Government of **Western Australia**
Department of **Health**

Screening and Withdrawal Management Toolkit

Screening Tools

Withdrawal Chart Templates

Version 2.0
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Contents

Preface

The **Walk With Me Project:** Pathways to Alcohol and Other Drug (AOD) Early Intervention and Withdrawal Management (the Project) was commissioned in response to several key findings and recommendations in the *WA Methamphetamine Action Plan Taskforce Final Report (2018)*, in particular:

- The challenges people face with accessing drug and alcohol services when, where and how they are needed; and without help to do so – juxtaposed against the relative ease of access to substances: *"Take a walk with me" meth users have said to me. "I'll find you three shots in 15 minutes."*
- The need to improve access to alcohol and other drug services, including withdrawal management care, within WA Health and at the interface between WA Health and Community-based AOD service providers.
- The need to intervene early to reduce AOD-related harm and prevent entrenched use, promoting the use of screening tools and establishing targeted early intervention pathways.

The Project is a Health Service Provider (HSP) collaborative between the East Metropolitan Health Service (EMHS), North Metropolitan Health Service (NMHS), South Metropolitan Health Service (SMHS) and WA Country Health Services (WACHS). The Project also incorporates relevant areas/directorates within the WA Department of Health.

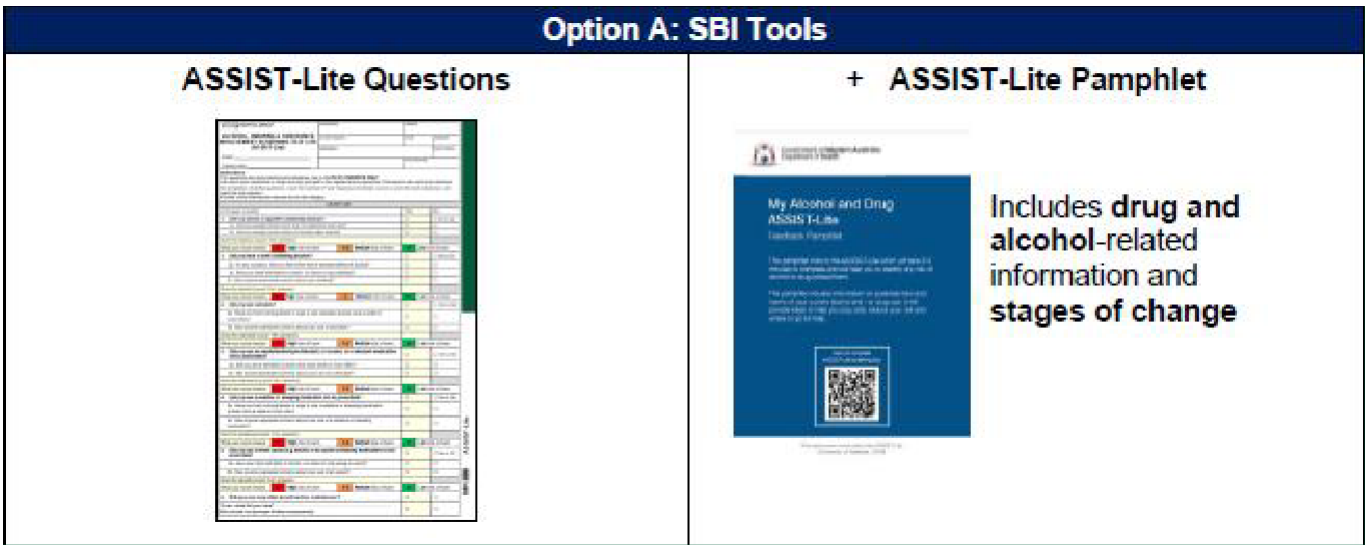
The Project reflects on how clinicians can better walk with our patients on their journey with alcohol and other drugs, including screening and early intervention to prevent harm and reduce entrenched use, provision of AOD withdrawal management, and the partnerships and pathways at the interface between HSPs, primary care providers and Community-based AOD services, through a patient-centred approach that reflects individual patient's wishes and goals.

This toolkit…

This toolkit should be utilised alongside the *Alcohol and Other Drugs Early Intervention and Withdrawal Management Practices and Pathways* clinical practice guidelines. The toolkit provides a framework and templates which can support HSPs in screening, brief intervention and alcohol and other drug withdrawal management.

