SUD Technical Assistance Webinar Series

VIRGINIA MEDICAID: 23—
ASAM CRITERIA ASSESSMENT
DIMENSIONS 1 & 2
PAUL BRASLER, LCSW
MARCH 29 & 30, 2021
Welcome and Meeting Information

- WebEx participants are muted
  - Please use Q&A feature for questions
  - Please use chat feature for technical issues
- Focus of today’s presentation is practice-based – please Contact SUD@dmas.virginia.gov with technical or billing questions
- SUPPORT 101 Webinar Series slide decks are available on the DMAS ARTS website – www.dmas.virginia.gov/#/ARTS
- We are unable to offer CEUs for this webinar series
Copyright

This material is copyrighted by Paul Brasler, LCSW, Behavioral Health Addiction Specialist, Virginia Department of Medical Assistance Services

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

Last revision: March 25, 2021
The Virginia Department of Medical Assistance Services (DMAS) SUPPORT Act Grant projects are supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $4,997,093 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.
The ASAM dimensions are designed to guide the assessment process and ensure that each client receives the most appropriate, individualized treatment. A clear understanding of these treatment assessment dimensions is critical for providers, Managed Care Organizations and other professionals in order to operationalize this content in practice with Medicaid members who have a substance use disorder.

**PLEASE NOTE** that the goal of this training is to help raise providers’ awareness and understanding around implementing ASAM Treatment Assessment dimensions. This training is not designed as a substitute for official ASAM training, nor is this to serve as a substitute for any ASAM training that is required by any local, state, or federal regulatory agency or certifying organization. **This training is not sponsored or endorsed by ASAM**
In conjunction with the VCU Wright Center and the VCU Institute for Drug and Alcohol Studies, we are conducting a survey for research purposes in order to gain a better understanding of provider impressions and experiences of individuals with substance use disorders (SUDs), medication assisted treatment, and Medicaid. The information obtained will be used to assist in identifying potential barriers to treating these individuals.

If you haven't already, before the start of today's webinar please use the link in the chat to access a brief (less than 5 minutes) electronic survey.

• Your name and contact information will not be linked to your survey responses.
• Your decision to complete the survey is completely voluntary.
• When exiting this webinar, you will be directed to complete the survey again as a post-training assessment. Again, it will be your decision to complete the follow-up survey or not.
• You are able to complete one pre and post survey per each webinar topic you attend.
• Your completion of the pre-webinar survey will enter you into a drawing to win a $50 Amazon gift card as well as participation in the post-webinar survey will enter you into another $50 Amazon gift card drawing!

If you have any questions about the current study, please feel free to contact, Dr. Lori Keyser-Marcus at Lori.keysermarcus@vcuhealth.org or (804) 828-4164. Thank you for helping us with this effort!
Naloxone Resources

- Get trained now on naloxone distribution
  - REVIVE! Online training provided by DBHDS every Wednesday
    - [https://getnaloxonenow.org/](https://getnaloxonenow.org/)
      - Register and enter your zip code to access free online training

- Medicaid provides naloxone to members at no cost and without prior authorization!

- Call your pharmacy before you go to pick it up!

- Getting naloxone via mail
  - Contact the Chris Atwood Foundation
    - [https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422](https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422)
    - Available only to Virginia residents, intramuscular administration
SUPPORT Act Grant Website -
https://www.dmas.virginia.gov/#/artssupport
The grant team has been working closely with Montserrat Serra, DMAS Civil Rights Coordinator, to provide closed captioning for our webinars and stakeholder meetings.

We were now able to provide closed captioning through Hamilton Relay for all upcoming webinars.

The link for transcription can be found on the Winter Webinar schedule and will be sent in the chat.
Paul Brasler is the Behavioral Health Addictions Specialist with the SUPPORT Grant Team at DMAS. Prior to working for DMAS, Paul was the Head of Behavioral Health at Daily Planet Health Services, a Federally-Qualified Health Center in Richmond, Virginia. Paul also works in Emergency Departments conducting Psychiatric and Substance Use Disorder assessments, and in a small medical practice. He has worked in community mental health and in residential treatment settings. He is a national presenter for PESI, specializing in training for clinicians working with high risk clients. His first book, *High Risk Clients: Evidence-based Assessment & Clinical Tools to Recognize and Effectively Respond to Mental Health Crises* was published in 2019.
Contact Information

Paul Brasler:
Paul.Brasler@dmas.virginia.gov

SUPPORT Act Grant Questions:
SUPPORTGrant@dmas.virginia.gov

ARTS Billing Questions
SUD@dmas.Virginia.gov
First Things First…

- Even the best assessment policy, process, tools or forms cannot replace an empathetic, trained provider.

