Department of Human Services
Division of Addiction Services
ADMINISTRATIVE BULLETIN

Subject: Clinical Guidelines, Ambulatory Detoxification

I. Background

Ambulatory Detoxification (AD) has become very popular as a treatment option over the past few years because of the changes observed in managed care. As a result of some of the changes that have occurred, there are a reduced number of residential treatment facilities for the treatment of drug and alcohol and the resources available to pay for such services have dwindled. Many managed care health benefit plans do not allow more than one residential treatment experience over a lifetime, including detoxification services.

The development of patient placement criteria, ASAM Patient Placement Criteria-2R, has greatly enhanced the number of treatment options for patients that require detoxification and who cannot access insurance benefits or who do not actually require hospitalization. Patient selection is the key step in the decision to employ an ambulatory detoxification. Some potential patients are not appropriate for AD, which is an outpatient procedure. AD performed under the right circumstances for the appropriate patient is safe and efficacious.

AD is the beginning step in the treatment of substance use disorders. It is the first part of the full treatment experience which includes detoxification, rehabilitation, and ongoing continuing care and support groups, as indicated. AD is a linkage opportunity for substance abuse counseling and 12-Step Recovery Programs.

II. Scope

Appropriately licensed substance abuse treatment providers or substance abuse treatment providers seeking licensure that will provide ambulatory detoxification.

III. Procedure

An initial Medical Assessment is performed to evaluate the risk and the severity of any potential withdrawal symptoms. The assessment should include a history and physical examination with a complete drug, alcohol use, previous

treatment, psychiatric, and bio-psychosocial history. The assessment will identify each and every drug class that the patient may be using. Over the counter medications should also be considered. Some drug classes have very little to be concerned about in terms of any significant physiologic withdrawal symptomatology. Withdrawal from drugs of the Sedative Hypnotic Class (benzodiazepines, barbiturates, and alcohol) can cause serious damage, medical complications, and death. Some patients do not require a medical detoxification, at all. The medical assessment will help to identify possible psychiatric co-occurring disorders, and other medical conditions, such as pregnancy, which may require alternative therapies and a more intensive level of care for treatment.

After a comprehensive medical assessment has been completed, a **patient placement assessment** needs to occur to select the level of care for the detoxification. The American Society of Addiction Medicine developed a patient placement tool to help select the level of treatment intensity according to the severity of the patient's illness **(ASAM PPC-2R).** This instrument determines care based on severity of illness in six dimensions. The dimensions are:

1. Acute Intoxication-Withdrawal Potential
2. Biomedical Conditions and Complications
3. Emotional/Psychological/Psychiatric Conditions
4. Treatment Acceptance
5. Relapse Potential
6. Recovering Environment

The levels of care range from level 0.5 brief intervention; level I traditional outpatient; level II Intensive Outpatient; level III Residential; and level IV hospital based care. The use of the ASAM PPC-2R will help to provide guidance to decisions that need to be made regarding a patient's appropriateness for an outpatient versus an inpatient detoxification.

A. Admission Criteria

Each AD program needs to have and routinely use admission criteria. These criteria mesh well and augment the ASAM PPC-2R. The guidelines for admission criteria are:

1. No prior history of a complicated medical or psychological detoxification. No history of a complicated or unstable medical disorder or potentially unstable psychiatric illness;
2. Patient should have a supportive recovering environment;
3. Reliable transportation to and from provider's office;
4. The patient should be able to demonstrate an ability to follow the detoxification regime;

5. The patient should be willing to accept recommendations for a "full treatment" experience with referral for counseling and support group follow-up.

Experience in addiction treatment has shown that detoxification alone does not have good treatment outcomes in terms of sustained abstinence or remission from substance use.

B. Discharge Criteria

The patient is discharged from AD when he or she no longer meets criteria for admission in all dimensions. Please note that all patients should be referred for counseling and any other follow-up medical care indicated.

C. Ambulatory Detoxification Office/Facility–Operations and Suggested Policies

Patients will need to be advised of the risks of treatment, sign releases of acceptance for treatment, and acknowledge the expectation that counseling and referral to support groups are part of the requirements to engage into AD. Patients should be provided with a description of AD and the expectation of patients in AD treatment.

