Non-iatrogenic (Recreational) Substance Withdrawal Care Guideline

**Inclusion Criteria:** Intoxicated and/or history or concern for alcohol abuse and/or benzodiazepine withdrawal [occurs after using high doses (above 2-3x the upper limit of therapeutic dose) for at least 2 months] and/or currently under the influence of and/or history of non-iatrogenic (recreational) opioid use.

**Exclusion Criteria:** Intubated patients

If withdrawing from multiple sources:
- Alcohol withdrawal supersedes benzodiazepine and opioid withdrawals.
- Benzodiazepine withdrawal supersedes opioid withdrawal.
- If alcohol is also abused with benzodiazepine or opioids, use the alcohol care guideline;
- If benzodiazepine is abused with opioids use benzodiazepine care guideline;
- If alcohol, benzodiazepine, and opioids are all abused, use the alcohol care guideline.

**Alcohol Withdrawal**

Tool = CIWA-Ar

[Clinical Institute Withdrawal Assessment Alcohol Scale – Revised (Appendix A)]

Proceed to page 2

**Benzodiazepine Withdrawal**

Tool = CIWA-B

[Clinical Institute Withdrawal Assessment Scale – Benzodiazepines (Appendix B)]

Proceed to page 3

**Opioid Withdrawal**

Tool = COWS

[Clinical Opiate Withdrawal Scale (Appendix C)]

Proceed to page 4

Overall Care Guideline GRADE: B

Approved Evidence Based Medicine Committee 7-21-2021

Reassess the appropriateness of Care Guidelines as condition changes and 24 hrs after admission. This guideline is a tool to aid clinical decision making. It is not a standard of care. The physician should deviate from the guideline when clinical judgment so indicates.

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Non-Iatrogenic (Recreational) Substance Withdrawal Care Guideline

**Alcohol Withdrawal**

**Inclusion Criteria:** Intoxicated and/or history or concern for alcohol abuse

**Exclusion Criteria:** Intubated patients

**Recommendations/Considerations**

- About 12-25hrs into withdrawal, we often see alcoholic hallucinosis. Vitals are normal. Often patients see and hear things that are not there. They can also feel things crawling on them when there is nothing apparent on their skin. Their sensorium is not clouded.

- About 12-48hrs into withdrawal, we often see withdrawal seizures in this time period.

- About 5% of patients in alcohol withdrawal undergo DTs (delirium tremens) which is a potentially fatal state. DTs begin 48-96hrs into withdrawal and include hallucinations, delirium (not oriented to self/place/time/situation), high BP, high temp, agitation and diaphoresis. They hyperventilate which can trigger respiratory alkalosis and therefore decreased cerebral flow. DTs often occur in those who have a long history of drinking, history of withdrawal seizures, prior DTs, older patients.

- Primary service to contact psychiatry if agitated and/or unable to bring down CIWA-Ar score x 24 hours

**Inclusion Criteria:**
- Intoxicated and/or history or concern for alcohol abuse

**Exclusion Criteria:**
- Intubated patients

**Minor Symptoms [Start about 6 hours after last drink]**

- Insomnia
- Tremulousness
- Anxiety
- GI upset, decreased appetite
- Headache
- Diaphoresis
- Palpitations

**Interventions**

- Begin CIWA-Ar (Clinical Institute Withdrawal Assessment Alcohol Scale – Revised) every 4 hours
- Supportive treatment: IVF @ 2x maintenance for 24h then reassess & daily PO multi-vitamin (see order set).

