Wexford Health
SOURCES INCORPORATED

Medical Guidelines

Region: Jails

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Corporate Authorization

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The Medical Guidelines are reviewed annually but may not require revision. If a change is made, a revision date will be added and updated accordingly.

Preface

This manual is intended to serve as a reference tool for clinicians practicing medicine in the jails and prisons served by Wexford Health Sources, Inc. (Wexford Health). The manual contains clinical pathways, treatment protocols, and algorithms designed to promote a standard level of quality and care at Wexford Health sites. The goal of each clinical pathway is to assist the clinician in reaching the best possible outcome for each patient, while reducing opportunities for errors or inefficiencies. Wexford Health's clinicians should incorporate the tools in this manual into daily practice.

The manual has been developed, and is maintained, by the Medical Advisory Committee of Wexford Health. This committee is composed of clinical and administrative peers charged with developing consensus on clinical issues utilizing the most recent professional standards, evidence-based studies, and accepted practices.

Clinical pathways do not replace sound clinical judgment, nor are they intended to strictly apply to all patients. The specific strategies and pathways presented in this manual provide a clinical management approach, but their application is a decision made by the practitioner accounting for individual circumstances.

Medical management and information is continually changing as better treatments, testing, or approaches are learned. Consequently, some items in this manual may become obsolete and, as a result, this manual will continually evolve. **Clinicians practicing at Wexford Health sites are encouraged to assist in keeping this manual updated and useful by presenting new information, sharing successful clinical approaches, and informing of adverse or suboptimal outcomes.**

As always, Wexford Health encourages its practitioners to utilize all accepted resources in providing care, as well as the leadership and advisement of its varied staff of medical directors and administrators. The "Quest for Excellence" is never complete.

If there are any conflicts between these guidelines and client-specific policies, administrative directives or institutional directives, then the respective client-specific policies, administrative directives or institutional directives language is controlling to resolve such conflict. In cases where state and local laws differ from these guidelines, Wexford Health will comply with the applicable local or state law.

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M-003: Drug Intoxication/Withdrawal Guidelines

Reference: ACA: 5-ACI-6A-41; 5-ACI-6A-42; NCCHC: F-04

I. DEFINITION

A group of symptoms brought about by abrupt discontinuance of heavy prolonged use of a specific class of drugs. The drugs may or not cause dependence, but all have a potential detrimental effect on the body. The goal is to preempt problems before they become life threatening. Drugs of high abuse and/or concern in the intoxication/withdrawal process include: alcohol, amphetamines, barbiturates, benzodiazepines, beta-adrenergic blockers, cocaine, hallucinogenics, and opiates.

The appearance of symptoms will vary by the amount of time the drug was used, the actual drug used, i.e., half-life, the status of the liver, and the concomitant use of other agents. The basic principle of pharmacodynamics is that it will take five (5) half-lives for the drug to be cleared and therefore, at least that long for symptoms to occur. That is to say that a short half-life drug like alcohol may exhibit the first signs of withdrawal in 12 to 24 hours after the last ingestion, whereas a long half-life drug like methadone may require 5 to 7 days after the last ingestion to exhibit withdrawal symptoms.

The goal is to prevent full-blown withdrawal, with all its accompanying physiologic aberrations from manifesting itself.

II. INFORMATION

Substance use disorders are highly prevalent among inmate populations, affecting an estimated 30--60% of inmates. Drug intoxication and withdrawal may be particularly evident at the time of incarceration. The Bureau of Justice Statistics reports that an estimated 70% of all inmates in local jail facilities in the U.S. had committed a drug offense or used drugs regularly, and an estimated 35% were under the influence of drugs at the time of the offense.

Any substance that alters perception, mood, or cognition can be abused. Commonly identified substances of abuse include illicit drugs, alcohol, and certain prescription drugs, which act through their hallucinogenic, stimulant, sedative, hypnotic, anxiolytic, or narcotic effects. Other less commonly recognized substances of abuse include medications with anticholinergic, antihistaminic, or stimulant effects, e.g., tricyclic antidepressants, antiparkinsonian agents, low potency antipsychotics, anti-emetics, and cold and allergy preparations.

Substances that produce dangerous withdrawal syndromes for individuals with physiological dependence include alcohol, sedative/hypnotics, and anxiolytics. Withdrawal from narcotics is not generally considered dangerous, except in pregnant women and the medically debilitated; however, narcotic withdrawal does result in significant symptomatology, which can be markedly reduced with targeted therapies.

Not all substances of abuse produce clinically significant withdrawal syndromes. However, discontinuing substances on which an individual is dependent will likely produce some psychological symptoms. Withdrawal from substances such as stimulants, cocaine, hallucinogens, and inhalants can be accomplished with psychological support and symptomatic treatment alone, along with periodic reassessment by a health care provider.

III. GUIDELINE

A. Function: This procedure is to facilitate and guide in the evaluation and treatment of alcohol/drug withdrawal. Detoxification is done by coordinating staff members but only under medical supervision of a physician in accordance with local, state, and federal laws when performed at the facility.

B. Inmates experiencing severe, life-threatening intoxication or withdrawal as described in this guideline should be transferred to a facility where specialized care is available.

C. Circumstances under which the licensed nurse may perform the function:

1. Setting: Wexford Health contracted sites.

2. Supervision: No direct supervision is required at the time of identifying and initiating care. Overall the Supervising Nurse, Medical Director, and/or clinic physicians, including contract and on-call physician as appropriate, provide supervision.

3. Patient conditions: Nurses shall routinely reevaluate and care for inmate health complaints following written procedures and order(s) by the responsible physician(s).

IV. PROTOCOL

Withdrawal can be a life-threatening situation. During intake screening an inmate should be questioned on alcohol and drug use using the intake screening tool. It is incumbent upon the staff to initiate withdrawal, detoxification protocols as soon as it is identified that the inmate has been actively using drugs that cause withdrawal symptoms or significant amounts of alcohol. (See attached Physician Detox Orders on Admission.)

A urine drug screen (UDS) is a cost-effective tool that may be used to determine an accurate listing of the substances of abuse instead of relying fully on the patient's history. Remember that claims of drug use/abuse may be exaggerated and/or diminished by the patient. Based on the clinical evaluation of the inmate, the staff member may contact the provider for orders for a UDS.

Do not wait until symptoms of withdrawal are evident to begin monitoring and/or therapy. Evaluation and monitoring of the inmate with potential withdrawal should begin at intake with the completion of the appropriate clinical monitoring tool.

Once the drug has washed out of the body (typically 5 half-lives), the withdrawal protocols can usually be terminated. Every case will be different, but it is important to begin therapy early. Signs and symptoms will vary but generally fall into the listed categories.

Opioids in Pregnancy. A urine drug screen should be completed on all pregnant female inmates at intake. Staff should not rely only on the inmate's reported drug use. Abrupt withdrawal of opiates in pregnancy may result in miscarriage, stillbirth or pre-term labor so substitution of alternative opioid narcotics like Methadone or Subutex is recommended.

V. NURSING MEASURES

A. Alcohol Withdrawal

1. General information:

a. The alcohol withdrawal syndrome can develop in any individual who has a history of regular, heavy use of alcohol, has a known dependence on alcohol, or has clinical signs of intoxication.

b. Alcohol withdrawal syndromes can be mild, moderate, or life-threatening. The severity of an individual's alcohol withdrawal syndrome is difficult to predict, although a history of problems with withdrawal makes it likely that a similarly severe withdrawal syndrome will occur again.

c. Individuals with a high blood alcohol level (>100 mg/dL) and concurrent signs of withdrawal are at particularly high risk for a severe withdrawal syndrome.

d. Uncomplicated alcohol withdrawal is generally completed within four to five days. Alcohol withdrawal symptoms can develop within a few hours of decreasing or discontinuing use. Symptoms generally peak within 24–36 hours after abstinence begins.

e. Early signs and symptoms of withdrawal include gastrointestinal distress, anxiety, irritability, increased blood pressure, and increased heart rate. Later,

symptoms of moderate intensity develop, including insomnia, tremor, fever, anorexia, and diaphoresis.

f. CIWA. The inmate's status should be scored using the Clinical Institute Withdrawal Assessment of Alcohol, (CIWA). The CIWA is an evidence-based scoring system that should be used over time to objectively assess the severity and progression of alcohol withdrawal symptoms.

2. Guidelines for using the *Alcohol/Drug Withdrawal Assessment and Treatment Flowsheet*:

a. The CIWA scale is the most sensitive tool for assessing a patient who is experiencing alcohol withdrawal.

b. Early intervention for a **CIWA score of 8 or greater** provides the best means of preventing the progression of withdrawal.

c. Use the attached *Alcohol/Drug Withdrawal Assessment and Treatment Flowsheet* to document the patient's vitals and CIWA scores, as well as the administration of PRN medications.

d. Follow the Assessment Protocol shown at the top of the flowsheet. Record the date, time, vitals, and the CIWA ratings and Total Score each time the patient is assessed.

e. To calculate the total CIWA score, rate the patient according to each of the 10 CIWA criteria, and then add together the 10 ratings. Each criterion is rated on a scale from 0 to 7 (except for "Orientation and Clouding of Sensorium," which is rated on a scale from 0 to 4). The health care professional can select any rating from 0 to 7 (or 0 to 4, in the case of "Orientation"), even for criteria where not every number on the rating scale is defined.

3. Complete the CIWA form at each assessment.

4. Do record in the medical record any signs of trauma, intoxication: odor of alcohol, or unsteady gait.

5. Record in the medical record any signs of liver disease: jaundice, or ascites.

6. Place on Detox protocol after contacting Clinician for approval. (See attached *Physician Detox Orders on Admission.*)

NOTE: While breathalyzers are not routinely performed onsite, if there is any report of a detainee who registers a 0.300 or above on a breathalyzer the detainee is to be sent to the Emergency Room unless previously medically cleared by the hospital.

If the detainee that blows a 0.300 or above on a breathalyzer has been medically cleared to return to the facility, he/she must be placed in the infirmary for observation.