Chapter 1: Screening Tools

1.1 Option A: ASSIST-Lite Screening Tool and Feedback Pamphlet



The **Assist-Lite** is an ultra-rapid screening tool based on the Alcohol, Smoking and Substance Involvement Test (ASSIST), which was developed by the World Health Organisation. Designed for time pressured environments, the ASSIST-Lite takes approximately 3-5 minutes to complete. The ASSIST-Lite helps identify the risk associated with substance use.

The personalised **My Alcohol and Drug ASSIST-Lite Feedback Pamphlet** provides information on potential risks and harms of current use identified from completing the ASSIST-Lite screening tool. It also provides ideas to reduce risk and where to go for help.

The My Alcohol and Drug ASSIST-Lite Feedback Pamphlet is also designed to enable a self-screening option where scanning a QR code links to the **eASSIST-Lite** tool which can be completed online. This can be utilised throughout HSPs in public areas, outpatient clinics etc.

Refer to the following attachments for access to these resources:

Attachment A: **ASSIST-Lite Clinical Form**

Attachment B: **My Alcohol and Drug ASSIST-Lite Feedback Pamphlet** and self-screening option

Attachment C: Poster with QR code link to the **eASSIST-Lite** self-screening tool

These pamphlets will also be available for download through the WA Department of Health website https://ww2.health.wa.gov.au/.

ASSIST-Lite Education

Refer to the following attachments for access to these resources:

Attachment D: **ASSIST-Lite Clinical Form Toolbox Education Package**

Attachment E: **ASSIST-Lite Feedback Pamphlet Education Package**

The ASSIST Portal provides several resources for clinicians including instructional videos on how to administer the ASSIST-Lite including in the emergency department. There are also resources for brief intervention, instruction manuals and eLearning.

The University of Adelaide also provides ASSIST-Lite Virtual Training via Eventbrite and future upcoming events can be accessed through https://www.assistportal.com.au/assist-lite-virtual-training-via-eventbrite.

1.2 Option B: AUDIT-C + DAST 10 + Stages of Change Pamphlet

<table>
<tr><th colspan="3">Option B: SBI Tools</th></tr>
<tr><th>AUDIT-C Pamphlet +</th><th>DAST-10 Pamphlet +</th><th>Stages of Change Pamphlet</th></tr>
<tr>
<td> 

Includes screening questions and alcohol- related information</td>
<td> 

Includes screening questions and alcohol- related information</td>
<td> 
</td>
</tr>
</table>

The **Alcohol Use Disorders Identification Test (AUDIT-C)** is an effective and reliable screening tool for detecting harmful drinking patterns. The AUDIT-C was developed by the World Health Organisation.

Follow link to download or print **AUDIT C**: MHC Alcohol Related Resources

The **Drug Abuse Screen Test (DAST-10)** is a brief self-report instrument for population screening, clinical case finding and treatment and evaluation research. It can be used with adults and older youth. The instrument takes about 5 minutes to administer and may be given in either a self-report or interview format and provides a quick index of drug abuse problems.

Refer to *Attachment F*: **DAST-10** for access to this resource

The **Stages of Change Pamphlet** was developed to use in conjunction with the AUDIT-C and/or DAST-10 to support brief intervention with patients and provides some motivational tools as well as information to reduce harm and where to get help.

Refer to *Attachment G*: **Stages of Change Pamphlet** for access to this resource

Brief Intervention Education

WA Health has comprehensive self-directed learning modules on the AUDIT-C and prenatal alcohol exposure, foetal alcohol spectrum disorder and alcohol and breastfeeding: WA Health AUDIT-C Learning Guide.

MHC provides online learning packages including Alcohol Brief Intervention, an Introduction to Alcohol and Other Drugs, Needle and Syringe Programs and AOD Prevention.

Chapter 2: Withdrawal Tools

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

The CIWA-Ar provides a reliable and consistent clinician generated score that helps rate severity of alcohol withdrawal and guide medication dosing, particularly benzodiazepine dose. The CIWA-Ar is less reliable in the presence of significant medical or psychiatric comorbidities and severe and complex withdrawal, therefore involvement and consultation from specialist AOD staff is recommended in these circumstances. Regular diazepam in addition to symptom trigger dosing using the CIWA-Ar or diazepam loading regimes may be utilised.

2.2 Clinical Opiate Withdrawal Scale (COWS) template

The COWS is a clinician administered instrument that rates eleven common opiate withdrawal signs or symptoms to assess the patient's level of opiate withdrawal and to provide guidance on pharmacological treatment approaches.

