

STATE OF RHODE ISLAND
DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES AND HOSPITALS
DIVISION OF BEHAVIORAL HEALTH CARE

UNIT **Center of Excellence**

POLICY/PROCEDURE NO.
COE - 027

SUBSECTION EFFECTIVE DATE

POLICY/PROCEDURE

02/10/2017

Toxicology Screening

AMENDMENT / REVISION HISTORY

Approved:

Amended:

POLICY

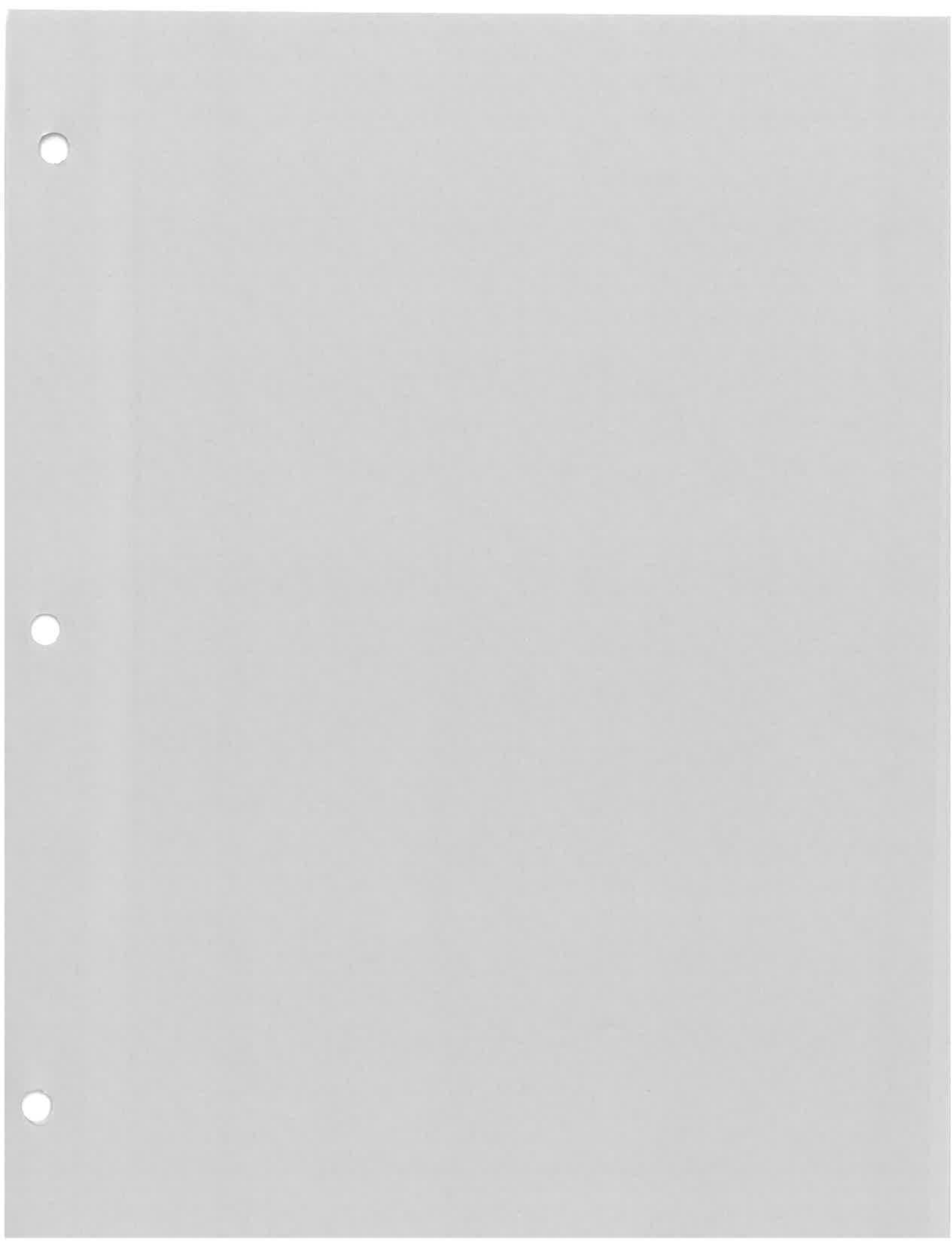
All individuals receiving care for substance use disorder(s) will undergo random, but regular toxicology screening to assist in determining progress in treatment and level of care necessary

PROCEDURE

Urine toxicology screening: Sample collection should be observed by a same-gender observer. Whether the sample collection is observed or unobserved, it will be collected under conditions where clients enter the restroom without bags, coats/jackets, or other items that could conceal a specimen not collected from the individual. All samples will be tested for temperature to assure a fresh specimen is collected. Samples will be tested onsite using a point of service, CLIA-waived test kit by staff trained to conduct the test.

Positive tests will be discussed with the patient. If a result is disputed, it will be tested at the clinical laboratory with confirmation by GC/MS testing. The result obtained will be final. Toxicology results are not used in a punitive manner, but will be used to assist in determination of level of care needed by the client.

Breath alcohol testing will be conducted randomly or if there is concern about recent alcohol use by staff using a standard breath alcohol instrument (breathalyzer) as according to the manufacturer's instruction.



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COE – 027A

SUBSECTION EFFECTIVE DATE

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03/20/2017

Pill Counts

AMENDMENT / REVISION HISTORY

Approved:

Amended:

POLICY

Individuals receiving buprenorphine treatment will have regular and random pill counts completed by the counselor/case manager, nurse or nurse practitioner to reduce the risk of medication diversion.

PROCEDURE

Pill counts/film counts will be completed at regular visits at least monthly. Patients should be told to bring their pill bottle (it should be the original pill bottle dispensed by the pharmacy with original labeling) to each visit. The Pill Count Form should be completed after the count has been done in the presence of the patient. If there is a discrepancy, it should be addressed at that time. Pill counts that are off must be considered by the treatment team to determine if alteration in visit schedule and prescribed medication will need to be adjusted so that the person comes to the clinic more frequently. In cases where there are other problems that the patient is experiencing in the treatment setting or if pill counts are off repeatedly; the person may be referred to a higher level of care such as methadone maintenance or inpatient treatment after consideration by the treatment team.

Pill Counts

Pill counts are one kind of strategy that can be very helpful for confirming medication adherence and helping to reduce the risk of diversion.

One approach is to provide a 28-day supply so that the medication is due on a regular basis, on the same day of the week, and then prescribe so that the patient should have residual medications to bring to an appointment. Ask the patient to bring in the medications at each and every visit, and then count out the medications to confirm that they are on track with the prescribed schedule.

Pill Counts

- Intended to:
 - Confirm medication adherence
 - Minimize diversion

Strategy	28 day supply (rather than 30 days)
	Prescribe so that patient should have residual medication at appointments
	Ask patient to bring in medications at each visit
	For identified risks or concerns, can request random call-backs for immediate counts

Things to Remember

Before the Count

- Contact your patient for the pill count by phone
 - Make sure you ask them to come in the same day or the next day.
 - Do not call on a Friday.
- When you cannot speak to them directly, try not to leave a message regarding the count. Instead, leave them a generic message asking them to call you.

During the Count

- Conduct the pill count in front of the patient.
- Filling out this Pill Count Form may help the patient understand the pill count.

- Positively identify the pills using a website like this (http://www.drugs.com/pill_identification.html) or this (<http://www.drugs.com/imprints.php>)
 - If needed, call the dispensing pharmacy to help with pill identification.
- Count from the day the rx was filled—not the day it was written.
- Medication should be presented for count in the container it was dispensed in by the pharmacy.
- Medication should appear clean and intact.
- Ask them the date/time of their last dose of medication and obtain UDS, if appropriate.

After the Count

You should keep records and note the following in their chart:

- Date/time they were called in for count
- Date/time they presented for count
- Date rx was filled
- Number of pills dispensed
- Number of pills presented for count
- Whether presented pills' identity was confirmed
- Date/time of last dose
- UTS results, if obtained
- Whether pill count was correct

Note that the patient may have “extra” medication if they were inpatient at any point after the fill date.

Patients should also be informed to bring their remaining medications with them for regularly scheduled appointments.