B. **Amphetamine withdrawal:** (Methamphetamines, uppers, stimulants, Dexedrine, Benzedrine, Adderall, speed etc.) Symptoms include: hyperactivity, irritability, delirium, hallucinations, psychosis, mydriasis, hyperpyrexia, hypertension, arrhythmias, vomiting, and diarrhea.

1. Record the type, amount, route of ingestion, and duration of habit.

2. Note and record vital signs daily for three days, if needed

3. Evaluate patient for:

a. Nutritional status

b. Mental alertness

c. Neurological dysfunction

d. Restlessness

e. Abnormal or variable pulse and blood pressure

f. Place on detox protocol after contacting clinician for approval.

g. Document in patient's file

C. **Barbiturate withdrawal** ("downers", sedatives, Amytal, Donnatol, Seconal, Quaaludes, etc.). Symptoms depend on which stage of withdrawal and may include:

1. Early Withdrawal

   a. Increased pulse and blood pressure, anxiety, panic attacks, restlessness, and gastrointestinal upset.

2. Mid Withdrawal

   a. In addition to the above early withdrawal symptoms, may progress to include tremor, fever, diaphoresis, insomnia, anorexia, and diarrhea.

3. Late Withdrawal

   a. If left untreated, a delirium may develop with hallucinations, changes in consciousness, profound agitation, autonomic instability, seizures, and death.

   b. Patients showing signs of late (severe) withdrawal may need to be hospitalized if treatment cannot be given.

4. Inmates experiencing barbiturate withdrawal should generally be actively medicated.

5. Phenobarbital. Substitute phenobarbital for the drug of abuse in equivalent doses – Equivalent doses can be found in the Federal Bureau of Prisons Clinical Practice Guideline for Chemically Dependent Inmates which is available at: http://www.bop.gov/resources/pdfs/detoxification.pdf

6. Specific treatment strategies for barbiturate withdrawal should be determined by the condition of the individual inmate, and should be reviewed and approved by a clinician.

7. Record the type, amount, and frequency of ingestion and duration of habit.

8. Place on detox protocol after contacting clinician for approval.

9. Utilizing the CIWA flowsheet record vital signs and assessments.

10. Should convulsions start, call clinician immediately.

11. Contact clinician for orders for disorientation, severe agitation, severe tremors, diaphoresis, pulse greater than 120, blood pressure greater than 150/100, temperature >101°F.

12. Should psychosis or hallucinations be present contact the clinician/psychiatrist for further orders.

D. **Benzodiazepine withdrawal** (e.g., Valium, Xanax, Dalmane). Symptoms depend on which stage of withdrawal and include:

1. Early Withdrawal

   a. Increased pulse and blood pressure, anxiety, panic attacks, restlessness, and gastrointestinal upset.

2. Mid Withdrawal

   a. In addition to the above early withdrawal symptoms, may progress to include tremor, fever, diaphoresis, insomnia, anorexia, and diarrhea.

3. Late Withdrawal

   a. If left untreated, a delirium may develop with hallucinations, changes in consciousness, profound agitation, autonomic instability, seizures, and death.

b. Patients showing signs of late (severe) withdrawal may need to be hospitalized if treatment cannot be given.

4. Record type, amount, and frequency of ingestion and duration of habit.

5. Record level of consciousness, general appearance, orientation, character of speech, pupil size and symmetry, and presence or absence of hallucinations.

6. Record vital signs.

7. Place on detox protocol after contacting clinician for approval.

E. **Beta blockade withdrawal** (Tenormin, Inderal, etc.). Symptoms include: hypertensive urgency, arrhythmias, angina, tremor, migraine, etc.

1. Record type, amount, and frequency of ingestion and duration of drug use. This class of drugs causes an acute exaggeration of sympathetic outflow upon abrupt cessation, i.e., if used for hypertension when stopped may cause blood pressure to soar.

2. Record level of consciousness, general appearance, and orientation.

3. Place on beta-blocker protocol, until verification of inmate's prescriptions, after contacting clinician for approval.

4. Record vital signs.

F. **Cocaine withdrawal.** Symptoms may include: depression, hypersomnia or insomnia, fatigue, anxiety, irritability, paranoia and decreased concentration.

1. Most cases of cocaine withdrawal do not require medical therapy.

2. Record the amount, route, and duration of habit/use.

3. If warranted, record vitals 4 times daily.

4. Place on detox protocol after contacting clinician for approval.

NOTE: Cocaine intoxication as demonstrated by sympathetic stimulation including advanced hypertension, tachycardia and tachypnea need heart protection and therefore requires immediate clinician notification.

Any detainee suspected of ingesting cocaine (balloon, etc.) is not to be accepted into the jail (medically) until cleared by an E.R. physician.

G. **Hallucinogen intoxication/withdrawal** (LSD, PCP, mescaline, psilocybin, THC, etc.). Symptoms of acute intoxication include: agitation, violent behavior, hypertension, tachycardia, nystagmus, impervious to pain, self-destructive, etc.

1. Symptoms of intoxication following ingestion of hallucinogenic substances may result in a state that produces a heightened "awareness of one's environment," distorted responses to sensory stimuli, and psychotic behavioral patterns.

2. Record the type, amount, and route of ingestion if possible.

3. Note and record vital signs.

4. Note and record presence or absence of:

   a. Hallucinations

   b. Distorted sensory perception

   c. Fever

   d. Coma

   e. Bizarre behavior patterns

5. While a typical withdrawal syndrome from hallucinogens has not been reported, it may be necessary to manage an acute intoxication.

6. Place patient in infirmary/medical housing and assign a calm, sympathetic person to frequently reassure patient during his period of intoxication/withdrawal.
7. Orient patient to reality frequently and protect him from obeying distracting or dangerous hallucinatory suggestions.
8. If restraints are considered, refer to treatment protocol for "Restraints."
9. Encourage fluids.
10. Place on detox protocol after contacting clinician for approval.
11. Contact clinician if vital signs become unstable or if patient is extremely agitated or appears to pose a threat to others or themselves.

H. **Opiate intoxication/withdrawal** (Heroin, codeine morphine, OxyContin, hydromorphone, Methadone, etc.). Symptoms include: depressed consciousness, miosis, respiratory depression, etc.

1. Record amount, route, and duration of habit/use. Taking into account the possibility of exaggerated dosages.
2. Keep patient on bed rest.
3. Place on detox protocol after contacting clinician for approval.
4. Record on the *Clinical Opioid Withdrawal Scale (COWS)* the presence or absence of signs and symptoms and calculate the severity score of the withdrawal:
5. Record vital signs.
6. Call clinician immediately for any patient suspected of having a severe narcotic withdrawal by either symptoms or through the COWS assessment.
7. DO NOT STOP OPIATES IN PREGNANT FEMALES.
    a. Obtain a urine drug screen.
    b. Immediate notification of the responsible provider is needed.
    c. Methadone induction in a licensed methadone program needs to be arranged ASAP and may in some cases require hospitalization for induction of Methadone or the substitution of prescription narcotics to prevent withdrawal.
8. Remember that claims of past substance abuse are often exaggerated.

I. **Polysubstance withdrawal**

1. It is generally best practice to prioritize the substances an individual has been dependent on and treat them according to the severity of the withdrawal produced by the substance.
2. The substances with the most serious withdrawal syndromes, those where the withdrawal syndrome can be fatal, are alcohol and sedative-hypnotics which includes barbiturates and benzodiazepines.
3. It is acceptable to order additional protocols to address multiple withdrawals while avoiding duplication within a medication class (not duplicating Ativan (lorazepam) orders).
4. When treating patients detoxifying from substances other than barbiturates, benzodiazepines and/or alcohol, the management of opioid detoxification should be the next priority.
5. Generally, other substances of abuse, including stimulants, marijuana, hallucinogenics (LSD and similar drugs), and inhalants, will not require specific treatment in patients who are being detoxified from barbiturates, benzodiazepines, alcohol and/or opioids.

6. If the patient has been abusing multiple sedative-hypnotic substances or a sedative-hypnotic and alcohol, withdrawal should be handled in the same way as withdrawal from one such substance.

VI. ATTACHMENTS

M-003: Physician Detox Orders on Admission

M-003: Clinical Opioid Withdrawal Scale (COWS)

M-003: CIWA – Alcohol/Drug Withdrawal Assessment and Treatment Flowsheet

M-003 CIWA-B Clinical Evaluation Record Guideline

M-003 CIWA-B Clinical Evaluation Record

M-003: FORM: Physician Detox Orders on Admission

Wexford Health Sources Incorporated

Medical Policies and Procedures
PHYSICIAN DETOX ORDERS ON ADMISSION

Name: _____ ID#: _____

DOB: _____ Drug Allergies: _____

I.	**ADMISSION ORDERS - ALL DETOX PATIENT(S) – (VALID ONLY WHEN SIGNED AND DATED)**	
	1.	House at Health Service Unit/Infirmary Diagnosis: _____
	2.	House diet (if vomiting, diarrhea, or signs of dehydration, give full liquid diet x 48 hours and inform clinician if symptoms persist).
	3.	Vital signs once per shift unless otherwise specified by clinician and/or until cleared from detox.
	4.	Multivitamin 1 tablet p.o. daily while in health services housing or infirmary.
	5.	Folic acid 1 mg 1 tablet p.o. daily while in health services housing or infirmary.
	6.	Increase oral fluids.
	CLINICIAN SIGNATURE _____ DATE _____ TIME _____	
II.	**ALCOHOL DETOX FOR MOST INMATES – (VALID ONLY WHEN SIGNED AND DATED)**	
	1.	Draw labs for CBC, CMP and Mg.
	2.	Obtain and send out urine drug screen.
	3.	Seizure precautions x 72 hours.
	4.	Thiamine 100 mg 1 tablet p.o. x 10 days.
	5.	Maalox 30 cc p.o. t.i.d. p.r.n. x 72 hours.
	6.	MOM 60 cc p.o. p.r.n. at h.s. for constipation x 72 hours.