- Prior to even thinking about doing an assessment, we need to agree:
  - People are worthy of help, have the right to self-determination, and should be treated with respect and dignity.
  - Our role is to walk with our clients; not live their lives for them, and to respect their choices, even when those choices are things we disagree about.
  - No one sets out to become addicted to substances or behaviors.
  - Recovery is possible and is defined by the client.
Language

- We want to use “Person-Centered language”
  - Not “Addict,” but Person who uses drugs or Person with a substance use/behavioral disorder
  - Not “Addiction,” but Substance Use Disorder (SUD)
  - Not “Abuse,” but Use
  - Not “Clean,” but In Recovery or Testing Negative
  - Not “Dirty,” but Testing Positive
  - Not “Relapse,” but Return to Use

- At the same time, out of habit, I may inadvertently use some of these older words/terminology—and some of the sources I quote use older terms

- Be cognizant that some people may describe themselves as “alcoholics,” “junkies,” etc., or may refer to “clean time” as how long they have been in recovery (and we need to respect this)
People with SUD may engage and dis-engage in treatment during their illness; knowledge gained during treatment can be cumulative, therefore this back-and forth pattern should not be viewed as treatment failure.
Why ASAM (American Society of Addiction Medicine) Criteria?

“The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions has its roots in the mid-1980s and was designed to help clinicians, payers, and regulators use and fund levels of care in a person-centered and individualized treatment manner. To increase access to care and improve the cost-effectiveness of addiction treatment, the ASAM Criteria represents a shift from [italics in original]:

(con’t)
Why ASAM (American Society of Addiction Medicine) Criteria?

- One-dimensional to multidimensional assessment—from treatment based solely on diagnosis to treatment that addresses multiple needs
- Program-driven to clinically and outcome-driven treatment—from placement in a program often with fixed lengths of stay to person-centered, recovery-oriented, individualized treatment response to specific needs and progress and outcomes in treatment
- Fixed length of service to a variable length of service, based on patient needs and outcomes; and
- A limited number of discrete levels of care to a broad and flexible continuum of care in a chronic disease management system of care” (Herron & Brennan, 2020, p. 172)
## ASAM Criteria Levels of Care

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Description (Herron &amp; Brennan, 2020, pgs. 174 – 175)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.0</td>
<td>Medically managed intensive inpatient. 24-hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2, or 3; counseling available to engage patient in treatment</td>
</tr>
<tr>
<td>3.7</td>
<td>Medically monitored intensive inpatient. 24-hour nursing care with physician availability for significant problems in Dimensions 1, 2, or 3; 16 hours per day for counselor availability</td>
</tr>
<tr>
<td>3.5</td>
<td>Clinically managed high-intensity residential treatment. 24-hour care with trained counselors to stabilize multi-dimensional imminent danger and prepare for outpatient treatment; able to tolerate and use a full active milieu or therapeutic community</td>
</tr>
<tr>
<td>3.3</td>
<td>Clinically managed-population-specific high-intensity residential. 24-hour care with trained counselors to stabilize multi-dimensional imminent danger; less intense milieu and group treatment for those with cognitive or other impairments unable to use a full active milieu or therapeutic community</td>
</tr>
<tr>
<td>3.1</td>
<td>Clinically managed low-intensity residential. 24-hour structure with available trained personnel with emphasis on re-entry to the community; at least 5 hours of clinical service per week</td>
</tr>
<tr>
<td>2.5</td>
<td>Partial Hospitalization. 20 hours of service or more per week in a structured program for multi-dimensional instability not requiring 24-hour care</td>
</tr>
<tr>
<td>2.1</td>
<td>Intensive Outpatient. 9 hours of service or more per week (adults); 6 hours or more per week (adolescents) in a structured program to treat multi-dimensional instability</td>
</tr>
<tr>
<td>1.0</td>
<td>Outpatient Services. Less than 9 hours or service per week (adults); &lt;6 hours per week (adolescents) for recovery or motivational enhancement therapies/strategies</td>
</tr>
</tbody>
</table>
ASAM Criteria Assessment Dimensions

