GOALS

- Recognize signs and symptoms of intoxication/withdrawal that may need stabilization at a higher level of care (HLOC)
- Successfully treat symptoms of withdrawal in a way that facilitates opportunities to offer access to treatment for substance use disorder (SUD)
- Patients who are eligible and interested in pursuing SUD treatment should be referred to addiction services (See CCHCS Care Guide: Substance Use Disorder)

ASSESSMENT

- The first step is stabilizing patient and airway, then determine whether signs and symptoms warrant transfer to a HLOC, or if the patient can be successfully treated within the institution in a treatment and triage area (TTA) or inpatient medical bed.
- The identification of withdrawal or intoxication must begin with the collection of pertinent patient information including: patient history, physical examination, and laboratory screening.
- Use intoxication diagnostic codes – search under intoxication and select for the specific substance(s) used.
- The signs and symptoms of intoxication and withdrawal differ by the specific type of substance used. This Care Guide covers intoxication and withdrawal related to the following substances:

| Alcohol (Pages 5-6) | Opioids (Pages 7-9) | Stimulants (Page 10) | Sedative-Hypnotics (Page 11) |

TREATMENT

Treatment for Intoxication

- For substances other than opioids and benzodiazepines, there are no specific antagonist (reversal) agents to treat an intoxication. Instead, treatment is primarily supportive with a focus on prevention of morbidity or mortality, and restoring/maintaining vital functions.
- For opioid intoxication, naloxone is available within CDCR/CCHCS and can reverse the effects of opioid intoxication including respiratory depression.
- Flumazenil is available within CDCR/CCHCS and can reverse the effects of benzodiazepine intoxication.

Treatment for Withdrawal

- Since the withdrawal phase is typically very unpleasant, it is during this phase where the opportunity to intervene and instigate changes in behavior is greatest.
- Use of long-acting agents that may ease withdrawal symptoms over time or initiation of a replacement agent should be carefully considered where appropriate (e.g., buprenorphine for opioid withdrawal).

MONITORING

- Serial clinical assessments including vital signs and use of other tools such as the Clinical Opioid Withdrawal Scale (COWS) or Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) instruments may help to provide objective measures of response to therapy.
- Laboratory analysis may detect significant nutrient deficiencies or complications caused by the effects of intoxication. Consider comprehensive metabolic panel (CMP), complete blood count (CBC), urine drug screen (UDS), electrocardiogram (EKG), and additional investigations as appropriate (see each section for additional guidance).
- Provide the patient with educational handouts on intoxication risks and relapse prevention and assure they understand how to access help for an underlying SUD if not pursued at the time surrounding acute intoxication and withdrawal.

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CCHCS Care Guide: Intoxication and Withdrawal

### Intoxication and Withdrawal Treatment Algorithm

**Patient presents with presumed intoxication or withdrawal**

- **Transfer to Hospital**

**Does the patient exhibit any high risk symptoms that require transfer to a higher level of care?**

  - **YES**
  - **NO**

- **PCP evaluation within 5 days upon return from HLOC, review hospital records**

**Provider evaluates patient for intoxication or withdrawal or other possible sources of distress or altered consciousness based on physical examination, patient history, and laboratory screening**

*See Page 4 for signs and symptoms*

**Treat patients according to guidelines for intoxication and withdrawal management**

- For alcohol see Pages 5-6
- For opioids see Page 7-9
- For stimulants see Page 10
- For sedative-hypnotics see Page 11
- For overview of symptomatic treatments, see table below

**Does the patient meet criteria for suspected Substance Use Disorder?**

  - **YES**
  - **NO**

- **Patient is referred to the addiction medicine provider and LCSW for evaluation for SUD and potential entry into ISUDT program**

*For details, refer to the CCHCS Care Guide: Substance Use Disorder*

- **Patient is monitored for potential complications from withdrawal or intoxication in TTA or inpatient medical bed**

### Overview of Symptomatic Treatments

<table>
<thead>
<tr>
<th>Sign or Symptom</th>
<th>Medication</th>
<th>Typical Doses</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Withdrawal (Mild)</td>
<td>Clonidine (Catapres®)</td>
<td>0.1 to 0.2 mg orally every 8 hours</td>
</tr>
<tr>
<td>Anxiety, Irritability, Restlessness</td>
<td>Hydroxyzine Pamoate (Vistaril®)</td>
<td>25 to 100 mg orally every 6 to 8 hours as needed</td>
</tr>
<tr>
<td>Seizures</td>
<td>Lorazepam (Ativan®)</td>
<td>2 mg IV, PO, IM initial, with repeated dosing for clinical response</td>
</tr>
<tr>
<td>Abdominal Cramping</td>
<td>Dicyclomine (Bentyl®)</td>
<td>20 mg 4 times per day</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Loperamide (Imodium®)</td>
<td>4 mg orally for first dose, followed by 2 mg orally after each loose stool. Maximum of 16 mg/day</td>
</tr>
<tr>
<td>Nausea/Vomiting</td>
<td>Ondansetron (Zofran®)</td>
<td>4 to 8 mg orally three times daily</td>
</tr>
<tr>
<td>Gastrointestinal (GI) Upset</td>
<td>Aluminum Hydroxide/Magnesium Hydroxide/ Simethicone (Maalox®, Mylanta®)</td>
<td>Regular Strength: 10 to 20 mL or 2 to 4 tablets orally 4 times daily Maximum Strength: 10 to 20 mL orally twice daily</td>
</tr>
<tr>
<td>Muscle Aches, Joint Pain, Headache</td>
<td>Acetaminophen (Tylenol®)</td>
<td>650 to 1000 mg orally every 4 to 6 hours. Max dose: 4000 mg in a 24 hour period from all sources</td>
</tr>
<tr>
<td></td>
<td>Ibuprofen (Advil®, Motrin®)</td>
<td>400 mg orally every 4 to 6 hours as needed</td>
</tr>
<tr>
<td></td>
<td>Naproxen (Naprosyn®)</td>
<td>500 mg initial, followed by 500 mg every 12 hours or 250 mg every 6-8 hours</td>
</tr>
</tbody>
</table>

*Refer to medication tables on pages 12-19 for details*
Intoxication and withdrawal treatment is often viewed as separate from longer-term treatment of substance use disorders. However, proper treatment in this acute situation often helps form trust and opens lines of communication between the patient and provider, offering a valuable opportunity to discuss further options and utilize motivational interviewing techniques to encourage the patient to seek treatment.

Detoxification may be the first step in substance abuse treatment that promotes recovery.

- Identification and treatment of intoxication can lead to appropriate management of withdrawal phenomenon and can provide an avenue for entry into treatment for an underlying SUD.
- Detoxification should be thought of as one component of a comprehensive treatment strategy.
- It is important to distinguish detoxification from SUD treatment, which involves a constellation of ongoing therapies intended to promote recovery for substance abuse patients (See CCHCS Care Guide: Substance Use Disorder).

The primary goals in recognizing and treating intoxication and withdrawal are safe clinical stabilization and prevention of morbidity and mortality related to an underlying SUD.

### General Guidance Regarding Intoxication

Utilize a systematic and consistent approach to evaluation and management.

**Presentation depends upon:**
- Substance ingested, smoked, snorted, or injected
- Whether ingestion involves a single substance or a combination of substances (such as both heroin and methamphetamine)
- Acute vs. chronic use
- Other medications the patient may be taking
- Comorbid conditions

**Intoxication States**
- Result from being under the influence of the acute effects of alcohol or another drug of abuse
- Range from euphoria or sedation to life-threatening emergencies when overdose occurs
- Mimics many psychiatric and medical conditions

**Assessing the Intoxicated Patient Focuses on:**
- Patient history - May be unreliable (patient is unable or unwilling to give history), though witnesses and medical records may be useful
- Physical examination - The symptoms that typically present with acute intoxication are summarized in the table on page 4
- Laboratory screening - Urine toxicology screens can provide valuable information for long-term treatment (although results not available STAT)
  - Appropriate interpretation of the UDS requires:
    - Knowledge of particular sensitivities, specificities, and cross-reactivities
    - Understanding of the usual duration of detectability of particular substances

### General Guidance Regarding Withdrawal

The signs and symptoms of withdrawal are usually the opposite of a substance’s direct pharmacologic effects and begin to manifest as the levels of the substance recede. See the table on the next page for symptoms of intoxication and withdrawal from various classes of substances.