Recommended Lorazepam Treatment Schedule Based on CIWA Score

7.	Mild Withdrawal (CIWA 8–9)	Moderate Withdrawal (CIWA 10–15)	Severe Withdrawal (CIWA >15)
	Repeat CIWA every 4–8 hours until CIWA has remained <10 for 24 hours without medication	1. Administer lorazepam 2 mg p.o. or IM q 1 hour. 2. Repeat CIWA in 1 hour (90 minutes if giving lorazepam PO) 3. Repeat lorazepam 2 mg q 60–90 minutes until CIWA score < 10 then discontinue lorazepam. 4. Repeat CIWA q 4–8 hours until the score has remained < 10 for 24 hours. If the score rises again within this 24-hour period, repeat steps 1–3 above.	Discuss with clinician: • Hospitalization for inpatient detoxification and monitoring is strongly suggested. • Lorazepam is administered according to the same schedule as described under *Moderate Withdrawal*. However, an increase in frequency of both lorazepam and CIWA may be indicated. • Lorazepam can be given up to 2–4 mg IV as frequently as q 15–20 minutes. This would require a patient-specific order.

CLINICIAN SIGNATURE _____ DATE _____ TIME _____

III.	Alcohol Detox for INMATES WITH HISTORY OF ALCOHOL WITHDRAWAL SEIZURES OR CO-MORBID CARDIOVASCULAR CONDITIONS – (VALID ONLY WHEN SIGNED AND DATED)		
1.	CV conditions include: Hypertension, angina, CHF, History of MI or CVA. (Consider lorazepam treatment even if only mild withdrawal symptoms are present.)		
2.	Patients with a history of alcohol withdrawal seizures will generally present with signs and symptoms of moderate to severe withdrawal. DO NOT GIVE ANTI-SEIZURE MEDICATIONS unless the inmate also has an underlying seizure disorder. Carbamazepine may be useful in treating patient with a history of alcohol withdrawal seizures.		
3.	Draw labs for CBC, CMP and Mg.		
4.	Obtain and send out urine drug screen.		
5.	Seizure precautions x 72 hours.		
6.	Thiamine 100 mg 1 tablet p.o. daily x 10 days.		
7.	Maalox 30 cc p.o. t.i.d. p.r.n. x 72 hours.		
8.	MOM 60 cc p.o. p.r.n. at h.s. for constipation x 72 hours.		
	Recommended Lorazepam Treatment Schedule Based on CIWA Score		
9.	**Suggested Initial Regimen***	**Moderate Withdrawal (CIWA 10–15)**	**Severe Withdrawal (CIWA >15)**
	Days 1–2: Lorazepam 2 mg t.i.d. Days 3–4: Lorazepam 2 mg b.i.d. Day 5: Lorazepam 2 mg single dose (AM or HS) Days 1–6: Monitor CIWA t.i.d.**	1. Administer lorazepam 2 mg p.o. or IM q 1 hour 2. Repeat CIWA in 1 hour (90 minutes if giving lorazepam p.o.) 3. Repeat lorazepam 2 mg q 60–90 minutes until CIWA score <10 then discontinue lorazepam. 4. Repeat CIWA q 4–8 hrs. until the score has remained < 10 for 24 hours. If the score rises again within this 24-hour period, repeat steps 1–3 above.	Discuss with clinician: • Hospitalization for inpatient detoxification and monitoring is strongly suggested. • Lorazepam is administered according to the same schedule as described under *Moderate Withdrawal*. However, an increase in frequency of both lorazepam and CIWA may be indicated. • Lorazepam can be given up to 2–4 mg IV as frequently as q 15–20 minutes. This would require a patient-specific order.
	* In these cases, the dose of lorazepam may need to be decreased if the inmate experiences somnolence, ataxic gait, slurred speech, or other signs of medication intoxication		
	** If the CIWA score is ≥ 10 at any time, follow the steps for *Moderate Withdrawal* or *Severe Withdrawal*		
	CLINICIAN SIGNATURE _____ DATE _____ TIME _____		

Name: _____ ID#: _____

DOB: _____ Drug Allergies: _____

IV.	**DELIRIUM TREMENS** ORDER ONLY – (VALID ONLY WHEN SIGNED AND DATED) INSTITUTE DELIRIUM TREMORS SYMPTOM FLOW SHEET	
	1.	Admit to infirmary.
	3.	Thiamine 100 mg 1 tablet p.o. daily for 30 days.
	4.	If unable to administer Lorazepam p.o. to patient proceed as follows: Lorazepam (Ativan) 2 mg IM q 4 hours PRN agitation x 72 hours. If above Lorazepam inadequate to treat agitation, contact clinician.
	5.	If psychosis or ongoing severe agitation contact clinician for possible order for haloperidol 5 mg p.o. p.r.n. q 4 hours or haloperidol 2.5 mg IM q 2 hours p.r.n. agitation/confusion/psychosis.
	6.	Draw blood and obtain urine and send out: Urine Drug Screen, CBC, CMP, and Mg.
	CLINICIAN SIGNATURE _____ DATE _____ TIME _____	
V.	**AMPHETAMINE DETOX** – (VALID ONLY WHEN SIGNED AND DATED) INSTITUTE ALCOHOL/DRUG WITHDRAWAL SYMPTOM FLOW SHEET	
	1.	Obtain urine and send out for Urine Drug Screen.
	2.	Metoprolol 25 mg p.o. b.i.d. x 72 hours p.r.n. tachycardia (pulse > 100).
	3.	Lorazepam (Ativan) 0.5 mg p.o. BID x 72 hours p.r.n. agitation.
	4.	Haldol 0.5 mg p.o. b.i.d. x 72 hours p.r.n. hallucinations.
	CLINICIAN SIGNATURE _____ DATE _____ TIME _____	
VI.	**BARBITURATE DETOX** ORDER ONLY – (VALID ONLY WHEN SIGNED AND DATED) INSTITUTE ALCOHOL/DRUG WITHDRAWAL SYMPTOM FLOW SHEET	
	1.	Obtain urine and send out for Urine Drug Screen.
	2.	100 meq IV sodium bicarbonate ASAP, then 150 meq sodium bicarbonate in 1000 cc D5W IV @ 10 ml/kg/hr. until adequate urine output then reduce to 3 ml/kg/hr. x 72 hours.
	3.	Serum potassium each day x 96 hours. If < 3.5 meq add 20 meq KCL to each 1000 cc's fluid.
	CLINICIAN SIGNATURE _____ DATE _____ TIME _____	
VII.	**BENZODIAZEPINE DETOX** ORDER ONLY – (VALID ONLY WHEN SIGNED AND DATED) INSTITUTE ALCOHOL/DRUG WITHDRAWAL SYMPTOM FLOW SHEET	
	1.	Obtain urine and send out for Urine Drug Screen.
	2.	Lorazepam (Ativan) 1.0 mg p.o. t.i.d. x 48 hours start now, then Lorazepam (Ativan) 0.5 mg p.o. t.i.d. x 72 hours, then Lorazepam (Ativan) 0.5 mg p.o. b.i.d. x 72 hours, then Lorazepam (Ativan) 0.5 mg q h.s. x 48 hours, then DC.
	CLINICIAN SIGNATURE _____ DATE _____ TIME _____	

Name: _____ ID#: _____

DOB: _____ Drug Allergies: _____

VIII.	BETA BLOCKER WITHDRAWAL ORDER ONLY – (VALID ONLY WHEN SIGNED AND DATED) INSTITUTE ALCOHOL/DRUG WITHDRAWAL SYMPTOM FLOW SHEET	
	1.	Metoprolol 25 mg p.o. b.i.d. until actual agent and dosage can be verified.
	CLINICIAN SIGNATURE _____ DATE _____ TIME _____	
IX.	COCAINE DETOX – (VALID ONLY WHEN SIGNED AND DATED) INSTITUTE ALCOHOL/DRUG WITHDRAWAL SYMPTOM FLOW SHEET	
	1.	Obtain urine and send out for Urine Drug Screen.
	CLINICIAN SIGNATURE _____ DATE _____ TIME _____	
X.	HALLUCINOGENIC DETOX ORDER ONLY – (VALID ONLY WHEN SIGNED AND DATED)	
	1.	Obtain urine and send out for Urine Drug Screen.
	2.	Haldol 0.5 mg p.o. q.i.d. x 72 hours p.r.n. for acute agitation.
	CLINICIAN SIGNATURE _____ DATE _____ TIME _____	
XI.	OPIATE DETOX ORDER ONLY – (VALID ONLY WHEN SIGNED AND DATED) INSTITUTE ALCOHOL/DRUG WITHDRAWAL SYMPTOM FLOW SHEET	
	1.	Obtain urine and send out for Urine Drug Screen.
	2.	Clonidine 0.1 mg p.o. b.i.d. x 24 hours Clonidine 0.1 mg p.o. q.i.d. x 48 hours Clonidine 0.2 mg p.o. q.i.d. x 48 hours Clonidine 0.1 mg p.o. q.i.d. x 48 hours Clonidine 0.1 mg p.o. b.i.d. x 24 hours Hold if blood pressure < 85/70.
	3.	COWS assessment t.i.d while on opiate detox protocol.
	4.	Ibuprofen, 600 mg p.o. t.i.d. x 72 hours p.r.n. for muscle aches.
	5.	Pepto-Bismol (bismuth subsalicylate), 30 ml p.o. q.i.d. x 72 hours p.r.n. for diarrhea.
	6.	Bentyl (dicyclomine), 20 mg p.o. q.i.d. x 72 hours p.r.n. for abdominal cramping.
	7.	Phenergan (promethazine), 25 mg IM q 6 hours x 72 hours p.r.n. for vomiting.
	CLINICIAN SIGNATURE _____ DATE _____ TIME _____	

M-003: FORM: Clinical Opioid Withdrawal Scale (COWS)

Clinical Opiate Withdrawal Scale (COWS)

For each item, circle the number that best describes the patient's signs or symptoms. Rate on just the relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name: _____ **Date and Time** ____/____/____ _____
Reason for this assessment _____

Resting Pulse Rate: _____ **beats/minute**
Measured after patient is sitting or lying for one minute

0 pulse rate 80 or below
1 pulse rate 81 – 100
2 pulse rate 101 - 120
4 pulse rate greater than 120

