Addictions & Mental Health ontario

Ontario Provincial Standards for Withdrawal Management Services

2021 Standards Manual

Addictions & Mental Health Ontario

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Introduction

Withdrawal Management Services (WMS) in the province of Ontario are designated as Provincial Services. In our growing mobile society, it is not uncommon for our clients to be from other districts, regions or parts of the province and these clients are provided services within the resource capability of funded agencies.

The Ontario Withdrawal Management Standards set out core standards of professional and clinical practice to guide the operation of Withdrawal Management Services in the Province of Ontario.

History of the Ontario Provincial Standards for Withdrawal Management Services

The 2021 WMS Standards build on previous iterations of the WMS Standards. For this version, the Advisory Committee reviewed the literature available since 2013. This included academic and clinical studies both from Canada and internationally, as well as standards from other jurisdictions.

The following is a history of the development of the Standards:

| **1997** The original Standards were published in 1997 after a two-year development period and addressed Residential Withdrawal Management Services.

| **2001** The first review and revision was published in 2001 and for the first time addressed the Community Withdrawal Management Service category that had been developed by the Ministry of Health and Long-Term Care (MOHLTC).

| **2004** The second review and revision was published in 2004 and included all of the prior content and the incorporation of revisions. Revisions included the addition of the Medication Guidelines and Protocols and addressed Methadone Maintenance.

| **2008** The review and revision to the 2008 Standards were funded as a special project by the MOHLTC. There were significant changes to the definitions to describe all categories of non-residential withdrawal management that developed through innovations in the field. This included Community Withdrawal Management Service (CWMS); Day Withdrawal Management Service (DWMS) and Telephone Supported Withdrawal Management Service (TSWMS).

| **2014** Following consultations within the WMS sector, the 2014 Standards were created as an updated version of 2008 and included recommendations of the 2012 Chase Coroner's Inquest.

Ontario Provincial Standards for Withdrawal Management Services 2021

The approach to creating the guidelines was evidence-informed and highly collaborative. Research included a review of recent clinical and grey literature on withdrawal management and substance use treatment. In addition, a scan of withdrawal management guidelines and standards was conducted to identify existing best practice in other jurisdictions. Various drafts of the guidelines were shared with Advisory Committee members throughout the development process. The standards were also shared at the withdrawal management community of practice where many service providers participated in the process and helped shape these guidelines. Additionally, a draft was circulated among groups of expert reviewers from across the province. Their feedback was used to refine the final version of the guidelines.

In total, there are 13 guidelines in this iteration of the standards, each organized into three main sections. Together they reflect the individual's pathway into withdrawal management and on to the next stages of treatment and recovery. The manual is divided into the following sections:

1. **Preparing for and Accessing Withdrawal Management Services;**

2. **During Withdrawal Management; and**

3. **Preparing for Ongoing Recovery After Withdrawal Management.**

Each standard area includes an overarching statement of intent and suggested elements. The elements represent components of evidence-informed practice that providers are encouraged to use as part of their service delivery model. It is critical to note that while these guidelines create a framework for safe and effective service delivery throughout the province, they do not constitute comprehensive practice guidance and must not replace appropriate staff training, clinical supervision and broader organizational needs. While many of the evidence-informed practices captured here are already in place across the province, others will involve a process of ongoing implementation for withdrawal management services.

Goals and Objectives of the Standards

The standards create a framework for safe and effective service delivery throughout the province. They were reviewed with providers in order to determine their ability to guide existing practice and provide a framework for service improvement to clients.

The standards apply to withdrawal management services offered throughout the province. If an organization is unable to meet all of the standards, they are encouraged to work with their funder and Addictions and Mental Health Ontario to take the necessary steps to meet the Standards.

The primary goals of the standards:

- To help ensure quality and consistency of withdrawal management services across the province;

- To support funders and service providers by establishing recognized criteria for effective services and supports across the province, while respecting regional differences between health funders and the need for innovative services that respond to local requirements and situations; and

- To improve the information available to people about what they can expect when accessing withdrawal management services in the province as well as what is expected of them while they are using a service.

The Standards

The information in this section provides a high-level description of the principles that need to be applied by all members of the care team as they interact with and deliver services to individuals seeking withdrawal management services. People seeking withdrawal management services and supports come from diverse backgrounds and realities. Each individual is unique based on their different personal, health, and social and economic needs.

Given the lack of evidence to support guidelines that address the unique needs of vulnerable individuals and populations. It is recommended that the following fundamental principles of effective withdrawal management services should be applied to all clients. Entrenching these principles into the organizational culture of various withdrawal management services ensures that services are delivered in a safe, supportive environment that facilitates positive outcomes for individuals using the services. Research strongly indicates that the relation between the client and their care provider is key to achieving positive outcomes.

It is also important to note that effective treatment begins with an assessment of the client's needs, strengths and preferences in order to determine which service is likely to benefit the client most. The care plan should be reflective of the needs of the individual, supported by proper collaboration and coordination across the system of care, which includes connections into other services that ensure the client is supported upon their return to their community.

The following eight principles should guide a provider's Withdrawal Management Services:

1. **Ensure services reflect evidence-informed best practices**
   The importance of evidence-informed best practices has been identified as a critical component to successful substance use treatment services. Providers should ensure that all interventions and supports offered at programs are informed by the best available evidence about what works in withdrawal management.

2. **Provide client-centric care**
   Providers should ensure that services and supports are responsive to the particular circumstances and preferences of individuals in order to facilitate positive outcomes.

3. **Provide accessible care and supports**
   Providers should take an active approach in identifying barriers to care and reducing them where possible. Barriers might include, but are not limited to geography, transportation needs, childcare requirements, program hours of operation, waits for service, admission criteria, etc.

4. **Foster a culture of respect**
   Providers must treat all individuals seeking care with dignity and respect throughout all stages of

the withdrawal management process. Treat all clients, families and caregivers in a friendly, welcoming and caring manner, and engage individuals using a non-judgmental, supportive and empathic approach.

5. **Ensure a culturally safe environment**
   Providers should demonstrate respect for and build on the values, preferences, beliefs, culture and identity of the individual, their family, their caregivers and their community. Staff should be aware of the power imbalances at play during all stages of service delivery.

6. **Provide trauma informed services and supports**
   Providers should ensure that all policies, procedures and service components are designed with an understanding of trauma in mind and with the goal of creating a culture of non-violence, mutual learning, and collaboration. Priority is placed on the individual's safety, choice and control.

7. **Commit to providing services that are anti-stigma**
   Providers should challenge harmful misconceptions and stereotypes that marginalize people who use substances. All service providers should see the people who access their services as whole individuals.

8. **Encourage family, partner and friend involvement**
   With the permission of the individual, providers should include supportive family members, partners and friends. Involvement of an individual's social support network will ensure better outcomes throughout the withdrawal process and into post-withdrawal services and supports.

Section 1: Preparing for and Accessing Withdrawal Management Services

This group of guidelines focuses on reducing barriers to accessing withdrawal management services. In order to ensure people receive appropriate treatment, which may or may not include, withdrawal management care, services must be visible and accessible. For many people, the decision to seek help with their substance use represents an act of significant courage and a time-sensitive opportunity to make a change. Therefore, admission procedures should be as efficient as possible and completed with sensitivity, compassion and warmth.

The screening process should aim to gather only as much information as is needed to identify the next appropriate steps for the individual seeking service. It should be neither intrusive nor too onerous.

When an individual is required to wait to access withdrawal management services, it is important that service providers make appropriate connections for that person with the community-based supports that can meet their immediate needs and help to sustain their engagement with the recovery / wellness process.

In this section:

Standard Area 1: Intake

Intent

Intake includes pre-admission screening and admission. The individual seeking service participates in a pre-admission screening to determine the least intensive and most appropriate withdrawal management program that can safely and effectively provide the resources that will meet their needs.

Suggested Elements

1.1 Program admission screening is carried out as part of a continuous assessment process and is done in a way that is sensitive and tailored to the individual's current state of emotional, mental, spiritual and physical wellbeing and capacity.

1.2 The individual understands their rights with respect to consent to service and the limits of confidentiality that apply to disclosure of personal information.

1.3 The purpose of screening is to gather the basic information that is necessary to make an appropriate referral to a withdrawal management service. This information includes:

- accurate identification of the individual;
- substance Use History: including recent substance use (e.g. substances, quantity, time and duration of last use), history of withdrawal syndromes related to substance(s) used, previous treatment experiences, implications for the withdrawal management approach of any polysubstance use;
- physical and mental health history;
- any recent completion of a screening and/or assessment process;
- current psychosocial support;
- behavioral addiction (gambling, gaming, etc.); and
- suitability for safe withdrawal in a minimally medical service (e.g. community-based, home/mobile withdrawal).

1.4 If the individual is able and willing, they are engaged in a brief conversation about the psychosocial factors that may affect their participation in a withdrawal management program.

1.5 If the individual has urgent medical and/or psychiatric needs, triaging these needs takes priority over the screening process for withdrawal management.

1.6 Where an individual has already participated in a screening and assessment process (i.e. with a family physician or trained addiction care provider), this information is accessed and used to make the most appropriate withdrawal management placement.

1.7 If the individual wishes to have a member of their family or social support network or a health care provider participate in the brief screening process, this is facilitated.

1.8 Wherever indicated an intake with the individual should be supplemented with the use of standardized scales (e.g. withdrawal scales, mental health scales, risk assessment screeners). More commonly used scales are available in the appendices.

Service Setting Considerations

Home / Mobile Withdrawal Management

Psychosocial factors to consider when screening someone for mobile withdrawal include:

- Does the individual have access to a safe and quiet "home" environment that is free from substance use?
- Does the individual have adequate social supports, including a trusted and reliable friend or family member who can provide support through the withdrawal process?
- If the individual has psychiatric symptoms, can these be managed safely in a community setting?
- What are the individual's withdrawal management and treatment goals? Is the individual prepared for the withdrawal process?

Standard Area 2: Pre-Admission Community Supports

Intent

When the individual is on a waiting list for withdrawal management support, they are connected to appropriate community supports and treatment resources or an alternative withdrawal management facility that can assist them with meeting immediate needs, preparing for addiction treatment and/or withdrawal, and establishing linkages that will be helpful after withdrawal.

Suggested Elements

2.1 The individual waiting to access withdrawal management support is connected to appropriate community mental health and/or addiction treatment services.

2.2 The individual is connected with appropriate psychosocial supports which may include, substance use counselor (if they do not already have one), housing, income support, and childcare.

2.3 The individual is connected with supports that will help them to maintain motivation, avoid high-risk activities and prepare for withdrawal management until withdrawal services can be accessed. This includes providing information and harm reduction education such as safe injecting/consumption supplies and take-home naloxone where accessible.

2.4 The withdrawal management service stays in touch with the individual during this time and contacts them as soon as a place is available.

2.5 Wherever possible, the withdrawal management service uses assertive follow-up and re-evaluates the treatment plan based on the individual's treatment goals and motivation, if the individual decides not to access the service or does not present when a space is available.

Section 2: During Withdrawal Management

Making the decision to participate in a withdrawal management program is a significant milestone. Individuals often have varying degrees of motivation and readiness to participate. Across program settings, service providers should do everything within their power to ensure the withdrawal experience meets each individual's needs and is as comfortable and safe as possible.

Although an individual's time in withdrawal management is relatively short, and the individual may be feeling quite unwell at the beginning of the process, withdrawal management nevertheless provides an opportunity for substance use professionals to engage a person in a longer-term wellness experience, which should include a holistic assessment of the individual's situation and developing a care plan that details the ongoing services and supports that the person will access after withdrawal.

Assessment is a continuous and cumulative process that creates an increasingly detailed and comprehensive picture of an individual's substance use and their needs, strengths, goals and preferences. Withdrawal management is not just a medical or physical process. Effective programs are aligned with the biopsychosocialspiritual model of care and provide supports that address the broader health, social, psychological, and spiritual issues underlying a person's substance use and/or resulting from it.

Withdrawal management exists within a continuum of substance use services and supports. It is an early step in a longer-term process. As such, it is important to start working with the individual on a personal plan as soon as they are ready in order to set goals and prepare for what will come after withdrawal management.

In this section:

Standard Area 3: Orientation

Intent

The individual participates in an orientation of the withdrawal management program and the withdrawal process.