Refer to the following attachments for access to these resources, which have been reviewed and approved by WATAG for use in Western Australian hospitals:

Attachment H: **CIWA-Ar Clinical Form Template**

Attachment I: **Clinical Opiate Withdrawal Scale (COWS) Template**

Withdrawal Tool Education

Refer to the following attachments for access to these resources:

Attachment J: **Alcohol Withdrawal Chart (CIWA-Ar) Toolbox Education Package**

Attachment K: **Clinical Opiate Withdrawal Scale (COWS) Toolbox Education Package**

Chapter 3: Substance-specific Quick Reference Guides

Substance-specific withdrawal management **Quick Reference Guides** have been developed for:

- alcohol withdrawal management
- amphetamine and amphetamine-type substances withdrawal management
- benzodiazepine withdrawal management
- cannabis withdrawal management
- opioid withdrawal management.

These Quick Reference Guides have been designed to provide a brief set of substance-specific guidelines for safe management of AOD withdrawal within the public hospital environment and should be tailored to individual requirements. These reference guides also present the level of evidence associated with the recommendation.

If the patient's symptoms are not improving despite implementing these recommendations, seek assistance from your AOD Clinicians (where available) or the Drug and Alcohol Clinical Advisory Service.

The **Drug and Alcohol Clinical Advisory Service** (DACAS) is a specialist telephone consultancy service that provides clinical advice to health professionals across WA on all issues relating to management of patients with alcohol and other drug use (excluding CPOP). The service is provided by experienced Next Step Addiction Medicine Specialists and is available to health professionals across Western Australia.

DACAS operates from 8:00am to 8:00pm Monday to Friday. If calling after hours, a message can be left and the call will be returned on the next business day.

Phone (08) 6553 0520.

The diagnosis of a withdrawal state is **clinical,** based on history, examination and clinical progress over time. A withdrawal syndrome may occur in some consumers with alcohol or other drug-dependence who stop or reduce their alcohol or drug use. Note that many patients who undergo unplanned withdrawal within the hospital environment may experience complex withdrawal issues complicated by co-existing physical or psychiatric illness.

These Quick Reference Guides include reference to standardised withdrawal monitoring scales. Such withdrawal scales are **not diagnostic** of withdrawal as many other medical and psychiatric conditions may cause similar symptoms and physiological signs.

Charts based on standardised withdrawal monitoring scales allow assessment of severity of withdrawal symptoms, track clinical progress over time and may help to guide pharmacotherapy and symptom management. Charts should be interpreted in the context of the patient's clinical situation, including co-existing acute illness and co-morbid physical and psychiatric diagnoses. They do not replace other hospital protocols and charts warning of acute clinical deterioration and standard responses to clinical deterioration (e.g. MET calls) should still be followed.

For further information, clinical tools and levels of evidence refer to *Alcohol and Other Drugs Withdrawal Management Practice and Pathways* clinical practice guideline.

3.1 Quick Reference Guide: Alcohol withdrawal management

<table>
<tr><th>Signs of intoxication</th><th>Signs of withdrawal</th><th>Mild to moderate withdrawal symptoms</th></tr>
<tr><td rowspan="3">Poor motor coordination
Impaired gait
Slurred speech
Disinhibition
Poor concentration
Mood instability
Altered level of consciousness</td><td rowspan="3">Onset 6-24 hours after last drink

Breath Alcohol Level may still be elevated at onset

Lasts for 3-5 days but can be as long as 10 days</td><td>Agitation, anxiety, disturbed sleep, nausea, restlessness, sweats, tachycardia, hypertension, tremor, raised temperature</td></tr>
<tr><td>Severe withdrawal symptoms</td></tr>
<tr><td>Worsening of above symptoms plus: delirium tremens, extreme agitation, confusion, paranoia, hallucinations, seizures (usually within the first 48 hours), death</td></tr>
<tr><td colspan="3">Wernicke’s encephalopathy</td></tr>
<tr><td colspan="3">Symptoms may include confusion (70%), ataxia, nystagmus, hypothermia</td></tr>
<tr><td colspan="3">Assessment / management tools (once diagnosis established)</td></tr>
<tr><td colspan="3">Clinical assessment and examination
Clinical tool examples: Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA-Ar)</td></tr>
<tr><td colspan="3">Acute withdrawal treatment models</td></tr>
<tr><td rowspan="2">Supportive care</td><td colspan="3">Benzodiazepines (Grade B): Select one of…</td></tr>
<tr><td>Fixed dose regimen (Grade D)</td><td>Symptom-triggered sedation (Grade D)</td><td>Diazepam loading (Grade D)</td></tr>
<tr><td>Symptomatic care:
Adequate hydration
Antiemetics
Paracetamol

Consider:
Vitamin B complex
Multivitamins
Folic acid
Magnesium

In severe liver disease (Childs-Pugh C) use lorazepam in preference to diazepam – monitor for sedation and confusion. Lorazepam 1 mg PO is equivalent to diazepam 5 mg PO.