Sweating: *Over past ½ hour not accounted for by room temperature or patient activity*

0 no report of chills or flushing
1 subjective report of chills or flushing
2 flushed or observable moistness on face
3 beads of sweat on brow or face
4 sweat streaming off face

Restlessness: *Observation during assessment*

0 able to sit still
1 reports difficulty sitting still, but is able to do so
3 frequent shifting or extraneous movements of legs/arms
5 unable to sit still for more than a few seconds

Pupil size

0 pupils pinned or normal size for room light
1 pupils possibly larger than normal for room light
2 pupils moderately dilated
5 pupils so dilated that only the rim of the iris is visible

Bone or joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored*

0 not present
1 mild diffuse discomfort
2 patient reports severe diffuse aching of joints/muscles
4 patient is rubbing joints or muscles and is unable to sit still because of discomfort

Runny nose or tearing *Not accounted for by cold symptoms or allergies*

0 not present
1 nasal stuffiness or unusually moist eyes
2 nose running or tearing
4 nose constantly running or tears streaming down cheeks

GI Upset: *Over last ½ hour*

0 no GI symptoms
1 stomach cramps
2 nausea or loose stool
3 vomiting or diarrhea
5 multiple episodes of diarrhea or vomiting

Tremor *Observation of outstretched hands*

0 no tremor
1 tremor can be felt, but not observed
2 slight tremor observable
4 gross tremor or muscle twitching

Yawning *Observation during assessment*

0 no yawning
1 yawning once or twice during assessment
2 yawning three or more times during assessment
4 yawning several times/minute

Anxiety or irritability

0 none
1 patient reports increasing irritability or anxiousness
2 patient obviously irritable / anxious
4 patient so irritable or anxious that participation in assessment is difficult

Gooseflesh skin

0 skin is smooth
3 piloerection of skin can be felt or hairs standing up on arms
5 prominent piloerection

Total Score: _____

The total score is the sum of all 11 items

Initials of person completing assessment: _____

SCORE: 5 -12 = mild; **13 -14** = moderate; **25 -36** = moderately severe; **more than 36** = severe withdrawal

Source: Wesson and Ling 2003

M-003: FORM: CIWA – Alcohol/Drug Withdrawal Assessment and Treatment Flowsheet

Assessment Protocol	Date								
a. Assess vitals and CIWA b. If total CIWA score ≥ 8, repeat every hour. Once the CIWA score < 8 then repeat every 4–8 hours until score has remained < 8 for 24 hours c. If initial Total CIWA score < 8, repeat CIWA every 4–6 hours for 24 hours d. If indicated, administer PRN medications per protocol	Time								
	Pulse								
	RR								
	O_2 sat								
	BP								
Use the CIWA Scale to assess and rate each of the following 10 criteria.									
Nausea/Vomiting: Rate on scale 0–7. 0 – none; 1 – mild nausea (no vomiting); 4 – intermittent nausea; 7 – constant nausea, frequent dry heaves and vomiting									
Tremors. Have patient extend arms and spread fingers. Rate on scale 0–7 0 – no tremor; 1 – not visible, but can be felt fingertip to fingertip; 4 – moderate with arms extended; 7 – severe, even with arms not extended									
Anxiety: Rate on scale 0–7 0 – none, at ease; 1 – mildly anxious; 4 – moderately anxious or guarded, so anxiety is inferred; 7 – equivalent to acute panic states, as in severe delirium or acute schizophrenic reactions									
Agitation. Rate on scale 0–7 0 – normal activity; 1 – somewhat normal activity; 4 – moderately fidgety and restless; 7 – constantly paces or thrashes about									
Paroxysmal Sweats: Rate on scale 0–7. 0 – no sweats; 1 – barely perceptible sweating, palms moist; 4 – beads of sweat obvious on forehead; 7 – drenching sweats									
Orientation & Clouding of Sensorium. Ask "What day is this? Where are you? Who am I?" Rate on scale 0–4. 0 – oriented; 1 – cannot do serial additions or is uncertain about date; 2 – disoriented to date by no more than 2 days; 3 – disoriented to date by > 2 days; 4 – disoriented to place and/or person									
Tactile Disturbances: Ask "Have you experienced any itching, pins and needles sensation, burning or numbness, or a feeling of bugs crawling on or under your skin?" Rate on scale 0–7 0 – none; 1 – very mild itch, P&N, burning, numbness; 2 – mild itch, P&N, burning, numbness; 3 – moderate itch, P&N, burning, numbness; 4 – moderate hallucinations; 5 – severe hallucinations; 6 – extremely severe hallucinations; 7 – continuous hallucinations									
Auditory Disturbances: Ask, "Are you more aware of sounds around you? Are they harsh? Do they startle you? Do you hear anything that disturbs you or that you know isn't there?" Rate on scale 0–7 0 – not present; 1 – very mild harshness or ability to startle; 2 – mild harshness or ability to startle; 3 – moderate harshness or ability to startle; 4 – moderate hallucinations; 5 – severe hallucinations; 6 – extremely severe hallucinations; 7 – continuous hallucinations									
Visual Disturbances: Ask, "Does the light appear to be too bright? Is its color different than normal? Does it hurt your eyes? Are you seeing anything that disturbs you or that you know isn't there?" Rate on scale 0–7. 0 – not present; 1 – very mild sensitivity; 2 – mild sensitivity; 3 – moderate sensitivity; 4 – moderate hallucinations; 5 – severe hallucinations; 6 – extremely severe hallucinations; 7 – continuous hallucinations									
Headache: Ask, "Does your head feel different than usual? Does it feel like there is a band around your head?" Rate on scale 0–7. Do not rate dizziness or lightheadedness 0 – not present; 1 – very mild; 2 – mild; 3 – moderate; 4 – moderately severe; 5 – severe; 6 – very severe; 7 – extremely severe									
Total CIWA Score: (8–9 = mild withdrawal; 10–15 = moderate withdrawal; > 15 = severe withdrawal)									
Indications for PRN Medication: Please follow the protocol for *Detoxification of Chemically Dependent Inmates* for use of lorazepam and other medications for withdrawal.									
Medication administered? (see Medication Administration Record) Yes/No									
Time of PRN medication administration:									
Assessment of response: (CIWA Score 30–60 minutes after medication administered)									
Provider initials:									

Patient Name: _____
ID No. _____
Date of Birth: ____/____/____
Institution: _____

Signature/Title	Initials	Signature/Title	Initials

*Each state/region may have individual variances, and a copy of those variances should be attached to this guideline.

M-003: CIWA-B Clinical Evaluation Record Guidelines

In order to streamline the assessment of the inmate-patient experiencing benzodiazepine withdrawal and to be able to quickly see improvement or worsening of symptoms, a *CIWA – B Clinical Evaluation Record* tool has been developed.

The multi-use tool is designed to be inmate-patient specific while allowing health care providers the ability to see improvement or worsening of symptoms at a quick glance.

The health care clinician/nurse begins by completing the inmate-patient's name and inmate number at the top of the form. The documentation of each assessment will start with a date and time at the top of the column. From there the form is divided into a subjective section and a clinical observations section.

To complete the subjective portion, the health care clinician/nurse will ask the inmate-patient a series of questions with the inmate-patient giving a numerical answer from 0 – 4. The scores from this section are totaled and the clinician/nurse begins the clinical observation portion of the evaluation.

The clinical observation piece is broken into three questions – agitation/restlessness, tremor, and sweating. The clinician/nurse scores each of these on a 0 – 4 scale and totals up this section.

The scores for the subjective and clinical observations sections are then totaled and the clinician/nurse completing the evaluation initials the bottom of the column. Each clinician/nurse completing an evaluation must include a signature corresponding to their initials at the bottom of the page.

In accordance with the Wexford Health Detox Guidelines, the benzodiazepine withdrawal protocol is to be followed. Unlike the alcohol withdrawal protocol, the benzodiazepine withdrawal protocol does NOT include PRN medications to be given based on the CIWA – B score. The CIWA – B Evaluation Record is designed to be an evaluation tool only, ensuring consistent evaluations and scoring of the inmate-patient experiencing benzodiazepine withdrawal.

The physician will need to be contacted for orders to initiate the Benzodiazepine Withdrawal Protocol.

M-003: CIWA-B Clinical Evaluation Record

CIWA-B Clinical Evaluation Record

For the evaluation of benzodiazepine withdrawal symptoms

Inmate Name:_____ **Number:**_____

Date														
Time														
SUBJECTIVE FINDINGS Ask the patient to rate each of the following on a scale of **0** (not at all) to **4** (very much so)														
Feeling irritable?														
Feeling fatigued?														
Feeling tense?														
Difficulty concentrating?														
Any loss of appetite?														
Numbness or burning in face, hands, or feet?														
Palpitations?														
Head feels full or achy?														
Muscle aches/stiffness?														
Anxious, nervous, or jittery?														
Feeling upset?														
Feeling weak?														
How restful was your sleep last night?														
Do you think you had enough sleep last night?														
Visual disturbances? (blurred vision, photopobia)														
Are you fearful?														
Have you been worrying about possible misfortunes lately?														
SUB-TOTAL SUBJECTIVE FINDINGS														
CLINICAL OBSERVATIONS														
Agitation/Restlessness Score 0 – 4 0 – None, normal activity 2 – Restless 4 – Pacing, unable to sit still														
Tremor 0 – No tremor 1 – Not visible, can be felt in fingers 2 – Visible but mild 3 – Moderate with arms extended 4 – Severe, without arms extended														
Sweating 0 – No visible sweating 1 – Barely perceptible sweating, palms moist 2 – Palms and forehead moist, reports axillary sweating 3 – Beads of sweat on forehead 4 – Severe, drenching sweats														
SUB-TOTAL CLINICAL OBSERVATIONS														
TOTAL SCORE (Subjective + Observations Score)														
Initials of Evaluator														

Total Score: 1 – 20: mild withdrawal 21 – 40: moderate withdrawal 41 – 60: severe withdrawal 61 – 80: very severe withdrawal

Initials/Signatures of Evaluators

M-003A: Pregnancy and Opioid Use

References: ACOG, ASAM, SAMSHA, ACA: 5-ACI-6A-41, 5-ACI-5E-11, 5-ACI-6A-10; NCCHC: P-F-05, MH-G-07, J-F-05

I. GUIDELINE

For the management of opioid use in pregnant inmate-patients Wexford Health's guidance is based on the guidelines set forth by SAMSHA, American Society of Addiction Medicine (ASAM) and The American College of Obstetricians and Gynecologists (ACOG).

