	•Orders baseline labs per protocol			X
Primary Care Team Licensed Nursing Staff	•Completes the NIDA Quick Screen	X	X	
	•If screen is positive, refers to LCSW for NIDA-MA	X	X	
	•Access to care via 7362 process: triage, address patient needs, refer as needed	X	X	
	•SUD-related nursing patient care and/or co-consultation with provider	X	X	
RN Care Manager / LVN Care Coordinators	•Completes the MAT Medication Evaluation	X	X	X
LVN (Medication Administration)	•Administer medications and document patient behavioral issues	X	X	X
Resource RN	•Coordinates all transitions between Primary Care Teams (PCT), jails, counties, parole, and probation; provides warm hand offs as appropriate	X	X	X
	•Provides care coordination for patients with chronic medical conditions	X	X	X
	•Develops discharge plan and provides patient with education, community resource information, and documentation with appointments, medications, etc. at time of release	X	X	X
Resource Supervising Registered Nurse II	•Oversees institutional ISUDT and pre-release preparation processes, outcome metrics, assists facilitation of institutional steering committee meetings, and collaborates with multiple disciplines to ensure patient needs are coordinated upon release.	X	X	X
Administrative Support Staff	•Provides support to various ISUDT programmatic roles	X	X	X
MSD Licensed Clinical Social Workers (LCSW)	•Assess patients with SUD using NIDA-MA and ASAM suite of tools	X	X	X
	•Provide Cognitive Behavioral Therapy (CBT) and Motivational Interviewing (MI) to address SUD and trauma	X	X	X
Psychiatrist	•Identify SUD-related complications, and refer to MSD LCSW for SUD assessment	X	X	
	•Collaborate with Care Team for complex patients	X	X	
MH Primary Clinician	•Offer psychotherapeutic approaches to encourage ISUDT participation	X	X	X
	•Educate patients about ISUDT program, and discuss possible referral in routine or specially scheduled IDTT	X	X	X

ISUDT PROGRAM

Team Composition and Roles Cont'd

This table continued from the previous page.

Team Member	Roles	Population: EPRD 0 to 24 Months	Population: Already Here	Population: Arrive on MAT
Laboratory Technicians	•Collects and processes UDS samples	X	X	X
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	X	X	X
Correctional Counselors (CC-III)	•Case manage patients toward their goals in rehabilitation •Assign job skills training and encourage education •Management of CBI assignment	X X	X X	X X
Addiction Medicine Central Team (AMCT)	•Provide consultation and technical support for PCP and Mental Health (MH) providers •Review Alternative Agent Authorization (AAA) requests	X X	X X	X X
Primary Care Providers (PCP)	•Identify SUD-related complications, evaluates for and initiates MAT services •Manage and monitor 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 •Refer to LCSW for SUD assessment •Consult with AMCT and/or complete MAT AAA form as needed	X X X X X X	X X X X X X	X X X X X X
Pharmacists	•Process and ensure appropriate MAT orders •Assure prescriber X-waivers for buprenorphine orders •Assists with medication reconciliation (transfers) •Fills and dispenses 30-day medication supply upon release •Arranges Naloxone on release via standing order	X X X X X	X X X	X X X
Dentists	•Evaluate, educate and treat patients with dental complications due to SUD	X	X	X

INSTITUTION MANAGEMENT—ISUDT STEERING COMMITTEE

The ISUDT Program introduces many new and evolving processes and resources to institutions which 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 trouble-shoot program barriers, and elevate issues as necessary to the statewide Planning and Implementation Team. 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 PIA Administrator or lead manager, CC IIIs, and a supervisory level ISUDT Ambassador.

The headquarters Planning and Implementation Team provide memoranda specifying ISUDT Program goals. Performance for each program goal are 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.

The ISUDT Program website offers many resources to help institutions run their ISUDT Steering Committee, including goals memoranda, links to the ISUDT Dashboard, templates for meeting agendas and other functions, and training materials. You can find them here – look for the Steering Committee tab at the bottom of the page.

SUBSTANCE USE DISORDER TREATMENT ALGORITHM

Patients Arriving at CDCR Reception Center

Reception Center RN:
- Use initial health screen
- Screens for patients already on MAT

For patients arriving on MAT:
- Obtains outside records to verify current MAT medication and dose
- Use MAT New Arrival Subphase of the R&R New Arrival Power Plan to:
  - Refer patients to LCSW for ASAM Co-triage and CBI referral
  - For patients on methadone, place order for NTP (transport)
  - Order baseline labs

Reception Center Provider
- Continue patient on the same medication/same dose for 30 days.
  - **For Methadone:** place 3-day bridge order, add Methadone (administered by NTP), and place medical hold
  - **If patient arrives on buprenorphine-only formulation, sublingual or tablet**, switch patient to buprenorphine/naloxone sublingual formulation, unless patient is pregnant.
  - For injectable buprenorphine, refer to AMCT for conversion to sublingual formulation.
  - For oral naltrexone, continue patient on same medication/dose. For patients arriving on injectable naltrexone, switch patient to naltrexone tablets, and order consult with the AMCT
- Provider must check the Controlled Substance Utilization Review and Evaluation System (CURES).
- **All patients**: order urine drug screen [CCHCS UTOX PANEL (374595)], CMP, and for methadone patients order baseline EKG

Patients Already in CDCR

Patient presents with opioid overdose or OUD-related infection/complication

Patient self-refers via 7362 process

Nursing assessment, with PCP co-consult as needed

Patients Leaving CDCR (releasing/paroling within 0-24 months)

Nursing screens patient with NIDA Quick Screen

Positive QS

Negative QS

Is patient already engaged in ISUDT programming?

Yes

No

- Consult to LCSW for assessment
- Order UDS [CCHCS UTOX PANEL (374594)]

Is NIDA-MA ≥ 4?

No

Yes

- Consult to LCSW for additional assessment and treatment modification
- Order UDS [CCHCS UTOX PANEL (374595)]

LCSW completes ASAM CO-Triage for level of care assignment (see page 10) and:
- Refers patient to CBI
- If NIDA-MA scores are >16 for opioids or alcohol refers to provider for MAT evaluation

Is patient on MAT?

No

Yes

MAT Medication Selection/Initiation
- Provider evaluates patient for MAT, see Page 12
- Provider determines if MAT is clinically indicated (based on DSM-V criteria, UDS result and NIDA-MA score) and determines which medication is most appropriate
- Provider obtains consent for MAT
- Provider orders Nursing MAT Medication Evaluation (see page 15)
- Patient is initiated on chosen medication and follow-up visit is ordered

Nursing MAT Medication Evaluation
Completed within 72 hours for outpatient and 24 hours for inpatient if MAT started (see page 15)

Monitoring by Provider
- Monitor labs as recommended in table on page 17
- Order random UDS (374595) based on frequency determined by treatment duration and patient stability, see page 19
- Consider alternate agents when appropriate (see page 14)

Patient continues recommended treatments, which may include MAT, CBI/CBT, peer support groups, supportive housing and Nursing-Led Therapeutic Groups

Parole/Release Planning:
- ASAM RISE completed 6 months prior to EPRD
- Treating provider prescribes MAT medication and checks CURES
- For patients on methadone, patient will be connected to county NTP prior to release
- Nursing/pharmacist dispenses naloxone upon release
- Transition team coordinates Medi-Cal enrollment, healthcare appointment scheduling, housing, transportation, and other needs

PATIENT SCREENING & ASSESSMENT - INSTRUMENT SUMMARY

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

PATIENT SCREENING - NIDA QS

Screening for SUD is accomplished using the NIDA QS 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 triggers further assessment to explore the risk related to specific substances, and eligibility for medication and/or psychoeducational treatment. 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.

PATIENT ASSESSMENT - NIDA Modified Assist (NIDA-MA)

- The NIDA-MA guides clinicians through a series of questions to identify risky substance use in their patients by considering lifetime substance use and consequences related to more recent use.
- Scoring involves summed responses for questions 2-7 for each substance, yielding a substance involvement score.
- The patient's risk level is based on their Substance Involvement (SI) score for each substance:
  - 0-3=lower risk 4-26=moderate risk ≥27= high risk
- Consideration for MAT Evaluation when SI score is greater than 16 for alcohol or opioids, or based on LCSW clinical discretion.

PATIENT ASSESSMENT - ASAM Criteria

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

PATIENT ASSESSMENT - ASAM CRITERIA (CONT'D)

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?

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

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

REFERRALS FOR ASSESSMENT FROM THE FIELD

All patients will be eligible for assessment and treatment within the ISUDT program (including MAT when appropriate).

