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

# Alcohol and Other Drugs Withdrawal Management

## Practice and Pathways

**Version 2.0**

**October 2021**

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## Preface

The *Alcohol and Other Drugs Withdrawal Management: Practice and Pathways* document is a product of the **Walk With Me Project**: Pathways to alcohol and other drug early intervention and withdrawal management.

The Walk With Me Project was commissioned in response to several key findings and recommendations in the *WA Methamphetamine Action Plan Taskforce Final Report*, in particular:

- The challenges that people face in independently accessing drug and alcohol services when, where and how they are needed, 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.
- The need to intervene early to reduce drug-related harm and prevent entrenched use, promoting the use of screening tools and establishing targeted early intervention pathways.

The Walk With Me Project (the Project) is a Health Service Provider (HSP) collaborative involving 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.

## Why withdrawal management?

### Alcohol and other drug (AOD) use is prevalent

According to the 2019 National Drug Strategy Household Survey [1]:

Nearly **1 in 4** Western Australians aged 14 years and older reported consuming 5 or more drink in one session at least monthly

**1 in 6** Western Australians aged 14 years and older reported using illicit drugs in the previous 12 months.

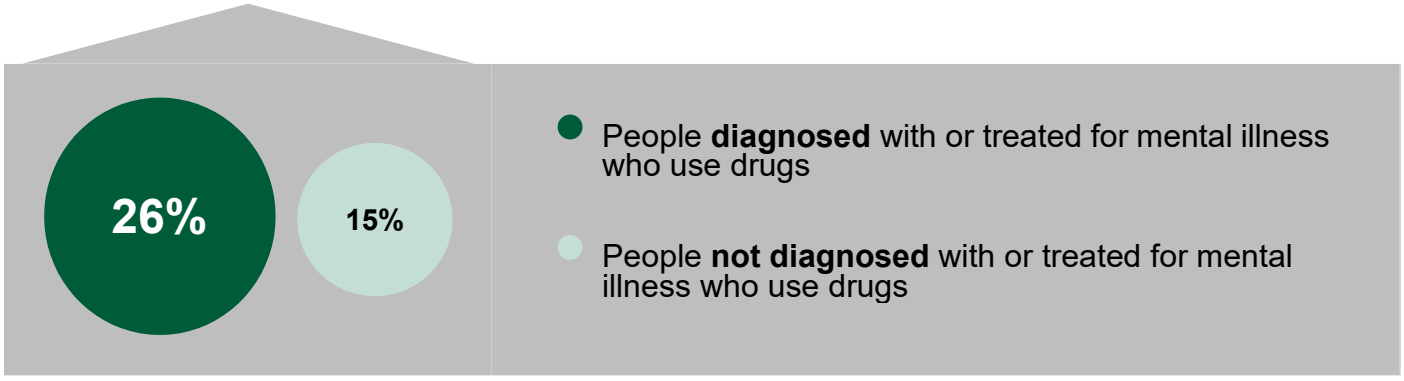
In Western Australia meth/amphetamine use was higher than the national average

**1 in 10** recent drinkers (9.9%) are likely to meet criteria for alcohol dependence

People in *Remote and very remote* areas were about 1.6 times as likely as those in *Major cities* to consume alcohol at levels that exceeded both the lifetime risk guideline and the single occasion risk guideline. Country Western Australia had one of the highest proportions of lifetime risk drinkers (24%).

### Substance use is higher among people with mental health conditions

In 2019 people aged 18 and over who had been diagnosed with, or treated for, a mental health condition in the last 12 months were 1.7 times as likely to have recently used an illicit drug.




A mental illness can make some people more likely to use substances, for example for short term relief of their symptoms. For other people substance use may trigger the first symptoms of mental illness.

Significant adverse health, social and economic impacts are associated with AOD use [2]:

| Health | Social | $ Economic |
|---|---|---|
| • burden of disease<br>• injury & hospitalisation<br>• drug-induced deaths<br>• mental health<br>• pregnancy complications<br>• injection-related harms | • risky behaviour & criminal activity<br>• victimisation & trauma<br>• family & domestic violence<br>• contact with the criminal justice system | • financial cost<br>• household expenditure<br>• lost productivity<br>*AOD use costs the Australian community an estimated $55.2 billion per year.* |

**Nearly 1 in 5** (19.07%) [3] presentations to Emergency Departments in Western Australia may be directly related to alcohol consumption, with **more than 50%** [4] of these due to injury.

Canadian cohort studies document one-year all-cause mortality 5.3%, and opioid-related mortality 1.9% after presentation to ED with non-fatal opioid overdose [5]. Similarly, one-year all-cause mortality for patients with 2 or more alcohol-related ED visits was 4.7%, rising to 8.8% among those with 5 or more visits [6].

### Withdrawing from alcohol and other drugs carries risk

Withdrawal from alcohol and other drugs of dependence carries risks of physical harm, psychological distress and (rarely) death. Alcohol and other drug withdrawal may complicate the clinical course of patients who are admitted to hospital for another reason and may prolong the duration of hospital stay. The primary aim of withdrawal management is to minimise the physical and psychological risks associated with withdrawal. Early detection and management of withdrawal symptoms, including the prevention of complications, are essential components in safe, high quality, comprehensive patient care.

### Withdrawal can be a key step

Withdrawal management can be a key step in alcohol and other drug treatment, aiding the short-term cessation or reduction of substance use in a safe supportive environment. However, if performed alone without ongoing post-withdrawal management and support, there is little effect on lasting behaviour change [7]. Planning for supportive care and ongoing treatment is essential.

It should be recognised that ongoing post-withdrawal treatment for AOD dependence is effective in improving long term health. Although dependence can be a chronically relapsing condition, individuals can be assisted to avoid or reduce a range of physical, psychological and social harms.

### We can support our patients to access withdrawal management and other AOD services

HSP clinicians[a] are in a unique position to walk with their patients along their individual AOD journey. It is essential to consider and address the underlying psychosocial factors that may contribute to dependence or complicate withdrawal management, rehabilitation and longer-term behavioural change.

[a] The term “clinicians” is used in this document to collectively describe health care staff of EMHS, NMHS, SMHS and WACHS.

The development of efficient communication and referral partnerships and pathways between HSPs and community-based alcohol and other drug treatment services will improve consumer access to the vital ongoing care and support required following withdrawal.

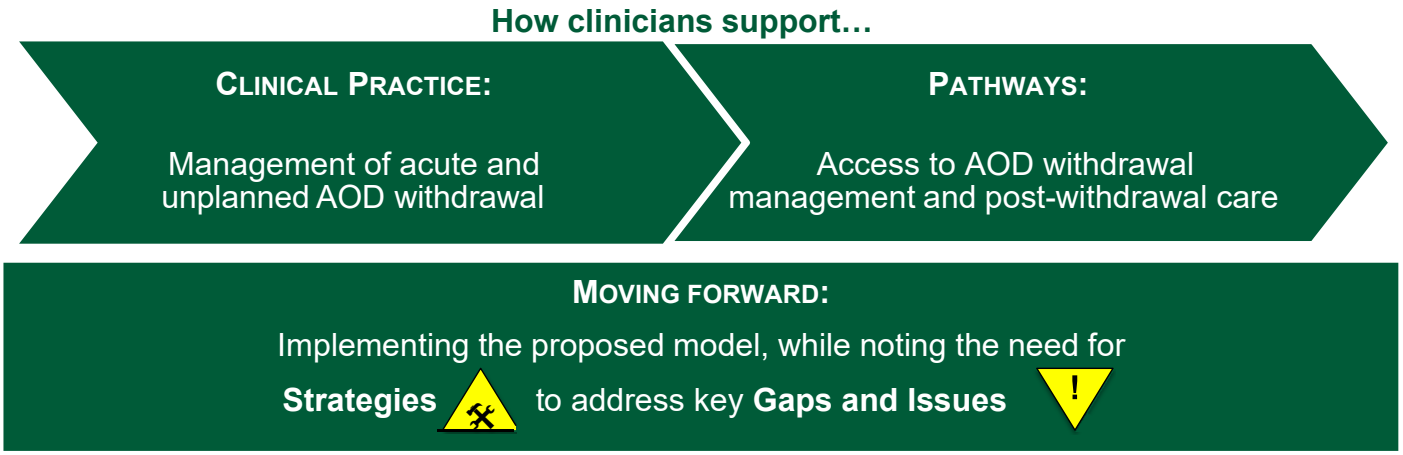
## This document…

The purpose of this document is to present a model of AOD withdrawal management practice and pathways for people who encounter public emergency, inpatient or outpatient (clinic and community) healthcare services delivered by EMHS, NMHS, SMHS and WACHS. This model provides HSPs with guidance and tools that support AOD withdrawal management, acknowledging that each HSP may be at a different stage of readiness to implement (further explored in Chapter 3: Moving forward).

As depicted in Figure 1, this model of AOD withdrawal management is comprised of:

- **Chapter 1: Clinical practice** – How clinicians provide withdrawal management services using evidence-based practice to patients who either present in a withdrawal state or undergo unplanned withdrawal while in our care.
- **Chapter 2: Pathways** – How clinicians support access to withdrawal management, including referral to community-based withdrawal management services and post-withdrawal management and support, fostering continuity of care.
- **Chapter 3: Moving forward** – Considerations for implementing this model, while recognising that key gaps and issues preventing or challenging implementation exist and strategies are required to address them (further explored in the *Walk With Me Project: Recommendations Report*).

