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

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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?

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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

Tele-Behavioral Health: Clinician

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

Creative Ways Clinicians are Connecting with Clients

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]

2. Withdrawal[2]

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

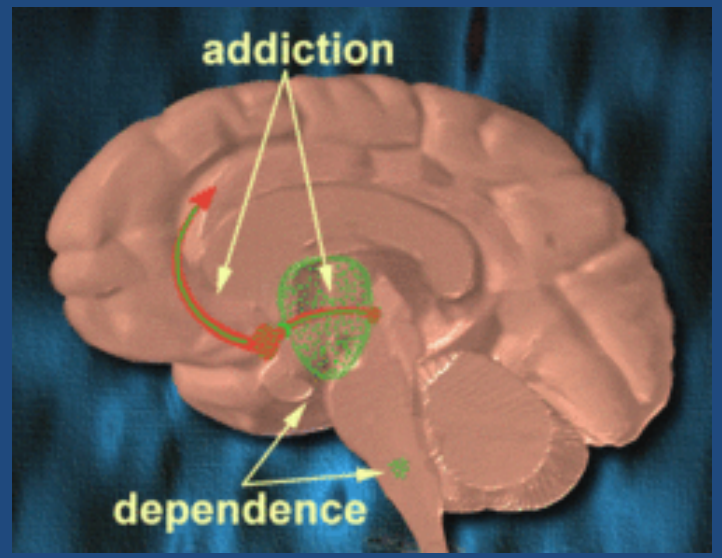
[1] Mild (2-3), moderate (4-5), severe (≥6)

[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)

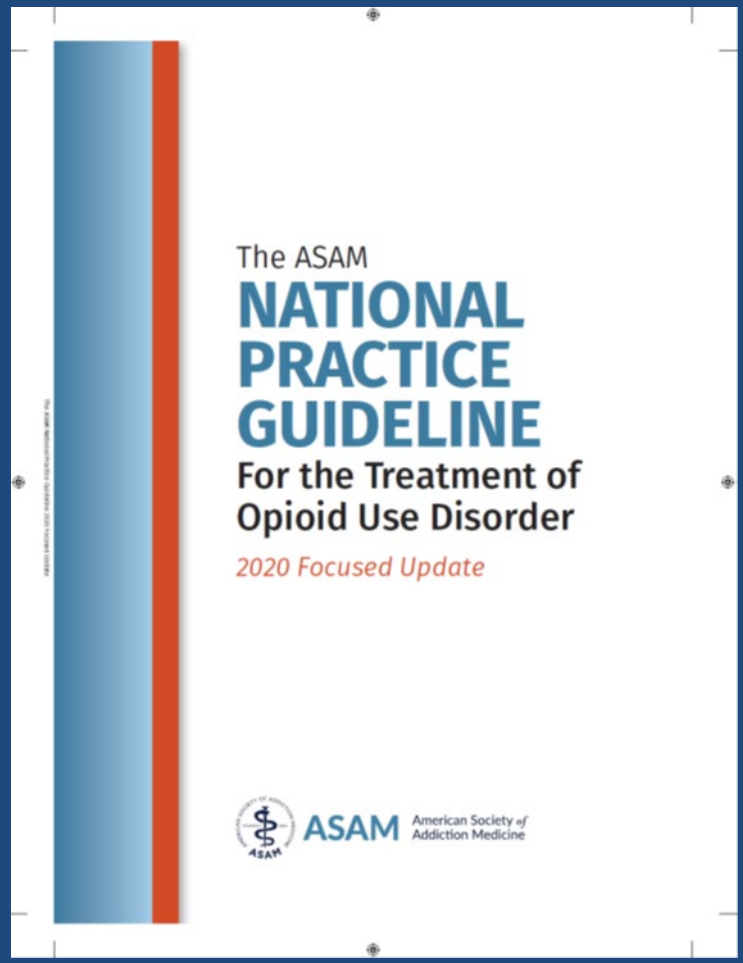
Dependence: affects thalamus and brainstem