- ASAM exists to provide best-practices guidance for SUD providers in all treatment settings
  - This includes guidance on how to conduct a comprehensive assessment for all clients receiving SUD treatment

- There is not a specific ASAM Assessment form or template
- Instead ASAM outlines **six criteria dimensions** that should be a part of every SUD assessment to ensure that the client’s needs are identified and met
<table>
<thead>
<tr>
<th>Assessment Dimensions</th>
<th>Assessment &amp; Treatment Planning Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acute intoxication and/or withdrawal potential</td>
<td>Assessment for intoxication or withdrawal management. Withdrawal management in a variety of levels of care and preparation for continued addiction services</td>
</tr>
<tr>
<td>2. Biomedical conditions and complications</td>
<td>Assess and treat co-occurring physical health conditions or complications. Treatment provided within the level of care or through coordination of physical health services</td>
</tr>
</tbody>
</table>
### ASAM Criteria Assessment Dimensions

(Herron & Brennan, 2015, p. 174)

<table>
<thead>
<tr>
<th>Assessment Dimensions</th>
<th>Assessment &amp; Treatment Planning Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Emotional, behavioral, or cognitive conditions and complications</td>
<td>Assess and treat co-occurring diagnostic or sub-diagnostic mental health conditions or complications. Treatment provided within the level of care or through coordination of mental health services</td>
</tr>
<tr>
<td>4. Readiness to change</td>
<td>Assess stage of readiness to change. If not ready to commit to full recovery, engage into treatment using motivational enhancement strategies. If ready for recovery, consolidate and expand action for change</td>
</tr>
<tr>
<td>Assessment Dimensions</td>
<td>Assessment &amp; Treatment Planning Focus</td>
</tr>
<tr>
<td>-----------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>5. Relapse, continued use, or continued problem potential</td>
<td>Assess readiness for relapse prevention services and teach where appropriate. Identify previous periods of sobriety or wellness and what worked to achieve this. If still at early stages of change, focus on raising consciousness of consequences of continued use or continued problems as part of motivational enhancement strategies</td>
</tr>
<tr>
<td>6. Recovery environment</td>
<td>Assess need for specific individualized family or significant others, housing, financial, vocational, educational, legal, transportation, childcare services. Identify any supports and assets in any or all of the areas</td>
</tr>
</tbody>
</table>
Assessment Recommendations (ASAM, 2020, p. 26)

Comprehensive assessment of the patient is critical for treatment planning.

However, completion of all assessments should not delay or preclude initiating pharmacotherapy for opioid use disorder.

If not completed before initiating treatment, assessments should be completed soon thereafter.
Assessment Criteria
Dimension 1
ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL
Assessment Criteria Dimension 1

- Assessment for intoxication or withdrawal management
  - “Of immediate concern is life-threatening intoxication or overdose” (Herron & Brennan, 2020, p. 285)
- Withdrawal management in a variety of levels of care and preparation for continued addiction services
Substance Intoxication

“Intoxication refers to the immediate effects of the drug and occurs during consumption of a drug in a large enough dose to produce significant behavioral, physiological or cognitive impairments. It is these intoxicating effects that drive initial use. When drugs are consumed, a cascade of short- and long-term effects follows. Although some of the effects of intoxication are pleasant and desired, other effects can be aversive” (Filbey, 2019, p. 64)

Some forms of intoxication require immediate medical treatment
Depressant Intoxication Symptoms

- Lowered inhibitions
- Mild euphoria
- Depression, sedation and relaxation
- Nausea & vomiting
- Memory loss
- Drowsiness, sleep induction
- Reduced coordination and speech
- Decreased respiration
Alcohol & Sedative-Hypnotic Intoxication

“Even with very high blood alcohol levels, survival is probable if the respiratory and cardiovascular systems can be supported” (Herron & Brennan, 2020, p. 290)

“Benzodiazepines cause impaired activity and memory, even at low (therapeutic) doses. Mild-to-moderate toxicity presents with slurred speech, ataxia, and incoordination. Severe intoxication can induce stupor and coma”