**Figure 1: AOD Withdrawal Management Practice and Pathways**




This document **does not** intend to replace each HSPs existing operational documents (e.g. clinical practice standards, guidelines or procedures), initiatives and programs but is to be used as reference material when updating operational documents at scheduled review dates and reviewing current initiatives and programs.

# Chapter 1: Clinical practice

**"Support me in my withdrawal**, and help me move forward"

The model of AOD withdrawal management practice by HSP clinicians is comprised of:

1.1 Definitions and principles of practice
1.2 Diagnosis of alcohol and other drug withdrawal
1.3 General withdrawal management guidelines
1.4 Substance-specific withdrawal management Quick Reference Guides.

## 1.1 Definitions and principles of practice

**Definitions**

**Withdrawal Management:** Providing a person with short-term support and supervision for the safe discontinuation or reduction in use of a substance of dependence, managing symptoms and reducing medical complications.

**Planned Withdrawal:** Admitting a patient electively for the primary purpose of withdrawing from a substance of dependence.

**Unplanned Withdrawal:** May occur when a patient is admitted as an emergency or for another medical reason and withdrawal occurs during their hospital stay.

**Acute Withdrawal:** May occur when a patient presents to the Emergency Department or other health setting with active withdrawal symptoms and signs as the primary cause for presentation.

**Principles of Practice**

Effective engagement with patients regarding their alcohol and other drug use requires:

- an empathic and unprejudiced approach
- seeing the patient as an individual with their own story, journey and needs
- allowing and assisting patients to choose the management option(s) that best suit their needs and goals at that presentation
- respect for the patient and their choices with objective, open discussion
- consideration of unique issues for consumers with complex medical or psychiatric, cultural and language-diverse needs, pregnant women, youth and the elderly who may require a tailored and individualised approach within existing services
- post withdrawal care planning is a vital component of successful withdrawal management. A collaborative partnership includes the patient, their family / significant others and community-based service providers engaged as mutual partners in treatment planning and all aspects of care.

The key concept in the management of withdrawal is **patient safety**. These guidelines are designed to support clinicians with offering safe withdrawal management to individuals with alcohol and other drug dependence issues.

## 1.2 Diagnosis of alcohol and other drug withdrawal

An understanding of the definition of substance use disorders may assist in the assessment and clinical management of consumers with AOD withdrawal syndromes. *The International Classification of Diseases*, 10th revision (ICD-10) defines the following:

**ICD-10 Classification of Substance Use**

**Acute Intoxication:** A condition that follows the administration of a psychoactive substance or alcohol resulting in disturbances in level of consciousness, cognition, perception, affect or behaviour, or other psycho-physiological functions and responses. The disturbances are directly related to the acute pharmacological effects of the substance and resolve with time, with complete recovery, except where tissue damage or other complications have arisen. Complications may occur and depend on the pharmacological class of substance and mode of administration.

**Harmful Use:** A pattern of psychoactive substance use that is causing physical (as in cases of hepatitis from the self-administration of injected psychoactive substances) or mental (e.g. episodes of depressive disorder secondary to heavy consumption of alcohol) damage to health.

**Dependence Syndrome:** A cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance and sometimes a physical withdrawal state.

**Withdrawal State:** A group of symptoms of variable clustering and severity occurring on absolute or relative withdrawal of a psychoactive substance after persistent use of that substance. The onset and course of the withdrawal state are time-limited and are related to the type of psychoactive substance and dose being used immediately before cessation or reduction of use.

*The Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5) classifies the severity of substance use disorder. Severity of disorder is assessed in terms of the number of symptoms which have occurred within the last 12-month period: (Mild: 2 or 3 symptoms; Moderate: 4 or 5 symptoms; Severe: 6 or more symptoms)

**DSM-5 Classification of Substance Use Disorder**

- Recurrent substance use in situations where it is physically hazardous.
- Recurrent substance use resulting in a failure to fulfil major role obligations at work, school, or home.
- Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
- Craving or a strong desire or urge to use the substance.
- Substance is taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or unsuccessful efforts to cut down or control substance use.
- A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
- Important social, occupational, or recreational activities are given up or reduced because of substance use.
- Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by substance use.
- Tolerance, as defined by either:
  - a need for markedly increased amounts of substance to achieve intoxication or desired effect or
  - a markedly diminished effect with continued use of the same amount of the substance.
- Withdrawal, as manifested by either:
  - the characteristic withdrawal syndrome for the substance or
  - the substance (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.

## 1.3 General withdrawal management guidelines

HSP clinicians are most likely to encounter patients requiring AOD withdrawal management in one of the following situations:

- **Acute Presentations:** Patients presenting with established AOD withdrawal symptoms, or patients presenting with issues related to acute intoxication or overdose.
- **Unplanned Withdrawal:** Patients with AOD dependence who present for a related or unrelated health condition and are at risk of withdrawal during admission.

HSP clinicians provide short-term withdrawal management on an inpatient basis for patients presenting with acute withdrawal symptoms and those who develop unplanned withdrawal whilst in our care for another health reason. Planned withdrawal management services are generally provided by community-based alcohol and other drug services (further explored in Chapter 2: Pathways).

### 1.3.1 Assessment for withdrawal management

Components of assessment for withdrawal management include:

- medical and psychiatric history and examination including a full medication history
- substance consumption history, including time and date of last use and history of poly-substance use
- history of withdrawal complications
- underlying psychosocial factors that may contribute to dependence or complicate withdrawal management.

If documenting a full substance consumption history is not initially feasible:

- obtain whatever history is available, especially details of use within the last three months
- identify signs of substance consumption and effects during examination
- take and document a full consumption history as soon as possible.

Predictors of severe or complicated withdrawal may include:

- heavy, recent consumption patterns - dose, regularity and duration of use
- heavy or regular use of multiple substances
- co-existing medical or psychiatric illness
- past severe withdrawal experience.

Patients with any of these factors may be at higher risk of severe or complicated withdrawal and may benefit from early referral to AOD Clinicians/Consultation Liaison[b] staff to assist with assessment and withdrawal management.

Many consumers with AOD issues have concurrent mental health issues. Patients presenting with either psychiatric illness or alcohol and other drug-related presentations should have a comprehensive assessment for both and be treated accordingly.

Additional considerations for patients with injecting drug use include:

- screening for blood borne viruses
- assessment of injecting site including signs of infection

[b] At some hospitals/health services, AOD Consultation Liaison is integrated or co-located with Mental Health Consultation Liaison.

- information on safe injecting practice, vein care, needle exchange services and overdose risk
- information and harm reduction such as provision of naloxone and the Access, Care and Empowerment (ACE) app which is free to download on the App store or Google Play.

### 1.3.2 Formulating a withdrawal management plan

A withdrawal management plan should consider the safest, most effective and most economical option(s) for that patient at that time, and patients should be assisted and allowed to choose the option(s) that best suit their needs and goals at that presentation. It is essential to consider and address the underlying psychosocial factors that may contribute to dependence or complicate withdrawal management, rehabilitation and long-term recovery. Detection of complications of AOD use (e.g. blood borne virus screening) should also be considered in the development of a withdrawal management plan.

Withdrawal settings can be determined by clinical factors, patient preference and resource availability (Grade B). This is particularly important for patients from different cultural backgrounds, including Aboriginal people where admission to a residential unit may impact culturally by not allowing the individual to remain close to family and country[8].

| | Ambulatory | Residential | Inpatient (hospital) |
|---|---|---|---|
| *Likelihood of severe withdrawal complications* | N/A | N/A | History of severe withdrawal (e.g. withdrawal seizures, delirium, cardiovascular complications or psychosis). |
| *Medical or psychiatric comorbidity* | Minor comorbidity. | Minor comorbidity. | Significant comorbidity. |
| *Other substance use* | No heavy drug use. | Heavy or unstable use of other drugs. | Heavy or unstable use of other drugs. |
| *Social environment* | Supportive home environment (not homeless, no substance use in home). Regular monitoring by reliable support people. Good access to outpatient services. | Unsupportive home environment or social supports. Poor access to outpatient services. | Unsupportive home environment or social supports. Poor access to outpatient services. |
| *Previous withdrawal attempts* | | Repeated failure at ambulatory withdrawal. | Repeated failure at ambulatory withdrawal. |

**Table: Choosing an Appropriate Withdrawal Setting**

The most important component of withdrawal management is regular clinical observation and supportive care including the provision of a suitable environment, information and reassurance, and ongoing development of coping skills. Medications may be prescribed to reduce unpleasant withdrawal symptoms, treat or prevent complications, and to manage any co-occurring pathology. All patients who are in, or potentially at risk of, a withdrawal syndrome should be commenced on

an appropriate standardised monitoring chart and have regular vital signs and clinical examination documented.

Post-withdrawal care planning is an integral part of treatment for withdrawal. At the time of discharge, strategies for harm reduction and referrals to appropriate community-based alcohol and other drug treatment services should be in place. Advice and support regarding this can be obtained from on-site AOD Clinicians, as well as through the Alcohol and other Drug Support Line (ADSL) – Phone: 9442 5000; Country Toll Free: 1800 198 024.

Patients assessed as dependent on Schedule 8 or illicit (Schedule 9) drugs are required to be reported to the Department of Health under the Medicines and Poisons Act 2014. Reports are reviewed and the Department may decide to include the name of the person on the Drugs of Addiction Record. More information and the required forms can be found at Reporting Drug Dependence.

