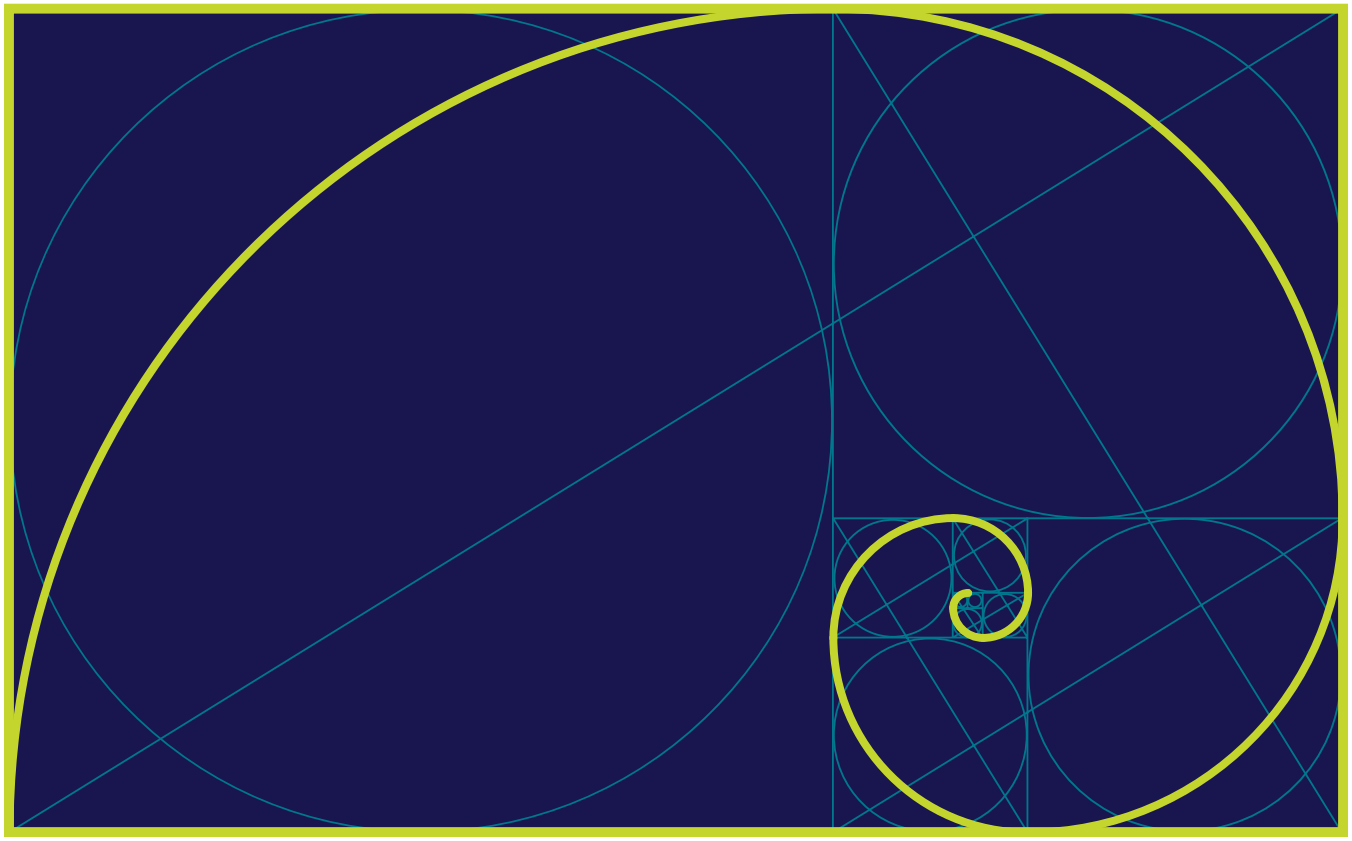
METAPHI

MENTORING, EDUCATION, AND CLINICAL TOOLS FOR ADDICTION

PARTNERS IN HEALTH INTEGRATION



WITHDRAWAL MANAGEMENT SERVICES TOOLKIT

Version date: 25 January 2024

Suggested citation:
Dunham K, Mathew M, Cheema K, Vandewiel M, Jones L, Rivest K, Bonis J, Kahan M, Wyman J. Withdrawal Management Services Toolkit. Toronto, ON: META:PHI: 2024. www.metaphi.ca.

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Withdrawal Management Services Toolkit

PURPOSE

This toolkit was created for providers working in residential community-based withdrawal management services (WMS) to standardize care, improve documentation and information sharing, and provide quick access to relevant information.

SCOPE

Because of the recent funding for nurse practitioners (NPs), registered nurses (RNs), and registered practical nurses (RPNs) in Ontario WMS, this toolkit has a focused lens, developed with the assumption that community-based WMS have (or will shortly have) at minimum one NP and one RPN to care for their clients. Documents and wording therefore assume this staffing complement and are NP- and nursing-focused; however, the content is largely universal for all health care providers. We hope and expect that documents will be adjusted to suit site-specific needs, staffing, and capabilities. We encourage an interdisciplinary approach to the toolkit, with forms being completed and used by staff with the appropriate knowledge and training to do so. Counsellors or withdrawal staff may be best suited to complete pre-arrival screening, while nursing staff are more likely to complete the medical intake.

DEVELOPMENT

This toolkit was written by nurse practitioners working in or with a special interest in WMS. The documents were developed through review of substance use guidelines, best practice recommendations, and relevant clinical research. This included review of existing policies, procedures, and practices of residential community-based WMS across Ontario. After development, the toolkit underwent a comprehensive review by persons with lived experience, WMS staff, RNs, NPs, and physicians with experience working in or with residential community-based WMS. After revisions, it was reviewed by META:PHI's advisory committee and made ready for publication.

RATIONALE

Residential community-based WMS are an essential component of the addiction care pathway. They provide immediate, low-barrier access to treatment. Until recently, however, these WMS lacked the medical capacity to provide medication-assisted treatment for withdrawal and other acute substance related conditions. This created a large gap in care from the fully medicalized inpatient withdrawal management units, creating inequitable access to medication-based treatment. This has resulted in preventable relapses and substance-related morbidity and mortality. For example, patients with opioid use disorder will often leave WMS if they are not given immediate, on-site access to OAT, putting them at high risk of overdose death. Residential community-based WMS are beginning to receive funds to hire NPs, RNs, and RPNs. This will give WMS the capacity to medically treat withdrawal and to initiate OAT and anti-craving medications.

LIMITATIONS

This is not an extensive review of withdrawal or addiction medicine but rather a focused group of documents to assist WMS providers when limited medical staffing is available. This toolkit should be used with consideration of local resources, including proximity of emergency departments (ED) and community care providers, and of WMS resources, including space, equipment, and staffing. When resources allow, eligibility criteria should be expanded and ED transfer criteria minimized, allowing WMS to serve clients with diverse medical needs on-site.

FUTURE GOALS

Ontario WMS should have a full complement of medical and non-medical staff with 24-hour medical support, providing a full service of withdrawal, addictions, and basic primary care needs to all clients equitably. Utilizing WMS to their full capability enhances communities through minimized ED transfers, providing a source of referral to and from community partners, and preventing unnecessary suffering and loss of life.

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Pre-Arrival Screening Tool

Date: _____ **Time:** _____

CLIENT INFORMATION	
Name	
Pronouns	
Preferred language	
Phone	
DOB	
Full address	
Health card number	
Referral source	

ADMISSION CRITERIA

1. Are you looking for a safe place to withdraw from substances used? ☐ Yes ☐ No
2. Are you looking for medical assistance to withdraw from substances used? ☐ Yes ☐ No
3. Are you currently suspended or restricted from any WMS? ☐ Yes ☐ No

YES to (1) is sufficient for admission; (2) may be YES or NO.

If NO to (1) and YES to (2), please refer to the Community Withdrawal Support Program.

If YES to (3), please contact the manager on call prior to admission.

SUBSTANCE USE

List each substance, pattern of use (e.g., daily/binge use), and time of last use:

_____

_____

_____

What does your typical withdrawal look like? Have you ever gone to the emergency department because it got so bad?

_____

_____

_____

EXCLUSION CRITERIA

If any of the following criteria are met, please refer to the appropriate service provider (e.g., emergency department, addiction clinic):*

- ☐ New cough, fever, vomiting, diarrhea (prior to the onset of withdrawal symptoms)
- ☐ Acute serious injuries requiring medical attention (e.g., broken bones, head injuries)
- ☐ Acute psychosis or mania
- ☐ Inadequately controlled chronic psychiatric disorders
- ☐ Active suicidal or homicidal ideation with plan or intent
- ☐ History of hallucinations or seizures when stopping substance use (NOTE: appropriate after loading doses)
- ☐ History of delirium tremens (DTs) (NOTE: appropriate after loading doses)
- ☐ In active withdrawal from benzodiazepine-class drugs
- ☐ Current agitation or aggression
- ☐ Chronic medical conditions requiring significant medical monitoring (e.g., severe CHF)
- ☐ 16 years of age or under

***Admission may be appropriate after medical assessment; encourage the client to return when acute concerns are addressed.**

If any of the following criteria are met, please contact WMS healthcare provider to determine if admission is appropriate):*

- ☐ Minor acute injuries (e.g., open sores, wounds, skin infections)
- ☐ Have stopped medication for chronic illnesses within the last 60 days
- ☐ Pregnant or thinks they may be pregnant
- ☐ Missing medications for chronic or acute illnesses (e.g., insulin, blood pressure medication)
- ☐ Concurrent benzodiazepine and alcohol withdrawal
- ☐ History of seizures

If yes: On treatment? ☐ Yes ☐ No

Date of last seizure: _____

***Timed admission may be appropriate when medical staff are on site.**

MEDICAL SCREEN

Allergies: _____

_____

Medical history (e.g., history of stroke, heart attack, blood pressure concerns, diabetes, hepatitis, HIV, or at risk for a medical condition):

_____

_____

Current medications (prescription, over-the-counter, supplements) and condition they are treating:

Are there medications you should be taking but are not? Please explain:

Are you currently or have you ever been on methadone, buprenorphine (Suboxone®), slow-release oral morphine (Kadian®), or safer supply? Please provide prescriber, dose, pharmacy, and last time taken:

Mental health history:

Have you been hospitalized overnight in the last 90 days? Please explain:

ADMISSION CRITERIA

Has the client been informed of the WMS guidelines, policies, and regulations?	☐ Yes	☐ No
Has the medication policy been explained?	☐ Yes	☐ No
Has the client passed the COVID screener?	☐ Yes	☐ No

How will you get here?

Can your ride stay while we check you in?	☐ Yes	☐ No
Are you being transferred from another facility?	☐ Yes	☐ No

If yes: What is the reason for your visit to that facility?

Will you be transferred back after your WMS stay? ☐ Yes ☐ No

Outcome of phone call (e.g., estimated time of arrival, referral to ED):

Form completed by:

Client Risk Assessment On Arrival

Date: _____ **Time:** _____

CLIENT INFORMATION	
DOB	
Age	
Health card number	
Chart number	

Complete this form to determine the client's risk requiring further medical assessment. This form does not replace staff judgment.

INTOXICATION

Monitoring is required for any of the following signs:

- ☐ Confused
- ☐ Unsteady gait
- ☐ Odour of alcohol
- ☐ Sleepy
- ☐ Agitated
- ☐ Eyes red, pinned, or dilated
- ☐ Loud voice
- ☐ Slurred speech
- ☐ Other: _____

Monitor every 15 minutes until resolved. **If the respiratory rate is below 10 breaths/min, an urgent medical assessment is required.** If the client is intoxicated at intake, the full risk assessment must be completed within 4 hours of admission regardless of the current time of day or night; wake the person if sleeping.

URGENT MEDICAL ASSESSMENT

Urgent medical assessment is required for any of the following signs:

CURRENT SIGNS OF INTOXICATION/WITHDRAWAL	CURRENT SIGNS OF MEDICAL CONDITIONS
☐ *Non-rousable – does not wake to voice/touch/shake	☐ Chest pain
☐ *Slow/shallow breathing	☐ Breathing difficulty/shortness of breath
☐ Active psychosis or hallucinations	☐ Loss or change of consciousness
☐ Confusion or disorientation	☐ Pregnant or thinks may be pregnant
☐ Tremulous +++	☐ Jaundice/yellowing of skin/eyes
☐ Sweating +++	☐ Severe abdominal pain
☐ Imbalanced/unable to walk	☐ Obvious injury
☐ Extreme agitation	☐ Severe vomiting or diarrhea
☐ Active suicidality/intent/plan	☐ Feverish
☐ Active homicidality/intent/plan	☐ New head injury
☐ Self-harm behaviour	☐ Symptomatic benzodiazepine withdrawal
☐ Aggression/violence	

*Requires **immediate medical assessment** and **overdose response.**

Does the client need urgent medical assessment? ☐ No ☐ Yes

If yes: Health care practitioner on site notified? ☐ No ☐ Yes

Sent to the emergency department? ☐ No ☐ Yes

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MEDICAL CLEARANCE

A client has *medical clearance* if an NP or MD has assessed them directly before admission and determined that it is safe for them to remain in the WMS; this can be done either on site at the WMS or in the ED. Medical clearance is required if client has history of any of the following:

- ☐ Withdrawal seizures — Date of last known seizure: _____
- ☐ Delirium tremens (DTs) — Date of last known DTs: _____
- ☐ Hospitalization for withdrawal

CURRENT MEDICAL CONCERNS

Does the client have any of the following concerns that should be flagged for medical attention?

- ☐ Stopped medication for chronic illnesses within the last 60 days
- ☐ Missing medications for chronic or acute illnesses (e.g., insulin, blood pressure medications)
- ☐ Withdrawal from benzodiazepine-class drugs, currently asymptomatic
- ☐ 65+ years of age
- ☐ Frail
- ☐ Diabetes
- ☐ High blood pressure (history or on intake greater than 140/90)
- ☐ Heart problems/angina
- ☐ COPD/asthma
- ☐ Cirrhosis
- ☐ Seizure disorder
- ☐ Currently taking methadone, buprenorphine, slow-release oral morphine, or other addiction treatment
- ☐ Obvious open sore/wound that has not yet been assessed/treated
- ☐ Functional issues:
    - ☐ Memory or cognition
    - ☐ Mobility
    - ☐ Hearing
    - ☐ Vision
    - ☐ Fall risk

Health care practitioner notified directly? ☐ No ☐ Yes

Health care practitioner e-mailed (subject "Non-urgent medical"): ☐ No ☐ Yes

Medical Intake

Date: _____ **Time:** _____

CLIENT INFORMATION	
Name	
DOB	
Sex assigned at birth	
Age	
Health card number	
Chart number	

Family practitioner name and contact info: _____

_____

Other care providers (e.g., psychiatrist, community social supports, etc.): _____

_____

Allergies: _____

EpiPen needed? ☐ Yes ☐ No

EpiPen available? ☐ Yes ☐ No

MEDICATIONS (prescriptions, over-the-counter, vitamins, supplements, inhalers, topicals, and samples)					
Medication	Dose, route, frequency	Reason	Prescriber	Pharmacy	Adherent?
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N

MEDICAL HISTORY

Medical issues and surgical history:

- ☐ Diabetes
- ☐ Sleep apnea
- ☐ Renal problems
- ☐ Liver problems
- ☐ Respiratory concerns
- ☐ Chronic pain

Other: _____

Pregnant or chance of pregnancy? ☐ No ☐ Yes

If yes: Care provider: _____

LMP & EDD: _____

High-risk behaviours (e.g., IVDU, sharing supplies):