**Goals of Withdrawal:**
1. Evaluation and safe withdrawal from the substance(s) used
2. Stabilization and provision of treatment that is humane and thus protects the patient’s dignity
3. Foster the patient’s readiness for entry into treatment for SUD

**Onset, duration, and intensity of withdrawal are variable and influenced by:**
- Specific agent used
- Duration of use
- Degree of neuroadaptation

**Pharmacologic Management** - There are two general strategies for pharmacologic management of withdrawal; either or both may be used to manage withdrawal syndromes effectively.

1. Suppressing withdrawal through use of a cross-tolerant medication
   - A longer-acting medication typically is used to provide a milder, controlled withdrawal.
   - Examples include use of **methadone** for opioid detoxification and **lorazepam** for alcohol detoxification.

2. Reducing signs and symptoms of withdrawal through alteration of another neuropharmacologic process.
   - Medications that are not cross-tolerant are used to treat specific signs and symptoms of withdrawal.
   - Examples include use of **clonidine** for opioid or mild alcohol withdrawal.
## General Principles Regarding Intoxication and Withdrawal - Cont’d

### Relapse

Many individuals undergo detoxification more than once, and some do many times. Although addicted persons are at increased risk of relapse at certain points in their recovery, relapse can occur at any time. The relapsed patient is an appropriate candidate for detoxification and continuing treatment, including relapse prevention education. It is not an indication of treatment failure or for treatment cessation.

### Special Populations

Patients in certain groups, such as older adults, pregnant, and nursing women, require special consideration. Comorbid medical and infectious conditions such as hepatitis and HIV, co-occurring chronic pain issues, and dually diagnosed psychiatric disorders all pose unique challenges in the management of the intoxication and/or withdrawal. Seek consultation for additional guidance as needed from mental health, or the AMCT as needed.

### Signs and Symptoms of Intoxication and Withdrawal

<table>
<thead>
<tr>
<th>Substance</th>
<th>Acute Intoxication</th>
<th>Withdrawal Syndrome</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alcohol</strong></td>
<td>- Eyes: nystagmus</td>
<td>- Physical: nausea, vomiting, headache, tremors, seizure, paroxysmal sweats</td>
</tr>
<tr>
<td></td>
<td>- Cardiovascular: hypotension, tachycardia</td>
<td>- Psychological: anxiety, agitation, audio disturbances, tactile disturbances</td>
</tr>
<tr>
<td></td>
<td>- Psychological: disinhibited behavior, euphoria, mood variability</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Neurological: slurred speech, incoordination, unsteady gait, memory impairment, seizure, stupor, coma</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Lab abnormalities: hypoglycemia, hypokalemia, hyperlactatemia, hypomagnesemia, hypocalcemia, hypophosphatemia</td>
<td></td>
</tr>
<tr>
<td><strong>Opioids</strong></td>
<td>- Eyes: pupils constricted (may be dilated with meperidine or extreme hypoxia)</td>
<td>- Physical: pupils dilated, pulse rapid, gooseflesh, abdominal cramps, muscle jerks, “flu” syndrome, vomiting, diarrhea, tremulousness, yawning</td>
</tr>
<tr>
<td></td>
<td>- Cardiovascular: respirations depressed, blood pressure decreased, sometimes shock, pulmonary edema</td>
<td>- Psychological: anxiety</td>
</tr>
<tr>
<td></td>
<td>- Neurological: reflexes diminished to absent, stupor or coma</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Other: temperature decreased, constipation, convulsions with propoxyphene or meperidine</td>
<td></td>
</tr>
<tr>
<td><strong>Stimulants</strong></td>
<td>- Eyes: pupils dilated and reactive</td>
<td>- Physical: muscular aches, abdominal chills, tremors, voracious hunger, prolonged sleep, lack of energy</td>
</tr>
<tr>
<td></td>
<td>- Cardiovascular: elevated blood pressure and heart rate, cardiac arrhythmias, chest pain, tachycardia, palpitations, rupture aneurysm, cardiogenic shock</td>
<td>- Psychological: anxiety, profound depression, sometimes suicidal, exhaustion</td>
</tr>
<tr>
<td></td>
<td>- Psychological: sensorium hyperacute or confused, paranoid ideation, hallucinations, impulsivity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Neurological: hyperactive reflexes, tremors, hyperactivity, convulsions, coma, psychosis, agitation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Other: nausea, vomiting, temperature elevated, respiration shallow, hyperventilation, dry mouth, sweating, headache, bruxism, exacerbation of asthma, diuresis, myoglobinuria</td>
<td></td>
</tr>
<tr>
<td><strong>Sedative-Hypnotics</strong></td>
<td>- Eyes: pupils in mid position and fixed (but dilated with glutethimide or in severe poisoning), nystagmus</td>
<td>- Physical: tremulousness, insomnia, sweating, fever, clonic blink reflex, cardiovascular collapse, convulsions, shock, headache, anorexia, palpitations, elevated vital signs, Gl upset, muscle aches, hypothermia</td>
</tr>
<tr>
<td></td>
<td>- Cardiovascular: respiration depressed, blood pressure decreased, sometimes shock</td>
<td>- Psychological: anxiety, agitation, delirium, hallucinations, disorientation, perceptual hyperacusis, depression, psychosis, decreased concentration, panic</td>
</tr>
<tr>
<td></td>
<td>- Psychological: confusion, delirium</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Neurological: depressed reflexes, drowsiness or coma, ataxia, slurred speech, convulsions or hyper-irritability with methaqualone overdose, serious poisoning rare with benzodiazepines alone</td>
<td></td>
</tr>
</tbody>
</table>
Assessment of Alcohol Intoxication

- As alcohol consumption increases and becomes persistent, both clinical presentation and blood alcohol level (BAL) may be poorly correlated and unreliable predictors of intoxication.
- As tolerance develops, more alcohol consumption is needed to achieve the same neurotransmitter effect, and the BAL will be higher with fewer signs and symptoms.
- Presentation may be altered with co-ingestion of other substances that may antagonize or augment the effects of alcohol.
- To measure a patient’s alcohol level, serum measurements provide the most accurate results.
- Breath analysis offers more rapid results but may return slightly lower alcohol concentrations.
- Patients experiencing severe alcohol intoxication should be considered for transfer to a HLOC.

<table>
<thead>
<tr>
<th>Blood Alcohol Level</th>
<th>Clinical Signs and Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.01 – 0.05 g/dl</td>
<td>Mild euphoria, decreased inhibitions, diminished attention and judgement</td>
</tr>
<tr>
<td>10 - 50 mg/dl</td>
<td>Euphoria, sedation, impaired coordination, decreased sensory responses to stimuli, decreased judgement</td>
</tr>
<tr>
<td>0.05 – 0.10 g/dl</td>
<td>Confusion, disorientation, impaired balance, slurred speech</td>
</tr>
<tr>
<td>50 – 100 mg/dl</td>
<td>Sleep or stupor, marked muscular incoordination, markedly decreased response to stimuli, incontinence</td>
</tr>
<tr>
<td>0.15 – 0.30 g/dl</td>
<td>Coma, hypothermia, respiratory and circulatory failure, possible death</td>
</tr>
</tbody>
</table>

Treatment of Alcohol Intoxication

- Treatment for isolated and mild acute alcohol intoxication is primarily supportive and rarely requires medical intervention.
- In the correctional setting, other causes for altered mental status, such as trauma or other drug use, must be carefully considered.
- For moderate - severe symptoms of alcohol intoxication (hypotension, tachycardia, fever, hypothermia, hypoxia, hypoglycemia, seizure, and need for parenteral medication), consider need to transfer to a HLOC for aggressive supportive care that includes:
  - IV fluids for evidence of volume depletion or hypotension
  - Preparation to protect the airway with intubation and ventilation as necessary
- Activated charcoal and gastric lavage are generally not helpful because of the rapid rate of absorption of ethanol from the gastrointestinal tract.
- All patients with suspected alcohol intoxication should be treated with thiamine. Be mindful that the CCHCS formulary includes oral thiamine (vitamin B1), but does not have intravenous thiamine readily available.
- **Thiamine before glucose**
  - A glucose infusion for hypoglycemia should not be started until after thiamine is delivered in order to avoid precipitating Wernicke’s encephalopathy.
  - Wernicke’s encephalopathy is characterized by altered gait, numb extremities, and nystagmus. In addition, if Korsakoff psychosis is also present, confusion, hallucinations, and confabulation can occur. This can progress to coma and death if untreated.

For more information on supportive medications used for alcohol intoxication, refer to the table on page 2 and the medication tables on pages 12-19.

Continued Treatment and Monitoring after Alcohol Intoxication

Patients may have other vitamin deficiencies and should receive a daily multivitamin, folic acid 1 mg daily, and thiamine 100 mg daily for one month after the intoxication/withdrawal episode; consider longer term treatment if indicated.