Unique issues for cultural and language-diverse groups, socially disadvantaged, patients with complex medical needs, pregnant women, youth and the elderly should be considered and may require a tailored and individualised approach within existing services.

The Mental Health Commission supply a range of AOD resources in different languages on their website: MHC Resources in Different Languages.

## 1.4 Pregnancy and women who use alcohol and other drugs

Maternal drug use is a risk factor for adverse pregnancy and neonatal outcomes including preterm birth. An infant born to a mother who uses illicit drugs is at risk of adverse neonatal outcomes in addition to the risk of neonatal drug withdrawal. All women who use alcohol and other drugs during pregnancy are entitled to accurate information, and to be treated empathetically.

### Management

Pregnant women with a history of potentially harmful AOD use benefit from early referral for specialist drug and alcohol assessment (in addition to midwifery and obstetriccare). Appointment of a case manager and care team who use effective communication systemshelps to facilitate specific treatment for their AOD use, which may include counselling, pharmacotherapy and relapse prevention strategies. Pregnancy is considered a priority referral by community AOD services.

**Women and Newborn Drug and Alcohol Service (WANDAS):** is a tertiary service providing specialist clinical services and professional support to care for pregnant women withalcohol and drug dependence. WANDAS is a midwifery-led team based at King Edward Memorial Hospital which accepts self-referrals in addition to referrals from GP, hospitals, community AOD services, Next Step, and Department of Child Protection.

WANDAS can provide telehealth services to rural and remote communities to enable women to remain in their communities until 34 weeks gestation depending on conditions.
WANDAS also provides education and training and is able to develop and deliver custom designed workshops on alcohol and other drug use during pregnancy, labour, and post- partum.
Women and Newborn Drug and Alcohol Service (WANDAS)

### Caring for pregnant women with acute substance withdrawal

Pregnant women who present intoxicated or with symptoms consistent with drug dependence (i.e. there is a risk of withdrawal) may require inpatient admission. Pregnant women, in particular those experiencing alcohol or opioid withdrawal, are at risk of miscarriage, premature labour, and fetal hypoxia and distress during the withdrawal period. For advice on management ofwithdrawal

in pregnancy please contact WANDAS. Further relevant information may also be obtained from the following links:

NSW Clinical Guidelines for the Management of Substance Use During Pregnancy, Birth and the Postnatal Period

Queensland Clinical Guidelines: Perinatal Substance Use: Neonatal

Supporting pregnant women who use alcohol and other drugs.

### Neonatal Abstinence Syndrome

Neonatal Abstinence Syndrome is a generalised disorder presenting a clinical picture of drug withdrawal in the infant. This includes CNS hyperirritability (tremors, high pitched cry, irritable, sleep disturbance), autonomic symptoms (sneezing, fever, yawning, sweating, mottling) and gastrointestinal dysfunction (excessive sucking, vomiting, posseting, loose/watery stools).

Withdrawal symptoms in the neonate may occur as a result of maternal alcohol and other drug use during pregnancy. With less certainty, abnormal neurobehavioral patterns have also been reported in newborn infants of mothers with high intakes of cannabis, volatile substances, caffeine and some antidepressants.

For clinical guidelines see Neonatal Abstinence Syndrome.

### Breastfeeding and alcohol and other drug use

The NHMRC Infant Feeding Guidelines (2012) state that 'maternal use of nicotine, alcohol, ecstasy, amphetamines, cocaine and related stimulants has been demonstrated to have harmful effects on breastfed infants. The Guidelines recommend appropriate support for women who use alcohol and drugs and who wish to breastfeed. This requires integrated services from drug and alcohol services, paediatrician, lactation consultant or other health professional with breastfeeding expertise. The woman should be informed about the likely effects to the infant of the drugs she is using.

See also WHNS Pharmaceutical and Medicines Management Guideline: Medications in Pregnancy and Breastfeeding: Commonly Used References.

Further advice about the use of medicines in pregnancy and breastfeeding is available from the KEMH Obstetric Medicines Information Service. For women who choose to use alcohol or other drugs while breastfeeding, appropriate precautions following a harm minimisation approach should be taken.

## 1.5 Management of Patients in a Community Programme for Opioid Pharmacotherapy (CPOP)

The WA Health Department *MP 139/20* – Medicines Handling Policy provides direction for patients currently 'in treatment', for example methadone or Suboxone programmes on the Community Program for Opioid Pharmacotherapy (CPOP). Refer to sections 3.4.11 and 3.4.12 and the supporting information Guideline on continuation of opioid substitution treatment in hospitals.

Next Step provides the **CPOP Advice and Support (CAS)** service which is a 24/7 specialist telephone consultancy service for all health professionals seeking clinical advice on any issues related to the Community Program for Opioid Pharmacotherapy (CPOP). CAS provides direct access to the Community Pharmacotherapy Program during office hours and Addiction Medicine Consultants after hours.

Phone 9442 5042 or 1800 688 847 (*phone numbers are strictly for health professionals only*).

CPOP Service Providers and pharmacies can access advice and support through the CPOP Advice and Support service (CAS). Information about the CPOP and supporting resources are available at Community Pharmacotherapy Program.

## 1.6 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. Appendix 3 outlines the classification schemes for categorisation/grading of evidence.

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[c] operates from 8:00am to 8:00pm Monday to Friday. 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 (see section 1.2 Diagnosis of alcohol and other drug withdrawal). 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 monitoringscales. 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.

[c] Note DACAS is a new service which will have its funding reviewed in June 2021.

### 1.6.1 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="4">Poor motor coordination<br>Impaired gait<br>Slurred speech<br>Disinhibition<br>Poor concentration<br>Mood instability<br>Altered level of consciousness</td><td rowspan="4">Onset 6-24 hours after last drink<br><br>Breath Alcohol Level may still be elevated at onset<br><br>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><th>Severe withdrawal symptoms</th></tr>
<tr><td>Worsening of above symptoms plus:<br>delirium tremens, extreme agitation, confusion, paranoia, hallucinations, seizures (usually within the first 48 hours), death</td></tr>
<tr><th>Wernicke’s encephalopathy</th></tr>
<tr><td colspan="3">Symptoms may include confusion (70%), ataxia, nystagmus, hypothermia</td></tr>
<tr><th colspan="4">Assessment / management tools (once diagnosis established)</th></tr>
<tr><td colspan="4">Clinical assessment and examination<br>Clinical tool examples: Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA-Ar)</td></tr>
<tr><th colspan="4">Acute withdrawal treatment models</th></tr>
<tr><th rowspan="2">Supportive care</th><th colspan="3">Benzodiazepines (Grade B): Select one of…</th></tr>
<tr><th>Fixed dose regimen (Grade D)</th><th>Symptom-triggered sedation (Grade D)</th><th>Diazepam loading (Grade D)</th></tr>
<tr><td>Symptomatic care:<br>Adequate hydration<br>Antiemetics<br>Paracetamol<br><br>Consider:<br>Vitamin B complex<br>Multivitamins<br>Folic acid<br>Magnesium<br><br>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.<br><br>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<br><br>Diazepam is the drug of choice for withdrawal symptoms<br><br>An example regimen:<br>Day 1: Diazepam PO 10 mg QID<br>Day 2-3: Diazepam PO 5-10 mg TDS<br>Day 4: Diazepam PO 5 mg BD<br>Day 5: Diazepam PO 5 mg nocte<br>then cease</td><td>As measured by assessment tool:<br><br>Moderate withdrawal (CIWA-Ar 9 -14): diazepam PO 5-10 mg every 2-4 hours PRN (maximum 100mg/24hrs)<br><br>Severe withdrawal (CIWA-Ar ≥ 15) diazepam PO 10-20mg every 2-4 hours PRN. (maximum 100mg/24hrs)<br><br>Consider regular diazepam PO 10mg QID if history of withdrawal seizures</td><td>Initiate diazepam PO 20 mg on development of withdrawal symptoms<br><br>Repeat doses of diazepam PO 10-20 mg every 2 hours until light sedation occurs or maximum 100mg/24hrs reached<br><br>Ongoing titration against symptoms<br><br>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)<br>Check and correct electrolytes, including magnesium[d] and phosphate to aid thiamine absorption (Grade D) | |
| Minimum dose for prophylaxis in all patients with acute alcohol withdrawal and normal mental state[e] (Grade D) | Thiamine IV / IM 300 mg daily for 3 days.<br>Continue 100 mg TDS orally until sober for 1 month<br>Then 100 mg PO daily thereafter |
| Suspected Wernicke's encephalopathy OR acute alcohol withdrawal with altered mental state (Grade D) | Thiamine IV 200 – 500 mg TDS for 5 – 7 days.<br>Continue 100 mg TDS orally until sober for 1 month<br>Then 100 mg PO daily thereafter |
| **Post withdrawal treatment options** | |
| Anti-craving medications[f] | Naltrexone[9] (Grade A)<br>Acamprosate (Grade A)<br>Second-line agents |
| Support and relapse prevention | Support groups e.g. SMART recovery<br>Ongoing counselling<br>Alcoholics Anonymous<br>Residential rehabilitation<br>Involve GP/AMS/CADS<br>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).

[d] Hypomagnesaemia is associated with the development of Wernicke's encephalopathy
[e] 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. Thiamine IV 250 mg in B Dose Forte is an acceptable alternative.
[f] 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.