HIV: ☐ Unknown ☐ Negative ☐ Positive

If positive: Care provider: _____

Viral load: _____

Therapy: _____

Hepatitis A: ☐ Unknown ☐ Never had ☐ Has had ☐ Immunized

Date last tested: _____

Hepatitis B: ☐ Unknown ☐ Never had ☐ Has had ☐ Chronic infection ☐ Immunized

Date last tested: _____

Hepatitis C: ☐ Unknown ☐ Never had ☐ Positive ☐ Treated

Date last tested: _____

If positive/treated: Care provider: _____

Viral load: _____

Therapy (if/when completed): _____

TB: ☐ Unknown ☐ Negative ☐ Positive

If positive: Symptoms (e.g., hemoptysis, weight loss): _____

COVID-19 vaccination status: ☐ Unvaccinated ☐ One dose ☐ Two doses ☐ Booster

PHYSICAL EXAM

General appearance (e.g., intoxicated, physical withdrawal, calm and well): _____

_____

Height: _____ ☐ Reported ☐ Measured

Weight: _____ ☐ Reported ☐ Measured

Resp: _____

Pulse: _____

BP: _____

SpO2: _____

Temp: _____

Skin (e.g., track marks, wounds, infection): _____

Other: _____

SUBSTANCE USE

Completed Psychoactive Drug History Questionnaire[1]: ☐ No ☐ Yes

Past overdose: ☐ No ☐ Yes

If yes: Details: _____

DSM-5 substance use disorder diagnosis: ☐ No ☐ Yes

Withdrawal scale completed: ☐ COWS[2] ☐ CIWA-Ar[3] ☐ CIWA-B[4]

Previous addiction treatment: ☐ No ☐ Yes

If yes: Details: _____

MENTAL HEALTH

Received treatment for mental health: ☐ Currently ☐ Within past 12 months ☐ Within lifetime

Received medication for mental health: ☐ Currently ☐ Within past 12 months ☐ Within lifetime

Psychiatric admissions (inpatient/admitted to hospital): ☐ Within past 12 months ☐ Within lifetime

Previous suicide or self-harm attempts: ☐ No ☐ Yes

Current suicidal ideation or self-harm intent: ☐ No ☐ Yes

Homicidal ideation: ☐ No ☐ Yes

Details: _____

[1] https://www.nova.edu/gsc/forms/Drug-History-Questionnaire.9.8.2022%20.pdf

[2] https://www.metaphi.ca/wp-content/uploads/COWS.pdf

[3] http://www.metaphi.ca/wp-content/uploads/WMS_6.1_CIWA-Ar.pdf

[4] https://insight.qld.edu.au/file/410/download

PTSD screen: In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you…

	YES	NO
Had nightmares about it or thought about it when you did not want to?	☐	☐
Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	☐	☐
Were constantly on guard, watchful, or easily startled?	☐	☐
Felt numb or detached from others, activities, or your surroundings?	☐	☐

**Yes to 3 or more should prompt further investigation.*

PHQ-2: Over the past 2 weeks, how often have you been bothered by the following problems?

	NOT AT ALL (0)	SEVERAL DAYS (1)	MORE THAN HALF THE DAYS (2)	NEARLY EVERY DAY (3)
Little interest or pleasure in doing things?	☐	☐	☐	☐
Feeling down, depressed, or hopeless?	☐	☐	☐	☐

**A score of 3 or greater indicates depression is likely and further assessment is warranted.*

GAD-2: Over the past 2 weeks, how often have you been bothered by the following problems?

	NOT AT ALL (0)	SEVERAL DAYS (1)	MORE THAN HALF THE DAYS (2)	NEARLY EVERY DAY (3)
Feeling nervous, anxious, or on edge?	☐	☐	☐	☐
Not being able to stop or control worrying?	☐	☐	☐	☐

**A score of 3 or greater indicates anxiety is likely and further assessment is warranted.*

DISCUSSION/PLAN

☐ Referrals: ☐ Family practitioner ☐ Psychiatry ☐ Outpatient program/support groups
☐ Residential treatment ☐ HCV/HIV treatment

☐ Opioid agonist therapy: ☐ Naloxone kit ☐ National overdose response services
☐ Discuss risks of overdose after detox

☐ Anti-craving medication

☐ NRT

☐ Harm reduction practices reviewed and recommended

☐ Ministry of transportation reporting responsibilities reviewed (if client is non-compliant with treatment and/or returns to uncontrolled substance use and continues driving)

Details: _____

_____

Consent to Release Personal Health Information

WITHDRAWAL MANAGEMENT SERVICES	
Phone	
Fax	
Name of client	
Date of birth	
Health card number	

My initials beside the names of those individuals and/or agencies is my consent for the Withdrawal Management Service to release and/or receive my personal health information (PHI):

Initials	Provider/agency type	Name
	Hospital	
	Family practitioner	
	Psychiatrist	
	Pharmacy	
	Addictions provider	
	Other:	
	Other:	

☐ Please see attached documents.

☐ Please assist in providing the following personal health information:

- ☐ Current dose of methadone, buprenorphine, or slow-release oral morphine
- ☐ Length of time on current dose of methadone, buprenorphine, or slow-release oral morphine
- ☐ Date of last dose increase
- ☐ Last witnessed dose of methadone, buprenorphine, or slow-release oral morphine
- ☐ Name of pharmacy where dose was received
- ☐ Carry status
- ☐ Last 2 urine and/or broad spectrum chromatography results
- ☐ Other: _____

_____

I understand the purpose for sharing this personal health information with the above noted person(s).

I understand that I can decline to sign this consent form.

I understand that I can withdraw my consent at any time by providing written or verbal notice. Consent is otherwise valid until the file is closed.

Signature of client	**Date**
Signature of parent/guardian/caregiver/ substitute decision maker (where applicable)*	**Date**
Signature of witness	**Date**

A copy of the Consent to Obtain or Release Information is available upon request to the person signing this form.

This form is in accordance with s.38(2) of the Freedom of Information and Protection of Privacy Act.R.S.O. 1990 c. F.31 as amended.

*Please note: A substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.

Clinical Pathway for Medical Management of Alcohol Withdrawal in WMS

Client presents with alcohol use disorder

Are loading doses required?
Does the client have a history of withdrawal complications such as seizures or delirium tremens, hallucinations or hospitalization for severe withdrawal?

Withdrawal typically begins 6–12h after the last drink. A protocol should typically begin within 6h of intake.

YES / NO

Are skilled staff available for monitoring and managing potential complications?

***In people who drink heavily, complications can occur as alcohol levels decrease. Aim to begin loading doses between intoxication and withdrawal.**

YES / NO

- Oral diazepam **20 mg** (lorazepam **2–4 mg**) q1–2h x 3 or until lightly sedated and has minimal to no tremor.
- Consider following this with symptom-triggered or fixed dosing as needed.

Send client to ED for stabilization

Is a symptom-triggered regimen possible?
- Skilled staff is available to implement a symptom-triggered regimen

YES / NO

Complete CIWA-Ar q1–2h
- Administer diazepam **10–20 mg/lorazepam 1–2 mg** when CIWA-Ar ≥ 10 or client presents with definite tremor or profuse sweating
- Continue until CIWA < 8 x 2 consecutive assessments AND minimal to no tremor

*If unsure if withdrawal is fully resolved, this can be followed by 1–2 days of diazepam **10 mg** (lorazepam **1 mg**) q4h PRN for tremor

Use a fixed-dose tapering regimen
- Only use if staff skilled in implementing a symptom-triggered regimen are not available

YES

Diazepam **10 mg** QID (lorazepam **1–2 mg** QID) on day 1. Taper over 4–5 days. Hold any dose if sedated/drowsy.

*See alcohol withdrawal order set for example regimens

*Consider starting with diazepam **20 mg** QID with a history of severe withdrawal, or known high tolerance to benzodiazepines

To prevent Wernicke-Korsakoff Syndrome, provide thiamine:
- **300 mg** IM/IV for 3–5 days (**100 mg** PO TID for 3–5 days if IM/IV are unavailable)
- THEN **100 mg** PO OD–TID for 2–3 weeks

MONITORING PROTOCOL

Complete the initial assessment and then assess according to symptoms & scoring:

Severe withdrawal **Monitor q1h**
CIWA-Ar ≥ 20, severe tremor, or profuse sweating

Moderate withdrawal **Monitor q2h**
CIWA-Ar 10–19, moderate tremor or sweating

Mild withdrawal **Monitor q4h**
CIWA-Ar 0–9, mild tremor
BP, HR, T, RR, Sp02 with each assessment

TRANSFER TO EMERGENCY DEPARTMENT IF:

- Tremor not improving/worsening despite **80 mg** diazepam (**8 mg** lorazepam)
- Tachycardia (HR > 120 bpm) or hypertension (elevation of systolic or diastolic BP 20–30 mm Hg above baseline)
- Repeated vomiting or profuse sweating
- Seizures, confusion, hallucinations, delusions, or agitation

USE LORAZEPAM IF:

- Taking opioids/sedating medications
- Severe liver dysfunction (cirrhosis, severe hepatitis)
- Low serum albumin
- Respiratory failure or distress (severe asthma, COPD, pneumonia)
- Age 60+

GABAPENTIN

Consider gabapentin in place of benzodiazepines when the client is taking opioids/sedating medications, has severe liver dysfunction, low serum albumin, respiratory failure or distress, or is 60+. Gabapentin is **not proven** to be effective against alcohol withdrawal seizures. Use this protocol only when low risk of seizures, DTs, or severe withdrawal.

Gabapentin for acute withdrawal:
Days 1–3: **300 mg** QID +/- **300–600 mg** hs
Day 4: **300 mg** TID +/- **300 mg** hs
Day 5: **300 mg** BID
Day 6: **300 mg** hs

When benzodiazepines are utilized, consider switching to gabapentin from day 3 on, as a benzodiazepine-sparing method, for management of post-acute withdrawal and as an anti-craving medication.

Gabapentin for post-acute withdrawal:
Day 3: **300 mg** hs
Day 4: **300 mg** BID
Day 5: **300 mg** TID
Continue to titrate to effect, max recommended dose **1800 mg/day**

Order Set For Alcohol Withdrawal

MONITORING

☐ Temp, HR, RR, BP, and O2 saturation with CIWA-Ar on initial assessment

Repeat q4h when CIWA-Ar < 10 and minimal tremor

Repeat q2h when CIWA-Ar 10–19 and moderate tremor or sweating

Repeat q1h when CIWA-Ar ≥ 20 and severe tremor or sweating, or history of withdrawal seizures/DTs

Note: Monitor q1–2h when medical comorbidities such as cardiovascular/hepatic disorders or concurrent opioid use are present

☐ Notify the most responsible provider (MRP) for any of the following (transfer to ED if MRP not available):

- CIWA-Ar ≥ 20
- Increasing agitation
- Profuse sweating
- Repeated vomiting or diarrhea
- Severe or worsening tremor
- Hallucinations or delirium
- Systolic BP > 180
- Diastolic BP > 110
- HR > 120 or < 50
- RR > 20 or < 10
- SpO2 < 92%
- T > 37.5°C or < 35°C

LABORATORY TESTS

☐ Urine toxicology (point of care drug screen if available)
☐ ECG (if available)
☐ Urine HCG
☐ Serum HCG
☐ Serum ethanol
☐ Urine ETG
☐ Serum CBC, electrolytes, creatinine, glucose, TSH, AST, ALT, ALP, GGT, bilirubin, albumin, INR

Note: Consider breathalyzer use when available to aid in predicting the onset of severe or complicated withdrawal. People who drink heavily can experience withdrawal symptoms and complications requiring benzodiazepines even when their alcohol levels are greater than 17 mmol/L (80 mg/dL or 0.08%). Rates of decline vary significantly but can be as high as 30–40 mg/dL per hour.

As required based on history:

☐ HIV serology
☐ Syphilis serology
☐ Gonorrhea & chlamydia urine
☐ Anti-HAV, HBsAg, HBsAb, HBcAb, Anti-HCV
☐ HCV RNA viral load if history of infection

Note: Do not delay treatment while waiting for investigation results.

MEDICATIONS

CHOICE OF BENZODIAZEPINE

- **Diazepam** is preferred for withdrawal management due to its long half-life.
- Use **lorazepam** if the client is older than 60, taking opioids or other sedating medications, has severe liver dysfunction (e.g., cirrhosis, severe hepatitis), low serum albumin, or respiratory failure or distress (COPD, pneumonia).

DOSES

CHOICE OF REGIMEN

- **Loading doses:**
  - Use when the client presents with withdrawal complications (delirium, hallucinations, or seizures), or has a history of DTs or withdrawal seizures.
  - A loading dose can be given when skilled staff is available for monitoring and managing potential complications.
  - If skilled staff is unavailable, transfer the client with a history of withdrawal complications or experiencing active withdrawal complications to the nearest emergency department.

- **Symptom-triggered doses:**
  - Use when skilled staff is available to monitor symptom severity using CIWA-Ar and respond to any potential complications.

- **Fixed-dose tapering schedule:**
  - Use when skilled staff is unavailable to implement a symptom-triggered regimen.
  - Clients in severe withdrawal or with a history of withdrawal complications (delirium, seizures, DT) should be sent to the ED for management if only fixed-dosing regimens are available at the WMS.

- **Gabapentin:**
  - Consider if the client is in mild withdrawal and there is no history of withdrawal complications (delirium, seizures, DTs), if benzodiazepines are potentially hazardous (e.g., severe liver dysfunction, respiratory failure or distress, taking opioids or sedating medications, age over 60, low serum albumin), or if the client refuses benzodiazepines.

LOADING DOSES

☐ Diazepam 20 mg q1–2h x 3 regardless of the CIWA-Ar score, until the client is lightly sedated and has minimal to no tremor **OR**
☐ Lorazepam 2–4 mg q1–2h x 3 regardless of the CIWA-Ar score, until the client is lightly sedated and has minimal to no tremor

After completion of the benzodiazepine loading dose, proceed with a symptom-triggered or fixed-dose tapering regimen as needed.

SYMPTOM-TRIGGERED DOSES

☐ Assess q1–2h with CIWA-Ar
☐ Diazepam 10–20 mg PO for CIWA-Ar ≥ 10 or definite tremor/profuse sweating **OR**
☐ Lorazepam 1–2 mg PO/SL for CIWA-Ar ≥ 10 or definite tremor/profuse sweating
☐ Stop the symptom-triggered regimen when the CIWA-Ar score is < 8 on two consecutive assessments and minimal to no tremor is present

If withdrawal is not fully resolved, follow with 1–2 days of PRN doses for tremor:

- ☐ Diazepam 10 mg PO q4h PRN x 1–2 days **OR**
- ☐ Lorazepam 1 mg PO/SL q4h PRN x 1–2 days

FIXED-DOSE TAPERING SCHEDULE

☐ **Mild withdrawal:** Diazepam 10 mg PO QID for one day
THEN diazepam 10 mg PO TID for one day
THEN diazepam 10 mg PO BID for one day
THEN diazepam 5 mg PO BID for one day
THEN diazepam 5 mg PO once daily for one day

☐ **Mild withdrawal:** Lorazepam 1 mg PO/SL QID for one day
THEN lorazepam 1 mg PO/SL TID for one day
THEN lorazepam 1 mg PO/SL BID for one day
THEN lorazepam 0.5 mg PO/SL BID for one day
THEN lorazepam 0.5 mg PO/SL once daily for one day

☐ **Moderate withdrawal:** Diazepam 20 mg PO QID for one day
THEN diazepam 10 mg PO TID for one day
THEN diazepam 10 mg PO BID for one day
THEN diazepam 5 mg PO BID for one day
THEN diazepam 5 mg PO once daily for one day

☐ **Moderate withdrawal:** Lorazepam 2 mg PO/SL QID for one day
THEN lorazepam 1 mg PO/SL QID for one day
THEN lorazepam 1 mg PO/SL TID for one day
THEN lorazepam 0.5 mg PO/SL BID for one day
THEN lorazepam 0.5 mg PO/SL once daily for one day

- Continue CIWA-Ar throughout, according to monitoring protocols.
- Adjust the schedule to the client's presentation and length of stay.
- If a client's withdrawal is worsening based on CIWA-Ar, worsening tremor, or sweating, contact the MRP to adjust the schedule, or if not available, arrange transfer to the ED.