A severity of illness assessment instrument should be chosen for use with every patient admitted for AD. There are a number of instruments available that can be used. The most frequently used instruments are the **Clinical Institute Withdrawal Assessment (CIWA)** and the **Modified Selective Severity Assessment (MSSA).**

The patient's **vital signs** must be monitored at baseline, before medical detoxification is initiated and at intervals once medical detoxification has started to help monitor the efficacy of the procedure. It is recommended that vital signs are minimally measured **twice daily during the stabilization phase** and then at least **daily during the tapering phase of detoxification.**

The patient should be monitored for the inappropriate continued use of substances by breathalyzer, oral fluid testing, or urine testing. These tests can be done daily or when there is concern that use maybe continuing during detoxification.

Detoxification medication should be monitored and **administered** by a responsible third party whenever possible. If the patient does not have some one who will resume responsibility, the medication should be dispensed on a daily basis.

Office Hours need to be planned carefully. The operational hours should reflect the availability of the medical provider, and should allow enough time for induction of the medication and time to observe its effects. It is suggested that a new patient be accepted during morning office hours on Mondays through Thursday, unless the facility or office is open during the weekends. **Medical supervision should be available at all times** during the detoxification process.

The **counseling component** of treatment is very important and in all cases, if possible, should begin simultaneously with the detoxification. The initiation of counseling during detoxification has been shown to be very helpful in retaining patients in treatment.

IV. Suggested Drug Specific Detoxification Guideline Protocols

These are suggested guidelines for detoxification. There are other evidence based protocols that may be used. Please consult with the resources listed at the end of this section.

A. Alcohol

Structure Scheduled Dosing, as opposed to symptom triggered dosing is recommended, because in AD the appropriately selected patient will not be in the office or facility all day.

Librium is the most widely used and studied medication for the detoxification of alcohol. Other medications have good efficacy, but may be less predictable in terms of the serum levels and have more complications due to the unpredictable effects of their psychoactive metabolites.

Stabilization Taper Method A: Librium 25mg or 50mg p.o. q6hr x 24 hours; then q8h x 24 hours; then q12h x 24 hours; then once daily x one and discontinue.

Stabilization-Taper Method B: Librium 50mg every 4 hours x 6 doses; q6h x 4 doses; q8h x 3 dose; q12h x 2 doses; then once daily x one and discontinue.

- Extra caution should be taken with pregnant patients. The detoxification should occur slowly. Pregnant patients should be under the care of an Obstetrician.

Adjunctive Medications can be used as needed or indicated.

B. Sedative Hypnotics

It is especially important to remember that **detoxification is a two-step process** when medically detoxifying patients from sedative hypnotic medications. The first step is **stabilization**. The patient is given enough medication to ameliorate all signs and symptoms of withdrawal. In some instances, the dose must be increased beyond the dose that the patient reports using. Once the patient is stabilized, the dose can be **tapered** slowly by 10% of the stabilization on a daily basis. Once the patient is stabilized the taper should take approximately ten days. The Tapering process may need to be slowed if withdrawal symptoms reemerge. Minor withdrawal symptoms may last for a few weeks up to a few months after discontinuation of the medication. Some symptoms of low dose sedative hypnotic withdrawal (insomnia and paresthesia) may last up to one or two years before fully resolving.

The most common method of detoxification is the substitution of a long acting benzodiazepine (Librium, Valium, or Klonopin). Other medications have been used with good efficacy and can be utilized. Once again, Librium has been used and studied more and there are fewer concerns in terms of psychoactive metabolites.

An example of Librium detoxification with a 10% reduction taper follows:

Day 1. 100mg
Day 2. 40mg
Day 3. 35mg
Day 4. 30mg
Day 5. 25mg
Day 6. 20mg
Day 7. 15mg
Day 8. 10mg
Day 9. 5mg
Day 10. Discontinue

Adjunctive medication may be utilized to treat minor symptoms of anxiety and depression (Buspirone, SSRIs) and insomnia (diphenhydramine).

C. Opioids

There are three approaches to withdraw or detoxify patients from opioid or opiate dependence. The choices are agonist substitution and taper; agonist maintenance therapy; and non-opioid therapy.