Patients who present with alcohol intoxication or withdrawal should be assessed for alcohol use disorder (AUD) and offered treatment for this chronic condition. If the patient is interested in pursuing treatment, a referral to a licensed clinical social worker (LCSW) and to the AMCT or institution Addiction Medicine Champion should be placed.
Alcohol Withdrawal

Assessment of Alcohol Withdrawal with the CIWA-Ar

- Alcohol withdrawal can be fatal. Therefore, risk stratification is necessary to determine if a patient may require hospitalization. Uncomplicated alcohol withdrawal is generally completed within five days.
- The primary tool used to assess the severity of alcohol withdrawal as well as the response to therapy is the CIWA-Ar.
- Be aware that symptoms generally progress in severity over time, with mild symptoms first, seizures generally between 6 and 48 hours of alcohol cessation, hallucinations between 12 to 48 hours, and delirium tremens after 48 hours.
- There is a great deal of overlap and variability in the presentation of these symptoms.

Characteristics of the CIWA-Ar:

- Completed in approximately 5 minutes.
- Measures ten signs and symptoms and assigns them a score of 1-7, except orientation which is assigned a score on a scale of 1-4. Higher numbers represent greater severity.
- Total score gives an objective measure for the severity of alcohol withdrawal.
- Built as a PowerForm within the Electronic Health Record System (EHRS).

<table>
<thead>
<tr>
<th>Signs and Symptoms Examined</th>
<th>Scores and Corresponding Severity of Withdrawal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea/Vomiting</td>
<td>0 to 9 points: Very mild withdrawal</td>
</tr>
<tr>
<td>Tremor</td>
<td>10 to 15 points: Mild withdrawal</td>
</tr>
<tr>
<td>Paroxysmal sweats</td>
<td>16 to 20 points: Modest withdrawal</td>
</tr>
<tr>
<td>Headache/fullness in head</td>
<td>21 to 67 points: Severe withdrawal</td>
</tr>
<tr>
<td>Orientation/Clouding of sensorium</td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
</tr>
<tr>
<td>Agitation</td>
<td></td>
</tr>
<tr>
<td>Visual disturbances</td>
<td></td>
</tr>
<tr>
<td>Tactile disturbances</td>
<td></td>
</tr>
<tr>
<td>Auditory disturbances</td>
<td></td>
</tr>
</tbody>
</table>

Overview of the CIWA-Ar

Treatment of Alcohol Withdrawal

Alcohol withdrawal severity often increases after repeated withdrawal episodes. This is known as the kindling phenomenon, and suggests that even patients who experience only mild withdrawal should be treated aggressively to reduce the severity of withdrawal symptoms in subsequent episodes. Kindling also may contribute to a patient’s relapse risk and to alcohol-related brain damage and cognitive impairment.

Patients who should be considered for transfer to the hospital include those who:
- Show severe withdrawal symptoms (CIWA-Ar score of 21 or greater)
- Are actively seizing or at risk for seizures (i.e., history of withdrawal seizures, seizure disorder) or exhibit delirium tremens
- Exhibit Wernicke encephalopathy characterized by confusion, lethargy, inattentiveness, impaired memory, vision changes, ophthalmoplegia, and ataxia. Left untreated, Wernicke Encephalopathy can progress to Korsakoff psychosis, which is a permanent condition characterized by impaired memory formation, hallucinations, and confabulation
- Have concomitant medical or psychiatric co-morbidities including pregnancy

Administration of thiamine and lorazepam should be considered while transfer to a hospital is arranged.

For most patients in alcohol withdrawal, the outpatient setting will be appropriate for treatment which would include:
- Oral thiamine. **This must be done before administering glucose.**
- Benzodiazepines are the treatment of choice to both treat symptoms and raise the seizure threshold.
- If the CIWA-Ar score is >8-10, lorazepam should be administered. See medication table on page 13 for details.
- Repeat the CIWA-Ar an hour after each dose is administered to determine if medication should be continued.

Individuals in alcohol withdrawal often develop fluid imbalances, electrolyte abnormalities, vitamin deficiencies and hypoglycemia. Careful attention to these issues can prevent significant medical complications. Treatment may require the use of intravenous fluids, glucose (after appropriate thiamine replacement), and electrolytes.
OPIOID INTOXICATION

- As with other intoxications, the immediate goal of treatment is supportive and/or resuscitative.
- When a patient presents with possible opioid intoxication or overdose, the variation in half-lives of various opioids will impact the rate at which symptoms of withdrawal develop and resolve.
- Supportive treatment at time of intoxication may segue into treatment of withdrawal and maintenance with MAT.

Assessment of Opioid Intoxication

- The clinical presentation of opioid intoxication can often be confounded by multiple substance ingestions.
- Given the high prevalence in the correctional setting, opioid intoxication should be considered in altered mental status.
- Typical signs in addition to unresponsiveness include: depressed respiratory rate, pinpoint pupils, and cyanosis.
- Look for other evidence of opioid use such as needle tracks.
- Diagnostic tests should target other causes for altered consciousness such hypoglycemia, trauma, and electrolyte abnormalities.
- Urine drug screen and Electrocardiogram (EKG) should be obtained.
- For pregnant patients, consult an Obstetrician and see CCHCS Care Guide: MAT for Opioid Use Disorder in Pregnancy.

Treatment of Opioid Overdose

Timely response to a patient found down is necessary to reverse this potentially fatal circumstance.

Action Steps:
1. Activate emergency response
2. Restore adequate ventilation and oxygenation
   - Open airway with chin-lift and jaw-thrust maneuver
   - Use bag-valve mask ventilation
3. Administer naloxone
   - Open nasal spray by peeling back tab with the circle.
   - Hold with your thumb on the bottom of the plunger and first and middle fingers on either side of the nozzle.
   - With the person's head tilted back, insert the tip of nozzle into nostril and press the plunger firmly to administer
   - If incomplete response in consciousness or breathing, repeated naloxone dosing at 2-3 minute intervals (in alternating nostrils) may continue during resuscitative efforts until transfer to HLOC or hospital setting where changing to an IV and/or continuous infusion can be arranged.
   - Naloxone time to onset is less than 2 minutes and duration of action ranges from 20-90 minutes.
4. If no pulse, begin CPR
   - Also consider other causes for cardiopulmonary collapse.
5. Monitor and transfer to HLOC
   - Even with successful reversal, transfer to a hospital for close monitoring should be considered when feasible.

CCHCS Guidelines for naloxone administration:

- The CCHCS Loss of Consciousness Protocol specifies up to 5 doses of naloxone may be administered by staff.
- If there is initial response to the loss of consciousness, additional doses can be authorized by a provider, and may be necessary to counter the effects of fentanyl or other high-affinity opioids.
- The CCHCS Loss of Consciousness Protocol also recommends administration of 50 ml of 50% dextrose IV push if the finger-stick glucose is less than 50 mg/dl, or Glucagon 1 mg IM if unable to obtain IV access.
### OPIOID WITHDRAWAL

Opioid withdrawal can be extremely unpleasant but generally is not fatal. However, patients with other existing conditions such as advanced age, HIV, or coronary artery disease may be prone to life-threatening complications.

- Short-acting opioids such as heroin and oxycodone may generate withdrawal symptoms within 12 hours of last opioid use; whereas, long-acting opioids such as MSContin or OxyContin may generate symptoms within 24 hours of last use. With methadone, symptoms may emerge within 30-72 hours of last exposure and may last up to 10 days.

Precipitated opioid withdrawal occurs when a patient who is physically dependent on opioids is administered an opioid antagonist such as naloxone or naltrexone, or an opioid partial agonist such as buprenorphine. Signs and symptoms of precipitated withdrawal are similar except that the time course is more rapid and symptoms may be much more severe.

### Assessment of Opioid Withdrawal

The primary tool used to assess the severity of opioid withdrawal is the COWS.

