SUPPORT ACT GRANT 101: WITHDRAWAL SYNDROMES & TELE-BEHAVIORAL HEALTH

Mishka Terplan, M.D.
Paul Brasler, M.A., L.C.S.W.
Copyright

• This material is to be used only by organizations receiving technical assistance through the SUPPORT Act Section 1003 Grant

• No reproduction, distribution, posting or transmission of any of this material is authorized without the expressed consent of the authors

• Last revision: April 23, 2020
Disclaimer

• The information contained in this material can change as we learn more about the brain and the ways it is impacted by the environment, trauma, medications, substances of misuse, and other things

• Always follow the guidelines of your agency, ethical and legal standards of your certifying Board, evidence-based practice methods; local, state and Federal laws as well as your judgement and commonsense when working with clients
Questions?

If you have any questions, please do not hesitate to contact the authors at

paul.brasler@dmas.Virginia.gov
mishka.terplan@dmas.Virginia.gov
Program Outline

I. Tele-Behavioral Health Basics

II. Substance Use Disorders, Withdrawal Syndromes and Detoxification

III. Opioid Withdrawal Syndrome & Treatment

IV. Alcohol Withdrawal Syndrome & Treatment
I. TELE-BEHAVIORAL HEALTH BASICS
Tele-Behavioral Health

We first need to admit that most of us do not enjoy “connecting” with clients this way; “I didn’t go to school for this!”

We also need to acknowledge that not all clients have access to technology to participate in tele-behavioral health and so we have to improvise.

Therefore practitioners and clients are using phones, Skype and FaceTime to conduct sessions; and getting creative in other ways.

Clinicians do not have to use HIPAA-compliant video conferencing technology during the current National Emergency; Health & Human Services will waive any penalties for HIPAA violations related to the platform used during this emergency.
Tele-Behavioral Health: Clinician

• Have a space set up where you can connect with your client without being disturbed

• Your work-space should provide some privacy for your client

• Internet connectivity and/or phone signal strength should be tested prior to engaging in tele-behavioral health

• If conducting a group therapy session, educate clients on muting themselves unless they are speaking

• I recommend against using your personal phone, but sometimes this cannot be avoided
  • If using a personal device, I would set firm boundaries with clients regarding when they can and cannot contact you
You’ll likely notice that the flow of clinical sessions will be slower than in-person.

Be aware that you will likely need to speak slower than in person.

Try to express empathy with your voice, especially when not connecting via video.
Tele-Behavioral Health: Client

- Try to have a private space where you can connect with your counselor that is also free from interruptions and distractions
- Test out your communications system (connectivity) prior to meeting with your counselor
- Most of us (counselors especially) don’t like meeting this way, so remember this is temporary and we (like you) look forward to meeting face-to-face again
Some clients do not have access to remote technology at all

What are some ways that people are connecting during this time?
Informed Consent to Treatment

Informed consent should be obtained prior to the start of tele-mental health

I recommend that the clinician review all aspects of the Consent to Treatment form with the client prior to the start of treatment to ensure that the client understands what is expected in treatment and the limits of what the clinician can and cannot disclose without the client’s permission.
Informed Consent to Tele-Behavioral Health Treatment—Essential Elements

• A statement explaining what tele-behavioral health will look like for you and the client (methods to be utilized: FaceTime, phone, etc.)

• A statement discussing the risks of tele-behavioral health (technology limitations and failures; possible/unintentional breaches of confidentiality)

• A statement agreeing that the sessions will not be recorded by either party

• A statement emphasizing that the content of the session is confidential and that a written release is required from the client to release information

• A statement noting the limits of confidentiality, including having to report suspected child abuse, vulnerable adult abuse, danger to self or others
Informed Consent to Tele-Behavioral Health Treatment—Essential Elements

- A statement explaining what steps must be taken should the clinician believe that the client is a danger to themselves, a danger to others or is unable to care for themselves
  - This could include a statement that participation in tele-behavioral health may not be appropriate and a higher level of care could be required

- A statement describing how you will handle technical problems should they arise

- A statement explaining that the client must disclose their physical location during the session and an individual the clinician can contact in case of an emergency

- A statement that you are continuing to maintain treatment records during this time
Documentation

• **If you don’t write it down, it never happened**

• Record where the client says they are contacting you from

• Record, in detail, all aspects of client interactions, including any known precipitating events, interventions, outcomes, staff members involved and all contacts with outside agencies

• Do this as quickly as possible following the session

• **Stick to the facts;** do not presuppose or assume anything

• See documentation as a necessary means to protect yourself, the people you serve, and your organization
II. SUBSTANCE USE DISORDER, WITHDRAWAL SYNDROMES AND DETOXIFICATION
What is 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.

