ASAM Monthly Technical Assistance Series

Withdrawal Management

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Reminders

- Questions should be submitted 7 days in advance of the call to RA-DAASAM@pa.gov. Please feel free to submit questions in the chat.
- This call is being recorded. Please exit now if you do not want to be recorded. You will be able to review the video in its entirety on the DDAP webpage following this event.
- Suggestions for future call topics should be submitted to RA-DAASAM@pa.gov.

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Disclaimers

Alignment with The ASAM Criteria is required of drug and alcohol treatment providers that receive funding for providing treatment services under agreements with Single County Authorities and/or Managed Care Organizations.

DDAP stresses the importance of reviewing the ASAM Criteria text in its entirety, attending the ASAM two-day training, and reviewing the resources available through DDAP including trainings and documents.

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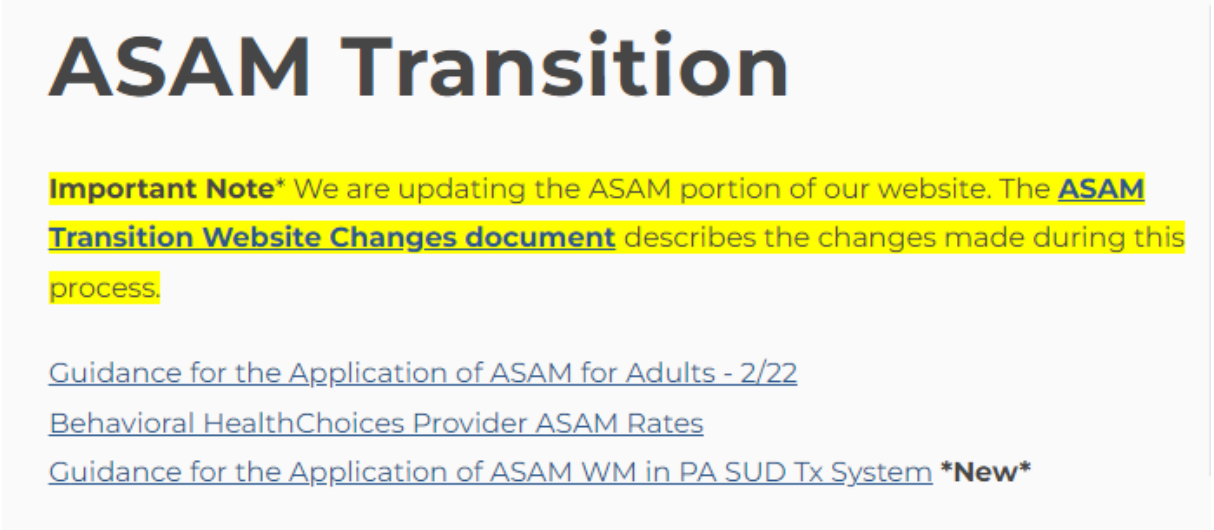
Learning Objectives

1. ASAM Withdrawal Management (WM) 101
2. Substance Specific Considerations in WM
3. Provide a brief overview of the five levels of Withdrawal Management (WM)



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ASAM Definition of Withdrawal Management

"Services required for Dimension 1, Acute Intoxication and/or Withdrawal Potential. The ASAM Criteria more accurately describes services to assist a patient's withdrawal. The liver detoxifies but clinicians manage withdrawal. If the person is intoxicated and not yet in withdrawal, Dimension 1 services needed would be intoxication management"(p.432).

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Role of Counseling & Therapy in WM

"The onset of a physical withdrawal syndrome, uncomfortable and potentially dangerous, arguably provides an unparalleled opportunity to engage a patient in what will hopefully be sustained recovery. Because current WM protocols can relieve withdrawal symptoms so quickly and effectively, counseling and therapy focused on initiation or resumption of recovery can be instituted at the same time as WM, rather than being delayed" (p.128).