Suggested Elements

To promote informed decisions by clients regarding their treatment, there will be a process for client orientation relevant to the client's level of impairment, and when appropriate, the involvement of family/significant others. Program staff members seek to enhance the individual's engagement with the program through the orientation process. The timing and pace of the orientation is adjusted according to the capacity of the individual to participate and to take in information.

3.1 The process for orientation for all withdrawal management services includes:

- A tour of the facility;
- Introduction to staff;
- Introduction to other clients, where applicable;
- Routines of care (e.g. process of delivery of service);
- A record that the client has been informed of the process for delivery of service;
- Relevant programs and services available; and
- A review of the program's rules and policies including:
    - The individual's Charter of Rights;
    - A record that the client has been informed of the Centre's/client's guidelines;
    - Visits and other forms of contact with family and friends;
    - Instances of when the individual might have to be referred to another service or hospital for withdrawal management care and/or transferred to hospital;
    - Reasons why the individual may be asked to leave the program; and
    - Consultation with a health care provider regarding evidence-based approaches to withdrawal management and treatment initiation and maintenance (targeted by substance(s) used).

The process for orientation for **Residential WMS** also includes:

- Handling and safekeeping of valuables;
- Policies and/or guidelines regarding visitation and passes; and

- Emergency/evacuation procedures.

3.2 Program staff members seek to enhance the individual's engagement with the program through the orientation process. The timing and pace of the orientation is adjusted according to the capacity of the individual to participate and to take in information.

3.3 If the individual wishes to have a supportive family member or other supportive person participate in the orientation, this is facilitated.

3.4 Program staff members engage the individual in a conversation about what to expect during the withdrawal process.

3.5 Information about client and family/significant other mutual expectations such as:

- Regulations regarding confidentiality;
- Explanation regarding the Circle of Care practices;
- Explanation on informed consent to service and for the disclosure of health records, the limitations of consent, such as mandatory reporting obligations, medical emergency, and instances where there is an imminent threat of harm to self or others;
- Ways in which personal choice is encouraged and supported;
- Opportunities to participate in care and treatment;
- Opportunities to participate in team conferences affecting their care;
- Ways in which issues or concerns related to the quality of care and treatment can be addressed;
- Complying with safety-related processes such as no smoking policies; and
- Complaints procedure.

A process to define mutual expectations for each WMS should be in place. Information about client and family/significant mutual expectations for **Community Day WMS** should also include:

- A service agreement between the client and the Service; and
- A service agreement between the in-home support provider(s) and the Service.

Standard Area 4: Intoxication and Withdrawal Management

Intent

The management of intoxication and withdrawal includes observation, ongoing assessments, support, documenting and crisis management. The frequency of observation and intensity of ongoing assessment is dependent upon the level of client impairment and scope of services and is tailored to their particular circumstances, needs, and preferences.

Suggested Elements

4.1 The Service develops a written protocol to address high-risk situations including:

- Individuals living with significant medical comorbidities which can impact withdrawal management (ex: cardiovascular disease, seizure disorder, traumatic brain injury);
- Individuals living with significant psychiatric symptoms or comorbidities which can impact withdrawal management (ex: psychosis, mania, suicidal ideation, self-harm);
- Individuals with a history of complicated withdrawal (ex: hallucinosis, delirium tremens, withdrawal seizure);
- Specific populations where there is increased risk or vulnerability (ex: youth, elderly, pregnancy);
- Other situations as identified from time to time such as fall risk assessment.

4.2 The assessment process is conducted in a way that is sensitive and appropriate to the individual's willingness and readiness to provide information. The process supports the development of a positive and mutually respectful relationship between the participant and program staff.

4.3 The assessment process is:

- Dynamic and ongoing;
- Aligned with the biopsychosocialspiritual model of care;
- Conducted collaboratively between the individual, program staff and, where appropriate, supportive family members and others;
- The person conducting the assessment utilizes trauma informed care practice approach throughout the assessment process; and
- Such informed care practice is culturally appropriate and seen through a lens that is conscious of sexual diversity.

4.4 Assessment is carried out with the individual's fully informed and ongoing consent. The individual understands the limits of confidentiality that apply to the disclosure of personal information.

4.5 The ongoing assessment process:

- Encourages and supports participants to identify their own strengths; and
- Engages participants in assessing the risks and benefits of their substance use and its effects on all areas of their lives.

4.6 If the individual seeking service wishes to have family or other external supports participate in the assessment process, this is facilitated.

4.7 As appropriate, and with the individual's consent, other health and social service professionals may be involved in the continuous assessment process in order to ensure that it is comprehensive.

4.8 The assessment includes determining the level of regular observation that is required to ensure the individual's safety and wellbeing.

4.9 Evidence-based assessment tools supported by the Province of Ontario are used to guide the service provider in conducting an assessment.

4.10 In line with the *Freedom of Information and Protection of Privacy Act* (FIPPA), relevant aspects of the assessment are shared with any other substance use or mental health service or program to which they are referred.

4.11 The service has clearly defined standards for documenting which will outline the format, content and frequency.

- The format, content and frequency are determined collaboratively between the service and any service they are accountable to for Residential WMS and the designate agency for Community, Day & Telephone and Teleconferencing WMS;
- A plan of care is developed collaboratively between service staff and the client, and when appropriate, in-home support provider(s) and/or the family/significant others, and other community workers currently providing care; and
- There is a process for review and revision of the individual plan of care. The process will include:
    - Reviewing the actual outcomes of care and treatment against the expected outcomes of the client and staff.

- Revising the plan of care in consultation with the client, based on the conclusions of the review.

Standard Area 5: Treatment Recovery / Wellness Planning

Intent

The individual begins the process by participating in creating a written personal treatment and recovery / wellness plan that clearly describes the addiction treatment supports and services they will receive that reflect their needs, preferences, strengths, culture and goals.

Suggested Elements

5.1 The assessment is ongoing and informs the development and revision of the treatment and recovery / wellness plan.

5.2 The personal treatment and recovery / wellness plan addresses supports and goals for withdrawal management, transition from the withdrawal management program to addiction treatment as well as ongoing, longer-term treatment and community supports.

5.3 Work on developing the personal treatment and recovery / wellness plan begins as soon as the individual feels ready to participate. The process is a collaborative one between the participant, program staff, supportive family members, and other relevant health care professionals. Care is taken to ensure that the individual understands and is engaged with the content of their recovery / wellness plan. If the individual wishes to have family or other external supports participate in the treatment and recovery / wellness planning process, this is facilitated.

5.4 With the individual's consent, their primary care provider is involved in the treatment and recovery / wellness planning process. Where an individual is not connected to a primary care provider, the withdrawal management service works to facilitate such a connection.

5.5 The treatment and recovery / wellness plan is a living document and evolves to reflect the individual's changing situation, preferences, and goals. The decisions made for withdrawal management and transition to ongoing services and supports are reviewed on an ongoing basis and are updated to reflect the participant's changing situation.

5.6 Where an individual already has a written plan from previous participation in substance use services and supports this may, with the agreement of the individual, be used to inform work on a new treatment and recovery / wellness plan or may be revised to reflect the individual's current situation and goals.

5.7 The process of developing the treatment and recovery / wellness plan includes educating the individual about the role of withdrawal management within the broader spectrum of substance use treatment options and services and setting appropriate expectations about the outcomes of withdrawal and the importance of ongoing treatment and supports.

5.8 As well as focusing on substance use, the treatment and recovery / wellness plan addresses the biopsychosocialspiritual domains covered by the continuous assessment process and incorporates the available supports detailed in Standard Area 7, as appropriate to the individual's needs, preferences, strengths, culture and goals.

5.9 The individual is offered a copy of the treatment and recovery / wellness plan upon leaving.

Standard Area 6: Retention

Intent

The program is committed to retaining the individual in the service and, in the event of an early exit, ensures that they are offered a written plan to ensure safety and ongoing care and a connection with an appropriate primary care providers and/or community-based services.

Suggested Elements

6.1 The program recognizes that individuals come to withdrawal management services with varying degrees of motivation and readiness to change, and staff members are prepared to work with each person where they are at.

6.2 The individual is reminded of the policies and rules that the program has and understands their responsibilities as a participant in the program.

6.3 Appropriate strategies are used to engage the individual with the program and to enhance their motivation to remain engaged with the program.

6.4 With the individual's permission, program staff members engage their family and social support network to provide encouragement to continue with the withdrawal management process.

6.5 Program staff members make every effort to engage with and support an individual who exhibits responsive behaviours that could affect their retention in the program or impact the safety of other staff and/or clients.

6.6 Staff members are provided with training on how to work effectively, respectfully and safely with individuals exhibiting responsive behaviours.

6.7 If the individual receiving service chooses to leave before completing the withdrawal management program or achieving their goals, or if the individual is asked to leave, this is managed in a sensitive and respectful way. Upon discharge:

- The agency should have policies with criteria for readmission. Service providers support the prompt readmission of any individual wishing to return to the program, if appropriate.

- The individual understands why they are being asked to leave and what needs to happen before they can be readmitted into the program. As appropriate, service providers support the readmission of the individual or facilitate their admission into an alternative program.
- The individual is offered a written plan to support their ongoing care. The individual is also offered active assistance to connect with their primary care provider and appropriate community-based services and agencies.
- The agency should document when an individual is asked to leave the service before completing the withdrawal process. The program reviews all such incidences regularly and, if necessary, reviews and adjusts its discharge policies to ensure that the program is working to retain people.
- The individual is offered harm reduction supplies and education as appropriate including take home naloxone for patients with an opioid use disorder and education about loss of tolerance upon discharge.

Standard Area 7: Provision of Biopsychosocialspirtual Supports

Intent

When the individual receiving service is ready, and in accordance with their treatment and recovery / wellness plan, the withdrawal management program provides or facilitates access to a range of treatment and recovery services and supports to enhance the individual's overall wellbeing.

Suggested Elements

7.1 The individual has access to a calm and comfortable physical environment such as sufficient personal/private space, access to outdoor space, access to natural light, etc.

7.2 Limited noise pollution the service endeavors to provide each participant with access to a primary care provider and nursing care as appropriate to their level of need.

7.3 The program provides encouragement and support for individuals to follow healthy sleep practices. Staff members recognize that participants may need to have more sleep early on in the withdrawal process.

7.4 The individual has access to healthy and appealing meals that meet their dietary needs and preferences. Nutrition and hydration education is offered on an as needed basis.

7.5 When the individual receiving service is required to refrain from using tobacco, they are provided with nicotine replacement therapy and other medications and supports for tobacco cessation as appropriate.

7.6 Program staff members are attentive to the physical comfort of the individual participant and provide, as necessary, a range of adjunctive supports to alleviate the physical symptoms of withdrawal.

7.7 The program offers supportive counselling aimed at helping the individual to deal with challenging feelings and thoughts. This includes support for dealing with cravings, easing anxiety/promoting relaxation, promoting mindfulness and being in the moment, and maintaining motivation.

7.8 The program provides educational sessions and/or presentations on a range of topics related to problematic substance use, including (but not limited to):

- Evidence-based pharmaceutical and psychosocial treatment intervention options for each substance used i.e. Rapid Access Addiction Medicine (RAAM);
- Public health;
- Harm reduction strategies;
- Community-based substance use resources and supports i.e residential treatment; and
- Peer support.

7.9 The program includes opportunities for the individual to develop and to enhance their interpersonal and life skills.

7.10 Programs endeavor to provide access to a range of evidence-based alternative therapies that have been shown to have beneficial impacts on an individual's physical, emotional and spiritual wellbeing. Such therapies may include massage therapy; art and music therapy; meditation and mind/body-based therapies; homeopathy; Chinese medicine; and auricular acupuncture (if possible).

7.11 Where possible participants have access to a range of exercise activities that promote general wellness and a healthy mind/body connection and that are suitable to their needs and capacity.

7.12 Participants have an opportunity to take part in a variety of recreational and social activities, including for example: arts and crafts; music; board games; reading groups; gardening; cooking; and fieldtrips if possible. Care is taken to ensure that the activities offered reflect the cultural diversity of the program participants.

7.13 Program staff members work with the individual to enhance their social connectedness and personal support network. This includes, with the consent of the individual, involving supportive family members and friends in the individual's recovery journey and providing them with information about how to support the individual effectively.

7.14 The service facilitates access to peer support programs such as peer-run self-help groups, peer mentoring and peer navigation and education.

7.15 The program offers or facilitates access to a range of spiritual activities and supports. These reflect the diversity of spiritual beliefs and practices among program participants.