#### Characteristics of the COWS:
- Measures eleven signs and symptoms with a score of 0-5, with higher numbers representing greater severity
- Total score gives an objective measure of the severity of withdrawal that can be tracked over time
- Can be used to measure readiness for and response to treatment

#### Overview of the COWS

**Signs and Symptoms Examined**
- Yawning
- Rhinorrhea and/or lacrimation
- Piloerection
- Perspiration
- Tremor
- Mydriasis (dilated pupils)
- Pulse rate
- Anxiety or irritability
- Restlessness
- Nausea and/or vomiting
- Bone or joint aches

#### Scores and Corresponding Severity of Withdrawal

<table>
<thead>
<tr>
<th>Score</th>
<th>Withdrawal Severity</th>
<th>Induction</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-12*</td>
<td>Mild (&lt;5 indicates no withdrawal)</td>
<td>For Score ≤ 7 may be ideal candidate for counseling and referral to the AMCT, but no need for induction</td>
</tr>
<tr>
<td>13-24</td>
<td>Moderate</td>
<td>*For Score ≥ 8 transfer to TTA (see Page 9 for Rapid Induction Protocol)</td>
</tr>
<tr>
<td>25-36</td>
<td>Moderately Severe</td>
<td></td>
</tr>
<tr>
<td>&gt;36</td>
<td>Severe</td>
<td></td>
</tr>
</tbody>
</table>

### Treatment of Opioid Withdrawal

- Simply discontinuing opioids during detoxification is not a recommended strategy for treating opioid withdrawal since withdrawal precipitates strong cravings and consequently increases risk of repeated use and possible fatal overdose.
- For patients in opioid withdrawal (COWS ≥8), transfer to TTA and see Rapid Induction Protocol on page 9. Be sure to alert addiction medicine team any time a patient is rapidly induced with buprenorphine.
- Use caution with patients with decompensated cirrhosis or other severe medical illness - not an absolute contraindication, but recommend coordinated care for high risk and complex patients before starting buprenorphine.
- Management of opioid withdrawal is best used as an opportunity to discuss longer-term treatment of their underlying opioid use disorder (OUD), and to use motivational interviewing techniques to encourage longer-term treatment.
- Refer to the LCSW to be evaluated for referral to Cognitive Behavioral Intervention and other ISUDT program elements.
- If induction with buprenorphine is not immediately available or patient refuses treatment with buprenorphine, consider the following alternatives:
  - Inform patient of the risks of subsequent relapse and death
  - Clonidine may be administered orally in doses of 0.1-0.3 mg every 8 hours to assist in the management of withdrawal symptoms
  - Medications for anxiety, nausea, diarrhea, etc. may be considered (see medication tables on pages 12-19 for formulary options)
  - Recommend enrolling in a peer support activity such as an Inmate Leisure Time Activity Group (ILTAG)
Opioid Withdrawal - Rapid Induction Protocol

Patient Presents to TTA with COWS ≥ 8

Any Complicating Factors*

No

For Buprenorphine/Naloxone 12 mg/3 mg SL Film

Symptomatic Improvement?

No

Apply For Buprenorphine/Naloxone 12 mg/3 mg SL Film

Yes

Document symptomatic improvement
Add diagnosis in EHRS: “Opioid Dependence”

1. Order Buprenorphine/Naloxone Bridge** (see insert) and 2. Refer to Addiction Medicine Provider:
   - Priority: 14 days
   - Select Reason: Documented Opioid Overdose
   - Special Instructions: NEW RAPID INDUCTION
3. Refer to the LCSW
   - Priority: 7 days
   - Select Reason: On MAT
   - Special Instructions: NEW RAPID INDUCTION
4. Send message to HQ Addiction Services Provider Message Pool noting “NEW RAPID INDUCTION.”
5. Check CURES if the patient is within 12 months of incarceration.
6. Arrange for medication follow-up within 1-3 days (including COWS assessment)

** Bridge Orders:
X-Waived: order buprenorphine/naloxone 12 mg/3 mg SL film daily for a total of 30 days
Non X-waived: order buprenorphine/naloxone 12 mg/3 mg SL film daily for a total of 30 days

Supportive/Symptomatic treatment
See pages 12-19 for medication dosing and other details

Highly unusual to have no improvement if in opioid withdrawal; consider alternate diagnosis:

Neurologic – postictal, intracranial hemorrhage, stroke, tumor
Metabolic – hypoglycemia, uremia, hypoxemia, hepatic encephalopathy
Psychiatric – acute presentation of primary psychiatric illness
Endocrine – thyrotoxicosis, diabetic ketoacidosis
Infection – sepsis

If suspected precipitated or incompletely treated withdrawal, proceed with repeat COWS and additional dosing as indicated.

Diagnosing Opioid Withdrawal using COWS:
Assure history and presentation are consistent with opioid use and at least one objective sign: restlessness, sweating, rhinorrhea, dilated pupils, watery eyes, tachycardia, yawning, goose bumps, vomiting, diarrhea, tremor
See COWS Attachment B

Continue

Follow-up visit

Medication Follow-Up/ COWS assessment
Send message to HQ Addiction Services Provider Message Pool
Noting: Post Induction Follow-up

* Altered mental status, delirium, intoxication
* Severe acute pain related to trauma, or has large surgery planned
* Organ failure or other severe medical illness
* Recent methadone use (if in last 72 hours, consult with AMCT since unpredictable precipitated withdrawal can occur)
Stimulant Intoxication

- High rates of stimulant use have been documented in persons involved with the criminal justice system.
- Stimulants share the same range of psychological and physiologic effects, while differing in potency and pharmacokinetic characteristics.
- The initial intoxication effects of stimulants include increased energy and alertness, elation, and euphoria; decreased exhaustion, need for sleep, and appetite.
- With high-doses of stimulants or continued use, stimulant intoxication usually progresses to unwanted effects such as anxiety, irritability, hypervigilance, suspiciousness, impaired judgement, stereotyped behavior, and psychotic symptoms such as hallucinations and bouts of paranoia.
  ⇒ Because of the possibility of psychotic symptoms, stimulant intoxication is often misdiagnosed as schizophrenia.

Assessment of Stimulant Intoxication

Severe symptoms of stimulant intoxication that may indicate transfer to a HLOC:
- Hyperpyrexia (excessively high fever)
- Severe hypertension
- Convulsions

Clinical evaluation should include a drug history and UDS to confirm stimulant intoxication and rule out other potential medical conditions (hyperthyroidism, hypoglycemia) or neuropsychiatric conditions (panic or bipolar affective disorder, schizophrenia). For a list of signs and symptoms of stimulants withdrawal, refer to the table on page 4.

Treatment of Stimulant Intoxication

The initial treatment approach should be non-pharmacologic such as:
- Placing the patient in a quiet environment with limited stimuli
- Explain procedures clearly, confidently, and calmly to keep the patient oriented to reality (or help reorient to reality)
- Avoid physical restraints to control agitation unless absolutely necessary
- Supportive therapies such as hydration

Pharmacologic treatment may be considered for severe toxicity including:
- Benzodiazepines for acute cardiovascular and central nervous system (CNS) toxicity
- Beta-blockers to control high blood pressure and tachycardia

Stimulant Withdrawal

Assessment of Stimulant Withdrawal

Symptoms of stimulant withdrawal include both those that are self-limited and will generally dissipate within 1 to 2 weeks without treatment, as well as symptoms that may linger over the longer term.

- Depression
- Anxiety
- Fatigue/anergia
- Difficulty concentrating
- Anhedonia
- Intense drug craving
- Return of appetite
- Hypersomnia
- Increased dreaming/REM sleep

Treatment of Stimulant Withdrawal

Treatment of stimulant withdrawal is primarily symptomatic support. See table on page 2 for overview.

Supportive treatments of stimulant withdrawal include:
- Rest, exercise, healthy diet
- Education on the risks of overdose and relapse

Monitoring of Stimulant Withdrawal

Patients withdrawing from stimulants should be monitored closely for:
- Depression/suicidality
- Prolonged QTc intervals—an EKG is recommended to monitor for cardiac complications
- Seizures
# Sedative-Hypnotics Intoxication

- The signs and symptoms of sedative-hypnotics intoxication are similar to those of alcohol intoxication. Characterized by physiologic depression and drowsiness, severe intoxication can lead to respiratory depression, coma, and death, especially with barbiturates and the older, non-benzodiazepine sedative-hypnotics.
- On the other hand, benzodiazepine intoxication rarely leads to death, even in the case of overdose, unless combined with other CNS depressants. Consequently, to the extent possible, assessing active substance(s) in the patient's system will help to determine risks.

## Assessment of Sedative-Hypnotics Intoxication

Acute toxicity of sedative–hypnotics, though rare in CDCR, should prompt consideration for transfer to the hospital if there are signs of:

- Delirium with hallucinations
- Changes in consciousness, coma
- Profound agitation
- Autonomic instability
- Seizures
- Progressive respiratory depression

## Treatment of Sedative-Hypnotics Intoxication

- Because sedative-hypnotic intoxication causes respiratory depression, the focus of managing overdose or severe intoxication while arranging transfer to the hospital is on maintaining the airway and respiratory support.
- Flumazenil may be considered in patients who have altered consciousness due to suspected benzodiazepine toxicity.
- Caution against using flumazenil in patients who have recently ingested medications or substances that lower the seizure threshold such as antidepressants.