Pregnant inmate-patients with opioid use disorder should not undergo withdrawal from opioids.

Medication Assisted Treatment (MAT) is the standard of care for pregnant women with opioid use disorder and will be provided for the duration of the pregnancy.

Coordination of care between with the OB/GYN and onsite medical/behavioral health is important for pregnant women with opioid use disorder.

Decisions on MAT during the postpartum period will be based on client guidance and policy.

II. BACKGROUND INFORMATION

The National Institute on Drug Abuse (NIDA) defines addiction as a chronic disease that can be managed and treated successfully. Like other chronic disease processes (e.g. diabetes, hypertension), the successful treatment of substance use disorders depends on social support, inmate-patients-provider rapport, as well as treatment availability.

Approximately 40–60% of inmate-patients relapse and resume illicit drug use in the first year after discharge from substance abuse treatment programs, which is similar to a 60% relapse rate for adults undergoing treatment for hypertension or asthma.

Barriers to treatment in pregnancy created by misguided policy approaches result from a fundamental misunderstanding of the chronicity of addiction and the need to provide ongoing treatment for addiction disorders with both medical and psychosocial interventions.

Opioid use disorder (OUD) may involve illicit or prescription medications, as well as heroin, methadone, buprenorphine diverted or misused prescription opioids, or other morphine-like drugs. Opioid addiction is a chronic, relapsing disease.

Acute opioid withdrawal is physiologically stressful, characterized by profound activation of the sympathetic nervous system with hypertension, tachycardia, and gastrointestinal symptoms. MAT during pregnancy improves prenatal care, reduces illicit drug use, and minimizes the risk of fetal in utero withdrawal.

Opioid use in pregnancy has escalated dramatically in recent years, paralleling the epidemic observed in the general population. The number of women with opioid use disorder in labor and delivery has recently more than quadrupled.

Opioid use during pregnancy is associated with substantial maternal, fetal, and neonatal risks. These risks are related to repeated opioid exposure (e.g., risk of overdose) as well as factors associated with opioid use (e.g., smoking, poor nutrition, needle sharing, unstable lifestyle).

Opioid exposure during pregnancy has been linked to negative health effects for both mothers and their babies. These include maternal death and poor fetal growth, preterm birth, stillbirth, possible specific birth defects, and neonatal abstinence syndrome. The effects of prenatal opioid exposure on these children over time are largely unknown. However, using prescribed opioids for treatment of opioid use disorder during pregnancy may be necessary and outweigh the risks of these potential negative health outcomes.

Opiate use or misuse may include heroin, codeine, morphine, OxyContin, Tylenol #3, hydromorphone, buprenorphine (Suboxone or Subutex), Tramadol, Fentanyl, etc. regardless of the route of transmission.

III. INTERVENTION

Medication Assisted Treatment (MAT) is defined as the use of FDA-approved medications, in combination with counseling, and behavioral interventions to provide individualized whole patient approach to treat opioid use disorders. This treatment combination can lead to more favorable outcomes.

Medication Assisted Treatment (pharmacotherapy) of opioid use disorder (OUD) is recommended for pregnant women with OUD and should be accompanied by close supportive clinical follow-up. The goal is to prevent obstetric and neonatal complications associated with OUD as well as detox, facilitate prenatal care, and help women avoid the myriad risks from the unstable lifestyle associated with the drug culture (e.g., drug-related criminal activity, homelessness, domestic violence, and infectious diseases).

The Substance Abuse and Mental Health Services Administration (SAMHSA) the American Society of Addiction Medicine (ASAM) and the American College of Obstetricians and Gynecologists. (ACOG) recommend MAT with either methadone or buprenorphine (without naltrexone which is Subutex) for pregnant women with opioid use disorder.

IV. MEDICATIONS USED FOR MAT

A. Buprenorphine - Subutex vs. Suboxone

1. Buprenorphine belongs to a class of drugs called partial opioid agonist.
2. The primary difference between **Suboxone** and **Subutex** is that Suboxone also contains a substance called "naloxone" while Subutex does not:
   a. **Subutex** contains a single active ingredient: **buprenorphine**.
   b. **Suboxone** contains two active ingredients: **buprenorphine** and **naloxone**.

B. Methadone

1. Methadone is a long-acting full opioid agonist.
2. Understanding the signs and symptoms of intoxication verses withdrawal is imperative when providing MAT intervention. If an inmate-patient is currently "intoxicated," adding medication could, in fact, cause an overdose. Clinical judgment is crucial during this process since methadone is a Schedule II controlled medication.

C. Methadone or Buprenorphine

1. While methadone has been the standard choice for pharmacotherapy of OUD during pregnancy since the 1970s, buprenorphine is increasingly used because neonatal withdrawal (also known as neonatal abstinence syndrome) appears to be less severe when the mother is treated with buprenorphine as opposed to methadone.
2. When determining the appropriate course of treatment, multiple factors must be evaluated including medication availability, during and after incarceration.

D. Pregnant individuals already established on MAT (methadone or buprenorphine) should continue the established medication.

1. Switching/ changing from methadone to buprenorphine or from buprenorphine to methadone is not recommended and may lead to withdrawal.

V. Recognizing Signs and Symptoms of Opioid Intoxication and Withdrawal

The table below lists signs and symptoms of opioid intoxication and withdrawal.

Opioid Intoxication	Opioid Withdrawal
Signs	Signs

Opioid Intoxication	Opioid Withdrawal
• Bradycardia (slow pulse)	• Tachycardia (fast pulse)
• Hypotension (low blood pressure)	• Hypertension (high blood pressure)
• Hypothermia (low body temperature)	• Hyperthermia (high body temperature)
• Sedation	• Insomnia
• Miosis (pinpoint pupils)	• Mydriasis (enlarged pupils)
• Hypokinesis (slowed movement)	• Hyperreflexia (abnormally heightened reflexes)
• Slurred speech	• Diaphoresis (sweating)
• Head nodding	• Piloerection (gooseflesh)
	• Increased respiratory rate
	• Lacrimation (tearing), yawning
	• Rhinorrhea (runny nose)
	• Muscle spasms
Symptoms	**Symptoms**
• Euphoria	• Abdominal cramps, nausea, vomiting, diarrhea
• Analgesia (pain-killing effects)	• Bone and muscle pain
• Calmness	• Anxiety

Source: Consensus Panelist Charles Dackis, M.D.

VI. MAT OF INCARCERATED PREGNANT INMATE-PATIENTS – GENERAL GUIDANCE

A. DO NOT STOP OPIOIDS IN PREGNANT INMATE-PATIENTS.

B. Contact the clinician as soon as possible for any pregnant inmate-patients suspected of being severely intoxicated.

C. For MAT, the inmate-patient should have clinical evidence of opioid dependency as well as a positive pregnancy test.

D. Screening will be provided by staff upon discovery of opioid use to determine frequency and severity of use. (See attached *M-003A.01 Opioid Use Screening* form.)

E. Record amount, route, and duration of habit/use considering the possibility of exaggerated dosages.

F. All female inmate-patients assessed for opioid use will be tested for pregnancy prior to beginning an opioid detox protocol. If pregnant, do not detox.

G. If available, an onsite urine drug test should be performed to confirm opioid use.

H. A Clinical Opiate Withdrawal Scale (COWS) assessment should be conducted as soon as possible to track and monitor the pregnant inmate-patient. (See attached *M-003A.05 Clinical Opiate Withdrawal Scale.*)

I. Call the clinician as soon as possible for any inmate-patients suspected of having a severe narcotic withdrawal if determined by either signs/symptoms or through the COWS assessment.

J. Frequency of the COWS is typically directed by a clinician.

1. The recommended frequency for a pregnant inmate-patient with a confirmed opioid use disorder is typically between 4 to 8 hours until stable and the provider requests that COWS is discontinued.

K. The clinician will be notified as soon as possible to ensure appropriate course of action is taken to ensure the safety of the mother and her fetus.

1. The provider should review both the *Opioid Use Screening* form and the COWS to determine the course of action needed to determine the time frame to start MAT.

2. The planned course of action will depend on the source of the opioids as described in later sections.

L. An additional form called DSM-5 Opioid Use Disorder (OUD) Diagnostic Criteria has been attached to this guideline to provide additional guidance when diagnosing OUD. (See attached *M-003A.04 DSM-5 Opioid Use Disorder (OUD) Diagnostic Criteria.*)

VII. PREGNANT INMATE-PATIENTS ENTERING THE FACILITY ESTABLISHED ON METHADONE THROUGH AN OTP

A. A Release of Information (ROI) should be obtained to discuss protected health information with the OTP.

B. Confirmation of established methadone dose should be obtained as soon as possible.

C. A pregnant inmate-patient should NOT DETOX.

D. A clinician needs to be involved/contacted as soon as possible to ensure detoxing does not occur.

E. If a pregnant inmate-patient arrives at the facility already established on methadone the onsite provider will **BRIDGE** the prescription of methadone to ensure no harm comes to the inmate-patient as well as the fetus.

1. **The DEA has clearly stated BRIDGING methadone in a PREGNANT INNMATE-PATIENT is considered a MEDICAL intervention for the safety of the fetus, NOT an opioid treatment intervention. Therefore, any clinician with a DEA license can BRIDGE methadone.**

a. In bridging methadone, the primary purpose is not to provide drug treatment; rather, it is to provide medical intervention to the fetus and to ensure no harm comes to the fetus and mother until the inmate-patient can be taken to an opioid treatment program OR services are continued by the current OTP provider.

b. "Bridging" methadone is considered the period 72 hours following the first dose administered.

c. Contacting the inmate-patient's current methadone provider and/or referring the inmate-patient to the methadone clinic that manages your site's methadone patients must certainly be a priority to ensure continuity of care within the time frame expected. This can be accomplished by the following steps:

i. Contact the inmate-patient's current OTP provider and have them provide an order (prescription) to your site to continue methadone. The 72-hour clock stops when the methadone order from the OTP is received.

ii. Contact your site's OTP and set up the next available appointment for the inmate-patient to be enrolled in their OTP (if the inmate-patient's current OTP is outside the geographic boundaries of your site).

d. Linking the inmate-patient to an OTP provider that can continue their current methadone prescription will ensure that they receive needed treatment while incarcerated.