- When patients are identified with a history of opioid overdose and/or known SUD-related complications such as endocarditis, osteomyelitis, poor oral health, HCV infection or cellulitis related to IV drug use, refer the patients to LCSW for assessment using the "Consult to LCSW" order, with "SUD-Related Complications" selected under *reason for consult*.
- Additionally, patients who are identified as having an OUD-related complication, as noted above, should have an order for CCHCS UTOX PANEL (374594), with ASAP selected under *collection priority*, and should be considered for MAT.
- For patients returning from higher level of care (HLOC), consider if the transfer was due to SUD-related complications, such as overdose, skin infections, trauma, and refer accordingly.
- For patients presenting for HCV treatment and/or recurrent viremia, or in newly-diagnosed HIV and HBV cases which may be due to intravenous drug use, refer for SUD evaluation and treatment as appropriate.
- For patients with significant co-occurring disorders including major depression disorder or other mental illness, it is important to collaborate with MH providers and coordinate care.
- Patients transferring to acute care MH beds (PIP) already on MAT are continued on MAT without interruption unless patient's condition requires adjustment via collaboration with MH provider.
- New admissions to acute care MH beds generally are not considered candidates for MAT initiation until condition is stabilized.

PATIENT ASSESSMENT - MOTIVATIONAL INTERVIEWING[1]

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

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

Five Principles of Motivational Interviewing

Principle	Application to Practice
1. Express Empathy (through active listening)	• Empathy communicates respect for and acceptance of patients and their feelings and encourages a non-judgmental, collaborative relationship. • Empathy is the foundation of a motivational counseling style.
2. Develop Discrepancy (between the patient's goals or values and their current behavior)	• Developing awareness of consequences helps patients examine their behavior. • A discrepancy between present behavior and important goals motivates change.
3. Avoid Argument (and direct confrontation)	• Arguments with patients can rapidly turn into a power struggle and do not enhance motivation for beneficial change.
4. Roll With Resistance (rather than opposing it directly)	• 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 in order to anchor patients to their strengths and resources as they address problem behaviors. Affirmations help patients feel more comfortable, forthcoming, and open to feedback. Affirmations can be brief but powerful in building a therapeutic alliance. • *"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 together and presented to the patient. Summaries help patients and families organize their experiences. Summarization brings closure and consensus to what has been discussed and sets the stage for next steps. A summary statement often ends with a question. • *"What you've said is important and I want to make sure I have it right…"*

PATIENT ASSESSMENT - HISTORY AND PHYSICAL EXAM

Health care providers will evaluate patients prior to initiating MAT.

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

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

Providers must check CURES if:

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

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:

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

PATIENT ASSESSMENT - DIAGNOSTIC TESTS

Prior to initiating MAT, screening for TB, HBV, HCV, Hepatitis A, HIV, and Syphilis is done along with Comprehensive Metabolic Panel (CMP), UDS, and Urine beta-hCG (for women), and EKG (for Methadone). See table on page 17 for more details.

PATIENT ASSESSMENT - DIAGNOSIS

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

SUD Diagnosis—DSM-5

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

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

- Inhalant-related disorders
- Tobacco-related disorders
- Other, or unknown, substance-related disorders
- Caffeine-related disorders
- Hallucinogen-related disorders
- Alcohol-related disorders
- Opioid-related disorders
- Cannabis-related disorders
- Sedative, hypnotic, or anxiolytic-related disorders
- Stimulant-related disorders

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

Loss of Control	Adverse Consequences	Physical Dependence
• Taking larger amounts or for longer than intended • Wanting to cut down or quit but unable to • Increasing 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

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

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

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

SUD Diagnosis - ICD-10

Documenting a specific diagnosis is important for subsequent treatment planning. Diagnostic ICD-10 master code numbers for specific drug(s) of use are listed here. The relevant ICD-10 code(s) can be selected using IMO box in the Electronic Health 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

TREATMENT OVERVIEW

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

TREATMENT - TRAUMA-INFORMED CARE AND SUD

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

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

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

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

TREATMENT - BEHAVIORAL INTERVENTIONS

Cognitive Behavioral Interventions (CBI)

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

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

These psychosocial interventions seek to teach participants to identify and change unhelpful thoughts, beliefs, and attitudes (cognitive distortions) and behaviors that often contribute to substance use. CBI participation is offered to appropriate 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 BPH hearing.

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

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

In order to communicate the assessment findings with the counselors in the DRP, the Medical Classification Chrono (MCC) is used to transmit the level of care assignment associated with the ASAM score. The corresponding range of hours of contact for CBI is shown under "CBI/CBT Intensity" in the table below. Those who have completed their CBI programming have their MCC code updated to T4. T5 indicates a patient who has refused or is unable to complete CBI, and is removed from the waitlist.

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

The range of needs for cognitive behavioral interventions for the incarcerated population is broad and delivering group and/or individual therapy contact hours achieves a higher level of care when delivered by licensed clinical therapists. AOD counselors are involved with delivering the basic intervention hours for outpatient level of care.

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

TREATMENT - BEHAVIORAL INTERVENTIONS (CONT'D)

Cognitive Behavioral Therapy (CBT)

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

For patients who are worsening or not progressing while receiving Outpatient Services, following further assessment, LCSWs may provide Complex Care Enhanced Treatment (CCET) including processing groups, CBT and trauma-informed care, using the Seeking Safety curriculum. Seeking Safety is an evidence-based curriculum that increases safety by addressing substance use and trauma in a structured, clinical environment. Addition of CCET to Outpatient Services programming provides an average 10 service hours weekly.

CBI Placement and Waitlist Prioritization

- Priority placement onto waitlists for Outpatient CBI is based on:
  - High risk medical, prioritized by release date, includes:
    - History of overdose
    - SUD-related hospitalization
    - 7362 submission requesting assistance with SUD
    - Pregnant with SUD
  - On MAT, prioritized by release date
  - 15-24 months to release EPRD and BPH controlling parole eligible date, prioritized by release date.
- Prioritization of placement onto Life Skills Waitlist (CB2/T3)
- Patients serving a life sentence without parole are ineligible for reserved slots for CBI

Those at Fire Camp

- Patients transferred to a camp, will be placed on a separate waitlist that keeps their original referral date and LOC.

Short-term Restricted Housing, Long-term Restricted Housing, Ad Seg, or PIP

- Those who are assessed and placed on a waitlist, and then moved to Short-term Restricted Housing, Long-term Restricted Housing, Administrative Segregation, or PIP, will be placed on a separate wait list that keeps their original referral date and LOC. If they are referred back to general population, they will be placed back into the main list, based on original referral date, and if determined to be the same LOC. If new LOC is determined, they will be placed on the waitlist of the new LOC.

Peer Support Groups/Inmate Leisure Time Activity Groups (ILTAG)

Peer support groups are another behavioral treatment option. They 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.

Peer 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 22, Inmate/Parolee Request for Interview, Item, or Service 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.

Examples of peer support groups that may be available are White Bison, Alcoholics Anonymous, and Celebrate Recovery.

⇒White Bison is a culturally-based addiction prevention and recovery program designed to support Native American populations.

⇒Narcotics Anonymous and Alcoholics Anonymous are based on the spiritually-informed Twelve Steps, focused on creating communities of people who support each other in their sobriety journey.

⇒Celebrate Recovery is a Christian recovery program based on the Twelve Steps and informed by Biblical principles.

TREATMENT - PEER MENTORS

Patients who complete CBI programming can apply to become a peer mentor who serves as a sponsor for others in recovery. They can begin this process by contacting their Community Partnership Manager. The process for becoming a peer mentor is outlined below:

- Candidate Recruitment & Selection
- Participates in 18-week CBI Intensive Outpatient Program
- Study Preparation & skill Building
- Formal Classroom Education
- Supervised Practicum Training
- Prepare and Sit for Written Exam
- Supervised Internship
- Complete Internship Hours/Receive Certification
- On-Going Work Experience/Continuing Education/ Certification Advancement

Once an individual is certified as a peer mentor, they can lead aftercare and other peer support activities in supportive housing.

TREATMENT - BEHAVIORAL INTERVENTIONS (CONT'D)

Nursing Led Therapeutic Groups

The CCHCS Nursing Led Therapeutic Groups (NLTG) Program was developed in compliance with the Patient Education Policy. NLTGs are structured and standardized to encourage and promote social skills, life skills, behaviors, and coping mechanisms to improve inmate patient health and wellness outcomes while incarcerated and upon release. The NLTG program is expanding, and each institution works with their executive leadership and offers groups based on the needs of the patient population and staff availability. For more information, refer to the local ISUDT Resource team.

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

Patients can be referred by Interdisciplinary Treatment Teams (IDTTs), ISUDT staff, PCPs, or can self-refer. NLTGs provide hour for hour Rehabilitation Achievement Credit (RAC) for the patient attendees.

TREATMENT - SUPPORTIVE HOUSING[2]

- Supportive housing units are a key treatment modality.
- While participation in supportive housing is voluntary, due to its known benefits, ISUDT program participants should be encouraged to participate in supportive housing therapeutic communities. 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.
- Studies find that therapeutic community participants show decreased substance abuse, criminal behavior, and MH symptoms.
- Supportive housing units will be available at all institutions.
- Supportive housing is recommended for those identified as being at high risk due to environmental factors.
- Oversight in supportive housing units will be provided by custody officers specifically trained in ISUDT support.