# Sedative-Hypnotics Withdrawal

- Sedative-hypnotic withdrawal is highly uncommon within our system.
- A clinically significant withdrawal syndrome is likely to occur after discontinuation of a high-dose sedative-hypnotic previously taken for 2 to 3 months or a low-dose sedative-hypnotic previously taken for 4 to 6 months.
- Withdrawal symptoms can occur sooner and are influenced by three main factors:
  - Dose
  - Duration of use
  - Duration of drug action

## Assessment of Sedative-Hypnotics Withdrawal

- Withdrawal symptoms for sedative-hypnotics are similar to those seen in alcohol withdrawal though timing may vary:
  - Symptoms generally begin within 12 to 24 hours and peaks within 1-3 days for agents with short half-lives.
  - For longer-acting agents, symptoms may begin later and not peak until 4 to 7 days after discontinuation.
- For signs and symptoms that may present during withdrawal from sedative-hypnotics, please refer to the table on page 4.

## Treatment of Sedative-Hypnotics Withdrawal

- The most supported approach to treating sedative-hypnotic withdrawal is using a tightly controlled taper of benzodiazepines over a long period of time.
- This strategy can be managed within the outpatient setting and minimizes withdrawal symptoms.
- Referral to the LCSW should be considered for evaluation and comprehensive treatment planning for underlying SUD.
- The AMCT and psychiatrist may be consulted for recommendations for tapered dosing, though managing the taper would generally remain with the psychiatrist.
### INTOXICATION/WITHDRAWAL CONTINUED

#### Managing Withdrawal Symptoms with Medication

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Medications</th>
<th>Usual Effective Dose Range*</th>
<th>Adverse Effects/Interactions*</th>
<th>Comments*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Withdrawal</strong></td>
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<tr>
<td>Mild Withdrawal</td>
<td>Clonidine (Catapres®)</td>
<td>0.1 to 0.2 mg orally every 8 hours, tapered off over 3–5 days as symptoms subside</td>
<td><strong>Adverse effects:</strong> somnolence, headache, hypotension, orthostatic hypotension, increased body temperature, xerostomia, abdominal pain, fatigue, upper respiratory infection (URI), nightmaraes, irritability, throat pain, anxiety, insomnia, confusion, dizziness, sedation, constipation, nausea, diarrhea, atrioventricular (AV) block, sexual dysfunction, syncope, bradycardia, nasal congestion, urinary incontinence.</td>
<td><strong>Contraindications:</strong> hypersensitivity to clonidine or any other component of the product. Use with caution in patients with recent myocardial infarction (MI), cerebrovascular disease, chronic renal insufficiency, severe coronary insufficiency, or conduction disturbances, elderly, history of depression, dehydration, alcohol use, pregnancy or lactation. Do not discontinue clonidine abruptly. Reduce dose gradually over 2-4 days to prevent rebound hypertension, nervousness, agitation, and headache.</td>
</tr>
<tr>
<td></td>
<td>Tablet: 0.1 mg, 0.2 mg, 0.3 mg</td>
<td>Maximum dose: 1 mg/day</td>
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<tr>
<td></td>
<td>$</td>
<td>Renal Impairment: Lower initial dose may be beneficial; patients should be carefully monitored for bradycardia, sedation, and hypotension.</td>
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</tr>
<tr>
<td></td>
<td>Hepatic impairment: Clonidine is substantially metabolized by the liver, monitor patients for sedation and hypotension and adjust the dose if necessary.</td>
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<tr>
<td>Sympathetic hyperactivity</td>
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<tr>
<td>Anxiety</td>
<td>Hydroxyzine Pamoate (Vistaril®)</td>
<td>25 to 100 mg orally every 6 to 8 hours as needed (usual dose for anxiety is 50-100 mg 4 times a day as needed)</td>
<td><strong>Adverse effects:</strong> xerostomia, somnolence, fatigue, prolonged QT interval, Torsade de Pointes, headache, blurred vision, confusion, dizziness, hyperpyrexia, hallucinations, urinary retention.</td>
<td><strong>Contraindications:</strong> hypersensitivity to hydroxyzine or any other component of the product, hypersensitivity to cetirizine or levocetirizine, concomitant use with dronedarone, pimozide, sodium oxybate, or thioridazine, known history of QT prolongation, early pregnancy. Use with caution in patients with narrow-angle glaucoma, cardiac disease, uncorrected electrolyte imbalance, benign prostatic hyperplasia, urinary stricture, asthma or chronic obstructive pulmonary disease COPD, breastfeeding, renal impairment, hepatic impairment, urinary retention or previous history of urinary retention, and in patients with advanced age.</td>
</tr>
<tr>
<td></td>
<td>Capsule: 25 mg, 50 mg</td>
<td>Maximum dose: 400 mg/day</td>
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<td></td>
<td>$-$</td>
<td>Renal Impairment: CrCl ≤50 mL/min: Dosage reduction may be necessary; a 50% dosage reduction is recommended.</td>
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<tr>
<td></td>
<td>Hepatic impairment: Dosage reduction may be necessary based on clinical response and degree of hepatic impairment; hydroxyzine is primarily metabolized by the liver.</td>
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</tr>
</tbody>
</table>

**Bold = Formulary**

*See prescribing information for complete description of dosing, adverse effects, drug interactions, precautions and contraindications.

The cost scale $-$$$$$ represents the relative cost of acquisition of medication only. Frequency and complexity of medication administration (institution workload, effect on adherence) should be considered when determining overall cost-effectiveness of treatment.
## INTOXICATION/withdrawal continued

### Managing Withdrawal Symptoms with Medication

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Medications</th>
<th>Usual Effective Dose Range*</th>
<th>Adverse Effects/Interactions*</th>
<th>Comments*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Seizures</strong></td>
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<tr>
<td></td>
<td>Lorazepam (Ativan®)</td>
<td><strong>Initial: 1-2 mg IV, IM, PO with repeated dosing until desired clinical response</strong></td>
<td>• Adverse effects: drowsiness, sedation, delirium, hallucinations, dizziness, unsteadiness, headache, hypotension, constipation, confusion, depression, asthma</td>
<td></td>
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<tr>
<td></td>
<td>Tablet: 1 mg $</td>
<td><strong>Initial: Elderly or Debilitated patient: 1 to 2 mg orally daily in 2 to 3 divided doses</strong></td>
<td>• Drug interactions: sodium oxybate is contraindicated, flumazenil, CNS depressants, opiate agonists, minocycline (injectable), magnesium salts, droperidol, aripiprazole, clozapine, quetiapine, ethinyl estradiol</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Injectable: 2 mg/mL-1mL $$$</td>
<td><strong>Usual dose: 2 to 6 mg orally daily in 2 to 3 divided doses</strong></td>
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<td></td>
<td></td>
<td><strong>Maximum oral dose: 10 mg/day</strong></td>
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<tr>
<td></td>
<td>Renal impairment: Dose should be modified based on clinical response and degree of renal impairment. Repeated or high doses of parenteral lorazepam may increase the risk of propylene glycol toxicity</td>
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<tr>
<td></td>
<td>Hepatic impairment: Dose should be modified based on clinical response and degree of hepatic impairment. Severe impairment and/or encephalopathy, use with caution; may require lower doses</td>
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<td></td>
<td>• Black Box Warning: The FDA has found that benzodiazepine drugs, when used in combination with opioid medications or CNS depressants, can result in serious adverse reactions including profound sedation, respiratory depression, and death</td>
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<td></td>
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<td>• Contraindications: hypersensitivity to lorazepam or any other component of the product, concomitant use with sodium oxybate, acute narrow-angle glaucoma, Injectable: sleep apnea, polyethylene glycol, propylene glycol or benzyl alcohol hypersensitivity, intraarterial administration</td>
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<td></td>
<td>Use with caution in patients with hepatic disease, insufficiency and/or encephalopathy, preexisting depression, psychiatric disorders, renal impairment, respiratory disease including COPD and sleep apnea, the elderly, pregnancy, breastfeeding</td>
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<tr>
<td></td>
<td><strong>Gastrointestinal (GI)</strong></td>
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<tr>
<td></td>
<td>Dicyclomine (Bentyl®)</td>
<td>20 mg 4 times per day Maximum dose: 160 mg /day</td>
<td>• Adverse effects: dizziness, xerostomia, nausea, blurred vision, drowsiness, nervousness, weakness, confusion, constipation, headache, asthenia</td>
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</tr>
<tr>
<td></td>
<td>Tablet: 20 mg $</td>
<td><strong>Renal impairment: Specific guidelines not available. The manufacturer warns to use with caution in patients with renal disease</strong></td>
<td>• Drug interactions: alosetron, cholinergic agonists, anticholinergic agents, opioid agonists, acetylcholinesterase inhibitors, mirabegron, nitroglycerin, potassium citrate, potassium chloride, secretin, thiadiazide and thiazide-like diuretics, topiramide, proton pump inhibitors, CNS depressants, seizure threshold lowering agents, amantadine</td>
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<tr>
<td></td>
<td>Capsule: 10 mg $</td>
<td><strong>Hepatic impairment: Specific guidelines not available. The manufacturer warns to use with caution in patients with hepatic disease</strong></td>
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<td>• Contraindications: hypersensitivity to dicyclomine or any other component of the product, GI obstruction, severe ulcerative colitis, reflux esophagitis, glaucoma, unstable cardiovascular status in acute hemorrhagic shock, myasthenia gravis, urinary tract obstruction, breastfeeding</td>
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<td>Use with caution in patients with coronary artery disease, tacharyrhythmias, heart failure, hypertension, hepatic impairment, hyperthyroidism, autonomic neuropathy, prostatic hyperplasia (known or suspected), renal impairment, salmonella dysentery, mild-moderate ulcerative colitis, gastroesophageal reflux disease (GERD), hiatal hernia, the elderly, pregnancy</td>
<td></td>
</tr>
</tbody>
</table>