### 1.6.2 Quick Reference Guide: Amphetamine substances withdrawal management

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

| Assessment / management tools (once diagnosis established) |
|---|
| Clinical assessment and examination<br>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<br>Regular review may be required to monitor progress | Hydration<br>Multivitamins<br>Anti-emetics<br>Simple analgesia<br>Calm environment<br>Psycho-social education | CONSIDER:<br>Low dose diazepam PO for agitation and poor sleep for up to 7 days<br><br>Antipsychotic (eg Olanzapine 2.5-10 mg PO daily) for paranoid or psychotic features<br>(Grade C) | Acute withdrawal whilst admitted should be managed supportively |

| Post-withdrawal treatment options |
|---|
| Ongoing counselling and support/groups, GP / AMS<br>Residential rehabilitation / therapeutic communities<br>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).

### 1.6.3 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">Poor motor coordination<br>Slurred speech<br>Disinhibition<br>Low blood pressure<br>Poor concentration<br>Mood instability<br>Sedation</td><td>Onset</td><td colspan="2">Common</td></tr>
<tr><td rowspan="2">1-10 days after last dose<br><br>Lasts 3-6 weeks<br>(depending on the half-life of the benzodiazepine)</td><td>Mental State:<br>Anxiety / panic<br>Insomnia / vivid dreams<br>Restlessness / agitation<br>Irritability<br>Poor concentration / memory<br>Depressed mood<br>Feelings of depersonalisation</td><td>Physical Symptoms:<br>Dry retching / Nausea<br>Decreased appetite<br>Aches and pains<br>Headaches<br>Palpitations<br>Tremor<br>Blurred vision<br>Increased temperature<br>Ataxia<br>Menstrual changes</td></tr>
<tr><td colspan="2">Uncommon (severe)<br>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<br>Clinical tool examples: Clinical Institute Withdrawal Assessment Scale - Benzodiazepines(CIWA-B Appendix 1.3)</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<br><br>Most benzodiazepine withdrawal is managed in the community with GP or specialist AOD service involvement<br><br>Refer patients on an opioid treatment program back to their prescribers<br><br>Do not prescribe to patients with whom you are not familiar<br><br>Check the Medicare prescription shopping hotline<br>Phone 1800 631 181 OR<br>WA Health S8 prescriber information service<br>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.<br><br>Clinical judgement on dose is required as history may be unreliable. Specialist advice is recommended for polysubstance users<br><br>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.<br>If history is uncertain, a conservative starting dose of 10mg QID PO is adequate, with dose adjustment based on symptoms<br><br>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<br>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 24hours |

### 1.6.4 Quick Reference Guide: Cannabis withdrawal management

| Signs of intoxication | Signs of withdrawal | | |
|---|---|---|---|
| | **Onset** | **Symptoms** | **Factors affecting severity** |
| Euphoria<br>Increased appetite<br>Increased pulse<br>Confusion<br>Restlessness<br>Hallucinations<br>Delusions<br>Anxiety / panic<br>Paranoia | 50-70% of dependent cannabis users will experience four or more withdrawal symptoms<br><br>Commence on day 1<br>Peak at day 2-4<br>Symptoms usually last 2-3 weeks<br><br>Occasional late development of anger and aggression up to two weeks after ceasing use | Anger / aggression<br>Decreased appetite / weight loss<br>Irritability<br>Nervousness / anxiety<br>Restlessness<br>Sleep difficulties (including strange dreams)<br>Cravings<br>Sweating<br><br>*Less common:*<br>Depressed mood<br>Paranoia | Psychiatric comorbidity<br><br>Dose: amount, potency and preparation consumed<br><br>History of aggression or violence<br><br>Duration of current use and other past or current substance use history |

| **Assessment / management tools (once diagnosis established)** |
|---|
| Clinical assessment and examination<br>Clinical tools: Cannabis Withdrawal Scale (see Appendix 1.4) *Note not validated in tertiary hospital settings* |

| **Acute withdrawal treatment models** | | | |
|---|---|---|---|
| **General principles** | **Symptomatic management** | **Pharmacotherapy** | **Inpatient withdrawal** |
| Most cannabis withdrawal can be managed in the community<br><br>Symptomatic care is the mainstay for treatment<br><br>Regular patient review is recommended<br><br>Consider adding Nicotine Replacement Therapy for tobacco withdrawal (often spun with cannabis) | Simple analgesia<br>Antiemetics<br>Antispasmodics<br>Hydration<br>Calm environment<br>Psycho-education<br><br>Decrease intake of caffeinated drinks | CONSIDER:<br>Short course (3-5 days) of low dose diazepam PO to manage anxiety<br><br>Antipsychotic (eg Olanzapine 2.5-10 mg PO daily) for paranoid or psychotic features<br>(Grade C) | Generally, not required. Patients may undergo withdrawal whilst admitted as an inpatient for other reasons.<br><br>Acute withdrawal while an inpatient should be managed in the same way as low medical withdrawal |

| **Cannabis hyperemesis** | |
|---|---|
| Recurrent nausea, vomiting and cramping abdominal pain due to cannabis use. | Capsaicin cream 0.025-0.075% applied topically to abdomen for symptoms of hyperemesis (Grade C) |

| **Post-withdrawal treatment options** |
|---|
| Consider an antidepressant for ongoing depressive symptoms (Grade D).<br>Ongoing counselling<br>GP / AMS and 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).

### 1.6.5 Quick Reference Guide: Opioid withdrawal management

<table>
<tr><th>Signs of intoxication</th><th colspan="3">Onset of withdrawal</th></tr>
<tr><td rowspan="3">Euphoria (sense of wellbeing)<br>Pinpoint pupils<br>Sedation – ‘nodding off’<br>Decreased blood pressure<br>Decreased pulse<br>Slurred speech<br>Decreased respiratory rate and oxygen saturations<br>Sedation and Coma<br>Death</td><td>Short acting opioids:<br>Commences 6-24 hours after the last dose,<br>peaks at 24-48 hours and resolves after 5-10 days</td><td>Long acting (methadone or controlled release pharmaceutical) opioids:<br>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:<br>withdrawal is generally milder, commences within<br>3-5 days of the last dose and can last for several weeks</td></tr>
<tr><td colspan="2">Signs</td><td>Symptoms</td></tr>
<tr><td colspan="2">Piloerection / Sweating<br>Muscle twitching<br>Vomiting / Diarrhoea<br>Restlessness<br>Yawning<br>Rhinorrhoea<br>Dilated pupils</td><td>Anorexia and nausea<br>Abdominal pain<br>Hot and cold flushes<br>Bone, joint and muscle pain<br>Insomnia and disturbed sleep<br>Muscle cramps<br>Intense craving for opioids</td></tr>
<tr><td colspan="4">Assessment/management tools (once diagnosis established)</td></tr>
<tr><td colspan="4">Clinical assessment and examination<br>Clinical tools: Clinical Opioid Withdrawal Scale (COWS, see Appendix 1.5)</td></tr>
<tr><td colspan="4">Acute withdrawal treatment models</td></tr>
<tr><td>General principles</td><td colspan="2">Symptomatic management</td><td>Pharmacotherapy</td></tr>
<tr><td>Most opioid withdrawal can be managed with GP or specialist AOD service involvement<br><br>Seek specialist AOD advice and referral for opioid substitution programmes[g] eg methadone or Suboxone®<br><br>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 colspan="2">Simple analgesia<br>Antiemetics<br>Antispasmodics<br>Antidiarrheal agents<br>Hydration<br>Calm environment<br>Psycho-social education<br><br>Consider:<br>Clonidine for autonomic symptoms (Grade B)<br><br>Example regimen:<br>75-150 microg clonidine QID PO and then tapering dose once peak symptoms pass. Omit or reduce dose if hypotensive or bradycardic</td><td>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.<br>See Opioid Detoxification Therapy within WA Public Hospitals notification and contact DACAS<br><br>Where overdose prevention programmes exist, consider take home naloxone and peer naloxone training on discharge<br><br>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>

[g] 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<br>Take home naloxone packs / information should be provided to support reduced risk<br>Ongoing counselling and support groups<br>Naltrexone[h] for relapse prevention<br>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.

[h] Naltrexone should be used in the context of an addiction management programme, under the direction of a consultant psychiatrist or addiction specialist.

## 1.7 Useful Clinical Guidelines

- Next Step Drug and Alcohol Services. A Brief Guide to the Management of Alcohol and Other Drug Withdrawal [10]
- Turning Point. Alcohol and Drug Withdrawal Guidelines [11]
- NSW Health. NSW Drug and Alcohol Withdrawal Clinical Practice Guidelines [12]
- Queensland Health. Queensland Alcohol and Drug Withdrawal Clinical Practice Guidelines. [13]
- Australian Government, Department of Health. Guidelines for the Treatment of Alcohol Problems. [14]
- NSW Health. Clinical Guidelines for the Management of Substance Use During Pregnancy, Birth and the Postnatal Period. [15]

# Chapter 2: Pathways

"Support me in my withdrawal, **and help me move forward"**

The model of AOD withdrawal management pathways within HSPs are presented in this chapter on pages 20-22 and outlined in Table 2.