TREATMENT- PHARMACOLOGIC [3, 4, 5]

Medication Assisted Treatment (MAT): Selecting a MAT Agent for OUD[6]

Selection of the appropriate agent involves consideration of patient laboratory results, history and preferences which are generally considered/discussed at the time of consent and initiation. These may include:
- Danger of overdose or possible harm to the patient (consider the patient's substance use history)
- Efficacy of MAT agent in limiting or eliminating problematic substance use
- Treatment retention and adherence
- Availability of chosen agent upon parole/release (relevant during pre-release stages; community acceptance may differ)
- Patient's preferences, past treatment history, and historical and current substance use patterns. Reviewing previous documentation may provide valuable information.
- Patient's concurrent medical and/or mental health conditions

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

	AGONISTS (Buprenorphine & Methadone)	**ANTAGONIST** (Naltrexone)
Action	Activate opioid receptors Maintain physical dependence on opioids	Competitive antagonist at opiate receptor; [At high concentrations, an opiate can displace naltrexone]
Initiation	While the patient is still dependent or detoxifying	Only after full detoxification to avoid withdrawal
Prescribing Restrictions	X-waiver (Buprenorphine) Licensed NTP (Methadone)	None; all providers may prescribe, may be dispensed KOP when appropriate (stable in recovery)
Side effects (see pages 26-30)	Lower extremity swelling, urinary hesitancy, constipation, sedation	Nausea, abdominal cramps/pain, anxiety, chills, possible precipitated withdrawal
Cautions	Drug-drug interactions with QT prolongation	Avoid in patients with advanced liver disease (F3-4) or renal impairment (CrCl , <30 ml/min)
Advantages	Comorbid pain control (See page 23)	No diversion, no dependence, lower stigma in some settings. No euphoric effects
Discontinuation	Associated with withdrawal symptoms	No withdrawal
Abuse potential	Medium to High	None

TREATMENT- PHARMACOLOGIC (CONT'D)

Medication Assisted Treatment (MAT): Selecting a MAT Agent for OUD[6] (Cont'd)

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

In considering the three agents for OUD:

- **Naltrexone**, an opioid antagonist, requires that the patient detoxify from opiates (typically 7 days) before beginning Naltrexone; this is commonly called the "detox hurdle." Because Naltrexone is an antagonist, it does not curb cravings as much as agonists and may not be suitable for those with a long history of OUD. Consequently, Naltrexone may be best for those who are highly motivated to abstain from all opioids and would prefer not to use an agonist. Naltrexone should be considered the first-line agent for those who already have established a period of sobriety.
- **Methadone**, a full opioid agonist, allows a transition from opioid use to medication maintenance without detoxification. Methadone is often used in patients physiologically dependent on opioids for greater than 2 years. The administration of methadone for OUD is monitored and administered under the regulations of a licensed NTP.
- **Buprenorphine**, a partial opioid agonist, is permitted to be prescribed in physician offices significantly increasing access. Under the Drug Addiction Treatment Act of 2000 (DATA 2000), qualified physicians and advanced practice providers with an X-waiver can offer buprenorphine for opioid dependency. Generally induction may occur at least 12-24 hours after the last use of heroin or other short-acting opioids, or 24-72 hours after the last use of a long-acting opioid, such as methadone. If timing is uncertain, a COWS can be done, and induction started when the score is 6-10. Please note that buprenorphine can bring on acute withdrawal for patents who are not in the early stages of withdrawal and who have other opioids in their bloodstream. However, complete detoxification is not a requirement. As a controlled substance (C-III), new start orders require re-evaluation within 7 days prior to renewal/continuation. This can be accomplished through a Nursing MAT Medication Evaluation (see page 15).

Medication Assisted Treatment (MAT): Selecting a MAT Agent for AUD[6]

For treatment of AUD, acamprosate and naltrexone are found to have similar rates for retention and positive patient outcomes.

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

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

Medication Administration

- When prescribing a MAT medication, providers should carefully consider administration time. This is needed to avoid overburdening any one administration time (AM, noon, PM or HS). This should be done by discussing with the patient their current schedule (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.
  - ⇒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 for Suboxone is standard, and dosage prescribed should be viable with a maximum of two strips.
- Suboxone is given as a sublingual film. Nursing will instruct the patient to place the Suboxone film under the tongue in a parallel direction and close mouth.
- 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.
- Observing the medications entering the mouth shall satisfy the verification requirement noted in the medications NA/DOT policy. If the medication enters the mouth and the nurse provides counseling for 30 seconds or more to initiate adherence to the oral mucosa, the nurse does not need to perform a mouth check.
- Nursing will communicate to the Suboxone prescriber of any misuse or refusal of the Suboxone film by sending a message in Cerner and copying the Resource RN or local ISUDT team (please note this is not the HQ AM message pool).

TREATMENT- PHARMACOLOGIC [3, 4, 5] (CONT'D)

MAT Agents Offered in CDCR

CCHCS offers four medications approved by the Federal Drug Administration (FDA) for MAT for OUD and AUD. During an initial consult, the provider will evaluate and initiate MAT when deemed appropriate. Consent for MAT will be obtained using the CDCR 7240 (see attachment D). Available MAT medications on CCHCS formulary are summarized below.

Medication	For	Use Criteria
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 in severe renal impairment (CrCl ≤ 30 mL/min)
Buprenorphine/Naloxone (Suboxone) sublingual films *(NA/DOT-SL)* *Opioid partial agonist*	*OUD*	•Recommended outpatient starting dose 8 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 •An X-waiver is required to prescribe buprenorphine •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 15
Naltrexone Oral *(NA/DOT or KOP after stable)* *Opioid Antagonist*	*AUD* *OUD*	•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 opioid use within 7 days (depending on last opioid agent used) •No opioid withdrawal symptoms •No acute hepatitis or liver failure •Avoid if CrCl < 30 ml/min
Restricted Use *Requires submission of AAA Form (see below)*	**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) •Preference for methadone over buprenorphine based on a patient's prior good result using methadone, or the need for a more structured delivery system •*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)*	*AUD* *OUD*	•The patient is on sublingual buprenorphine therapy for more than 7 days *and* •Patient is unable to manage daily dosing with oral formulations upon release •*An X-waiver is required to prescribe buprenorphine*
	Naltrexone Injection *(NA)*	*AUD* *OUD*	•The patient is on oral naltrexone therapy and is within 3 months of release *and* •Patient is unable to manage daily dosing with KOP medication *and* •Patient is considered at high risk for overdose

Alternative Agent Authorization (AAA) Form

- The AAA form provides a pathway for consideration of alternative MAT agents or formulations, such as methadone, topiramate, injectable buprenorphine, or injectable naltrexone and is found in the ad-hoc section in Cerner, in the MAT folder. Providers should not order a Consult to the AMCT for consideration of an alternative agent, this will be placed by the AMCT if the patient is deemed appropriate. The provider should continue to follow the patient as the AAA request is processed.
- The "Request" portion of the form is completed and submitted by the patient's provider (Medical, MH), with the AMCT providing the "Review" after submission to determine if the patient is appropriate for the alternate agent requested.
  - ⇒ If in review, the request is approved, the AMCT member will order the patient consult and consent the patient
  - ⇒ If the request is not approved, the requestor will receive correspondence in Cerner with recommendations

Rapid Induction

- For patients that present in active opioid withdrawal (COWS ≥8), providers should consider a rapid induction. For more information on rapid induction including the workflow, see CCHCS Care Guide: Intoxication and Withdrawal.
- Communication should be made to the Addiction Medicine Team via the HQ Addiction Services Provider Message Pool.
- Rapid induction does not replace an initial Addiction Medicine evaluation and a consultation order is needed.

TREATMENT - PHARMACOLOGIC (CONT'D)

Patients Requiring Bridge Orders While Treatment Continuity Arranged

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

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

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

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

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

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

Methadone:

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

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

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

- CCHCS UTOX PANEL (374595)
- CMP
- Consult to LCSW for assessment

Patients Arriving on Alternative Agents (Methadone, Sublocade, Vivitrol) should be referred to the AMCT for consultation and formulation adjustments as needed.

MAT Initiation

- Using the DSM-5 criteria (see page 9), diagnose patient with specific SUD (AUD or OUD)
- The MAT PowerForm (see page 17) is a decision-support tool that standardizes and assures the coverage of essential elements typically captured in an addiction medicine encounter, and should be used for initiation and all follow-up visits. Providers should have all data documented to support initiation of selected MAT agent, i.e.:
  - ◊ NIDA MA/Co-Triage results
  - ◊ HLOC-related data
  - ◊ Documentation of SUD-related complications such as endocarditis, HCV
  - ◊ Additional items to consider are covered within *ISUDT Didactic Training Series* and the *Putting the Pieces Together* video which can be found in the Provider Resource Library.
  - ◊ Consider the patient's current medication regiment and any potential interactions, i.e. CNS depressants such as anti-epileptics and antipsychotics
- For details on each MAT agent including starting dose, maximum recommended dose and contraindications, see pages13-14
- Be mindful of efficient dosing for Suboxone, e.g. 16 mg should be accomplished with two 8 mg strips rather than a 12 mg and 4 mg strip.
- If patient enters buprenorphine-induced precipitated withdrawal, send patient to TTA
- Provider should order a 72 hour medication check appointment with Nursing (see Standard Induction Workflow), detailed in the section below

Nursing MAT Medication Evaluation

Following MAT initiation, providers should order a nursing follow-up for *MAT Medication Evaluation*. This evaluation includes a COWS and medication check to assess for any adverse effects.