• https://www.asam.org/Quality-Science/definition-of-addiction
  September, 2019
Addiction: Medical Student Mnemonic

• The five Cs:
  – Craving
  – Compulsive use
  – Continued use despite harm (consequences)
  – Impaired control over drug use
  – Chronicity
Substance Use Disorder: DSM-5

1. Tolerance
2. Withdrawal

Loss of Control
3. Larger amounts and/or longer periods
4. Inability to cut down on or control use
5. Increased time spent obtaining, using or recovering

6. Craving/Compulsion

Use Despite Negative Consequences
7. Role failure, work, home, school
8. Social, interpersonal problems
9. Reducing social, work, recreational activity
10. Physical hazards
11. Physical or psychological harm

1. Mild (2-3), moderate (4-5), severe (≥6)
2. Not valid if opioid taken as prescribed

APA. (2013). Diagnostic and statistical manual of mental disorders (5th ed.)
Addiction vs Dependence/Tolerance

- Physical dependence/tolerance is not addiction
  - Addiction is a brain-centered disease whose visible symptoms are behaviours
  - Dependence is an expected adaptation of the body to a specific substrate so that in the absence of that substrate a withdrawal syndrome develops
  - Tolerance is pharmacologic principle where reaction to specific concentration of drug is reduced with repeated use
  - Affect different parts of the brain
- Many medications cause either tolerance or dependence or both (SSRIs, HTN medication, Opioids)

Addiction: affects reward pathway (mesolimbic and mesocortical)

Dependence: affects thalamus and brainstem
Withdrawal is due to Dependence

Withdrawal Management is part of SUD treatment

• Withdrawal risk and consequence differ by substance
  – Alcohol/Benzo withdrawal can be life-threatening
• Withdrawal assessment
  – COWS, CIWA
• Medical intervention to treat withdrawal
  – Either taper or “induction”
• “Withdrawal management alone does not constitute adequate treatment for addictive disease” (ASAM)
ASAM has replaced term “Detoxification” with “Withdrawal Management”

Opioid withdrawal management (i.e. detoxification) on its own, without ongoing treatment for opioid use disorder, is not a treatment method for opioid use disorder and is not recommended. Patients should be advised about the risk of relapse and other safety concerns, including increased risk of overdose and overdose death. Ongoing maintenance medication, in combination with psychosocial treatment appropriate for the patient’s needs, is the standard of care for treating opioid use disorder.

https://www.asam.org/docs/default-source/quality-science/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2
III. OPIOID WITHDRAWAL SYNDROME
Opioid Withdrawal

• Symptoms:
  – Muscle aches
  – Insomnia, Agitation, Anxiety
  – Tearing, Sweating, Runny nose
  – Yawning, Piloerection
  – Dilated pupils
  – Abdominal cramping, Nausea, Vomiting, Diarrhea

• Assessment:
  – COWS, SOWS

<table>
<thead>
<tr>
<th>Drug</th>
<th>Onset, Hours</th>
<th>Peak</th>
<th>Resolution, Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buprenorphine</td>
<td>4–48</td>
<td>96 h</td>
<td>14–21</td>
</tr>
<tr>
<td>Fentanyl (intravenous)</td>
<td>2–5</td>
<td>8–12 h</td>
<td>4–5</td>
</tr>
<tr>
<td>Heroin</td>
<td>6–12</td>
<td>24–72 h</td>
<td>7–10</td>
</tr>
<tr>
<td>Short-acting prescription opioids</td>
<td>6–12</td>
<td>24–72 h</td>
<td>7–10</td>
</tr>
<tr>
<td>Long-acting prescription opioids</td>
<td>12–36</td>
<td>2–5 days</td>
<td>10–14</td>
</tr>
<tr>
<td>Methadone</td>
<td>24–72</td>
<td>4–6 days</td>
<td>14–21</td>
</tr>
</tbody>
</table>
Opioid Withdrawal

• Symptoms:
  – Muscle aches
  – Insomnia, Agitation, Anxiety
  – Tearing, Sweating, Runny nose
  – Yawning, Piloerection
  – Dilated pupils
  – Abdominal cramping, Nausea, Vomiting, Diarrhea

• Assessment:
  – COWS, SOWS

Table 2
Symptom of opioid withdrawal

<table>
<thead>
<tr>
<th>Time from Last Use</th>
<th>Withdrawal Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-4 h after last use</td>
<td>Drug craving, Anxiety, Fear of withdrawal</td>
</tr>
<tr>
<td>8-14 h after last use</td>
<td>Generalized malaise, Flu-like symptoms, Anxiety, Restlessness, Insomnia, Yawning, Rhinorrhea, Lacrimation, Diaphoresis, Abdominal cramps, Mydriasis</td>
</tr>
<tr>
<td>1-3 d after last use</td>
<td>Tremor, Muscle spasms, GI distress: nausea, vomiting, diarrhea, Hypertension, Tachycardia, Hyperthermia, Chills, Piloerection</td>
</tr>
</tbody>
</table>