Standard Area 8: Medication

Intent

All standards are intended to be the foundation upon which local policies and procedures are developed. They are not meant to replace the need for the creation of specific local service policies and procedures. This is meant to be a guide for local policy and procedure development, not replace it. Due to the complex nature of pharmacotherapy, policies and procedures will be, in part, dictated by regional and local factors such as human resources, proximity to medical and pharmaceutical services, physical layout of the facility, geographical area, policies and procedures of the sponsoring agency and fiscal resources.

The withdrawal management service needs to be evidence-based, and individual-centered, ensuring both psychological and pharmacological needs are being met. Withdrawal services should offer medication reviews, and allow physician-prescribed medications that are necessary for withdrawal management and supportive to the individual's health and wellbeing. Care should be individualized with individual needs considered i.e. youth, older adults, pregnancy, chronic health conditions and financial limitations, etc. All withdrawal management services need to be adaptive to allow for the development of updated policies and procedures as new medical therapies become available for substance use disorders.

Suggested Elements

8.1 All participants receive a comprehensive health assessment, involving physical examination, psychiatric history, current medications, and substance use history.

- As appropriate, a medication plan for the individual is followed and reviewed on an ongoing basis.
- All decisions taken as a result of medication reviews are recorded in the personal treatment and recovery plan.
- When gathering the substance use history the provider must be aware that substances may be laced with other contaminants without the knowledge of the individual (i.e. opiate and benzodiazepines, cannabis and amphetamines).

8.2 There will be policies and procedures in place related to the use of potentially addictive pain or psychoactive medications for the treatment of chronic pain or diagnosed mental health disorders, whether pre-existing or diagnosed while in the service.

- The policies and procedures will address risk assessment and consultation with the prescribing health provider regarding the indications, benefits and potential harms for continued use of these medications, while balancing the risks of a taper or abrupt cessation.

- The policies and procedures will address consultation with the prescribing health provider regarding an alternative medication when the prescribed medication is not indicated by current evidence-based treatment guidelines or when it is the drug of choice used by the individual. Consultation may include the use of evidence-based non-pharmacological treatments (e.g. mindfulness).

- Individuals who are on moderate, therapeutic doses of a prescribed opioid medication for chronic pain should be allowed to continue the same dose while in withdrawal management if the current dosing regimen is not causing harm.
    - In some cases, individuals on above moderate doses may at the clinician's discretion be allowed to continue the same dose, however, clinicians should review the risk of higher opioid doses with the individual, and review the potential to use OAT as an alternative. Clinicians should document their reasons for the continuation of moderate and above-moderate doses of opioids. Individuals on moderate and above-moderate doses of opioids for chronic pain should be provided with naloxone kits and instruction on how to administer.

- Individuals on moderate, therapeutic doses of benzodiazepine medications for sleep or anxiety should be allowed to continue the same dose while in withdrawal management, if the prescription is not causing harm.

- Individuals with suspected Benzodiazepine Use Disorder should be offered a medically supervised benzodiazepine taper, with the knowledge that the taper will need to be finalized during the outpatient phase of treatment over weeks or months.

8.3 There will be policies and procedures in place to address the time frame required between the last drink or ingestion of any other drug(s) used and resumption of the prescribed medication regime.

- Some medications may be contraindicated in conjunction with alcohol consumption or may interact with other medications/drugs taken prior to admission.
- As a general rule, medications should be held no longer than 12 hours after admission into a withdrawal management service or otherwise advised by health providers.

8.4 All withdrawal management services should have policies and procedures in place to assist individuals in active withdrawal that align with current evidence-based standards. Following an evidence-based withdrawal protocol or tapering schedule aims to improve individual tolerability and retention in the program.

The policies and procedures will reflect the need to work closely with the prescribing health providers in following an evidence-based patient-centered tapering regime. Recommended tapering regimes can be found in the appendices.

8.5 There will be policies and procedures to address the pharmacotherapeutic needs of patients experiencing withdrawal, cravings, and requiring agonist therapist.

- Opioid agonist therapy (OAT) is an important component of a comprehensive strategy to treat Opioid Use Disorder and the potential benefits needs to be discussed with every patient suffering from Opioid Use Disorder in withdrawal management services.

- After initiating OAT, the withdrawal management service must take steps to ensure continuity of treatment. The community prescriber should be informed about any changes to a patient's existing opioid prescription. Patients who discontinue OAT are at high risk of relapse and overdose death.

- Opioid antagonist therapy (naltrexone) should be discussed with those declining or not suitable for opioid agonist therapy.

- The policies and procedures will address the process for patients to obtain their daily methadone or buprenorphine while in withdrawal management services. Withdrawal management services should not undertake a rapid methadone or buprenorphine taper. Tapering should only be done by an experienced prescriber who knows the patient well and is able to follow the patient over many weeks or months.

- Buprenorphine and/or clonidine should be offered to treat opioid withdrawal, with the emphasis on buprenorphine having the best evidence and efficacy for withdrawal management.

- Anti-craving therapy, such as naltrexone and acamprosate, as well as disulfiram therapy are important components of a comprehensive strategy to treat Alcohol Use Disorder and the potential benefits needs to be discussed with every patient suffering from Alcohol Use Disorder in withdrawal management services.

- Benzodiazepines or gabapentin should be offered to treat alcohol withdrawal, with the agent of choice based on age, liver function and medical co-morbidities.

- Diazepam is preferred in supervised settings and in the absence of liver disease, significant medical co-morbidities and/or sedative medications. Lorazepam and gabapentin may be preferred in outpatient settings where the risk of diversion is higher, and in the presence of liver disease and significant medical co-morbidities.

8.6 There will be policies and procedures to address allowing the use of nicotine replacement therapy (NRT) and medical marijuana while in withdrawal management.

- Patients smoking tobacco who are in the action phase of change should be offered bupropion or varenicline if there is no contraindication to do so (history of psychosis or mania).

8.7 There will be policies and procedures to address the assessment of psychotic symptoms and the availability of antipsychotic treatment while in withdrawal management. It is important to recognize the increased incidence of Drug-Induced Psychotic Disorder, especially with the use of stimulant substances such as methamphetamine.

Standard Area 9: Continuous Program Improvement

Intent

The withdrawal management program is committed to ongoing evaluation and improvement in order to ensure that individuals receiving service are provided with effective, evidence-informed services and supports.

Suggested Elements

9.1 The program facilitates access to a range of evidence-based supports that are appropriate to the individual's needs, strengths, preferences and culture.

9.2 Participants are given formal and informal opportunities to provide feedback on program activities and supports.

9.3 There are opportunities for other service providers who link with the withdrawal management program to provide formal feedback.

9.4 Withdrawal management service providers participate with the Ministry of Health (MOH) in regular program and outcomes-based evaluations.

9.5 Evaluation data and feedback from all sources is used to help inform the program about how well it is doing and how it can improve.

Standard Area 10: Staff Qualifications and Experience

Intent

Appropriately trained and qualified staff deliver withdrawal management supports.

Suggested Elements

10.1 Members of staff and volunteers stay within the scope of the role for which they are adequately qualified. Individuals receiving service are welcome to ask about an employee's qualifications.

10.2 Required training that may include refresher education in the following areas at frequency recommended by the provider of the training[1]:

- Current CPR practices (including two-person CPR and the use of automated external defibrillators);
- Mental Health First Aid Training;
- Trauma-informed care delivery;
- Nonviolent Crisis Intervention (NVCI);
- Recognition of toxidromes/ overdose situations;
- Naloxone training;
- Risk assessments;
- Applied Suicide Intervention and Skills Training (ASIST) training; and
- Documenting principles.

10.3 Volunteers working at the program receive adequate and appropriate training, support and supervision for the work they are doing.

10.4 Each staff member receives the necessary supervision to ensure that they are meeting the standards for their role.

10.5 Staff roles and responsibilities are clearly outlined.

10.6 All medical staff have appropriate training, supervision and support in the area of addiction

[1] 2012 Chase Coroner's Recommendation #10 - 15

medicine.

10.7 The service has a professional development plan for ensuring training is completed annually or as required.

10.8 The service has written policies and procedures as it pertains to basic education, core competencies and professional development.

Section 3: Preparing for ongoing recovery after withdrawal management

Effective withdrawal management programs include a robust process of transition planning. Preparation for what will happen after the individual leaves the program should begin as soon as the individual feels ready to participate in the process.

Transition planning forms part of the personal treatment and recovery / wellness plan. It should be done thoroughly, and in full collaboration with the individual receiving service, the individual's circle of support, and appropriate allied health and social services. It is an opportunity to focus on the strengths that each individual has and the progress that they have made during withdrawal management.

The transition plan should pay attention to the individual's immediate and longer-term needs, preferences and goals in areas such as: ongoing care and treatment; access to social services; and strengthening personal and social supports. Relapse prevention, maintenance treatment and harm reduction should also form an integral component of this planning.

All individuals leaving withdrawal management should be actively and meaningfully supported. Successful transitions from withdrawal management rely on strong linkages and relationships between residential and community-based substance use services, and other health and social service agencies.

In this section:

Standard Area 11: Reducing Risks

Intent

The withdrawal program provides the individual with relapse prevention strategies and harm reduction education to lower the potential risks should relapse occur.

Suggested Elements

11.1 The withdrawal management program provides participants with the opportunity to learn about the risk of relapse after withdrawal and to develop strategies to prevent relapse.

11.2 Relapse prevention education includes information about Post-Acute Withdrawal Syndrome (PAWS), and support and interventions for managing PAWS symptoms.

11.3 The program provides participants with:

- Information about the elevated risk of overdose due to decreased tolerance following withdrawal;
- Specific advice, techniques and resources for reducing the harms from substance use; and
- Harm reduction supplies (on leaving the program).

Standard Area 12: Transition Planning

Intent

The individual receiving service participates in developing a plan for their stabilization and ongoing treatment and recovery / wellness journey following withdrawal management.

Suggested Elements

12.1 Work on the transition plan starts early in the withdrawal management process (i.e. as soon as the individual is able to participate actively in developing a longer-term treatment and recovery/ wellness plan).

12.2 Planning for and coordinating post-withdrawal care is a fundamental part of withdrawal management and is a collaborative process between the individual, program staff, other health professionals and service providers (as appropriate), and the individual's circle of support.

12.3 The transition plan reflects the individual's successes, preferences and ongoing goals, and addresses any concerns that they may have about the longer-term recovery process.

12.4 As appropriate, the plan includes provision for the individual to access support and ongoing treatment (see 11.6).

12.5 The transition planning process enhances the individual's understanding of the available ongoing services and supports that meet their needs and preferences.

12.6 The plan may deal with any or all of the following elements, as appropriate to each individual's situation:

- Ongoing substance use treatment and supports (residential and community-based);
- Connection to a primary care provider and/or addiction medicine specialist;
- Mental health services and supports;
- Other health and medical supports;
- Pharmacotherapy (including, as appropriate, Opioid Agonist Therapy, medications for alcohol use);
- Residential supportive housing;
- Psychosocial treatment interventions;
- Support for healthy diet and nutrition;
- Life skills;
- Stress management skills;

- Relapse prevention skills and education about Post-Acute Withdrawal Syndrome (PAWS);
- Harm reduction;
- Relationships with family;
- Personal and social supports (including community groups);
- Safety from violence and abuse, including intimate partner violence (IPV);
- Income support;
- Employment, education and/or vocational training;
- Housing;
- Legal services;
- Child protection services;
- Case management;
- Parenting skills;
- Spiritual and cultural practices and preferences; and
- Recreational interests (e.g. arts, sports, social activities).

12.7 When discussing the individual's options for ongoing treatment and supports, it may be necessary – and helpful – to advise them that even if their preferred option is unavailable, alternative programs or supports may still be beneficial.

12.8 The transition plan includes strategies for addressing any barriers to accessing ongoing services and supports, including for example: transportation; childcare housing needs; and/or safety issues.

12.9 The individual is offered a copy of their transition plan and with the individual's consent the plan is shared with the appropriate health and social services and supports.

Standard Area 13: Ongoing Treatment and Supports

Intent

The withdrawal management program links the individual with the ongoing substance use treatment and other health and social supports identified in their transition plan.

Suggested Elements

13.1 The withdrawal management program is to make every effort to ensure that the individual is successfully linked with the substance use service providers that they will work with after leaving the withdrawal service. Wherever possible, this involves facilitating face-to-face interaction between the individual and ongoing service providers while the individual is in the withdrawal program.

13.2 The withdrawal management program facilitates connections between participants and self-help and peer supports, as appropriate.

13.3 The withdrawal management program actively supports the individual to make contact with other health and social service agencies and community organizations (e.g. primary care, housing, childcare, employment services and support groups) as needed.

Additional Considerations for Vulnerable Populations

The contents of these standards are guidelines for general practice. Staff, practitioners, and WM service providers are encouraged to practice their own judgement, knowledge, and experience when working with patients, especially of vulnerable populations. Vulnerable populations might include, but are not limited to, pregnant people, elderly adults, individuals with multiple medical conditions, individuals involved with the criminal justice system, or youth (children or adolescents) populations.

The literature on treatment for problematic substance use for many of the vulnerable populations is limited, and there is a recognized need for more research on the challenges of treating these populations. This section provides some guidance with respect to specific considerations for supporting these populations through withdrawal. This guidance broadly aligns with the principles of the withdrawal management guidelines previously outlined but offers some more nuanced direction and advice for meeting the specific needs of these populations.

Individuals with Problematic Polysubstance Use

Problematic polysubstance use is associated with a higher incidence of concurrent mental health issues, more complicated and severe withdrawal experiences, and increased challenges for recovery in general. Because of the risk of complicated withdrawal severity (including changes in withdrawal onset and duration), the service provider should:

- Carefully consider, with the individual, an evidence-based treatment plan for withdrawal and/or linkages into maintenance/relapse prevention treatment for each different substance;
- Ensure that the individual is closely monitored during withdrawal. This may mean that inpatient withdrawal is the most appropriate option;
- Individuals should be made aware of the possible impacts that eliminating the use of one substance may have on their physical and psychological relationship with the other substance(s) that they are using. They should be provided with a range of coping skills and strategies to reduce the risk that their use of the other substance(s) will become more problematic; and
- Research suggests that smoking cessation reduces the risk of relapse for other substances. Therefore, smoking cessation supports should be offered to individuals in withdrawal management who use tobacco.

Pregnant People

Given the potential effects of substance use on fetal development, pregnancy may motivate people to start to change their substance use patterns. Pregnant people with problematic substance use often face additional stigma, including self-stigma, which may be a barrier to accessing prenatal care and/or substance use treatment.

Recommendations for withdrawal management for pregnant people include:

- Policies and procedures should be in place for priority admission and extended stays;
- Education about the impact of substance use on pregnancy and fetal development and the provision of necessary prenatal care;
- Staff must be informed about all possible complications associated with pregnancy and substance use and withdrawal and must be employ the appropriate evidence-based therapies for treatment during pregnancy;
- Linkages to supports including other health care providers, legal, nutritional and other social service needs. This includes supports that would help the individual prepare mentally, as well as practically, for being a parent; and
- With the person's consent, the withdrawal management service should support the involvement of the partner in the individual's substance use treatment and prenatal care.
    - If the partner is using substances, service providers should try to engage them in taking steps towards recovery.

Parents of Dependent Children

When a person who is seeking withdrawal management services is the parent of dependent children, concern about the care and safety of the child or children represents one of the most significant barriers to the person's participation in and completion of a program. In particular, fear of child apprehension may be a major barrier to seeking help.

- Providers should work with the individual to ensure that the children have a safe place to stay while their parent or caregiver is participating in withdrawal management;
- Parents may require support for dealing with this worry related to the wellbeing of their children during the withdrawal management process. Wherever possible, the care team should include linkages to parenting and childcare services in a parent's recovery plan; and
- Wherever possible, withdrawal management services should help parents of dependent children to access parenting education classes/support.

Survivors of Violence

The concurrent incidence of violence and problematic substance use is high. Recovery plans need to address both issues simultaneously. Trauma-informed care is particularly pertinent in this context.

- Staff must work with the individual to create a long-term safety plan and make referrals to appropriate services and supports. The plan must address access to safe accommodation and linkages to longer-term counselling supports. Parents who are survivors of violence may also require help securing supports such as childcare and family counselling; and

- It may be important for the individual to avoid communicating with their abuser while in withdrawal management.

People with Cognitive Disabilities

Individuals with cognitive disabilities face significant barriers to accessing withdrawal management and other substance use services. They are also more likely to have a negative experience with mainstream services. Past trauma and physical or sexual abuse increase the risk of problematic substance use for people with cognitive disabilities. It is crucial, therefore, that services take a trauma-informed approach and connect individuals with appropriate counselling/therapy as needed.

- The assessment process in withdrawal management should include an initial evaluation of an individual's cognitive functioning. If significant cognitive challenges are suspected, a more comprehensive assessment by a qualified professional should be arranged. It may also be appropriate to defer this assessment until the physical and psychological process of withdrawal is complete.

- Program staff should carefully consider whether group-based models of care are the most appropriate option for the individual with cognitive disabilities. When possible, one-on-one approaches may be more effective.

- Individuals with cognitive disabilities may need help with self-care, coping strategies, communication, learning, social skills, and planning and decision-making.

- Withdrawal management programs may need to work with an expert on cognitive disabilities to better understand the needs of an individual with cognitive disabilities, including which challenges derive from substance use and which are a result of the disability.

- Communication should be as simple and clear as possible. Information may need to be repeated several times. It is important to be sure that the service provider and the person receiving

service understand what each is saying to the other.

- Some individuals with cognitive disabilities may have difficulty with changes to patterns of thought and behaviour. The service provider should not mistake this for a denial of the substance use problem or a refusal to change. It may be necessary to try different approaches to engage the person with treatment.

- Individuals with cognitive disabilities will benefit from a more active approach to referral and follow-up to support their ongoing treatment engagement and/or connect with relevant community supports.

People with Physical or Sensory Disabilities

Individuals with physical and/or sensory disabilities face barriers of access to withdrawal management facilities, especially when these facilities are in older buildings that were not purpose built or have not been adapted to accommodate people with disabilities. There is some evidence to suggest that individuals with physical disabilities experience higher rates of co-occurring problematic substance use and post-traumatic stress disorder (PTSD). Therefore, it is particularly important to take a trauma-informed approach to withdrawal management and subsequent treatment and supports.

- Withdrawal management programs should be able to accommodate the particular communication needs of individuals with physical or sensory disabilities. Clear communication and understanding between program participant and staff is crucial for the delivery of effective care; and

- For some individuals, the best option might be the provision of appropriately supported home-based withdrawal management.

Lesbian, Gay, Bisexual, Two-Spirit, Transgender or Questioning and Others (LGB2STQ+) Individuals

LGB2STQ+ individuals entering treatment for problematic substance use may have greater mental and physical health needs. A recent study found that there is a significantly higher rate of co-occurring mental health issues among the LGB2STQ+ population than among the general population. Such findings suggest that additional screening, outreach, service provider training, and service delivery integration are needed to facilitate effective care. Withdrawal management services must become LGB2STQ+ responsive. This may include:

- Revising policies and procedures to be inclusive of LGB2STQ+ people;

- Having openly LGB2STQ+ individuals on staff and among volunteers;
- Ensuring that staff receive training on culturally appropriate care for LGB2STQ+ individuals; and
- Including representations of LGB2STQ+ people in any advertising or outreach materials.

Older Adults

Older adults have particular and (often) complex health and social needs. The recognition of the age-specific biological, psychological, social, and spiritual realities of older adults is the foundation of effective treatment. This includes being sensitive to the values, attitudes, beliefs, and fears of older adults, and incorporating these into the recovery / wellness plan. It is important to note that older adults have an increased risk of having or developing co-occurring medical issues, and because they are more vulnerable to the complications of withdrawal, an older individual may need to undergo withdrawal in a more intensive setting and at a slower pace.

Promising principles and practices for working with older adults with substance use issues include:

- Policies and procedures should be in place to address consideration for a longer length of stay for withdrawal from alcohol or other substances, based on individual circumstances;
- The policies and procedures should address the possible need for older adults to receive a medical assessment at a less intense level of withdrawal than younger adults;
- Being sensitive to the fact that older adults may have physical and/or sensory limitations (e.g. mobility, hearing, vision), and ensuring that any limitations do not have an adverse effect on communication, comprehension, or success of recovery;
- Adjusting the pace of treatment to suit the older adults' needs including the capacity to recognize and manage cognitive impairments associated with age and/or long-term substance use;
- Helping older adults living at home to get connected to necessary health and social services, including the appropriate range of medical and non-medical home supports and facilitating linkages to supports that ensure their basic living needs are met as well as facilitating connections to support services that reduce social isolation;
- Program staff should be aware that, during withdrawal, the threshold for medical assistance might be lower for older adults than it is for younger adults;

- Program staff should be mindful and aware that older adults are likely to be on a number of different medications;
- Providing the older adult with written, rather than oral information. Material should be provided to older adults in accessible formats, particularly if the individual is experiencing sensory or cognitive challenges; and

- Closely following older adults after they have completed withdrawal management so that help can be provided at the first signs of risk of relapse (at minimum, this involves placing follow-up outreach calls).

Clients with Concurrent Disorders

Clients with concurrent (addiction and mental health) disorders are at increased risk of medical and psychosocial negative outcomes. It is important to provide specifically designed interventions for these clients.

- The individual should be assessed for co-occurring mental health issues. In particular, screening for common conditions such as anxiety, mood and post-traumatic stress disorders should be a routine part of the screening and ongoing assessment process; and

- The recovery / wellness plan for someone with a concurrent disorder includes integrated treatment and supports for both the mental health and substance use challenges that the person is experiencing.

First Nations and Indigenous Individuals

Given the challenging and traumatic historical relationship between these groups and government institutions, withdrawal management service providers must acknowledge and work towards addressing the historical and present-day impacts of colonization in the context of the lives of Indigenous Peoples throughout the province. This work involves being sensitive to the impacts of intergenerational and present-day traumas and the physical, mental, emotional, and social harms experienced by Indigenous people, families, and communities.

Supporting the uptake of home-based withdrawal (when appropriate) may help to address significant barriers First Nations and Indigenous individuals face with accessing supports because of geographic location, jurisdictional complexities, and the lack of culturally appropriate services. That being said, the following considerations are also relevant especially since the bulk of the standards use evidence developed by groups that may not include culturally relevant care or acknowledge traditional Indigenous beliefs, practices, and models of care.

- Withdrawal management service providers must be trained and supported to provide culturally appropriate and safe treatment and care for Indigenous populations;

- Withdrawal services should include culturally appropriate and inclusive programing such as smudging, sharing circles, access to elders, etc.;

- Wherever possible, services should involve Indigenous staff and/or community members. Some individuals will prefer to be supported by Indigenous staff, whereas others will prefer to keep some distance from staff that they may know personally;

- Clients should be referred to culturally relevant groups, as part of the recovery and wellness process; and

- Withdrawal management services and supports should support the use of traditional medicines, practices and initiatives that are based on Indigenous peoples' customs, values and beliefs.

Glossary of Terms

Assessment

An ongoing process by which strengths, weaknesses, problems, needs and opportunities are determined or addressed.

Biopsychosocialspiritual Model

The biopsychosocialspiritual model has been developed to explain the complex interaction between the biological, psychological, social and spiritual aspects of problematic substance use. It is the model that is most widely endorsed by researchers and clinicians.

The model promotes an approach to assessment that seeks to capture the full range of underlying causes of an individual's substance use, including (but not limited to) genetic predisposition; learned behaviour; social factors, such as relationships with family, peers and the larger community; and, feelings and beliefs about problematic substance use. Treatment plans developed from such assessments seek to address the impacts of substance use on an individual's physical and mental health, social support circle, and spiritual or moral values.

Diversity

The concept of diversity encompasses the recognition of and respect for the unique characteristics and preferences of every individual. These characteristics and preferences can be along the dimensions of race, ethnicity, culture, gender, sexual orientation, gender identity, age, physical and mental ability, faith, and socioeconomic status.

Evidence-Informed

The integration of the best available evidence from systematic research with experience, judgment and expertise to inform the development and implementation of health and social policy and programs.

Family

While the word "family" traditionally refers to persons related by blood, marriage or adoption, it is used in this document in a broader sense to encompass partners (including common-law and same-sex), friends, mentors and significant others. Increasingly, the term "family of choice" is being used to describe the circle of supportive and trusted people that an individual has assembled to replace or to augment her or his family of origin.

Harm Reduction

The International Harm Reduction Association defines harm reduction as policies, programmes and practices that aim primarily to reduce the adverse health, social or economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption. Initiatives include needle exchange programs, supervised injection sites, substitution therapies (such as methadone maintenance), health and drug education, and safe housing options. Abstinence may not be the preferred goal for some people and harm reduction methods can be inclusive to other goals including low risk drinking, safer substance use, or 'drug vacations.

Mobile Withdrawal Management Services

Home/mobile withdrawal management programs are defined by the fact that service providers go to where the individual is requiring service – whether this be the individual's home, the home of a family member or friend, a shelter or a supportive recovery facility. Services could be delivered either in-person or virtually by the appropriate addictions professional.

Peer Support

Peer support is emotional and practical support between two people who share a common experience, such as a mental health challenge or illness. A Peer Supporter has lived/ is living through that similar experience, and is trained to support others.

Pharmacotherapy

Is the treatment of a disorder or disease with medication. In the treatment of addiction, medications are used to reduce the intensity of withdrawal symptoms, reduce alcohol and other drug cravings, and reduce the likelihood of use or relapse for specific drugs by blocking their effect.

Professional Development

Systematic and sustained learning activities for the purpose of bringing about changes in knowledge, attitudes, values or skills.

Rapid Access Addiction Medicine (RAAM)

A rapid access addiction medicine (RAAM) clinic is a low-barrier, walk-in clinic that patients can attend to get help for a substance use disorder without an appointment or formal referral. RAAM clinics provide time-limited medical addiction care (including pharmacotherapy, brief counselling, and referrals to community services).

Relapse Prevention

In the context of substance use, a set of skills designed to reduce the likelihood that a person will return to using alcohol or drugs. Skills include, for example, identifying early warning signs of relapse; recognizing high risk situations for relapse; managing lapses; and employing stimulus control and urge-management techniques.

Screening and Assessment

Screening is a brief process that determines whether an individual has a substance use issue — and/or related mental health problem — that requires further exploration and intervention. A positive screen indicates the need for a more comprehensive assessment. The assessment is a collaborative process between client and clinician that explores the nature and extent of the problem and gathers information to inform the development of a treatment plan.

Standard

Desired and achievable level of performance against which actual performance can be compared.

Trauma-Informed

Trauma-informed services take into account knowledge about the impacts of trauma and paths to recovery from trauma and incorporate this knowledge into all aspects of service delivery, policies and procedures. Trauma survivors are involved in designing and evaluating services; and priority is placed on trauma survivors' safety, choice and control. Specific trauma-informed interventions are designed to address the consequences of trauma in the individual and to promote and facilitate healing. Treatment programs recognize the interrelationship between trauma and the symptoms of trauma; the survivor's need to be respected and informed; and the need to work in a collaborative and empowering way with survivors (and their significant others where appropriate). At the organizational level trauma-informed practices provide a lens through which administration, management, strategic and program planning, workforce development, resource allocation, evaluation, and service delivery, should be reviewed and assessed.

Treatment Plan

The treatment plan is a written document developed collaboratively between a clinician and a client for the purpose of informing the client's course of treatment. Typically, the treatment planning process involves the identification of short- and long-term goals for treatment; the most appropriate interventions to meet the client's needs and preferences; and any perceived barriers to treatment. The plan is a living document in which the client's progress, as well as her or his changing needs and situation, are recorded.

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Appendix A: Patient Declaration of Values for Ontario

Withdrawal Management Services in Ontario should be delivered, according to the Patient Declaration of Values for Ontario. This declaration "is a vision that articulates a path toward patient partnership across the health care system in Ontario". It describes a set of foundational principles from the perspective of Ontario patients, and serves as a guidance document for those involved in our health care system.

Respect and Dignity

1. We expect that our individual identity, beliefs, history, culture, and ability will be respected in our care.
2. We expect health care providers will introduce themselves and identify their role in our care.
3. We expect that we will be recognized as part of the care team, to be fully informed about our condition, and have the right to make choices in our care.
4. We expect that families and caregivers be treated with respect and seen as valuable contributors to the care team.
5. We expect that our personal health information belongs to us, and that it remain private, respected and protected.

Empathy and Compassion

1. We expect health care providers will act with empathy, kindness, and compassion.
2. We expect individualized care plans that acknowledge our unique physical, mental and emotional needs.
3. We expect that we will be treated in a manner free from stigma and assumptions.
4. We expect health care system providers and leaders will understand that their words, actions, and decisions strongly impact the lives of patients, families and caregivers.

Accountability

1. We expect open and seamless communication about our care.
2. We expect that everyone on our care team will be accountable and supported to carry out their roles and responsibilities effectively.
3. We expect a health care culture that values the experiences of patients, families and caregivers and incorporates this knowledge into policy, planning and decision making.
4. We expect that patient/family experiences and outcomes will drive the accountability of the health care system and those who deliver services, programs, and care within it.

5. We expect that health care providers will act with integrity by acknowledging their abilities, biases and limitations.
6. We expect health care providers to comply with their professional responsibilities and to deliver safe care.

Transparency

1. We expect we will be proactively and meaningfully involved in conversations about our care, considering options for our care, and decisions about our care.
2. We expect our health records will be accurate, complete, available and accessible across the provincial health system at our request.
3. We expect a transparent, clear and fair process to express a complaint, concern, or compliment about our care and that it not impact the quality of the care we receive.

Equity and Engagement

1. We expect equal and fair access to the health care system and services for all regardless of language, place of origin, background, age, gender identity, sexual orientation, ability, marital or family status, education, ethnicity, race, religion, socioeconomic status or location within Ontario.
2. We expect that we will have opportunities to be included in health care policy development and program design at local, regional and provincial levels of the health care system.

Appendix B: Professional Boundaries

Withdrawal Management staff have a duty to maintain professional boundaries with their clients. Appropriate boundaries are about establishing what is considered to be appropriate verbal and physical behaviors. Professional boundaries are vital in order to provide safe, effective and goal orientated treatment to our clients.

1. In public, unless the client acknowledges the staff, the staff will not acknowledge the client in order to retain confidentiality.

2. Staff will not add or accept any client on any type of social media.

3. Staff will not be engaging in any type of physical contact.

4. No verbal or physical abuse will be tolerated.

5. Respect should always remain at the forefront of treatment.

6. No gifts will be accepted.

Appendix C: Clinical Institute of Withdrawal Assessment

Alcohol Withdrawal Assessment Scoring Guidelines (CIWA - Ar)

Nausea/Vomiting - Rate on scale 0 - 7

0 - None
1 - Mild nausea with no vomiting
2
3
4 - Intermittent nausea
5
6
7 - Constant nausea and frequent dry heaves and vomiting

Tremors - have patient extend arms & spread fingers. Rate on scale 0 - 7.
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 w/ arms not extended

Anxiety - Rate on scale 0 - 7
0 - no anxiety, patient at ease
1 - mildly anxious
2
3
4 - moderately anxious or guarded, so anxiety is inferred
5
6
7 - equivalent to acute panic states seen in severe delirium or acute schizophrenic reactions.

Agitation - Rate on scale 0 - 7
0 - normal activity
1 - somewhat normal activity
2
3
4 - moderately fidgety and restless
5
6
7 - paces back and forth, or constantly thrashes about

Paroxysmal Sweats - Rate on Scale 0 - 7.
0 - no sweats
1- barely perceptible sweating, palms moist
2
3
4 - beads of sweat obvious on forehead
5
6
7 - drenching sweats

Orientation and clouding of sensorium - Ask, "What day is this? Where are you? Who am I?" Rate scale 0 - 4
0 - Oriented
1 – cannot do serial additions or is uncertain about date

2 - disoriented to date by no more than 2 calendar days

3 - disoriented to date by more than 2 calendar days
4 - Disoriented to place and / or person

Tactile disturbances - Ask, "Have you experienced any itching, pins & needles sensation, burning or numbness, or a feeling of bugs crawling on or under your skin?"
0 - none
1 - very mild itching, pins & needles, burning, or numbness
2 - mild itching, pins & needles, burning, or numbness
3 - moderate itching, pins & needles, burning, or numbness
4 - moderate 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 startle you? Do you hear anything that disturbs you or that you know isn't there?"
0 - not present
1 - Very mild harshness or ability to startle
2 - mild harshness or ability to startle
3 - moderate harshness or ability to startle
4 - moderate hallucinations
5 - severe hallucinations
6 - extremely severe hallucinations
7 - continuous hallucinations

Visual disturbances - Ask, "Does the light appear to be too bright? Is its color different than normal? Does it hurt your eyes? Are you seeing anything that disturbs you or that you know isn't there?"
0 - not present
1 - very mild sensitivity
2 - mild sensitivity
3 - moderate sensitivity
4 - moderate hallucinations
5 - severe hallucinations
6 - extremely severe hallucinations
7 - continuous hallucinations

Headache - Ask, "Does your head feel different than usual? Does it feel like there is a band around your head?" Do not rate dizziness or lightheadedness.

0 - not present
1 - very mild
2 - mild
3 - moderate
4 - moderately severe
5 - severe
6 - very severe
7 - extremely severe

Procedure:

1. Assess and rate each of the 10 criteria of the CIWA scale. Each criterion is rated on a scale from 0 to 7, except for "Orientation and clouding of sensorium" which is rated on scale 0 to 4. Add up the scores for all ten criteria. This is the total CIWA-Ar score for the patient at that time. Prophylactic medication should be started for any patient with a total CIWA-Ar score of 8 or greater (ie. start on withdrawal medication). If started on scheduled medication, additional PRN medication should be given for a total CIWA-Ar score of 15 or greater.
2. Document vitals and CIWA-Ar assessment on the Withdrawal Assessment Sheet. Document administration of PRN medications on the assessment sheet as well.
3. The CIWA-Ar scale is the most sensitive tool for assessment of the patient experiencing alcohol withdrawal. Nursing assessment is vitally important. Early intervention for CIWA-Ar score of 8 or greater provides the best means to prevent the progression of withdrawal.

Assessment Protocol a. Vitals, Assessment Now. b. If initial score ≥ 8 repeat q1h x 8 hrs, then if stable q2h x 8 hrs, then if stable q4h. c. If initial score < 8, assess q4h x 72 hrs. If score < 8 for 72 hrs, d/c assessment. If score ≥ 8 at any time, go to (b) above. d. If indicated, (see indications below) administer prn medications as ordered and record on MAR and below.	**Date**												
	Time												
	Pulse												
	RR												
	O_2 sat												
	BP												
Assess and rate each of the following (CIWA-Ar Scale):	**Refer to reverse for detailed instructions in use of the CIWA-Ar scale.**												
Nausea/vomiting (0 - 7) 0 - none; 1 - mild nausea ,no vomiting; 4 - intermittent nausea; 7 - constant nausea , frequent dry heaves & vomiting.													
Tremors (0 - 7) 0 - no tremor; 1 - not visible but can be felt; 4 - moderate w/ arms extended; 7 - severe, even w/ arms not extended.													
Anxiety (0 - 7) 0 - none, at ease; 1 - mildly anxious; 4 - moderately anxious or guarded; 7 - equivalent to acute panic state													
Agitation (0 - 7) 0 - normal activity; 1 - somewhat normal activity; 4 - moderately fidgety/restless; 7 - paces or constantly thrashes about													
Paroxysmal Sweats (0 - 7) 0 - no sweats; 1 - barely perceptible sweating, palms moist; 4 - beads of sweat obvious on forehead; 7 - drenching sweat													
Orientation (0 - 4) 0 - oriented; 1 - uncertain about date; 2 - disoriented to date by no more than 2 days; 3 - disoriented to date by > 2 days; 4 - disoriented to place and / or person													
Tactile Disturbances (0 - 7) 0 - none; 1 - very mild itch, P&N, ,numbness; 2-mild itch, P&N, burning, numbness; 3 - moderate itch, P&N, burning ,numbness; 4 - moderate hallucinations; 5 - severe hallucinations; 6 – extremely severe hallucinations; 7 - continuous hallucinations													
Auditory Disturbances (0 - 7) 0 - not present; 1 - very mild harshness/ ability to startle; 2 - mild harshness, ability to startle; 3 - moderate harshness, ability to startle; 4 - moderate hallucinations; 5 severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous.hallucinations													
Visual Disturbances (0 - 7) 0 - not present; 1 - very mild sensitivity; 2 - mild sensitivity; 3 - moderate sensitivity; 4 - moderate hallucinations; 5 - severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations													
Headache (0 - 7) 0 - not present; 1 - very mild; 2 - mild; 3 - moderate; 4 - moderately severe; 5 - severe; 6 - very severe; 7 - extremely severe													
Total CIWA-Ar score:													
PRN Med: (circle one) Diazepam Lorazepam	**Dose given (mg):**												
	Route:												
Time of PRN medication administration:													
Assessment of response (CIWA-Ar score 30-60 minutes after medication administered)													
RN Initials													

Scale for Scoring:
Total Score =
0 – 9: absent or minimal withdrawal
10 – 19: mild to moderate withdrawal
more than 20: severe withdrawal

Indications for PRN medication:
a. Total CIWA-AR score 8 or higher if ordered PRN only (Symptom-triggered method).
b. Total CIWA-Ar score 15 or higher if on Scheduled medication. (Scheduled + prn method)
Consider transfer to ICU for any of the following: Total score above 35, q1h assess. x more than 8hrs required, more than 4 mg/hr lorazepam x 3hr **or** 20 mg/hr diazepam x 3hr required, or resp. distress.

Patient Identification (Addressograph)

Signature/ Title	Initials	Signature / Title	Initials

Alcohol Withdrawal Assessment Flowsheet (revised Nov 2003)

Appendix D: Clinical Opiate Withdrawal Scale (COWS)

Clinical Opiate Withdrawal Scale (COWS)

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.

Patient's Name:_____ Date and Time___/___/_____:_____

Reason for this assessment:_____

Resting Pulse Rate:_____beats/minute
Measured after patient is sitting or lying for one minute

0 pulse rate 80 or below
1 pulse rate 81-100
2 pulse rate 101-120
4 pulse rate greater than 120

GI Upset: *over last ½ hour*
0 no GI symptoms
1 stomach cramps
2 nausea or loose stool
3 vomiting or diarrhea
5 Multiple episodes of diarrhea or vomiting

Sweating: *over past ½ hour not accounted for by room temperature or patient activity.*

0 no report of chills or flushing
1 subjective report of chills or flushing
2 flushed or observable moistness on face
3 beads of sweat on brow or face
4 sweat streaming off face

Tremor *observation of outstretched hands*

0 No tremor
1 tremor can be felt, but not observed
2 slight tremor observable
4 gross tremor or muscle twitching

Restlessness *Observation during assessment*

0 able to sit still
1 reports difficulty sitting still, but is able to do so
3 frequent shifting or extraneous movements of legs/arms
5 Unable to sit still for more than a few seconds

Yawning *Observation during assessment*

0 no yawning
1 yawning once or twice during assessment
2 yawning three or more times during assessment
4 yawning several times/minute

Pupil size

0 pupils pinned or normal size for room light
1 pupils possibly larger than normal for room light
2 pupils moderately dilated
5 pupils so dilated that only the rim of the iris is visible

Anxiety or Irritability

0 none
1 patient reports increasing irritability or anxiousness
2 patient obviously irritable anxious
4 patient so irritable or anxious that participation in the assessment is difficult

Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored*

0 not present
1 mild diffuse discomfort
2 patient reports severe diffuse aching of joints/ muscles
4 patient is rubbing joints or muscles and is unable to sit still because of discomfort

Gooseflesh skin

0 skin is smooth
3 piloerection of skin can be felt or hairs standing up on arms
5 prominent piloerection

Runny nose or tearing *Not accounted for by cold symptoms or allergies*

0 not present
1 nasal stuffiness or unusually moist eyes
2 nose running or tearing
4 nose constantly running or tears streaming down cheeks

Total Score _____
The total score is the sum of all 11 items

Initials of person completing Assessment: _____

Score:
5-12 = mild;
13-24 = moderate;
25-36 moderately severe;
more than 36 = severe withdrawal
Source: Wesson and Ling 2003

Appendix E: Opioid Withdrawal Management - Sample Order Set

☑Height:___ cm ☑Weight:___ kg ☑Last Opioid Use:___ hours ☑Initial COWS Scale:____

☑ Clinical Opiate Withdrawal Scale Assessment (COWS) Use the COWS to assess and monitor symptoms Repeat the assessment as follows: a) If COWS score is 0-9, repeat the Clinical Opiate Withdrawal Scale q6h b) If COWS score is 10-15, repeat the Clinical Opiate Withdrawal Scale q4h c) If COWS score is 16 or greater, repeat the Clinical Opiate Withdrawal Scale q2h	☐BUPRENORPHINE/NALOXONE PROTOCOL Offer all patients with opioid use disorder buprenorphine/naloxone treatment for withdrawal and maintenance therapy. The clonidine protocol can be used if the buprenorphine/naloxone protocol is not indicated (e.g.: ongoing opioid use or the patient declines) DAY 1 Prior to starting a buprenorphine/naloxone induction, the patient must abstain from opioid use for at least 12 hours and must be in moderate withdrawal (COWS 13+) ☑Give 2/0.5 mg sl test dose and monitor for 2 hours for signs of precipitated withdrawal ☑ THEN give 2/0.5 mg sl q2h prn up to a maximum total dose of 8/2 mg sl on Day 1 DAY 2 ☑Give total amount from Day 1 (2/0.5 mg – 8/2 mg) in one dose in AM and monitor for 2 hours ☑THEN give 2/0.5 mg sl q2h prn up to a maximum total dose of 16/4 mg sl on Day 2 DAY 3 (choose one option) ☐Give total amount from Day 2 (2/0.5 mg – 16/4 mg) in one dose in AM and refer to new MRP orders for adjustment in the dosage OR ☐If patient declines maintenance therapy, decrease by 2/0.5 mg sl per day if dose is 8/2 mg or less or by 4/1 mg sl per day if dose is 10/2.5 mg or more *Crush tablets before administering and monitor the patient directly for 10 minutes to prevent misuse

☐CLONIDINE PROTOCOL (to be used if buprenorphine not indicated) ☑Test Dose if COWS is equal or more than 5 Give clonidine 0.1 mg po x 1 dose and check vital signs one hour afterwards If BP less than 90/60 or HR less than 60, discontinue clonidine If vital signs stable, continue with clonidine protocol and withhold dose if BP less than 90/60 or HR less than 60 ☑Initial COWS score is 5 - 9 If patient weighs less than or equal to 91 kg give: Clonidine 0.1 mg po q6h x 72 hours, then, Clonidine 0.05 mg po q6h x 48 hours, then, Clonidine 0.025 mg po q6h x 48 hours, then stop If patient weighs more than 91 kg give: Clonidine 0.2 mg po q6h x 72 hours, then, Clonidine 0.1 mg po q6h x 48 hours, then, Clonidine 0.05 mg po q6h x 24 hours, then, Clonidine 0.025 mg po q6h x 24 hours, then stop ☑Initial COWS score is 10 - 15 If patient weighs less than or equal to 91 kg give: Clonidine 0.2 mg po q6h x 72 hours, then, Clonidine 0.1 mg po q6h x 48 hours, then, Clonidine 0.05 mg po q6h x 24 hours, then, Clonidine 0.025 mg po q6h x 24 hours, then stop If patient weighs more than 91 kg give: Clonidine 0.3 mg po q6h x 72 hours, then, Clonidine 0.2 mg po q6h x 48 hours, then, Clonidine 0.1 mg po q6h x 24 hours, then, Clonidine 0.05 mg po q6h x 24 hours, then, Clonidine 0.025 mg po q6h x 24 hours, then stop	NOTE: Clonidine and buprenorphine can be used along with the following medications for symptomatic relief of opioid withdrawal (choose from the following) Nausea, Vomiting and/or Diarrhea ☐dimenHYDRINATE 25-50 mg po/IM q6h prn (max 200 mg per 24 hours) ☐loperamide 4 mg po once THEN 2 mg po after each loose bowel movement (max 16 mg per 24 hours) Generalized Discomfort and/or Pain ☐acetaminophen 325-650 mg po q4h prn (max 4 grams per 24 hours) ☐ibuprofen 400 mg po q6h prn (max 1600 mg per 24 hours) Anxiety and/or Insomnia ☐quetiapine 25-50 mg po q4h prn (max 200 mg per 24 hours) ☐melatonin 6 mg sl qhs prn ☐trazodone 50-100 mg po qhs prn Additional Orders _____ _____ _____ _____ _____

Appendix F: Alcohol Withdrawal Protocol

Alcohol Withdrawal begins within several hours to a few days after cessation or reduction of use that has been heavy/prolonged with two or more of the following:

- Autonomic hyperactivity (e.g. sweating, pulse greater than 100)
- Increased hand tremor
- Insomnia
- Nausea or vomiting
- Transient visual, tactile, or auditory hallucinations or illusions
- Psychomotor agitation
- Anxiety
- Generalized tonic-clonic seizures (3% in alcohol, 20-30% in sedatives)

Initial Investigations :

- CBC
- Electrolytes
- Liver profile (AST, ALT, GGT, Bilirubin, Albumin, INR)
- Renal profile
- TSH
- B12
- Metabolic workup (fasting glucose or HbA1c, lipid profile)
- Urine analysis, urine BHCG and urine drug screen
- ECG

Clinical features of alcohol withdrawal:

- Starts 6–12 hours after last drink
- Peaks at 24–72 hours
- Resolves in 3–10 days (or longer), delirium tremens can occur up to 7 days
- Tremor is the most reliable feature (postural, intention, not a resting tremor)
- Other features include diaphoresis, nausea and vomiting, anxiety, tachycardia, hypertension, ataxic gait, perceptual disturbances

Risk factors for alcohol withdrawal:

- 6+ standard drinks/day for 1+ weeks
- History of serious withdrawal (seizures, delirium tremens)

Indications for outpatient management of alcohol withdrawal:

- Committed to abstinence, willing to start treatment and agrees to not drink while being treated for alcohol withdrawal
- No history of severe withdrawal (seizures, delirium tremens, hospital admissions)
- Not on high doses of opioids or sedating medications, no history of misuse
- Has good supports at home and spouse, relative, or friend agrees to dispense the medication
- Age < 65
- No hepatic decompensation (ascites, encephalopathy), no cirrhosis with liver dysfunction

Service providers should:

- Advise the patient to have their last drink the night before the morning appointment
- If patient shows up acutely intoxicated, reschedule the appointment
- Clinical Institute Withdrawal Assessment for Alcohol, Revised (CIWA-Ar) is the standard monitoring scale with strong evidence of validity
- Diazepam is the first-line medication
- Use lorazepam instead if patient is 60 or older, is on opioids or other sedating medications, has low serum albumin from any cause, or has liver dysfunction (signs of cirrhosis such as low albumin, high bilirubin/INR)
- Administer CIWA-Ar every 1–2 hours
- Give diazepam 10–20 mg PO or lorazepam 2–4 mg PO for CIWA-Ar ≥ 10
- Gabapentin can also be used. An example of a protocol is highlighted below:
    - 300 mg q6h = 1200 mg/d – days 1-3
    - 300 mg q8h = 900 mg/d – day 4
    - 300 mg q12h = 600 mg/d – day 5
    - 300 mg hs = 300 mg/d – day 6
- Treatment is complete when CIWA-Ar < 8 on 2 consecutive occasions and patient has minimal or no tremor
- Send the patient to ED if patient has not improved or has worsened despite 3–4 doses

- Do not forget about thiamine supplementation (100 mg IM x 3 days then 100 mg PO; some experts suggest 250-500 mg daily)
- If you cannot monitor the patient throughout the day, we usually recommend diazepam 10 mg Q4h, max 60 mg per day
- Ideally it should be administered by a trusted family member or friend if possible
- The patient agrees to be supervised and not drink while on the medication
- The patient should have a phone check-in the next day
- Ensure the patient is seen again in 48-72 hours

Anti-Craving therapy

Health Canada Indication:

- Naltrexone (Revia) – suggested in harm reduction (APA recommended) H
- Acamprosate (Campral) – suggested in abstinence (APA recommended) R
- Disulfiram (Antabuse) – abstinence with good supervision (APA suggested) H

Off label in Canada:

- Topiramate (Topamax) – off label (APA suggested) R
- Gabapentin (Neurontin) – off label (APA suggested) R
- Baclofen – off label (less evidence, not mentioned in 2018 APA guidelines) R

*H = Mainly metabolized by the hepatic system
*R = Mainly metabolized by the renal system

General advice to patients:

- Take it everyday, especially when you are drinking as it will reduce the pleasurable effects of drinking and help you drink less
- The medication will not reduce the effects of alcohol such as impaired co-ordination and judgment
- The medication will not affect your blood alcohol level or “sober you up” if you drink
- The medication will not change the way the body metabolizes (breaks down) alcohol, so it will not make you feel sick if you drink (Not applicable for disulfiram)
- Recommend continuing for at least 6-12 months initially, although anti-craving medication may be prescribed for many years and patients can have intermittent periods of therapy

Anti-craving therapy may be safely discontinued when the patient:

- No longer has cravings
- Is confident that relapse will not happen if the medication is stopped
- Has strong supports in place
- No longer has contact with people who misuse alcohol
- Has learned alternative and more adaptive coping strategies.

Appendix G: Benzodiazepines

- Tapering is always recommended over abrupt cessation unless the patient has only been taking the medication intermittently or for a few weeks.
- Controlled trials have shown that many adults are able to successfully reduce their benzodiazepine dose with appropriate support.
- Slow, flexible tapers work better than rapid tapers, with halting or reversing the taper if the patient experiences clinically significant increase in anxiety.
- Ideally, follow the patient regularly (every 2-4 weeks) and review tolerability of tapering, as well as reminding the patient of the ongoing benefits of the taper, and providing psychotherapeutic support.
- Taper slowly, for example 10% of dose every visit until at 20% of original dose, then taper by 5% every visit. Tapering may be easier with a switch to a longer acting benzodiazepine such as clonazepam or diazepam, although diazepam has a longer duration of action and may increase the risk of prolonged sedation in the elderly.

Appendix H: Patient Health Questionnaire (PHQ-9)

Patient Health Questionnaire (PHQ-9)

Name_____ Date:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

For office coding: Total Score_____=_____+_____+_____

Total Score_____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely

How to Score the PHQ-9

Major depressive disorder (MDD) is suggested if:

- Of the 9 items, 5 or more are checked as at least 'more than half the days'
- Either item 1 or 2 is checked as at least 'more than half the days'

Other depressive syndrome is suggested if:

- Of the 9 items, between 2 to 4 are checked as at least 'more than half the days'
- Either item 1 or 2 is checked as at least 'more than half the days'

PHQ-9 scores can be used to plan and monitor treatment. To score the instrument, tally the numbers of all the checked responses under each heading (not at all=0, several days=1, more than half the days=2, and nearly every day=3). Add the numbers together to total the score on the bottom of the questionnaire. Interpret the score by using the guide listed below.

Guide for Interpreting PHQ-9 Scores		
Score	**Depression Severity**	**Action**
0 - 4	None-minimal	Patient may not need depression treatment.
5 - 9	Mild	Use clinical judgment about treatment, based on patient's duration of symptoms and functional impairment.
10 - 14	Moderate	Use clinical judgment about treatment, based on patient's duration of symptoms and functional impairment.
15 - 19	Moderately severe	Treat using antidepressants, psychotherapy or a combination of treatment.
20 - 27	Severe	Treat using antidepressants with or without psychotherapy.

Functional Health Assessment

The instrument also includes a functional health assessment. This asks the patient how emotional difficulties or problems impact work, life at home, or relationships with other people. Patient response of 'very difficult' or 'extremely difficult' suggest that the patient's functionality is impaired. After treatment begins, functional status and number score can be measured to assess patient improvement.

Note: Depression should not be diagnosed or excluded solely on the basis of a PHQ-9 score. A PHQ-9 score ≥ 10 has a sensitivity of 88% and a specificity of 88% for major depression.1 Since the questionnaire relies on patient self-report, the practitioner should verify all responses. A definitive diagnosis is made taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.

Reference: Kroenke K, Spitzer RL, Williams JB. The PHQ-9: Validity of a brief depression severity measure. J Gen Intern Med. 2001;16(9):606-613.

Appendix I: Inventory of Depressive Symptomatology (IDS) and Quick Inventory of Depressive Symptomatology (QIDS)

INVENTORY OF DEPRESSIVE SYMPTOMATOLOGY (SELF-REPORT) (IDS-SR)

NAME: _____ TODAY'S DATE _____

Please circle the one response to each item that best describes you for the past seven days.

1. Falling Asleep:

   0 I never take longer than 30 minutes to fall asleep.
   1 I take at least 30 minutes to fall asleep, less than half the time.
   2 I take at least 30 minutes to fall asleep, more than half the time.
   3 I take more than 60 minutes to fall asleep, more than half the time.

2. Sleep During the Night:

   0 I do not wake up at night.
   1 I have a restless, light sleep with a few brief awakenings each night.
   2 I wake up at least once a night, but I go back to sleep easily.
   3 I awaken more than once a night and stay awake for 20 minutes or more, more than half the time.

3. Waking Up Too Early:

   0 Most of the time, I awaken no more than 30 minutes before I need to get up.
   1 More than half the time, I awaken more than 30 minutes before I need to get up.
   2 I almost always awaken at least one hour or so before I need to, but I go back to sleep eventually.
   3 I awaken at least one hour before I need to, and can't go back to sleep.

4. Sleeping Too Much:

   0 I sleep no longer than 7-8 hours/night, without napping during the day.
   1 I sleep no longer than 10 hours in a 24-hour period including naps.
   2 I sleep no longer than 12 hours in a 24-hour period including naps.
   3 I sleep longer than 12 hours in a 24-hour period including naps.

5. Feeling Sad:

   0 I do not feel sad
   1 I feel sad less than half the time.
   2 I feel sad more than half the time.
   3 I feel sad nearly all of the time.

6. Feeling Irritable:

   0 I do not feel irritable.
   1 I feel irritable less than half the time.
   2 I feel irritable more than half the time.
   3 I feel extremely irritable nearly all of the time.

7. Feeling Anxious or Tense:

   0 I do not feel anxious or tense.
   1 I feel anxious (tense) less than half the time.
   2 I feel anxious (tense) more than half the time.
   3 I feel extremely anxious (tense) nearly all of the time.

8. Response of Your Mood to Good or Desired Events:

0 My mood brightens to a normal level which lasts for several hours when good events occur.
1 My mood brightens but I do not feel like my normal self when good events occur.
2 My mood brightens only somewhat to a rather limited range of desired events.
3 My mood does not brighten at all, even when very good or desired events occur in my life.

9. Mood in Relation to the Time of Day:

0 There is no regular relationship between my mood and the time of day.
1 My mood often relates to the time of day because of environmental events (e.g., being alone, working).
2 In general, my mood is more related to the time of day than to environmental events.
3 My mood is clearly and predictably better or worse at a particular time each day.

9A. Is your mood typically worse in the morning, afternoon or night? (circle one)

9B. Is your mood variation attributed to the environment? (yes or no) (circle one)

10. The Quality of Your Mood:

0 The mood (internal feelings) that I experience is very much a normal mood.
1 My mood is sad, but this sadness is pretty much like the sad mood I would feel if someone close to me died or left.
2 My mood is sad, but this sadness has a rather different quality to it than the sadness I would feel if someone close to me died or left.
3 My mood is sad, but this sadness is different from the type of sadness associated with grief or loss.

11. Decreased Appetite:

0 There is no change in my usual appetite.
1 I eat somewhat less often or lesser amounts of food than usual.

12. I eat much less than usual and only with Increased Appetite:

0 There is no change from my usual appetite.
1 I feel a need to eat more frequently than usual.
2 I regularly eat more often and/or greater amounts of food than usual.
3 I feel driven to overeat both at mealtime and between meals.
2 personal effort.
3 I rarely eat within a 24-hour period, and only with extreme personal effort or when others persuade me to eat.

Please complete either 13 or 14 (not both)

13. Decreased Weight (Within the Last Two Weeks):

0 I have not had a change in my weight.
1 I feel as if I've had a slight weight loss.
2 I have lost 2 pounds or more.
3 I have lost 5 pounds or more.

14. Increased Weight (Within the Last Two Weeks):

0 I have not had a change in my weight.
1 I feel as if I've had a slight weight gain.
2 I have gained 2 pounds or more.
3 I have gained 5 pounds or more.

15. Concentration/Decision Making:

0 There is no change in my usual capacity to concentrate or make decisions.
1 I occasionally feel indecisive or find that my attention wanders.
2 Most of the time, I struggle to focus my attention or to make decisions.
3 I cannot concentrate well enough to read or cannot make even minor decisions.

16. View of Myself:

0 I see myself as equally worthwhile and deserving as other people.
1 I am more self-blaming than usual.
2 I largely believe that I cause problems for others.
3 I think almost constantly about major and minor defects in myself.

17. View of My Future:

0 I have an optimistic view of my future.
1 I am occasionally pessimistic about my future, but for the most part I believe things will get better.
2 I'm pretty certain that my immediate future (1-2 months) does not hold much promise of good things for me.
3 I see no hope of anything good happening to me anytime in the future.

18. Thoughts of Death or Suicide:

0 I do not think of suicide or death.
1 I feel that life is empty or wonder if it's worth living.
2 I think of suicide or death several times a week for several minutes.
3 I think of suicide or death several times a day in some detail, or I have made specific plans for suicide or have actually tried to take my life.

19. General Interest:

0 There is no change from usual in how interested I am in other people or activities.
1 I notice that I am less interested in people or activities.
2 I find I have interest in only one or two of my formerly pursued activities.
3 I have virtually no interest in formerly pursued activities.

20. Energy Level:

0 There is no change in my usual level of energy.
1 I get tired more easily than usual.
2 I have to make a big effort to start or finish my usual daily activities (for example, shopping, homework, cooking or going to work).
3 I really cannot carry out most of my usual daily activities because I just don't have the energy.

21. Capacity for Pleasure or Enjoyment (excluding sex):

0 I enjoy pleasurable activities just as much as usual.
1 I do not feel my usual sense of enjoyment from pleasurable activities.
2 I rarely get a feeling of pleasure from any activity.
3 I am unable to get any pleasure or enjoyment from anything.

22. Interest in Sex (Please Rate Interest, not Activity):

0 I'm just as interested in sex as usual.
1 My interest in sex is somewhat less than usual or I do not get the same pleasure from sex as I used to.
2 I have little desire for or rarely derive pleasure from sex.
3 I have absolutely no interest in or derive no pleasure from sex.

23. Feeling slowed down:

0 I think, speak, and move at my usual rate of speed.
1 I find that my thinking is slowed down or my voice sounds dull or flat.
2 It takes me several seconds to respond to most questions and I'm sure my thinking is slowed.
3 I am often unable to respond to questions without extreme effort.

24. Feeling restless:

0 I do not feel restless.
1 I'm often fidgety, wring my hands, or need to shift how I am sitting.
2 I have impulses to move about and am quite restless.
3 At times, I am unable to stay seated and need to pace around.

25. Aches and pains:

0 I don't have any feeling of heaviness in my arms or legs and don't have any aches or pains.
1 Sometimes I get headaches or pains in my stomach, back or joints but these pains are only sometime present and they don't stop me from doing what I need to do.
2 I have these sorts of pains most of the time.
3 These pains are so bad they force me to stop what I am doing.

26. Other bodily symptoms:

0 I don't have any of these symptoms: heart pounding fast, blurred vision, sweating, hot and cold flashes, chest pain, heart turning over in my chest, ringing in my ears, or shaking.
1 I have some of these symptoms but they are mild and are present only sometimes.
2 I have several of these symptoms and they bother me quite a bit.
3 I have several of these symptoms and when they occur I have to stop doing whatever I am doing.

27. Panic/Phobic symptoms:

0 I have no spells of panic or specific fears (phobia) (such as animals or heights).
1 I have mild panic episodes or fears that do not usually change my behavior or stop me from functioning.
2 I have significant panic episodes or fears that force me to change my behavior but do not stop me from functioning.
3 I have panic episodes at least once a week or severe fears that stop me from carrying on my daily activities.

28. Constipation/diarrhea:

0 There is no change in my usual bowel habits.
1 I have intermittent constipation or diarrhea which is mild.
2 I have diarrhea or constipation most of the time but it does not interfere with my day-to-day functioning.
3 I have constipation or diarrhea for which I take medicine or which interferes with my day-to-day activities.

29. Interpersonal Sensitivity:

0 I have not felt easily rejected, slighted, criticized or hurt by others at all.
1 I have occasionally felt rejected, slighted, criticized or hurt by others.
2 I have often felt rejected, slighted, criticized or hurt by others, but these feelings have had only slight effects on my relationships or work.
3 I have often felt rejected, slighted, criticized or hurt by others and these feelings have impaired my relationships and work.

30. Leaden Paralysis/Physical Energy:

0 I have not experienced the physical sensation of feeling weighted down and without physical energy.
1 I have occasionally experienced periods of feeling physically weighted down and without physical energy, but without a negative effect on work, school, or activity level.
2 I feel physically weighted down (without physical energy) more than half the time.
3 I feel physically weighted down (without physical energy) most of the time, several hours per day, several days per week.

Range 0-84

Score:

Appendix J: PTSD Assessment

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully. Then enter the appropriate number in the right-hand column to show how much you have been bothered by that problem in the last month.

1 = Not at all 2 = A little bit 3 = Moderately 4 = Quite a bit 5 = Extremely

Repeated, disturbing memories, thoughts, or images of a stressful experience from the past.	
Repeated, disturbing dreams of a stressful experience from the past.	
Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it).	
Feeling very upset when something reminded you of a stressful experience from the past.	
Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience from the past.	
Avoiding thinking about or talking about a stressful experience from the past or avoiding having feelings related to it.	
Avoiding activities or situations because they reminded you of a stressful experience from the past.	
Trouble remembering important parts of a stressful experience from the past.	
Loss of interest in activities that you used to enjoy.	
Feeling distant or cut off from other people.	
Feeling emotionally numb or being unable to have loving feelings for those close to you.	
Feeling as if your future will somehow be cut short.	
Trouble falling or staying asleep.	
Feeling irritable or having angry outbursts.	
Having difficulty concentrating.	
Being "super-alert" or watchful or on guard.	
Feeling jumpy or easily startled.	
To find your score, add up the numbers you entered. If your score is: 0 – 16 = No symptoms of PTSD. 17 – 20 = No to minimum symptoms of PTSD. 21 – 29 = Mild symptoms of PTSD. 30 – 49 = Moderate symptoms of PTSD. 50 – 86 = Severe symptoms of PTSD.	

Reference: Weathers FW, et al. (1994). PCL-C for DSM-IV. Boston: National Center for PTSD, Behavioral Science Division

Appendix K: GAD-7

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score ___ = Add Columns ___ + ___ + ___

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Appendix L: The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST v3.1)

Clinician Name | Clinic

Client ID or Name | Date

Introduction (please read to client or adapt for local circumstances)*

The following questions ask about your experience of using alcohol, tobacco products and other drugs across your lifetime and in the past three months. These substances can be smoked, swallowed, snorted, inhaled or injected (show response card).

*Some of the substances listed may be prescribed by a doctor (like amphetamines, sedatives, pain medications). For this interview, we will **not** record medications that are used **as prescribed** by your doctor. However, if you have taken such medications for reasons **other** than prescription, or taken them more frequently or at higher doses than prescribed, please let me know.*

While we are also interested in knowing about your use of various illicit drugs, please be assured that information on such use will be treated as strictly confidential.

Before asking questions, give ASSIST response card to client

QUESTION 1 | In your life, which of the following substances have you *ever used* (non-medical use only)?		
a Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	No	Yes
b Alcoholic beverages (beer, wine, spirits, etc.)	No	Yes
c Cannabis (marijuana, pot, grass, hash, etc.)	No	Yes
d Cocaine (coke, crack, etc.)	No	Yes
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)	No	Yes
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)	No	Yes
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)	No	Yes
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	No	Yes
I Opioids (heroin, morphine, methadone, buprenorphine, codeine, fentanyl, etc.)	No	Yes
J Other – specify: _____	No	Yes

Probe if all answers are negative: "Not even when you were in school?"	If "No" to all items, stop interview. If "Yes" to any of these items, ask Q2 for each substance ever used

QUESTION 2 | In the *past three months*, how often have you used the substances you mentioned (first drug, second drug, etc)?	Never	Once or twice	Monthly	Weekly	Daily or almost daily
a Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	2	3	4	6
b Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
c Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
d Cocaine (coke, crack, etc.)	0	2	3	4	6
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)	0	2	3	4	6
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	2	3	4	6
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)	0	2	3	4	6
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	0	2	3	4	6
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)	0	2	3	4	6
j Other – specify: _____	0	2	3	4	6

If "Never" to all items in Q2, skip to Q6.

If any substances in Q2 were used in the previous three months, continue with Questions 3, 4 & 5 for each substance used.

QUESTION 3 | During the *past three months*, how often have you had a strong desire or urge to use (first drug, second drug, etc)?	Never	Once or twice	Monthly	Weekly	Daily or almost daily
a Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3	4	5	6
b Alcoholic beverages (beer, wine, spirits, etc.)	0	3	4	5	6
c Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
d Cocaine (coke, crack, etc.)	0	3	4	5	6
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)	0	3	4	5	6
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3	4	5	6
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)	0	3	4	5	6
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	0	3	4	5	6
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)	0	3	4	5	6

j Other – specify: _____	0	3	4	5	6

QUESTION 4 | During the *past three months*, how often has your use of (first drug, second drug, etc) led to health, social, legal or financial problems?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	4	5	6	7
b Alcoholic beverages (beer, wine, spirits, etc.)	0	4	5	6	7
c Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
d Cocaine (coke, crack, etc.)	0	4	5	6	7
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)	0	4	5	6	7
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	4	5	6	7
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)	0	4	5	6	7
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	0	4	5	6	7
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)	0	4	5	6	7
j Other – specify: _____	0	4	5	6	7

QUESTION 5 | During the *past three months*, how often have you failed to do what was normally expected of you because of your use of (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a Tobacco products					
b Alcoholic beverages (beer, wine, spirits, etc.)	0	5	6	7	8
c Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
d Cocaine (coke, crack, etc.)	0	5	6	7	8
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)	0	5	6	7	8
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	5	6	7	8
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)	0	5	6	7	8
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	0	5	6	7	8
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)	0	5	6	7	8
j Other – specify: _____	0	4	5	6	7
Ask questions 6 & 7 for all substances ever used (i.e. those endorsed in Q1).					

QUESTION 6 | Has a friend or relative or anyone else *ever* expressed concern about your use of (first drug, second drug, etc)?	No, never	Yes, in the past 3 months	Yes, but not in the past 3 months
a Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d Cocaine (coke, crack, etc.)	0	6	3
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)	0	6	3
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)	0	6	3
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	0	6	3
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)	0	6	3
j Other – specify: _____	0	6	3
Ask questions 6 & 7 for all substances ever used (i.e. those endorsed in Q1).			

QUESTION 7 | Have you *ever* tried to cut down on using (first drug, second drug, etc) but failed?	No, never	Yes, in the past 3 months	Yes, but not in the past 3 months
a Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d Cocaine (coke, crack, etc.)	0	6	3
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)	0	6	3
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)	0	6	3
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	0	6	3
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)	0	6	3
j Other – specify: _____	0	6	3
Ask questions 6 & 7 for all substances ever used (i.e. those endorsed in Q1).			

QUESTION 8 | Have you *ever* used any drug by injection (non-medical use only)?	No, never	Yes, in the past 3 months	Yes, but not in the past 3 months
(Please tick the appropriate box)			

IMPORTANT NOTE
Clients who have injected drugs in the last 3 months should be asked about their pattern of injecting during this period, to determine their risk levels and the best course of intervention.

ASSIST v3.1 response card

RESPONSE CARD | Substances
a Tobacco products (cigarettes, chewing tobacco, cigars, etc.)
b Alcoholic beverages (beer, wine, spirits, etc.)
c Cannabis (marijuana, pot, grass, hash, etc.)
d Cocaine (coke, crack, etc.)
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)
j Other – specify: _____

RESPONSE CARD | Frequency responses	
Response card **Last 3 months (ASSIST questions 2 to 5)**	**Response card** **Lifetime (ASSIST questions 6 to 8)**
❙❙ **Never:** not used in the last 3 months. ❙❙ **Once or twice:** 1 to 2 times in the last 3 months. ❙❙ **Monthly:** average of 1 to 3 times per month over the last 3 months. ❙❙ **Weekly:** 1 to 4 times per week. ❙❙ **Daily or almost daily:** 5 to 7 days per week.	❙❙ **No, never.** ❙❙ **Yes, but not in the past 3 months.** ❙❙ **Yes, in the past 3 months.**

ASSIST v3.1 feedback report card

Client ID or Name _____ Date _____

Specific substance involvement scores	Score	Risk Level	
a Tobacco products		0 – 3 4 – 26 27+	Lower Moderate High
b Alcoholic beverages		0 – 10 11 – 26 27+	Lower Moderate High
c Cannabis		0 – 3 4 – 26 27+	Lower Moderate High
d Cocaine		0 – 3 4 – 26 27+	Lower Moderate High
e Amphetamine-type stimulants		0 – 3 4 – 26 27+	Lower Moderate High
f Inhalants		0 – 3 4 – 26 27+	Lower Moderate High
g Sedatives or sleeping pills		0 – 3 4 – 26 27+	Lower Moderate High
h Hallucinogens		0 – 3 4 – 26 27+	Lower Moderate High
i Opioids		0 – 3 4 – 26 27+	Lower Moderate High
j Other – specify: _____		0 – 3 4 – 26 27+	Lower Moderate High

What do your scores mean?
Lower: You are at lower risk of health and other problems from your current pattern of use. **Moderate:** You are at moderate risk of health and other problems from your current pattern of substance use. **High:** You are at high risk of experiencing severe problems (health, social, financial, legal, relationship) as a result of your current pattern of use and are likely to be dependent.

Source: World Health Organization 2010

Appendix M: Alcohol Use Disorders Identification Test (AUDIT)

The Alcohol Use Disorders Identification Test: Interview Version

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this past year." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks" . Place the correct answer number in the box at the right.

1. How often do you have a drink containing alcohol? (0) Never [Skip to Qs 9-10] (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week	6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
2. How many drinks containing alcohol do you have on a typical day when you are drinking? (0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8, or 9 (4) 10 or more	7. How often during the last year have you had a feeling of guilt or remorse after drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
3. How often do you have six or more drinks on one occasion? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily *Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0*	8. How often during the last year have you been unable to remember what happened the night before because you had been drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	9. Have you or someone else been injured as a result of your drinking? (0) No (2) Yes, but not in the last year (4) Yes, during the last year
5. How often during the last year have you failed to do what was normally expected from you because of drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down? (0) No (2) Yes, but not in the last year (4) Yes, during the last year
Record total of specific items here *If total is greater than recommended cut-off, consult User's Manual.*	

The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest.
Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remem- ber what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

Appendix N: Drug Use Screening Test

DRUG USE QUESTIONNAIRE (DAST-20)

Name:_____ Date: _____

The following questions concern information about your potential involvement with drugs not including alcoholic beverages during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No". Then, circle the appropriate response beside the question.

In the statements "drug use" refers to (1) the use of prescribed or over the counter drugs in excess of the directions and (2) any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g. marijuana, hash), solvents, tranquilizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD) or narcotics (e.g. heroin). Remember that the questions do not include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

For information on the DAST, contact Dr. Harvey Skinner at the Addiction Research Foundation, 33 Russell St., Toronto, Canada, M5S 2S1.

These questions refer to the past 12 months.

1. Have you used drugs other than those required for medical reasons?....Yes No
2. Have you used prescription drugs?..... Yes No
3. Do you use more than one drug at a time?.....Yes No
4. Can you get through the week without using drugs?.....Yes No
5. Are you always able to stop using drugs when you want to?.....Yes No
6. Have you had "blackouts" or "flashbacks" as a result of drug use?.....Yes No
7. Do you ever feel bad or guilty about your drug use?.....Yes No
8. Does your spouse (or parents) ever complain about your involvement with drugs?.....Yes No
9. Has drug use created problems between you and your spouse or your parents?.....Yes No
10. Have you lost friends because of your use of drugs?..... Yes No
11. Have you neglected your family because of your use of drugs?.....Yes No
12. Have you been in trouble at work because of drug abuse?.....Yes No
13. Have you lost a job because of drug use?.....Yes No
14. Have you gotten into fights when under the influence of drugs?.....Yes No
15. Have you engaged in illegal activities in order to obtain drugs?.....Yes No
16. Have you been arrested for possession of illegal drugs?.....Yes No
17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?.....Yes No
18. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?.....Yes No
19. Have you gone to anyone for help for a drug problem?.....Yes No
20. Have you been involved in a treatment program specifically related to drug use?..... Yes No