- 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)
  - ◊ In the order be sure to indicate Reason for Follow-up is *MAT Medication Evaluation.*
  - ◊ Timeframe: within 72 hours for outpatient, within 24 hours for inpatient
  - ◊ Within special instructions provider should indicate whom the results should be messaged

TREATMENT - PHARMACOLOGIC (CONT'D)

Overview on Switching MAT Medications[5]

Switching medications will be done by the AMCT or local subject matter expert. General considerations:

- Medication changes should be considered on a case-by-case basis. For consideration of switching a patient to methadone, injectable buprenorphine, or injectable naltrexone, providers should submit a MAT AAA form, outlined on page 14.
- Unless there is a strong indication to switch medications, patients already established on a specific therapy should be continued on that therapy.
- Changes in medication formulation may be necessary to conform to CCHCS formulary restrictions. For example, a patient who enters CDCR on MAT using buprenorphine/naloxone tablets will be transitioned to sublingual (SL) films.
- Switching MAT agents for the treatment of OUD may be appropriate if the patient experiences intolerable side effects or is not successful in attaining or maintaining treatment goals through the current agent.

Methadone to Buprenorphine

- Patient 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 *(Requires submission of MAT AAA Form (See page 14)*

- Arrangement to transition the patient to an institution with access to an NTP will be necessary

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 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).
- Due to the absence of physical dependence on opioids, initial doses of buprenorphine (or NTP prescribed methadone) should be low.

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.
- Clonidine can be used to help with symptoms at doses of 0.1 mg TID PRN.
- Naltrexone can be started 7-10 days after cessation of buprenorphine, and 10-14 days after cessation of methadone.

Overview on MAT Medication Discontinuation/Tapering

- If the patient decides they no longer want to continue taking MAT or there is a medical indication for discontinuing MAT, tapering off of their medication needs to be done instead of abrupt discontinuation (except naltrexone and acamprosate). In the case of refusal, the treating provider will get a signed **CDCR 7225, Refusal of Examination and/or Treatment** form (see attachment E).
- **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 just discontinue medication.
- **Methadone:** tapering is challenging and is generally directed by a licensed NTP.
- **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.

Opioid Overdose Risk & Prevention Counseling[5]

Patients with OUD all have an increased risk of overdose if they are abstinent from or significantly reduce their use of opioids due to their loss of physiologic tolerance.

Additional Overdose Risk with Naltrexone: Patients on naltrexone (opioid antagonist) are at risk of sudden overdose if taking opioids while on naltrexone.

- Naltrexone blocks the opioid receptor initially, and the patient gets no effect from the opioid taken. However, if more opioids are taken, the opioids can overcome the blockade and result in **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.

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 depressants (alcohol or benzodiazepines).
- Do not use multiple doses of opioids in a short duration of time and if using, do not use alone.
- After release from prison, have naloxone available.

MONITORING FOR PATIENTS ON MAT

Follow-up Visits Overview

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

Preparation for a Follow-up Visit

- Review patient chart notes since last visit, including prior addiction medicine notes, 7362s submitted, hospital sendouts, etc., which may indicate need for a higher intensity of SUD care including greater frequency of follow-up visits and UDS
- Review and document UDS results (per monitoring guidelines, see pages 19-20). Note for any CNS depressants, e.g. alcohol
- Review Medication Administration Record (MAR): 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
- Focus physical exam on individual patient history
- Ensure medication is ordered in your name, and refill as needed
- Schedule follow-up visit and random UDS (see page 19) according to duration of treatment and clinical need:
  - ◊ Follow-up visits should be scheduled more frequently during initial dosage titration (i.e., every few days to a week) upwards toward every 3 months if on a controlled substance. If the patient is showing signs of poor disease management i.e. missed medication doses, relapse, lack of attendance of assigned CBI, etc., follow-up and UDS frequency should be increased until patient shows signs of improved disease management
    - ⇒If the patient wishes to discontinue MAT a signed informed refusal shall be obtained (see page 16). **SUD follow-up visits should continue to be scheduled at least every 90 days, and based on clinical need for ongoing monitoring of their SUD**
- Order interim diagnostic tests as needed (see table below)

MAT Medication	Diagnostic Test	Annual	PRN
Acamprosate	Comprehensive Metabolic Panel (CMP)	✓	✓
Buprenorphine	Screening for HAV, HBV, HCV, HIV, RPR	✓	✓
Naltrexone	Random UDS (see page 19 for frequency based on stage of care)		✓
Methadone	Urine beta-hCG for women		✓
Methadone	EKG	✓	✓*

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

Documenting Addiction Medicine Encounters

- Providers should use the MAT PowerForm at each visit. 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.
- Providers can utilize the PCP workflow and tag relevant UDS results.
- Providers should utilize the Outpatient Progress Note, with the MAT PCP Consult Note template. Providers can utilize the .hmat and .amat dotphrases, which pull information from the PowerForm into their documentation, and ensures it includes the following:
  - ◊ Motivation to continue on 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)
  - ◊ Patient's group and/or programming participation
  - ◊ Any identified relapse risk factors (e.g., recent bad news, poor self care, avoiding peer support groups (see page 18))

MONITORING FOR PATIENTS ON MAT - (CONT'D)

Recovery and Sobriety

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

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

Relapse

Relapse: a process in which an individual who has established abstinence or sobriety experiences recurrence of signs and symptoms of active addiction. Relapse is 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. **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.

When relapse occurs, there is often disengagement from recovery activities. This may present itself through the following:

- Resumption of the pathological pursuit of reward through the use of illicit or unprescribed substances
- Avoidance of peer support groups and CBI
- Poor self-care, including lapses in other disease management, such as refusal of medications and other appointments
- Increase of environmental triggers and poor management of cravings

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

Triggers: Triggers include people, places, and things that a person associates with substance use that may spark potential relapse. The four categories of triggers include pattern, social, emotional and withdrawal:

⇒ Patterns are situations that incite recollections of substance use (i.e. time of day, location, seasonal events)

⇒ Social triggers are a person or group associated with drug use

⇒ Emotional triggers associated with drug use may stem from a wide range of emotions such as celebrating happiness or self-medicating for sadness and anxiety

Be aware of the warning signs of a potential relapse and offer support and education to the patient on relapse and overdose prevention (See Patient Education pages 34-37)

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 (i.e., death of a family member, divorce, increase in sentencing, 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 (i.e., 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, remember cravings end, and journaling.

Do not overly rely on medication to address cravings.

MONITORING FOR PATIENTS ON MAT - (CONT'D)

Urine Drug Screening[8]

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

- CCHCS uses Urine Drug Screens (UDS) as clinical tools to help providers make informed decisions about patient induction, and to provide support in monitoring the disease and keeping the patient safe. UDSs are for chronic disease monitoring and 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. q 4 wks.) frequency.
- Every UDS result should be discussed with the patient. Compliant results provide an opportunity for providers to encourage the patient's progress, and noncompliant results offer opportunity to discuss any obstacles patient is facing.
- The various UDS orders that are used are summarized below, along with ordering parameters and frequency. 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 visit.

Test Type & Order Number	Screening 374594	Monitoring 374595	Comprehensive 373993	
Scenario for Use	Used in preparation for a Consultation	This is the test most commonly used for routine follow-up	**Rarely used**. Used when a patient exhibits severe, unstable, co-occurring disorders that require a fuller panel	
Turnaround time	Most rapid, 1-2 days	3 days	Longest turnaround time	
Collection Priority	ASAP	Timed Study	Timed Study	
Collection Time	2359	2359	2359	
Notes	Auto-fires from a NIDA-MA Assessment from the LCSW, if appropriate	Will not include Mental Health medications	Includes a comprehensive testing of MH medications	
Stage of Care		< 30 days	31-90 days	91 days – 2 years
UDS Order Frequency for Monitoring Tests*		Random	Random 2-4 wks	Random 4-6 wks

- Patient should NOT be told when test is to be done.
- If relapse occurs after an abstinence period, reset stage of care to <30 days with more frequent monitoring.
- If UDS consistent with therapy >2 years on controlled medication, continue random testing at least every 3 months.
- For questions on UDS testing or interpretation contact the AMCT.
- Many factors including state of hydration, other medications, genetics, patient's age, gender and urinary pH can affect the rate of excretion of parent drug and metabolites.