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Common Themes

1. WM can be managed effectively on an ambulatory basis.
2. Need for WM services to be provided under a defined set of Physician approved policies and Physician monitored procedures or clinical protocols.
3. Length of service is individualized.
4. Access to higher and lower levels of care.
5. Family involvement.
6. Patient education.
7. Access to range of therapies as appropriate to the individual.
8. Interdisciplinary teams.

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Alcohol

- Severity of alcohol withdrawal can be difficult to predict
- The most predictive factors are history of complicated withdrawal
- The Prediction of Alcohol Withdrawal Severity Scale (PAWSS) has performed better than other predictive tools[1]
- The Clinical Institute Withdrawal Assessment-Revised (CIWA-Ar) can be used to assess the severity of active withdrawal, but is not predictive
  - Withdrawal Assessment Score (WAS) adds vital signs to CIWA-Ar
- Alcohol withdrawal can be complex and potentially life-threatening with multiple possible treatment pathways
- Critical to evaluate for co-occurring illness and nutrition in heavy drinkers

1. Maldonado JR, Sher Y, Das S, Hills-Evans K, Frenklach A, Lolak S, Talley R, Neri E. Prospective Validation Study of the Prediction of Alcohol Withdrawal Severity Scale (PAWSS) in Medically Ill Inpatients: A New Scale for the Prediction of Complicated Alcohol Withdrawal Syndrome. Alcohol Alcohol. 2015 Sep;50(5):509-18. doi: 10.1093/alcalc/agv043. Epub 2015 May 21. PMID: 25999438.

Prediction of Alcohol Withdrawal Severity Scale (PAWSS)

Maldonado et al., 2014

Part A: Threshold Criteria:

("+" or "-", no point)

Have you consumed any amount of alcohol (i.e., been drinking) within the last 30 d? OR did the patient have a "+" BAL upon admission? _____

IF the answer to either is YES, proceed with test:

Part B: Based on patient interview:

(1 point each)

1. Have you ever experienced previous episodes of alcohol withdrawal? _____
2. Have you ever experienced alcohol withdrawal seizures? _____
3. Have you ever experienced delirium tremens or DT's? _____
4. Have you ever undergone alcohol rehabilitation treatment? _____
   (i.e., in-patient or out-patient treatment programs or AA attendance)
5. Have you ever experienced blackouts? _____
6. Have you combined alcohol with other "downers" like benzodiazepines or barbiturates during the last 90 d? _____
7. Have you combined alcohol with any other substance of abuse during the last 90 d? _____
8. Have you been recently intoxicated/drunk within the last 30 d ? _____

Part C: Based on clinical evidence:

(1 point each)

9. Was the patient's blood alcohol level (BAL) on presentation >200? _____
10. Is there evidence of increased autonomic activity?
    (e.g., HR >120 bpm, tremor, sweating, agitation, nausea) _____

Total Score: _____

Notes: Maximum score = 10. This instrument is intended as a SCREENING TOOL. The greater the number of positive findings, the higher the risk for the development of alcohol withdrawal syndromes. A score of ≥4 suggests HIGH RISK for moderate to severe AWS; prophylaxis and/or treatment may be indicated.

Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

Patient:_____ **Date:** _____ **Time:** _____ (24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute:_____ **Blood pressure:**_____

NAUSEA AND VOMITING -- Ask "Do you feel sick to your stomach? Have you vomited?" Observation.
0 no nausea and no vomiting
1 mild nausea with no vomiting
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves and vomiting

TACTILE DISTURBANCES -- Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.
0 none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning or numbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

TREMOR -- Arms extended and fingers spread apart. Observation.
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 with arms not extended

AUDITORY DISTURBANCES -- Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.
0 not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

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

VISUAL DISTURBANCES -- Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.
0 not present
1 very mild sensitivity
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

ANXIETY -- Ask "Do you feel nervous?" Observation.
0 no anxiety, at ease
1 mild anxious
2
3
4 moderately anxious, or guarded, so anxiety is inferred
5
6
7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

HEADACHE, FULLNESS IN HEAD -- Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.
0 not present
1 very mild
2 mild
3 moderate
4 moderately severe
5 severe
6 very severe
7 extremely severe