2. The site's contracted pharmacy will supply the methadone once the site's DEA licensed provider has written the patient-specific order.

a. The bridged order MUST include the verbiage "PREGNANT FEMALE."

3. The site clinician should continue the current dose the pregnant inmate-patient is established on UNLESS detox symptomatology becomes present.

a. In this event the OTP clinician should be contacted for additional guidance.

F. Coordination with an OTP must be established for ongoing treatment of the pregnant inmate-patient.

G. Transportation must be arranged for a pregnant inmate-patient for transport to the OTP as determined by the OTP physician and the onsite medical provider if deemed appropriate.

VIII. PREGNANT INMATE-PATIENTS ENTERING THE FACILITY ESTABLISHED ON SUBUTEX THROUGH AN OTP

A. A release of information (ROI) should be obtained to discuss protected health information with the OTP.

B. Confirmation of established Subutex dose should be obtained as soon as possible from the OTP.

1. A copy of the prescription is to be faxed from the current supervising OTP clinician.

C. A pregnant inmate-patient should NOT DETOX.

D. A clinician needs to be contacted as soon as possible to ensure detoxing does not occur.

E. If a pregnant inmate-patient arrives at the facility already established on Subutex, a provider with a DEA-X should order the Subutex to ensure no harm comes to the inmate-patient as well as the fetus.

1. The new prescriber will typically assume the care of the opioid use disorder while the inmate-patient is pregnant and incarcerated.

2. If there is no available clinician with a DEA-X waiver then the inmate-patient will need to continue care at the OTP.

F. The site clinician should continue the pregnant inmate-patient's current established dose UNLESS detox symptomatology becomes present.

1. In this event the OTP clinician should be contacted for additional guidance.

G. Coordination with OB/GYN should be established for ongoing treatment of the pregnant inmate-patient.

IX. PREGNANT INMATE-PATIENTS ENTERING THE FACILITY ON PRESCRIBED OPIOIDS

A. A release of information (ROI) should be obtained to discuss protected health information with the inmate-patient's clinician.

B. A pregnant inmate-patient should NOT DETOX.

C. A clinician needs to be contacted as soon as possible to ensure detoxing does not occur.

D. If a pregnant inmate-patient arrives at the facility already established on ongoing prescribed opioids, a clinician should order the prescribed opioids to ensure no harm comes to the inmate-patient as well as the fetus.

1. The continuing of opioids does not automatically apply to opioids prescribed for an acute condition.

E. The site clinician should continue the pregnant inmate-patient's current established medication/dose UNLESS detox symptomatology becomes present.

1. In this event the OB clinician should be contacted for additional guidance.

F. Coordination with OB/GYN should be established for ongoing treatment of the pregnant patient on opioids.

X. PREGNANT INMATE-PATIENTS ENTERING THE FACILITY ON OPIOIDS THAT WERE NOT PRESCRIBED AND AVAILABILITY OF A PRESCRIBER WITH A DEA-X WAIVER TO PRESCRIBE SUBUTEX

A. Opiate use may include heroin, codeine, morphine, OxyContin, hydromorphone, buprenorphine (Suboxone or Subutex), Tramadol, Fentanyl, etc. regardless of the route of transmission.

B. A pregnant inmate-patient should NOT DETOX.

C. A clinician needs to be contacted as soon as possible to ensure detoxing does not occur.

D. If a pregnant inmate-patient arrives at the facility on opioids that were not prescribed for the patient, then a designated provider with a DEA-X license should be contacted for consideration of a Subutex induction protocol.

E. Coordination with OB/GYN should be established for ongoing treatment of the pregnant patient on opioids.

XI. SUBUTEX (BUPRENORPHINE WITHOUT NALOXONE) INDUCTION PROTOCOL

A. Because Suboxone (buprenorphine with naloxone) can precipitate withdrawal, pregnant inmate-patients should not typically receive Suboxone.

B. Induction to Subutex typically involves considering the type of opioid – i.e., short-acting opioids or long-acting opioids – that an inmate-patient is using.

C. If an inmate-patient is using short-acting opioids, there should be a minimum of 12 to 24 hours between opioid use and buprenorphine administration, and, as a result, the inmate-patient should exhibit mild to moderate withdrawal symptoms (as assessed by the COWS).

D. Induction can take place in one day or over a week.

1. A typical induction takes place over a three-day to one-week period.
2. The induction period is a time frame where constant monitoring is needed as well as possible dosage adjustment – to ensure the individual is on an appropriate dose.
3. It is important to ensure that the individual remains stable on that dose.

E. The following are general recommendations on Subutex induction:

1. Recognizing that each inmate-patient is unique the following guidance is meant to be a guidance not a prescribed plan of care.
2. Providers should consider an inmate-patient's recent drug history when determining a therapeutic dose.
3. Most inmate-patients can stay in outpatient status through induction.
4. Initial dose may begin with 2 mg or 4 mg of Subutex and monitored for 2 to 4 hours.
5. If withdrawal symptoms are not relieved, then additional Subutex can be administered, followed by ongoing monitoring.
6. If withdrawal symptoms persist, manage symptomatically with a suggested maximum first day dose of Subutex of 8 mg.
7. Inmate-patients who require an initial dose greater than 8 mg should be under direct observation.
8. If an inmate-patient is still exhibiting withdrawal on subsequent days, follow the same procedure with a first dose equal to the total amount administered on the previous day plus 4 mg until the inmate-patient has no withdrawal symptoms since the last dose.

9. Typical recommendations are 8 mg –16 mg per day until withdrawal no longer occurs.
10. The typical dose for most inmate-patients is 8 mg –16 mg per day by the end of the first week.
11. Doses greater than 24 mg per day are not believed to offer any clinical advantage in treatment.

XII. SUBUTEX MAINTENANCE

A. The dose of Subutex must be adequate to be therapeutic for the individual.

B. Pregnant women may develop symptoms of withdrawal as pregnancy progresses and may require dose increases in order to maintain the same plasma level.

C. The maternal dose should not generally be reduced during pregnancy to minimize neonatal abstinence syndrome (NAS).

D. Buprenorphine (Subutex) dose reduction during pregnancy does not improve fetal outcomes and may increase the risk of recurrent substance use disorder in the mother.

XIII. PREGNANT INMATE-PATIENTS ENTERING THE FACILITY ON OPIOIDS THAT WERE NOT PRESCRIBED AND WITHOUT THE AVAILABILITY OF A PRESCRIBER TO PRESCRIBE SUBUTEX

A. Opiate use may include heroin, codeine, morphine, OxyContin, Tylenol #3, hydromorphone, buprenorphine (Suboxone or Subutex), Tramadol, Fentanyl, etc. regardless of the route of transmission. A pregnant inmate-patient should NOT DETOX.

B. A clinician needs to be contacted as soon as possible to ensure detoxing does not occur.

C. If a pregnant inmate-patient arrives at the facility on opioids that were not prescribed for the patient the clinician should be contacted for consideration of an OTP.

D. Coordination with the accepting OTP needs to occur ASAP.

E. If the inmate-patient starts to exhibit significant withdrawal symptoms prior to being evaluated by the OTP, then the inmate-patient should be sent to the ER for evaluation.

1. The plan of care will follow the ER's/hospital's plan of care until follow-up with an OTP can be arranged.

F. Coordination with OB/GYN should be established for ongoing treatment of the pregnant patient on opioids.

XIV. INMATE-PATIENTS ON MAT POSTPARTUM TREATMENT

A. **Subutex/Buprenorphrine – Postpartum**

1. Wexford Health recognizes that each client may have different guidelines or policies related to MAT in the postpartum period. Wexford Health will work cooperatively with their client's policies and guidelines related to this subject.
2. Following birth, most inmate-patients will be tapered off the MAT, unless the site has an existing MAT program for non-pregnant patients.
3. Tapering the inmate-patient off the MAT after birth should typically be done at a comfortable rate and without inducing severe withdrawal symptoms.
    a. Tapering an inmate-patient off the MAT varies depending on the patient's current dosage of Subutex as well as the providers medical determination of the taper schedule.
    b. Tapering schedules should consider postpartum pain management for the individual.

c. Start nursing assessments with the COWS to monitor withdrawal symptomatology.

i. When Subutex leaves the body, the inmate-patient will experience not only physical but emotional withdrawal.

ii. With the risk of postpartum depression, the possibility of mother-child separation following birth which could cause depression, as well as the withdrawal from Subutex inducing depression, it is recommended that the patient is referred to mental health services if available; if not available, monitor the patient's emotional status and follow up as needed.

d. Gradually reduce the dose.

e. Quitting or stopping Subutex abruptly is NOT recommended.

f. Buprenorphrine half-life is 37 hours for a single dose.

g. Create a taper schedule reducing the amount of Subutex given in increments.

h. When monitoring withdrawal symptoms, if symptomatology is too prevalent and causing extreme discomfort, return to the previous dose for a few days then decrease again.

B. **Methadone – Postpartum**

1. Wexford Health recognizes that each client may have different guidelines or policies related to MAT in the postpartum period. Wexford Health will work cooperatively with their client's policies and guidelines related to this subject.

2. Following birth, most patients will be tapered off the MAT, unless the site has an existing MAT program for non-pregnant patients.