“Benzodiazepines are rarely lethal when used alone but may become so when high doses are combined with alcohol, barbiturates, or opiates” (Herron & Brennan, 2020, p. 298)
Signs of Stimulant Intoxication

- Dilated Pupils
- Fast heart rate (tachycardia)
- Hypertension
- Increased activity
- Fever
- Aggression
- Panic
- Paranoia
- Psychosis
- Seizures

**COMMON:**
- Dry mouth
- Headache
- Uncontrollable shaking

**Side Effects of Adderall**
- Pounding heartbeat
- Vision change
- Death

**SERIOUS**
Opiate Abuse
Physical signs someone you know is abusing opiates.

- Sedation
- Nausea
- Constipation
- Pinpoint Pupils
- Slowed Breathing
- Coma & Death

- Nodding
  This is when a person temporarily falls asleep at an unusual time like during a conversation or while standing.

- Constricted Pupils
  Heroin or other opiates will cause the user to have constricted pupils which will appear as pinpoints or a small dot.

- Covering their Arms
  A person may wear long sleeve shirts, and keep their arms covered, even if it is hot outside.

- Needle Marks
  Also known as track marks. If someone is shooting the drugs, they may have needle marks on the arms, behind their knees, or ankles.

- Bad coordination
  If someone is high on opiates, their balance may be off, and they might stumble and tip while walking.

- Scratching
  Another clue is that someone on opiates will usually itch and scratch frequently.

Are you concerned someone you love has an opiate addiction? Visit newroadstreatment.com and see what you can do to help.
Opioid Intoxication: Mortality & Morbidity

Over 81,000 drug overdose deaths occurred in the United States in the 12 months ending in May 2020.

- The highest number of overdose deaths ever recorded in a 12-month period.
- 132 People every day from an opioid overdose.
- Drug overdose deaths now exceed those attributable to firearms, car accidents, homicides, or HIV/AIDS.

Learn more about the evolving opioid overdose crisis: www.cdc.gov/drugoverdose
“Physical examination of the patient with opioid intoxication may find CNS [Central Nervous System] and respiratory depression as well as miosis [excessive shrinking of the pupils] and direct evidence of intravenous drug use, such as needle tracts or soft tissue infection”

“The opioid overdose syndrome, described as a triad of altered mental status, depressed respiration, and miotic pupils, has a sensitivity of 92% and a specificity of 76%” (Herron & Brennan, 2020, p. 304)
Ways to Assess for Substance Intoxication

- **Ask:**
  - “What substances are you using now?”
  - “How much (of each substance) do you use per day?”
  - “How long have you been using (each substance)?”
  - “When was the last time you used (each substance)?”
  - “How are you feeling now?”

- **Physical exam**

- **Urine drug screening** (be aware of false-positive results on rapid tests and that many substances cannot be detected on standard tests)
Urine Drug Screens

- No form of drug testing is accurate 100% of the time
- Drug testing can be a part of the therapeutic process, and should not be used punitively
- UDS are the cheapest and easiest-to-use form of drug testing
  - There should be a testing protocol in place for your agency before you use these tests
  - UDS have limited value if the person is not directly observed giving the sample but this can be at odds with attracting people to treatment
UDS: Point of Care

Point-of-Care [POC] urine drug testing (e.g., immunoassay) uses antibodies to locate metabolites of drugs the person may have used.

The possibility of a false-positive (or a false negative) varies, so POC tests should be verified by lab tests (see slide 37): Do not make treatment or legal decisions based on a POC test alone!

Be aware that many chemicals/agents are available to add or substitute in a sample to create a false reading.
## Approximate Detection Time Using Screening Urine Immunoassays (with Commonly Used Cutoffs)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Duration of Detection (Approximate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amphetamine</td>
<td>1 – 3 Days</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>3 Days</td>
</tr>
<tr>
<td>Barbiturate</td>
<td></td>
</tr>
<tr>
<td>• Short acting</td>
<td>1 – 4 Days</td>
</tr>
<tr>
<td>• Long acting</td>
<td>Several weeks</td>
</tr>
<tr>
<td>Cocaine</td>
<td>3 Days</td>
</tr>
<tr>
<td>Cannabis</td>
<td></td>
</tr>
<tr>
<td>• Single joint</td>
<td>2 Days</td>
</tr>
<tr>
<td>• Heavy Use</td>
<td>Up to 27 Days</td>
</tr>
<tr>
<td>Opioids</td>
<td></td>
</tr>
<tr>
<td>• Heroin, codeine, morphine</td>
<td>1 – 2 Days</td>
</tr>
<tr>
<td>• Methadone (using a specific assay)</td>
<td>2 – 3 Days</td>
</tr>
<tr>
<td>Phencyclidine</td>
<td>7 Days <em>(Herron &amp; Brennan, 2020, p. 131)</em></td>
</tr>
</tbody>
</table>
UDS: Lab Testing