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

Chronicity of withdrawal following opioid discontinuation

Drug	Onset, Hours	Peak	Resolution, Days
Buprenorphine	4–48	96 h	14–21
Fentanyl (intravenous)	2–5	8–12 h	4–5
Heroin	6–12	24–72 h	7–10
Short-acting prescription opioids	6–12	24–72 h	7–10
Long-acting prescription opioids	12–36	2–5 days	10–14
Methadone	24–72	4–6 days	14–21

Herring AA, Perrone J, Nelson LS. Ann Emerg Med 2018 PMID 30616926

Opioid Withdrawal

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Table 2
Symptom of opioid withdrawal

Time from Last Use[a]	Withdrawal Symptoms
3–4 h after last use	Drug craving Anxiety Fear of withdrawal
8–14 h after last use	• Generalized malaise • Flu-like symptoms • Anxiety • Restlessness • Insomnia • Yawning • Rhinorrhea • Lacrimation • Diaphoresis • Abdominal cramps • Mydriasis
1–3 d after last use	• Tremor • Muscle spasms • GI distress: nausea, vomiting, diarrhea • Hypertension • Tachycardia • Hyperthermia • Chills • Piloerection

[a] 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 (eg, 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

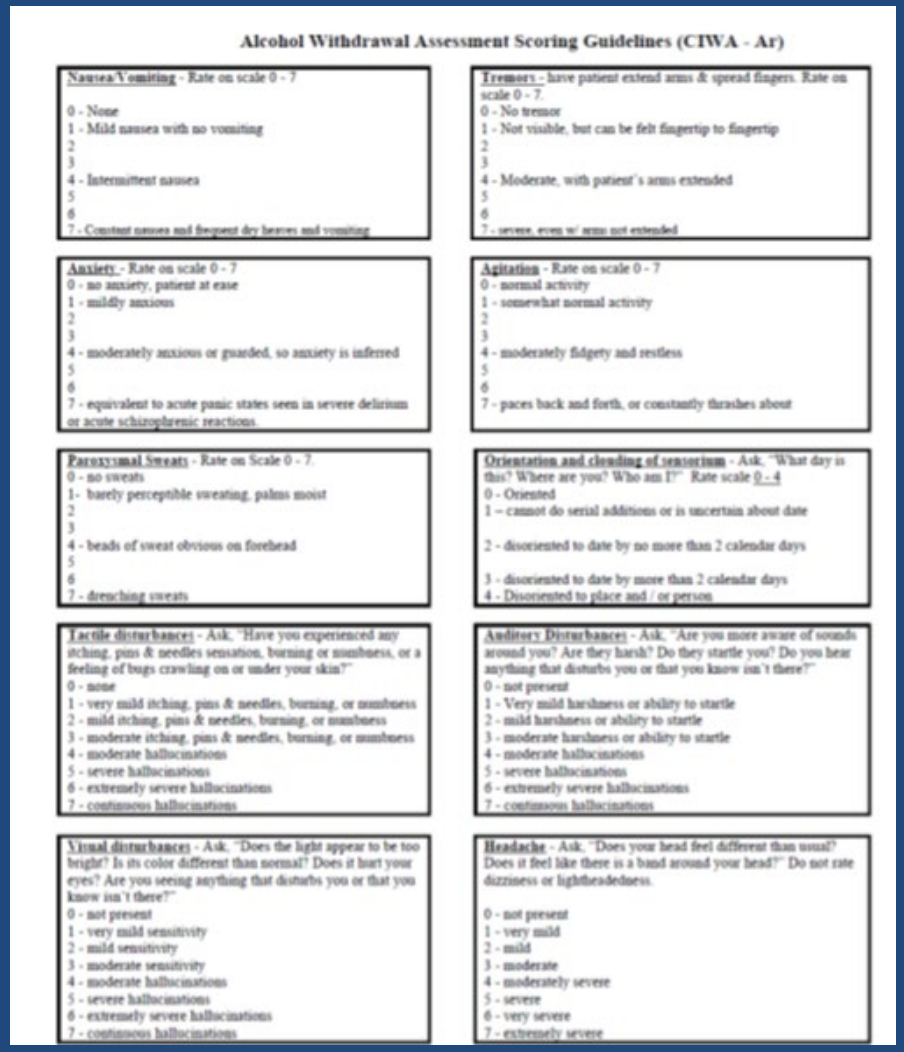
IV. ALCOHOL WITHDRAWAL SYNDROME

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.