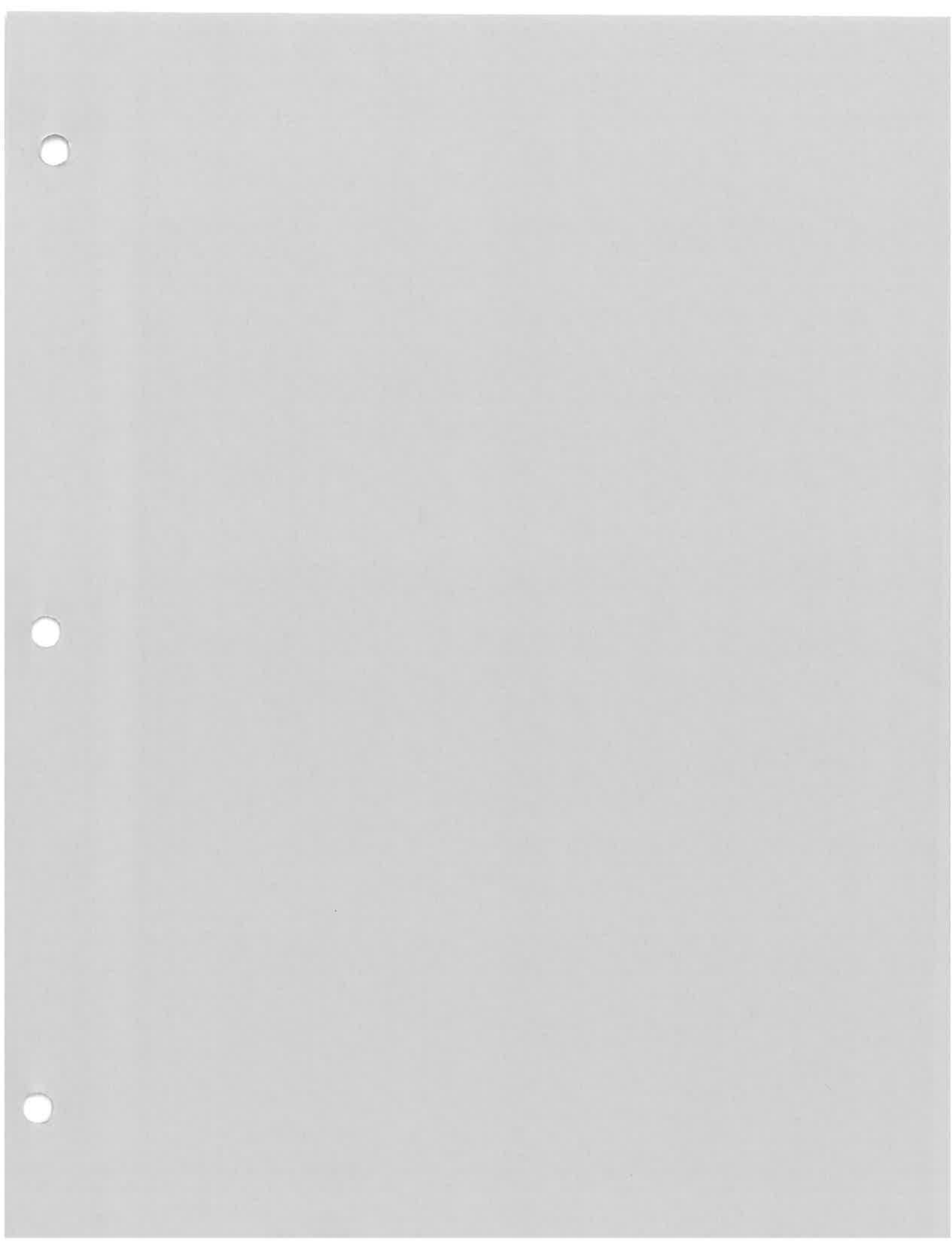
Pill Count

Name:

MR#

Date:

- Date/time called in for count: _____
-
- Date/time presented for count: _____
-
- Date prescription was filled: _____
-
- Number of pills dispensed: _____
-
- Number of pills presented for count: _____
-
- Buprenorphine formulation identity was confirmed: ___ yes ___ no
-
- Date/time of last dose: _____
-
- UTS results, if obtained: _____
-
- Buprenorphine: ___ Positive ___ Negative
-
- Pill count was correct: ___ Yes ___ No



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COE - 028

SUBSECTION EFFECTIVE DATE

POLICY/PROCEDURE

02/10/2017

Billing for Services

AMENDMENT / REVISION HISTORY

Approved:

Amended:

POLICY

ESH COE clinicians will record clinical services for the purpose of billing for services provided

PROCEDURE

Currently the COE uses a paper and pencil medical record. Billing slips will be present on each patient medical record. Staff will complete a charge slip after all clinical interventions following procedures provided by Medicaid staff trainers.

If an electronic health record is implemented; billing will be completed electronically according to procedures provided by Medicaid staff.

Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

Center of Excellence

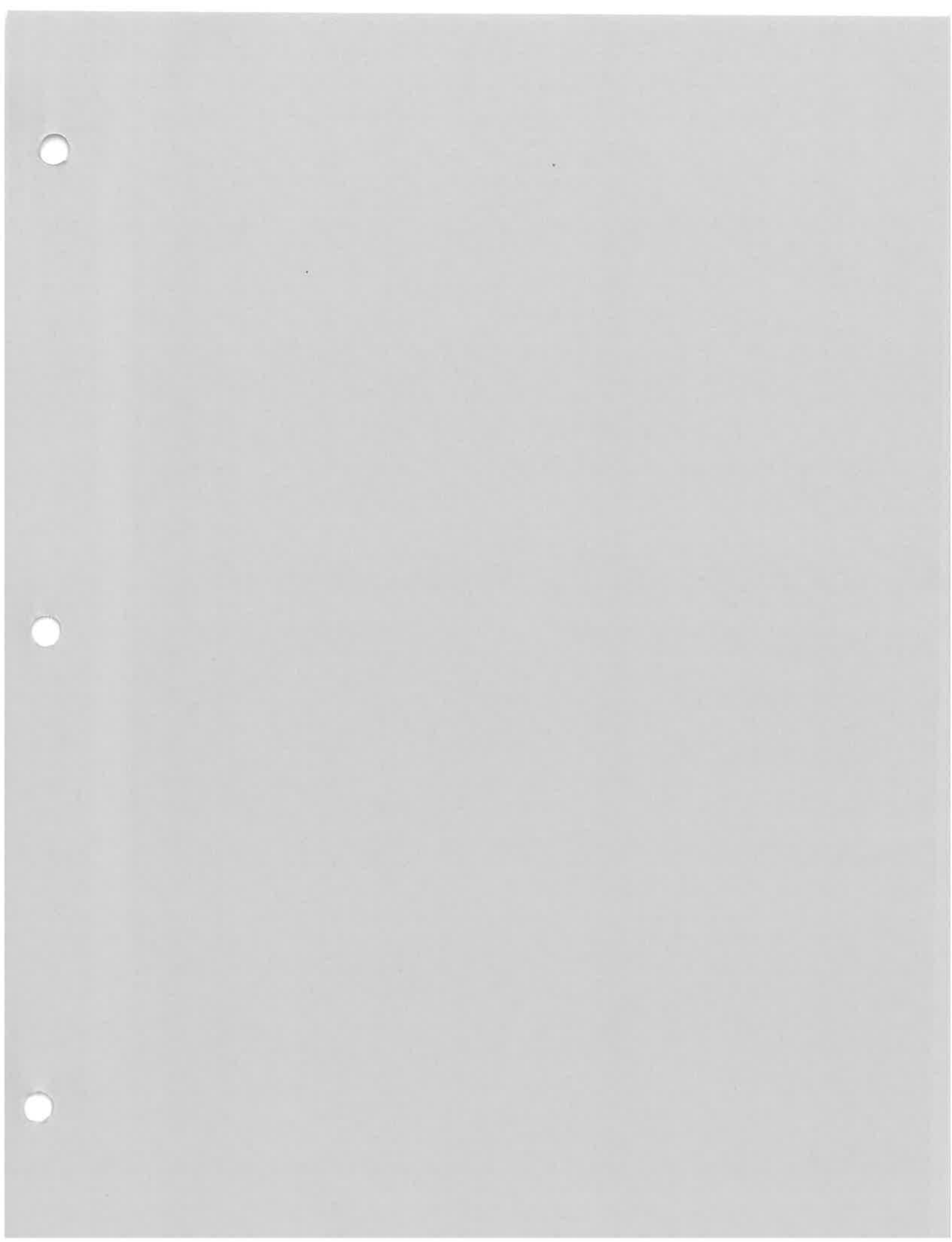
Clinician:

Service Delivery

Date of Service:

Patient:

- Weekly Enhanced Rate for COE services (included: Medical history and physical examination with diagnoses, OUD Medication induction, counseling, psychotherapy related to substance use disorder(s), Case management, Vocational/educational therapy, Naloxone education and dispensing of overdose kit, treatment planning, ongoing care referral, physician visits for prescribing of medication for treatment of opioid use disorder, Urine toxicology screen, Breath alcohol test, PPD placement and reading)
- Psychiatric evaluation and diagnoses
- Medication Cost
 - Buprenorphine/naloxone
 - Buprenorphine
 - Injectable naltrexone
- Individual Consultation (Pharmacy)
- Individual Consultation (Other _____ (e.g.: Specialized Medical Care))
- Laboratory Testing (Blood): ___CBC, ___Chemistry Profile (glucose, BUN, creat, electrolytes, lipid profile, liver function tests (AST, ALT, total protein, alkaline phosphatase, bilirubin (total/direct), GGT, other: _____)
- Phlebotomy
- Urine Pregnancy test
- Cardiogram (ECG)
- Cardiogram interpretation
- PPD placement
- PPD reading and recording
- HIV testing with pre and post test counseling
- HIV viral load
- Hepatitis Panel (HBsAg, HBsAb, HBcAg, HBeAg, HCV antibody, HCV viral load, HCV genotyping
- Vaccination (DPT, Hepatitis B series, Varicella zoster, Hflu, HPV, influenza)
- Codes to be used for treatment of conditions other than Opioid Use Disorder:
 - Medication Management
 - Medical visit (follow up) Complexity
 - Psychiatric visit (follow up) Complexity



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POLICY/PROCEDURE NO.
COE - 029

SUBSECTION EFFECTIVE DATE

POLICY/PROCEDURE

02/10/2017

Clinical Supervision

AMENDMENT / REVISION HISTORY

Approved:

Amended:

POLICY

All clinical staff in the COE will participate in supervision on a regular basis to provide guidance to staff providing care and to assure quality of care provided.

PROCEDURE

Staff providing clinical services will participate in clinical supervision weekly for a minimum of 30 minutes. Licensed independent practitioners will be supervised by the Medical Director. Case managers, therapists and other clinical staff will be supervised by the Program Director or designee.

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POLICY/PROCEDURE NO.
COE - 030

SUBSECTION EFFECTIVE DATE

POLICY/PROCEDURE

02/10/2017

Treatment Planning

AMENDMENT / REVISION HISTORY

Approved:

Amended:

POLICY

All individuals entering the COE will have a Care Plan developed with 7 business days following admission work-up.

PROCEDURE

The Care Plan will be developed by the assigned Case Manager with input from all team members. The initial Care Plan is completed on admission workup and is modified as needed and with any changes in treatment that are instituted. As treatment goals are met, this will be indicated on the Care Plan and that goal removed from the Care Plan. Care plans will be reviewed by the treatment team in an ongoing fashion at weekly treatment team meetings where the plan will be updated as needed. Updates endorsed by the treatment team will be recorded in the Care Plan by the team member responsible for that goal.

Treatment Plan

Name:

MR#

Problem: Physical Dependence on Opioids/Opioid Use Disorder/Other Substance Use Disorders:

MAT: _____

Urine toxicology screen Result:

Breath alcohol test Result:

Problem: Develop sober living skills; improve stress management, relaxation abilities, self-control; focus on means of improving social supports

Weekly meeting with case manager/counselor

Psychoeducation group weekly

Relapse prevention/cognitive behavioral therapy oriented to sober living skills weekly

Anger management group

Participation in 12 Step fellowship

Goals:

Problem: Lack of employment/financial issues

Goals:

Problem: Family/Marital Discord

Goals:

Problem: Other Medical Issues

Goals:

Problem: Co-occurring mental disorder(s)

Goals:

Problem: Discharge Planning:

Signature:
Counselor/Case Manager

Date:

Signature:

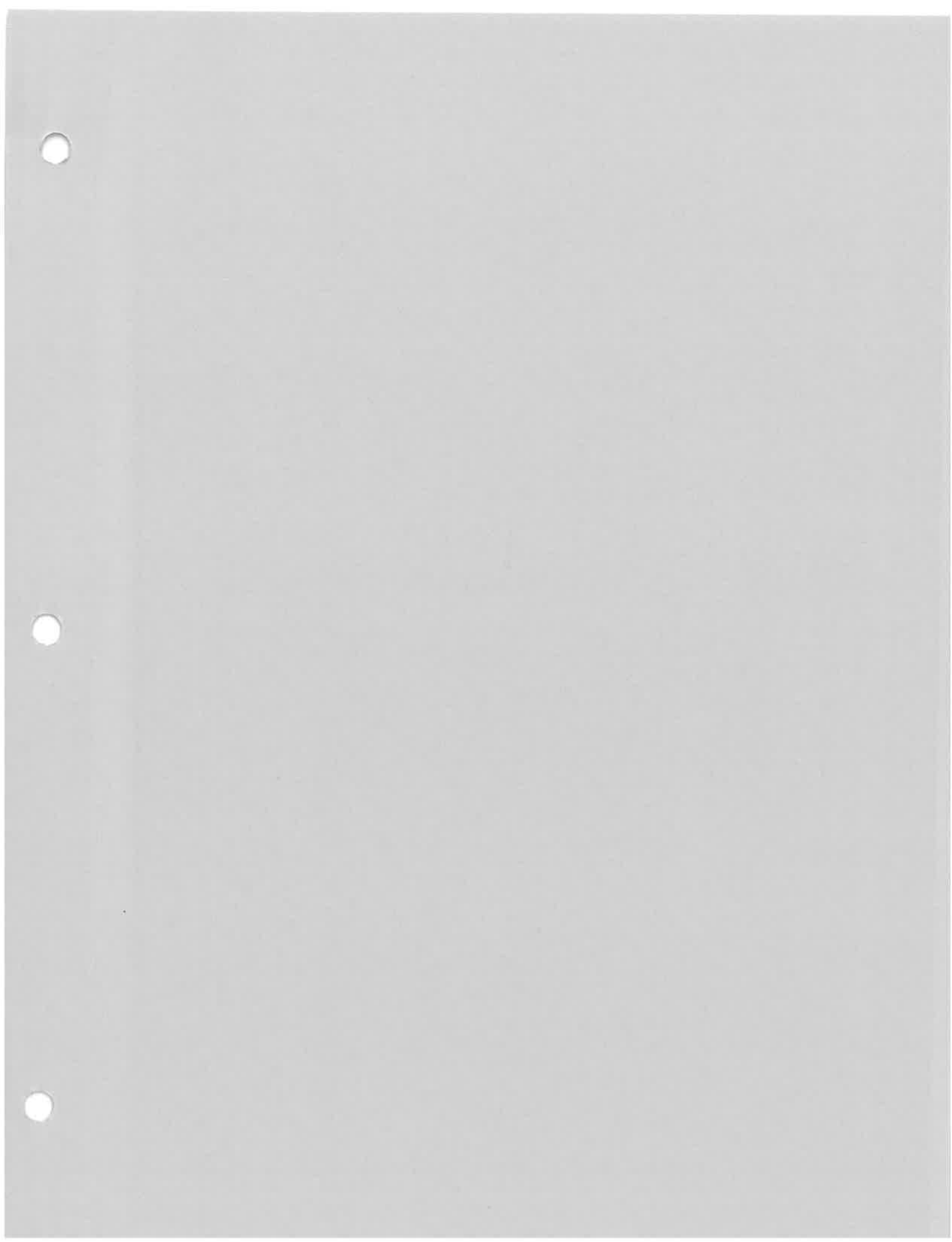
Signature:

Signature:

Signature:

Signature (Patient):

Date:



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COE – 030A

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03/20/2017

POLICY/PROCEDURE

Addressing Relapse

AMENDMENT / REVISION HISTORY

Approved:

Amended:

POLICY

Relapse is an important risk to be monitored during treatment for all patients. All staff will be familiar with the interventions to address relapse should it occur with a patient.