**Bold = Formulary** *See prescribing information for complete description of dosing, adverse effects, drug interactions, precautions and contraindications.

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### Managing Withdrawal Symptoms with Medication

<table>
<thead>
<tr>
<th>Symptoms (Gastrointestinal (GI) cont.)</th>
<th>Medications</th>
<th>Usual Effective Dose Range*</th>
<th>Adverse Effects/Interactions*</th>
<th>Comments*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diarrhea</strong></td>
<td>Loperamide (Imodium®)</td>
<td>4 mg orally for the first dose, followed by 2 mg orally after each loose stool</td>
<td>• Adverse effects: dizziness, constipation, abdominal cramps, nausea, abdominal pain/discomfort, fatigue, drowsiness, vomiting, xerostomia, urinary retention</td>
<td>• Contraindications: hypersensitivity to loperamide or any other component of the product, concomitant use with alosetron, dronedarone, fluconazole, pimozide, posaconazole, or thioridazine, abdominal pain without diarrhea, acute dysentery, acute ulcerative colitis, bacterial enterocolitis caused by Salmonella, Shigella, and Campylobacter, pseudomembranous colitis associated with broad spectrum antibiotic use</td>
</tr>
<tr>
<td></td>
<td>Capsule: 2 mg</td>
<td>$ - $$$</td>
<td>4 mg orally for the first dose, followed by 2 mg orally after each loose stool</td>
<td>Maximum dose: 16 mg in a 24 hour period</td>
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<td></td>
<td>Renal impairment: no dosage adjustments are needed</td>
<td>Renal impairment: no dosage adjustments are needed</td>
<td>Renal impairment: no dosage adjustments are needed</td>
<td>Renal impairment: no dosage adjustments are needed</td>
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<tr>
<td></td>
<td>Hepatic impairment: Specific guidelines not available. Use caution since loperamide undergoes significant first-pass hepatic metabolism, monitor for signs of CNS toxicity</td>
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<td>Maximum dose: 16 mg in a 24 hour period</td>
<td>Maximum dose: 16 mg in a 24 hour period</td>
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<td>Renal impairment: no dosage adjustments are needed</td>
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<td>Hepatic impairment: Specific guidelines not available. Use caution since loperamide undergoes significant first-pass hepatic metabolism, monitor for signs of CNS toxicity</td>
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</tr>
<tr>
<td>Nausea/Vomiting</td>
<td>Ondansetron (Zofran®)</td>
<td>4 to 8 mg orally three times daily</td>
<td>• Adverse effects: constipation, diarrhea, drowsiness, fatigue, headache, malaise, dizziness, agitation, anxiety, pruritus, rash, urinary retention, hypoxia, fever, chills, bradycardia, bronchospasm, QT prolongation and other EKG alterations, hypotension, elevated hepatic enzymes, anaphylactoid reactions</td>
<td>• Contraindications: hypersensitivity to ondansetron or any other component of the product, concomitant use with apomorphine, quinidine, dronedarone, fluconazole, pimozide, posaconazole, or thioridazine</td>
</tr>
<tr>
<td></td>
<td>Oral: 24 mg/day in 3 divided doses</td>
<td>Oral: 24 mg/day in 3 divided doses</td>
<td>Oral: 24 mg/day in 3 divided doses</td>
<td>Oral: 24 mg/day in 3 divided doses</td>
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<td>IV: 0.45 mg/kg/day in 3 divided doses, max single dose = 16 mg</td>
<td>IV: 0.45 mg/kg/day in 3 divided doses, max single dose = 16 mg</td>
<td>IV: 0.45 mg/kg/day in 3 divided doses, max single dose = 16 mg</td>
<td>IV: 0.45 mg/kg/day in 3 divided doses, max single dose = 16 mg</td>
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<td></td>
<td>Renal impairment: Specific guidelines not available</td>
<td>Renal impairment: Specific guidelines not available</td>
<td>Renal impairment: Specific guidelines not available</td>
<td>Renal impairment: Specific guidelines not available</td>
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<tr>
<td></td>
<td>Hepatic impairment: Severe impairment (Child-Pugh Class C)</td>
<td>Hepatic impairment: Severe impairment (Child-Pugh Class C)</td>
<td>Hepatic impairment: Severe impairment (Child-Pugh Class C)</td>
<td>Hepatic impairment: Severe impairment (Child-Pugh Class C)</td>
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<td>Maximum dose: 8 mg/day</td>
<td>Maximum dose: 8 mg/day</td>
<td>Maximum dose: 8 mg/day</td>
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<td></td>
<td>Tablet: 4 mg, 8 mg, 24 mg</td>
<td>Tablet: 4 mg, 8 mg, 24 mg</td>
<td>Tablet: 4 mg, 8 mg, 24 mg</td>
<td>Tablet: 4 mg, 8 mg, 24 mg</td>
</tr>
<tr>
<td></td>
<td>Oral Solution 4 mg/5 mL</td>
<td>Oral Solution 4 mg/5 mL</td>
<td>Oral Solution 4 mg/5 mL</td>
<td>Oral Solution 4 mg/5 mL</td>
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<tr>
<td></td>
<td>Injection: 2 mg/mL</td>
<td>Injection: 2 mg/mL</td>
<td>Injection: 2 mg/mL</td>
<td>Injection: 2 mg/mL</td>
</tr>
</tbody>
</table>

**Bold = Formulary**  *See prescribing information for complete description of dosing, adverse effects, drug interactions, precautions and contraindications*

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### Managing Withdrawal Symptoms with Medication