Seek specialist AOD service advice in patients with decompensated liver cirrhosis where benzodiazepines may contribute to hepatic encephalopathy</td><td>Suitable for patients with mild to moderate withdrawal symptoms who have good support, no complicating factors and no history of seizures

Diazepam is the drug of choice for withdrawal symptoms

An example regimen:
Day 1: Diazepam PO 10 mg QID
Day 2-3: Diazepam PO 5-10 mg TDS
Day 4: Diazepam PO 5 mg BD
Day 5: Diazepam PO 5 mg nocte then cease</td><td>As measured by assessment tool:

Moderate withdrawal (CIWA-Ar 9 -14): diazepam PO 5-10 mg every 2-4 hours PRN (maximum 100mg/24hrs)

Severe withdrawal (CIWA-Ar ≥ 15) diazepam PO 10-20mg every 2-4 hours PRN. (maximum 100mg/24hrs)

Consider regular diazepam PO 10mg QID if history of withdrawal seizures</td><td>Initiate diazepam PO 20 mg on development of withdrawal symptoms

Repeat doses of diazepam PO 10-20 mg every 2 hours until light sedation occurs or maximum 100mg/24hrs reached

Ongoing titration against symptoms

Consider regular diazepam PO 10mg QID if history of withdrawal seizures</td></tr>
</table>

Wernicke's encephalopathy prevention and treatment	
Thiamine should be administered prior to any glucose or supplementary nutrition (Grade D) Check and correct electrolytes, including magnesium[1] and phosphate to aid thiamine absorption (Grade D)	
Minimum dose for prophylaxis in all patients with acute alcohol withdrawal and normal mental state[2] (Grade D)	Thiamine IV / IM 300 mg daily for 3 days. Continue 100 mg TDS orally until sober for 1 month Then 100 mg PO daily thereafter
Suspected Wernicke's encephalopathy – acute alcohol withdrawal with altered mental state (Grade D)	Thiamine IV 200 – 500 mg TDS for 5 – 7 days. Continue 100 mg TDS orally until sober for 1 month Then 100 mg PO daily thereafter
Post withdrawal treatment options	
Anti-craving medications[3]	Naltrexone (Grade A) Acamprosate (Grade A) Second-line agents
Support and relapse prevention	Support groups e.g. SMART recovery Ongoing counselling Alcoholics Anonymous Residential rehabilitation Involve GP/AMS/CADS Involve appropriate support people

If the patient is not improving on this regimen, seek assistance from specialist AOD Clinicians or the Drug and Alcohol Clinical Advisory Service (DACAS).

[1] Hypomagnesaemia is associated with the development of Wernicke's encephalopathy
[2] Parenteral thiamine is preferred as orally administered thiamine has poor bioavailability (maximum 4.5 mg available per 100 mg) and is further reduced by up to 70% in the context of alcohol intoxication and malnutrition. B Dose Forte is an acceptable alternative.
[3] Anti-craving medications for the management of alcohol addiction should be used in the context of an addiction management programme, under the direction of a consultant psychiatrist or addiction specialist, with the goal of maintaining abstinence.

3.2 Quick Reference Guide: Amphetamine substances withdrawal management

Signs of intoxication	Withdrawal timeframe	Crash phase	Withdrawal phase	Extinction phase
Autonomic Increased blood pressure Increased body temperature Rapid or irregular heartbeat Excessive sweating Muscle rigidity ***Central*** Euphoria Agitation / confusion Thought disturbance Anxiety / panic Paranoia Psychotic features Acute behavioural disturbance	*Crash:* starts 12-24 hours after last dose and lasts 24-48 hours *Withdrawal:* starts 2-4 days after last use, peaks in severity over 7-10 days, then subsides over 2-4 weeks *Extinction:* lasts for weeks, and may persist for up to 12 months	Exhaustion Fatigue Generalised aches and pains *Sleep disturbance:* Increased sleep Insomnia Restlessness Flat mood or dysphoria Anxiety / agitation Low level craving Thought disturbance usually masked during crash	Fatigue Anhedonia Generalised aches and pains Headache *Sleep disturbance:* Vivid dreams Insomnia *Fluctuating mood and energy:* Irritability Restlessness Anxiety / agitation Poor concentration and attention Strong cravings *Thought disturbance:* Paranoid ideation Strange beliefs Misperceptions Hallucinations	*Episodic fluctuations in mood and energy levels:* Irritability Restlessness Anxiety / agitation Fatigue Lacking energy Anhedonia. Episodic cravings Disturbed sleep Gradual resumption of normal mood