GABAPENTIN

☐ Gabapentin 300 mg PO QID and 300–600 mg PO hs for one day
THEN Gabapentin 300 mg PO TID and 300 mg PO hs for one day
THEN Gabapentin 300 mg PO BID for one day
THEN Gabapentin 300 mg PO hs for one day

THIAMINE

- ☐ Thiamine 300 mg IM/IV once daily x 3–5 days OR
- ☐ Thiamine 100 mg PO TID x 1–2 days (when IM/IV administration is unavailable)

MEDICAL COMPLICATIONS

☐ Contact MRP (or transfer to ED if MRP is not available) for any of the following:

- Tremor not improving/worsening despite 80 mg diazepam or 8 mg lorazepam
- Tachycardia (HR > 120 bpm)
- Hypertension (elevation of systolic or diastolic BP 20–30 mm Hg above baseline)
- Repeated vomiting or profuse sweating
- Seizures, confusion, hallucinations, delusions, or agitation

ANTI-CRAVING MEDICATIONS

☐ Naltrexone 50 mg PO once daily (contraindicated in clients taking opioids) **OR**

☐ Acamprosate 666 mg PO TID **OR**

☐ Acamprosate 333 mg PO TID **OR**

☐ Acamprosate 666 mg PO BID (if weight < 60kg) **OR**

☐ Gabapentin 100 mg PO hs x 1 day, then 100 mg PO BID for one day, then 100 mg PO TID

DISCHARGE ORDERS

☐ Confirm follow-up plans, including outpatient referral

☐ Ensure client has a prescription for anti-craving medication lasting at least until their confirmed follow-up

☐ Thiamine 100 mg PO once daily for 2–4 weeks **OR**

☐ Thiamine 100 mg PO TID for 2–4 weeks

☐ Fax client summary to the appropriate clinic(s) and community providers

Name _____ **Signature** _____

Prescriber _____

Date _____ **Time** _____

Clinical Pathway for Medical Management of Opioid Withdrawal and Opioid Use Disorder in Community Residential WMS

Client presents with opioid use disorder *Indications, contraindications, & precautions on next page

Is buprenorphine indicated?

YES

Is the client in moderate withdrawal? COWS ≥ 13

YES

Sufficient time since last opioid use?
- **Short-acting opioid: > 12h**
- **Intermediate-acting opioid: > 18h**
- **Fentanyl: > 48h**

YES

Day 1

Initiate buprenorphine
- Usual starting dose: **4 mg**
- Elderly/on BZD/unsure of last opioid use: **2 mg**

Reassess in 1 hour
Symptoms improved or stayed the same?

YES

Give another 2–4 mg
- Reassess every 1–2h, repeating **2–4 mg** dosing as required for ongoing withdrawal symptoms
- Max **16 mg** for day one

NO

- Offer microdosing with symptomatic support until appropriate time frame from last use, then standard start.

OR

- If regular fentanyl use, COWS ≥ 13, and at least 18h from last use, consider macrodosing: 16 mg, followed by 8–16 mg q1h until symptoms relieved, max 32 mg/24h.

OR

- Instruct staff or client to monitor for withdrawal symptoms using SOWS and complete a cli ent-led induction or "home-start" in the facility, when appropriate timeframe and withdrawal.

Rapid worsening of symptoms is likely precipitated withdrawal:
- Offer symptomatic treatment.
- Hold buprenorphine for 24h before restart or microdosing.

OR

- With known high tolerance, consider macrodosing (see above).

NO

Is methadone indicated?

YES

Day 1

Initiate methadone
- Usual starting dose: **30 mg**
- If at higher risk of toxicity: **20 mg**
- If recently abstinent from opioids: **10 mg** *(see higher risk of opioid-induced sedation or toxicity risks on next page)*
- Offer symptomatic treatment of withdrawal symptoms

*Consider adding SROM for people who use fentanyl daily

Days 2+

Titrate methadone
- Starting dose **20 or 30 mg**: Maintain dose for 3 days, then increase by **10–15 mg**
- Starting dose **10 mg**: Maintain dose for 5 days, then increase by **5 mg**

Before discharge
- Ensure client has a prescription to last them until their follow-up prescriber appointment.
- Provide naloxone kit.
- Provide harm reduction resources.

Day 2
- Give total Day 1 dose as a single dose
- Give an additional **2–4 mg** if necessary; goal is alleviation of withdrawal symptoms for 24h

Days 3+
- Increase by **2–4 mg** daily if needed for alleviation of withdrawal symptoms for 24h

NO

Is slow-release oral morphine (SROM) indicated?

YES

Day 1

Initiate SROM
- High tolerance: **200–400 mg**
- Moderate tolerance: **100–150 mg**
- Low tolerance or high risk for toxicity: **30–50 mg**

Days 2+

Titrate SROM
- High tolerance: Increase by **100 mg** daily OR **200 mg** every 48h to **800 mg**, then increase by **50–200 mg** every 48h
- Moderate tolerance: Increase by **50–100 mg** every 48h
- Low tolerance or high risk for toxicity: Increase by **50 mg** every 48h

NO

- Offer symptomatic management.
- Offer RAAM referral/ harm reduction resources.
- Provide naloxone kit.

METAPHI
MENTORING, EDUCATION, AND CLINICAL TOOLS FOR ADDICTION
PARTNERS IN HEALTH INTEGRATION

BUPRENORPHINE

Use buprenorphine when…

- Client prefers buprenorphine
- Higher risk of opioid-induced sedation or toxicity
- Known QT prolongation/history of ventricular arrhythmias
- Difficulty accessing methadone after discharge

METHADONE

Use methadone when…

- Client prefers methadone
- Contraindication to buprenorphine
- Unsuccessful with buprenorphine initiation or tolerance in the past
- Ongoing high-risk use despite **24+ mg** of buprenorphine

High-risk use: Regular use of fentanyl, opioid + benzodiazepine use, overdoses, injection-related infections

SROM

Use SROM when…

- Client prefers SROM
- Contraindications to buprenorphine or methadone
- Unsuccessful with buprenorphine or methadone initiation or tolerance in the past
- SROM can be added to methadone when there is ongoing high-risk use on methadone alone

PRACTICAL PRECAUTIONS TO OAT

- Hold OAT medication if intoxicated, sedated, or impaired level of consciousness.
- Consider referring to hospital for management if client is on OAT and has acute liver or respiratory illness.
- Use lower starting doses and monitor closely if the client is on high doses of sedating drugs, especially benzodiazepines. Methadone can be particularly dangerous when combined with benzodiazepines.
- SROM is contraindicated in renal insufficiency. Measure renal function before SROM start in the elderly.
- Clients on higher doses of methadone (**120+ mg**) should have an ECG to check QT interval.
- Send the client on OAT to the ED if they show signs of impending overdose (methadone overdose has an insidious onset and is easily missed).

FOR COMPLETE INFORMATION ON PRESCRIBING AND A LIST OF CONTRAINDICATIONS, REFER TO THE PRODUCT MONOGRAPHS

HIGHER RISK OF OPIOID-INDUCED SEDATION OR TOXICITY:

- Use of any sedating substance (BZD, alcohol, other)
- Respiratory disease, e.g., COPD, sleep apnea
- Lower opioid tolerance, e.g., recent incarceration or discharge from inpatient rehabilitation, use of prescription opioids vs. illicit fentanyl
- 60+ years old
- Liver dysfunction, e.g., cirrhosis with low albumin, high INR

Order Set For Opioid Withdrawal

MONITORING

☐ Temp, HR, RR, BP, O2 saturation, and COWS on initial assessment

Repeat q1h when COWS ≥ 8

Repeat q2h when COWS < 8

☐ Notify the most responsible provider (MRP) for any of the following (transfer to ED if MRP not available):

- COWS ≥ 13
- Severe or worsening tremor
- Increasing agitation
- Profuse sweating
- Repeated vomiting or diarrhea
- Hallucinations or delirium
- Systolic BP > 180
- Diastolic BP > 110
- HR > 120
- RR < 10
- SpO2 < 92%
- T > 37.7°C

LABORATORY TESTS

☐ Urine toxicology (point of care drug screen if available)

☐ Urine HCG

☐ Serum HCG

☐ Serum CBC, creatinine, glucose, TSH, AST, ALT, ALP, GGT, bilirubin, albumin, INR

As required based on history:

☐ HIV serology

☐ Syphilis serology

☐ Gonorrhea & chlamydia urine

☐ Anti-HAV, HBsAg, HBsAb, HBcAb, Anti-HCV

☐ HCV RNA viral load if history of infection

☐ ECG

Note: Do not delay treatment while waiting for investigation results.

MEDICATIONS

Note: All doses should be observed by a staff member or local pharmacist.

BUPRENORPHINE/NALOXONE

1. **Standard induction:** For COWS ≥ 13 AND appropriate timing from last opioid use:
    - At least 12h since last short acting opioid (heroin, IR oxycodone, hydromorphone, morphine)
    - At least 18h since last controlled-release opioid (e.g. CR oxycodone, hydromorphone, morphine)
    - At least 48h since last street fentanyl use
    - At least 72h since last methadone use

Day 1:

☐ Buprenorphine 4 mg (2 x buprenorphine/naloxone 2 mg/0.5 mg tablets) SL q1h, maximum 16 mg as long as client is not drowsy and COWS > 8 **OR**

☐ Buprenorphine 2 mg (1 x buprenorphine/naloxone 2 mg/0.5 mg tablet) SL q1h if elderly (maximum 8 mg), on benzodiazepines, or unsure of time of last opioid (maximum 16 mg)

☐ Notify prescriber if COWS score **increases** by 2+ after first dose

Day 2:

☐ Provide Day 1 total daily dose plus 2–4 mg (1–2x buprenorphine/naloxone 2 mg/0.5 mg tablets) SL for withdrawal relief not lasting 24h

Day 3:

☐ Provide Day 2 total daily dose plus 2–4 mg (1–2x buprenorphine/naloxone 2 mg/0.5 mg tablets) SL for withdrawal relief not lasting 24h

Note: Clients in naloxone-induced withdrawal after reversal of overdose still need to meet criteria for time from last opioid use to avoid precipitated withdrawal. For clients not meeting the criteria for a standard induction, offer a home start or microdosing protocol.

2. **Microdosing induction:** For clients that are not in the timeframe from last opioid use for standard induction and MRP is available to provide medical support

☐ Buprenorphine 0.5 mg (quarter of buprenorphine/naloxone 2 mg/0.5 mg tablet) SL once daily x 1 day
THEN buprenorphine 0.5 mg (quarter of buprenorphine/naloxone 2 mg/0.5 mg tablet) SL BID x 1 day
THEN buprenorphine 1 mg (half of buprenorphine/naloxone 2 mg/0.5 mg tablet) SL BID x 1 day

Note: Switch to standard induction once enough time has passed since last opioid use. Support patients with symptomatic care as needed during microdosing.

3. **Macrodosing induction:** For clients using fentanyl, COWS ≥ 13, AND at least 18h from last use

☐ Buprenorphine 16 mg (2 x buprenorphine/naloxone 8 mg/2 mg tablet) SL once, then 8–16 mg q1h PRN for COWS > 8 to a maximum of 32 mg on Day 1
THEN continue, titrate, or taper buprenorphine by 2–4 mg per day as needed

4. **Home start (client-led induction):** For clients that are not in the timeframe from last opioid use for standard induction and MRP is not available, COWS < 12, or client declines microdosing
(refer to **http://www.metaphi.ca/wp-content/uploads/ED_OUD_RxHome.pdf** and **http://www.metaphi.ca/wp-content/uploads/ED_OUD_HomeStartInfo.pdf** for protocol and client instructions)

Note: Switch to standard induction once MRP is available.

METHADONE

☐ Methadone 30 mg PO once daily x 3 days

THEN methadone 40–45 mg PO once daily x 3 days

☐ Methadone 20 mg PO once daily x 3 days if at high risk of toxicity

THEN methadone 30–35 mg PO once daily x 3 days

☐ Methadone 10 mg PO once daily x 5 days if unknown tolerance or recent abstinence from opioids

THEN methadone 15 mg PO once daily x 5 days

Note: Symptomatic management of ongoing withdrawal should be offered during methadone titration. This can include the addition of SROM for clients with known high opioid tolerance and/or daily fentanyl use.

SLOW-RELEASE ORAL MORPHINE (SROM)

☐ SROM 60–120 mg PO once daily x 2 days (open capsules and sprinkle beads onto yogurt or applesauce for witnessed ingestion

THEN titrate dose by 30–60 mg every 48h as needed, with consideration of opioid tolerance

Note: Average daily dose of 200–800 mg PO once daily, maximum recommended dose 1200 mg PO once daily

MEDICAL COMPLICATIONS

☐ Contact MRP (or transfer to ED if MRP is not available) for any of the following:

- Tachycardia (HR > 120bpm)
- Hypertension (elevation of systolic or diastolic BP 20–30 mmHG above baseline)
- Repeated vomiting or profuse sweating
- Seizures, confusion, hallucinations, delusions, or agitation

SYMPTOMATIC MANAGEMENT

☐ Acetaminophen 1000 mg PO q6h PRN for pain, maximum 4 g in 24h

☐ Ibuprofen 400 mg PO q6h PRN for pain, maximum 3.2 g in 24h

☐ Dimenhydrinate 25–50 mg PO/IM q4h PRN, maximum 200 mg in 24h

☐ Ondansetron 4–8 mg PO/IM q4–6h PRN for nausea, maximum 32 mg in 24h

☐ Clonidine 0.1–0.3 mg q6–8h PO PRN for sweats/goosebumps/restlessness, maximum 1.2 mg in 24h

☐ Loperamide 4 mg PO, followed by 2 mg after each loose stool, maximum 16 mg in 24h

DISCHARGE ORDERS

- ☐ Confirm follow-up plans, including outpatient referral
- ☐ Ensure client has a prescription with daily observed dosing lasting at least until their confirmed follow-up
- ☐ Provide naloxone kit (document on naloxone dispensing record)
- ☐ Fax client summary to the appropriate clinic(s) and community providers

Name _____ **Signature** _____

Prescriber _____

Date _____ **Time** _____

Declining Opioid Agonist Therapy

By signing this consent form, I confirm that I understand and agree with the following statements:

- I understand that, according to current medical evidence, the safest and greatest chance of recovery from opioid use disorder can be achieved by starting opioid agonist treatment (OAT) with buprenorphine/naloxone, injection buprenorphine, methadone, or slow-release oral morphine.
- I understand that, if I choose to proceed with withdrawal management (also known as detox) and decline OAT, I have greater risk of the following:
    - Relapse (returning to opioid use)
    - Overdose (which can cause severe harm including brain damage, coma, and death) due to decreased tolerance to opioids
- I understand that withdrawal management without OAT is not advised.
- I have been given sufficient time and opportunity to ask questions about the information above and have received satisfactory clarification and advice.
- I fully release and discharge _____ employees, and my personal healthcare providers from any responsibility or liability for any losses, damages, or injuries I may suffer as a result of my decision not to start OAT.

CONFIRMATION

- I decline OAT at this time.
- I understand that I can ask for medical consultation to reconsider OAT at any time throughout my stay.