**CIWA-Ar < 10**

- No medications
- Can use Clonidine for sleep

**CIWA-Ar 10-15**

- Give Lorazepam 0.02 mg/kg for < 50kg Q4H
- Give Lorazepam 1 mg IV for > 50kg Q4H

**CIWA-Ar 15+**

- Give Lorazepam 0.04 mg/kg for < 50kg Q2H
- Give Lorazepam 2 mg PO/IV > 50kg Q2H
- Evaluate for possible DTs
- Contact PICU for possible admit/transfer

**Interventions Continued**

- If no meds are given – monitor patient q 4 hrs with CIWA-Ar x 24hrs then q12hr x 72hr, then discontinue
- If medicated – reassess patient with CIWA-Ar within 1 hour
- Monitor patient every 4 hours with CIWA-Ar until score is 8-10 or below for 24hrs
- If scores remain low (10-24) after 24hrs, then taper lorazepam to 1mg Q4H PO/IV, then 1mg Q8H PO/IV then 0.5mg PO/IV Q8H then stop.
- One decrease every 24 hours.
- If less than 10 for 24 hrs, can switch to PO after initial 24 hours
- If patient is requiring 2 or more every 2 hour doses of lorazepam (scores >15), contact provider to assess effectiveness prior to administering 3rd dose

**Patient/Family Education**

- ‘Substance Abuse Withdrawal’ handout
- Can go home with taper but need to ensure patient/family educated and safe via teach-back

**Discharge Criteria**

- Safe to taper at home
- Has safe home with caregivers
- Scheduled F/U with PCP within 1 week of discharge +/- outpatient rehab
**Inclusion Criteria:** Benzodiazepine withdrawal occurs after using high doses (above 2-3x the upper limit of therapeutic dose) for at least 2 months.

**Exclusion Criteria:** Intubated patients. If also withdrawing from alcohol use the CIWA-Ar tool and alcohol withdrawal guidelines.

**Symptoms**
[Starts about 12 hours after last use]
- Tachycardia
- Agitation
- Anxiety
- Delirium
- Seizures
- Insomnia and nightmares
- Tremor and hyperreflexia
- Tinnitus
- Nausea, diarrhea, no appetite

**Interventions**
- **Treatment:** We use benzodiazepines to treat benzodiazepine withdrawal.
- **Supportive treatment:** IVF @ 2x maintenance for 24h then reassess & daily PO multi-vitamin (see order set).
- **Start CIWA-B** (Clinical Institute Withdrawal Assessment Scale – Benzodiazepines).
- **Repeat scale** every 4 hours.
- **Convert patient’s daily benzodiazepine intake** into equivalent dose of long-acting benzodiazepine, preferably diazepam.
- **Start diazepam at half the determined dose** (i.e. pt uses 80mg diazepam equivalent per day = 20mg QID so start with 10mg QID).
- **If patient is on other CNS depressants,** then use half diazepam dosing.
- **If patients level of consciousness is less than awake and alert,** hold dose, notify provider and reassess at next scheduled dose.
- **Taper diazepam dose by 10mg each day** until on 10mg QID then taper to TID, BID, QD, then discontinue.
- **If symptoms worsen,** stay at that same diazepam dose for 1-2 days then start taper again (do not increase dose).

**Recommendations/Considerations**
- Depends on which benzodiazepine they are using, how long they have been using for and if benzo is short-acting or long-acting.
- Withdrawal starts about 12hrs after last use.
- We do not use the scale to dose meds unlike other drug withdrawal states.
- Primary service to contact psychiatry if agitated and/or unable to bring down CIWA-B score x 24 hours.

**Patient/Family Education**
- ‘Substance Abuse Withdrawal’ handout
- Can go home with taper but need to ensure patient/family educated and safe via teach-back.

**Discharge Criteria**
- Safe to have benzodiazepine taper at home, with appropriate supervision by caregiver (taper as above in intervention box).
- Has safe home with caregivers.
- Scheduled follow up with PCP within 1 week of discharge +/- outpatient rehab.
**Non-Iatrogenic (Recreational) Substance Withdrawal Care Guideline**

**Opioid Withdrawal**

**Inclusion Criteria:** Currently under the influence of and/or history of non-iatrogenic (recreational) opioid use.

**Exclusion Criteria:** Intubated patients. If alcohol is also abused, use the alcohol care guideline; if benzodiazepine is abused with opioids use benzodiazepine care guideline; if alcohol, benzodiazepine and opioids are all abused, use the alcohol care guideline.