- Gas Chromatography/Mass Spectrometry Combined (GC/MS) is the industry-standard for drug testing
  - Very sensitive and accurate
  - Expensive and time-consuming
  - GC/MS can also provide levels of a drug in the sample

- Understand that levels can decrease and increase without the client consuming more of a substance between tests
  - This variation in levels depends on several factors, including the person’s metabolism

- Once a specific cut-off for the test is established, the test should only be read as positive or negative
“Withdrawal is a negative state that occurs following cessation from use of a drug that has caused physical dependence. In other words, withdrawal most often occurs in those who have used a drug on a regular basis rather than occasionally” (Filbey, 2019, p. 81)

Some forms of substance withdrawal (specifically alcohol, and other central nervous system depressants) may require immediate and ongoing medical attention to prevent further illness or death

“Confounding or exacerbating conditions, such as head trauma, central nervous system infections, other drug influences, and metabolic disturbances must be appropriately excluded” (Herron & Brennan, 2020, p. 291)
ASAM Goals for Withdrawal Management  
(Herron & Brennan, 2015, p. 252)

Withdrawal management alone is NOT treatment and rarely successful without follow-on treatment and multi-dimensional support.

Three immediate goals for withdrawal management:

1. To provide a safe withdrawal from the drug(s) of dependence and enable the patient to become drug free.
2. To provide a withdrawal that is humane and thus protects the patient’s dignity.
3. To prepare the patient for ongoing treatment of his or her dependence on alcohol or other drugs.
Alcohol/Depressant Withdrawal Symptoms

- Nausea/vomiting
- Cravings
- Malaise & weakness
- Tachycardia
- Delirium, including hallucinations
- Anxiety rebound and agitation
- Sweating
- Irritability
- Orthostatic Hypotension
- Tremors
- Insomnia
- Seizures possible
- Depersonalization
- High fever
- Depression
Alcohol Withdrawal Course

- Begins within 4 – 24 hours after the last drink
- In mild forms of withdrawal, the symptoms resolve after 48 hours
- Tremulousness is the earliest symptom and many people with AUD know that this indicates a need to drink again to avoid more pronounced symptoms
- This appears within hours after drinking stops and peaks in 1 – 2 days but can persist for weeks
- In more severe forms, visual hallucinations can occur within 24 hours of cessation—to the patient these are real
Alcohol Withdrawal Course

- Between 6 – 48 hours after stopping ETOH use, 3 – 4% of untreated patients will have a seizure
- 30 – 40% of patients who have a seizure will progress into Delirium-Tremens if they are left untreated
- Delirium-Tremens are fatal in up to 25% of people who are not treated
- D-Ts can precede or follow a seizure
- Repeated withdrawal episodes seem to “kindle” more serious withdrawal episodes

(Inaba & Cohen, 2014)
Withdrawal Management: Alcohol (CIWA-AR)

- Measures signs (objective findings) and symptoms (subjective reports) to determine the number and intensity of withdrawal symptoms and the need for medication (diazepam or lorazepam) to address symptoms OR the need to transfer the patient to an Intensive Care Unit
- CIWA is used in inpatient and outpatient settings
- Medication can be administered on a schedule or as a PRN
- Signs: Pulse, Resting Heart Rate, O2 Saturation & Blood Pressure
- Symptoms cover 10 areas and are scored on an 8-point scale (except for “Orientation and clouding of sensorium” which is a 4-point scale); with higher numbers describing severe symptoms and 0 meaning no symptoms
CIWA-AR Symptoms

- Nausea/Vomiting
- Anxiety
- Paroxysmal Sweats
- Tactile Disturbances
  - “Have you experienced any itching, pins & needles sensation, burning or numbness, or a feeling of bugs crawling on or under your skin?”
- Visual Disturbances
  - “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?”