Client name: _____

_____ _____

Client signature **Date**

_____ _____

Witness signature **Date**

Management of Stimulant Use

OVERVIEW

TIMELINE	COMMON PRESENTATIONS
Acute withdrawal Onset: Within 24 hrs of last use Duration: 7–10 days, with "crash" first 1–2 days	**Stimulant overuse/psychosis** Nausea/vomiting, aches/pains, tremors, fever, hypertension, tachycardia, panic, extreme agitation, paranoia, hallucinations, skin-picking
Post-acute withdrawal Can last weeks to months	**Stimulant withdrawal** Fatigue, depressed mood, anxiety, sleep disturbance, increased appetite *Psychosis can continue into withdrawal

ASSESSMENT

- Intake & vital signs
  - Complete substance use history will guide monitoring and treatment
  - Polysubstance use increases OD risk and concurrent withdrawal syndromes may be present
  - Wake clients for assessment during their first 6h of their WMS stay
- Monitor for suicidal ideation
- Monitor with **Level of Agitation (LOA) Scale** q2h while awake days 1 to 3:

LOA 1–2	LOA 3–4 +/- PSYCHOSIS	LOA 5 +/- AGITATED DELIRIUM
No treatment required Continue to monitor	See treatment options for agitation and drug-induced psychosis below	Transfer to ED

TREATMENT OF WITHDRAWAL

- Minimize stimuli throughout withdrawal (e.g., dim lights, quiet setting)
- Treat based on the client's LOA scoring +/- presence of psychosis
- Discuss long-term treatment options (see below)

TREATMENT OF AGITATION

- Diazepam 5 mg PO q2–6h PRN (ED transfer if no improvement after 40 mg)
- Lorazepam 0.5 mg PO q2–6h PRN (ED transfer if no improvement after 4 mg)

TREATMENT OF DRUG-INDUCED PSYCHOSIS*

- Olanzapine 5 mg PO q2h PRN (max 20 mg/day)
- Risperidone 1 mg PO q1h PRN (max 4 mg on day 1)
- Quetiapine 12.5–25 mg PO TID PRN + 50 mg PO hs PRN or standing

*Combination antipsychotic-benzodiazepine therapy may be required. For clients on opioids or opioid agonist treatment, dual therapy requires additional caution and medical monitoring.

WHEN TO SEND TO THE EMERGENCY DEPARTMENT

- No improvement after max day 1 dosing
- Escalating LOA and declining oral meds
- Escalation to LOA 5
- **Any of** SBP > 180, DBP > 120, HR > 120, T > 37.5°C, chest pain, shortness of breath

LONG-TERM TREATMENT OPTIONS

- First line: **Contingency management**
- Limited evidence for medication, and all medications are off-label for stimulant use disorder

MEDICATION	DOSING AND TITRATION	CONSIDERATIONS
Bupropion	150 mg PO once daily x 3 days, then 150 mg PO twice daily *or* XR 150 mg PO once daily, titrate over 3 days to 450 mg PO once daily	Useful for concurrent ADHD Useful for desired smoking cessation Useful with symptoms of low energy, low mood
Naltrexone	25 mg PO hs x 4 days, then 50 mg PO once daily Increase by 25–50 mg weekly as needed Max 150 mg PO once daily	Useful for concurrent stimulant/alcohol use Cannot be used with opioid or opioid agonist treatment on board
Mirtazapine	15–30 mg hs Can increase to 45 mg hs	Useful for sleep assistance and low mood
Disulfiram	125 mg PO once daily Can increase to 250 mg PO once daily	Complete abstinence from alcohol required Compounding required Complete labs before starting, hepatic risk
Topiramate	25–50 mg PO qhs, then increase by 25–50 mg weekly as needed, dividing doses BID, to a max 300 mg/day	Useful for concurrent stimulant/alcohol use Pregnancy category D

Management of Benzodiazepine Use

OVERVIEW

TIMELINE	COMMON PRESENTATIONS
Acute withdrawal Occurs with abrupt cessation after daily use for 4 wks. or more; onset is within 8–96 hrs. of last use. Risk increases with higher doses, longer use, and shorter-acting agents.	**Benzodiazepine overuse** Depression, suicidal ideation, sedation, falls, decreased reaction time, motor incoordination, motor vehicle accidents, respiratory depression, sleep apnea, confusion, worsening cognitive impairments
	Benzodiazepine withdrawal Anxiety, panic, insomnia, emotional lability, abdominal cramping, diarrhea, nausea, decreased appetite, tinnitus, diaphoresis, tremor 50+ mg DE: Tachycardia, hypertension, confusion, disorientation, seizures, delirium, psychosis *Slower onset & predominance of psychological symptoms compared to alcohol withdrawal

ASSESSMENT

- Intake & vital signs
  - Complete substance use history will guide monitoring and treatment
  - Polysubstance use increases OD risk and concurrent withdrawal syndromes may be present
  - Wake clients for assessment during their first 6h of their WMS stay
- Consider closer monitoring of clients with long-term, daily use of fentanyl, due to potential long-term daily exposure to BZD in the unregulated opioid supply
- Care decisions will largely be based on the source of the BZD, the client's risk of harm., the presence of withdrawal, and the presence of BZD use disorder

TREATMENT OF WITHDRAWAL

- BZD withdrawal can be life-threatening; early recognition and treatment is crucial
- If the patient has known BZD use but is not yet showing signs of withdrawal, consider restarting BZD at 50% of their usual dose and titrate/taper as appropriate
- For patients with **any substance use history*** showing signs of BZD withdrawal (e.g., seizures, agitation, severe anxiety despite OAT, psychosis), consider administering lorazepam 2–4 mg SL for stabilization (higher doses may be required for concurrent management of alcohol withdrawal) and send to ED

*Unregulated opioids may be contaminated with BZD; patients who use unregulated opioids are at risk of BZD withdrawal.

MANAGING BENZODIAZEPINE PRESCRIPTIONS

- Low to moderate therapeutic doses not causing harm: Continue prescription
- Imminent risk of BZD toxicity: Immediate dose reduction to reduce risk (e.g., consider lowering dose by 25–50% for patients with concurrent opioid or alcohol use)
- Risk of harm and/or high dosing: Consider long-term outpatient taper (e.g., 30+ mg DE, risk factors such as older age or COPD
- BZD use disorder: Initiate long-term taper with daily dispensing
    - Inpatient management required for abrupt withdrawal of BZD/initial stabilization
    - Referral to outpatient addiction provider highly recommended

GENERAL PRINCIPLES FOR A BENZODIAZEPINE TAPER

The goal of a benzodiazepine taper is not always discontinuation but reaching a safe and effective therapeutic dose. These are general principles only; the taper should be customized to the client.

1) **Address underlying mental health concerns:** Underlying mental health concerns for which BZD may have been originally prescribed (anxiety disorders, mood disorders, post-traumatic stress disorder) should be considered and addressed with psychological therapies and appropriate medications (e.g., SSRIs, SNRIs) throughout a BZD taper.

2) **Convert to a longer-acting BZD:**
    - **a)** Choose the agent: Consider switching from a shorter-acting agent (alprazolam, lorazepam) to a longer-acting agent (diazepam, clonazepam) during BZD taper. This step is not mandatory, but a long-acting agent provides slower onset of withdrawal symptoms, and therefore a smoother taper.
    - **b)** Calculate equivalency: Calculate the client's usual BZD dose equivalency in the chosen long-acting agent (**TIP:** use a table or conversion calculator) and start at 50–75% of this dose, in divided doses, to prevent oversedation. Titrate to the patient's comfort, not exceeding the original dose. Because of differences in potency and drug profiles, consider converting prescription BZD users gradually, substituting one dose at a time.

3) **Plan a taper rate:** There are many approaches for tapering BZD, such as *percentage* (taper 10% q1–2 weeks) and *milligrams* (taper 5–10 mg DE q1–2 weeks). When the dose has reached 20% of the original dose or 20 mg DE, slow the taper to 5% or 1–2 mg q2–4 weeks.

4) **Set a schedule:** Use scheduled doses and avoid PRN dosing. The taper will take longer than the WMS stay. Prescribers should develop and share the taper schedule with the patient's care team.

5) **Determine dispensing:** Use client-centered strategies. Consider daily, every 2–3 days, or weekly dispensing as needed to avoid overuse.

TIPS

Clonazepam is less likely to cause prolonged sedation (consider it in the elderly and those with liver impairment), while diazepam is available in low-dose formulations (e.g., 2 mg) for a smooth taper.

Use a table or conversion calculator to find equivalency.

Conversion and titration can take days or weeks to complete.

Hold the taper for a few weeks if the client experiences negative impacts on function, withdrawal, rebound anxiety, or markedly decreased mood.

A slower taper is required in the elderly.

Use a template or spreadsheet for easy tracking, sharing, or adjusting the taper as needed.

Long-acting BZDs are only required 1–2 times/day. Try to move clients away from frequent dosing when converting from short- to long-acting BZD, e.g., TID to BID.

Management of Cannabis Use

OVERVIEW

TIMELINE	COMMON PRESENTATIONS
Withdrawal Onset: Within 1–3 days of last use Peak: Within 4–6 days of last use Duration: 12–16 days	**Cannabis overuse** Anxiety, mood disorder, suicidality, chronic bronchitis, lung cancer, myocardial infarction, arrhythmias, cognitive impairment (including decreased impulse control, memory, and executive functioning), cannabis hyperemesis syndrome, triggering/exacerbation of psychosis (risk greater for youth) Use during pregnancy can lead to preterm delivery and low birth weight
	Cannabis withdrawal Psychological: Extreme anxiety, insomnia, vivid dreams, irritability, depression, cravings Physical: Loss of appetite, headache, abdominal discomfort, nausea, sweating *High % THC use, frequent use, and high dosing are associated with more severe withdrawal symptoms

ASSESSMENT

- Intake & vital signs
  - Complete substance use history will guide monitoring and treatment
  - Polysubstance use increases OD risk and concurrent withdrawal syndromes may be present
  - Wake clients for assessment during their first 6h of their WMS stay
- The Marijuana Withdrawal Checklist[1] can be used to track occurrence and severity of withdrawal
- Assess for depression and suicide risk at intake
- Level of agitation (LOA) scale[2] can be used to monitor clients that are showing signs of irritability/anxiety

TREATMENT OF WITHDRAWAL

- No approved medication for management of withdrawal
- Some evidence for gabapentin and cannabinoid agonists (nabiximols, CBD oil, nabilone)
  - Nabiximols and CBD oil not commonly used in WMS due to expense/difficulty of administration
  - Trial of nabilone or gabapentin recommended during WMS stay

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1 https://www.phenxtoolkit.org/toolkit_content/supplemental_info/saa_assessments/measures/Marijuana_Withdrawal_Checklist.doc

2 https://www.metaphi.ca/wp-content/uploads/WMS_6.3_LevelOfAgitation.pdf

	NABILONE	GABAPENTIN
Action	Cannabinoid agonist	GABA analogue
Dose	1 mg TID, titrate to effect to a max of 6 mg/day	1200 mg daily in divided doses
Side effects	Sleepiness, dry mouth, ataxia	Somnolence, dizziness May exacerbate depression and suicidal ideation (depression)
Considerations	Slower onset and longer duration of action than smoked cannabis	Doses of 18+ mg associated with pedal edema Risk of dependence
Contraindications	Pregnancy or breastfeeding Use caution with renal or hepatic disease	Renal insufficiency Third trimester of pregnancy Use caution in early pregnancy, elderly clients, with use of other sedating medications, or in clients with depression/ suicidal ideation

LONG-TERM TREATMENT OPTIONS

- The Cannabis Use Disorders Identification Test–Revised (CUDIT-R)[2] can be used to screen for high-risk cannabis use
- Use DSM-V criteria to clinically diagnose cannabis use disorder
    - Main clinical features to look for: Daily use, increasing amount/strength/frequency over time, inability to stop, withdrawal or strong cravings to use when trying to stop, smoking in place of social activities with friends/family
- Best evidence for cannabis use disorder: Motivational enhancement therapy, cognitive behavioral therapy, and contingency management
- Assess and manage underlying anxiety and mood disorders
- Consider behavioural strategies to avoid future use:
    - Identify situation where the client is at increased risk of use (boredom, certain social settings)
    - Make a list of activities to do when struggling with cravings (exercise, call a friend)
    - Quit tobacco, as this is often a trigger for and associated with cannabis use (offer NRT)
- Provide advice for lower-risk use (e.g., use lower THC content, use a vaporizer/edibles rather than smoking, avoid driving after using cannabis)[3]
- For clients using cannabis for an underlying condition, use motivational interviewing and patient education in discussions about appropriate and safe medical cannabis use

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2 **http://mycannabisiq.ca/wp-content/uploads/2018/07/2010_CUDIT-R-revised-with-scoring-EN.pdf**

3 **https://www.camh.ca/-/media/files/pdfs---reports-and-books---research/canadas-lower-risk-guidelines-cannabis-pdf.pdf**

Medical Directive: Point of Care Testing

MONITORING

This directive will allow Nurse Practitioners (NPs), Registered Nurses (RNs), and Registered Practical Nurses (RPNs) of the Withdrawal Management to perform point of care (POC) testing with a breathalyzer for monitoring of blood alcohol concentration, and with urine dipstick analysis for urinalysis, pregnancy testing, and urine drug screening for patients of the Withdrawal Management.

AUTHORIZED IMPLEMENTER

NPs, RNs, and RPNs employed by Withdrawal Management in good standing with the College of Nurses of Ontario possessing the knowledge, skill, and judgment to safely implement this medical directive.

Following review of this directive the authorizing physician must sign for Authorizer Approval and the NPs, RNs, RPNs must sign for Implementer Approval.

RECIPIENT PATIENTS

Patients of the Withdrawal Management who do not have contraindications to POC testing.

INDICATIONS

1. **Breathalyzer:** Patients presenting with or at risk for alcohol intoxication or alcohol withdrawal, or with a history of alcohol withdrawal seizures, delirium tremens, or withdrawal complications.
2. **Urinalysis:** Patients with specific complaints of dysuria, urinary frequency, urgency, hematuria, lower abdominal or pelvic pain, lower back pain, fevers/chills, nausea, vomiting, abdominal trauma or acute back injuries.
3. **Urine bHCG:** Patients who think they are pregnant, are uncertain of pregnancy status, have a possibility of pregnancy, lower abdominal or pelvic pain, back pain, abdominal trauma, or for commencement of birth control.
4. **Urine Drug Screen (UDS):** Patients presenting for assessment or treatment of substance use disorder.
    a. It is acknowledged that the primary utilization of urine drug screen POC testing is to support the client and clinician in assessing and formulating treatment plans.
5. **Glucometer:** Patients presenting with or at risk for hypoglycemia, or requiring glucose monitoring.

CONTRAINDICATIONS

Patient or caregiver does not consent to point of care testing.

CONSENT

The NPs, RNs, or RPNs obtains verbal patient consent for point of care testing.

DOCUMENTATION

All diagnostic tests ordered and their results must be documented in the patient record as outlined in the CNO Standards of Practice in accordance with standard documentation.

REVIEW AND QUALITY MONITORING GUIDELINES

- Tests will be ordered based on clinical indications.
- The RNs or RPNs will interpret and document results of the POC testing, act according to predetermined order sets, or verbally relay this information to the NP if further action or interpretation is required.
- The NP will interpret and act upon the results of the POC testing in accordance with the NP Scope of Practice, best practice, and personal knowledge, skill, and judgment.
- When there are questions of POC interpretation or consequential actions, the NP will collaborate with a physician.
- Annual routine renewal of this directive will occur on the anniversary of the activation date and will involve collaboration between the authorizing physician and the implementing NPs, RNs, and RPNs.

PHYSICIAN AUTHORIZER APPROVAL

Name of Authorizer: _____

_____ _____

Signature of Authorizer **Date**

NP, RN, RPN IMPLEMENTER APPROVAL

Name of Implementer: _____

_____ _____

Signature of Implementer **Date**

Name of Implementer: _____

_____ _____

Signature of Implementer **Date**

Name of Implementer: _____

_____ _____

Signature of Implementer **Date**

Date of last renewal: _____ _____

_____ _____

Special Considerations

CHRONIC HEALTH CONDITIONS

Chronic health conditions can be a risk factor for complications of withdrawal. The severity of the health condition and associated factors that can complicate withdrawal should be used to determine the level of monitoring. Clients with uncontrolled or severe illnesses such as cardiovascular disease, liver diseases, COPD, or renal impairment should have their withdrawal symptoms managed in a hospital setting. Clients with controlled medical illness can be managed in WMS with medication protocol modification in consultation with specialists as required.

CARDIAC DISORDERS

- Initiate aggressive withdrawal treatment measures to prevent the exacerbation of cardiac disorders due to autonomic hyperactivity associated with alcohol withdrawal.