MONITORING FOR PATIENTS ON MAT - (CONT'D)

Urine Drug Screening[8]— (CONT'D)

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

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

The ISUDT program has implemented a collection policy and procedures to mitigate some or all of these concerns. Normally:

- pH of 4.5-8
- Creatinine >20 mg/dl
- Specific Gravity >1.002-1.030
- Temperature between 90-100 Fahrenheit within 4 minutes

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

- MAT medication prescribed and relevant metabolites (See **Attachment C**)
- All medications prescribed to the patient and important metabolites, if any
- Opioid metabolism if unexpected opioid metabolites (See page 21)
- Alcohol and other substances of abuse metabolites and detection time (See **Attachment C**)
- Engage the patient regarding results (see page 21)

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

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

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

MONITORING FOR PATIENTS ON MAT - (CONT'D)

Urine Drug Screening Interpretation[8]

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

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

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

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

What to do with results NOT consistent with treatment:

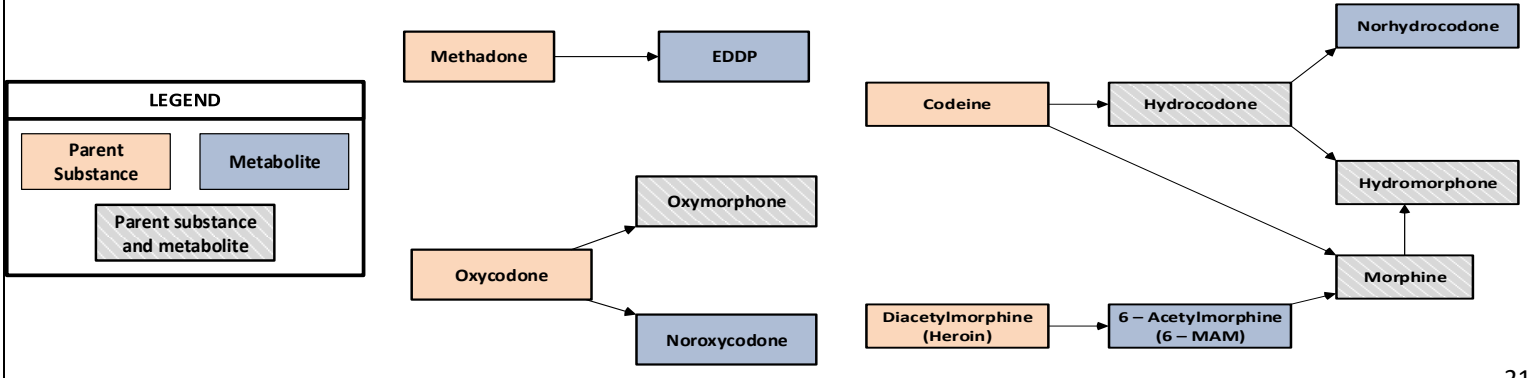
- Have a conversation with the patient
- Consider a change in housing—discuss triggers with your patient, including those linked to housing such as a cellmate who continues to use
- Consider identifying and treating a co-occurring use disorder
- Consider a referral to mental health for suspected co-occurring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

Do not over-interpret the UDS: It is tempting to utilize concentrations of substances in the urine to infer compliance with ingestion of the drug. To do so, one must have the dose delivered at the same time multiple days in a row, give a urine sample at the same time of the day, 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-compliance: If you receive reports of patient non-compliance during medication administration, see page 24.

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 CER 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[9]

People leaving prison are at significantly higher risk of dying of an overdose compared with age/sex controls in the general population. Therefore, the population leaving CDCR will be a focus of careful screening, assessment and treatment initiation.

The Whole Person Care Transition Services Team comprised of Nursing and other CCHCS CDCR partners collaborates with community stakeholders in all 58 counties in California to arrange treatment continuity as patients prepare for release back into their community. This care coordination is collaborated through a routine pre-release coordination meeting consisting of the institution resource team, mental health pre-release coordinators, Transitional Case Management Program benefit workers and parole service associates. The interdisciplinary transition services team discusses patients' health and social needs to obtain the appropriate services upon release.

Services provided to all patients leaving CDCR may include, but are not limited to:

- Enrollment and activation of Medi-Cal benefits
- Scheduling health care appointments, including connecting patients on methadone to community NTP
- Obtaining housing
- Arranging transportation to and from appointments
- Engaging family & peer support
- Assisting with employment and/or education resources as needed
- Providing a release packet that includes community resources with their contact information such as substance use, mental health, local county and city resources, free Internet and cell phones
- Offering naloxone to each patient upon release, along with education on its use

Additional Release Coordination for Patients on MAT

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) shall be provided with a 30-day supply of their MAT medication, and patients receiving acamprosate or naltrexone will be provided a 60-day supply. Patients on injectable buprenorphine are switched to films in order to more easily coordinate with community resources.
- Provider must consult CURES when any controlled medications are prescribed at the time of parole or release, because these prescriptions will be dispensed to the patient and reported to CURES. Checking CURES protects the provider in the event of an audit against the dispensed medication at time of discharge.
- Patients who are placed on injectable naltrexone within 3 months of release will be provided a medical alert card.

SPECIAL CIRCUMSTANCES

Managing Patients with Acute Pain While on MAT

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

- Treatment of acute post-operative pain in patients on buprenorphine maintenance includes continuing the patient's baseline dosing to avoid increased pain and/or withdrawal.
- **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 Part 2—Therapy—Non-Opioid).
- Consider use of local and regional anesthesia as needed.
- 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.
- Patient Controlled Analgesia (PCA) without a basal component may be considered in addition to a patient's buprenorphine if pain is not adequately captured. If a PCA is utilized, discontinue oral PRN opioids.
- The buprenorphine/naloxone provider should be contacted pre– and post-procedure to assist in ongoing assessment, support and pain management.

In order to overcome the pharmacologic blockade on extended-release injectable naltrexone or buprenorphine, extremely high doses of opioids are required to achieve adequate analgesia. This could lead to accidental overdose, **respiratory depression, and death**. Non-opioid analgesics are recommended whenever possible. Regional nerve blocks and dissociative analgesics such as ketamine may be considered. Generally, transfer to a higher level of care is necessary to manage the patient in a setting that offers a full range of cardiopulmonary monitoring and ventilator support if necessary.

Patients with oral pain should be referred for dental consultation.

Co-consultation with the AMCT and a Pain Specialist should occur with any of these scenarios.

Co-Occurring Mental Illnesses and SUD[7]

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 begin to 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 depression is identified through conversation with patient or through PHQ-2/PHQ-9, patient should be referred to MH.

<u>MAT In the Inpatient Setting</u>

As clinically indicated, the integration of MAT treatment decisions into the overall psychiatric treatment plan is encouraged.

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 (hospitalization length of days to weeks)
- PIP Acute (Acute Psychiatric Program - APP) - longer term crisis stabilization (hospitalization length of weeks to months)
- PIP Intermediate (Intermediate Care Facility - ICF) - long term inpatient care for patients who cannot function in outpatient settings but not requiring acute crisis stabilization (hospitalization length of months to years)

In many cases, it may be preferable to initiate MAT within the longer-term PIP programs, rather than during the shorter-term crisis stabilization treatment settings (e.g., MHCB), although treatment determinations should be coordinated by the treatment team as noted above.

SPECIAL CIRCUMSTANCES (CONT'D)

Reports of Noncompliance

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

- For all reported cases of misuse, providers should have a conversation with the patient and conduct their own assessment
- Meet with the patient to explore potential triggers or reasons for reported behaviors
- Review the patient's MAR and UDS to determine if they are consistent
- Consider next steps including therapeutic adjustments as necessary, which may include:
  - ⇒ Supportive housing to remove some potential triggers
  - ⇒ Medication agent, dose, and timing of treatment
- If additional guidance is needed, consider Care Team Enhance Conferences (CTEC) or other resources
- Consider the use of alternative MAT agent such as an injectable through submission of a MAT AAA form (see page 14)
- Report systemic issues to your local ISUDT Steering Committee
- Document the outcome of the above in a progress note in EHRS

Common Scenarios

Some common scenarios in treatment that may need to be addressed include:

- Behavior issues at the medication line: have a conversation with the patient and ensure documentation regarding the correct manner of taking the strip.
- No buprenorphine/norbuprenorphine 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.
- Patient wants to stop suboxone due to yard politics: remember that these patients have a high risk of overdose, consider KOP naltrexone. In addition, have the patient sign an informed refusal.
- Patient refuses to participate in CBI or supportive housing: these programs, while helpful in establishing sobriety and recovery, are NOT mandatory for MAT medication. We do not stop MAT due to refusal of these other treatment components.
- 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 for assistance.

Care Team Enhanced Conference Referrals

- For patients with complex co-occurring diagnoses, Care Team Enhanced Conferences (CTEC) are available to assist in developing a comprehensive care plan.
- CTEC aims to gather representatives form 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.

RESOURCES

- The local institution Addiction Medicine SME is the first line for questions that arise while managing patients on MAT.
- The Addiction Medicine Central Team is available for questions unresolved by SME outreach.
- For patient specific questions or concerns, use the **HQ Addiction Services Provider Message Pool** in EHRS.
- For programmatic questions, 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.
- An up-to-date listing of contacts and resources for addiction medicine is located here.

PRIVACY & CONFIDENTIALITY

Medical Records

The U.S. Department of Health and Human Services ("HHS") issued the *Standards for Privacy of Individually Identifiable Health Information* (AKA the privacy Rule) to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Privacy Rule standards address the use and disclosure of individuals' health information—called protected health information (PHI) by organizations. A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well-being.

