GENERAL MANAGEMENT

Screening for all individuals entering jail

Review substance use with validated screening tool

Suggestions:
- Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)
- Brief Screener for Alcohol, Tobacco, and other Drugs (BSTAD)
- Tobacco, Alcohol, Prescription medications, and other Substances (TAPS)

Is immediate clinical assessment required? (see below)

- Recent, regular, and heavy use of alcohol or sedatives
- Recent use of alcohol or sedatives and history of complicated withdrawal
- Positive screen for alcohol or opioid use in a pregnant person
- Individual appears unwell

NO

Positive screen for substance misuse?

- Recent, regular substance use
- Substance use disorder
- Risk of withdrawal

NO

Be alert to developing signs of withdrawal (especially during first 72 hours)

YES

Monitor for signs or symptoms of withdrawal for at least 72 hours

Frequency depends on substance and at a minimum should occur:
- Alcohol or sedative use - every 6 hours
- Opioid use - every 4 hours
- Stimulant use - twice daily

Positive finding of withdrawal or patient looks unwell?

NO

YES

YES

Send for evaluation by qualified health professional

Assess risk for withdrawal

Assess risk based on:
- Current substance use (frequency, duration, route, etc.)
- History and severity of prior withdrawal
- Medical and psychiatric comorbidities

Identify emergent medical or psychiatric needs (including suicide risk)

Evaluate signs and symptoms of withdrawal

Does patient require a higher level of care?

Reasons for transfer
- Recommended resources are not immediately available
- Suspected overdose or severe ongoing oversedation
- Severe or complicated withdrawal (seizures, hallucinations, delirium)
- Worsening medical or psychiatric condition
- Known or suspected withdrawal from barbiturates or gamma-hydroxy-butyrate (GHB)

Consider transfer for
- History of severe withdrawal
- History of severe psychiatric symptoms
- Pregnant patient at risk for alcohol or opiate withdrawal

NO

Perform clinical assessment at least twice daily

- General physical condition
- Vital signs
- Hydration
- Orientation
- Sleep
- Mental health status (including risk of self harm)
- Fall risk
- Progression of withdrawal symptoms
- Timing of next assessment

Provide supportive care

- Minimize environmental stimuli (lights reduce lights/ noise levels, house in smaller units when available)
- Avoid isolating patients as this increases risk of self-harm
- Nutritional supplements, IV fluids, glucose, electrolyte management as clinically indicated

YES

Prepare patient for transfer

- Stabilize patient using principles of first aid and CPR
- Give naloxone if breathing is not sufficient
- Give medication as clinically indicated and feasible

Important points
- Monitoring should be done by qualified health professionals or well-trained and supervised custody staff
- Anyone who looks unwell or reports or appears to have withdrawal symptoms, even outside of first 72 hours, should be referred for immediate clinical evaluation
- Prescription medications taken as prescribed do not warrant treatment for withdrawal - verify and continue all prescriptions
- Treatment should not change based on potential timeline for release

Signs that can indicate substance withdrawal:
- Seizure
- Seeing, hearing, or responding to people or things that are not present
- Incoherent speech
- Unaware of who or where they are
- Talking about hurting themselves or others
- Confusion, agitation, paranoia
- Appearing severely depressed
- Diarrhea
- Vomiting
- Tremor
- Dilated pupils

Bureau of Justice Assistance. (2023). *Guidelines for Managing Substance Withdrawal in Jails.* https://bja.ojp.gov/news/new-resource-guidelines-managing-substance-withdrawal-jails

OPIOID WITHDRAWAL MANAGEMENT

Screening positive for opioid use

Monitor at least every 6 hours for 72 hours after intake

- Short acting opioid withdrawal (heroin, oxycodone) starts 12 hours after use, peaks after 24-48 hours, and lasts 3-5 days
- Long acting opioid withdrawal (methadone) starts within 30 hours of last use and last up to 10 days
- Fentanyl can be short or long acting depending on frequency of use

Immediate clinical assessment if individual appears unwell or has COWS 3+ (Ref 1, p.42)

Symptoms of opioid withdrawal include:

- agitation, anxiety
- nausea, vomiting, diarrhea
- dilated pupils
- teary eyes, runny nose
- muscle aches

Initial clinical assessment

Confirm opioid use disorder or opioid withdrawal

- Obtain history of opioid used, route/length of time used, last use, and symptoms when usage stopped or decreased
- Identify symptoms of withdrawal and risk of overdose and withdrawal

Start on medication as detailed below

- Transfer to higher level of care if buprenorphine or methadone are not available.
- Treatment can be provided under the 72 hour emergency rule while finding an appropriate facility

Monitor for changes in withdrawal symptoms and oversedation

- Monitor with COWS at least every 4 hours for short acting opioids and every 8 hours for long acting opioids
- Worsening symptoms after starting treatment suggest misdiagnosis or precipitated withdrawal - recommend transfer to higher level of care.

Titrate medications and provide supportive care

- Monitor for hydration status
- Nausea, vomiting, diarrhea indicate that dosage is not adequate

Continue maintenance treatment for opioid use

- Continued treatment for opioid use disorder after withdrawal reduces the risk of relapse, overdose, and death
- Assist with finding community based treatment upon release

Initiating buprenorphine (Ref 3, p.42)

Monitor for withdrawal before starting

Mild/moderate symptoms should be present to avoid precipitating withdrawal

Starting dose of 2-4mg and observe for 30min

Worsening symptoms suggest precipitated withdrawal - consider transfer to higher level of care

Wait 60-90min, and advance dose by 2-8mg as needed

Advance dose until acute symptoms improve

Continue to titrate dose over 1-3 weeks

Increase dose until symptoms are alleviated, then continue on a daily basis

Initiating methadone (Ref 3, p.36)

Withdrawal symptoms are not required prior to starting methadone

Start with dose of 10-30mg

Maximum initial dose allowed by federal law is 30mg (Ref 1, p.48)

Reevaluate in 2-4 hours

- Maximum allowed dose on day 1 is 40mg (Ref 1, p.48)
- See Appendix-2 for adjuvant medications if symptoms not controlled with max allowed dose

Continue to titrate dose over 1-3 weeks

Increase dose by up to 10mg every 2-3 days until symptoms are alleviated

Important points

- Individuals may not be aware they used drugs contaminated with opioids, and they are at risk for withdrawal
- Polysubstance use or withdrawal from other substances does not preclude treatment for opioid withdrawal
- See Appendix-3 for low dose buprenorphine initiation that can avoid precipitating withdrawal

Considerations for pregnant patients (Ref 1, p.51):

- Methadone and buprenorphine are safe for use during pregnancy and reduce the risk of miscarriage and preterm delivery
- Provider should have obstetric experience and care may require transfer to the hospital
- Pregnancy increases medication clearance - regularly evaluate need for increased and/or split dose starting in 2nd trimester
- After delivery, continue maintenance treatment but reduce dose if there is oversedation

Adjuvant medications:

- Can be used while titrating dose of first-line medications, but should not be required once buprenorphine/methadone is at adequate dose
- See Appendix-2 for full list
- Alpha-2-adrenergic antagonists (e.g. lofexidine or clonidine) can be used in people declining buprenorphine/methadone, but are contraindicated if low blood pressure
- Naltrexone is not approved for treatment of acute withdrawal

Bureau of Justice Assistance. (2023). *Guidelines for Managing Substance Withdrawal in Jails.* https://bja.ojp.gov/news/new-resource-guidelines-managing-substance-withdrawal-jails

ALCOHOL WITHDRAWAL MANAGEMENT

Screening positive for alcohol use

Is immediate clinical assessment required? (see below)

- Intoxication
- Heavy alcohol use (8+ drinks for men, or 6+ for women, 4+ times a week)
- Alcohol use in the last week and history of complicated withdrawal

NO → **Monitor every 6 hours and refer for clinical evaluation if individual appears unwell to layperson**

Symptoms of alcohol withdrawal include:
- Seizures, hallucinations
- Confusion, agitation
- Fever, increased heart rate or blood pressure
- Sweating/clammy skin, tremors
- Nausea/vomiting

YES → **Send for evaluation by qualified health professional**

Important points:
- If there is concurrent opioid withdrawal, stabilize patient on treatment with buprenorphine or methadone prior to tapering benzodiazepines
- If at any point the patient develops complicated withdrawal, they should be stabilized and transferred to a higher level of care
- See Appendix-1 for dose equivalencies of other benzodiazepines

Considerations for pregnant patients (Ref 1, p.31-32):
- Typically require transfer to higher level of care or management with an obstetrician
- Do not delay starting treatment while awaiting transfer or consultation
- There is a small risk of teratogenicity with benzodiazepines in the first trimester, but this should be weighed against risk for Fetal Alcohol Spectrum Disorder or risk of withdrawal syndrome
- If there is risk of preterm delivery or during the late third trimester, short-acting benzodiazepines are recommended

Initial clinical assessment

Rule out other serious illness that can present in similar

Differential diagnosis:
- Acute coronary syndrome
- Infection/sepsis
- Pulmonary embolism
- Hyperthyroidism
- Intoxication
- Other withdrawal syndrome

Evaluate need to transfer to higher level of care

Reasons for transfer
- Severe or complicated withdrawal (seizures, delirium)
- Known/suspected Wernicke-Korsakoff syndrome (severe confusion, loss of muscle coordination, vision changes)
- Pregnant patient
- Severe/worsening condition after several doses of meds

Start treatment with long-acting benzodiazepine as detailed below

Start daily thiamine 100mg for 3-5 days (PO, IM, or IV as available)

Evaluate with clinical assessment at least every 8 hours

- CIWA-Ar
- Vital signs
- Signs of oversedation
- Hydration status
- Need for higher level of care

Is CIWA-Ar score <19?

YES → **Continue assessment and treatment at least every 8 hours until CIWA-Ar <10 for 24 hours** → **Begin to taper dose until discontinued**

- Taper daily dose by 25-50% per day over 3-5 days.
- Can taper dose amount and/or frequency.

NO → **Increase assessment frequency to every 6 hours and evaluate need for higher level of care**

Medication management of acute withdrawal (Ref 1, 2)

Treat with long-acting benzodiazepine (e.g. chlordiazepoxide, diazepam or lorazepam) based on severity of CIWA-Ar score

Dose equivalencies:
- 25mg chlordiazepoxide
- 5mg diazepam
- 1mg lorazepam

High risk of severe or complicated withdrawal?

- CIWA-AR >21 or seizures
- History of multiple or complicated withdrawals
- Heavy, regular alcohol use or concurrent sedative use

YES → **Start on front loaded dose regimen, preferred agents are chlordiazepoxide and diazepam (Ref 1, p.30)**

Suggested regimen with chlordiazepoxide (Ref 2, p.70):
Fixed dose
- 50-100mg PO q1-2h for 3 doses

Symptom-triggered dose
- 50-100mg PO q1-2 until CIWA-Ar <10

NO → **CIWA-Ar >10?**

YES → **Start on long acting benzodiazepine with fixed dose regimen**

Suggested regimen with chlordiazepoxide (Ref 2, p.70):
- Day 1: 25-100mg PO q4-6h
- Day 2: 25-100mg PO q6-8h
- Day 3: 25-100mg PO q8-12h
- Day 4: 25-100mg PO at bedtime

NO → **Manage with supportive care - consider prophylactic dose of medication (e.g. 25-50mg PO chlordiazepoxide)**

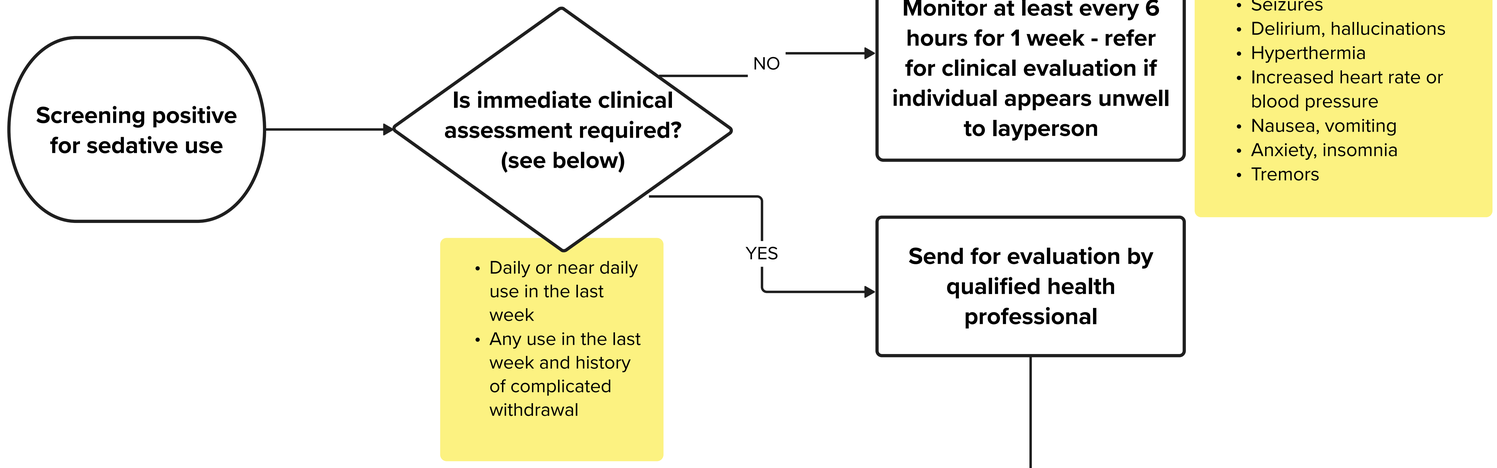
Add symptom-triggered dose regimen

Evaluate by CIWA-Ar

- **Mild withdrawal: CIWA-Ar <10** → **Supportive care, or treat with 25-50mg PO chlordiazepoxide (Ref 2, p.70)**
- **Moderate withdrawal: CIWA-Ar 10-18** → **Treat with 50-100mg PO chlordiazepoxide (Ref 2, p.70)**
- **Severe withdrawal: CIWA-Ar >19** → **Treat with 75-100mg PO chlordiazepoxide (Ref 2, p.70)**

Bureau of Justice Assistance. (2023). *Guidelines for Managing Substance Withdrawal in Jails.* https://bja.ojp.gov/news/new-resource-guidelines-managing-substance-withdrawal-jails

SEDATIVE WITHDRAWAL MANAGEMENT



Symptoms of sedative withdrawal include:
- Seizures
- Delirium, hallucinations
- Hyperthermia
- Increased heart rate or blood pressure
- Nausea, vomiting
- Anxiety, insomnia
- Tremors

Important points
- If there is concurrent opioid withdrawal, stabilize patient on treatment with buprenorphine or methadone prior to tapering benzodiazepines
- Withdrawal management in pregnant patients should proceed slowly and in consultation with an obstetrician
- CIWA-B can be used for monitoring, though the validity and reliability of this score has not been fully determined

Evaluate risk/ severity of withdrawal
- Sedative withdrawal has a high risk of complications and should always be treated
- Evaluate for type and frequency of use to determine intensity of treatment

Evaluate need to transfer to higher level of care

Reasons for transfer
- Known or suspected withdrawal from GHB or barbiturates
- Signs of complicated withdrawal (seizures, delirium)

Start treatment with long-acting benzodiazepine
- Clonazepam is preferred medication (Ref 1, p.38)
- Convert prior sedative dose to equivalent dose for treatment (see Appendix-1)
- Individual dose may vary but should control withdrawal symptoms

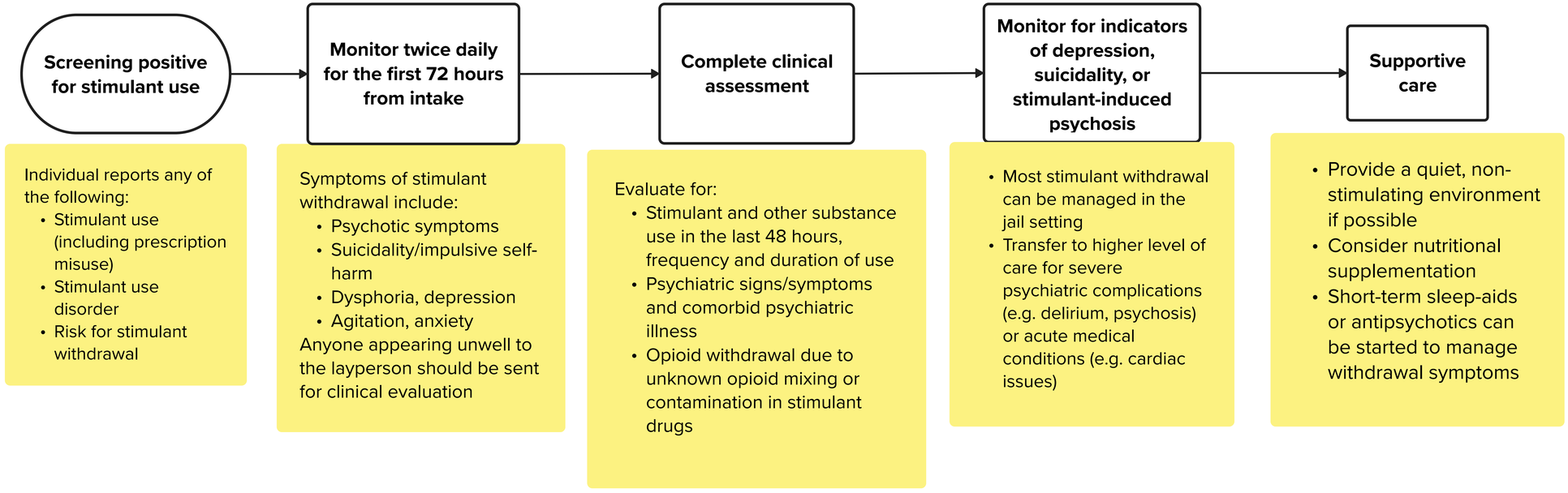
Monitor with daily clinical assessment for first week
- After first week, can reduce assessments to twice weekly until taper is completed
- Return to daily assessment if symptoms worsen at any point
- Consider using CIWA-B for monitoring

Gradual taper over period of weeks to months
- Taper dose by no more than 10-25% per week
- Stabilize or increase dose if withdrawal symptoms worsen
- May need to slow the taper towards the end if anxiety or insomnia develops

Continue supportive care during and after taper
- Cognitive behavioral therapy
- Stress management
- Sleep hygiene
- Relaxation techniques

Bureau of Justice Assistance. (2023). *Guidelines for Managing Substance Withdrawal in Jails.* https://bja.ojp.gov/news/new-resource-guidelines-managing-substance-withdrawal-jails

STIMULANT WITHDRAWAL MANAGEMENT



Important point
- Stimulant drugs are increasingly contaminated with strong synthetic opioids
- Individuals may not be aware they have been using opioids and are at risk for opioid withdrawal

Bureau of Justice Assistance. (2023). *Guidelines for Managing Substance Withdrawal in Jails.* https://bja.ojp.gov/news/new-resource-guidelines-managing-substance-withdrawal-jails

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Wolters Kluwer

Pharmacology of benzodiazepines used to treat anxiety symptoms/disorders

Drug	Adult oral total daily dose (mg)*	Comparative potency (mg)¶	Onset after oral dose (hours)	Metabolism	Elimination half-life (hours)Δ
Alprazolam	0.5 to 6	0.5	1	CYP3A4 to minimally active metabolites.	11 to 15 16 (older adults) 20 (hepatic impairment) 22 (obesity)
Alprazolam extended release	0.5 to 6 once daily	0.5	1		
Bromazepam◇ §	6 to 30	7.5	1	CYP1A2. No active metabolite.	8 to 20
Chlordiazepoxide§	5 to 100	10	1	CYP3A4 to active metabolites.	30 to 100 Prolonged in older adults and hepatic impairment
Clonazepam	0.5 to 4	0.25 to 0.5	0.5 to 1	CYP3A4. No active metabolite.	18 to 50
Clorazepate	15 to 60	7.5	0.5 to 1	CYP3A4 to active metabolite.	36 to 200
Diazepam	4 to 40	5	0.25 to 0.5	CYP2C19 and 3A4 to active metabolites.	50 to 100 Prolonged in older adults and renal or hepatic impairment

Lorazepam immediate release	0.5 to 6 0.5 to 4 (hypnotic)	1	0.5 to 1	Non-CYP glucuronidation in liver. No active metabolite.	10 to 14
Lorazepam extended release	1 to 6 mg¥	1	0.5 to 1	Non-CYP glucuronidation in liver. No active metabolite.	13 to 27
Oxazepam	30 to 120 15 to 30 (hypnotic)	15 to 30	1 to 2	Non-CYP glucuronidation in liver. No active metabolite.	5 to 15
Prazepam◇ §	15 to 60	15	2 to 3	CYP3A4 to active metabolites.	30 to 200 Prolonged in older adults

Data on drug metabolism and activity of metabolite(s) are for assessment of potential for CYP drug interactions and risk of accumulation. Risk of accumulation is greater, and dose reduction necessary, for older or debilitated adults and for patients with renal or hepatic insufficiency.

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* Range of usual **total** daily dose for treatment of adults with anxiety or panic disorder typically given in divided doses two to four times daily.

¶ Important: Data shown are approximate equal potencies relative to lorazepam 1 mg orally and are NOT recommendations for initiation of therapy or for conversion between agents.

Δ Half-life of parent drug and pharmacologically active metabolite, if any.

◇ Not available in the United States.

§ Use only when other preferred agents are unavailable or not tolerated.

¥ To be used only when converting from immediate release lorazepam. Total daily dose is equal to the current total daily dose of immediate release lorazepam. Dose is given once daily in the morning after discontinuing immediate dose lorazepam tablets the night before.

Graphic 65653 Version 13.0

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Wolters Kluwer

Adjunctive treatments for opioid withdrawal symptoms

Symptoms	Medication	Usual effective dose range (adult)	Notes
Anxiety			
Anxiety, irritability, restlessness	Diphenhydramine*	50 to 100 mg orally every 4 to 6 hours as needed (maximum 300 mg daily)	▪ May also treat nausea ▪ Use reduced dose in hepatic impairment ▪ IV and IM administration available
	Hydroxyzine	25 to 100 mg orally every 6 to 8 hours as needed (maximum 400 mg daily)	▪ May also treat lacrimation and rhinorrhea ▪ Use reduced dose (50%) in renal or hepatic impairment ▪ IM administration available
	Clonazepam¶	0.5 to 1.5 mg orally every 6 to 8 hours as needed (maximum 6 mg daily)	▪ Use with caution and reduce dose in mild hepatic or renal impairment; active metabolites can accumulate ▪ Avoid in moderate to severe hepatic impairment or hepatic encephalopathy
	Lorazepam¶	1 mg orally every 4 to 6 hours as needed (maximum 6 mg daily)	▪ Relatively safe in mild to moderate hepatic impairment; use of reduced dose may be needed ▪ Avoid in severe hepatic impairment or hepatic encephalopathy ▪ IV and IM administration available; use caution in renal impairment due to propylene glycol diluent
	Oxazepam¶	15 to 30 mg orally every 6 to 8 hours as needed (maximum 120 mg daily)	▪ Relatively safe in mild to moderate hepatic or renal impairment ▪ Use with caution in severe renal impairment ▪ Avoid in severe hepatic impairment or hepatic encephalopathy
Gastrointestinal			

Abdominal cramping	Dicyclomine*	10 to 20 mg orally every 6 to 8 hours as needed (maximum 160 mg daily)	▪ IM administration available (lower doses are used) ▪ Use with caution and reduce dose in renal or hepatic impairment
Diarrhea	Bismuth*	~524 mg orally every 30 to 60 minutes as needed (up to 4200 mg daily)	▪ Monitor for dehydration and maintain fluid levels with oral and/or IV hydration
	Loperamide	4 mg orally followed by 2 mg after each loose stool (maximum 16 mg daily)	
Nausea/vomiting	Ondansetron*$^{\Delta}$	4 to 8 mg orally or IV every 12 hours as needed (maximum 16 mg/day)	▪ Monitor for dehydration and maintain fluid levels with oral and/or IV hydration ▪ Dose-dependent QT interval prolongation; risk of rare, potentially fatal, ventricular arrhythmia; use with caution (eg, monitor baseline and post-dose ECG) or avoid in patients with features of elevated risk$^{\Delta}$ ▪ Use caution and reduced dose (50%) in severe hepatic impairment
	Prochlorperazine	5 to 10 mg orally three times daily before meals or every six hours as needed (maximum 40 mg/day)	▪ Monitor for dehydration and maintain fluid levels with oral and/or IV hydration ▪ Use with caution in mild to moderate hepatic impairment; avoid in severe hepatic impairment ▪ IV and rectal administration available
	Promethazine	25 mg orally every 4 to 6 hours as needed (maximum 50 mg/day)	▪ Monitor for dehydration and maintain fluid levels with oral and/or IV hydration ▪ Use with caution in mild to moderate hepatic impairment; avoid in severe hepatic impairment ▪ IM and rectal administration available (IV use not recommended)
Insomnia, pain, muscle spasm, and restless legs			
Insomnia	Trazodone*	25 to 100 mg orally at bedtime	▪ May titrate nightly up to 300 mg at bedtime if needed ▪ Use with caution in severe hepatic or renal impairment

	Doxepin	6 to 50 mg orally at bedtime	▪ Use with caution and reduce dose in severe hepatic impairment
	Mirtazapine	7.5 to 15 mg orally at bedtime	▪ May need to use lower dose in moderate to severe hepatic or renal impairment
	Quetiapine	50 to 100 mg orally at bedtime	▪ Use lower initial dose (25 mg) in hepatic impairment and adjust based on response
	Zolpidem ¶	5 to 10 mg orally at bedtime	▪ A dose of 5 mg is usually appropriate for female patients, and those with mild or moderate hepatic impairment ▪ Avoid in severe hepatic impairment or hepatic encephalopathy
Muscle aches ◇, joint pain, headache	Ibuprofen* §	400 mg orally every 4 to 6 hours as needed (maximum 2400 mg daily)	▪ Patient should be well hydrated and without significant kidney disease ▪ Use with caution in mild to moderate hepatic or renal impairment ▪ Avoid all NSAIDs in severe renal or hepatic impairment or cirrhosis
	Acetaminophen	650 to 1000 mg orally every 4 to 6 hours as needed (maximum 4000 mg daily)	▪ Appropriate analgesic for most patients ▪ Use reduced dose (ie, 2000 mg daily) or avoid in hepatic impairment or if malnourished
	Ketorolac §	15 to 30 mg IV or IM every 6 hours as needed (maximum 120 mg daily)	▪ Patient should be well hydrated and without significant kidney disease ▪ Limit use to 5 days or less ▪ Use with caution and reduce dose (50%) in older adults and patients with mild to moderate renal impairment ▪ Use with caution in mild to moderate hepatic impairment ▪ Contraindicated in severe renal or hepatic impairment or volume depletion
	Naproxen §	500 mg orally twice daily with meals	▪ Patient should be well hydrated and without significant kidney disease ▪ Use with caution in mild to moderate hepatic or renal impairment ▪ Avoid all NSAIDs in severe renal or hepatic impairment or cirrhosis
Muscle spasm ◇, restless legs	Cyclobenzaprine*	5 to 10 mg orally every 8 hours as needed (maximum 30	▪ Use reduced dose in mild hepatic impairment ▪ Avoid in moderate to severe haptic impairment

		mg daily)	
	Baclofen	5 to 10 mg orally every 8 hours as needed (maximum 60 mg daily)	▪ Use reduced dose in renal impairment
	Diazepam ¶	5 to 10 mg orally every 6 to 12 hours as needed (maximum 40 mg daily)	▪ Use with caution in hepatic or renal impairment ▪ Avoid in severe hepatic impairment or hepatic encephalopathy ▪ IM and IV administration available
	Methocarbamol	750 to 1500 mg orally every 8 hours as needed (maximum 6 g daily)	▪ Use with caution in hepatic or renal impairment ▪ IM and IV administration available (lower doses are used); avoid parenteral formulation in renal impairment (propylene glycol additive)

- A calm quiet environment with supportive and reassuring staff can be instrumental for helping patients overcome most symptoms of acute opioid withdrawal and decreases the need for pharmacologic interventions.
- Patients who have diarrhea, vomiting, or sweating should be monitored for dehydration and fluid levels maintained with oral and/or intravenous fluids.
- The role of opioid replacement therapies and alpha-2 agonists (eg, clonidine) in management of acute opioid withdrawal and maintenance pharmacotherapy in opioid use disorder is discussed separately; refer to accompanying text.
- This is not a complete list of cautionary information or dose adjustments in organ impairment. For additional information refer to the Lexicomp drug monographs included within UpToDate.

IV: intravenous; IM: intramuscular; NSAID: nonsteroidal anti-inflammatory drug.
* Author's first choice.
¶ Use of benzodiazepines and benzodiazepine agonists (eg, zolpidem) is NOT recommended in patients receiving methadone or buprenorphine therapy unless under close medical supervision. Patients who resume heroin (diamorphine) use after a period of abstinence are at high risk of fatally overdosing, particularly if heroin use is resumed in combination with benzodiazepines, alcohol, or other drugs with sedative characteristics (eg, quetiapine). The use of benzodiazepines should be limited to 5 to 10 days in total and tapered. They are not recommended for use in supervised outpatient withdrawal and should be reserved for inpatient settings where frequent clinical monitoring is provided.
Δ Risk of QTc prolongation or torsades de pointes is also elevated with advanced age, female sex, heart disease, congenital long QT syndrome, hypokalemia or hypomagnesemia, overly rapid IV administration, and combination of drugs with QTc prolonging effects (eg, methadone). Refer to topic on acquired long QT syndrome.
◇ Warm baths, rehydration, and gentle stretching are also helpful for relieving muscle aches and cramps.
§ Safety concerns of NSAID use in older adults and patients with, or at elevated risk for, cardiovascular disease, gastrointestinal bleeding, organ dysfunction, or thrombotic events are addressed separately in UpToDate.

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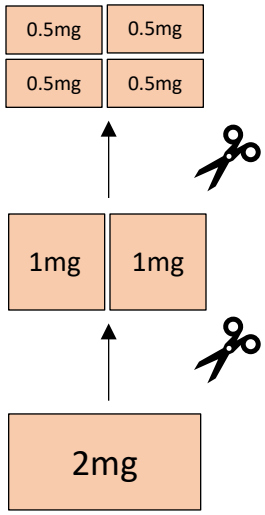
Graphic 106793 Version 6.0

Patient Guidelines for Buprenorphine "Micro-Dosing" Induction

To reduce the risk of precipitated withdrawal when starting buprenorphine/naloxone, we would like you to start at very low doses and increase slowly. Please follow the schedule below and call us at _____ if there are any problems.

PREPARING YOUR DOSES:



*On Days 1-5, we will use **2mg buprenorphine/naloxone films:***

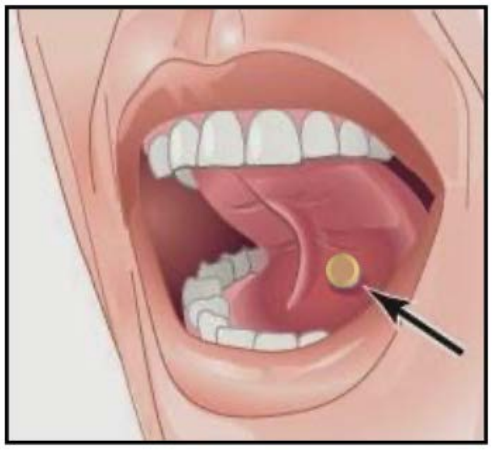
- **Days 1-2:** Cut ONE 2mg film into four equal pieces to achieve the lowest dose needed (0.5mg or 1/4th of a 2mg film).
- **Day 3:** Cut ONE 2mg film into two equal pieces to achieve the lowest dose needed (1mg or ½ of a 2mg film).
- **Days 4-5:** Use full 2mg films. You do NOT need to further prepare the films.

*On Days 6-7, we will use **8mg buprenorphine/naloxone films**. You do NOT need to cut or further prepare these films.*

DAILY DOSING INSTRUCTIONS:

On each day, take your 1st dose of buprenorphine/naloxone about 10-15 minutes ***BEFORE*** using any other opioid-based substances (i.e. heroin, fentanyl, methadone, prescription pills, etc.)

Place the film ***under your tongue*** and let it melt completely.



Day 1: _____	Take ¼ of a 2mg film (0.5 mg) ONCE
Day 2: _____	Take ¼ of a 2mg film (0.5 mg) TWICE daily
Day 3: _____	Take ½ of a 2mg film (1 mg) TWICE daily
Day 4: _____	Take one full 2mg film (2mg) TWICE daily
Day 5: _____	Take two full 2mg films (4mg) TWICE daily
Day 6: _____	Take one full 8mg film (8mg) TWICE daily
Day 7: _____	**STOP** using any non-buprenorphine opioid-based substances. Continue taking buprenorphine/naloxone 8mg films TWICE or THREE TIMES daily (as advised by your medical provider).

PLEASE RETURN TO CLINIC ON:

_____

Starting Buprenorphine
Symptom Management Guide

Clinic Name: _____
Clinic Phone Number: _____

The following medications have been prescribed to help you manage the symptoms of opioid withdrawal while you wait to take the first dose of buprenorphine. You can keep using these medications after you take your first dose if you keep on having withdrawal symptoms.

If you feel much worse after starting medications within 1-2 hours after starting buprenorphine, please call us at _____ during business hours or seek care in a local Urgent Care of Emergency Department.

	If You Feel This, Then…	Take This…	In This Way…
Prescribed? ☐	**Cold sweats, Chills, Feeling "Jittery"** 	Clonidine 0.1 mg tablet	Take 1 tablet by mouth every 6 hours as needed. Stop taking if you feel dizzy. Do not use more than 4 tablets in one day.
Prescribed? ☐	**Anxiety, Problems Sleeping** 	Hydroxyzine 50 mg tablet	Take 1 tablet by mouth every 6 hours as needed. Stop taking if you feel too sleepy. Do not use more than 4 tablets in one day.
Prescribed? ☐	**Nausea or Vomiting** 	Ondansetron 4 mg tablet	Take 1 tablet by mouth every 6 hours as needed. Do not use more than 4 tablets in one day.
Prescribed? ☐	**Diarrhea** 	Loperamide 2 mg tablet	Take 2 tablets as your first dose. Take 1 additional tablet after each episode of diarrhea. Do not use more than 6 tablets in one day.

Symptom management guide is adapted from Highland Hospital's Buprenorphine Induction Clinic guide, prepared by David Tian, MD MPP.

Clinical Opiate Withdrawal Scale

Introduction

The Clinical Opiate Withdrawal Scale (COWS) is an 11-item scale designed to be administered by a clinician. This tool can be used in both inpatient and outpatient settings to reproducibly rate common signs and symptoms of opiate withdrawal and monitor these symptoms over time. The summed score for the complete scale can be used to help clinicians determine the stage or severity of opiate withdrawal and assess the level of physical dependence on opioids. Practitioners sometimes express concern about the objectivity of the items in the COWS; however, the symptoms of opioid withdrawal have been likened to a severe influenza infection (e.g., nausea, vomiting, sweating, joint aches, agitation, tremor), and patients should not exceed the lowest score in most categories without exhibiting some observable sign or symptom of withdrawal.

APPENDIX 1
Clinical Opiate Withdrawal Scale

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

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* 1/2 *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* 1/2 *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 or 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 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
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

This version may be copied and used clinically.

Source: Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). *J Psychoactive Drugs,* 35(2), 253–9.

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