LIVER DISEASES

- Caution should be taken when prescribing to individuals with severe liver disease or dysfunction such as cirrhosis:
  - Because of diazepam's hepatic metabolism, lorazepam is the preferred benzodiazepine in these clients.
  - Gabapentin can be used when benzodiazepines are contraindicated because it has no appreciable hepatic metabolism.

CHRONIC PAIN

- Clients with high-risk prescription medications for chronic pain management (opioid and non-opioid, e.g., gabapentin) should be assessed for potential harm.
- Clients on moderate therapeutic doses of opioid or non-opioid medications for chronic non-cancer pain should be maintained on their current dose if the prescription is not causing harm.
- Clients on high opioid doses at potential risk (e.g., requiring high doses of benzodiazepines to manage alcohol withdrawal) should be tapered within safe prescribing guidelines. Consider following the Management of Chronic Non-Cancer Pain Guideline of 90 morphine milligram equivalents (MME) as a safe upper limit for opioid prescriptions.
- When there is potential harm, the benefits and risks of continued use, taper, abrupt cessation, or rotation to a different medication should be explored.

COMPLICATIONS OF ALCOHOL WITHDRAWAL

SEIZURES

- The highest risk for alcohol withdrawal seizures is during the first 72 hours from last drink, though they can occur anytime in the first week after alcohol cessation. Though the onset of withdrawal is typically six to twelve hours from the last drink, clients with a history of recurrent withdrawal seizures and/or high levels of consumption can have seizures occur even earlier, while their blood alcohol level is still elevated but dropping.
- Withdrawal-related seizures are usually, but not always, proceeded by autonomic hyperactivity such as sweating and tremor, and are generalized, brief, and typically without a post-ictal phase. Withdrawal-related seizures are not a risk for chronic seizure disorder.
- Benzodiazepines are the only evidence-based prevention and treatment for alcohol withdrawal seizures, though anticonvulsants can be used as adjunct treatment for management of withdrawal.
- Clients with a history of alcohol withdrawal seizures are at risk for recurrent alcohol withdrawal seizures and should receive loading doses of benzodiazepines (e.g., diazepam 20 mg every hour for three hours or until lightly sedated with minimal to no tremor) as early as possible in their presentation as blood alcohol levels lower and they move into withdrawal. If loading doses cannot be accommodated, clients should be transferred to the emergency department for this care and can be returned to WMS once loading doses are completed.

ALCOHOLIC HALLUCINOSIS

- Alcoholic hallucinosis presents as predominantly visual hallucinations without a clouding of the sensorium. Consider other diagnoses (such as schizophrenia) for reports of auditory or command hallucinations.
- Alcoholic hallucinosis presents within twelve to 24 hours from the last drink, and typically resolves within 48 hours.
- Appropriate treatment of alcohol withdrawal will typically resolve alcoholic hallucinosis, though addition of antipsychotics can be added if required for distressing or persistent hallucinations. Caution is required when using antipsychotics while the client is in moderate to severe alcohol withdrawal, as both antipsychotics and withdrawal can cause QT prolongation; first-generation antipsychotics pose the greatest risk.

DELIRIUM TREMENS

- Delirium tremens (DTs) presents with confusion and disorientation. It is typically preceded and accompanied by autonomic hyperactivity such as tachycardia, hypertension, tremor, low-grade fever, agitation, and diaphoresis. It usually begins three to five days from the last drink, following several days of severe withdrawal.
- The mortality rate for DTs has declined over time with fast and appropriate access to treatment but can range from 1–15%, with higher risk for those with older age or concomitant conditions.
- Risk factors for DTs include a history of sustained drinking, a history of seizures or DTs, recent withdrawal seizures, older age, use of sedating medications, concurrent medical illness (such as pneumonia), and a high CIWA-Ar score (unrecognized or undertreated withdrawal).
- Clients with suspected or confirmed DTs should be transferred to the emergency department.
- Early and aggressive benzodiazepine treatment has been shown to reduce the duration of DTs and reduce the need for intubation and ICU admission.

WERNICKE'S ENCEPHALOPATHY

- Wernicke's encephalopathy presents with confusion, ataxia (slow, unsteady gait), and ocular abnormalities (double vision, nystagmus, or paralysis of ocular muscles). Diagnosis can be difficult in clients who are intoxicated or in withdrawal.
- If left untreated, this can lead to Wernicke-Korsakoff Syndrome, resulting in a chronic memory deficit usually affecting short-term memory.
- Risk factors include poor diet, poor absorption (e.g., gastric bypass), and liver disease.
- Wernicke's can be prevented by routinely administering thiamine; the usual dose is 300 mg IM or IV (to bypass poor gastric absorption). Higher doses of 500 mg IM or IV at least twice daily are needed for treatment. Clients should be prescribed oral thiamine 100 mg once daily for at least one month post-discharge.

OLDER ADULTS

Older adults require specialized screening for the following unique concerns:

ISOLATION

- Ask older adults about support and connections with family, friends, and/or community. Limited social interactions are a risk factor for mental health and substance-related concerns. Make onsite connections or offer referrals to social work, personal support work, and/or other services to help build social connections.

RENAL FUNCTION

- Renal clearance declines with age and can be affected by other health conditions and medications. As many medications are renally cleared, Cr and GFR should be ordered. Consider the use of a renal adjustment calculator to determine appropriate dose adjustments.
- Acamprosate requires dose adjustment with CrCl 30–50 ml/min to 333 mg (one tab) three times daily.

MEDICATION INTERACTIONS

- Many older adults will be on multiple medications, both prescription and non-prescription. It is important that all medications be checked for drug-drug interactions.

SEDATION AND FALL RISK

- Special caution should be taken when adding medications that can cause sedation due to the increased risk of falls. Ensuring that clients have access to their mobility devices will help to decrease the risk of falls. It is important to ensure an assessment of the individual's mobility needs prior to the admission.
- Diazepam has a long half-life; due to decreased hepatic metabolism, diazepam increases the risk of sedation in older adults. Consider the use of lower-dose lorazepam when benzodiazepines are required.

PREGNANCY

Substance withdrawal poses great risks during pregnancy. Some of these risks include dehydration, hypertension, miscarriage, and premature birth.

ALCOHOL WITHDRAWAL

Pregnant people with moderate to severe alcohol withdrawal (CIWA-Ar ≥ 10) should be managed in an inpatient setting where they can receive symptom-triggered treatment with close monitoring. Based on the stage of pregnancy, fetal heart rate monitoring may be warranted for early detection of fetal distress. If pregnant people with mild alcohol withdrawal are managed in a WMS, consultation with a provider specialized in addictions and obstetrical care is highly recommended.

Consider the following general guidelines for management of alcohol withdrawal in pregnancy:

- Gabapentin can be utilized when there is a low risk for withdrawal complications.
- Long-acting benzodiazepine can be used for a short duration in pregnancy except in the late third trimester; use short-acting benzodiazepine in the late third trimester to minimize benzodiazepine intoxication in the newborn.
- Naltrexone and acamprosate are both FDA pregnancy category C, with no human trials completed. We recommend contacting an addiction and obstetrics specialized clinician for further advice on anti-craving medication in pregnancy.

OPIOID WITHDRAWAL

Consultation with a provider specializing in addictions and obstetrical care is highly recommended for the management of opioid withdrawal in pregnancy.

Opioid withdrawal should be avoided during pregnancy, as it can cause fetal distress; OAT should be offered urgently to all pregnant clients in withdrawal. Buprenorphine/naloxone and methadone should be considered; choice should be based upon client presentation, history, preference, and accessibility. Consider short-term hospitalization to expedite OAT initiation and titration, and for safe monitoring of both the client and the fetus during this process.

YOUTH

Youth with addictions are greatly underserved in Ontario. Because of the specific criteria for substance use disorder in the DSM-5, many adolescents and young adults go undiagnosed.

- Substance use predisposes youth to relationship difficulties, trouble in school/work, and homelessness. A full biopsychosocial assessment should be completed for every youth seeking care.

- Youth are at high risk for polysubstance and binge use of their substances of choice. This complicates intoxication and withdrawal presentations and management. Toxicology can be useful in determining substances exposure and developing an appropriate care plan.
- Having a peer support worker specifically for youth can help to reduce barriers to care by meeting clients where they are at in their journey and offering appropriate harm reduction services, community connections, and accessible information..

Unfortunately, there are limited residential withdrawal management centers in Ontario that admit youth. Each facility should assess their resources and make every attempt to safely accommodate youth when they are able to do so.

POLYSUBSTANCE WITHDRAWAL

Clients may present with concurrent substance use disorders and polydrug withdrawal. There is commonly overlap in withdrawal symptoms from different substances, and this overlap can increase the severity of withdrawal experienced. This overlap also means that withdrawal monitoring scales, such as the CIWA-Ar, should not be solely relied upon, as their accuracy decreases (e.g., tremor can be from opioid or alcohol withdrawal if occurring concurrently). For this reason, closer monitoring of clients with polydrug withdrawal is needed; they may require transfer to a higher-care facility such as the hospital. The inaccuracy of monitoring scales decreases the effectiveness of symptom-triggered regimens, and fixed dosing regimens with increased monitoring is recommended.

It is important to prioritize withdrawal from the substance with the greatest risk for complications and severe withdrawal. This usually means prioritizing alcohol withdrawal, as it presents with risks such as withdrawal seizures, delirium tremens, and Wernicke's encephalopathy.

The experienced clinician may initiate treatment for non-prioritized substances (e.g., methadone, buprenorphine/naloxone, NRT, or benzodiazepines) while managing the prioritized substance. However, caution should be taken when combining two substances with the risk of sedation and respiratory depression such as methadone and benzodiazepines (e.g., start and remain at methadone 10–20 mg while benzodiazepines are provided for alcohol withdrawal).

ALCOHOL AND OPIOIDS

- Clients are at increased risk of sympathetic stimulation and dehydration from excessive vomiting/diarrhea.
- Management of opioid use disorder requires OAT; relief of opioid withdrawal may help to reduce alcohol consumption.
- Caution should be taken when combining two medications with the risk of sedation and respiratory depression such as methadone and benzodiazepines.
- Management considerations:
  - Clients on opioids or OAT should not be started on naltrexone as an anti-craving medication for alcohol use, given the risk for precipitated withdrawal. Consider acamprosate as an alternative.
  - Benzodiazepines enhance the respiratory suppressing effect of opioid medications; therefore, caution is needed when treating alcohol withdrawal in clients who are taking opioid analgesics, OAT, or unregulated opioids. Shorter-acting benzodiazepines and/or lower doses should be considered.
  - Any ongoing OAT prescriptions should be continued. For clients not already on OAT, consider initiating after management of acute alcohol withdrawal; of the available options, buprenorphine has the best safety profile and is usually the treatment of choice when concurrent withdrawal is being managed.

ALCOHOL AND STIMULANTS

- Clients are at increased risk of severe and protracted withdrawal, anorexia, insomnia, and agitation.
- Management considerations:
  - Higher doses of benzodiazepines may be needed to manage acute withdrawal.

ALCOHOL AND BENZODIAZEPINES

- Clients are at increased risk of delayed alcohol withdrawal onset due to the presence of benzodiazepines, increased severity of symptoms, prolonged course of withdrawal, and increased risk of seizures.
- Management considerations:
  - Higher doses of benzodiazepines may be needed to manage acute withdrawal.
  - Acute withdrawal management should smoothly transition into a benzodiazepine taper. For example:
    - Excessive alcohol use and clonazepam 0.5 mg BID
    - Equivalent to ~15 mg diazepam once daily
    - Provide diazepam 10–20 mg q1h until diminished tremor and/or light sedation
    - Then begin diazepam 5 mg TID–QID for one week and organize an outpatient taper

BENZODIAZEPINE USE

- Clients on moderate, therapeutic doses of benzodiazepines for sleep or anxiety should be maintained on their current dose while in withdrawal management, if the prescription is not causing harm.
- Clients with suspected benzodiazepine use disorder should be offered a medically supervised benzodiazepine taper, with the knowledge that the taper will need to be finalized during the outpatient phase of treatment over weeks or months.
- Clients with concurrent benzodiazepine use disorder experiencing alcohol withdrawal are likely to require higher doses of benzodiazepines for the management of alcohol withdrawal. Benzodiazepine taper can begin once acute alcohol withdrawal is managed.
- Clients with concurrent benzodiazepine dependence and opioid withdrawal will require lower starting doses of opioid replacement therapy (e.g., buprenorphine/naloxone starting dose of 2 mg and methadone starting dose of 10–20 mg) and closer monitoring for respiratory depression and sedation.

When to Transfer to the Emergency Department

Community residential withdrawal management services (WMS) are generally non-medical facilities with limited access to medical care. Transfer to the emergency department (ED) will be required if the client meets one of the following criteria and there is no on-site medical support. Please note that this is not an exhaustive list; in the absence of on-site medical support, staff should err on the side of caution when considering transfer to the ED for any medical concern. The transfer process should include consideration of WMS and local resources and the best interest and safety of the clients and staff.

INDICATIONS FOR TRANSFERRING CLIENTS FROM WMS TO THE ED

A. GENERAL

- Withdrawal from multiple substances (when appropriate medical expertise is not available for close monitoring on site)
- Inadequately controlled medical illnesses (cardiovascular diseases, liver diseases, respiratory diseases, or renal impairment), or patients presenting without their treatments for these conditions when prescribers are not available
- Wernicke's encephalopathy, presented with ophthalmoplegia (weakening eye muscles), ataxia (lack of muscle control), and confusion.
- Severe abdominal pain
- Chest pain
- Actively suicidal or homicidal with intent/plan and means
- Any of the following clinical features:
    - SpO2 < 92% on room air
    - RR < 10 OR > 20 breaths/min
    - T < 35°C OR > 38.5°C (if provider not on site)
- Irregular pulse or HR < 50 bpm OR > 120 bpm
- Systolic BP ≥ 180 or diastolic BP ≥ 120 in acute withdrawal

B. ALCOHOL INTOXICATION

- Symptoms are not consistent with estimated level of intoxication (e.g., the patient is drowsy, confused, ataxic even though their last reported drink was 24 hours ago and there is no odour of alcohol)

C. ALCOHOL WITHDRAWAL

- Tremor and other signs not improving or getting worse despite 80 mg of diazepam or 8 mg of lorazepam
- Risk for dehydration or electrolyte imbalance, e.g., repeated vomiting, profuse sweating
- In withdrawal but at high risk for benzodiazepine toxicity, e.g., COPD, liver dysfunction or failure, elderly, on methadone or high doses of opioids
- Seizure
- Possible early withdrawal delirium: Delusions, hallucinations, disorientation
- Pregnant
- Vitals of concern: Irregular pulse or HR > 120, systolic BP ≥ 180, or diastolic BP ≥ 120

D. OPIOID INTOXICATION/OVERDOSE

- Any signs of impending overdose:
  - Nodding off
  - Drowsiness
  - Pinpoint pupils
  - Sweating
  - Slow shallow breathing and/or loud snoring when asleep
  - Vitals of concern: SPO2 < 92%, RR < 10 breaths/min

E. OPIOID WITHDRAWAL

- Persistent severe withdrawal symptoms despite medical management, e.g., methadone, buprenorphine, clonidine, etc.
- Has a medical condition that warrants close monitoring and more intensive medical care, e.g., severe COPD, on high doses of sedating medications

F. CRYSTAL METH INTOXICATION

- Agitation, aggression, or psychosis not relieved with reassurance, benzodiazepines, antipsychotics
- Frightening delusions or hallucinations
- Vitals of concern: Irregular pulse or HR > 120, systolic BP ≥ 180, or diastolic BP ≥ 120

G. BENZODIAZEPINE WITHDRAWAL

- Benzodiazepine dependence suspected and provider not on site (daily benzodiazepine or daily fentanyl use reported)
- Benzodiazepine withdrawal with high risk for benzodiazepine toxicity, e.g., liver dysfunction or failure, on methadone or high doses of opioid, frail elderly, severe COPD
  - Has any of the following symptoms:
    - Disorientation, confusion, hallucinations
    - Seizure
    - Severe agitation
- Has not responded to one or two doses of provided benzodiazepine
- Vitals of concern: HR > 120, systolic BP ≥ 180, or diastolic BP ≥ 120

Emergency Department to WMS Transfer Checklist

Community residential withdrawal management services (WMS) are generally non-medical facilities with limited access to medical care. Please use the appropriate substance use order set and address the following to ensure safe transition to WMS.