Assessment / management tools (once diagnosis established)

Clinical assessment and examination

Clinical tool examples: *currently there are no validated withdrawal scales for hospital settings*

Acute withdrawal treatment models

General principles	Symptom management	Pharmacotherapy	Inpatient withdrawal
Most amphetamine withdrawal can be managed in the community with good support Regular review may be required to monitor progress	Hydration Multivitamins Anti-emetics Simple analgesia Calm environment Psycho-social education	CONSIDER: Low dose diazepam PO for agitation and poor sleep for up to 7 days Antipsychotic (eg Olanzapine PO 2.5-10 mg daily) for management of paranoid or psychotic features (Grade C)	Acute withdrawal whilst admitted should be managed supportively

Post-withdrawal treatment options

Ongoing counselling and support/groups, GP / AMS

Residential rehabilitation / therapeutic communities

Consider an antidepressant if ongoing depressive symptoms (Grade D).

If the patient is not improving on this regimen, seek assistance from specialist AOD Clinicians or the Drug and Alcohol Clinical Advisory Service (DACAS).

3.3 Quick Reference Guide: Benzodiazepine withdrawal management

<table>
<tr><th>Signs of intoxication</th><th colspan="3">Signs of withdrawal</th></tr>
<tr><td rowspan="3"></td><th>Onset</th><th colspan="2">Common</th></tr>
<tr><td rowspan="2">1-10 days after last dose

Lasts 3-6 weeks (depending on the half-life of the benzodiazepine)</td><td>Mental State:
Anxiety / panic
Insomnia / vivid dreams
Restlessness / agitation
Irritability
Poor concentration / memory
Depressed mood
Feelings of depersonalisation</td><td>Physical Symptoms:
Dry retching / Nausea
Decreased appetite
Aches and pains
Headaches
Palpitations
Tremor
Blurred vision
Increased temperature
Ataxia
Menstrual changes</td></tr>
<tr><td>Poor motor coordination
Slurred speech
Disinhibition
Low blood pressure
Poor concentration
Mood instability
Sedation</td><td colspan="2">Uncommon (severe)
Delirium, Delusions, Paranoia, Hallucinations, Catatonia, Seizures</td></tr>
<tr><th colspan="4">Assessment / management tools (once diagnosis established)</th></tr>
<tr><td colspan="4">Clinical assessment and examination
Clinical tool examples: Clinical Institute Withdrawal Assessment Scale - Benzodiazepines</td></tr>
<tr><th colspan="4">Acute withdrawal treatment models</th></tr>
<tr><th colspan="2">General principles</th><th colspan="2">Inpatient management</th></tr>
<tr><td colspan="2">Tolerance to benzodiazepines develops quickly

Most benzodiazepine withdrawal is managed in the community with GP or specialist AOD service involvement

Refer patients on an opioid treatment program back to their prescribers

Do not prescribe to patients with whom you are not familiar

Check the Medicare prescription shopping hotline
Phone 1800 631 181 OR
WA Health S8 prescriber information service
Phone 08 9222 4424</td><td colspan="2">Acute withdrawal is managed by dose stabilisation whilst in hospital and then referred for management in the community.

Clinical judgement on dose is required as history may be unreliable. Specialist advice is recommended for polysubstance users

If there is no hepatic impairment, convert daily dose to a diazepam-equivalent dose. Reduce this by 20-40% and prescribe this dose (up to 80 mg/day, whichever is lesser) in 4 divided doses daily.
If history is uncertain, a conservative starting dose of 10mg QID PO is adequate, with dose adjustment based on symptoms

Dose reduction should be slow aiming for 10% reduction every 1-2 weeks. Reduction rate can be slowed if preferred by the patient (Grade B)</td></tr>
<tr><th colspan="4">Post-withdrawal treatment options</th></tr>
<tr><td colspan="4">Ongoing counselling and support groups
Involve GP/AMS and significant others</td></tr>
</table>

If the patient is not improving on this regimen, seek assistance from specialist AOD Clinicians or the Drug and Alcohol Clinical Advisory Service (DACAS).