AGITATION -- Observation.
0 normal activity
1 somewhat more than normal activity
2
3
4 moderately fidgety and restless
5
6
7 paces back and forth during most of the interview, or constantly thrashes about

ORIENTATION AND CLOUDING OF SENSORIUM -- Ask "What day is this? Where are you? Who am I?"
0 oriented and can do serial additions
1 cannot do serial additions or is uncertain about date
2 disoriented for date by no more than 2 calendar days
3 disoriented for date by more than 2 calendar days
4 disoriented for place/or person

Total **CIWA-Ar** Score _____
Rater's Initials _____
Maximum Possible Score 67

 This assessment for monitoring withdrawal symptoms requires approximately 5 minutes to administer. The maximum score is 67 (see instrument). Patients scoring less than 10 do not usually need additional medication for withdrawal.

Sullivan, J.T.; Sykora, K.; Schneiderman, J.; Naranjo, C.A.; and Sellers, E.M. Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (**CIWA-Ar**). *British Journal of Addiction* 84:1353–1357, 1989.

Sedative/Hypnotics

- Important to screen for non-traditional sedative-hypnotics
  - Z drugs, some muscle relaxers (methocarbamol, carisoprodol), and illicit/synthetic benzos (etizolam, flubromazolam)
  - GABA-B agonists, e.g. baclofen, GHB, and phenibut
- Not all sedative/hypnotics will result in a positive benzodiazepine screen or be found on all confirmatory drug tests
  - Clonazepam is well known to give a false negative benzo screen
- Pathophysiology and risk is similar to ethanol withdrawal and the PAWSS and WAS/CIWA-Ar can be adapted to gauge severity
- Withdrawal can be prolonged and associated with persistent delirium
- Outpatient tapering may be more protracted than with ethanol

Opioids

- Opioid withdrawal management rarely requires hospitalization unless there are significant confounding factors, e.g. GABA agonist use or complicated medical history
- Withdrawal management should ideally utilize opioid agonist therapy, e.g . Buprenorphine or methadone
  - Non-opioid medication treatment may be appropriate depending upon patient goals
- Withdrawal management should be initiated immediately and should not be made contingent upon completion of intake assessments and counseling[1,2]
- Clinical Opioid Withdrawal Scale (COWS) should be assessed to guide medication management, especially buprenorphine induction
  - Alternatively the Clinical Institute Narcotic Assessment (CINA) Scale
- The Subjective Opioid Withdrawal Scale (SOWS) can be self-administered to help patients guide home induction of buprenorphine

1. American Society of Addiction Medicine (ASAM) National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update. J Addict Med. 14(2S Suppl 1):1-91
2. National Academies of Sciences, Engineering, and Medicine 2019. Medications for Opioid Use Disorder Save Lives. Washington, DC: The National Academies Press. https://doi.org/10.17226/25310.

APPENDIX 1
Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent 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

GI Upset: *over last 1/2 hour*
0 no GI symptoms
1 stomach cramps
2 nausea or loose stool
3 vomiting or diarrhea
5 multiple episodes of diarrhea or vomiting

Sweating: *over past 1/2 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

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

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

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

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

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

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

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

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

Total Score _____
The total score is the sum of all 11 items
Initials of person completing assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

This version may be copied and used clinically.

The Clinical Institute Narcotic Assessment (CINA) Scale for Withdrawal Symptoms

The Clinical Institute Narcotic Assessment (CINA) Scale measures 11 signs and symptoms commonly seen in patients during narcotic withdrawal. This can help to gauge the severity of the symptoms and to monitor changes in the clinical status over time.