Alcohol Withdrawal Assessment Scoring Guidelines (CIWA - Ar)

Nausea/Vomiting - Rate on scale 0 - 7

0 - None
1 - Mild nausea with no vomiting
2
3
4 - Intermittent nausea
5
6
7 - Constant nausea and frequent dry heaves and vomiting

Tremors - have patient extend arms & spread fingers. Rate on scale 0 - 7.

0 - No tremor
1 - Not visible, but can be felt fingertip to fingertip
2
3
4 - Moderate, with patient's arms extended
5
6
7 - severe, even w/ arms not extended

Anxiety - Rate on scale 0 - 7

0 - no anxiety, patient at ease
1 - mildly anxious
2
3
4 - moderately anxious or guarded, so anxiety is inferred
5
6
7 - equivalent to acute panic states seen in severe delirium or acute schizophrenic reactions

Agitation - Rate on scale 0 - 7

0 - normal activity
1 - somewhat normal activity
2
3
4 - moderately fidgety and restless
5
6
7 - paces back and forth, or constantly thrashes about

Paroxysmal Sweats - Rate on Scale 0 - 7.

0 - no sweats
1- barely perceptible sweating, palms moist
2
3
4 - beads of sweat obvious on forehead
5
6
7 - drenching sweats

Orientation and clouding of sensorium - Ask: "What day is this? Where are you? Who am I?" Rate scale 0 - 4

0 - Oriented
1 – cannot do serial additions or is uncertain about date
2 - disoriented to date by no more than 2 calendar days
3 - disoriented to date by more than 2 calendar days
4 - Disoriented to place and / or person

Tactile disturbances - Ask: "Have you experienced any itching, pins & needles sensation, burning or numbness, or a feeling of bugs crawling on or under your skin?"

0 - none
1 - very mild itching, pins & needles, burning, or numbness
2 - mild itching, pins & needles, burning, or numbness
3 - moderate itching, pins & needles, burning, or 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?"

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?"

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?" 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

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

Alcohol Withdrawal

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REVIEW ARTICLE

WILEY Acta Neurologica Scandinavica

Alcohol withdrawal syndrome: mechanisms, manifestations, and management

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The alcohol withdrawal syndrome is a well-known condition occurring after intentional or unintentional abrupt cessation of heavy/constant drinking in patients suffering from alcohol use disorders (AUDs). AUDs are common in neurological departments with patients admitted for coma, epileptic seizures, dementia, polyneuropathy, and gait disturbances. Nonetheless, diagnosis and treatment are often delayed until dramatic symptoms occur. The purpose of this review is to increase the awareness of the early clinical manifestations of AWS and the appropriate identification and management of this important condition in a neurological setting.

KEYWORDS
alcohol withdrawal, clinical management, delirium tremens, epileptic seizures, therapy