**Symptoms**

[start about 4 - 24 hours after last use depending on type of opioid]

- Tachycardia
- Dilated pupils
- Rhinorrhea
- Piloection
- Tremor
- GI upset – nausea, diarrhea
- Insomnia
- Muscle/Joint pain, whole body pain
- Anxiety/Irritability
- Chills

**Interventions**

- Supportive treatment: IVF @ 2x maintenance for 24h then reassess & daily PO multi-vitamin (see order set).
- Initiate COWS (Clinical Opiate Withdrawal Scale).
- Repeat COWS every 4 hours.

**Mild (5-12)**

- Symptomatic support
- Clonidine 0.1mg to 0.2mg PO q4h to help with insomnia, aches, rhinorrhea, temperature dysregulation
- Ibuprofen for body aches/pain
  - 10mg/kg PO q6h PRN Pain
  - 600mg PO q6h >50kg PRN Pain

**Moderate (13-24), Moderate Severe (25-36), & Severe (36+)**

- Use Mild criteria support
  AND
  - Loperamide for diarrhea
    - 0.1 mg/kg PO BID <20kg PRN
    - 2mg PO BID >20kg PRN
  - Hydroxyzine for anxiety
    - 0.5mg/kg PO q6h PRN (max 25mg)
  - Ondansetron for nausea
    - 0.1 mg/kg IV q8h <40kg PRN
    - 4 mg IV q8h >40 kg PRN
  - Melatonin for sleep
    - 1 mg PO at bedtime for >6y PRN

**Discharge Criteria**

- Stable off medications
- Has safe home with caregivers
- Scheduled follow up with PCP within 1 week of discharge +/- outpatient rehab

**Considerations**

- If patient agitated:
  - Call psychiatry to discuss medication
  - iSTEP consult
  - CCM trained staff, if available

**Recommendations/Considerations**

- Of note, many drug rehabs will NOT accept someone in acute withdrawal or someone on benzodiazepine or methadone. Another reason to avoid use except in severe cases.

**Patient/Family Education**

- ‘Substance Abuse Withdrawal’ handout
## CIWA-Ar

**Clinical Institute Withdrawal Assessment of Alcohol Scale - Revised**

### 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: Intermittent nausea with dry heaves
- 4:
- 5:
- 6: 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:
- 3:
- 4: Moderate itching, pins and needles, burning or numbness
- 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:
- 3:
- 4: Moderate harshness or ability to frighten
- 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:
- 3:
- 4: Moderate sensitivity
- 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?" **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:**

---


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### Patient self-report

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

<table>
<thead>
<tr>
<th>Item</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Do you feel irritable?</td>
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</tr>
<tr>
<td>5. Do you feel fatigued (tired)?</td>
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<tr>
<td>6. Do you feel tense?</td>
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<td>7. Do you have difficulties concentrating?</td>
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<tr>
<td>8. Do you have any loss of appetite?</td>
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<tr>
<td>9. Have you any numbness or burning in your face, hands or feet?</td>
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<tr>
<td>10. Do you feel your heart racing (palpitations)?</td>
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<tr>
<td>11. Does your head feel full or achy?</td>
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<tr>
<td>12. Do you feel muscle aches or stiffness?</td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>13. Do you feel anxious, nervous or jittery?</td>
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<tr>
<td>14. Do you feel upset?</td>
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<tr>
<td>15. How restful was your sleep last night?</td>
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<tr>
<td>16. Do you feel weak?</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>17. Do you think you had enough sleep last night?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>18. Do you have any visual disturbances? (sensitivity to light, blurred vision)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Are you fearful?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Have you been worrying about possible misfortunes lately?</td>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Objective physiological assessment**

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

<table>
<thead>
<tr>
<th>Item</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Observe behaviour for restlessness and agitation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Ask patient to extend arms with fingers apart, observe tremor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Observe for sweating, feel palms</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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

Withdrawal scales were developed to assist the monitoring and management of withdrawal.