The agonist substitution approach involves the use of **dolophine** (methadone) started at 30mg in single or divided dose to stabilize the patients symptoms of withdrawal. Once stabilized over 24-48 hours, the dose is tapered by 5mg daily

to zero. If significant withdrawal symptoms emerge, the patient can be re-stabilized at the lowest dose that was effective and then the taper can begun again more slowly to zero.

The agonist / antagonist maintenance approach uses **dolophine** (agonist) to switch over from prescription medication or heroin and then the effective dose is maintained. Special DEA licensure is required.

Buprenorphine (Subutex) and **buprenorphine/naloxone** (Suboxone) can be used to detoxify or to provide maintenance therapy for opiate dependence on prescription medicines or heroin. If the patient is to be detoxified, once the stabilization dose is established, the dose can be slowly reduced over a few days or weeks as required. If it is used for maintenance, once the withdrawal symptoms are stabilized, the dose can be continued until such as it is appropriate to begin to taper it. ***Buprenorphine injectable is not approved for treatment of opiate dependence.***

Non-Opiate Medication Detoxification approaches are primarily symptomatic relief measures of opiate withdrawal symptoms. Clonidine therapy is very efficacious. A transdermal Clonidine patch is applied and left in place for one week. Simultaneously, oral clonidine is started for the first 72 hours. Doses of oral clonidine from 0.1mg to 0.2mg q4 h (titrated to symptom complaints) are used for the first three days until the transdermal patch delivery system has reached maximum level. Then the oral clonidine is discontinued. The use of non-steroidal medications for the arthralgias and myalgias and the use of diphenhydramine for agitation and insomnia have had good results.

Opiate dependent pregnant patients should not be detoxified. Methadone maintenance is the treatment of choice. Patients have been maintained successfully on buprenorphine with informed consent.

Adjunctive medications are available for use in patients that have undergone a full detoxification. Naltexone is effective to reduce craving. Diphenhydramine at 50 -100mg has been shown to be effective for insomnia. Non-steroidal medications are effective in managing the musculoskeletal complaints of aches in pains in detoxifying and detoxified opiate dependent patients.

D. Poly-Substance Detoxification

Patients admitted for detoxification should undergo a ***simultaneous detoxification*** for all drug classes, including alcohol. Alcohol and opiate detoxifications are relatively short and can be accomplished usually with a one week time frame. Sedative hypnotic detoxifications cannot be done safely with less than a ten day course after an initial stabilization before tapering.

When detoxification is initiated for a poly-substance abusing patient, all classes of drugs and alcohol can be safely detoxified simultaneously. Each detoxification protocol can be employed at the same time. If the patient is using ***alcohol and sedative hypnotic drugs***, the ***sedative hypnotic protocol is utilized*** instead of the alcohol protocol because it is longer in duration and will effectively address the required purposes of the alcohol detoxification protocol. The sedative hypnotic detoxification ***will require minimally 10 days*** after the initial stabilization. If the patient is also being detoxified from opiates, the usual opiate detoxification protocol can be followed, simultaneously.

V. Criteria for Ambulatory Detoxification

A. Initial Medical Assessment

The initial medical assessment should evaluate:

a. The severity of withdrawal
b. The coexistence of medical problems
c. The coexistence of psychiatric illness
d. The need for medication and medical management
e. Selection of appropriate level of care for counseling services
f. Pregnant patients need special care (referral and follow-up for prenatal care)

B. Ambulatory Detoxification Admission Criteria

a. No prior history of a complicated detoxification (medical or psychological)
b. No history of complicated medical conditions or psychiatric illness
c. Must have supportive and appropriate recovery environment
d. Available reliable transportation to and from treatment site
e. The ability to follow the instructions for detoxification
f. Reasonable treatment acceptance

C. Patient Placement/Level of Care Assessment

a. Ongoing process to be assessed before and after detoxification is completed
b. Utilization of ASAM PPC-2R Criteria for Level I and Level II
c. Level I – Outpatient settings such as Substance Use Disorder Programs, Physician's office, Home Health Agencies, Psychiatric Clinics, etc.
d. Level II – Partial Hospitalization Programs, Intensive Outpatient Programs, etc.
e. Level II b – Halfway Houses

VI. Clinical Guideline References

Refer to CSAT TIP # 8, TIP #19, and TIP# 45.

EFFECTIVE DATE: IMMEDIATELY

As Approved by:

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