Benzodiazepine Equivalents					
Generic Name	*Duration of Action	Approximate dose equivalent to 5mg Diazepam	Trade Names	Tablet Strengths	Schedule
Alprazolam	Short	0.5 – 1 mg	Alprax, Kalma, Xanax, Ralozam	0.25 mg, 0.5 mg 1 mg, 2 mg	Schedule 8 Controlled Drug
Bromazepam	Intermediate	**3** – 6 mg	Lexotan	3 mg, 6 mg	S4R
Clobazam	Long	**10** – 15 mg	Frisium	10 mg	S4R
Clonazepam	Long	**0.25** – 0.5 mg	Rivotril, Paxam	0.5 mg, 2 mg	S4R
Diazepam	Long	**5** mg	Antenex, Ducene, Ranzepam, Valium, Valpam	2 mg, 5 mg	S4R
Flunitrazepam	Long	**1** – 2 mg	Hypnodorm	1 mg	Schedule 8 Controlled Drug
Lorazepam	Intermediate	0.5 – **1** mg	Ativan	1 mg, 2.5 mg	S4R
Nitrazepam	Long	5 mg	Alodorm, Mogadon	5 mg	S4R
Oxazepam	Short	15-30 mg	Alepam, Murelax, Serepax	15 mg, 30 mg	S4R
Temazepam	Short	**10** – 20 mg	Normison, Temaze, Temtabs	10 mg	S4R
Triazolam	Very short	**0.25** mg	Halcion	0.125 mg	S4R
Non-benzodiazepine agents					
Zolpidem	Very Short	10 mg	Dormizol, Somidem, Stildem, Stilnox, Zolpibell	10mg (6.25mg & 12.5mg modified release)	S4R
Zopiclone	Very short	7.5 mg	Imovane, Imrest	7.5 mg	S4R

*Approximate duration of action	Approximate Time
Very Short	Less than 6 hours
Short	6 – 12 hours
Intermediate	12 – 24 hours
Long	Greater than 24 hours

3.4 Quick Reference Guide: Cannabis withdrawal management

<table>
<tr><th rowspan="2">Signs of intoxication</th><th colspan="3">Signs of withdrawal</th></tr>
<tr><th>Onset</th><th>Symptoms</th><th>Factors affecting severity</th></tr>
<tr><td>Euphoria
Increased appetite
Increased pulse
Confusion
Restlessness
Hallucinations
Delusions
Anxiety / panic
Paranoia</td><td>50-70% of dependent cannabis users will experience four or more withdrawal symptoms

Commence on day 1
Peak at day 2-4
Symptoms usually last 2-3 weeks

Occasional late development of anger and aggression up to two weeks after ceasing use</td><td>Anger / aggression
Decreased appetite / weight loss
Irritability
Nervousness / anxiety
Restlessness
Sleep difficulties (including strange dreams)
Cravings
Sweating

Less common:
Depressed mood
Paranoia</td><td>Psychiatric comorbidity

Dose: amount, potency and preparation consumed

History of aggression or violence

Duration of current use and other past or current substance use history</td></tr>
<tr><th colspan="4">Assessment / management tools (once diagnosis established)</th></tr>
<tr><td colspan="4">Clinical assessment and examination
Clinical tools: Cannabis Withdrawal Scale (see Appendix 1.4) Note not validated in tertiary hospital settings</td></tr>
<tr><th colspan="4">Acute withdrawal treatment models</th></tr>
<tr><th>General principles</th><th>Symptomatic management</th><th>Pharmacotherapy</th><th>Inpatient withdrawal</th></tr>
<tr><td>Most cannabis withdrawal can be managed in the community

Symptomatic care is the mainstay for treatment

Regular patient review is recommended

Consider adding Nicotine Replacement Therapy for tobacco withdrawal (often spun with cannabis)</td><td>Simple analgesia
Antiemetics
Antispasmodics
Hydration
Calm environment
Psycho-education

Decrease intake of caffeinated drinks</td><td>CONSIDER:
Short course (3-5 days) of low dose diazepam PO to manage anxiety

Antipsychotic (e.g. Olanzapine 2.5-10 mg PO daily) for paranoid or psychotic features (Grade C)</td><td>Generally, not required. Patients may undergo withdrawal whilst admitted as an inpatient for other reasons.

Acute withdrawal while an inpatient should be managed in the same way as low medical withdrawal</td></tr>
<tr><th colspan="4">Cannabis hyperemesis</th></tr>
<tr><td colspan="2">Recurrent nausea, vomiting and cramping abdominal pain due to cannabis use.</td><td colspan="2">Capsaicin cream 0.025-0.075% applied topically to abdomen for symptoms of hyperemesis (Grade C)</td></tr>
<tr><th colspan="4">Post-withdrawal treatment options</th></tr>
<tr><td colspan="4">Consider an antidepressant for ongoing depressive symptoms (Grade D).
Ongoing counselling
GP / AMS and appropriate support people</td></tr>
</table>

If the patient is not improving on this regimen, seek assistance from specialist AOD Clinicians or the Drug and Alcohol Clinical Advisory Service (DACAS).