- Tremors
  - Have patient extend arms and spread fingers
- Agitation
- Orientation
  - “What day is this? Where are you? Who am I?”
- Auditory Disturbances
  - “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?”
- Headache
  - “Does your head feel different than usual? Does it feel like there is a band around your head?”
Sedative-Hypnotic Withdrawal Syndrome

- “Short-acting benzodiazepines [e.g., alprazolam] have more intense withdrawal syndromes than longer acting agents” (Herron & Brennan, 2020, p. 300)

- “Pseudowithdrawal [italics in original] occurs when the expectations of withdrawal lead to the experience of abstinence symptoms in the absence of decreased medication dosages” (Herron & Brennan, 2020, p. 299)
Stimulant Withdrawal Symptoms

- Anhedonia; Depressed mood; Apathy
- Anxiety; Irritability
- Cravings
- Fatigue
- Insomnia or hypersomnialia
- Psychomotor retardation at first, then agitation
- Paranoia
- Headaches
- Increase in appetite
- Social withdrawal
Stimulant Withdrawal Course

- Tolerance often develops quickly
- Acute withdrawal symptoms usually peak within two – four days…
- …but depression, anxiety and irritability can continue for months
- Craving often continues for months or years
- Antidepressants may be used to address withdrawal-related depressive symptoms
Opioid Withdrawal Symptoms

- Cravings
- Irritability
- Depression, anxiety
- Nausea, vomiting, stomach cramps, diarrhea
- Lacrimation
- Rhinorrhea
- Piloerection

- Muscle (and possibly bone) aches and pains
- Hot and cold flashes
- Uncontrolled sweating
- Yawning
- Anorexia
- Insomnia
- Fever
- Dilated pupils
Opioid Withdrawal Course

- Symptoms appear within 6 – 8 hours of last dose
- Symptoms peak on the 2\textsuperscript{nd} or 3\textsuperscript{rd} day
- Symptoms usually disappear within 7 – 10 days
- Duration is much longer with Methadone (about twice as long as heroin takes)
  - Methadone withdrawal can last at least three weeks after the last use if the patient was using a large amount of Methadone
- Post-acute withdrawal symptoms continue for many months afterward
Withdrawal Management Protocols: Opioids (COWS)

- The Clinical Opiate Withdrawal Scale examines 11 areas that comprise subjective and objective (observations & clinical measures) to assess the severity of the client’s withdrawal process.
- Items are scored from 0 – 4 (sometimes 5).
- The resulting score can be utilized to determine the frequency, route, dosage and type of medication that may be used to alleviate some of the symptoms.
- The COWS is used in inpatient and outpatient settings.
- The Subjective Opiate Withdrawal Scale (SOWS) is also sometimes used.
COWS Items

- Resting pulse rate (bpm: measured after the patient is sitting or lying for one minute)
- Sweating (over past 30 minutes not accounted for by room temperature or patient activity)
- Restlessness (observation during assessment)
- Bone or Joint aches (if patient was having pain previously, only the additional component attributed to opioid withdrawal is scored)

- Pupil size
- Runny nose or tearing (not accounted for by cold symptoms or allergies)
- GI Upset (over last 30 minutes)
- Tremor (observation of outstretched hands)
- Yawning (observation during assessment)
- Anxiety or Irritability
- Gooseflesh skin
<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory withdrawal</td>
<td>Level of Withdrawal Management Service for Adults (Herron &amp; Brennan, 2020, p. 175)</td>
</tr>
<tr>
<td>management without</td>
<td>1-WM Mild withdrawal with daily or less than daily outpatient supervision; likely to complete withdrawal management and to continue treatment or recovery</td>
</tr>
<tr>
<td>extended on-site</td>
<td>2-WM Moderate withdrawal with all-day withdrawal management support and supervision; at night, has supportive family or living situation; likely to complete withdrawal management</td>
</tr>
<tr>
<td>monitoring</td>
<td>3.2-WM Minimal to moderate withdrawal but needs 24-hour support to complete withdrawal management and to increase the likelihood of continuing treatment or recovery</td>
</tr>
<tr>
<td>Clinically-managed</td>
<td>3.7-WM Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete withdrawal management without medical, nursing monitoring</td>
</tr>
<tr>
<td>residential</td>
<td>4-WM Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify the withdrawal management regimen and manage medical instability</td>
</tr>
<tr>
<td>withdrawal management</td>
<td></td>
</tr>
<tr>
<td>Medically monitored</td>
<td></td>
</tr>
<tr>
<td>inpatient withdrawal</td>
<td></td>
</tr>
<tr>
<td>management</td>
<td></td>
</tr>
<tr>
<td>Medically managed</td>
<td></td>
</tr>
<tr>
<td>inpatient withdrawal</td>
<td></td>
</tr>
<tr>
<td>management</td>
<td></td>
</tr>
</tbody>
</table>
Inpatient Withdrawal Management