**Table 1: Outline of AOD Withdrawal Management Pathways**

| | **Withdrawal Management** |
|---|---|
| Patient presenting to the Emergency Department (ED) in acute withdrawal | Path 2.1 |
| Patient at risk of unplanned withdrawal during hospital admission for another cause | Path 2.2 |
| AOD Consultation Liaison care and referral | Path 3 |

*Note:* Early intervention pathways (Path 1) feature in the *AOD Early Intervention Practice and Pathways* document.

Path 2.1 outlines the actions, decisions and considerations (collectively termed 'activities') of HSP clinicians in managing **patients presenting in acute withdrawal** to the ED, including the withdrawal management care provided by the inpatient treating team where the patient is admitted for another cause.

Path 2.2 outlines the activities of HSP clinicians in managing **patients at risk of unplanned withdrawal during their hospital admission for another cause**. This involves: (i) identifying patients at risk of withdrawal in the outpatient setting who will be electively admitted for another cause, and (ii) providing withdrawal management care by the inpatient treating team for these patients during admission.

Path 2.1 and 2.2 involve a referral to AOD Clinicians. The subsequent care and referral pathway used by AOD Clinicians is outlined in Path 3.

Additionally, the *AOD Early Intervention Practice and Pathways* guides referral to community-based alcohol and other drug services (including withdrawal management services) further to screening and brief intervention.

**Supporting family members and significant others…**

All pathways acknowledge the importance of supporting the family members and/or significant others of people who use alcohol and other drugs by including reference to the Parent and Family Information and Support Pack**.**

The pack provides comprehensive information and help designed specifically for family members and significant others of people who use alcohol and other drugs. It also includes the **Parent and Family Drug Support Line**, which provides 24-hr confidential, anonymous, professional and peer support. Phone: 9442 5050; Country Toll Free: 1800 653 203.

An overview of AOD withdrawal management services in WA is provided in the next section to support referral activities identified in the withdrawal management pathways.

## 2.1 AOD withdrawal management services in WA

In WA, AOD withdrawal management services are classified into low, high and complex medical withdrawal services with the following definitions[16]:

| Definitions | |
|---|---|
| | **Low medical withdrawal services:** The average length of stay is five to seven days and is most appropriate when symptoms are likely to be low to moderate. This type of service provides supervised alcohol and other drug withdrawal programs from a psychoactive drug of dependence. Where appropriate, low medical withdrawal services can also be provided in the home by registered nurses and General Practitioners (GPs). |
| | **High medical withdrawal services:** Inpatient services that provide medically supervised alcohol and other drug withdrawal and are staffed 24-hours a day by a combination of specialist alcohol and other drug doctors, GPs, nurses and allied health workers. Generally, withdrawal takes place over a short-term inpatient admission period (e.g. seven days). High medical inpatient withdrawal is for clients with withdrawal symptoms that are moderate to severe. |
| | **Complex medical withdrawal services:** Complex medical inpatient withdrawal is similar in all aspects to the high medical withdrawal service, except it provides a greater level of service with regard to co-existing complex medical issues, mental health issues, and those with a history of complicated withdrawals. |

Appendix 2 provides a snapshot of community-based low and high medical withdrawal management services in WA[i]. At present, there are no community-based services providing complex medical withdrawal care for acute withdrawal and this gap is being filled *ad hoc* by general hospital and mental health wards.

Further information on community-based providers of medical withdrawal management services can be sourced from a number of online directories, including:

http://greenbook.org.au/

Provided by WANADA

https://mappa.org.au/

Provided by Aboriginal Health Council WA

https://wa.communityhealthpathways.org/

Provided by WAPHA

https://myservices.org.au/

Provided by Mental Health Commission

Additionally, referral support and advice is available through the Alcohol and other Drug Support Line (ADSL), which is a 24-hour, confidential telephone service for anyone concerned about their own or another person's alcohol or other drug use.

**Phone: 9442 5000; Country Toll Free: 1800 198 024.**

[i] Does not include private withdrawal management services.

The *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025, Update 2018 (Plan Update 2018)* is the Mental Health Commission's key planning tool for the mental health, alcohol and other drug sector. The Plan Update 2018 guides the Commission in its activities of providing and purchasing AOD treatment services and programs for the State.

Table 2 is an extract of AOD community based and hospital-based withdrawal management beds described in the Plan Update 2018 Matrix. It indicates the significant transformation and ongoing investment required to meet the optimal levels of AOD withdrawal management beds.

**Table 2: Extract of AOD withdrawal management beds from the Plan Update 2018 Matrix**

| | | Community Based Services | Hospital Based Services |
|---|---|---|---|
| | | **AOD Low Medical Withdrawal beds** | **AOD High/Complex Medical Withdrawal beds, incl private** |
| **State Total** | 2017 Actual | 27 | 39 *(refer to clarification below*)* |
| | 2020 Optimal | 32 | 96 |
| | 2025 Optimal | 46 | 103 |
| **State-wide Services** | 2017 Actual | - | 22 |
| | 2020 Optimal | - | 22 |
| | 2025 Optimal | - | 22 |
| **Metropolitan*** | 2017 Actual | 23 | 17 |
| | 2020 Optimal | 25 | 55 |
| | 2025 Optimal | 34 | 61 |
| **Regional**** | 2017 Actual | 4 | - |
| | 2020 Optimal | 7 | 18 |
| | 2025 Optimal | 11 | 20 |

Extracted from: *Mental Health Commission 2019. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (Plan) Update 2018, Mental Health Commission, Government of Western Australia.*
*Comprising East Metropolitan, North Metropolitan and South Metropolitan areas.
**Comprising of the Northern and Remote (Goldfields, Kimberley, Pilbara and Midwest), and Southern Country (Great Southern, South West and Wheatbelt)
Notes: Some total columns may not add, due to rounding; Beds determined as an actual count of beds where possible (via master bed list maintained by the Commission).

As outlined in Table 2, the current (2017) levels of AOD withdrawal management beds are:

- *Community Bed-Based Services*: AOD low medical withdrawal – A state total of 27 beds comprised of 23 beds in metropolitan areas and 4 beds in regional areas.
- *Hospital Based Services*: AOD high/complex medical withdrawal (including private) – A state total of 39 beds comprised of 22 state-wide dedicated withdrawal beds in private hospitals, and 17 public metropolitan beds provided by the Next Step Inpatient Withdrawal Unit.
  **Note: these 17 public metropolitan withdrawal beds do not have capacity to manage patients experiencing AOD withdrawal in addition to co-occurring mental or physical health issues and therefore the number of beds that more accurately reflects this complexity of care is zero beds in Western Australia.*

## Path 2.1 - Emergency Department (ED) Presentations *+/- Emergency Admission*

# Alcohol and Other Drug (AOD) Withdrawal Management

**Patient exclusion criteria** to this pathway:
- Medically unstable
- Acute intoxication
- Altered conscious state

These pts should follow established care pathways, and be assessed for AOD issues once medically stable.

Note: Where a patient presents in acute withdrawal within the outpatient setting, established care pathways (e.g. ED referral) should be followed, and the following withdrawal management pathway (Path 2.1) activated.

**Clinician** = Nurse, Doctor or Allied Health professional who first assesses the pt in ED

**Triage Nurse**: Assess and triage the patient (pt) as per Australasian Triage Scale (ATS)

Start here: Patient (pt) arrives at ED

Quick Screen*: Is the pt at risk of AOD issues?
- Yes → Is the pt presently in withdrawal?
  - Yes → **Clinician**: Conduct mental and physical assessment, and commence appropriate withdrawal management protocol, liaise with AOD CL
  - No → **Clinician:** Will the pt be admitted for another cause (not withdrawal)?
    - No → Manage as per usual care
    - Yes → **Clinician:** Is the pt at risk of withdrawal as an inpatient?
      - Recent, regular substance use
      - No → Manage as per usual care
      - Yes → Within 24hrs of admission:
        - **Inpatient Treating Team:** Liaise with AOD CL for in-hospital specialist AOD support and liaison with GP and community-based AOD services as part of discharge planning, including post-withdrawal care
        - AND
        - **Inpatient Treating Team:** Anticipate/assess and manage withdrawal according to relevant withdrawal management protocol
          - Withdrawal management advice after hours: Contact the Drug and Alcohol Clinical Advisory Service**
- No → Reinforce abstinence and manage as per usual care

**Clinician**: Is there evidence of an acute mental health concern?
- Yes → **Clinician:** Refer for mental health assessment when medically stable → **Psychiatric Team:** Once admitted engage in remainder of withdrawal management pathway as part of mental health care
  - acute psychosis, or
  - concern of acute suicidal risk/deliberate self-harm risk, or
  - other acute mental health concern
- No → Does the pt require admission for another cause (not withdrawal)?
  - Yes → In-hospital withdrawal management for **up to 48hrs**:
    - **Clinician:** Admit to appropriate inpatient or short-stay ward
    - **Inpatient Treating Team:** Assess and manage withdrawal according to relevant withdrawal management protocol
      - Withdrawal management advice after hours: Contact the Drug and Alcohol Clinical Advisory Service**
    - → Pt admitted to ***community-based withdrawal management service or community supported AOD management plan
  - No → Does the pt require admission for withdrawal management?
    - No → **Treating ED Doctor:** Consider short-term supply of medication for symptom-control, and ongoing support with GP / referral to Community Alcohol and Drug Services, as required
    - Yes → **Clinician:** Liaise with AOD CL to activate admission pathway to community-based high/complex medical withdrawal management service based on admission criteria
      - *For patients who are medically or psychiatrically unsuitable for transfer:* → In-hospital withdrawal management for **up to 48hrs** (see above)
      - → Pt admitted to ***community-based withdrawal management service or community supported AOD management plan

Not admitted → moderate to severe symptoms or complex medical or psychosocial needs preventing management in the community

**For the pt's family/ significant others seeking support:** Provide the *Parent & Family Information & Support Pack* (Includes: *Parent & Family Drug Support Line*)


**See AOD Early Intervention Practice and Pathways for information on quick screening.*
***In addition to withdrawal management advice, the Drug and Alcohol Clinical Advisory Service provides clinicians with specialist advice on the medical management of people using drugs and alcohol.*
**** See appendix 2 for community-based withdrawal management service*

**Path 2.2a** - Outpatient Clinic Appointment
*+/- Elective Admission*

# Alcohol and Other Drug (AOD) Withdrawal Management

**Patient (pt) exclusion criteria** to this pathway:

- Medically unstable
- Altered conscious state
- Acute intoxication
- Acute withdrawal

These pts should follow established care pathways (e.g. ED referral), and be assessed for AOD issues once medically stable.