<table>
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<tr>
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<th>Usual Effective Dose Range*</th>
<th>Adverse Effects/Interactions*</th>
<th>Comments*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gastrointestinal (GI) cont.</strong></td>
<td></td>
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<tr>
<td>GI Upset</td>
<td>Aluminum Hydroxide/ Magnesium Hydroxide/ Simethicone (Maalox®, Mylanta®)</td>
<td>Regular strength: 10 to 20 mL or 2 to 4 tablets orally 4 times daily Max. strength: 10 to 20 mL orally twice daily</td>
<td>• Adverse effects: constipation, decreased gastrointestinal motility, fecal impaction, hemorrhoids, stomach cramps, chalky taste, nausea, vomiting, diarrhea, diuresis, dehydration</td>
<td>• Contraindications: Over-the-counter (OTC) labeling for self-medication: <em>Do not use if you have kidney disease.</em> Concomitant use with citric acid, potassium citrate and sodium citrate</td>
</tr>
<tr>
<td></td>
<td>Chew Tablet: 200/200/25 mg $</td>
<td>Regular strength: 80 mL or 16 tablets per 24 hours Max. strength: 40 mL per 24 hours</td>
<td>• Drug interactions: Sodium citrate, potassium citrate, and citric acid are contraindicated, ascorbic acid, allopurinol, captopril, atazanavir, bictegravir, amphotericin, bisacodyl, bisphosphonate derivatives, cefuroxime, calcium channel blockers, cefpodoxime, daptomycin, dexamethasone, furosemide, gabapentin, itraconazole, quinolones, levotyroxine, mephenytoin</td>
<td>• Use with caution in patients with renal impairment, ulcerative colitis, diverticulitis, colostomy, ileostomy, the elderly, constipation, fecal impaction, GI obstruction, hemorrhoids, undiagnosed rectal or GI bleeding, congestive heart failure (CHF), severe hepatic disease</td>
</tr>
<tr>
<td></td>
<td>Oral Suspension: Regular Strength 200/200/25 mg per 5 mL Max. strength 400/400/40 mg per 5 mL $</td>
<td>Renal impairment: Specific guidelines not available. Patients may be at risk of accumulating aluminum and magnesium. Modify dose based on clinical response and evidence of aluminum or magnesium accumulation. CrCl &lt;10 mL/min: <strong>Avoid use due to potential for aluminum and magnesium accumulation.</strong></td>
<td>• Hepatic impairment: Specific guidelines not available. No dosage adjustment appears to be needed, unless the patient also has declining renal function</td>
<td></td>
</tr>
<tr>
<td><strong>Insomnia, Pain, Muscle Spasm, and Restless Legs</strong></td>
<td>Acetaminophen (Tylenol®)</td>
<td>650 to 1000 mg orally every 4 to 6 hours as needed Max. dose: 4000 mg in a 24 hour period from all sources</td>
<td>• Adverse effects: rash, decreased serum bicarbonate, calcium, and sodium, hypercholesteremia, hyperuricemia, increased serum glucose, anemia, leukopenia, neutropenia, pancytopenia, increased serum bilirubin and alkaline phosphatase</td>
<td>• Contraindications: hypersensitivity to acetaminophen or any other component of the product</td>
</tr>
<tr>
<td>Muscle Aches, Joint Pain, Headache</td>
<td>Tablet: 325 mg, 500 mg $</td>
<td>Renal impairment: Specific guidelines not available. CrCl &lt;30 mL/min: Longer dosing interval and reduced total daily dose may be warranted CrCl &lt;10 mL/min: Recommended to increase the dosing interval to every 8 hours</td>
<td>• Drug interactions: isoniazid, imatinib, ethanol, lamotrigine, warfarin, phenytoin, carbamazepine, ethinyl estradiol, boceprevir, zidovudine, diflunisal, ritonavir, rifampin, rifabutin, salicylates, probenecid, polyvalent pneumococcal vaccine, cholestyramine</td>
<td>• Use caution in patients with alcoholic liver disease, G6PD deficiency, hepatic impairment, hepatic disease, chronic malnutrition, renal impairment, renal disease, the elderly</td>
</tr>
<tr>
<td></td>
<td>ER Tablet: 650 mg $$</td>
<td>Hepatic impairment: Use with extreme caution. Consider reducing the total daily dose to ≤ 2 gm/day if hepatic function is impaired. Avoid use in patients with advanced chronic liver disease or cirrhosis who are actively drinking alcohol, malnourished, not eating, or receiving a concomitant interacting medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Suppositories: 650 mg $</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oral Suspension: 160 mg/5 mL $</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Bold = Formulary*  
*See prescribing information for complete description of dosing, adverse effects, drug interactions, precautions and contraindications*  

The cost scale $-$$$$$$ represents the relative cost of acquisition of medication only. Frequency and complexity of medication administration (institution workload,
### Managing Withdrawal Symptoms with Medication

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Medications</th>
<th>Usual Effective Dose Range*</th>
<th>Adverse Effects/Interactions*</th>
<th>Comments*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insomnia, Pain, Muscle Spasm, and Restless Legs cont.</td>
<td><strong>Ibuprofen</strong> <em>(Advil®, Motrin®)</em></td>
<td>400 mg orally every 4 to 6 hours as needed</td>
<td>Hypertension, hypotension, rash, heartburn, nausea, dizziness, headache, edema, fluid retention, epigastric pain, anemia, abdominal pain, tinnitus, prolonged bleeding time, diarrhea, constipation, elevated hepatic enzymes, pruritus, GI bleed or other injury, arrhythmia exacerbation</td>
<td>Black Box Warning: NSAIDs may cause an increased risk of serious cardiovascular thrombotic events, myocardial infarction, and stroke, which can be fatal. This risk may be increased in patients with cardiovascular disease or risk factors for cardiovascular disease. Ibuprofen is contraindicated for the treatment of peri-operative pain in the setting of coronary artery bypass graft (CABG) surgery. NSAIDs can also cause an increased risk of serious gastrointestinal adverse events especially in the elderly, including bleeding, ulceration, and perforation of the stomach or intestines, which can be fatal</td>
</tr>
</tbody>
</table>

| Muscle Aches, Joint Pain, Headache | **Ibuprofen** *(Advil®, Motrin®)* | 2400 mg/day Maximum dose: 2400 mg/day | Use is not recommended in advanced renal disease. | |
| Tablet: 200 mg | | Renal impairment: Specific guidelines not available. Use with caution. Not studied in severe renal insufficiency. | Kidney Disease | |
| Oral Suspension: 100 mg/5 mL | | Use is not recommended in advanced renal disease. | Improving Global Outcomes (KDIGO) 2012 guidelines provide the following recommendations for non-steroidal anti-inflammatory drugs (NSAIDs): |
| $-$-$-$ | | | - eGFR <60 mL/min/1.73 m²: Prolonged therapy not recommended |
| | | | - eGFR 30 to <60 mL/min/1.73 m²: Avoid use in patients with co-occurrent disease that increases risk of acute kidney injury. |
| | | | - GFR <30 mL/min/1.73 m²: Avoid use |
| | | | Hepatic impairment: Consider lower initial dose or dose reduction in patients with moderate to severe hepatic impairment. | |
### Managing Withdrawal Symptoms with Medication

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Medications</th>
<th>Usual Effective Dose</th>
<th>Adverse Effects/Interactions</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Muscle Aches, Joint Pain, Headache | Naproxen (Naprosyn®)   | Tablet: 250 mg, 500 mg $ | 500 mg, followed by 500 mg every 12 hours or 250 mg every 6 to 8 hours | - **Adverse effects:** edema, palpitations, dizziness, drowsiness, headache, vertigo, pruritus, rash, fluid retention, ecchymosis, diaphoresis, abdominal pain, constipation, nausea, heartburn, diarrhea, dyspepsia, GI bleed or other injury, anemia, tinnitus, ototoxicity, increased liver enzymes, prolonged bleeding time, dyspnea, renal function abnormality, urinary tract infection (UTI), influenza-like syndrome, photosensitivity, hypertension  
- **Drug interactions:** Cidofovir and ketorolac are contraindicated, aspirin/salicylates, apixaban, betrixaban, celecoxib, benecocid, dabigatran, NSAIDs, desmopressin, TCAs, SNRs, SSRIs, ARBs, ACE Inhibitors, lithium, beta-blockers, tacrolimus, edoxaban, rivaroxaban, thiazide and thiazide –like diuretics, potassium sparring diuretics, loop diuretics, methotrexate, low molecular weight heparins, dasatinib, cyclosporine, antiplatelet agents, trazodone,  
- **Black Box Warning:** NSAIDs may cause an increased risk of serious cardiovascular thrombotic events, myocardial infarction, and stroke, which can be fatal. This risk may be increased in patients with cardiovascular disease or risk factors for cardiovascular disease. Naproxen is contraindicated for the treatment of peri-operative pain in the setting of coronary artery bypass graft (CABG) surgery. NSAIDs can also cause an increased risk of serious gastrointestinal adverse events especially in the elderly, including bleeding, ulceration, and perforation of the stomach or intestines, which can be fatal  
- **Contraindications:** hypersensitivity to naproxen or any other component of the product, history of asthma, urticaria, or other allergic-type reaction following aspirin or other NSAID administration (severe and sometimes fatal anaphylactic reactions have been reported), treatment of peri-operative pain in the setting of CABG  
- **Use caution in patients with asthma, history of bariatric surgery, hepatic impairment, renal impairment, cardiac disease, cardiomyopathy, cardiac arrhythmias, coronary artery disease, peripheral vascular disease, hypertension, cerebrovascular disease, renal disease, hematological disease, thrombocytopenia, fluid retention, GI bleed/perforation or history of, on anticoagulant therapy, the elderly, pregnancy, breast-feeding |
| Insomnia, Pain, Muscle Spasm, and Restless Legs cont. |                    | Maximum daily dose: Day 1: 1,250 mg; subsequent daily doses should not exceed 1,000 mg | Renal impairment: CrCl ≥30 mL/minute: Specific guidelines not available. Use with caution and consider using a reduced dose. CrCl <30 mL/minute: Not recommended; avoid use in patients with advanced renal disease. | KIDGO 2012 guidelines provide the following recommendations for NSAIDs:  
- eGFR <60 mL/min/1.73 m²: Prolonged therapy not recommended  
- eGFR 30 to <60 mL/min/1.73 m²: Avoid use in patients with co-occurrent disease that increases risk of acute kidney injury.  
- GFR <30 mL/min/1.73 m²: Avoid use  
Hepatic impairment: Specific guidelines not available. Use with caution. Use lowest effective dose, dose reduction may be necessary |