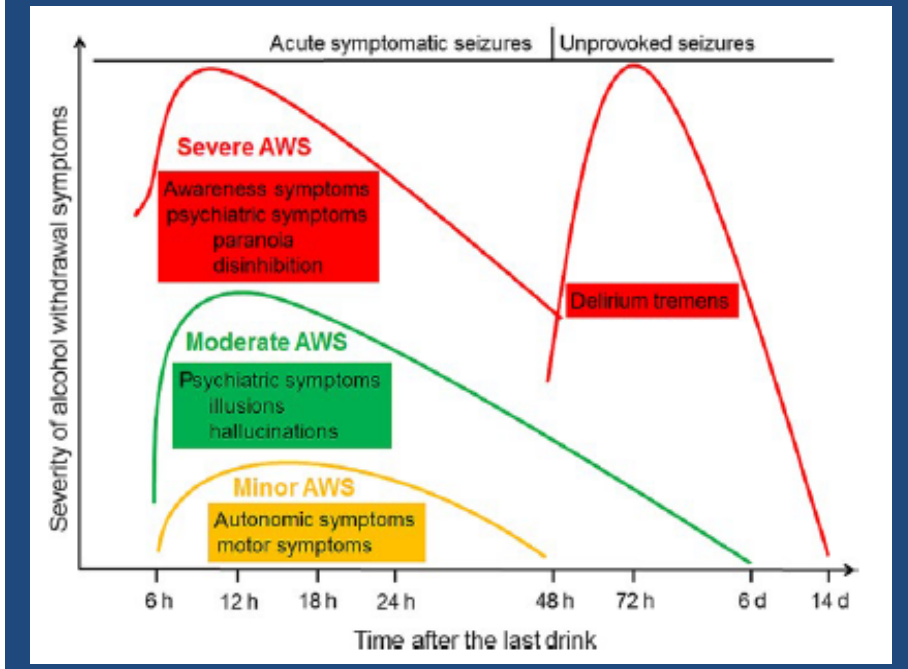
1 | INTRODUCTION - MEDICAL BURDEN OF ALCOHOL ABUSE

An estimated 76.3 million people worldwide have alcohol use disorders (AUDs), and these account for 1.8 million deaths each year.[1] It is estimated that up to 42% of patients admitted to general hospitals, and one-third of patients admitted to hospital intensive care units (ICU) have AUD.[2] Alcohol withdrawal syndrome (AWS) is a well-known condition occurring after intentional or unintentional abrupt cessation of heavy/constant drinking, and it occurs in about 8% of hospitalized AUD inpatients.[3] Severe AWS more than doubles the length of stay and frequently requires treatment at the ICU. A complicated AWS includes epileptic seizures and/or delirium tremens (DT), the occurrence of which may be as high as 15% in AUD patients.[4,5] Delirious patients show high rates of comorbidities, and their mortality rate is comparable to patients having severe malignant diseases. However, with early detection and appropriate treatment, the expected mortality is in the range of 1% or less.[6]

AUDs are common in patients referred to neurological departments, admitted for coma, epileptic seizures, dementia, polyneuropathy, and gait disturbances. Nonetheless, diagnosis and treatment are often delayed until dramatic symptoms occur. The purpose of this review is to increase the awareness of the early clinical manifestations of AWS and the appropriate identification and management of this important condition in a neurological setting.