- Occurs in medical hospitals, psychiatric hospitals and medically-managed residential programs
- The focus is on safety and medical stability while using medications to assist in the detoxification process
- Methadone or buprenorphine are typically used to taper patients withdrawing from opioids; Clonidine, Zofran, Lofexidine, and other medications are also used to help alleviate symptoms
- Diazepam, lorazepam, Librium, or barbiturates are used to taper clients withdrawing from alcohol or other sedatives
- Once the patient is stable, they are transitioned to a less-intense level of care, sometimes within the same facility (as in residential programs), or another program
Assessment Criteria
Dimensions 2

BIOMEDICAL CONDITIONS AND COMPLICATIONS
Assessment Criteria Dimension 2

- Assess and treat co-occurring physical health conditions or complications
- Treatment provided within the level of care or through coordination of physical health services
Signs & Symptoms

Signs and symptoms are often used interchangeably in clinical terminology; however, they have specific meanings:

- **Signs** can be detected by someone other than the patient (e.g., elevated heart rate or blood pressure)
- **Symptoms** are experienced and reported by the patient (e.g., depression, anxiety or pain)

*Distinguishing between medical, mental health, or SUD problems, or specifically, ruling out a medical problem, requires medical testing and attention to the symptom profile—obtain a medical assessment*
Medical Assessment

- **Vital signs:**
  - Body temperature
  - Blood oxygen level
  - Heart rate
  - Respirations
  - Blood pressure

- **Blood work:**
  - Complete blood count
  - Blood chemistry
  - Metabolic panel
  - Blood alcohol level
  - Therapeutic medication blood levels
  - Hep B, C; HIV Testing

- **Urine Testing:**
  - Urinalysis
  - Urine drug screen

- **Pregnancy Test**

- **Electrocardiogram (EKG/ECG)**

- **Medical imaging (if necessary):**
  - X-ray
  - C-T scans

- **Physical exam by a medical provider**
<table>
<thead>
<tr>
<th>Medical Problems That May Appear As Mental Health or SUD Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delirium</td>
</tr>
<tr>
<td>Hypoxia</td>
</tr>
<tr>
<td>Blood sugar levels too high or too low</td>
</tr>
<tr>
<td>Urinary Tract Infections</td>
</tr>
<tr>
<td>Stevens-Johnson Syndrome</td>
</tr>
<tr>
<td>Medication allergies</td>
</tr>
<tr>
<td>Stroke</td>
</tr>
<tr>
<td>Neuroleptic Malignant Syndrome</td>
</tr>
<tr>
<td>Cancer</td>
</tr>
<tr>
<td>Brain bleeds</td>
</tr>
<tr>
<td>Medication reactions</td>
</tr>
<tr>
<td>Thyroid levels too high or too low</td>
</tr>
<tr>
<td>Traumatic Brain Injury</td>
</tr>
<tr>
<td>Environmental poisonings</td>
</tr>
<tr>
<td>Chronic illnesses (Multiple Sclerosis, H.I.V./A.I.D.S.)</td>
</tr>
</tbody>
</table>
Hospitalization
(Herron & Brennan, 2020, pgs.161 – 162)

Hospitalization is appropriate for patients whose assessed need cannot be treated safely in an outpatient or Emergency Department setting due to:

- Severe or medically complicated withdrawal potential,
- Co-occurring medical or psychiatric conditions that complicate detoxification or impair treatment,
- Failure to engage in treatment at a lower level of care,
- Life- or limb-threatening medical conditions that would require hospitalization,
- Psychiatric disorders that make the patient an imminent threat to self or others, or
- Failure to respond to care at any level such that the patient endangers others or poses a self-threat