Note: Where a patient presents in acute withdrawal within the outpatient setting, established care pathways (e.g. ED referral) should be followed, and Path 2.1 activated.

**Clinician** = Clinic Nurse, Doctor or Allied Health professional

During outpatient (OP) clinic appointment:

Start here: **Patient (pt) attends clinic appt**

**Clinician:** Will the pt be electively admitted for another cause (not withdrawal) related to this OP appt?

- No → Manage as per usual care
- Yes →

**Clinician:** Is the pt at risk of withdrawal as an inpatient?

- Recent, regular substance use
- No → Manage as per usual care
- Yes →

**Clinician:** Plan and discuss inpatient withdrawal management plan with pt

- Seek withdrawal management advice from AOD CL if required

**For the pt's family/ significant others seeking support:** Provide the *Parent & Family Information & Support Pack* (Includes: *Parent & Family Drug Support Line*)


**Clinician:** Discuss inpatient withdrawal management plan with admitting team and AOD CL

Within 24hrs of admission:

**Inpatient Treating Team:** Liaise with AOD CL for in-hospital specialist AOD support and liaison with community-based AOD services as part of discharge planning, including post-withdrawal care

AND

**Inpatient Treating Team:** Anticipate/assess and manage withdrawal according to relevant withdrawal management protocol

Where assessment of withdrawal risk is <u>not</u> conducted prior to admission (including elective admission from private specialist rooms), the inpatient treating team has the opportunity to assess the patient's risk of withdrawal during the patient's inpatient stay. It is recommended that assessment and management of withdrawal risk is conducted early in the patient's inpatient stay, as appropriate.

**In addition to withdrawal management advice, the Drug and Alcohol Clinical Advisory Service provides clinicians with specialist advice on the medical management of people using drugs and alcohol.*

## Path 3 – AOD Consultation Liaison (CL) Care and Referral Pathway

**Start here:**

**Early Intervention Pathways**

**Medium Risk** | **High Risk**

**Withdrawal Management Pathways**

*Referral/liaison with AOD CL*

**AOD CL Staff:** Conducts comprehensive assessment with the pt and provides intervention

**Will the pt be admitted?**

**Yes**

AOD CL Staff: Consults and liaises with inpatient team on AOD care plan based on assessment findings and patient consent:

**AOD CL Staff:**
Refer pt for additional hospital-based support services as required – all support services where the pt will not be admitted (see Activity 14) AND:

Pain Medicine for advice on pain management as an inpatient and post-discharge.

**AOD CL Staff:** Liaise with Inpatient Treating Team to anticipate and manage withdrawal risk as an inpatient, e.g. via notes in pt's file

*Should withdrawal symptoms arise:* **Inpatient Treating Team** manages withdrawal, with AOD CL support as required

Withdrawal management after hours: Contact the Drug and Alcohol Clinical Advisory Service*

**AOD CL Staff:** Liaise with Inpatient Treating Team, and other inpatient support teams to plan discharge

**AOD CL Staff:** Refer pt to community-based services:

**No**

For pregnant women: Referral to WANDAS

**AOD CL Staff:** Activates relevant referral pathway/s based on assessment findings and patient consent:

**AOD CL staff and treating team:**
Refer pt for additional hospital-based support services as required

For pts with a co-occurring psychiatric condition: Psychiatry/Mental Health care and liaison.

Pharmacy for shared verification of opioid substitution treatment and liaison.

Social Work for domestic violence issues, child protection issues, homelessness and centrelink issues.

For Aboriginal pts: Aboriginal Liaison for additional pt support, and liaison with Aboriginal support services.

*Liaise with dietetics, occupational therapy and physiotherapy, as required.*

***Interventions to reduce harm^:***

- Sobering up shelters
- Needle and syringe programs (including exchange programs)
- Overdose prevention (including Naloxone provision)
- Drop-in services
- Peer support
- Family support

***Interventions to screen, assess and coordinate^:***

- Screening and brief intervention
- Assessment
- Consultation liaison
- Case management and care coordination

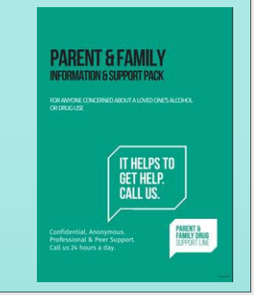
***Intensive interventions^:***

- Withdrawal management (non-residential and residential)
- Psycho-social counselling (delivered individually (one-on-one), in groups, and may involve family members or delivered to family members alone)
- Supported self referral to rehabilitation (delivered on a non-residential basis (e.g. day programs), in a residential setting, or in a therapeutic community)
- Pharmacotherapy

*Other wrap-around services and support eg AMS, family support, GP, community services such as RUAH*

*^Description of interventions based on the National Framework for Alcohol, Tobacco and other Drug Treatment (2019-2029)*

**For the pt's family/ significant others seeking support:** Provide the *Parent & Family Information & Support Pack* (Includes: *Parent & Family Drug Support Line*)




**In addition to withdrawal management advice, the Drug and Alcohol Clinical Advisory Service provides clinicians with specialist advice on the medical management of people using drugs and alcohol.*

## Chapter 3: Moving forward

This model of AOD withdrawal management practice and pathways provides guidance for HSP clinicians to: (i) provide safe withdrawal management services using evidence-based practice to patients who either present in a withdrawal state or undergo unplanned withdrawal while in our care, and (ii) support their patients on pathways to AOD withdrawal management and post-withdrawal care.

Each HSP is at a different stage in applying AOD withdrawal management practice and pathways. Therefore, implementing this model should take into consideration:

- Existing operational documents, initiatives and programs that support the principles of AOD withdrawal management, and how elements of the model can complement or add value to them.
- Current organisational and staffing culture and attitudes towards AOD use, and people who use alcohol and other drugs.
- Benefits of taking a phased approach to applying the model to practice (e.g. training and education to support withdrawal management practice and pathways in ED and other high areas who see a high number of inpatients at risk of developing withdrawal during their admission).

It is acknowledged that implementing certain elements of this model is prevented or challenged by a number of key gaps and issues. Examples of key gaps and issues related to the model of AOD withdrawal management practice and pathways include:

- Attitudes and underlying beliefs held by HSP clinicians regarding AOD use and people who use alcohol and other drugs.
- Capacity constraints of AOD treatment services (internal access to AOD Clinicians, and external access to community-based AOD services or to clinical support provided by the Clinical Advisory Service) and significant shortfall below optimal bed numbers.
- The majority of country hospitals and health services in WACHS, and some metropolitan public hospitals, do not have access to AOD Clinicians.
- Where there are existing AOD Clinicians, staffing levels in the majority of these hospitals and health services do not support out-of-hours service provision and funding is non-recurrent.

Through the Project's stakeholder engagement process, strategies to address identified key gaps and issues have been explored and put forward through the *Walk With Me Project: Recommendations Report.*

# Appendix 1: Withdrawal Scales

## Appendix 1.1 Clinical Institute Withdrawal Assessment of Alcohol Scale – Revised (CIWA-Ar)

**NAUSEA AND VOMITING**
**Ask "Do you feel sick to your stomach? Have you vomited?" Observation.**

0 No nausea and no vomiting
1 Mild nausea with no vomiting
2
3
4 Intermittent nausea with dry heaves
5
6
7 Constant nausea, frequent dry heaves and vomiting

**TREMOR**
**Arms extended and fingers spread apart. Observation.**

0 No tremor
1 Not visible, but can be felt fingertip to fingertip
2
3
4 Moderate, with patient's arms extended
5
6
7 Severe, even with arms not extended

**PAROXYSMAL SWEATS**
**Observation.**

0 No sweat visible
1 Barely perceptible sweating, palms moist
2
3
4 Beads of sweat obvious on forehead
5
6
7 Drenching sweats

**ANXIETY**
**Ask "Do you feel nervous?" Observation.**

0 No anxiety, at ease
1 Mild anxious
2
3
4 Moderately anxious, or guarded, so anxiety is inferred
5
6
7 Equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

**AGITATION**
**Observation.**

0 Normal activity
1 Somewhat more than normal activity
2
3
4 Moderately fidgety and restless
5
6
7 Paces back and forth during most of the interview, or constantly thrashes about