PARAMETERS	FINDINGS	POINTS
Parameters based on Questions and Observation:		
(1) abdominal changes: Do you have any pains in your abdomen?	No abdominal complaints; normal bowel sounds Reports waves of crampy abdominal pain Crampy abdominal pain; diarrhea; active bowel sounds	0 1 2
(2) changes in temperature: Do you feel hot or cold?	None reported Reports feeling cold; hands cold and clammy to touch Uncontrolled shivering	0 1 2
(3) nausea and vomiting: Do you feel sick in your stomach? Have you vomited?	No nausea or vomiting Mild nausea; no retching or vomiting Intermittent nausea with dry heaves Constant nausea; frequent dry heaves and/or vomiting	0 2 4 6
(4) muscle aches: Do you have any muscle cramps?	No muscle aching reported; arm and neck muscles soft at rest Mild muscle pains Reports severe muscle pains ; muscles in legs arms or neck in constant state of contraction	0 1 3
Parameters based on Observation Alone:		
(5) goose flesh	None visible Occasional goose flesh but not elicited by touch; not permanent Prominent goose flesh in waves and elicited by touch Constant goose flesh over face and arms	0 1 2 3
(6) nasal congestion	No nasal congestion or sniffling Frequent sniffling Constant sniffling watery discharge	0 1 2
(7) restlessness	Normal activity Somewhat more than normal activity; moves legs up and down; shifts position occasionally Moderately fidgety and restless; shifting position frequently Gross movement most of the time or constantly thrashes about	0 1 2 3
(8) tremor	None Not visible but can be felt fingertip to fingertip Moderate with patient's arm extended Severe even if arms not extended	0 1 2 3
(9) lacrimation	None Eyes watering; tears at corners of eyes Profuse tearing from eyes over face	0 1 2
(10) sweating	No sweat visible Barely perceptible sweating; palms moist Beads of sweat obvious on forehead Drenching sweats over face and chest	0 1 2 3
(11) yawning	None Frequent yawning Constant uncontrolled yawning	0 1 2
TOTAL SCORE	[Sum of points for all 11 parameters]	

Minimum score=0, Maximum score=31. The higher the score, the more severe the withdrawal syndrome. Percent of maximal withdrawal symptoms=((total score)/31) x 100%.
Source: Adapted from Peachey, J.E., and Lei, H. Assessment of opioid dependence with naloxone. British Journal of Addiction 83(2):193–201, 1988. Reprinted with permission from Blackwell Publishing, Ltd.

Fentanyl

- Found in “heroin”, stimulants including cocaine and methamphetamine, and pills pressed to look like Rx opioids and sedatives
- Withdrawal management is essentially the same as other opioids
- Buprenorphine induction has been associated with anecdotal reports of precipitated withdrawal despite 1-2 days of abstinence and the presence of opioid withdrawal symptoms
  - Low dose/microdose induction protocols should be considered with buprenorphine

Name: _____

DOB: _____

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Subjective Opiate Withdrawal Scale (SOWS)

Instructions: We want to know how you're feeling. In the column below today's date and time, use the scale to write in a number from 0-4 about how you feel about each symptom right now.

Scale: 0 = not at all 1 = a little 2 = moderately 3 = quite a bit 4 = extremely

DATE						
TIME						
SYMPTOM		SCORE	SCORE	SCORE	SCORE	SCORE
1	I feel anxious					
2	I feel like yawning					
3	I am perspiring					
4	My eyes are tearing					
5	My nose is running					
6	I have goosebumps					
7	I am shaking					
8	I have hot flushes					
9	I have cold flushes					
10	My bones and muscles ache					
11	I feel restless					
12	I feel nauseous					
13	I feel like vomiting					
14	My muscles twitch					
15	I have stomach cramps					
16	I feel like using now					
TOTAL						

Mild Withdrawal = score of 1 – 10
Moderate withdrawal = 11 – 20
Severe withdrawal = 21 – 30

Marijuana

- Withdrawal from cannabinoids is primarily subjective with mild physical manifestations
- Care is symptomatic
- Complicated withdrawal is not anticipated
- Treatment is supportive and does not require hospitalization
- Acute intoxication can be severe depending upon concentration or presence of synthetic cannabinoid, aka “K2” or “spice”

Stimulants

- Stimulant withdrawal is typically characterized by fatigue and sedation
- Stimulant withdrawal is not medically dangerous
- Complications of recent stimulant use should be considered:
  - Cardiovascular
  - Rhabdomyolysis
  - Trauma
- Acute intoxication requires emergency management with sedation