3. Tapering the patient after birth should typically be done at a comfortable rate and without inducing severe withdrawal symptoms.

a. Tapering a patient varies depending on the patient's current dosage of methadone and should be determined by the off-site OTP medical provider (if applicable).

b. Tapering schedules should consider postpartum pain management.

c. Postpartum patients should be monitored for over sedation as therapeutic dosing requirements may change.

d. Frequent clinical assessments need to occur in monitoring methadone dosing delivery to ensure over-sedation doesn't occur.

e. Start nursing assessments with the COWS to monitor withdrawal symptomatology.

i. When methadone leaves the body, the patient will experience not only physical but emotional withdrawal.

ii. With the risk of postpartum depression, the possibility of mother-child separation following birth which could cause depression, as well as the withdrawal from methadone inducing depression, it is recommended that the patient is referred to mental health services if available, if not available monitor the patient's emotional status and follow up as needed.

f. Quitting or stopping methadone abruptly is NOT recommended.

g. A gradual reduction in dosing is recommended.

h. Methadone half-life is 24 to 36 hours for a single dose.

i. This can vary person to person, there are several mitigating factors that can influence half-life.

i. Reduce the amount of methadone given in increments as instructed by the OTP provider.

j. When monitoring withdrawal symptoms, if symptomatology is too prevalent and causing extreme discomfort, return to the previous dose for a few days then decrease again or contact the OTP provider as soon as possible to discuss.

XV. REFUSAL OF MAT – HOW TO MANAGE PREGNANT INMATE-PATIENTS WITH OUD WHO REFUSE MAT

A. ALL individuals have a right to refuse treatment, if a pregnant female chooses to exercise these rights, and refuse medical intervention, the following should occur:

1. An urgent consultation with the OB/GYN specialist for your facility should occur within 48 hours.
2. The OB/GYN specialist will determine the appropriate treatment for the pregnant inmate-patient.
3. This consultation can occur the following ways.
   a. The OB/GYN clinician can be consulted via conference call for a peer-to- peer review with the onsite provider.
   b. A face-to-face consultation occurs.
   c. If no OB/GYN is available for consultation within 48 hours, the pregnant inmate-patient can be taken to the nearest emergency room to receive clearance as well as a treatment plan.
4. Informed consent: the pregnant inmate-patient will be informed of ALL risks associated with detoxification during pregnancy and a refusal of medical treatment form should be signed and witnessed by staff.

B. The inmate-patient should be supervised throughout the duration of the detoxification process; follow the OB/GYN clinician's guidance as well as the following:

1. Document signs and symptoms with the COWS assessment.
   a. A COWS assessment should generally occur at minimum every 8 hours. The frequency should be ordered by the onsite clinician.
2. If symptoms begin, suggesting a miscarriage may be occurring, inform the OB/GYN clinician and follow their instructions, as well as:
   a. Transport the pregnant inmate-patient to the hospital when medically indicated.
3. Communication and monitoring the inmate-patient in collaboration with the OB/GYN specialist is crucial throughout this process.

C. A referral to behavioral health services and/or a mental health screening should occur. This will be determined by what is available at your facility, follow your facility's protocol.

1. Individuals withdrawing/detoxing from opioids will exhibit several behaviors and emotions throughout the detox process as the opiates leave their system.
2. An individual may change their mind during the actual detox process. It is important to "check with the individual" to ensure they want to continue detoxification without MAT.

D. If the OB/GYN clinician agrees with managing the inmate-patient's detox symptomatology, consider other options to increase the individual's comfort level throughout the detox process. If the inmate-patient consents, additional support can be provided in the following ways:

1. Mild withdrawal can be treated with acetaminophen (Tylenol), aspirin, or nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen.
2. Plenty of fluids and rest are important.

3. Medications such as loperamide (Imodium) can help with diarrhea and hydroxyzine (Vistaril, Atarax) may ease nausea. (Please refer to *M-003: Drug Intoxication/ Withdrawal Guidelines* for additional information.)

XVI. ATTACHMENTS

Provider Resources

References

M-003A.01 Opioid Use Screening Form

M-003A.02 Consent to Participate in Medication Assisted Treatment (MAT)

M-003A.03 Refusal to Participate in Medication Assisted Treatment (MAT)

M-003A.04 DSM-5 Opioid Use Disorder (OUD) Diagnostic Criteria

M-003A.05 Clinical Opioid Withdrawal Scale (COWS)

Provider Resources

Wexford Health supports all providers seeking additional experience as well as obtaining their waiver to provide treatment with Buprenorphine. The following is a list of resources available to providers.

I. SUBSTANCE ABUSE MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

The Substance Abuse and Mental Health Services Administration (SAMHSA) (https://www.samhsa.gov) is the agency within the U.S. Department of Health and Human Services (HHS) that leads public health efforts to advance the behavioral health of the nation and to improve the lives of individuals living with mental and substance use disorders, and their families.

II. PROVIDER CLINICAL SUPPORT SYSTEM (PCSS)

The Provider Clinical Support System (PCSS) (https://pcssnow.org/medication-assisted-treatment/) is a program funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) created in response to the opioid overdose epidemic to train primary care providers in the evidence-based prevention and treatment of opioid use disorders (OUD) and treatment of chronic pain.

The project is geared toward primary care providers who wish to treat OUD. PCSS is made up of a coalition, led by American Academy of Addiction Psychiatry (AAAP), of major healthcare organizations all dedicated to addressing this healthcare crisis. Through a variety of trainings and a clinical mentoring program, PCSS's mission is to increase healthcare providers' knowledge and skills in the prevention, identification, and treatment of substance use disorders with a focus on opioid use disorders.

III. AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM)

The American Society of Addiction Medicine (ASAM) (https://www.asam.org/asam-home-page) founded in 1954, is a professional medical society representing over 6,000 physicians, clinicians and associated professionals in the field of addiction medicine. ASAM is dedicated to increasing access and improving the quality of addiction treatment, educating physicians and the public, supporting research and prevention, and promoting the appropriate role of physicians in the care of patients with addiction.

IV. NATIONAL INSTITUTE ON DRUG ABUSE (NIDA)

The mission of the National Institute on Drug Abuse (NIDA) (https://www.drugabuse.gov/) is to advance science on the causes and consequences of drug use and addiction and to apply that knowledge to improve individual and public health. This involves:

- Strategically supporting and conducting basic and clinical research on drug use (including nicotine), its consequences, and the underlying neurobiological, behavioral, and social mechanisms involved.
- Ensuring the effective translation, implementation, and dissemination of scientific research findings to improve the prevention and treatment of substance use disorders and enhance public awareness of addiction as a brain disorder.

References

The following is a list of references consulted, reviewed and/or utilized in the development of this policy:

The American College of Obstetricians and Gynecologists (ACOG), Women's Health Care Physicians & The American Society of Addiction Medicine (ASAM); ACOG Committee Opinion. Number 711, August 2017.

Substance Abuse and Mental Health Services Administration. Medications for Opioid Use Disorder. Treatment Improvement Protocol (TIP) Series 63, Part 3. HHS Publication No. (SMA) 18-5063 Rockville, 2018.

Prescribing guidelines for Pennsylvania, Use of Addiction Treatment Medications in the Treatment of Pregnant Patients with Opioid Use Disorder. The Commonwealth Pennsylvania 2016.

Center for Substance Abuse Treatment, Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. Treatment Improvement Protocol (TIP) Series 43. HHS Publication No. (SMA) 12-4214. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

Peeler M, Fiscella K, Terplan M, Sufrin C. Best Practices for Pregnant Incarcerated Women with Opioid Use Disorder. *J Correct Health Care.* 2019;25(1):4–14. doi:10.1177/1078345818819855.

ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use; 2015.

Substance Abuse and Mental Health Services Administration. A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders. HHS Publication No. (SMA) 16-4978. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016.

Substance Abuse and Mental Health Services Administration. Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants. HHS Publication No. (SMA) 18-5054. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018.Substance Abuse and Mental Health Services Administration (SAMHSA) by the Knowledge Application Program (KAP), a Joint Venture of The CDM Group, Inc., and JBS International, Inc., under contract number 270-04-7049, with SAMHSA, U.S. Department of Health and Human Services (HHS). Christina Currier served as the Government Project Officer, 2014.

M-003A.01 Opioid Use Screening Form (SAMPLE)

Opioid Use Screening

Patient Name:_____ **Date:**_____

	QUESTION	YES	NO
1	Do you use opioids for larger amounts or over a longer period of time than intended?		
2	Have you tried to cut down or control your opioid use?		
3	Are you taking a lot of time finding opioids, using opioids, or recovering from opioids?		
4	Do you have cravings or a strong desire to use opioids?		
5	Have opioids interfered with your roles at work, school, or home?		
6	Have you continued to use opioids despite people telling you that you need help?		
7	Have you given up social, occupational or recreational activities due to opioids?		
8	Have you continued to use opioids in situations where it is physically hazardous?		
9	Do you continue using opioids despite knowing it is hurting you physically and mentally?		
10	Have you noticed you needing more opioids to get the desired effect you want?		
11	Have you gotten ill when trying to quit opioids or do you keep using to avoid withdrawal symptoms?		
12	How many times have you been in treatment for opioid addiction?		
13	Are you currently in an opioid treatment program?		
	If Yes to 13 – Which one?		
14	Are you currently on methadone under the supervision of a provider?		
15	Are you currently on buprenorphine under the supervision of a provider?		

This section is to be completed by staff.

Contact information of opioid treatment program:_____

_____

Was contact made with OTP? _____

Was methadone/or buprenorphine RX confirmation received from OTP?_____

Signature:_____ **Title:**_____

Date:_____

M-003A.02 Consent to Participate in Medication Assisted Treatment (MAT) (SAMPLE)

Consent to Participate in Medication Assisted Treatment (MAT)

☐ Methadone ☐ Buprenorphine Treatment

☐ Pregnant ☐ Not Pregnant

Patient's Name:_____ **ID:**_____

I authorize and give voluntary consent to Wexford Health Sources Inc. to dispense and administer Medication Assisted Treatment medications—including methadone or buprenorphine—to treat my opioid use disorder. Treatment procedures have been explained to me, and I understand that I should take my medication at the scheduled time determined by the program physician, or his/her designee, in accordance with federal and state regulations.