**TACTILE DISTURBANCES**
**Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.**

0 None
1 Very mild itching, pins and needles, burning or numbness
2 Mild itching, pins and needles, burning ornumbness
3 Moderate itching, pins and needles, burning ornumbness
4 Moderately severe hallucinations
5 Severe hallucinations
6 Extremely severe hallucinations
7 Continuous hallucinations

**AUDITORY DISTURBANCES**
**Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.**

0 Not present
1 Very mild harshness or ability to frighten
2 Mild harshness or ability tofrighten
3 Moderate harshness or ability to frighten
4 Moderately severe hallucinations
5 Severe hallucinations
6 Extremely severe hallucinations
7 Continuous hallucinations

**VISUAL DISTURBANCES**
**Ask "Does the light appear to be too bright? Is its colour different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.**

0 Not present
1 Very mild sensitivity
2 Mild sensitivity
3 Moderate sensitivity
4 Moderately severe hallucinations
5 Severe hallucinations
6 Extremely severe hallucinations
7 Continuous hallucinations

**HEADACHE, FULLNESS IN HEAD**
**Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.**

0 Not present
1 Very mild
2 Mild
3 Moderate
4 Moderately severe
5 Severe
6 Very severe
7 Extremely severe

**ORIENTATION AND CLOUDING OF SENSORIUM**
**Ask "What day is this? Where are you? Who am I?"**

0 Oriented and can do serial additions
1 Cannot do serial additions or is uncertain about date
2 Disoriented for date by no more than 2 calendar days
3 Disoriented for date by more than 2 calendar days
4 Disoriented for place/or person

Withdrawal scales were developed to assist the monitoring and management of withdrawal symptoms. It is important to note that withdrawal scales are not diagnostic tools.

Interpretation of scores. The maximum score is 67. Patients scoring less than 10 do not usually need additional medication for withdrawal.

**Total CIWA-Ar Score:**

Source: Sulivan JT, Sykora K, Schneiderman J, Naranjo CA, Sellers EM. Assessment of alcohol withdrawal: The Revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-Ar). British Journal of Addiction to Alcohol and Other Drugs. 1989;84(11):1353-7. doi: 10.1111/j.1360-0443.1989.tb00737.x

## Appendix 1.2 Stimulant withdrawal scale

Stimulant withdrawal can be considered for drugs such as ecstasy, MDMA, speed, PMA, amphetamine, methamphetamine and cocaine.

| **In the last 12 hours have you felt…?** | 0 – None | 1 – Very Little | 2 – A Little | 3 – Quite A Lot | 4 – Very Much |
|---|---|---|---|---|---|
| Are you having cravings for Stimulants such as methamphetamine? | | | | | |
| Are you feeling sad? | | | | | |
| Have you lost Interest in things or no longer take pleasure in them? | | | | | |
| Are you feeling anxious? | | | | | |
| Do you feel as if your movements are slow? | | | | | |
| Do you feel agitated? | | | | | |
| Do you feel tired? | | | | | |
| Has your appetite increased or are you eating too much? | | | | | |
| Are you experiencing nausea or stomach cramps? | | | | | |
| Have you had any vivid or unpleasant dreams? | | | | | |
| Are you craving for sleep or sleeping too much? | | | | | |
| Are you experiencing any hallucinations (auditory, visual or tactile)? | | | | | |

| **TOTAL SCORE** | **Symptoms** |
|---|---|
| 1-12 | Very Little - four consecutive scores consider ceasing scale |
| 13-24 | A Little |
| 25-36 | Quite A Lot |
| 37-48 | Very Much |

**This Withdrawal Scale is not prescriptive.**

**A reduction in score will indicate that the withdrawal symptoms are being effectively managed.**

[j]**Medical team to prescribe medications in response to patient current symptoms.**

[j] The stimulant withdrawal scale is not validated for use in tertiary hospital settings.

## Appendix 1.3 Clinical Institute Withdrawal Assessment Scale – Benzodiazepines (CIWA-B)

### Objective physiological assessment

For each of the following items, please circle the number which best describes the severity of each symptom or sign.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1 | Observe behaviour for restlessness and agitation | 0 None, normal activity | 1 | 2 Restless | 3 | 4 Paces back and forth, unable to sit still |
| 2 | Ask patient to extend arms with fingers apart, observe tremor | 0 No tremor | 1 Not visible, can be felt in fingers | 2 Visible but mild | 3 Moderate, with arms extended | 4 Severe, with arms not extended |
| 3 | Observe for sweating, feel palms | 0 No sweating visible | 1 Barely perceptible sweating, palms moist | 2 Palms and forehead moist, reports armpit sweating | 3 Beads of sweat on forehead | 4 Severe drenching sweats |

### Patient self-report

For each of the following items, please circle the number which best describes how you feel.

| | | | | | | |
|---|---|---|---|---|---|---|
| 4 | Do you feel irritable? | 0 Not at all | 1 | 2 | 3 | 4 Very much so |
| 5 | Do you feel fatigued (tired)? | 0 Not at all | 1 | 2 | 3 | 4 Unable to function due to fatigue |
| 6 | Do you feel tense? | 0 Not at all | 1 | 2 | 3 | 4 Very much so |
| 7 | Do you have difficulties concentrating? | 0 No difficulty | 1 | 2 | 3 | 4 Unable to concentrate |
| 8 | Do you have any loss of appetite? | 0 No loss | 1 | 2 | 3 | 4 No appetite, unable to eat |
| 9 | Have you any numbness or burning in your face, hands or feet? | 0 No numbness | 1 | 2 | 3 | 4 Intense burning or numbness |
| 10 | Do you feel your heart racing (palpitations)? | 0 No disturbance | 1 | 2 | 3 | 4 Constant racing |
| 11 | Does your head feel full or achy? | 0 Not at all | 1 | 2 | 3 | 4 Severe headache |
| 12 | Do you feel muscle aches or stiffness? | 0 Not at all | 1 | 2 | 3 | 4 Severe stiffness or pain |
| 13 | Do you feel anxious, nervous or jittery? | 0 Not at all | 1 | 2 | 3 | 4 Very much so |
| 14 | Do you feel upset? | 0 Not at all | 1 | 2 | 3 | 4 Very much so |
| 15 | How restful was your sleep last night? | 0 Very restful | 1 | 2 | 3 | 4 Not at all |
| 16 | Do you feel weak? | 0 Not at all | 1 | 2 | 3 | 4 Very much so |
| 17 | Do you think you had enough sleep last night? | 0 Yes, very much so | 1 | 2 | 3 | 4 Not at all |
| 18 | Do you have any visual disturbances? (sensitivity to light, blurred vision) | 0 Not at all | 1 | 2 | 3 | 4 Very sensitivity to light, blurred vision |
| 19 | Are you fearful? | 0 Not at all | 1 | 2 | 3 | 4 Very much so |
| 20 | Have you been worrying about possible misfortunes lately? | 0 Not at all | 1 | 2 | 3 | 4 Very much so |

| | | |
|---|---|---|
| 21 | How many hours of sleep do you think you had last night? | |
| 22 | How many minutes do you think it took you to fall asleep last night? | |

| | |
|---|---|
| Total CIWA-B Score: | |

**Interpretation of scores: Sum of items 1-20**

1–20 = mild withdrawal
21–40 = moderate withdrawal
41–60 = severe withdrawal
61–80 = very severe withdrawal

Source: 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

## Appendix 1.4 Cannabis withdrawal scale[k]

This version of the CWS asks about symptoms experienced over the last 24 hours, and can be administered by an interviewer OR by self report. The following statements describe how you have felt over the last 24 hours. Please circle the number that most closely represents your personal experiences for each statement. For each statement, please rate its negative impact on normal daily activities on the same scale (0=Not at all to 10=Extremely), writing the number in the right hand column.

| | | Not at all | | | | | Moderately | | | | | Extremely | Negative impact on daily activity (0-10) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | The only thing I could think about was smoking some cannabis | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| 2 | I had a headache | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| 3 | I had no appetite | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| 4 | I felt nauseous (like vomiting) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| 5 | I felt nervous | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| 6 | I had some angry outbursts | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| 7 | I had mood swings | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| 8 | I felt depressed | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| 9 | I was easily irritated | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| 10 | I had been imagining being stoned | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| 11 | I felt restless | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| 12 | I woke up early | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| 13 | I had a stomach ache | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| 14 | I had nightmares and / or strange dreams | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| 15 | Life seemed like an uphill struggle | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| 16 | I woke up sweating at night | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| 17 | I had trouble getting to sleep at night | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| 18 | I felt physically tense | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| 19 | I had hot flashes | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |

**Scores**

Score by summing each items value to a maximum withdrawal score of 190 (you can derive two scores from the scale: one for withdrawal intensity and one for the negative impact of withdrawal – each separate score has a theoretical maximum of 190).

| Total CWS Score: | |
|---|---|

Source: Allsop DJ, Norberg MM, Copeland J, Fu S, Budney AJ. The Cannabis Withdrawal Scale development: patterns and predictors of cannabis withdrawal and distress. Drug Alcohol Dependence. 2011;119(1-2):123-9. doi: 10.1016/j.drugalcdep.2011.06.003 (Reprinted with permission from Elsevier, Licence number 2872801116106).

[k] Note: The cannabis withdrawal scale is not validated for use in tertiary hospital settings.