Xylazine

- Xylazine has been found as an adulterant in heroin and cocaine for nearly 20 years
- Recent significant increase primarily in the Philadelphia area (identified in ~40% of overdose deaths last year)
- It acts on different receptors than opioids, the same ones that clonidine and lofexidine activate
- Acute toxicity includes sedation, pinpoint pupils, slow heart rate and low blood pressure which can intensify opioid toxicity
- Anecdotally associated with wounds and soft tissue infections, but reason for that association has not been found
- Withdrawal is similar to clonidine withdrawal: fast heart rate, high blood pressure, sweating, anxiety, and tremor
  - Treatment is supportive including clonidine or lofexidine, symptomatic medications, and benzodiazepines in severe cases
  - Acute stimulant toxicity can look similar and complicate assessment of withdrawal

Level 1-WM **Ambulatory WM without Extended On-Site Monitoring**	Mild withdrawal with daily or less than daily outpatient supervision; Likely to complete withdrawal management and to continue treatment or recovery.
Level 2-WM **Ambulatory WM with Extended On-Site Monitoring**	Moderate withdrawal with all day withdrawal management support and supervision; At night, has supportive family or living situation; Likely to complete withdrawal management.
Level 3.2-WM **Clinically Managed Residential Withdrawal Management**	Moderate withdrawal but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.
Level 3.7 -WM **Medically Monitored Inpatient Withdrawal Management**	Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; Unlikely to complete withdrawal management without medical, nursing monitoring.
Level 4-WM **Medically Managed Intensive Inpatient Withdrawal Management**	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.

Assessment, Treatment Plan Review, and other Documentation

- SUD history, reviewed by Physician during admission (4-WM = requires approval of admission by Physician)
- Physical exam (3.7WM = within 24 hours, 4-WM= within 12 hours)
- Biopsychosocial screening assessments (Dimensions 2-6)
- Individualized Treatment Plan (Dimensions 2-6)
- Daily assessment of progress.
- Transfer/DC planning.
- Referral arrangements as needed.
- Withdrawal rating scales as needed.
- Progress notes reflecting implementation of the tx plan.

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Therapies (Level 1-WM and 2-WM)

a. Individual assessment.
b. Medication and non-medication methods of WM.
c. Patient education.
d. Nonpharmacological clinical support.
e. Involvement of family members or significant others in the WM process.
f. Discharge and transfer planning, including referral for counseling and involvement in community recovery support groups.
g. Physician and/or nurse monitoring, assessment, and management of signs and symptoms of intoxication and withdrawal.

Therapies (Level 3.2- WM, 3.7-WM, and 4-WM)*

a. Daily clinical services.
b. A range of cognitive, behavioral, medical, mental health, and other therapies are administered to the patient on an individual or group basis.
c. Interdisciplinary individualized assessment and treatment.
d. Health education services.
e. Services to families and significant others.

***The following therapies are provided as clinically necessary, depending on the patient's progress through withdrawal management and his or her assessed needs in dimensions 2-6.**

Substance	Variable Withdrawal Risk	Risk Rating Matrix	Dimensional Admission Criteria Rules
Alcohol	145-146	147-154	165, 171-173, 166 (examples)
Sedative/Hypnotics	154-155	155-161	165, 171-173, 167 (examples)
Opioids	161 - 162	162	165, 171-173, 168 (examples)
Tobacco	163	N/A	165, 171-173, 170 (examples)
Marijuana	163	N/A	165, 171-173
Stimulant (and Dissociative Anesthetics	163	N/A	169 (examples)
All substances	N/A	N/A	170 (examples)
More than one substance used at the same time	164	N/A	N/A

Risk Levels	
0	No or stable problem
1	Minimal risk
2	Moderate Risk
3	Significant Risk
4	Severe Risk

Across all levels of WM, ASAM Criteria, 3rd Edition, 2013 emphasizes the need for services to be provided under a defined set of Physician approved policies and Physician monitored procedures or clinical protocols.

Reminders

Next ASAM TA Call = Monday, October 3, 2022
10am-11am

Topic = Individualizing Daily Programming

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