ALCOHOL WITHDRAWAL TRANSFER CRITERIA

- ☐ CIWA-Ar < 10 x 3 consecutive assessments 1–2h apart
- ☐ Patient not at risk for dehydration or electrolyte imbalance (e.g., repeated vomiting, profuse sweating)
- ☐ Patient does not show signs of DT (confusion, disorientation, delusions, agitation)
- ☐ Patient does not show signs of Wernicke's encephalopathy (e.g., weakening eye muscles, lack of muscle control, confusion)
- ☐ Withdrawal medication prescribed if indicated (see below)
- ☐ Patient with withdrawal seizures or DT in current or previous withdrawal episode has been given benzodiazepine loading doses (i.e., diazepam 20 mg q1h x 3 OR lorazepam 2 mg q1h x 3 until lightly sedated and diminished tremor)

ALCOHOL WITHDRAWAL MANAGEMENT PRESCRIPTIONS

To be dispensed to WMS staff for observed client administration on site only. Hold if drowsy or sedated before any dose.

☐ **For moderate to severe alcohol withdrawal:** Diazepam 10 mg PO QID PRN for withdrawal x 1 day
THEN diazepam 10 mg PO TID PRN for withdrawal x 1 day
THEN diazepam 10 mg PO BID PRN for withdrawal x 1 day
THEN diazepam 10 mg PO once daily x 1 day

☐ **For moderate to severe alcohol withdrawal in patients on opioids or other sedating medications, with severe liver or respiratory disease, or over 60 years old:** Lorazepam 2 mg PO QID PRN for withdrawal x 1 day
THEN lorazepam 2 mg PO TID PRN for withdrawal x 1 day
THEN lorazepam 2 mg PO BID PRN for withdrawal x 1 day
THEN lorazepam 2 mg PO once daily x 1 day

☐ **For mild alcohol withdrawal:** Gabapentin 300 mg PO QID PRN for withdrawal x 3 days
THEN gabapentin 300 mg PO TID PRN for withdrawal x 1 day
THEN gabapentin 300 mg PO BID PRN for withdrawal x 1 day
THEN gabapentin 300 mg PO once daily PRN for withdrawal x 1 day

TRANSFER CHECKLIST

- ☐ Medically cleared for transition to WMS based on above guidance
- ☐ Medication has been prescribed and faxed to pharmacy
- ☐ Copy of ED records including treatments received and investigations faxed to WMS and sent with patient

Additional information about ED visit, including presentation, complications, and treatments received:

STANDARD WMS EXCLUSION CRITERIA

- Delirious or confused from any cause (e.g., alcohol or benzodiazepine withdrawal delirium)
- History of hallucinations or seizures when stopping substance use (appropriate after loading doses)
- History of delirium tremens (appropriate after loading doses)
- In active withdrawal from benzodiazepine-class drugs
- Acute psychosis or mania
- Inadequately controlled chronic psychiatric disorders
- Active suicidal or homicidal ideation with plan or intent
- Current agitation or aggression
- New cough, fever, vomiting, diarrhea (prior to the onset of withdrawal symptoms)
- Acute serious injuries requiring medical attention (e.g., broken bones, head injuries)
- Chronic medical conditions requiring significant medical monitoring (e.g., severe CHF)
- Mobility, hearing, or visual impairments affecting ability to manage own ADLs/basic needs
- 16 years of age or younger

POSSIBLE WMS EXCLUSION CRITERIA

Contact WMS healthcare provider to determine if admission is appropriate if any of the following; timed admission may be appropriate when medical staff are on site:

- Minor acute injuries (e.g., open sores, wounds, skin infections)
- Have stopped medication for chronic illnesses within the last 60 days
- Pregnant or thinks they may be pregnant
- Missing medications for chronic or acute illnesses (e.g., insulin, blood pressure medications)
- Concurrent benzodiazepine and alcohol use disorder
- History of seizures

Withdrawal Management Service Discharge

CLIENT INFORMATION	
Name	
DOB	
Health card number	
Phone number	
Address/living situation	
Benefits/government support	
Family practitioner	
Other care providers	
Case worker	

STATE OF DISCHARGE

☐ This client had an unplanned discharge from the WMS

- ☐ Client left early against medical advice
- ☐ Client was discharged early due to safety concerns for staff or other clients
- ☐ Client was discharged early due to behaviour that went against WMS policies

Discharge documents are being forwarded to you for continuity of care, though they are only accurate as of this discharge date. The client's needs and treatment may have changed since this time. We would be happy to receive repeat referrals for this client as appropriate in the future.

☐ This client left the WMS ambulatory, with acute withdrawal managed. Please see discharge plan below for more details of ongoing care.

TREATMENT

While at the WMS, the client withdrew from:

☐ Alcohol ☐ Opioids ☐ Stimulants ☐ Other: _____

☐ The client received supportive care only during their stay.

☐ The client received the following medications for acute withdrawal management during their stay:

☐ Diazepam ☐ Lorazepam ☐ Gabapentin ☐ Thiamine
☐ Olanzapine ☐ Risperidone ☐ Quetiapine ☐ Other: _____

- ☐ The client received a prescription for naltrexone 50 mg once daily.
- ☐ The client received a prescription for acamprosate 666 mg TID.
- ☐ The client received a prescription for thiamine 100 mg once daily.
- ☐ The client has been started on nicotine replacement therapy with _____.
- ☐ The client received slow-release oral morphine titrated to a dose of_____mg.
- ☐ The client received methadone titrated to a dose of_____mg.
- ☐ The client received buprenorphine titrated to a dose of_____mg.
- ☐ The client received ☐ 300 mg ☐ 100 mg of extended-release depot buprenorphine (Sublocade) on date _____

Prescription details, including pharmacy, prescription end date, and observed doses vs. carries: _____

- ☐ No complications were experienced during the client's stay.
- ☐ The following complications were experienced during the client's stay:
  - ☐ Seizures
  - ☐ Drug-induced psychosis
  - ☐ DTs
  - ☐ Hospital transfer (records attached)

Details of complication: _____

- ☐ The client has been given a naloxone kit.

DISCHARGE DETAILS

- ☐ Documents attached: _____

Referrals made: _____

Medications (including medications stopped, started, adjusted, and reasoning): _____

Information and instructions provided to client:

- ☐ The client was asked to follow-up with your clinic within 2 weeks of discharge for dose titration and script renewal

Buprenorphine/Naloxone Discharge Information for Primary Care

Date: _____

Client: _____

Dear _____

This patient has been started on **sublingual buprenorphine/naloxone,** hereafter *SL buprenorphine* (trade name Suboxone®), as treatment for opioid use disorder (OUD).

Buprenorphine is a long-acting opioid that prevents withdrawal symptoms and limits cravings for opioids. It has a higher affinity for the opioid receptors than other opioids and blocks the effect or "high" of full-agonist opioids that are used concurrently, which further helps people reduce their use. Buprenorphine does not cause someone to become ill if they use opioids. Buprenorphine has a ceiling effect; there is no additional risk for respiratory depression above a certain dose, making it a good alternative to methadone. It also has fewer drug interactions and less QT-prolonging effect than methadone. Long-term buprenorphine use is associated with improved health outcomes and reduced overdose rates.

The usual dose of SL buprenorphine is 16–24 mg/day, usually prescribed in combinations of 2 mg and 8 mg tablets (as they are covered on the ODB formulary). Tablets must be taken sublingually, as the buprenorphine is not readily absorbed when tablets are swallowed. Naloxone is included in the medication only as a deterrent to injection; it is not absorbed when tablets are taken sublingually or orally.

Therapeutic results are best when this medication is combined with counselling and/or community support.

Please keep the following considerations in mind:

- Unlike methadone, SL buprenorphine usually does not need to be dispensed daily. Most patients can start with weekly pick-up and move toward monthly pick-up as long as they are stable and managing their medications well. For patients who have ongoing severe substance use or are unable to store medication safely, consider having buprenorphine doses dispensed daily at the pharmacy until these issues are resolved.
- There is no required frequency of urine drug testing for patients on buprenorphine. Testing is usually done at the time of an appointment. Urine drug screens can be ordered on the usual laboratory requisition by writing "urine broad spectrum toxicology". The report will typically indicate buprenorphine and/or norbuprenorphine (the metabolite) along with naloxone. A urine screen with unexpected results, such as the absence of buprenorphine/norbuprenorphine or the presence of opiates, alcohol, benzodiazepines, or other drugs, should prompt a discussion with the patient about their substance use and safety.
- Prescriptions for SL buprenorphine should specify the daily dose, start and end dates, the pharmacy, the days that the patient should pick up the medication at the pharmacy (e.g., pick up 7 days' supply every Monday), and a request that the pharmacy notify you if the patient misses any doses.
- During buprenorphine treatment, non-opioid medications are recommended for acute pain management. If opioids are required, be aware that it can take higher doses to reach a therapeutic effect.
- Clients that continue high-risk opioid use (i.e., use of fentanyl, intravenous administration) while taking SL buprenorphine should be considered for transition to another form of OAT, such as methadone. This transition is best completed by an experienced addictions provider.

Please see the attached prescription that the patient was given on discharge. For ongoing substance-related support, please contact your local rapid access addiction medicine (RAAM) clinic at _____

Sincerely,

Phone: _____ Fax: _____

Acknowledgment of Loss of Opioid Tolerance Following Withdrawal

CLIENT INFORMATION

It is important that you fully understand the risks of using opioids following your discharge because of loss of tolerance to the effects of opioids.

Tolerance occurs in response to prolonged exposure to drugs like opioids. Tolerance means that you no longer feel the desired effects at the same dose you have been using and must take more of the drug to feel the desired effects. This is why some people who take opioids for a long time are on high doses that would be toxic and potentially fatal to individuals who have never taken the drug.

Tolerance to opioids is lost very rapidly, within a few days of your last opioid use. After withdrawal (detox), it is very dangerous to use similar amounts of opioids as you did before. It can lead to toxic effects, such as increased sedation, suppression of breathing, or death. This effect is worse if you are taking sedating medications such as benzodiazepines or if you consume alcohol. **If you take the same amount of opioids as you did before you detoxed, you can have a fatal overdose**.

Even if you have started a different opioid medication like methadone or Suboxone, your tolerance may be decreased. In light of this serious risk, if you choose to start using opioids after discharge, it is essential that you use much less than you did before admission, have a naloxone kit available, avoid using alone, and avoid consuming alcohol and other sedating medications.

ACKNOWLEDGMENT OF UNDERSTANDING

I have read this warning information sheet and have had the opportunity to ask questions. I understand the serious risk of choosing to use opioids following my discharge.

☐ I have received a naloxone kit and have been instructed in its use.

Client name: _____

_____ _____

Client signature **Date**

_____ _____

Witness signature **Date**

Naltrexone Discharge Information for Primary Care

Date: _____

Patient: _____

Dear _____

This patient has been started on **naltrexone** as an anti-craving medication for alcohol use disorder (AUD).

Naltrexone is an opioid receptor antagonist (blocker). **Naltrexone and acamprosate are the two first-line treatments for AUD;** neither medication makes people ill if they drink alcohol. Naltrexone is compatible with a range of drinking goals (i.e., abstinence or reduced drinking) and is appropriate for patients who do not use opioids or have severe liver disease. It works by reducing the euphoric effects of alcohol, which helps to curb alcohol cravings and consumption.

Naltrexone is provided in 50 mg oral tablets. The dose can be titrated to effect, with a maximum daily dose of 150 mg. If a patient continues to drink while on naltrexone, advise them to take their dose one hour before alcohol consumption for maximum benefit. Possible side effects include fatigue, headache, and stomach upset. These side effects typically dissipate after a few days of use; if they persist, consider reducing the daily dose to 25 mg. Naltrexone is covered by ODB with LU code 532.

Therapeutic results are best when this medication is combined with counselling and/or community support.

Please keep the following considerations in mind:

- Concurrent use of naltrexone and opioids is contraindicated; naltrexone will displace opioids at the mu receptor, resulting in opioid withdrawal symptoms. When patients receiving naltrexone require opioids for analgesia, naltrexone should be discontinued one to two days before opioid use and restarted seven days after the last opioid dose to prevent precipitated withdrawal.
- Naltrexone is metabolized by the liver; for patients with suspected liver disease, liver enzymes should be checked at baseline and one month after initiation. If liver enzymes rise more than three times above baseline level, consider hepatic consultation and/or alternative medication (e.g., acamprosate and/or gabapentin).
- Naltrexone can be continued as long as it is effective and tolerated. An alternative to daily use for people who have achieved stability with their alcohol use is to take naltrexone on an "as-needed" basis for cravings or specific events.

Please see the attached prescription that the patient was given on discharge. For ongoing substance-related support, please contact your local rapid access addiction medicine (RAAM) clinic at _____ .

Sincerely,

Phone: _____ Fax: _____

Acamprosate Discharge Information for Primary Care

Date: _____

Patient: _____

Dear _____

This patient has been started on **acamprosate** as an anti-craving medication for alcohol use disorder (AUD).

Acamprosate is a GABA agonist and NMDA glutamate antagonist. **Acamprosate and naltrexone are the two first-line treatments for AUD;** neither medication makes people ill if they drink alcohol. Acamprosate is typically used with people who are seeking to stop rather than reduce their drinking. It is an alternative to naltrexone for patients who use opioids, have severe liver disease, or do not tolerate naltrexone. Acamprosate relieves mild ongoing acute withdrawal symptoms such as insomnia, dysphoria, and cravings. It works best in patients who are abstinent from alcohol for one to two days before starting it.

Acamprosate is provided in 333 mg tablets. It is usually started as 333 mg (one tab) three times daily and titrated to 666 mg (two tabs) three times daily over one week to minimize side effects. Common dose-related side effects experienced on this medication include diarrhea, fatigue, and anxiety. These are likely to resolve over time; if they persist, consider a dose reduction (one tab three times daily). Acamprosate is covered by ODB with LU code 531.

Therapeutic results are best when this medication is combined with counselling and/or community support.

Please keep the following considerations in mind:

- It is safe to consume alcohol while taking acamprosate, although its benefits (relief of insomnia, dysphoria, and cravings) are only felt if the patient is abstinent.
- Monitor patients with depression closely for suicidal thoughts and attempts at initiation (rare).
- Acamprosate is renally cleared; monitor kidney function tests at baseline and one month after initiation. Reduce dose to 333 mg three times daily if CrCl is 30–50 ml/min. Avoid use if CrCL is < 30 ml/min.
- Acamprosate can be continued as long as it is effective and tolerated.

Please see the attached prescription that the patient was given on discharge. For ongoing substance-related support, please contact your local rapid access addiction medicine (RAAM) clinic at _____ .

Sincerely,

Phone: _____ Fax: _____

Gabapentin Discharge Information for Primary Care

Date: _____

Patient: _____

Dear _____

This patient has been started on **gabapentin** as an anti-craving medication for alcohol use disorder (AUD).

Gabapentin is an anti-convulsant that is commonly used as an off-label treatment in AUD.

Gabapentin is used to treat acute alcohol withdrawal in people without a history of withdrawal seizures or delirium tremens, manage post-acute withdrawal symptoms, and as an anti-craving medication. It works by reducing the hyper-excitatory neurological symptoms of acute alcohol withdrawal, including tremor and anxiety, and symptoms of post-acute withdrawal syndrome such as dysphoria and insomnia that can last for weeks. As an anti-craving agent, gabapentin reduces heavy drinking days and increases non-drinking days. It can be useful for individuals who cannot take or have not benefited from naltrexone or acamprosate, or it can be used as an add-on to these medications.