PROCEDURE

Approaches to Relapse

Patients should be monitored for risk of relapse during their entire treatment at the Center of Excellence. This is accomplished by individual meetings with the counselor/case manager, observation during group therapy sessions, regular but random urine toxicology screening, and call-back for pill counts.

If a person is found to have relapsed to substance use, obtain the history of the relapse, determine current use and discuss with the covering physician. There are several options available in terms of response to relapse:

1. Increase attendance at program; increase meetings with counselor.
2. Review MAT dosage and determine if an adjustment is needed.
3. Consider whether there may be a co-occurring mental disorder that needs assessment and possible treatment.
4. Consider whether a person needs a different level of care: e.g.: methadone maintenance or admission to an inpatient or residential facility.
5. Document the facts of the relapse, discussion with the patient, and plan to address relapse.
6. Implement plan to address relapse.

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5. Document the facts of the relapse, discussion with the patient, and plan to address relapse.
6. Implement plan to address relapse.

Relapse Prevention

Relapse is a process, it's not an event. In order to understand relapse prevention you have to understand the stages of relapse. Relapse starts weeks or even months before the event of physical relapse. There are three stages of relapse.(1)

- Emotional relapse
- Mental relapse
- Physical relapse

Emotional Relapse

In emotional relapse, the person is not thinking about using. But emotions and behaviors are setting up for a possible relapse in the future.

The signs of emotional relapse are:

- Anxiety
- Intolerance
- Anger
- Defensiveness
- Mood swings
- Isolation
- Not asking for help
- Not going to meetings
- Poor eating habits
- Poor sleep habits

The signs of emotional relapse are also the symptoms of post-acute withdrawal. If you understand post-acute withdrawal it's easier to avoid relapse, because the early stage of relapse is easiest to pull back from. In the later stages the pull of relapse gets stronger and the sequence of events moves faster.

Post-Acute Withdrawal Syndrome

Post-acute-withdrawal syndrome (PAWS) refers to a constellation of **symptoms experienced by some individuals who are addicted to alcohol or certain drugs after a prolonged period of withdrawal.**

PAWS is also known by several similar terms, including post-withdrawal, protracted withdrawal, prolonged withdrawal syndrome, and protracted abstinence.

PAWS is separate and distinct from the acute phase of withdrawal, which typically occurs in the first two weeks after drug cessation.

Acute withdrawal has long been studied by addiction researchers and, dependent on the type of drug from which withdrawal is occurring, is **characterized primarily by physical symptoms**. These symptoms may include:

- Tremors.
- Seizures.
- Autonomic nervous system hyperactivity (sweating, nausea, rapid heart rate).
- Intense drug craving.

In contrast to acute withdrawal, symptoms of PAWS generally occur 2 months or more after drug cessation and are primarily psychological in nature, affecting a person's mood, sleep patterns, and response to stress. **The symptoms of PAWS generally last for several months** in people recovering from addiction, though they can disappear in a matter of weeks or, in rare cases, persist for a year or more.

Symptoms of PAWS

There are a myriad of symptoms associated with PAWS. Though each of these is fairly common among people withdrawing from drugs and alcohol, the exact number, combination, and timing of specific symptoms is different for each person. Physical differences between people, as well as differences in the types of drugs used and the amount and frequency of use all affect each individual's experience of PAWS.

Mood swings: The brain of a chronic drug user, including patients taking medications under their doctor's supervision, has become adapted to a constant supply of a mood-altering substance. When that substance is removed, periods of mania or depression can occur for no apparent reason while the brain rebalances itself.

Anhedonia: Although they work in different ways, virtually all addictive drugs, and many medications like antidepressants, have the end result—in the short term, at least—of boosting neurotransmitters and neural pathways that make the user feel good. Otherwise, why would people take them? Once these drugs and medications are stopped, however, it can take some time for the brain to produce normal levels of these feel-good chemicals on its own again. Until it does, an individual may find that nothing seems fun or interesting anymore – even activities they used to enjoy.

Anxiety: For addicts and patients alike, cessation of a drug or medication is a major life change. Therefore, it is understandable that there can be a great deal of anxiety, and even panic attacks, that accompany this shift. Additionally, drugs such as alcohol and BZDs that chronically inhibit brain activity result in a hyperexcitable, anxiety-prone state when they are stopped.

Insomnia: Many psychoactive drugs and medications affect sleep patterns, and the brain adapts to long-term use. Once these drugs are stopped, it can take time to re-establish healthy sleep patterns.

Sleep disturbances: Subconscious desires to take alcohol or drugs, or to resume some aspect of the drug-using lifestyle, can manifest themselves in vivid, realistic dreams. Though such dreams may be very disturbing to a person in recovery, they are not a warning of impending relapse, but simply a reflection of how deeply the drug-taking compulsion can be ingrained in the mind.

Cognitive impairment: Like mood changes, this is another symptom of neurotransmitter imbalance. It is important to remember that difficulties in thinking clearly and maintaining concentration are usually temporary and not a sign of permanent brain damage.

Depression and fatigue: Many people who stop chronic drug habits or long-term medications experience such intense feelings of depression and fatigue that they fit the criteria for Major Depressive Disorder or Chronic Fatigue Syndrome. Unlike these conditions, however, these symptoms are a phase of readjustment in the brain and generally diminish without treatment over time.

Drug cravings: People with PAWS often have intermittent cravings for the drug or medication that they took before. Because the most intense physical withdrawal symptoms have subsided, the individual may feel physically healthy but continue experiencing negative psychological symptoms which make the return to drug use seem appealing.

Sensitivity to stress: Many people dealing with the effects of PAWS find that their threshold for daily stress is very low. Trivial irritations or setbacks can feel like the end of the world. Considering that these individuals have given up what has been, for months or years, their primary tool for coping with life's stresses, this difficulty is easy to understand. New life skills must be learned, and even dealing with normal emotions brought on by stress can take time.

These are some of the most common manifestations of PAWS but not an exhaustive list. One unifying theme among these symptoms is that they all impair various facets of an individual's emotional state, or their "affect." Another common aspect of these symptoms is that they are intermittent and may come and go over days and weeks, and they generally do not impact a person to the same extent over the entire course of their withdrawal.

Common Drug Classes Associated with PAWS

Opioids

Long-term symptoms of opiate withdrawal are commonly reported in individuals recovering from opioid addictions. Both pharmaceutical and illicit opioid painkillers such as oxycodone (OxyContin), hydrocodone (Vicodin), hydromorphone (dilaudid), fentanyl, or heroin, can elicit PAWS symptoms such as **anxiety, fatigue, and sleep disturbances** in dependent individuals when they stop taking these drugs.

All opioid drugs work by activating opiate receptors in the brain and spinal cord, which modulates perceived pain levels, induces a feeling of well being, and produces, at higher doses, a euphoric high.

The body adapts to chronic overstimulation of opioid receptors by increasing the number of them on the surface of brain cells, so that more receptors need to be activated by opioid drugs to produce an effect.

Also, the amount of endorphins, the natural chemicals that activate opiate receptors, is decreased in chronic opioid drug users as the body compensates for overstimulation of this system. These adaptations by the nervous system reduce opiate signaling to the brain and have been linked to increased pain sensitivity and mood disturbances in individuals addicted to opiates. These changes can take months or even years to completely reverse themselves and for opiate signaling to return to normal levels. Some researchers have been experimenting with indirectly increasing opiate signaling in patients recovering from addiction with low-dose naloxone (Narcan) to alleviate symptoms of PAWS.

Psychostimulants

Stimulant drugs such as cocaine and amphetamine provide some of the clearest evidence that PAWS is a true medical condition, and not simply an extension of acute withdrawal.

The psychological symptoms of PAWS such as **paranoia, anxiety, impulse control problems, depression and other emotional regulation issues** are frequently observed in chronic users who stop stimulants suddenly:

Similar to other drugs, these symptoms are thought to be caused by adaptations in the brain to long-term stimulant use, and they can take several months or longer to resolve themselves.