Title 42 part 2 in the code of federal regulations (CFR) (Part 2) serve to protect patient records created by federally assisted programs for the treatment of SUD. Part 2 has been revised to further facilitate better coordination of care in response to the opioid epidemic while maintaining its confidentiality protections against unauthorized disclosure and use. Part 2 prohibits law enforcement's use of SUD patient records in criminal prosecutions against patients, absent a court order. Part 2 also continues to restrict the disclosure of SUD treatment records without patient consent, other than as statutorily authorized in the context of a bona fide medical emergency; or for the purpose of scientific research, audit, or program evaluation; or based on an appropriate court order.

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.

Summary

- 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 Board of Parole Hearings (BPH) to determine if an inmate should be released from prison. Such a hearing is often a very stressful and significant event for inmates, victims, victims' family members, correctional staff, and the community. The Board is dedicated to protecting public safety, treating all persons who participate in a parole hearing with respect and dignity, applying the law in an unbiased manner, and protecting the rights of inmates and victims.

The Board conducts parole suitability hearings for a variety of inmates 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 have 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.

In order to consider whether a patient is safe to reintegrate into the community, the Board of Parole Hearings (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 BPH and that their engagement in their sobriety and programming is looked upon favorably by the Board.

MEDICATION TABLES

Acamprosate

MEDICATION	DOSING*	ADVERSE EFFECTS/ INTERACTIONS*	COMMENTS*
Acamprosate **Delayed Release Tablet: 333 mg** **$$$$**	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	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

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.

MEDICATION TABLES CONT'D

Buprenorphine/Naloxone

MEDICATION	DOSING*	ADVERSE EFFECTS/ INTERACTIONS*	COMMENTS*
Buprenorphine/ Naloxone (Suboxone®) Sublingual Films: 2 mg/0.5 mg 4 mg/1 mg 8 mg/2 mg 12 mg/3 mg $$$ - $$$$ **Buprenorphine (plain) [Limited use for pregnancy only] Sublingual Tablets: 2 mg, 8 mg $$$ - $$$$** **RESTRICTED USE (Only managed by AMCT)** **Injection, ER (Sublocade®) 300 mg/mL $$$$$**	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. • Day 1: Initial, buprenorphine/naloxone 8/2 mg SL for standard induction, 12/3 mg for rapid induction (see Rapid Induction Protocol). Checking COWS between doses administered every 1-2 hours may guide medication titration (i.e., additional doses for COWS≥6; end titration once COWS≤5). • Continue daily at established dose for 1 week. 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 2/0.5 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: Do NOT use the combined formulation (buprenorphine/naloxone); use the single ingredient buprenorphine SL tablets. Pregnant patients require specialist management. See Appendix 1: MAT for OUD in Pregnant Patients for details. **RESTRICTED USE** **SQ Injection, Extended Release:** **For patients who have been stabilized on SL buprenorphine for a minimum of 7 days.** **Recommended dose: 300 mg SQ once monthly for the first 2 months, followed by 100 mg once monthly with a minimum of 26 days between doses. Based on clinical response, maintenance dose may be increased to 300 mg once monthly if benefits outweigh the risks** • **Serious harm or death can occur if given IV** • **SQ Injection - Use not recommended in moderate to severe hepatic impairment (Child Pugh B or C)**	Adverse effects: • Major: Addiction, abuse, misuse, lethargy, respiratory and CNS depression- avoid combining with other depressants, hypersensitivity reactions, elevation of cerebrospinal fluid pressure - caution in patients with head injury, elevation of intracholedochal pressure - caution in patients with biliary tract dysfunction, adrenal insufficiency • 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	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.

MEDICATION TABLES CONT'D

Methadone

MEDICATION	DOSING*	ADVERSE EFFECTS/ INTERACTIONS*	COMMENTS*
Methadone (Dolophine®) for OUD can only be given in a federally licensed facility and must be given as a solution. This is achieved by dissolving tablets in a designated volume of water **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 must be made for the patient to be seen at nearby NTP by day 4.	• Typical dose: 60-120 mg orally daily for maintenance • Max effect: Achieved in 7 days • 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**	Adverse effects: • 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	**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 • Significant respiratory disorder, acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment, paralytic ileus 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.

MEDICATION TABLES CONT'D

Naltrexone

MEDICATION	DOSING*	ADVERSE EFFECTS/ INTERACTIONS*	COMMENTS*
Naltrexone Oral Tablet **50 mg-100 mg** **$$-$$$** **RESTRICTED USE** **Naltrexone Extended Release Injectable Solution (Vivitrol®)** **380 mg/vial** **$$$$$**	**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 **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**	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, nasopharyngitits 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.	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 must 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 • Women 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.

MEDICATION TABLES CONT'D

Topiramate

MEDICATION	DOSING*	ADVERSE EFFECTS/INTERACTIONS*	COMMENTS*
Topiramate Oral tablets Tablet: 25 mg, 50 mg, 100 mg **$** **RESTRICTED USE—requires submission of a MAT AAA Form for consideration**	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	**Adverse effects:** • 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	**Contraindications:** • Patients with known allergies or sensitivity to topiramate **Use with caution in:** • Women 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 woman. When administered to an infant in utero, this medication has shown to cause cleft lip and/or cleft palate and being small for gestational age.

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.

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Appendix 1: MAT for OUD in Pregnant Patients

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); 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. 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 the 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 coordinates 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 depression 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 monthly 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 in order to reduce false positive rates.

Appendix 1: MAT for OUD in Pregnant Patients

Labor and Delivery

Communication is critical when preparing to transfer the patient to the hospital for labor and delivery in order 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 to 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 for signs and symptoms of intoxication or withdrawal during the postpartum period is important since as fluid shifts and volume of distribution change, medication doses may need to be adjusted.
- Breastfeeding is recommended in women 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.
- Women 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 conjugal visitations, discuss postpartum contraception options.
- Monitor the patient for postpartum depression.
- Maintain 'PREGNANCY' designation in the MCC for at least six weeks post-partum in order to continue bottom bunk assignment and other restrictions.
- MAT is continued by the Addiction Medicine Provider, as clinically appropriate.

Monitoring

Close monitoring is important to the health and safety for both the mother and baby.

- The frequency of UDS to monitor 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 monthly and more often as clinically indicated (e.g., during dose adjustments).
- An EKG should be performed at baseline (within the first month of initiating MAT) and annually to monitor for QT Prolongation.

Appendix References

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PATIENT EDUCATION/SELF-MANAGEMENT
OPIOID USE DISORDER (OUD)

WHAT IS OPIOID USE DISORDER?

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

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

Symptoms include:

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

WHAT ARE THE COMPLICATIONS CAUSED BY OPIOID USE DISORDER?

Short-term

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

Longer-term

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

HOW IS IT TREATED?

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

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

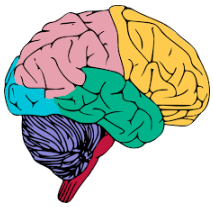
- Move away from doing things that are harmful to you
- Change addictive thoughts into healthy thoughts
- Make healthy decisions
- Handle setbacks and stress
- Deal with feelings such as depression or low self-esteem
- Recognize the cues and habits that lead to opioid use

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

PATIENT EDUCATION/SELF-MANAGEMENT
ALCOHOL USE DISORDER (AUD)

ALCOHOL USE DISORDER: WHAT IS IT?

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



WHAT COMPLICATIONS ARE CAUSED BY ALCOHOL USE DISORDER?

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

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

CONSEQUENCES OF ALCOHOL USE

Short-term

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

Longer-term

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

HOW IS ALCOHOL USE DISORDER TREATED?

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

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

CBI may help you learn to:

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

PATIENT EDUCATION/SELF-MANAGEMENT
RELAPSE PREVENTION

WHAT IS A RELAPSE?

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

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

SIGNS AND RISKS OF RELAPSE

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

Signs and Risks of Relapse:

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

STRATEGIES FOR PREVENTING RELAPSE

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

PATIENT EDUCATION/SELF-MANAGEMENT
OVERDOSE PREVENTION

WHAT IS AN OVERDOSE?

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

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

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

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

RISKS FOR OVERDOSE

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

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

SIGNS OF OVERDOSE

- Slow and difficult breathing
- Fingernails and lips turning blue or purple
- Very small "pinpoint" pupils
- Slow heartbeat and/or low blood pressure
- Cold, clammy skin
- Frequent vomiting
- Extreme sleepiness or unable to wake up
- Dizziness and confusion

STRATEGIES FOR PREVENTING OVERDOSE

⇒ Start at a lower dose or do a test shot if you haven't used in a while (because in the hospital, jail, or detox) because your body is not used to the same amount as before.

⇒ Don't use alone (no one can help you).

⇒ Don't mix drugs like benzos, alcohol, and opioids (like heroin).

PATIENT EDUCATION—SUBLOCADE®

What is Sublocade®?

- Sublocade® is a type of buprenorphine (BUE-pre-NOR-feen) that is injected. It is used to treat adults with addiction to opioid drugs.
- Sublocade® is given every 28 days by a nurse. It helps control withdrawal and reduce opioid cravings.