To download more of this resource visit www.insight.qld.edu.au
APPENDIX 1
Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient’s signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

<table>
<thead>
<tr>
<th>Patient’s Name: ____________________________</th>
<th>Date and Time <strong><strong><strong>/</strong>__/</strong></strong>:________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for this assessment:__________________</td>
<td>------------------------------------------</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resting Pulse Rate: ______ beats/minute</th>
<th>GI Upset: over last 1/2 hour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measured after patient is sitting or lying for one minute</td>
<td>0 no GI symptoms</td>
</tr>
<tr>
<td>0 pulse rate 80 or below</td>
<td>1 stomach cramps</td>
</tr>
<tr>
<td>1 pulse rate 81-100</td>
<td>2 nausea or loose stool</td>
</tr>
<tr>
<td>2 pulse rate 101-120</td>
<td>3 vomiting or diarrhea</td>
</tr>
<tr>
<td>4 pulse rate greater than 120</td>
<td>5 multiple episodes of diarrhea or vomiting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sweating: over past 1/2 hour not accounted for by room temperature or patient activity.</th>
<th>Tremor: observation of outstretched hands</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 no report of chills or flushing</td>
<td>0 no tremor</td>
</tr>
<tr>
<td>1 subjective report of chills or flushing</td>
<td>1 tremor can be felt, but not observed</td>
</tr>
<tr>
<td>2 flushed or observable moistness on face</td>
<td>2 slight tremor observable</td>
</tr>
<tr>
<td>3 beads of sweat on brow or face</td>
<td>4 gross tremor or muscle twitching</td>
</tr>
<tr>
<td>4 sweat streaming off face</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Restlessness: Observation during assessment</th>
<th>Yawning: Observation during assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 able to sit still</td>
<td>0 no yawning</td>
</tr>
<tr>
<td>1 reports difficulty sitting still, but is able to do so</td>
<td>1 yawning once or twice during assessment</td>
</tr>
<tr>
<td>3 frequent shifting or extraneous movements of legs/arms</td>
<td>2 yawning three or more times during assessment</td>
</tr>
<tr>
<td>5 unable to sit still for more than a few seconds</td>
<td>4 yawning several times/minute</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pupil size</th>
<th>Anxiety or Irritability</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 pupils pinned or normal size for room light</td>
<td>0 none</td>
</tr>
<tr>
<td>1 pupils possibly larger than normal for room light</td>
<td>1 patient reports increasing irritability or anxiousness</td>
</tr>
<tr>
<td>2 pupils moderately dilated</td>
<td>2 patient obviously irritable or anxious</td>
</tr>
<tr>
<td>5 pupils so dilated that only the rim of the iris is visible</td>
<td>4 patient so irritable or anxious that participation in the assessment is difficult</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bone or Joint aches: If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored</th>
<th>Gooseflesh skin</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 not present</td>
<td>0 skin is smooth</td>
</tr>
<tr>
<td>1 mild diffuse discomfort</td>
<td>3 piloerrection of skin can be felt or hairs standing up on arms</td>
</tr>
<tr>
<td>2 patient reports severe diffuse aching of joints/muscles</td>
<td>5 prominent piloerrection</td>
</tr>
<tr>
<td>4 patient is rubbing joints or muscles and is unable to sit still because of discomfort</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Runny nose or tearing: Not accounted for by cold symptoms or allergies</th>
<th>Total Score _______</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 not present</td>
<td>The total score is the sum of all 11 items</td>
</tr>
<tr>
<td>1 nasal stuffiness or unusually moist eyes</td>
<td></td>
</tr>
<tr>
<td>2 nose running or tearing</td>
<td></td>
</tr>
<tr>
<td>4 nose constantly running or tears streaming down cheeks</td>
<td></td>
</tr>
</tbody>
</table>

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

This version may be copied and used clinically.

References

Non-Iatrogenic (Recreational Substance) Withdrawal Care Guideline


The specific chapter is Ch. 4 withdrawal management. It can be found at: https://www.ncbi.nlm.nih.gov/books/NBK310652/?report=reader