3.5 Quick Reference Guide: Opioid withdrawal management

<table>
<tr><th>Signs of intoxication</th><th colspan="3">Onset of withdrawal</th></tr>
<tr><td rowspan="2">Euphoria (sense of wellbeing)
Pinpoint pupils
Sedation – ‘nodding off’
Decreased blood pressure
Decreased pulse
Slurred speech
Decreased respiratory rate and oxygen saturations
Sedation and Coma
Death</td><td>Short acting opioids:
Commences 6-24 hours after the last dose,
peaks at 24-48 hours and resolves after 5-10 days</td><td>Long acting (methadone or controlled release pharmaceutical) opioids:
Commences 24-48 hours after the last dose, peak severity less than for heroin withdrawal, but may be prolonged lasting 3-6 weeks</td><td>Buprenorphine:
withdrawal is generally milder, commences within
3-5 days of the last dose and can last for several weeks</td></tr>
<tr><td colspan="2">Signs
Piloerection / Sweating
Muscle twitching
Vomiting / Diarrhoea
Restlessness
Yawning
Rhinorrhoea
Dilated pupils</td><td>Symptoms
Anorexia and nausea
Abdominal pain
Hot and cold flushes
Bone, joint and muscle pain
Insomnia and disturbed sleep
Muscle cramps
Intense craving for opioids</td></tr>
<tr><th colspan="4">Assessment/management tools (once diagnosis established)</th></tr>
<tr><td colspan="4">Clinical assessment and examination
Clinical tools: Clinical Opioid Withdrawal Scale (COWS)</td></tr>
<tr><th colspan="4">Acute withdrawal treatment models</th></tr>
<tr><th>General principles</th><th>Symptomatic management</th><th colspan="2">Pharmacotherapy</th></tr>
<tr><td>Most opioid withdrawal can be managed with GP or specialist AOD service involvement

Seek specialist AOD advice and referral for opioid substitution programmes[4] e.g. methadone or Suboxone®

It is recommended that pregnant women who are opioid dependent do not undergo opioid withdrawal due to risk of miscarriage or premature delivery</td><td>Simple analgesia
Antiemetics
Antispasmodics
Antidiarrheal agents
Hydration
Calm environment
Psycho-social education

Consider:
Clonidine for autonomic symptoms (Grade B)

Example regimen:
75-150 microg clonidine QID PO and then tapering dose once peak symptoms pass. Omit or reduce dose if hypotensive or bradycardic</td><td colspan="2">Sublingual buprenorphine / naloxone is effective for managing opioid withdrawal and may be considered for severe opioid withdrawal where clinical guidelines are in place (Grade B). Seek specialist AOD advice as an authorised prescriber is required. See Opioid Detoxification Therapy within WA Public Hospitals notification and contact DACAS

Where overdose prevention programmes exist, consider take home naloxone and peer naloxone training on discharge

Continuation of Suboxone® on discharge requires prior approval from the Department of Health and must be requested by a CPOP prescriber – seek specialist AOD Advice.</td></tr>
</table>

[4] For patients in a community programme for opioid pharmacotherapy who present to hospital, follow the WA Department of Health: Medicines Handling Policy (MP 0139/20). 2020 [cited 2021 Feb 4]. Available from: https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Public-Health/Mandatory-requirements/Medicines-and-Poisons-Management/Medicines-Handling-Policy

Post withdrawal treatment options
Risk of accidental overdose and death due to a reduction in tolerance to opioids needs to be clearly discussed should relapse occur Take Home Naloxone Packs/Information should be provided to support reduced risk Ongoing counselling and support groups Naltrexone for relapse prevention GP/AMS/CADS/Significant others

If the patient is not improving on this regimen, seek assistance from specialist AOD Clinicians or the Drug and Alcohol Clinical Advisory Service (DACAS).
Under S80 of the Medicines and Poisons Act 2014 an Authorised Health Practitioner who reasonably believes that a patient is a drug dependent person commits an offence if the practitioner does not make a report to the Department of Health.

Chapter 4: Discharge and Care Transfer Standard Operating Procedure Template

Hospital discharge and transfer of care refers to the safe exit of patients from a service and the transfer of information and care between services or to the patient themselves. Discharge planning should be patient-centred and consider the needs of the patient and their family / carers, including them in planning and decision making wherever possible and providing appropriate information and education.