Tell your provider if any of the following applies before starting Sublocade®:

- 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 Sublocade®:

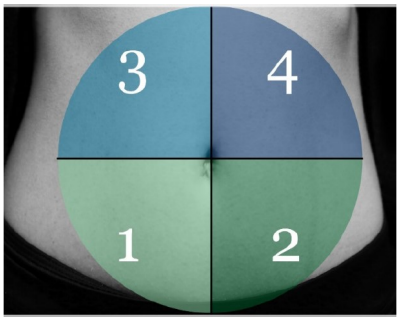
- Before you take Sublocade® you should have taken buprenorphine under the tongue for at least 7 days. This will help control withdrawal symptoms.
- Make sure that your follow-up visit has been scheduled.
- Ask your doctor any questions you have about this medicine.

How does Sublocade® work?

- Sublocade® is injected under the skin into the fat of your stomach. This then forms into a firm gel which is called a depot (dee-poh).
- 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.
- Sublocade® 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.
- Each month the injection site will change to a different area of the abdomen. *(This is pictured to the right.)*
- As medicine releases into your body, the bump gets smaller.
- Do not try to remove the depot. Do not rub the injection site. Try to not let belts or waistbands rub the injection site.



When to Contact Your Provider:

Contact your health care provider right away if you get any of these symptoms:

- 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

Continued use of opioids medicines, benzodiazepines, alcohol, and other substances, can cause severe side effects. Make sure your provider knows which medicines you are taking before you are prescribed Sublocade®.

PATIENT EDUCATION—MAT FOR OUD DURING PREGNANCY

WHAT ARE THE RISKS OF OUD DURING PREGNANCY?

OUD in pregnancy has a high risk of serious complications to you and your baby including:

- Fetal growth problems
- Preterm birth
- Stillbirth/death
- Increased risk of infection for the mother

You are also at risk of overdose. If you take too much of the drug you can pass out, your breathing can slow down or stop and you can die.

If you are on Medication-Assisted Treatment (MAT), it is helpful to you and your baby to continue the medication. Stopping MAT is dangerous, and increases risks for you and your baby.

HOW DOES OPIOID USE DURING PREGNANCY AFFECT A NEWBORN?

When a baby is born to a woman who used opioids during pregnancy, they may have withdrawal symptoms. This is called neonatal abstinence syndrome (also known as NAS) and can last for days to weeks or months.

Symptoms of NAS include:

- Shaking and tremors
- Poor feeding or sucking
- Inconsolable crying
- Fever
- Diarrhea
- Vomiting
- Sleep problems

NAS is a treatable condition, generally with no long-term effects on development. The use of other substances can make NAS syndrome worse in your baby. You should avoid smoking, alcohol use, and any other illicit drugs.

CAN I BREASTFEED WHILE ON MAT?

Only a very small amount of MAT medication is transferred through breastmilk, so mothers on buprenorphine or methadone are still able to breast feed their newborns.

Additionally, breast feeding provides many health benefits, and has been shown to reduce the severity or length of NAS.

COMMUNITY PRISON MOTHER PROGRAM

The Community Prison Mother Program provides an opportunity for pregnant individuals and mothers with children under the age of six to be housed with their children in a facility away from the prison setting. The focus is promoting family bonds and providing education on parenting skills. The program also helps address substance use issues.

If you would like to be part of this program, discuss with your health care team.

RESUMEN	APOYO PARA TOMAR DECISIONES	EDUCACIÓN PARA EL PACIENTE/CONTROL PERSONAL DEL CASO

EDUCACIÓN PARA EL PACIENTE/CONTROL PERSONAL DEL CASO
TRASTORNO POR CONSUMO DE OPIOIDES (TCO)

¿QUÉ ES EL TRASTORNO POR CONSUMO DE OPIOIDES?

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

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

Los síntomas incluyen:

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

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

A corto plazo

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

A largo plazo

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

¿CÓMO SE TRATA?

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

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

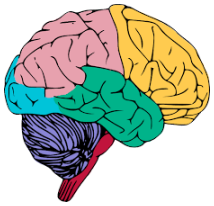
Las intervenciones cognitivas conductuales pueden ayudarle a:

- Alejarse de situaciones que sean peligrosas para usted
- Cambiar pensamientos adictivos por otros saludables
- Tomar decisiones saludables
- Manejar las complicaciones y el estrés
- Lidiar con sentimientos de depresión o baja autoestima
- Reconocer los impulsos y hábitos que conducen al consumo de opioides
- Algunos medicamentos MAT pueden afectar su salud dental. Hable con su dentista sobre preocupaciones.

RESUMEN	APOYO PARA TOMAR DECISIONES	EDUCACIÓN PARA EL PACIENTE/CONTROL PERSONAL DEL CASO

EDUCACIÓN PARA EL PACIENTE/CONTROL PERSONAL DEL CASO
TRASTORNO POR CONSUMO DE ALCOHOL (TCA)

TRASTORNO POR CONSUMO DE ALCOHOL: ¿QUÉ ES?



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

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

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

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

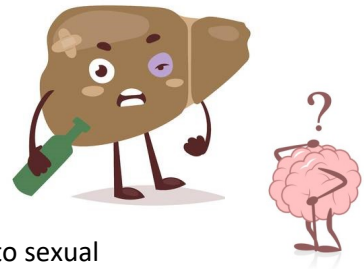
Este Trastorno por Consumo de Alcohol puede dañar las relaciones de una persona. A menudo, el deseo de beber puede superar el deseo de participar en otras actividades sociales como pasar tiempo con la familia o amigos. En casos más graves, también puede afectar la capacidad de una persona para asumir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

CONSECUENCIAS DEL USO DEL ALCOHOL

A corto plazo

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

A largo plazo



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

¿CÓMO SE TRATA EL TRASTORNO POR CONSUMO DE ALCOHOL?

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

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

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

Las intervenciones cognitivas conductuales pueden ayudarle a:

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

Resumen	Apoyo para tomar decisiones	Educación Para El Paciente/Control Personal Del Caso

Educación Para El Paciente/Control Personal Del Caso
Prevención de sobredosis

¿Qué es una sobredosis?

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

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

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

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

Riesgo de sobredosis

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

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

Signos de una sobredosis

- Respiración lenta y difícil
- Las uñas y los labios se tornan azules o morados
- Pupilas muy pequeñas, como puntos
- Latidos cardíacos lentos y/o presión arterial baja
- Vómitos frecuentes
- Somnolencia extrema o incapacidad para despertarse
- Mareos y confusión

Estrategias para prevenir una sobredosis

⇒ Comience con una dosis más baja o aplique una inyección de prueba si no la ha usado por un tiempo (ha estado en el hospital, en la cárcel o en un centro de desintoxicación), porque su cuerpo no está acostumbrado a la misma cantidad que antes.

⇒ No lo use si esta solo (nadie puede ayudarle).

⇒ No mezcle drogas como benzodiacepinas, alcohol y opioides (como la heroína).

RESUMEN	APOYO PARA TOMAR DECISIONES	EDUCACIÓN PARA EL PACIENTE/CONTROL PERSONAL DEL CASO

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

¿QUÉ ES UNA RECAÍDA?

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

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

SIGNOS Y RIESGOS DE UNA RECAÍDA

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

Signos y riesgos de una recaída:

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

ESTRATEGIAS PARA PREVENIR UNA RECAÍDA

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

PREVENCIÓN DE RECAÍDAS

EDUCACIÓN DEL PACIENTE—SUBLOCADE®

¿Qué es Sublocade®?

- Sublocade® es un tipo de buprenorfina que se inyecta. Se utiliza para tratar a los adultos con adicción a los medicamentos opiáceos.
- Sublocade® es administrado cada 28 días por una enfermera. Ayuda a controlar el síndrome de abstinencia y a reducir el deseo de consumir opiáceos.

Informe a su proveedor si algo de lo siguiente es aplicable, antes de comenzar a usar Sublocade®:

- Problemas respiratorios o pulmonares
- Problemas para orinar
- Hígado, vesícula biliar o riñón problemas
- Una lesión en la cabeza o en el cerebro
- Problemas de la glándula tiroides
- Embarazo o lactancia materna

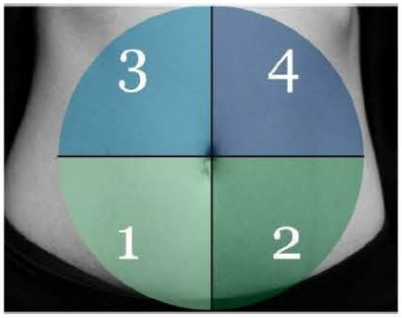
Antes de comenzar el tratamiento con Sublocade®:

- Antes de tomar Sublocade® debe haber tomado buprenorfina debajo de la lengua, durante al menos 7 días. Esto ayudará a controlar los síntomas de abstinencia.
- Asegúrese de que se ha programado su consulta de seguimiento.
- Pregunte a su médico cualquier duda que tenga sobre este medicamento.

¿Cómo funciona Sublocade®?