Alcohol

Of all drugs, prolonged withdrawal resulting from ceasing alcohol intake has received the most scientific attention. Studies examining symptoms now attributed to PAWS have been published in medical journals since the 1990s.

Alcohol is a sedative drug and works, in part, by activating γ -aminobutyric acid (GABA) receptors in the brain. Increased GABA activity inhibits, or decreases, brain activity

overall, and the brain adapts to counteract chronic inhibition. An individual who has become dependent on alcohol will find that their nervous system is overactive, or hyperexcitable, when they stop drinking.

Initially, this hyperexcitable state can lead to seizures and tremors, but less severe symptoms such as sleep disturbances, mood swings, anxiety, and lack of sexual interest can continue for several months or even years. Though gradually decreasing the amount of alcohol ingested over time, or tapering, can help reduce the intensity of acute withdrawal, this strategy appears to be much less effective for the longer-lasting symptoms of PAWS.

Risk Factors for PAWS

Individuals in recovery—even those with similar drug histories—report widely variable and unique experiences as they present in PAWS. Many factors can influence the types of post-acute withdrawal symptoms that manifest and the intensity with which they are

experienced. These factors include:

- The pattern of substance abuse.
- Duration of the addiction.
- Intensity of the drug use.
- Genetics.
- Physiology.
- Psychological makeup.
- The existence of other physical or psychological conditions.

History of drug use is the best-known risk factor for PAWS. Those who have used psychoactive substances for longer, more often, and at higher doses are more likely to experience PAWS, and the symptoms will be more intense than those whose drug use was lighter.

Genetics and physiological factors are very likely to play a role, however, since PAWS can manifest differently in two individuals who have used the same substance in the same manner. Because so little research has been conducted into this syndrome, it is not possible to predict in advance how someone will be affected.

The Challenges of PAWS

In addition to the subtle and unpredictable symptoms of PAWS, individuals in recovery frequently experience challenges stemming from the fact that this syndrome is not universally recognized in the medical community and little scientific research has been conducted into the causes of and treatments for this condition.

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In addition to the subtle and unpredictable symptoms of PAWS, individuals in recovery frequently experience challenges stemming from the fact that this syndrome is not universally recognized in the medical community and little scientific research has been conducted into the causes of and treatments for this condition.

Though its existence is widely accepted among recovery professionals, PAWS is not officially recognized by any medical associations, nor is it listed in the American Psychiatric Association's Diagnostic-Statistical Manual of Mental Disorders (DSM), the standard classification of mental disorders used by all mental health professionals in the U.S.

What to Expect

Symptoms of PAWS will manifest themselves after the end of acute withdrawal, but can appear anytime within several weeks to several months after drug cessation. The drug classes discussed above have different long-term effects on the brain, and the symptoms of PAWS will be different, depending on which substance, or combination of substances, was used.

Effects of this syndrome may then continue for anywhere from 2-3 months to several years. There are anecdotal reports of individuals who continue experiencing prolonged withdrawal for the rest of their lives, though this appears to be extremely rare.

It is important to remember that **symptoms of PAWS come and go**. The vast majority of people do not experience excessive fatigue or anxiety for months or years on end, without a break. Instead, these symptoms fluctuate, lasting days or weeks, and are separated by periods that are symptom-free.

PAWS: A Normal Part of Recovery

Though it can be upsetting, PAWS is a normal part of the recovery process from unhealthy dependence and addiction. It is important to be aware of the symptoms of prolonged abstinence from substance use, because some of these negative symptoms can be discouraging to recovering individuals and tempt them to return to drug use.

Steps that can be taken to manage PAWS and improve well being during recovery include:

- **Education.** Becoming aware and educated about both acute and post-acute withdrawal so the person knows what to expect as they navigate the recovery process.
- **Focusing on positive changes and achievements.** Although it is normal to focus on continued difficulties caused by PAWS, one should not lose sight of how recovery is changing life for the better.
- **Stay active.** Physical activity and exercise help the body and brain heal more quickly—bolstering immune system activity and restoring healthy balance to neurotransmitter levels—and can reduce anxiety and stress, as well as help with sleep in the long-term.

Though the experience of PAWS can be unpleasant and frustrating for both the recovering person and his friends and family, these symptoms will subside with time.

Patience and understanding are therefore the keys to successfully navigating PAWS and learning how to live a healthy and happy life in recovery.

Early Relapse Prevention

Relapse prevention at this stage means recognizing emotional relapse and changing behavior. Help the person recognize that they are isolating and remind them to ask for help. Recognize anxiety and practice relaxation techniques. Recognize that sleep and eating habits are slipping and practice self-care. These are all risk factors for relapse.

Practice self-care. The most important thing a person can do to prevent relapse at this stage is take better care of themselves. Help the person to think through why they use—to escape, relax, or reward themselves. Relapse is more of a risk when the person doesn't take care of themselves and creates situations that are mentally and emotionally draining making them want to escape.

Mental Relapse

In the early phase of mental relapse the person is just considering using. But in the later phase they are definitely *thinking* about using.

The signs of mental relapse are:

- Thinking about people, places, and things the person used with
- Glamorizing past use
- Lying
- Hanging out with old using friends
- Fantasizing about using
- Thinking about relapsing
- Planning relapse around other people's schedules

It gets harder to make the right choices as the pull of the disease of addiction gets stronger.

Preventing Relapse

Help the person to think through their relapse. The fantasy will be that they will be able to control their use this time. They'll just use one time. But point out the person's history, their uncontrolled use, how quickly their body will crave and become physically dependent and get them back to the place where they are at risk for all the consequences of using—loss of family, children, legal problems, work problems, health problems.

Openly question about and discuss urges to use. When not at the program, encourage them to call a friend, a support, or someone in recovery when feeling

the urges/cravings to use. Sharing these feelings is important because it will help them to decrease and help the person to get the support they need to avoid relapse.

Distraction techniques are important. Help the person to develop distraction techniques when thinking about using. Call a friend. Go to a meeting. Get up and go for a walk. These alternative activities can help to avoid relapse.

Explain that cravings are short-lived. Most urges usually last for less than 15 to 30 minutes. Developing distraction methods that last 30 minutes can help to avoid use.

Remind the person that recovery happens one day at a time. Help the person to understand that they should not be thinking about never using again. That can be overwhelming even for people who've been in recovery for a long time. People need to give themselves time to recover and not to think too far ahead—take one day at a time and build their sobriety.

Help the person to identify relaxing activities. Relaxation is an important part of relapse prevention, because it can help a person to be comfortable and able to use the methods they are learning in treatment to maintain their recovery.

Physical Relapse

Once a person has slipped with substance use, the risk is quite high that they will start regular use again and, for those substances that produce physical dependence (opioids, alcohol, benzodiazepines), that dependence will happen quickly. Recognize the early warning signs of relapse, and understand the symptoms of post-acute withdrawal, and the person will be able to catch themselves before it's too late.

References

- 1) The stages of relapse were first described by Terence Gorski. Gorski, T., & Miller, M., *Staying Sober: A Guide for Relapse Prevention*: Independence Press, 1986.
- 2) Adapted from: <http://drugabuse.com/library/post-acute-withdrawal-syndrome/>
- 3) Adapted from: <https://www.addictionsandrecovery.org/relapse-prevention.htm>

Relapse Prevention

An Overview of Marlatt's Cognitive-Behavioral Model

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Relapse prevention (RP) is an important component of alcoholism treatment. The RP model proposed by Marlatt and Gordon suggests that both immediate determinants (e.g., high-risk situations, coping skills, outcome expectancies, and the abstinence violation effect) and covert antecedents (e.g., lifestyle factors and urges and cravings) can contribute to relapse. The RP model also incorporates numerous specific and global intervention strategies that allow therapist and client to address each step of the relapse process. Specific interventions include identifying specific high-risk situations for each client and enhancing the client's skills for coping with those situations, increasing the client's self-efficacy, eliminating myths regarding alcohol's effects, managing lapses, and restructuring the client's perceptions of the relapse process. Global strategies comprise balancing the client's lifestyle and helping him or her develop positive addictions, employing stimulus control techniques and urge-management techniques, and developing relapse road maps. Several studies have provided theoretical and practical support for the RP model. KEY WORDS: AODD (alcohol and other drug dependence) relapse; relapse prevention; treatment model; cognitive therapy; behavior therapy; risk factors; coping skills; self efficacy; expectancy; AOD (alcohol and other drug) abstinence; lifestyle; AOD craving; intervention; alcohol cue; reliability (research methods); validity (research methods); literature review

Relapse, or the return to heavy alcohol use following a period of abstinence or moderate use, occurs in many drinkers who have undergone alcoholism treatment. Traditional alcoholism treatment approaches often conceptualize relapse as an end-state, a negative outcome equivalent to treatment failure. Thus, this perspective considers only a dichotomous treatment outcome—that is, a person is either abstinent or relapsed. In contrast, several models of relapse that are based on social-cognitive or behavioral theories emphasize relapse as a transitional pro-

cess, a series of events that unfold over time (Annis 1986; Litman et al. 1979; Marlatt and Gordon 1985). According to these models, the relapse process begins prior to the first posttreatment alcohol use and continues after the initial use. This conceptualization provides a broader conceptual framework for intervening in the relapse process to prevent or reduce relapse episodes and thereby improve treatment outcome.

This article presents one influential model of the antecedents of relapse and the treatment measures that can be taken to prevent or limit relapse after

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maintain the change. Certain situations or events, however, can pose a threat to the person's sense of control and, consequently, precipitate a relapse crisis. Based on research on precipitants of relapse in alcoholics who had received inpatient treatment, Marlatt (1996) categorized the emotional, environmental, and interpersonal characteristics of relapse-inducing situations described by study participants. According to this taxonomy, several types of situations can play a role in relapse episodes, as follows:

- Negative emotional states, such as anger, anxiety, depression, frustration, and boredom, which are also referred to as intrapersonal high-risk situations, are associated with the highest rate of relapse (Marlatt and Gordon 1985). These emotional states may be caused by primarily intrapersonal perceptions of certain situations (e.g., feeling bored or lonely after coming home from work to an empty house) or by reactions to environmental events (e.g., feeling angry about an impending layoff at work).
- Situations that involve another person or a group of people (i.e., interpersonal high-risk situations), particularly interpersonal conflict (e.g., an argument with a family member), also result in negative emotions and can precipitate relapse. In fact, intrapersonal negative emotional states and interpersonal conflict situations served as triggers for more than one-half of all relapse episodes in Marlatt's (1996) analysis.
- Social pressure, including both direct verbal or nonverbal persuasion and indirect pressure (e.g., being around other people who are drinking), contributed to more than 20 percent of relapse episodes in Marlatt's (1996) study.
- Positive emotional states (e.g., celebrations), exposure to alcohol-related stimuli or cues (e.g., seeing an advertisement for an alcoholic beverage or passing by one's favorite bar), testing one's personal control

(i.e., using "willpower" to limit consumption), and nonspecific cravings also were identified as high-risk situations that could precipitate relapse.

Coping. Although the RP model considers the high-risk situation the immediate relapse trigger, it is actually the person's *response* to the situation that determines whether he or she will experience a lapse (i.e., begin using alcohol). A person's coping behavior in a high-risk situation is a particularly critical determinant of the likely outcome. Thus, a person who can execute effective coping strategies (e.g., a behavioral strategy, such as leaving the situation, or a cognitive strategy, such as positive self-talk) is less likely to relapse compared with a person lacking those skills. Moreover, people who have coped successfully with high-risk situations are assumed to experience a heightened sense of self-efficacy (i.e., a personal perception of mastery over the specific risky situation) (Bandura 1977; Marlatt et al. 1995, 1999; Marlatt and Gordon 1985). Conversely, people with low self-efficacy perceive themselves as lacking the motivation or ability to resist drinking in high-risk situations.

Outcome Expectancies. Research among college students has shown that those who drink the most tend to have higher expectations regarding the positive effects of alcohol (i.e., outcome expectancies) and may anticipate only the immediate positive effects while ignoring or discounting the potential negative consequences of excessive drinking (Carey 1995). Such positive outcome expectancies may become particularly salient in high-risk situations, when the person expects alcohol use to help him or her cope with negative emotions or conflict (i.e., when drinking serves as "self-medication"). In these situations, the drinker focuses primarily on the anticipation of immediate gratification, such as stress reduction, neglecting possible delayed negative consequences.

The Abstinence Violation Effect. A critical difference exists between the first violation of the abstinence goal (i.e.,

an initial lapse) and a return to uncontrolled drinking or abandonment of the abstinence goal (i.e., a full-blown relapse). Although research with various addictive behaviors has indicated that a lapse greatly increases the risk of eventual relapse, the progression from lapse to relapse is not inevitable.

Marlatt and Gordon (1980, 1985) have described a type of reaction by the drinker to a lapse called the abstinence violation effect, which may influence whether a lapse leads to relapse. This reaction focuses on the drinker's emotional response to an initial lapse and on the causes to which he or she attributes the lapse. People who attribute the lapse to their own personal failure are likely to experience guilt and negative emotions that can, in turn, lead to increased drinking as a further attempt to avoid or escape the feelings of guilt or failure. Furthermore, people who attribute the lapse to stable, global, internal factors beyond their control (e.g., "I have no willpower and will never be able to stop drinking") are more likely to abandon the abstinence attempt (and experience a full-blown relapse) than are people who attribute the lapse to their inability to cope effectively with a specific high-risk situation. In contrast to the former group of people, the latter group realizes that one needs to "learn from one's mistakes" and, thus, they may develop more effective ways to cope with similar trigger situations in the future.

Covert Antecedents of High-Risk Situations

Although high-risk situations can be conceptualized as the immediate determinants of relapse episodes, a number of less obvious factors also influence the relapse process. These covert antecedents include lifestyle factors, such as overall stress level, as well as cognitive factors that may serve to "set up" a relapse, such as rationalization, denial, and a desire for immediate gratification (i.e., urges and cravings) (see figure 2). These factors can increase a person's vulnerability to relapse both by increasing his or her exposure to high-risk situations and by decreasing motivation to resist drinking in high-risk situations.

anyone expect me not to drink when there's a bottle of liquor in the house?").

Lifestyle Factors. Marlatt and Gordon (1985) have proposed that the covert antecedent most strongly related to relapse risk involves the degree of balance in the person's life between perceived external demands (i.e., "shoulds") and internally fulfilling or enjoyable activities (i.e., "wants"). A person whose life is full of demands may experience a constant sense of stress, which not only can generate negative emotional states, thereby creating high-risk situations, but also enhances the person's desire for pleasure and his or her rationalization that indulgence is justified ("I owe myself a drink"). In the absence of other non-drinking pleasurable activities, the person may view drinking as the only means of obtaining pleasure or escaping pain.

Urges and Cravings. The desire for immediate gratification can take many forms, and some people may experience it as a craving or urge to use alcohol. Although many researchers and clinicians consider urges and cravings primarily physiological states, the RP model proposes that both urges and cravings are precipitated by psychological or environmental stimuli. Ongoing cravings, in turn, may erode the client's commitment to maintaining abstinence as his or her desire for immediate gratification increases. This process may lead to a relapse set-up or increase the client's vulnerability to unanticipated high-risk situations.

Although they are often used interchangeably, the terms "urges" and "cravings" can be associated with distinct meanings. Thus, Marlatt and Gordon (1985) have defined an urge as a relatively sudden impulse to engage in an act such as alcohol consumption, whereas craving is defined as the subjective desire to experience the effects or consequences of such an act. Nevertheless, the same processes may mediate both urges and cravings. Two such processes have been proposed: (1) conditioning¹ elicited by stimuli associated with past gratification and (2) cognitive processes associated with anticipated gratification (i.e., the expectancies for the immediate pleasurable effects of alcohol).

RP INTERVENTION STRATEGIES

The RP model includes a variety of cognitive and behavioral approaches designed to target each step in the relapse process (see figure 2). These approaches include specific intervention strategies that focus on the immediate determinants of relapse as well as global self-management strategies that focus on the covert antecedents of relapse. Both the specific and global strategies fall into three main categories: skills training, cognitive restructuring, and lifestyle balancing.