Gabapentin is available in 100 mg, 300 mg, and 400 mg capsules. Gabapentin may be started for acute withdrawal management at doses of 300 mg three times daily. It can then be increased to 600 mg three times daily and 600–1200 mg at bedtime if required and as long as there is no sedation, to a maximum of 3600 mg daily. Once acute withdrawal is resolved, this dose can be tapered over three to five days or maintained at 300–600 mg three times daily (consider a dose of 100 mg three times daily for patients who are elderly, on sedating medications, or with renal insufficiency). Common side effects of gabapentin include dizziness, drowsiness, fatigue, and ataxia.

Therapeutic results are best when this medication is combined with counselling and/or community support.

Please keep the following considerations in mind:

- Alcohol and gabapentin are CNS depressants; patients should be counselled about potential risks of this combination with regards to sedation, falls, and driving.
- Gabapentin should not be prescribed to individuals experiencing active, persistent suicidal ideation.
- There should be continual evaluation for risks or signs of addiction with gabapentin use.
- Gabapentin can be continued as long as it is effective and tolerated. This medication should be tapered before discontinuation.

Please see the attached prescription that the patient was given on discharge. For ongoing substance-related support, please contact your local rapid access addiction medicine (RAAM) clinic at _____ .

Sincerely,

Phone: _____ Fax: _____

Buprenorphine Extended-Release Injection Discharge Information for Primary Care

Date: _____

Patient: _____

Dear _____

This patient has been started on **buprenorphine extended-release injection**, hereafter *depot buprenorphine* (trade name Sublocade®).

Buprenorphine is a long-acting opioid that prevents withdrawal symptoms and limits cravings for opioids. Buprenorphine has a higher affinity for the opioid receptors than other opioids and blocks the effect or "high" of full-agonist opioids that are used concurrently, which further helps people reduce their use. Buprenorphine does not cause someone to become ill if they use opioids. Buprenorphine has a *ceiling effect*; there is no additional risk for respiratory depression above a certain dose, making it a good alternative to methadone. It also has fewer drug interactions and less QT-prolonging effect than methadone. Long-term buprenorphine use is associated with improved health outcomes and reduced overdose rates.

Depot buprenorphine is administered as a once-monthly subcutaneous injection. This removes the need for frequent clinic or pharmacy visits, allowing the person more freedom to focus on other aspects of their life. It also provides higher and more stable serum levels than sublingual buprenorphine and avoids the risks and complications associated with missed doses. Patients must be stabilized on at least 8 mg of sublingual buprenorphine prior to receiving the injection. Depot buprenorphine requires two initial loading doses of 300 mg/1.5 mL 28 days apart. The dose can then be maintained on 300 mg/1.5 mL or reduced to 100 mg/0.5 mL every 28 days (determined by individual considerations).

Therapeutic results are best when this medication is combined with counselling and/or community support.

Clinical considerations:

- Depot buprenorphine is given as a subcutaneous injection into the abdomen, where a small firm depot can often be palpated. It dissolves slowly over time. Though the injection is given monthly, it is not unusual for the depot to be palpable longer than one month after the injection.
- People should be advised not to pick, poke, or scratch at their injection site or the depot.
- Administration can cause a painful stinging or burning sensation. This pain resolves quickly after administration. Ongoing complaints of pain or irritation, as well as any redness or swelling at the injection site, should be flagged for further attention and to rule out infection and ulceration.
- During buprenorphine treatment, acute pain management with opioid medications may require higher than expected doses to reach a therapeutic effect. Adjunct medication options are recommended.
- Depot buprenorphine is not currently recommended in pregnancy. Patients should be counselled about potential fetotoxic effects of depot buprenorphine in pregnancy and offered contraception where indicated. If a patient is at risk for pregnancy, pregnancy testing should be completed before dosing. Should pregnancy occur while receiving depot buprenorphine, an addiction or addictions-obstetrics specialist should be consulted.

- There is no required frequency for urine drug testing for patients on depot buprenorphine. It is always helpful to revisit the risk of combining this medication with other substances that are sedating such as alcohol, benzodiazepines, and other illicit substances. Evidence of these substances in a urine drug test should prompt a conversation with your patient around their substance use and safety.
- Additional doses of sublingual buprenorphine tablets can be provided for people experiencing withdrawal or cravings while on depot buprenorphine. This is most likely to occur during their first month of treatment. If this does occur, the prescriber may also choose to provide the second injection of depot buprenorphine early, off-label.
- People that continue high-risk opioid use (i.e., use of fentanyl, intravenous administration) while receiving depot buprenorphine should be considered for transition to methadone or slow-release oral morphine. This transition is best completed by an experienced addictions provider.

Follow-up plan:

- Depot buprenorphine [300 mg / 100 mg] was last administered on _____
- An appointment has been scheduled for the next dose of [300 mg / 100 mg] on _____ at _____ [CLINIC].
- [Your patient has been given an additional buprenorphine-naloxone sublingual prescription of _____ _____]

Depot buprenorphine can be safely provided in primary care. Prescribers must complete an online certification, available at **https://www.sublocadecertification.ca/**.

For ongoing substance-related support, please contact your local rapid access addiction medicine (RAAM) clinic at

_____

Sincerely,

_____

Phone: _____ Fax: _____

Sample Medication Policy

INTRODUCTION

The withdrawal management service (WMS) will provide short-term community-based non-medical elective withdrawal management support. For patient safety, the following policy and procedures provide guidance on minimum standards for the intake, storage, provision, discharge, and disposal of medications at the withdrawal management site.

POLICY

1. Client's medication dispensed by a community pharmacy and brought into WMS must be safely stored and adhere to the following: (a) be in its original, labelled containers; (b) have instructions clearly indicated on the pharmacy label; and (c) be made available to the client according to pharmacy label.

1.1. Any changes from instructions on the pharmacy-dispensed label require approval by the prescriber or most responsible provider.

1.2. There will be procedures in place related to the clients' use of medication and will address issues of verification, validity, and integrity of the medication/prescription brought into the service: (a) verifying ownership of the medication; and (b) addressing currency, accuracy, and duplication of the medication, i.e., is the medication current? Does the medication appearance match the description on the label? Are there multiple prescriptions for the same medication?

1.3. Medications that are off count may indicate concern. Too many medications may be an indication that the client has not been taking them as prescribed, whereas missing medications may be an indication of inappropriate use, diversion, or loss of the medication. All medications that are off count will require prescriber approval for the client to resume taking them at the prescribed dosage. The only exception will be PRN (as needed) medications, as this indicates the count may not align with days since last dispensed.

1.4. Counselling staff will monitor and supervise client's access to medications dispensed by community pharmacy for clients to take as directed while at the WMS. Dispensing medication is a regulated act and is done once by the community pharmacy. Withdrawal staff do not dispense medication but rather provide supervision and access to the client's own medication. There will be clear procedures that outline this process.

2. There will be policies related to the accurate recording of information in the client record relating to the medication brought into the service and the medication returned upon discharge.

2.1. Procedures will outline safe storing and disposal of over-the-counter (OTC) medications, prescribed medications, illicit drugs, and other addictive substances.

2.2. There will be policies in place related to provision of access to client medications to take as directed on dispensing label and staff supervision/monitoring of this activity.

2.3. There will be policies in place related to an accurate and timely record of medication taken or missed under staff supervision.

3. Training and education support for medication policies and procedures will be provided to the WMS staff.

4. There will be policies in place related to the use of potentially addictive, controlled, or monitored substances.
   4.1. Policies will address consultation with the prescribing/most responsible provider regarding an alternative medication or non-pharmacological alternative when the prescribed medication is the drug of choice used by the client.

5. Policies will address allowing the clients to have access to medications prescribed for a condition that was in existence prior to admission to the service, or that is prescribed through medical assessment after admission to the WMS. This may be a chronic condition such as high blood pressure, diabetes, or it may be acute in nature such as an infection.

6. There will be policies to address the time frame required between the last drink or ingestion of any other drug(s) used and resumption of the medication regime; many medications are contraindicated in conjunction with alcohol consumption or may interact with other medications/drugs taken prior to admission, requiring professional pharmacological advice.

7. There will be policies to support clients on opioid agonist therapy (OAT) such as methadone or buprenorphine/naloxone to access their daily medication from an offsite community pharmacy while staying in the WMS.

8. Clients will have access to information and will be offered consultation with the health care team regarding anti-craving medication to be used in treatment of substance use, e.g., naltrexone, nicotine replacement therapy.

9. There will be instances whereby the health care team will support client care by dispensing medications and/or administering a medication by inhalation or injection within the scope of practice for that health care provider.

10. OTC products/medications/supplements brought in sealed original bottles will need to be flagged for approval by the health care team for clients to take while at the WMS.

PROCEDURES

1. Clients are responsible for medication-related costs. If they do not have access through the Ontario Drug Benefit program, private insurance, or other coverage, WMS staff will assist clients with identifying ways to access medications where possible.

2. A medication list is initiated by WMS staff at intake. As medications are changed, altered, or added, the medication list is updated. Effort will be made to develop a comprehensive list of all prescribed and OTC medications including supplements.
   a. A medication list is a shared responsibility involving the client, WMS staff, and the entire health care team, including WMS health care providers, the emergency department, the addiction clinic, and the pharmacist. With consent, a client's family or support may be asked to assist.
   b. When WMS staff note discrepancies while assisting clients to develop a best possible medication list, staff will attempt to clarify through gathering relevant information from the client and other sources, including accessing a client's previous admission information. The WMS healthcare provider or other healthcare provider (e.g., general practitioner, walk-in clinics) may be consulted. The WMS site healthcare provider will be notified when discrepancies cannot be resolved at intake.
   c. A client's best possible medication list is provided during urgent transfer (e.g., emergency department transfer) and during planned transfers (e.g., to treatment programs). Upon request, a client's record of medication use in WMS will be provided to the client or third party, with client consent.

3. At intake, staff will examine medication for safe and appropriate use.
    a. Medications with obvious tampering or contamination will be safely disposed of according to the site policy.
    b. Medications brought in by clients for use in WMS must have been dispensed according to dispensing standards in the Province of Ontario, or, in the case of OTC medications, must have clear instructions. Prescription medications will include:
        - Client name
        - Pharmacy information
        - Medication name, dosage, route, frequency
        - Date dispensed
        - Number of pills dispensed
        - Refill information
    c. Prescriptions that do not have the appropriate labelling as above, are mislabeled, are difficult to interpret, are scheduled dose prescriptions (not as needed) and more than 30 days old, or have the incorrect quantity remaining will require approval by a health care provider before they are approved for use on site.

4. Some medication use in WMS may require further authorizing mechanisms, such as any OTC medication or supplement, any medication with unclear reason for use, or any high-risk prescription or OTC medication (see Appendix A).
    a. If a High-Risk/Red Flag medication (see Appendix A) is identified, the client may be at increased withdrawal, medical, or mental health risks. WMS staff will make the WMS health care provider aware of flagged items.
    b. Unapproved prescription medications will be documented, verified, and signed by the client, and kept for safekeeping in a locked cabinet until client discharge. Other non-approved medications will be disposed of.

5. It is an expectation that clients hand in ALL medications for safekeeping, both at intake and throughout their stay. As medication access is frequently an issue for WMS clients, the exceptions to this will include medication that must be carried on the person for urgent use, such as inhalers, nitroglycerine, or epi-pens. Items for personal or frequent use such as creams, lotions, and other topical agents may be retained on the person at WMS staff discretion. These will be the only medications available to clients for unsupervised self-administration (see procedure 8).

6. WMS staff will ensure safe-keeping and storage of client medications as follows:
    a. After verification and documentation in the best possible medication list, the client's own medication will be stored for safekeeping behind a minimum of two locks (e.g., locked cabinet/drawer/fridge in a locked office).
    b. Client medications that are controlled/monitored substances will be verified, counted, and documented at every shift change.

7. Due to the clinical context of supporting clients to have a safe community-based withdrawal in the context of substance use and dependency, client self-administration of medications is not an option in WMS, except for medications falling under procedure 5.

8. Clients and staff share dual responsibilities for safe medication use in WMS. Clients retain the responsibility to present for their medication(s) as per their prescription's frequency or per site policy, and client and staff jointly monitor and verify client medication use.
    - **a**. Unless otherwise specified, clients will not be woken to take medications.
    - **b**. QID (four times daily) medications will be taken at approximately 7am, 12pm, 5pm, and 10pm.
    - **c.** TID (three times daily) medications will be taken at approximately 7am, 3pm, and 11pm.
    - **d.** BID (twice daily) medications will be taken at 7am and 7pm.
    - **e.** Once daily medications will be taken at 7am.
    - **f.** QHS (before bed) will be taken before bedtime, at approximately 10pm.

9. Clients will be provided access to their medications according to the dispensing instructions on the pharmacy label or prescriber/most responsible provider instructions. Procedures for safe access to medications include the following:
    - **a.** Clients will be provided access to their own medications to take as per instruction on dispensing label or prescriber/most responsible provider instructions at designated medication times under staff supervision and monitoring.
    - **b.** Due to the context of a withdrawal management setting, staff will need to supervise and monitor client access to medication and cannot provide the client with the whole vial/supply of medication at once. Staff will prepare the exact amount indicated on the dispensing label or approved amount authorized by a prescriber/most responsible provider in front of the client so that the medication can be taken as directed.
    - **c.** If a client takes more than the prescribed dose and the incident appears to be intentional, the client may be discharged from the program or sent to the emergency department depending on the medication and dose consumed.
    - **d**. An error may occur in the client taking the wrong medication, at the wrong time, the wrong route, or the wrong dose. As soon as these medication errors are identified, the WMS staff will contact the most responsible provider to ensure patient safety. The incident will also be documented and reported to the site manager or supervisor as per site policy.
    - **e.** Near-misses that do not result in incorrect medication administration are to be documented according to site policy.

10. Off-site administration of OAT may be required according to site policies.
    - **a.** If off-site administration of OAT is required, clients will be asked to sign a Release of Personal Information to allow WMS staff to communicate with the OAT prescriber.
    - **b.** Client will be asked to sign out of the WMS to get their OAT and sign in when they return.
    - **c.** When possible, a peer support worker will accompany the client for off-site OAT.
    - **d.** When a peer support worker is not able to accompany the client, the client will be searched upon their return. A urine drug screen may be asked of the client at the WMS health care provider's discretion. Unexpected results in the UDS will warrant follow-up with the health care provider and may result in dismissal from the program.

11. As a general practice, non-urgent medication will not be provided while WMS clients are intoxicated in order to prevent drug interactions. In these situations, it may be necessary for WMS staff to clarify safe medication use with the original prescriber or WMS health care provider.

12. All aspects of the medications system are documented.

- **a.** Medications used by clients while in WMS are documented in a client medication record. Both WMS staff and clients will initial medication entries to verify medication usage.
- **b.** Medications such as OAT that are administered off-site require verification (i.e., medication receipt) to confirm use and dosage. This will also be recorded in the medication record by WMS staff.
- **c.** Medications handed in but not used and all medications provided at discharge will be documented and verified by the WMS staff and client.

13. At discharge, clients will be provided with all medications that were kept in storage and medications that were prescribed to them during their stay. This will be documented by WMS staff and verified by the client.

- **a.** Clients that are prescribed medications for the purpose of withdrawal support (e.g., benzodiazepines, gabapentin) while in the WMS will not be discharged with these medications unless otherwise specified on the prescription. If there is any uncertainty by the client or WMS staff, every effort should be made to contact the prescriber before discharge. This includes clients that leave the program before withdrawal is completed.
- **b.** Medications left by clients after exit or discharge from the program are safely stored and disposed of according to site policy.