*The time to onset of opioid withdrawal symptoms depends on the half-life of the substance being used. This example assumes the use of a short-acting opioid (e.g., heroin).*

Maldonado 2010, *Medical Clinics of North America*
Opioid Withdrawal

• Management Goal:
  – Make person comfortable

• Medications:
  – Opioids:
    • BUP and Methadone recommended over abrupt cessation
  – Non-opioids:
    • Alpha-2 Adrenergic Agonists
      – Lofexidine (FDA approved)
      – Clonidine slight increased risk of hypotension c/w Lofexidine
    • Loperamide, Ondansetron, NSAIDS
IV. ALCOHOL WITHDRAWAL SYNDROME
Alcohol/Benzo Withdrawal: Neuroscience

• Alcohol binds to GABA and glutamate receptors – and chronic use leads to downregulation of GABA and upregulation of glutamine receptors

• Abrupt alcohol cessation – high glutaminergic (excitatory) and low GABAergic (inhibitory) state – i.e. imbalance of excitatory vs inhibitory signaling – withdrawal symptoms (tremor, seizure, nausea, delirium) – why certain medications (those w GABAergic activity – i.e. reversing GABA deficiency)
Alcohol Withdrawal

- DSM Criteria
- A. Cessation of (or reduction in) alcohol use that has been heavy and prolonged.
- B. Two (or more) of the following, developing within several hours to a few days after the cessation of (or reduction in) alcohol use described in Criterion A:
  - 1. Autonomic hyperactivity (e.g., sweating or pulse rate greater than 100 bpm)
  - 2. Increased hand tremor
  - 3. Insomnia
  - 4. Nausea or vomiting
  - 5. Transient visual, tactile, or auditory hallucinations or illusions
  - 6. Psychomotor agitation
  - 7. Anxiety
  - 8. Generalized tonic-clonic seizures
- C. The signs or symptoms in Criterion B cause clinically significant distress or impairment in social, occupation, or other important areas of functioning.
- D. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.

https://www.mdcalc.com/ciwa-ar-alcohol-withdrawal
Alcohol Withdrawal

TABLE 1: Common signs and symptoms of AWS

<table>
<thead>
<tr>
<th>Autonomic symptoms</th>
<th>Motor symptoms</th>
<th>Awareness symptoms</th>
<th>Psychiatric symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tachycardia</td>
<td>Hand tremor</td>
<td>Insomnia</td>
<td>Illusions</td>
</tr>
<tr>
<td>Tachypnea</td>
<td>Tremulousness of body</td>
<td>Agitation</td>
<td>Delusions</td>
</tr>
<tr>
<td>Dilated pupils</td>
<td>Seizures</td>
<td>Irritability</td>
<td>Hallucinations</td>
</tr>
<tr>
<td>Elevated blood pressure</td>
<td>Ataxia</td>
<td>Delirium</td>
<td>Paranoid ideas</td>
</tr>
<tr>
<td>Elevated body temperature</td>
<td>Gait disturbances</td>
<td>Disorientation</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Diaphoresis</td>
<td>Hyper-reflexia</td>
<td>Affective instability</td>
<td></td>
</tr>
<tr>
<td>Nausea/vomiting</td>
<td>Dysarthria</td>
<td>Combativeness</td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td></td>
<td>Disinhibition</td>
<td></td>
</tr>
</tbody>
</table>

Graph: Severity of alcohol withdrawal symptoms over time.

Acute symptomatic seizures vs. Unprovoked seizures.
Alcohol Withdrawal Management

**Figure 2** Clinical workflow of diagnosis and therapy of AWS
Alcohol Withdrawal Management

B. Pharmacotherapy

1. Risk of Severe, Complicated, Complications of Withdrawal
   - High
     - BZD
     - PB of BZD contraindicated
     - Continue prophylaxis during acute risk window
   - Low/Moderate
     - At least one dose of BZD
   - None
     - Withdrawal Severity?
       - Severe (CTCAE ≥ 3.0)
         - BZD
       - Moderate (CTCAE ≥ 2.0)
         - BZD
       - Mild (CTCAE ≤ 1.0)
         - Setting?
           - Ambulatory
             - Risk of Symptoms Worsening?
               - Yes
                 - BZD, CAR, GAB
               - No
                 - No Rx, BZD, CAR, GAB
           - Inpatient
             - Monitor frequency over next 24 hrs

2. BZD, Benzodiazepine, CAR, Carbamazepine, GAB, Gabapentin, No Rx, No medication (supportive care alone), PB, Phenobarbital.
Alcohol and Alcohol Use Disorder are Common: Medications for AUD

• Naltrexone
• Acamprosate
• Gabapentin
Questions?
REFERENCES
References