- Sublocade® se inyecta bajo la piel en la grasa del estómago. A continuación, se forma un gel firme que se denomina depósito.
- El depósito libera medicamentos a lo largo del mes.
- Deberá regresar mensualmente para recibir su dosis. Si se olvida de su dosis, comuníqueselo a su equipo de atención médica de inmediato.
- Sublocade® 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.
- Cada mes, el lugar de la inyección cambiará a una zona diferente del abdomen. *(Esto se muestra en la imagen de la derecha).*
- A medida que el medicamento se libera en su cuerpo, el bulto se hace más pequeño.
- No intente quitar el depósito. No frote el lugar de la inyección. Procure que los cinturones o las fajas no rocen el lugar de la inyección.

Cuándo contactar con su proveedor:

Póngase en contacto con su proveedor de atención médica de inmediato, si presenta alguno de estos síntomas:

- Agitación
- Sudar más de lo normal
- Sentir calor o frío más de lo normal
- Goteo nasal
- Ojos acuosos
- Piel de gallina
- Diarrea
- Vómitos
- Dolores musculares
- Enrojecimiento y dolor en el lugar de la inyección

El uso continuo de medicamentos opiáceos, benzodiacepinas, alcohol y otras sustancias, puede causar efectos secundarios graves. Asegúrese de que su proveedor sabe qué medicamentos está tomando antes de que le receten Sublocade®.

RESUMEN	APOYO PARA TOMAR DECISIONES	EDUCACIÓN PARA EL PACIENTE/CONTROL PERSONAL DEL CASO

EDUCACIÓN PARA EL PACIENTE– TAM PARA EL OUD DURANTE EL EMBARAZO

¿CUÁLES SON LOS RIESGOS DEL OUD DURANTE EL EMBARAZO?

El trastorno por consumo de opioides (OUD, por sus siglas en inglés) durante el embarazo conlleva un alto riesgo de complicaciones de carácter grave para ti y para tu bebé, incluidas:

- Problemas de crecimiento fetal
- Nacimiento prematuro
- Mortinato/muerte
- Mayor riesgo para la madre de sufrir una infección

También corres el riesgo de sufrir una sobredosis. Si consumes una cantidad excesiva de la medicación puedes desmayarte, tu respiración puede ser más lenta o detenerse y puedes morir.
Si estás en Tratamiento Asistido con Medicamentos (MAT, por sus siglas en inglés), es recomendable para ti y para tu bebé continuar con la medicación. Suspender el TAM es peligroso, y aumenta los riesgos para ti y tu bebé.

¿CÓMO AFECTA EL CONSUMO DE OPIOIDES DURANTE EL EMBARAZO AL RECIÉN NACIDO?

Cuando un bebé nace de una mujer que ha consumido opioides durante el embarazo, puede tener síntomas de abstinencia. Esto se llama síndrome de abstinencia neonatal (también conocido como NAS, por sus siglas en inglés) y puede prolongarse durante días, semanas o meses.

Los síntomas del NAS incluyen:

- Estrecimiento y tremblors
- Alimentación o lactancia deficientes
- Llanto inconsolable
- Fiebre
- Diarrea
- Vómitos
- Problemas para dormir

El NAS es una condición tratable, generalmente sin efectos a largo plazo en el desarrollo.
El consumo de otras sustancias puede empeorar el síndrome NAS en tu bebé.
Debes evitar fumar, consumir alcohol y cualquier otra droga ilícita.

¿PUEDO AMAMANTAR MIENTRAS ESTOY CON EL TAM?

Solo una cantidad muy pequeña de la medicación del TAM se transfiere a través de la leche materna, por lo que las madres que toman buprenorfina o metadona pueden continuar amamantando a sus recién nacidos.
Asimismo, la lactancia materna proporciona muchos beneficios para la salud y se ha demostrado que reduce la gravedad o la duración del NAS.

PROGRAMA COMUNITARIO PARA MADRES EN PRISIÓN

El Programa Comunitario para Madres en Prisión ofrece a las embarazadas y a las madres con hijos menores de seis años la oportunidad de ser alojadas con sus hijos en un centro alejado del entorno penitenciario. El enfoque es promover los vínculos familiares y proporcionar educación sobre prácticas de crianza. El programa también ayuda a abordar los problemas de consumo de sustancias.
Si desea formar parte de este programa, consúltelo con su equipo de atención médica.

Attachment A

NIDA Quick Screen V1.0[8]

(Health care staff completes with patient)

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

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 http://archinte.ama-assn.org/cgi/reprint/170/13/1155) *and the National Institute on Alcohol Abuse and Alcoholism's screening question on heavy drinking days (available at http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm). The NIDA-modified ASSIST was adapted from the World Health Organization (WHO) Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), Version 3.0, developed and published by WHO (available at http:/www.who.int/substance_abuse/ activities/assist_v3_english.pdf).*

CCHCS Care Guide: Substance Use Disorder

Attachment B

Health care staff completes with patient

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

NIDA-Modified ASSIST V2.0[9]

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

Question 2 of 8, NIDA-Modified ASSIST **2. In the past three months, how often have you used the substances you mentioned (first drug, second drug, etc.)?**	**Never**	**Once or twice**	**Monthly**	**Weekly**	**Daily or Almost Daily**
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/.

CCHCS Care Guide: Substance Use Disorder

NIDA-Modified ASSIST V2.0

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

CCHCS Care Guide: Substance Use Disorder

Attachment B

NIDA-Modified ASSIST V2.0

5. During the past three months, how often have you failed to do what was normally expected of you because of your use of (first drug, second drug, etc.)?	**Never**	**Once or twice**	**Monthly**	**Weekly**	**Daily or Almost Daily**
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
b. Cocaine (coke, crack, etc.)	0	5	6	7	8
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	5	6	7	8
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	5	6	7	8
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	5	6	7	8
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHC, etc.)	0	5	6	7	8
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	5	6	7	8
h. Street opioids (heroin, opium, etc.)	0	5	6	7	8
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	5	6	7	8
j. Other- specify: 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

Attachment B

NIDA-Modified ASSIST V2.0

7. Have you ever tried and failed to control, cut down or stop using (first drug, second drug, etc.)?	No, Never	Yes, but not in the past 3 months	Yes, in the past 3 months
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	6
b. Cocaine (coke, crack, etc.)	0	3	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	6
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	0	3	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	6
h. Street opioids (heroin, opium, etc.)	0	3	6
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	6
j. Other- specify: 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.
  - If the patient responds that they inject once weekly or less OR fewer than 3 days in a row, provide a brief intervention including a discussion of the risks associated with injecting.
  - If the patient responds that they inject more than once per week OR 3 or more days in a row, refer for further assessment.

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

Scoring the full NIDA-Modified ASSIST:

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

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

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

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

December 2022

URINE DRUG SCREEN MONITORING: METABOLITES AND DETECTION TIME

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

Monitoring MAT – Expected Results on UDS and Confirmatory Testing

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

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

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

URINE DRUG SCREEN MONITORING: METABOLITES AND DETECTION TIME (CONT)

Monitoring MAT – Expected Results on UDS and Confirmatory Testing

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

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

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

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

STATE OF CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION

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

CDCR 7240 (Rev. 02/22) Page 1 of 1

I consent to allowing_____ (my provider) to prescribe Medication-Assisted Treatment (MAT) as part of my Substance-Use-Disorder (SUD) Treatment Plan.

I understand that my MAT agent selected is:

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

If I miss a dose, I will let health care staff know so that I can receive my dose as soon as possible.

Skipping doses may increase risk of harm.

I understand that MAT has risks related to the agent used and 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**. Residual medication in the mouth, especially with sublingual films, may increase dental erosions if I am not attentive to my oral health care.
- **Risk of an Overdose.** Especially if used with other medications, alcohol, or illegal drugs. This can cause death.
- **Physical Dependence.** If medication is suddenly stopped, I may be at increased risk for overdose or withdrawal symptoms (flu like symptoms: nausea, diarrhea, aches, sweats, chills, irritability, tremors, and confusion), which are uncomfortable, but not life threatening.
- **Physical Deformity.** Injectable medication may be visible to and/or felt by others in the injection area.

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

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

I understand that if I violate this agreement in any way, my provider may alter treatment and follow-up frequency.

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

Patient Name (print): _____ Patient Signature: _____ Date/Time: _____

Provider Name (print): _____ Provider Signature: _____ Date/Time: _____

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: 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

Distribution: Original - Patient Chart; Copy - Patient

REFUSAL OF EXAMINATION AND/OR TREATMENT—CDCR 7225

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

DEPARTMENT OF CORRECTIONS AND REHABILITATION

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:
☐ TABE score ≤ 4.0
☐ DPH ☐ DPV ☐ LD
☐ DPS ☐ DNH
☐ DDP
☐ Not Applicable

2. Accommodation:
☐ Additional time
☐ Equipment ☐ SLI
☐ Louder ☐ Slower
☐ Basic ☐ Transcribe
☐ Other*

3. Effective Communication:
☐ Patient asked questions
☐ Patient summed information
Please check one:
☐ Not reached* ☐ Reached
*See chrono/notes

4. Comments:

CDCR #:
Last Name:
First Name: MI:
DOB: