SOUTHERN HIGHLANDS COMMUNITY MENTAL HEALTH CENTER

COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT (CPST)

Philosophy – Southern Highlands Community Mental Health Center believes that for some consumers who are exhibiting acute or severe psychiatric symptoms following a crisis episode, short-term intensive services, known as CPST, in a protective environment can result in the consumer being maintained in the community without the need for inpatient hospitalization. Southern Highlands is committed to providing quality behavioral health services to consumers in Mercer, McDowell, and Wyoming counties.

Goal – The goal of CPST is to prevent unnecessary inpatient hospitalization for those consumers who can benefit from rapid stabilization after an acute episode of severe psychiatric signs and symptoms and who, after assessment and crisis intervention, require continued stabilization to restore the consumer to pre-crisis functioning and prevent placement breakdowns.

Crisis Stabilization Services – CPST is an organized program of services designed to provide quick intervention and support to stabilize an individual immediately following a crisis episode. During this "crisis episode" the person exhibits acute or severe psychiatric signs and symptoms which cannot be successfully managed with a less intense level of services and which do not require a more intensive inpatient setting. Services are also available to those individuals who, after assessment and treatment in an inpatient setting, require continued stabilization prior to their return to their natural environment. Consumers must meet one of three specific admission criteria which are described in section 2-A, B, and C. Consumers can receive pharmacotherapy evaluation and administration, psychiatric nursing services, psychiatric evaluation and ongoing psychiatric review, individual and group counseling, interdisciplinary team evaluation and treatment planning, family intervention, psychological/functional evaluations, discharge planning/follow-up and psycho-education. Services must be ordered, in writing, by a physician and provided on consecutive days. Any person who still requires services at the end of the 72-hour service limit and does not meet criteria for continued stay authorization by APS may be discharged following referral to a lower or higher level of service intensity.

Target Population – The CPST Program serves adults with a mental health and/or substance abuse who meet admission criteria. These individuals can be stabilized with short term intensive services outside a hospital setting and, with supportive care, can receive treatment while remaining in the community.

Admission Criteria

1. General Criteria

    A. Consumer must be at least 18 years of age.
    B. Must be willing to be treated voluntarily.

C. Must be willing to and able to contract for safety.
D. Must be free from active homicidal ideations and excessive violent acting out.
E. Must agree to a search and inventory of personal belongings and body search at admission.
F. Must agree to urine drug screen and/or breathalyzer if there is suspicion of substance abuse.
G. Must have a primary diagnosis of mental illness and/or substance abuse.
H. Must be medically stable. This includes not having the potential for serious chemical withdrawals, and having a BAC below 0.08, and not requiring skilled nursing care.
I. Needs a protective environment that is less restrictive than inpatient hospitalization.
J. If the consumer as the financial means, he/she is expected to secure any needed medications that are a critical element in psychiatric management and/or substance abuse detoxification. Stock medications may be used to treat indigent individuals without third party insurance coverage. The full cost of co-pay of any non-psychiatric medication that may be prescribed is the responsibility of the consumer.
L. Must have a viable placement after discharge from the CPST.

2. Specific Admission Criteria

A. Psychiatric Signs and Symptoms

1) The consumer is having a crisis episode due to a mental health condition and/or impairment in functioning due to acute psychiatric signs and symptoms. Impairments may range from impaired daily living skills to severe disturbances in conduct and emotions. The crisis results in emotional and/or behavioral instability which may be exacerbated by family dysfunction, transient situational disturbance, physical or emotional abuse, failed placement or other current living situation **and**

2) The consumer is in need of structured, intensive intervention because less restrictive/intensive services alone are not sufficient or resolve the current crisis and meet the consumer's needs.

OR

B. Danger to Self / Others

1) The consumer is in need of intensive treatment intervention to prevent hospitalization (e.g. engages in self-injurious behavior, is currently physically aggressive and/or communicates verbal threats but not at a level that would require hospitalization).

C. Medication Management / Active Drug or Alcohol

1) The consumer is in need of a medication regimen that requires intensive monitoring/medical supervision or is being evaluated for a medication regimen that requires titration to reach optimum therapeutic effect.

OR

2) There is evidence on admission that the consumer is using drugs, which have produced a physical dependency as evidenced by clinically significant withdrawal symptoms, which require medical supervision.

Criteria for Continuing Stay

1. Acute Psychiatric Symptoms

A. The acute psychiatric signs and symptoms and/or behaviors that necessitated the admission continue at the level documented at admission and treatments and interventions tried are documented. A modified care plan must be developed which documents treatment methods and projected discharged ate based on the change in the care plan.

OR

B. New symptoms and/or maladaptive behaviors have appeared which have been incorporated into the care plan and modified the discharge date of the consumer. These new acute symptoms/behaviors can be treated safely in the CPST setting, and a less intensive level of care would not adequately meet the consumer's needs.

OR

C. Consumer progress toward crisis resolution and progress clearly and directly related to resolving the factors that warranted admission to CPST continue to warrant this level of care.

2. Danger to Self / Others

A. Consumer progress toward resolution of the crisis and progress clearly and directly related to resolving the factors that warranted admission to CPST have been observed and documented, but symptoms and impairments continue to warrant this level of care.

OR

B. It has been documented that no progress has been made toward treatment goals nor has progress been made toward alternative placement (more or less restrictive care), but the care plan has been modified to introduce further evaluation and appropriate interventions and treatment options for the consumer.

OR

C. New symptoms, maladaptive behaviors and/or functional impairments have occurred and been incorporated into the treatment plan and modified the discharge date. These new symptoms/functional impairments/maladaptive behaviors can be safely treated in the CPST Program and a less intense level of service would not adequately meet the consumer's needs.

3. Medication Management / Active Drug or Alcohol Withdrawal

A. Consumer progress toward crisis resolution and progress clearly and directly related to resolving the factors that warranted admission to CPST have been observed and documented, but symptoms and impairments continue to warrant this level of care.

OR

B. It has been documented that the consumer has made no progress toward treatment goals nor has progress been made toward alternative placement (less or more restrictive care), but the care plan has been modified to introduce further evaluation of the consumer's needs and other appropriate interventions and treatment options.

OR

C. New symptoms and/or maladaptive behaviors have emerged and been incorporated into the treatment plan, modifying the consumer's projected discharge date. The consumer may be treated safely in the CPST Program and a less restrictive setting would not meet the consumer's needs.

Discharge Criteria

1. The crisis episode which necessitated placement has been resolved and the consumer has returned to a level of functioning that allows return to their previous living arrangement and can be safely treated with a less intensive level of service.

2. The consumer exhibits symptoms and functional impairments which cannot be safely treated in the CPST Program because they require a more intense level of care.

3. The consumer is unwilling to participate in available treatment.

4. The consumer is disruptive to the point that his/her presence causes others not to be able to benefit from treatment.

Clinical Exclusions

1. The consumer is so dangerous to himself or others that he/she cannot be maintained in the CPST Program environment (i.e., hurting others, requiring physical restraints, etc.).

2. The severity of the clinical issues precludes provision of services at this level of care.

3. Crisis stabilization is not utilized solely for physical or environmental conditions (i.e., DT's, Alzheimer's, loss of living arrangements, etc.).

4. Consumers who do not meet the general or specific admission criteria.

SOUTHERN HIGHLANDS DETOXIFICATION PROGRAMS

SEDATIVE, HYPNOTIC, ANXIOLYTIC DETOXIFICATION PROTOCOL

Alprazolam 0.5mg---Lorazepam 1mg--Clonazepam 0.25-0.5mg---Diazepam 5-(10mg) --- Chlordiazepoxide 10-(25mg)—Oxazepam 15mg

Alprazolam- onset 30 minutes, duration 3-4 hours, half-life 6-12 hours
Lorazepam- onset 15-30 minutes, duration 4-6 hours, half-life 10-20 hours
Clonazepam- onset 60 minutes, duration 6-8 hours, half-life 20-50 hours
Diazepam- onset 15 min, duration 4-6 hours, half-life 20-60 hours, metabolite 100 hours
Chlordiazepoxide-onset 15-30 minutes, half-life 5-30 hours, metabolite 200 hours
Oxazepam- onset 30-60 minutes, half-life 8-14 hours

Dependence happens within 3-6 weeks of regular use.

Benzodiazepine withdrawal depends on the:
• Dose • Duration of use • Duration of drug action
There is high variability in the intensity and duration of benzodiazepine withdrawal symptoms.

Withdrawal begins 12-48 hours after last use, depending on drug used (6-8 hours after short acting, 1-4 days after long acting), peaks after approx. 14 days, and may persist 5-28 days.

Signs and Symptoms of Benzo Withdrawal:

• Tachycardia, hypertension, fever, diaphoresis • Agitation, anxiety, irritability • Delirium, seizures • Hallucinations (tactile, visual, auditory) • Insomnia, nightmares • Tremor, hyperreflexia • Tinnitus, mydriasis, photosensitivity, hyperacusis • Anorexia, nausea, diarrhea • Death

Protracted withdrawal can continue weeks or months and include sleep disturbance, anxiety, irritability, sensory hypersensitivity, muscles spasms, and tinnitus.

Assess for severity of benzodiazepine use (amount, frequency, last use, and complications), comorbid medical and psychiatric conditions, history of complicated withdrawal such as withdrawal seizures, delirium, hallucinations. Educate the patient about the benzodiazepine withdrawal course and duration, especially protracted withdrawal such as anxiety, insomnia, and paresthesias.

Usually, a long taper is recommended: 10-25%/week, over months, with less reduction (5-10%) towards the end of the taper.

There are two major types of taper: fixed taper or symptom driven protocols. Studies did not show a difference in terms of outcome between the two types of protocols.

The value of using a rating scale for benzodiazepine withdrawal is unproven; the scores on benzodiazepine withdrawal scales do not predict accurately the severity of the withdrawal.

• **CIWA-B** • 22 items, scored 0-4 • 17 self-report, 3 observation • Mild (1-20), moderate (21-40), severe (41-60), very severe (61-80)

Benzodiazepine Withdrawal Protocol:

Give tapering dose of medication at scheduled intervals.

Convert the current dosage of the patient's benzodiazepine to an equivalent dose of diazepam (long acting).

Do not give more than 80mg diazepam/day.

Administer the dose first in 4 divided doses (6 am, noon, 6pm, MN), then in 3 divided doses: 8am, 4pm, MN, and then every 12 hours (8 am and 8pm).

Reduce the dose if the patient becomes over sedated.

D1: 10-20MG QID
D2: 10mg QAM, 10mg QNoon, 5mg Q6PM, 10mg QMN
D3: 10mg QAM, 5mg QNoon, 5mg Q6PM, 10mg QMN
D4: 10mg QAM, 5mg QNoon, 5mg Q6PM, 5mg QMN
D5: 5mg QAM, 5 mg QNoon, 5mg Q6PM, 5 mg QMN

Change to every 8 hours:
D6: 5mg QAM, 5mg Q4PM, 5mg QMN
D7: 5mg QAM, 2 mg Q4PM, 5mg QMN
D8: 5mg QAM, 2mg Q4PM, 2mg QMN
D9: 2mg QAM, 2mg Q4PM, 2mg QMN

Change to every 12 hours:
D10: 2mg QAM, 2mg Q8PM
D11: 2mg QAM

Adjunctive Medications:

Use hydroxyzine 25-50mg, carbamazepine 200mg BID (continue for 4 weeks after taper), trazodone, buspirone

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Sedative Hypnotic Anxiolytic Detoxification Order

Consumer Name: _____ **Chart Number:** _____

Obtain Vital Signs Q4H while awake. If the consumer wakes up during the night, obtain vital signs.

Changes in medications and procedures may occur on a case-by-case basis as determined by the medical provider.

ROUTINE DETOX Diazepam (Valium) oral (fixed-dose regimen):

Administer the dose first in 4 divided doses (6 am, noon, 6pm, MN), then in 3 divided doses: 8am, 4pm, MN, and then every 12 hours (8 am and 8pm).

Reduce the dose if the patient becomes over sedated.

D1: 10-20mg QID
D2: 10mg QAM, 10mg QNoon, 5mg Q6PM, 10mg QMN
D3: 10mg QAM, 5mg QNoon, 5mg Q6PM, 10mg QMN
D4: 10mg QAM, 5mg QNoon, 5mg Q6PM, 5mg QMN
D5: 5mg QAM, 5 mg QNoon, 5mg Q6PM, 5 mg QMN

Change to every 8 hours:
D6: 5mg QAM, 5mg Q4PM, 5mg QMN
D7: 5mg QAM, 2 mg Q4PM, 5mg QMN
D8: 5mg QAM, 2mg Q4PM, 2mg QMN
D9: 2mg QAM, 2mg Q4PM, 2mg QMN

Change to every 12 hours:
D10: 2mg QAM, 2mgQ8PM
D11: 2mg QAM

☐ Carbamazepine 200 mg PO BID

Verbal order per _____ transcribed by _____ _____
Physician Nurse Date

_____ _____
Physician Signature Date