TABLE 1 Common signs and symptoms of AWS

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



Alcohol Withdrawal Management

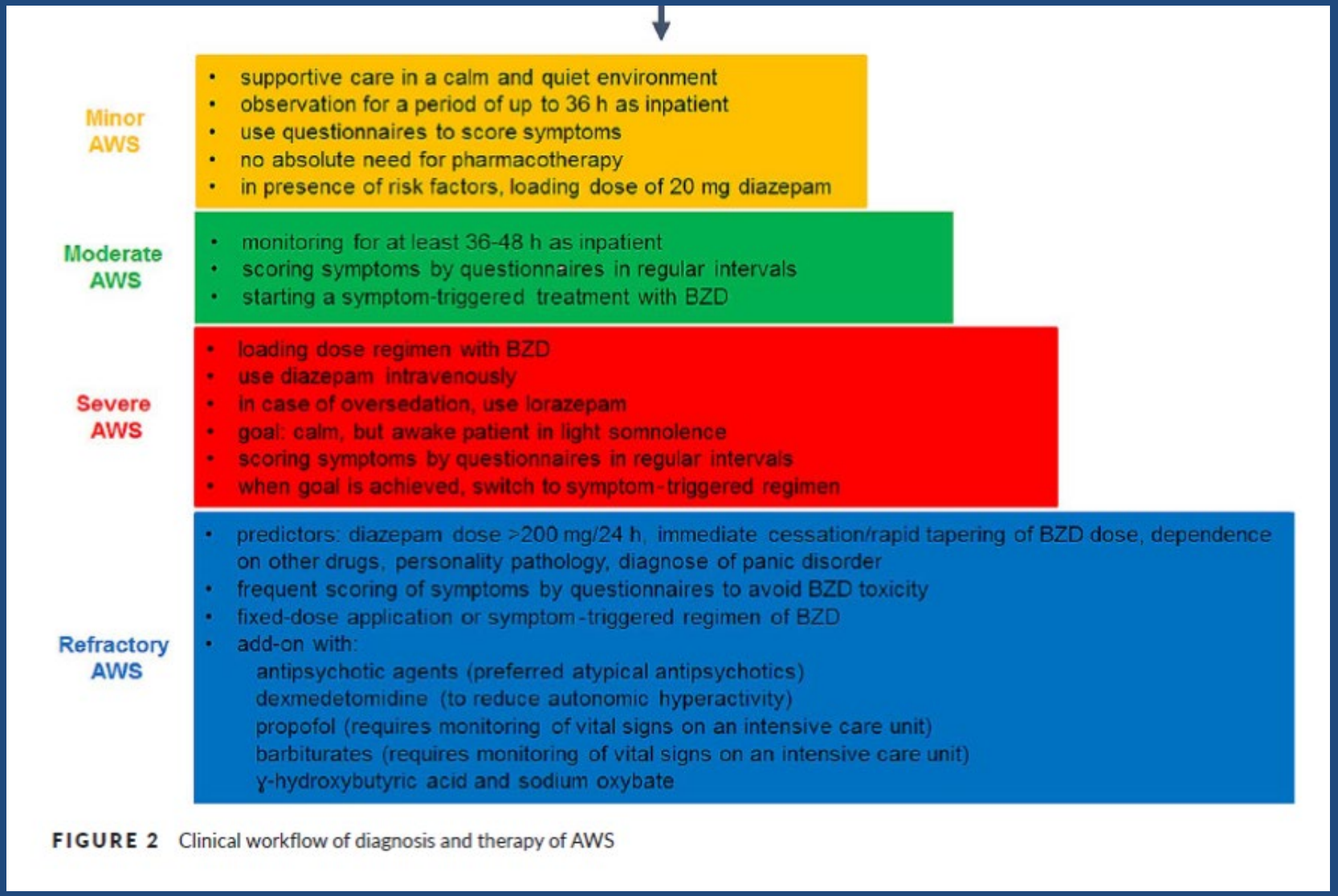
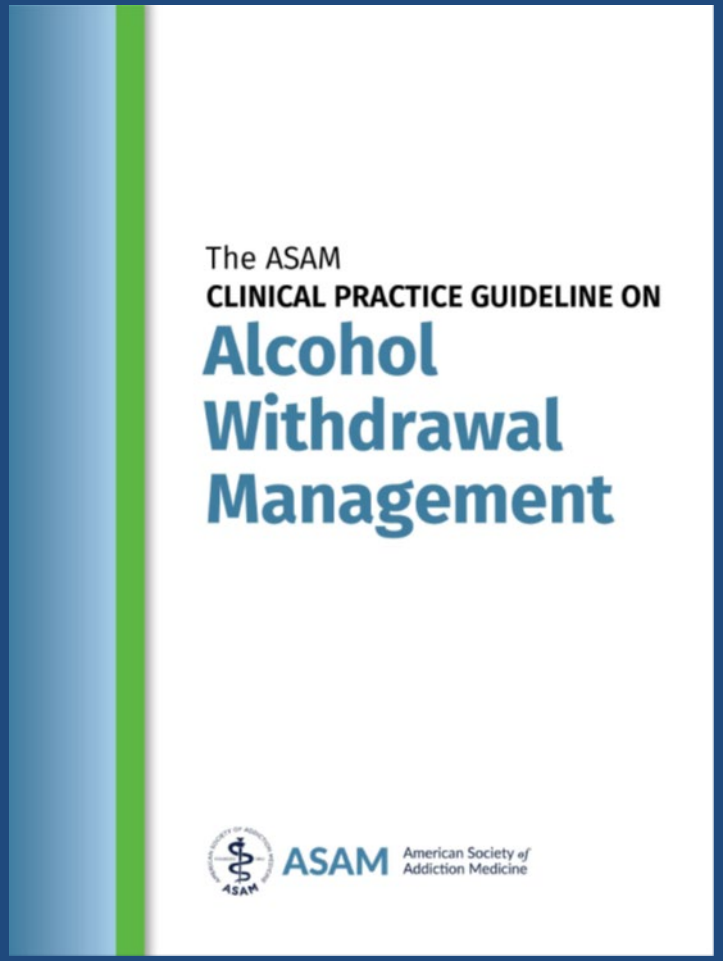
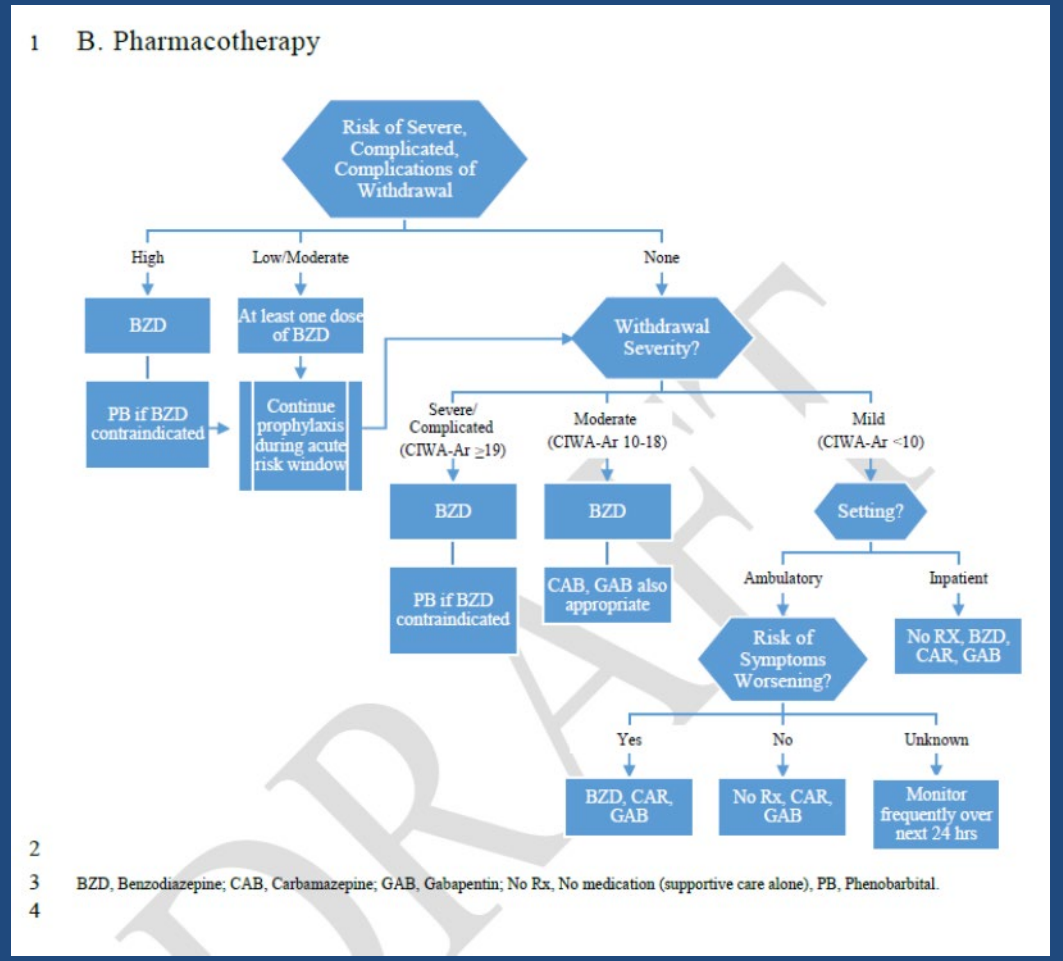


FIGURE 2 Clinical workflow of diagnosis and therapy of AWS

Alcohol Withdrawal Management





Alcohol and Alcohol Use Disorder are Common: Medications for AUD

- Naltrexone
- Acamprosate
- Gabapentin

Questions?

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