4.1 Roles and Responsibilities

Improving client discharge and transfer of care outcomes is a shared responsibility of all service providers and should be considered in developing procedures at the interface between hospital and community services. Procedures should address roles and responsibilities, discharge criteria, care planning, management of unscheduled departure, referrals, documentation, information transfer and feedback.

4.2 Discharge and Follow up Procedures

- Before discharge, facilitate engagement with service providers who will provide ongoing care.
- Ensure patients are provided with information and support to enact the discharge plan and how to seek additional support if needed, including return to the current service.
- Some patients with appropriate support systems may benefit from discharge dispensing of medications for ambulatory treatment of residual withdrawal symptoms. This should be assessed on an individual basis accounting for severity and expected duration of withdrawal symptoms, recent dispensing history, co-existing illness and regular medications. Discharge medications may include (see also *Alcohol and Other Drugs Withdrawal Management Practice and Pathways*):
    - symptomatic care, e.g. antiemetics
    - fixed dose short course benzodiazepine or antipsychotic regimen (consider reduced doses for patients who take other CNS depressants, e.g. opioids, antipsychotics or antihistamines to avoid excessive sedation or respiratory depression).
- Clinical Handover should follow the WA Health Clinical Handover Policy MP 0095/18 v2.2 and use a consistent structure such as ISoBAR.
- Transfer of care between HSP and community services should occur between at least one of the treating clinicians responsible for the current care of the patient, and one who will be providing ongoing care. Handovers to community AOD services should be supported by a locally agreed transfer document which should arrive prior to or with the patient at time of transfer.
- A discharge summary should be completed within 24 hours of discharge and be forwarded to the patient's GP as per local HSP policy. This should include ongoing and follow-up plans.

4.3 Special Situations

Patients who identify as Aboriginal or Torres Strait Islanders and other patients from culturally and linguistically diverse backgrounds

Clinicians must ensure that patients:

- understand any questions asked and information provided
- are supported by an Aboriginal Liaison Officer or family wherever possible
- are provided with an interpreter when needed.

Country and regional areas

Clinicians should consider the expertise and community alcohol and other drug resources available locally. Further advice is available from DACAS.

Pregnant patients

Alcohol and drug use have harmful effects on the foetus and management of withdrawal is complex. Withdrawal may increase the risk of spontaneous abortion and pre-term delivery. Specialist advice can be provided from the Women and Newborn Drug and Alcohol Service (WANDAS). In country areas, it is recommended to involve an obstetrician or GP-obstetrician in the patient's care.

Patients intending to drive

If the patient has been assessed by a clinician as being intoxicated and/or impaired and is indicating their intention to drive, the following interventions should be considered:

- advise the patient that they are intoxicated and should not be operating a motor vehicle
- discuss alternative options such as public transport, phoning a friend or relative, leave vehicle keys and return at an agreed time when not intoxicated
- in exceptional circumstances, if the consumer is unable to obtain alternative transportation, a taxi voucher may be provided – seek further information from relevant manager.

If the patient is not receptive to these interventions then he/she should be reminded that the service has a duty of care to ensure the consumer's personal safety and the safety of others, and that the police will be contacted. The police should be called to attend urgently if the person is intending to drive with minors in the vehicle.[5]

Staff should not attempt to physically restrain the patient or take possession of the vehicle keys.

4.4 Resource packs for patients who decide to discharge earlier than planned

Some patients may initiate their discharge earlier than planned. Pre-packaged early discharge kits should be immediately available to all patients who are discharging early.

Suggested components may include:

- health advice and what to do in an emergency
- local contact numbers and referral information for community AOD services, including options to return or present to their GP
- ASSIST-Lite Feedback pamphlet or AUDIT-C / DAST-10 pamphlets
- information on downloading the free ACE app or ASSIST-Lite check-up app for harm reduction and self-help options.

[5] Metro Community and Alcohol & Drug Services (CADS) and Drug and Alcohol Youth Service (DAYS) – Integrated Services (IS) – Management of Consumers Intending to Drive Whilst Intoxicated Policy. MHC19/76825[v3]

Version control

Month/Year	Minor/major amendment	Date endorsed
01/2021	Endorsed by the Methamphetamine Action Plan (MAP) Committee	01/2021
10/2021	This version has been updated to comply with the State Medicines Formulary (SMF) and endorsed by the Western Australian Therapeutic and Advisory Group (WATAG) and the CPOP Management Committee. The WATAG are not responsible for the clinical information in the document.	07/2021

This document can be made available in alternative formats on request for a person with disability.