Specific Intervention Strategies

The goal of the specific intervention strategies—identifying and coping with high-risk situations, enhancing self-efficacy, eliminating myths and placebo effects, lapse management, and cognitive restructuring—is to teach clients to anticipate the possibility of relapse and to recognize and cope with high-risk situations. These strategies also focus on enhancing the client's awareness of cognitive, emotional, and behavioral reactions in order to prevent a lapse from escalating into a relapse. The first step in this process is to teach clients the RP model and to give them a "big picture" view of the relapse process. For example, the therapist can use the metaphor of behavior change as a journey that includes both easy and difficult stretches of highway and for which various "road signs" (e.g., "warning signals") are available to provide guidance. According to this metaphor, learning to anticipate and plan for high-risk situations during recovery from alcoholism is equivalent to having a good road map, a well-equipped tool box, a full tank of gas, and a spare tire in good condition for the journey.

Identifying and Coping With High-Risk Situations. To anticipate and plan accordingly for high-risk situations, the person first must identify the situations in which he or she may experience difficulty coping and/or an increased desire to drink. These situations can be identified using a variety of assessment strategies. For example, the therapist can interview the client about past lapses or

relapse episodes and relapse dreams or fantasies in order to identify situations in which the client has or might have difficulty coping. Several self-report questionnaires also can help assess the situations in which clients have been prone to drinking heavily in the past as well as the clients' self-efficacy for resisting future drinking in these situations (Annis and Davis 1988; Annis 1982a). Furthermore, clients who have not yet initiated abstinence are encouraged to self-monitor their drinking behavior—for example, by maintaining an ongoing record of the situations, emotions, and interpersonal factors associated with drinking or urges to drink. Such a record allows clients to become more aware of the immediate precipitants of drinking. Even in clients who have already become abstinent, self-monitoring can still be used to assess situations in which urges are more prevalent.

Once a person's high-risk situations have been identified, two types of intervention strategies can be used to lessen the risks posed by those situations. The first strategy involves teaching the client to recognize the warning signals associated with imminent danger—that is, the cues indicating that the client is about to enter a high-risk situation. Such warning signals to be recognized may include, for example, AIDs, stress and lack of lifestyle balance, and strong positive expectancies about drinking. As a result of identifying those warning signals, the client may be able to take some evasive action (e.g., escape from the situation) or possibly avoid the high-risk situation entirely.

The second strategy, which is possibly the most important aspect of RP, involves evaluating the client's existing motivation and ability to cope with specific high-risk situations and then helping the client learn more effective coping skills. Relevant coping skills can be behavioral or cognitive in nature and can include both strategies to cope

¹Classical or Pavlovian conditioning occurs when an originally neutral stimulus (e.g., the sight of a beer bottle) is repeatedly paired with a stimulus (e.g., alcohol consumption) that induces a certain physiological response. After the two stimuli have been paired repeatedly, the neutral stimulus becomes a conditioned stimulus that elicits the same physiological response.

to view them not as failures or indicators of a lack of willpower but as mistakes or errors in learning that signal the need for increased planning to cope more effectively in similar situations in the future. This perspective considers lapses key learning opportunities resulting from an interaction between coping and situational determinants, both of which can be modified in the future. This reframing of lapse episodes can help decrease the clients' tendency to view lapses as the result of a personal failing or moral weakness and remove the self-fulfilling prophecy that a lapse will inevitably lead to relapse.

Global Lifestyle Self-Control Strategies

Although specific intervention strategies can address the immediate determinants of relapse, it is also important to modify individual lifestyle factors and covert antecedents that can increase exposure or reduce resistance to high-risk situations. Global self-control

strategies are designed to modify the client's lifestyle to increase balance as well as to identify and cope with covert antecedents of relapse (i.e., early warning signals, cognitive distortions, and relapse set-ups).

Balanced Lifestyle and Positive Addiction. Assessing lifestyle factors associated with increased stress and decreased lifestyle balance is an important first step in teaching global self-management strategies. This assessment can be accomplished through approaches in which clients self-monitor their daily activities, identifying each activity as a "want," "should," or combination of both. Clients also can complete standardized assessment measures, such as the Daily Hassles and Uplifts Scale (DeLongis et al. 1982), to evaluate the degree to which they perceive their life stressors to be balanced by pleasurable life events.

Many clients report that activities they once found pleasurable (e.g., hobbies and social interactions with family

and friends) have gradually been replaced by drinking as a source of entertainment and gratification. Therefore, one global self-management strategy involves encouraging clients to pursue again those previously satisfying, non-drinking recreational activities. In addition, specific cognitive-behavioral skills training approaches, such as relaxation training, stress-management, and time management, can be used to help clients achieve greater lifestyle balance.

Helping the client to develop "positive addictions" (Glaser 1976)—that is, activities (e.g., meditation, exercise, or yoga) that have long-term positive effects on mood, health, and coping—is another way to enhance lifestyle balance. Self-efficacy often increases as a result of developing positive addictions, largely caused by the experience of successfully acquiring new skills by performing the activity.

Stimulus-Control Techniques.

Although achieving a more balanced lifestyle may reduce the risk of cravings

An Example of a Decision Matrix for Alcohol Abstinence or Alcohol Use*

	Immediate Consequences		Delayed Consequences	
	Positive	Negative	Positive	Negative
Remain Abstinent	Improved self-efficacy and self-esteem, family approval, better health, more energy, save money and time, greater success at work	Frustration and anxiety, denied pleasures of drinking, unable to go to bars, anger at not being able to do what one wants without "paying the price"	Greater control over one's life, better health and longevity, learn about one's self and others without being intoxicated, more respect from others	Not able to enjoy drinking while watching sports, bored and depressed, not able to remain friends with heavy-drinking buddies
Resume Alcohol Use	Automatic pleasure, reduced stress and anxiety, not feel pain, not worry about one's problems, able to enjoy sports and drink with buddies	Feel weak from drinking, risk of accidents and embarrassment, anger of wife and family, arrive late to or miss work, hangovers, waste money	Maintain friendships with drinking buddies, able to drink while watching sports, not have to cope with wife and family by staying out drinking	Possible loss of family and job, deterioration of health and early death, loss of nondrinking or light-drinking friends, ridicule by others, low self-esteem

*In such a matrix, the client lists both the positive and negative immediate and delayed consequences of remaining abstinent versus resuming drinking. This list can facilitate the client's decisionmaking process regarding his or her future alcohol consumption.

that is, whether different researchers coded a given relapse episode in an identical or similar manner.

- It evaluated whether the key relapse episodes predicted the types of relapse episodes that study participants reported after undergoing treatment (Maisto et al. 1996; Stout et al. 1996).
- It extended research on the RP model beyond the taxonomy by evaluating alternative methods for assessing high-risk situations as well as evaluating the relative contribution of negative affect, abstinence violation effect, coping, and expectancies on the likelihood of relapse.

The results reported in the RREP study indicate that the original relapse taxonomy of the RP model has only moderate inter-rater reliability at the highest level of specificity, although reliability of the more general categories (e.g., negative affect and social pressure) was better. The model's predictive validity also was modest; however, the definition of the key relapse episodes utilized in these studies failed to clarify whether these were voluntary change episodes or simply a return to drinking following a short period of abstinence that did not represent a serious attempt to quit drinking. Therefore, the RREP studies do not represent a good test of the predictive validity of the taxonomy.

Nevertheless, the study provides relatively good support for other aspects of the RP model. For example, Miller and colleagues (1996) found that although mere exposure to specific high-risk situations did not predict relapse, the manner in which people coped with those situations strongly predicted subsequent relapse or continued abstinence. Furthermore, in that study the majority of relapse episodes after treatment occurred during situations involving negative emotional states, a finding that has been replicated in other studies (Cooney et al. 1997; McKay 1999; Shiffman 1992). Finally, the results of Miller and colleagues (1996) support the role of the abstinence violation effect in predicting which participants would experience a full-blown relapse follow-

ing an initial lapse. Specifically, those participants who had a greater belief in the disease model of alcoholism and a higher commitment to absolute abstinence (who were most likely to experience feelings of guilt over their lapse) were most likely to experience relapse in that study. In a recent review of the literature on relapse precipitants, Dimeff and Marlatt (1998) also concluded that considerable support exists for the notion that an abstinence violation effect can precipitate a relapse.