DEFINITIONS

DISPENSING

Dispensing a drug (as defined in the Drug and Pharmacies Regulation Act)[1] is one of the twelve controlled acts in the Regulated Health Professions Act (RHPA).[2] The act of dispensing means filling a prescription and involves cognitive and technical components.[3] Dispensing includes the selection, preparation, and transfer of one or more doses of a drug to a client or his or her representative for administration. Dispensing includes checking the expiry date of the drug, repackaging the drug, and correctly labelling it. Dispensing a drug to an individual occurs only once.[3,4]

ADMINISTRATION

Administration of medication occurs after dispensing and involves one individual preparing a dose of a drug and providing it to the client at the time the medication is due. Administration of a medication is not a controlled act (unless a person is administering the medication by injection or inhalation) and therefore is within the public domain.[4-6] Administering a substance by injection or inhalation is a controlled act.[5,6]

CONTROLLED ACT

The Registered Health Professions Act (RHPA)[2] restricts the performance of controlled acts in the course of providing health care services. With a few exceptions, a controlled act may only be performed by a member of a regulated health profession College where the RHPA authorizes members of such profession to perform the controlled act. A controlled act may also be performed where the performance of the controlled act has been delegated to a person by a member of a regulated health profession College where the RHPA authorizes members of such profession to perform the controlled act.

CONTROLLED SUBSTANCE

A ***controlled substance*** is any type of drug that the federal government has categorized as having a higher-than-average potential for abuse or addiction. Such drugs are divided into categories based on their potential for abuse or addiction. Controlled substances range from illegal street drugs to prescription medications.[7, 8]

MONITORED DRUGS

Monitored drugs are defined as follows:

1. Any controlled substance under the federal Controlled Drugs and Substances Act.[7] These include narcotics (e.g., Tylenol 3®, OxyNEO™) and non-narcotic controlled drugs (e.g., Ritalin®, Valium®, Phenobarbital).

AND

2. Other opioid medications not listed in the Controlled Drugs and Substances Act.[7] This includes tramadol-containing products such as Ralivia®, Tramacet®, Tridural®, and Ultram®.[9]

REFERENCES

1. Drug and Pharmacies Regulation Act (1990). R.S.O. c. H4.
   Accessible via **https://www.ontario.ca/laws/statute/90h04**

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   Accessible via **https://www.ontario.ca/laws/statute/91r18**

3. Ontario College of Pharmacists (2011). Dispensing Components Included in the Usual and Customary Fee. Guideline.
Accessible via **https://www.ocpinfo.com/regulations-standard**

4. Ontario College of Social Workers and Social Service Workers (2009). Practice guidelines for Medication Practices: Guidelines for Social Work and Social Service Work Members of the Ontario College of Social Workers and social Service Workers.
   Accessible via: **https://www.ocswssw.org/wp-content/uploads/2015/01/OCSWSSW-Medication-Practices-Guide-2014-E.pdf**

5. College of Nurses of Ontario (2020). Legislation and regulation RHPA: Scope of Practice, Controlled Acts Model.
   Accessible via **https://www.cno.org/globalassets/docs/policy/41052_rhpascope.pdf**

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   Accessible via **https://www.cno.org/globalassets/docs/prac/41007_medication.pdf**

7. Controlled Drugs and Substances Act. (1996). S.C. c. 19.
   Accessible via **https://laws-lois.justice.gc.ca/eng/acts/c-38.8/**

8. Health Canada (2020). Controlled Substances and Precursor Chemicals.
   Accessible via **https://www.canada.ca/en/health-canada/services/health-concerns/controlled-substances-precursor-chemicals.html**

9. Ministry of Health and Long-Term Care, Ontario. (2020). List of Monitored Drugs.
   Accessible via **https://www.health.gov.on.ca/en/pro/programs/drugs/monitored_productlist.aspx**

Appendix A

HIGH-RISK/RED FLAG MEDICATIONS

- Opioids, including but not limited to:
  - Methadone
  - Buprenorphine/naloxone
  - Slow-release oral morphine
  - Morphine IR
  - Fentanyl
  - Hydromorphone
  - Oxycodone
  - Codeine
- Benzodiazepines, including but not limited to:
  - Diazepam
  - Lorazepam
  - Clonazepam
  - Alprazolam
- Sedatives, including but not limited to:
  - Trazodone (antidepressant with sedating properties)
  - Zopliclone
- Stimulants
- Antipsychotics
- Antidepressants
- Antihistamines

Sample Cannabis Policy

BACKGROUND

The Federal Cannabis Act of 2018 allows individuals to cultivate, possess, acquire, and consume cannabis and its by-products. Pharmaceutical cannabinoids for medical purposes are currently approved in Canada for use in chemotherapy-induced nausea/vomiting (nabilone) and spasticity in MS (nabiximols).

POLICY

Cannabis for non-medical purposes cannot be consumed on site, even if from a legal source. If brought on site, it will be stored and locked until the client is discharged from the service.

Cannabis for medical purposes may be allowed after review by the withdrawal management service (WMS) health care provider.

PROCEDURE

- Whenever possible, clients currently taking medically authorized cannabis via inhalation will be transitioned to the oral synthetic cannabinoid nabilone during their stay.
- In the rare case that a client cannot be transitioned to nabilone, the use of inhaled cannabis for medical purposes may be permitted if the WMS health care provider deems it to be clinically appropriate and the following criteria are met:
    - The client must provide either a copy of their original authorization or a note from the authorizer to the WMS outlining the medical purpose, form, route, dose, and frequency of use.
    - The medically authorized cannabis must arrive at the facility in unopened packaging.
- Medically authorized cannabis will be kept stored and locked by facility staff throughout the client's stay. It will only be accessible to the client at scheduled times as indicated by their authorization. As-needed or "PRN" dosing will generally not be available to the clients.
- Medically authorized inhaled cannabis shall be consumed in designated areas only and in the presence of staff. Given the nature of the facility, if there are any concerns brought forward by other clients, such as "triggering", the use of smoked medical cannabis may be discontinued, and the client offered nabilone in its place for the duration of their stay.

Sample Tobacco and Nicotine Replacement Therapy Policy

POLICY

The smoking of tobacco will be permitted only in designated outside areas and during designated times.

All clients will be provided with information on smoking cessation, including information on the STOP program, and will have access to a medical professional to discuss options to support cessation. Whenever possible, nicotine replacement therapy (NRT) will be supported and provided.

PROCEDURE

- Only cigarettes in unopened packaging will be allowed on admission to the withdrawal management service (WMS). Opened packages of cigarettes will be disposed of on admission.
- Clients may keep one lighter on them throughout their stay at the WMS. Additional lighters will be disposed of on admission.
- Clients may keep their vaping device or e-cigarettes on them throughout their stay so long as there are no signs of misuse or tampering (such as dripping, dabbing, or storing other substances in the battery compartment). Clients may keep one e-cigarette cartridge on them at a time, and staff will safely lock up additional cartridges, providing them to clients as required. Any equipment that appears tampered with will be disposed of on admission.
- Staff should consider monitoring a client in acute withdrawal when outside. The need to accompany the client will be based on wellness of the client and level of intoxication or withdrawal.
- Staff will not smoke in the presence of clients. According to the Smoke-Free Ontario Act, 2017, the smoking of tobacco or medical cannabis, use of electronic cigarettes, and consumption of prescribed products and substances is prohibited in enclosed public and workplaces, including agency vehicles.
- Only staff trained by the TEACH program can admit clients into the STOP program and provide NRT. Any staff may assist clients to self-administer NRT that has previously been provided.
- The NRT product will be logged on the WMS medication sheet and secured in the medication cupboard. The product will be labelled with the client's name and chart number.
- Clients can sign out one day of NRT at a time. The STOP provider will help to determine the appropriate amount per day.
- NRT inhalers must be used outside the building in designated smoking areas.
- Clients will be given two weeks of NRT to take with them when they are discharged from the WMS. Staff will ensure ongoing support and access to NRT has been arranged for the client before discharge.

Clinical Institute Withdrawal Assessment for Alcohol, revised

Date: _____ **Name:** _____ **DOB:** _____

Time of assessment				
HR				
BP				
Temp				
Nausea/vomiting (0–7) 0- none; 1- mild nausea, no vomiting; 4- intermittent nausea; 7- constant nausea, frequent dry heaves & vomiting				
Tremors (0–7) 0- no tremor; 1- not visible but can be felt; 4- moderate with arms extended; 7- severe, even with arms not extended				
Anxiety (0–7) 0- none, at ease; 1- mildly anxious; 4- moderately anxious or guarded; 7- equivalent to acute panic state				
Agitation (0–7) 0- normal activity; 1- somewhat normal activity; 4- moderately fidgety/restless; 7- paces or constantly thrashes about				
Paroxysmal sweats (0–7) 0- no sweats; 1- barely perceptible sweating, palms moist; 4- beads of sweat obvious on forehead; 7- drenching sweat				
Orientation (0–4) 0- oriented; 1- uncertain about date; 2- disoriented to date by no more than 2 days; 3- disoriented to date by > 2 days; 4- disoriented to place and/or person				
Tactile disturbances (0–7) 0- none; 1- very mild itch, P&N 2- mild itch, burning, P&N 3- moderate itch, P&N, burning 4- moderate hallucinations; 5- severe hallucinations; 6- extremely severe hallucinations; 7- continuous hallucinations				
Auditory disturbances (0–7) 0- not present; 1- very mild harshness/ability to startle; 2- mild harshness/ability to startle; 3- moderate harshness/ ability to startle; 4- moderate hallucinations; 5- severe hallucinations; 6- extremely severe hallucinations; 7- continuous hallucinations				
Visual disturbances (0–7) 0- not present; 1- very mild sensitivity; 2- mild sensitivity; 3- moderate sensitivity; 4- moderate hallucinations; 5- severe hallucinations; 6- extremely severe hallucinations; 7- continuous hallucinations				
Headache (0–7) 0- not present; 1- very mild; 2- mild; 3- moderate; 4- moderately severe; 5- severe; 6- very severe; 7- extremely severe				
TOTAL				

Subjective Opioid Withdrawal Scale

Date: _____ **Name:** _____ **DOB:** _____

Rate each symptom according to how you are feeling **right now:**

0 = Not at all | **1** = A little | **2** = Moderately | **3** = Quite a bit | **4** = Extremely

TIME					
SYMPTOMS					
I feel anxious					
I feel like yawning					
I am perspiring					
My eyes are teary					
My nose is running					
I have goosebumps					
I am shaking					
I have hot flashes					
I have cold flashes					
My bones and muscles ache					
I feel restless					
I feel nauseous					
I feel like vomiting					
My muscles twitch					
I have stomach cramps					
I feel like using now					
TOTAL*					

***Total withdrawal levels:** **1-10** = Mild withdrawal | **11-20** = Moderate withdrawal | **21-30** = Severe withdrawal

TIME	SCORE	NOTES/ACTIONS

Level of Agitation

Date: _____

Name: _____

DOB: _____

RATING	DESCRIPTION
1	Patient is asleep
2	Patient is awake but calm, without verbal aggression or agitation
3	Patient is angry, but this is primarily focused on the situation, and requests are not delivered in an obviously threatening or aggressive manner
4	Patient is awake and agitated with some verbal outbursts but no physical aggression
5	Patient is severely agitated with extreme verbal outbursts and/or physical aggression

TIME	SCORE	NOTES/ACTIONS

Resources

ALCOHOL

Standard drink calculator (University of Victoria, Canadian Institute for Substance Use Research)
http://aodtool.cfar.uvic.ca/index-stddt.html

AUD pharmacotherapy table (British Columbia Centre on Substance Use)
https://www.bccsu.ca/wp-content/uploads/2020/04/AUD-Pharmacotherapy-Tables.pdf

Managing co-occurring OUD and AUD (British Columbia Centre on Substance Use)
https://www.bccsu.ca/wp-content/uploads/2021/04/ATG-Managing-Co-occuring-Opioid-and-Alcohol-Use-Disorders.pdf

OPIOIDS

Naloxone education (Narcan)
https://www.narcan.com/#isi_anchor
https://narcannasalspray.ca/en/

Naloxone distribution policy, medical directive, and record (META:PHI)
https://www.metaphi.ca/wp-content/uploads/ED_OUD_NaloxonePolicy.pdf
https://www.metaphi.ca/wp-content/uploads/ED_OUD_NaloxoneDirective.pdf
https://www.metaphi.ca/wp-content/uploads/ED_OUD_NaloxoneRecord.pdf

Clinical opioid withdrawal scale (Wesson DR, Ling W. The Clinical Opiate Withdrawal Scale (COWS). J Psychoactive Drugs. 2003;35(2):253–259.)
https://www.metaphi.ca/wp-content/uploads/COWS.pdf

Buprenorphine microdosing how-to (Patel P, Dunham K, Lee K. Buprenorphine/naloxone microdosing: The Bernese method. Sept 2019.)
http://www.metaphi.ca/wp-content/uploads/Guide_Microdosing.pdf

Microdosing prescription (META:PHI)
http://www.metaphi.ca/wp-content/uploads/ED_OUD_RxMicrodosing.pdf

Buprenorphine information for community providers (META:PHI)
http://www.metaphi.ca/wp-content/uploads/ED_OUD_CommunityProvider.pdf

Buprenorphine/naloxone home start patient handout (META:PHI)
http://www.metaphi.ca/wp-content/uploads/ED_OUD_HomeStartInfo.pdf

Extended-release depot buprenorphine patient handout (META:PHI)
http://www.metaphi.ca/wp-content/uploads/Handout_SublocadeTreatment.pdf

STIMULANTS

Stimulants in RAAM: Pharmacologic and contingency management (Stephanie Rochon and Tanya Hauck)
https://www.youtube.com/watch?v=SW0ECJJp590&t=6s

BENZODIAZEPINES

Equivalency tables and general taper principles (Ashton CH. Benzodiazepines: How they work and how to withdraw. The Ashton Manual, Aug 2002.)
https://www.benzo.org.uk/manual/index.htm

Equivalency calculator (ClinCalc)
https://clincalc.com/Benzodiazepine/

Equivalency calculator (MDCalc)
https://www.mdcalc.com/benzodiazepine-conversion-calculator

CIWA-B (Busto UE, Sykora K, Sellers EM. A clinical scale to assess benzodiazepine withdrawal. Journal of Clinical Psychopharmacology. 1989;9(6):412-6. doi: 10.1097/00004714-198912000-00005.)
https://insight.qld.edu.au/file/410/download

NICOTINE AND CANNABIS

Algorithm for tailoring nicotine pharmacotherapy (Centre for Addiction and Mental Health)
https://www.nicotinedependenceclinic.com/en/teach/Documents/Pharmacotherapy%20Algorithm%20JAN2018%20updated.pdf

Canada's lower risk cannabis use guidelines (Centre for Addiction and Mental Health)
https://www.camh.ca/-/media/files/pdfs---reports-and-books---research/canadas-lower-risk-guidelines-cannabis-pdf.pdf

CUDIT-R (Adamson SJ, Kay-Lambkin FJ, Baker AL, Lewin TJ, Thornton L, Kelly BJ, Sellman JD. An improved brief measure of cannabis misuse: the Cannabis Use Disorders Identification Test-Revised (CUDIT-R). Drug Alcohol Depend. 2010 Jul 1;110(1-2):137-43. doi: 10.1016/j.drugalcdep.2010.02.017. Epub 2010 Mar 26. PMID: 20347232.)
http://mycannabisiq.ca/wp-content/uploads/2018/07/2010_CUDIT-R-revised-with-scoring-EN.pdf

Marijuana withdrawal checklist (PhenX Toolkit)
https://www.phenxtoolkit.org/toolkit_content/supplemental_info/saa_assessments/measures/Marijuana_Withdrawal_Checklist.doc

OTHER

Psychoactive drug history questionnaire (Addiction Research Foundation)
https://www.nova.edu/gsc/forms/Drug-History-Questionnaire.9.8.2022%20.pdf

ED discharge referral to RAAM (META:PHI)
http://www.metaphi.ca/wp-content/uploads/ED_OUD_Discharge.pdf

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