I understand that, like all other medications, methadone or buprenorphine can be harmful if not taken as prescribed. It has been explained to me that I must follow the medication protocol of the program and safeguard these medications and not attempt to "cheek" them nor share with anyone because they can be fatal to children and adults if taken without medical supervision. I also understand that methadone and buprenorphine produce physical opioid dependence. Like all medications, they may have side effects. Possible side effects, as well as alternative treatments and their risks and benefits, have been explained to me.

I understand that it is important for me to inform any medical provider who may treat me that I am currently in MAT. In this way, the provider will be aware of all the medications I am taking, can provide the best possible care, and can avoid prescribing medications that might affect my treatment as well as my fetus.

I understand that I may withdraw voluntarily from this treatment program and discontinue the use of these medications at any time. If I choose this option, I understand I will be offered medically supervised withdrawal as well as a need to sign a refusal of treatment, and this may affect my unborn fetus and could possibly cause a miscarriage.

I understand that pregnant women treated with methadone or sublingual buprenorphine (SUBUTEX) have better outcomes than pregnant women not in treatment who continue to use opioid drugs. Newborns of mothers who are receiving methadone or buprenorphine treatment may have opioid withdrawal symptoms (i.e., neonatal abstinence syndrome). The delivery hospital may require babies who are exposed to opioids before birth to spend a number of days in the hospital for monitoring of withdrawal symptoms. Some babies may also need medication to stop withdrawal.

If I am or become pregnant, I understand that I should tell the medical staff right away so that I can receive or be referred to prenatal care. I understand that there are ways to maximize the healthy course of my pregnancy while I am taking methadone or buprenorphine.

Patient Name (Print): _____

Patient Signature:_____ **Date:** _____

M-003A.02 Consent to Participate in Medication Assisted Treatment (MAT) (SAMPLE)

Treatment Agreement

I agree to accept the following treatment contract for buprenorphine office-based opioid addiction treatment:

1. The risks and benefits of buprenorphine treatment have been explained to me.
2. The risks and benefits of other treatment for opioid use disorder (including methadone, naltrexone, and nonmedication treatments) have been explained to me.
3. I will keep following my medication schedule that has been explained to me by the medical staff.
4. I will show up to medication time (as indicated by the facility) to receive my dosing on time as prescribed by the provider, and I understand if I no-show to the medication time that I could possibly begin "withdrawal" which could be harmful to my baby.
5. Medication times: _____ _____ _____ _____ _____
6. I will take the medication exactly as my healthcare provider prescribes. If I want to change my medication dose, I will speak with my healthcare provider first.
7. Taking the medication by snorting or by injection is also medication misuse and may result in supervised dosing at the clinic, referral to a higher level of care, or change in medication based on my healthcare provider's evaluation.
8. If I am going to have a medical procedure that will cause pain, I will let my healthcare provider know in advance so that my pain will be adequately treated.
9. I understand that random urine drug testing is a treatment requirement. If I do not provide a urine sample, it will count as a positive drug test.
10. I understand that people have died by mixing buprenorphine with alcohol and other drugs like benzodiazepines (drugs like Valium, Klonopin, and Xanax).
11. I understand that treatment of opioid use disorder involves more than just taking medication. I agree to comply with my healthcare provider's recommendations for additional counseling and/or for help with other problems.
12. I understand that I may experience opioid withdrawal symptoms when I stop taking buprenorphine.
13. I have been educated about the increased chance of pregnancy when stopping illicit opioid use and starting buprenorphine treatment and been informed about methods for preventing pregnancy.

Patient Name (Print): _____

Patient Signature: _____ **Date:** _____

This form is adapted from the American Society of Addiction Medicine's Sample Treatment Agreement, which is updated periodically; the most current version of the agreement is available online at: (https://www.asam.org/docs/default-source/advocacy/sample treatmentagreement30fa159472bc604ca5b7ff000030b21a.pdf?sfvrsn).

M-003A.03 Refusal to Participate in Medication Assisted Treatment (MAT) (SAMPLE)

Refusal to Participate in Medication Assisted Treatment (MAT)

☐ Refusal of MAT Intervention ☐ Pregnant

Patient's Name: _____ **Patient ID:** _____

I REFUSE TO give voluntary consent to Wexford Health Sources Inc. to dispense and administer Medication Assisted Treatment medications—including methadone or buprenorphine—to treat my opioid use disorder. Treatment procedures have been explained to me, and I understand that, should I REFUSE medication INTERVENTION WHILE PREGNANT, that this puts me at risk for miscarriage.

I understand that, I CAN REVOKE THIS REFUSAL AT ANY TIME. If I decide to change my mind, I will immediately notify medical personnel.

I understand I will be offered medically supervised withdrawal as well as a need to sign a refusal of treatment, and this may affect my unborn fetus and could possibly cause a miscarriage.

I understand that pregnant women treated with methadone or sublingual buprenorphine (SUBUTEX) have better outcomes than pregnant women not in treatment who continue to use opioid drugs. Newborns of mothers who are receiving methadone or buprenorphine treatment may have opioid withdrawal symptoms (i.e., neonatal abstinence syndrome). The delivery hospital may require babies who are exposed to opioids before birth to spend a number of days in the hospital for monitoring of withdrawal symptoms. Some babies may also need medication to stop withdrawal.

Signature of Patient: _____

Date: _____

Witness: _____

Name & Title (print): _____

Date: _____

Witness: _____

Name & Title (print): _____

Date: _____

M-003A.04 DSM-5 Opioid Use Disorder (OUD) Diagnostic Criteria (SAMPLE)

DSM-5 Opioid Use Disorder (OUD) Diagnostic Criteria

Patient Name:_____ **ID:**_____

This form is to provide assistance as well as documentation to diagnose individuals with OUD. Reviewing the *Opioid Use Screening* tool, the *COWS*, as well as discussing the individual's presentation with staff, should allow all providers to appropriately diagnose individuals with an OUD to start MAT intervention or withdrawal management. Please refer to M-003 and M-003A for additional guidance.

This tool is intended for guidance purposes only. Each provider has individual experience with OUD, and this tool is to assist when certainty is questionable.

A problematic pattern of opioid use leading to clinically significant impairment or distress is manifested by *at least two* of the following, occurring within a 12-month period:

1. Opioids are often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect.
    b. A markedly diminished effect with continued use of the same amount of an opioid.
11. Withdrawal, as manifested by either of the following:
    a. The characteristic opioid withdrawal syndrome.
    b. Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms.

Note: The last two criteria are not considered to be met for those individuals taking opioids solely under appropriate medical supervision.

Number of criteria:	0–1	2–3	4–5	6+____
Interpretation:	No OUD	Mild OUD	Moderate OUD	Severe OUD

Comments/TX plan: _____

_____

_____

_____ _____ _____

Provider's Signature **Title** **Date**

M-003A.05 Clinical Opioid Withdrawal Scale (COWS) (SAMPLE)

Wexford Health Sources Incorporated

Clinical Opiate Withdrawal Scale (COWS)

Clinical Opiate Withdrawal Scale (COWS)

For each item, circle the number that best describes the patient's signs or symptoms. Rate on just the relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

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

Reason for this assessment: _____

Resting Pulse Rate: _____beats/minute
Measured after patient is sitting or lying for one minute

0 pulse rate 80 or below
1 pulse rate 81 – 100
2 pulse rate 101 - 120
4 pulse rate greater than 120

Sweating: *Over past ½ hour not accounted for by room temperature or patient activity*

0 no report of chills or flushing
1 subjective report of chills or flushing
2 flushed or observable moistness on face
3 beads of sweat on brow or face
4 sweat streaming off face

Restlessness: *Observation during assessment*

0 able to sit still
1 reports difficulty sitting still, but is able to do so
3 frequent shifting or extraneous movements of legs/arms
5 unable to sit still for more than a few seconds

Pupil size

0 pupils pinned or normal size for room light
1 pupils possibly larger than normal for room light
2 pupils moderately dilated
5 pupils so dilated that only the rim of the iris is visible

Bone or joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored*

0 not present
1 mild diffuse discomfort
2 patient reports severe diffuse aching of joints/muscles
4 patient is rubbing joints or muscles and is unable to sit still because of discomfort

Runny nose or tearing *Not accounted for by cold symptoms or allergies*

0 not present
1 nasal stuffiness or unusually moist eyes
2 nose running or tearing
4 nose constantly running or tears streaming down cheeks

GI Upset: *Over last ½ hour*

0 no GI symptoms
1 stomach cramps
2 nausea or loose stool
3 vomiting or diarrhea
5 multiple episodes of diarrhea or vomiting

Tremor *Observation of outstretched hands*

0 no tremor
1 tremor can be felt, but not observed
2 slight tremor observable
4 gross tremor or muscle twitching

Yawning *Observation during assessment*

0 no yawning
1 yawning once or twice during assessment
2 yawning three or more times during assessment
4 yawning several times/minute

Anxiety or irritability

0 none
1 patient reports increasing irritability or anxiousness
2 patient obviously irritable / anxious
4 patient so irritable or anxious that participation in assessment is difficult

Gooseflesh skin

0 skin is smooth
3 piloerection of skin can be felt or hairs standing up on arms
5 prominent piloerection

Total Score: _____

The total score is the sum of all 11 items

Initials of person completing assessment: _____

SCORE: 5 -12 = mild; **13 -14** = moderate; **25 -36** = moderately severe; **more than 36** = severe withdrawal

Source: Wesson and Ling 2003

M-004: Primary Care Guidelines

Reference: ACA: 5-ACI-6D-10; NCCHC: A-05

I. GUIDELINE

Wexford Health's primary care guidelines are intended to assist the health care staff in clinical decision-making by describing a range of generally acceptable approaches for the diagnosis and management of specific diseases or conditions. Although these guidelines are based on evidence-based research, they should not preclude the use of other methods directed at obtaining the same results.

II. PROCEDURE

A. The guidelines are continually updated and reviewed by the Medical Advisory Committee for their suitability to the inmate health care setting.

B. The guidelines do not supersede established state/county guidelines and/or facility contractual obligations nor are they mandated for sites which have limited facility equipment and resources.

C. All medical decisions regarding the care of inmates should be made with consideration given to the individual circumstances presented by the patient.