## Appendix 1.5 Clinical Opioid Withdrawal Scale

| Interval | 0 | 30 minutes | 2 hours | 4 hours |
|---|---|---|---|---|
| Time | | | | |
| | Score | Score | Score | Score |
| Resting heart rate (measure after lying or sitting for 1 minute):<br>[0] HR 80 or below [1] HR 81-100<br>[2] HR 101-120 [4] HR greater than 120 | | | | |
| Sweating (preceding 30 minutes and not related to room temp /activity):<br>[0] No report of chills or flushing<br>[1] Subjective report of chills or flushing<br>[2] Flushed or observable moistness on face<br>[3] Beads of sweat on brow or face<br>[4] Sweat streaming off face | | | | |
| Restlessness (observe during assessment):<br>[0] Able to sit still<br>[1] Reports difficulty sitting still, but is able to do so<br>[3] Frequent shifting or extraneous movements of legs/arms<br>[5] Unable to sit still for more than a few seconds | | | | |
| Pupil size:<br>[0] Pupils pinned or normal size for room light<br>[1] Pupils possibly larger than normal for room light<br>[2] Pupils moderately dilated<br>[5] Pupils so dilated that only the rim of the iris is visible | | | | |
| Bone or joint aches (not including existing joint pains):<br>[0] Not present<br>[1] Mild diffuse discomfort<br>[2] Patient reports severe diffuse aching of joints/muscles<br>[4] Patient is rubbing joints / muscles plus unable to sit still due to discomfort | | | | |
| Runny nose or tearing (not related to URTI or allergies):<br>[0] Not present<br>[1] Nasal stuffiness or unusually moist eyes<br>[2] Nose running or tearing<br>[4] Nose constantly running or tears streaming down cheeks | | | | |
| GI upset (over last 30 minutes):<br>[0] No GI symptoms<br>[1] Stomach cramps<br>[2] Nausea or loose stool<br>[3] Vomiting or diarrhea<br>[5] Multiple episodes of vomiting or diarrhoea | | | | |
| Tremor (observe outstretched hands):<br>[0] No tremor<br>[1] Tremor can be felt, but not observed<br>[2] Slight tremor observable<br>[4] Gross tremor or muscle twitching | | | | |
| Yawning (observe during assessment):<br>[0] No yawning<br>[1] Yawning once or twice during assessment<br>[2] Yawning three or more times during assessment<br>[4] Yawning several times/minute | | | | |
| Anxiety or irritability<br>[0] None<br>[1] Patient reports increasing irritability or anxiousness<br>[2] Patient obviously irritable or anxious<br>[4] Patient so irritable or anxious that participation in the assessment is difficult | | | | |
| Gooseflesh skin<br>[0] Skin is smooth<br>[3] Piloerection (goosebumps) of skin can be felt or hairs standing up on arms<br>[5] Prominent piloerection | | | | |
| Score interpretation:<br>5-12 = Mild<br>13-24 = Moderate<br>25-36 = Moderately severe<br>> 36 = Severe withdrawal | Total | | | | |
| | Initials | | | | |

Source: Wesson DR, Ling W. The Clinical Opiate Withdrawal Scale (COWS). Journal of Psychoactive Drugs. 2003;35(2):253-9. doi: 10.1080/02791072.2003.10400007

## Appendix 2: Community-based withdrawal management services in WA

| Service (Provider)* | | Treatment Setting | | |
|---|---|---|---|---|
| | | Home based | Non-residential (e.g. outpatient) | Residential |
| *Low medical withdrawal management services* | | | | |
| Bridge Program (The Salvation Army) | | | | ● |
| Drug and Alcohol Withdrawal Network (St John of God) | | ● | | |
| Drug and Alcohol Youth Service (DAYS) Outpatient Service (Mission Australia and Next Step) | | | ● | |
| DAYS Youth Withdrawal and Respite Service (Mission Australia and Next Step) | | | | ● |
| Fresh Start Recovery Programme (Fresh Start) | | | ● | |
| *Low medical withdrawal services - Kalgoorlie* (Goldfields Rehabilitation Service) | | | | ● |
| *Low medical withdrawal services - Roebourne* (Yaandina Community Services) | | | | ● |
| Nannup Therapeutic Community Service (Cyrenian House) | | | | |
| Serenity Withdrawal Unit (Cyrenian House) | | | | ● |
| Metropolitan CADS | North East Metro CADS (Holyoake and Next Step) | | ● | |
| | North Metro CADS (Cyrenian House and Next Step) | | ● | |
| | South East Metro CADS (Palmerston and Next Step) | | ● | |
| | South Metro CADS (Palmerston and Next Step) | | ● | |
| *High medical withdrawal management services (planned withdrawal services)* | | | | |
| Next Step Inpatient Withdrawal Unit | | | | ● |

*Does not include private withdrawal management services.

## Appendix 3: Evidence of Classification Scheme

Identification and assessment of evidence is best achieved through systematic reviews where all available evidence is assessed for its applicability to the clinical question being considered, reviewing the evidence for bias, and summarising the findings.

The type of evidence required is dependent on the question under consideration. Where efficacy of treatment interventions is the issue, as was the case in this literature review; randomised, controlled trials are most relevant.

The summarised evidence is then categorised based on its susceptibility to bias, which is often related to study design, or analysis of the findings e.g. selection bias (sample is not representative of the population) and confirmation bias (interpreting data to prove a predetermined assumption).

### NHMRC Levels of evidence

| Grade | Evidence Description | Recommendation |
|---|---|---|
| A | One or more level I studies with a low risk of bias or several level II studies with a low risk of bias. All studies consistent. Very large clinical impact. Population/s studied in body of evidence are the same as the target population for the guideline. Directly applicable to Australian healthcare context. | Excellent<br>Body of evidence can be trusted to guide practice.<br>Recommendation based on high quality evidence. Strongly recommended for implementation. |
| B | One or two level-II studies with a low risk of bias or a SR/several level III studies with a low risk of bias. Most studies consistent and inconsistency may be explained. Substantial clinical impact. Population/s studied in the body of evidence are similar to the target population for the guideline. Applicable to Australian healthcare context with few caveats. | Good<br>Body of evidence can be trusted to guide practice in most situations.<br>Recommendation based on good evidence. Strongly recommended for implementation. |
| C | One or two level III studies with a low risk of bias, or level I or II studies with a moderate risk of bias. Some inconsistency reflecting genuine uncertainty around clinical question. Moderate clinical impact. Population/s studied in body of evidence differ to target population for guideline, but it is clinically sensible to apply this evidence to target population. Probably applicable to Australian healthcare context with some caveats. | Satisfactory<br>Body of evidence provides some support for recommendation(s) but care should be taken in its application. Recommendation based on supportive evidence and a strong theoretical rationale.<br>Recommended for implementation. |

| | | |
|---|---|---|
| D | Evidence level 3 or 4, or Extrapolated evidence from studies rated as 2+, or Formal consensus. | Poor<br>Body of evidence is weak, and recommendation must be applied with caution. Recommendation based on limited, inconsistent or extrapolated evidence. Recommendation supported by expert opinion. Recommended for implementation. |
| D (GPP) | A good practice point (GPP) is a recommendation for best practice based on the experience of the Guideline Development Group. | GPP<br>Evidence limited or non-existent. Recommendation based on current expert opinion and trends in clinical practice. Recommended for implementation. |

# Appendix 4: Useful Resources for HSP Clinicians

**Policy/Procedure Guidelines:**

- Department of Health Alcohol and Other Drug Withdrawal Management Policy
- Three Walk With Me Project Partnerships, Pathways and Practices Documents
- HSP Alcohol and Other Drugs Management Policy
- Department of Health Guidelines to manage nicotine withdrawal and cessation support in nicotine dependent patients [17]

**WA Health AOD Plans:**

- Better Choices, Better Lives, Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 **Error! Bookmark not defined.**
- Western Australian Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025 [18]
- Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (Plan Update 2018) [19]

**Screening and Withdrawal Tools (see Project Documents 2&3):**

- ASSIST-Lite (Alcohol, Smoking and Substance Involvement Screening Tool) https://www.assistportal.com.au/#screening for electronic versions and education
- AUDIT-C and DAST-10 screening tools
- "At a glance" withdrawal management tables
- CIWA-Ar (Alcohol Withdrawal Chart)
- CIWA-B (Benzodiazepine Withdrawal Chart)
- COWS (Clinical Opiate Withdrawal Scale)

**Clinician Resources and Training:**

- Mental Health Professional Online Development Learning Portal - A Commonwealth platform which aims to support Australia's health workforce involved in delivering mental health and associated services
- Mental Health Commission AOD Training – Training Courses for health professionals eLearning Portal
- Smoking cessation training for health professionals – Access free training specifically for health professionals to support patients to be smoke free or quit
- **AOD Connect Project Echo** provided by RACGP to support GPs caring for patients with AOD issues, including case discussions

**Patient Resources:**

- Alcohol and Other Drug Support Line 9442 5000; Country Callers: 1800 198 024
- Parent and Family Support Line 9442 5050; Country Callers 1800 653 203
- 'Daybreak' app and program A self-directed online program with a supportive community, habit-change experiments and one-on-one chat with health coaches
- Quitline and Clinician Referral

**Service Mapping Tools:**

- **MAPPA** (AHCWA)
- **Green Book** (WANADA)
- **WA HealthPathways** (WAPHA)
- **My Services** (MHC)

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**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 |

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