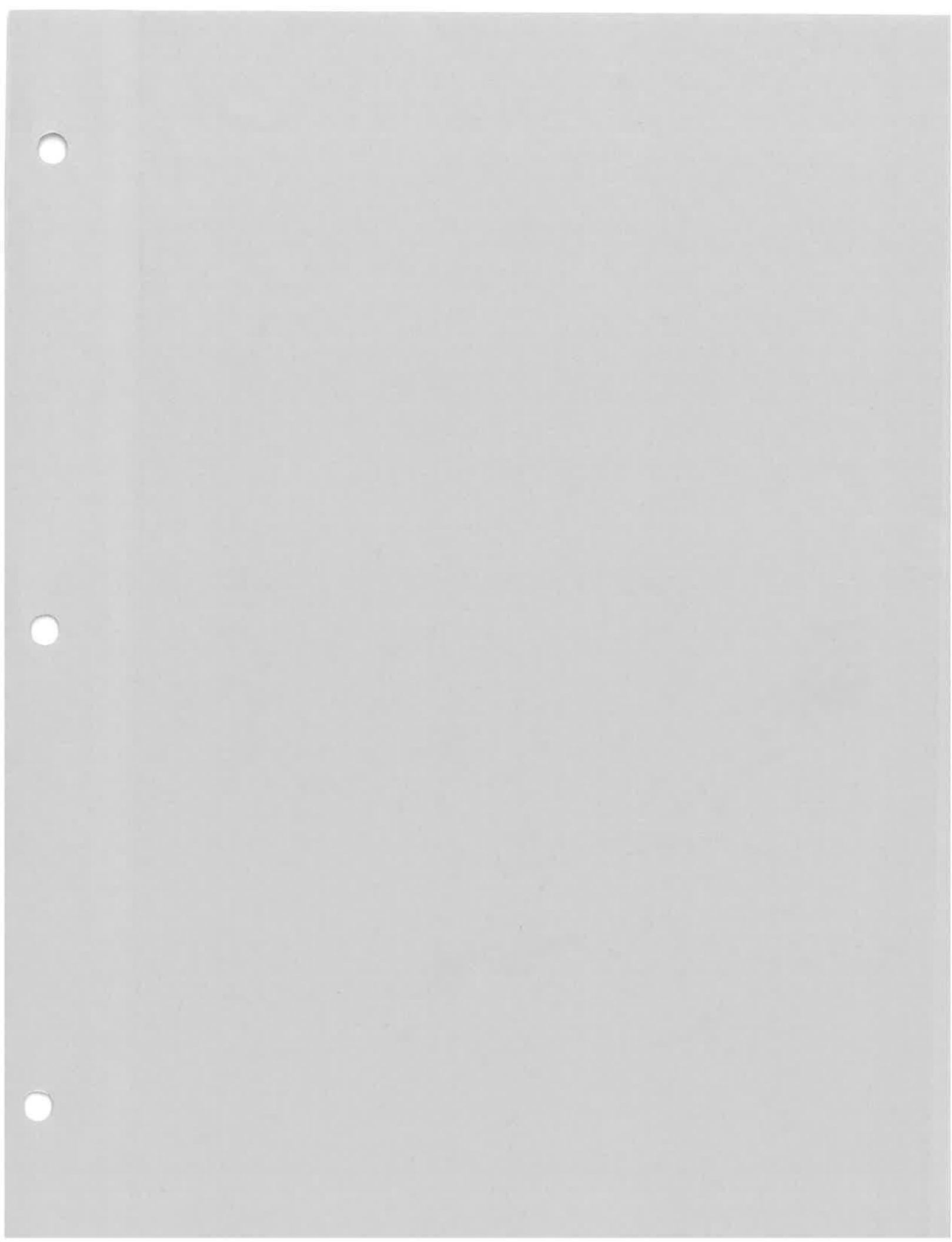
Several recent review articles and meta-analyses have examined the effectiveness of treatments based on the RP model in preventing relapse (Dimeff and Marlatt 1998; Rawson et al. 1993; Carroll 1996; Irvin et al. 1999). The RP-based treatments included in those analyses were delivered both as stand-alone treatments for initiating abstinence and as adjuncts to other treatment programs. Although the reviews differ in their methodology and in their criteria for including or excluding certain treatments, the conclusions regarding overall effectiveness of the RP approach are similar. The findings can be summarized as follows:

- The studies conducted to date tend to support the effectiveness of cognitive-behavioral RP-based approaches in reducing the frequency of relapse episodes as well as the intensity of lapse and/or relapse episodes among people who resumed alcohol use after treatment (Irvin et al. 1999). The effectiveness of RP was particularly great in studies that compared relapse rates in patients before and after treatment or that compared patients receiving RP-based treatment with controls receiving no treatment.
- Despite its benefits, RP-based treatment is not associated with higher abstinence rates compared with other valid treatment approaches (Carroll 1996; Irvin et al. 1999). RP-based treatment is, however, often associated with lower drinking rates and fewer drinking problems among patients who have experienced a relapse (e.g., Chaney et al. 1978).

- RP is associated with "delayed emergence effects"—that is, significant effects favoring RP as compared with other treatment approaches are often found only at later followup points (i.e., 1 year or more after treatment) (Carroll 1996). This delayed effectiveness may result from the fact that it takes time to learn new skills and that consequently RP effects become more obvious as patients acquire additional practice.
- Although RP has been applied with some success to various addictive behaviors, the effects of RP-based approaches are greatest in the treatment of alcoholism or multiple drug use (Irvin et al. 1999).
- Combining RP with medications (e.g., disulfiram or naltrexone) to treat alcoholism leads to improved outcomes as compared with either RP or medication alone (Irvin et al. 1999).

SUMMARY

The RP model of relapse is centered around a detailed taxonomy of emotions, events, and situations that can precipitate both lapses and relapses to drinking. This taxonomy includes both immediate relapse determinants and covert antecedents, which indirectly increase a person's vulnerability to relapse. Based on the classification of relapse determinants and high-risk situations proposed in the RP model, numerous treatment components have been developed that are aimed at helping the recovering alcoholic cope with high-risk situations. The results of recent research, particularly the RREP study, likely will lead to modifications of the original RP model, particularly with regard to the assessment of high-risk situations as well as the conceptualization of covert and immediate antecedents of relapse. Overall, however, research findings support both the overall model of the relapse process and the effectiveness of treatment strategies based on the model. ■



STATE OF RHODE ISLAND
DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES AND HOSPITALS
DIVISION OF BEHAVIORAL HEALTH CARE

UNIT **Center of Excellence**

POLICY/PROCEDURE NO.
COE - 031

SUBSECTION EFFECTIVE DATE

POLICY/PROCEDURE

02/10/2017

Discharge Planning

AMENDMENT / REVISION HISTORY

Approved:

Amended:

POLICY

Discharge planning begins at the time of admission and is person-centered to meet the needs of the individual. Discharge planning is part of the treatment plan which is discussed by staff in collaboration with the patient. The patient is engaged at treatment initiation and monthly thereafter to discuss treatment and discharge goals. Discharge planning is also discussed by treatment team members at weekly treatment team meetings. Discharge planning will also require collaborative work with community clinicians who will be providers of ongoing necessary services for patients including ongoing MAT, psychotherapies, medical and/or psychiatric services.

PROCEDURE

Discharge planning is a component of the initial treatment plan and every treatment plan drafted thereafter. The goal of treatment is to stabilize patients in terms of their opioid use disorder and to plan for discharge to occur within 6 months of admission.

Discharge may be undertaken if any of the following situations occurs:

The patient has achieved maximal benefit from the COE program.

The patient wishes to transfer to a different treatment setting.

The patient is not benefitting from services and needs referral to a different level of care.

Discharge plans will include input from the patient, caregivers in the COE, and community providers who may accept the patient for ongoing care.

Patients who transfer to the community and experience relapsive disease such that the community providers do not feel they can provide the level of care necessary to assure ongoing recovery and safe opioid treatment (MAT), may be transferred back to the COE. Such events will take place with the coordination of the COE with community providers to best address the patient's care needs.