**Bold = Formulary**  
*See prescribing information for complete description of dosing, adverse effects, drug interactions, precautions and contraindications*  
The cost scale $-$$$$$ represents the relative cost of acquisition of medication only. Frequency and complexity of medication administration (institution workload, effect on adherence) should be considered when determining overall cost-effectiveness of treatment.
### Specific Reversal Agents

<table>
<thead>
<tr>
<th>Benzodiazepine Intoxication</th>
<th>Flumazenil</th>
<th>Usual Effective Dose Range*</th>
<th>Adverse Effects/Interactions*</th>
<th>Comments*</th>
</tr>
</thead>
</table>
| **Injectable**<br>0.1 mg/mL<br>5 mL MDV<br>$$-$$$$$ | Initial: 0.2 mg IV over 30 seconds. If desired level of consciousness is not obtained after 30 seconds, an additional dose of 0.3 mg IV over 30 seconds can be administered. Further doses of 0.5 mg IV over 30 seconds can be administered at 1-minute intervals up to a cumulative dose of 3 mg.<br>P*Arnal response to 3 mg: May require additional slow titration to a total dose of 5 mg. If no response 5 minutes after receiving total dose of 5 mg, unresponsive sedation is unlikely to be benzodiazepine-related<br>Reoccurrence of sedation: May repeat dose at 20-minute intervals; not to exceed 1 mg (0.5 mg/minute) per dose up to a maximum of 3 mg/hour<br>Maximum dose limits: 5 mg IV total cumulative dose for suspected benzodiazepine overdose. If patient unresponsive at this dose, cause of sedation not likely to be benzodiazepine-related<br>Hepatic Dosing: Initial dose – no adjustment needed<br>Subsequent doses should be reduced in size or frequency (specific recommendations not available)<br>Renal Dosing: Specific guidelines not available; appears no adjustment needed | **Adverse effects:** Dizziness, vertigo, ataxia, headache, paresthesia, seizures (convulsions), somnolence, speech disorder, agitation, anxiety, tremor, insomnia, emotional lability, confusion, delirium, perspiration, cardiac dysrhythmias, bradycardia, tachycardia, abnormal/blurred vision, vomiting<br>**Drug interactions:** Tricyclic antidepressants (amitriptyline, doxepin, clomipramine, desipramine, mirtazapine, or nortriptyline), benzodiazepines, non-benzodiazepine benzodiazepine receptor agonists (zolpidem, zaleplon, eszopiclone)<br>**Black Box Warning:** The use of flumazenil has been associated with the occurrence of seizures. These are most frequent in patients who have been on benzodiazepines for long-term sedation or in overdose cases where patients are showing signs of serious cyclic antidepressant overdose. Practitioners should individualize the dosage of flumazenil and be prepared to manage seizures.<br>**Contraindications:** hypersensitivity to flumazenil, benzodiazepines, or any component of the formulation, signs of serious cyclic antidepressant overdose, in patients receiving a benzodiazepine for the control of life-threatening conditions such as the control of increased intracranial pressure or status epilepticus<br>**Use with caution in the following:** patients who are relying on benzodiazepine effects to control seizures, hepatic impairment, drug/alcohol dependence, benzodiazepine dependence, head trauma, pulmonary disease, pregnancy, breastfeeding | **Bold = Formulary**  
*See prescribing information for complete description of dosing, adverse effects, drug interactions, precautions and contraindications

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### Managing Toxicity with Medication

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Medications</th>
<th>Usual Effective Dose Range*</th>
<th>Adverse Effects/Interactions*</th>
<th>Comments*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioid Intoxication</td>
<td><strong>Naloxone</strong> (Narcan®)</td>
<td>Nasal Spray: 1 spray (4 mg) by intranasal administration. Use a new nasal spray for subsequent doses and administer into alternating nostrils. May repeat dose every 2 to 3 minutes as needed if the desired response is not attained or if the patient relapses into respiratory depression</td>
<td>• Adverse effects: Acute withdrawal symptoms - aches, fever, sweating, runny nose, sneezing, piloerection, yawning, weakness, shivering or trembling, nervousness, restlessness or irritability, diarrhea, nausea or vomiting, abdominal cramps, increased blood pressure, tachycardia Additional adverse effects associated with the Nasal Spray - dental pain, constipation, muscle spasms, musculoskeletal pain, headache, nasal dryness, nasal edema, nasal congestion, nasal irritation, rhinalgia, nasal inflammation, xeroderma</td>
<td>• Contraindications: hypersensitivity to naloxone or any component of the formulation • Use with caution in the following: patients with a known hypersensitivity to nalmefene or naltrexone, cardiovascular disease, seizures, known or physical dependence on opioids, pregnancy, breast-feeding</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Solution for Injection: 0.4 mg/mL to 1 mL</td>
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<td>$ - $$$$</td>
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</tbody>
</table>

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CCHCS Care Guide: Intoxication and Withdrawal

October 2020

SUMMARY  DECISION SUPPORT  PATIENT EDUCATION / SELF-MANAGEMENT

REFERENCES


**What is intoxication?**

Intoxication happens when a person consumes a lot of a substance which changes their mood and physical or mental abilities.

The stages of intoxication can range from mild to life-threatening. Mild intoxication may result in sleepiness, trouble speaking, lack of balance, and difficulty focusing. Severe intoxication may result in vomiting and blackouts. In life-threatening situations, there may be loss of consciousness and loss of vital functions that could lead to death.

Continued use of drugs may be signs of an underlying Substance Use Disorder (SUD), commonly known as addiction, which can cause lasting physical harm including brain damage. More information on SUD is available from your provider, and you may wish to discuss treatment options with them.

**Support for Addiction**

Ready to deal with your drug addiction? Decide to make a change. CDCR/CCHCS now has an Integrated Substance Use Disorder Treatment (ISUDT) Program.

Abusing drugs creates changes in the brain, causing powerful cravings and a compulsion to use that makes sobriety seem like an impossible goal. But recovery is never out of reach, no matter how hopeless your situation seems or how many times you’ve tried and failed before. With the right treatment and support, change is possible.

Recovery requires time, motivation, and support. By making a commitment to change, you can overcome your addiction and regain control of your life.

Start your path to recovery – complete a CDCR 7362 and let us help. You will be scheduled for an assessment and get referred for the treatment you need.

Within 2 years of release? We offer screening, assessment, and treatment for those nearing release to help with making community transitions smoother and safer.

Treatments are individualized and may include Cognitive Behavioral Interventions as well as medications along with long term follow-up to help prevent relapse and maintain sobriety either within CDCR or as you transition back to your community.

The toughest step toward recovery is the very first one: recognizing that you have a problem and deciding to make a change.
Prevention of Intoxication/Withdrawal

**Substance intoxication and withdrawal, and the difficult symptoms that come with them, can be avoided by reducing or stopping use of substances. This may be helped with long-term treatment.**

People who suffer from intoxication and withdrawal may be suffering from Substance Use Disorder (SUD) and should seek treatment to reduce their use and their desire to use substances.

**What Is Substance Use Disorder?**

SUD is a treatable disease that can be caused by frequent substance use. It is commonly known as “addiction.”

- Substance Use Disorder is a chronic disease. No one knows exactly why some people get SUD and others do not.
- Your genes are a part of it and SUD often runs in families.
- Lifestyle and your surroundings can increase the risk of SUD.
- SUD cannot be cured, however, it can be managed with counseling, medication, and support from family and friends.
- Recovery takes a lifetime of commitment, one day at a time.

Symptoms include:

- Strong cravings for substances
- Feeling unable to stop or reduce substance use
- Having work, school, legal, or family problems caused by your substance use
- Needing more of the substance over time to get the same effect
- Feeling sick after stopping or lowering use

**How is it treated?**

Substance Use Disorder can be treated with counseling in some cases, the addition of medication may be appropriate. The support of family and friends can also be critical to the success of treatment.

Medication Assisted Treatment (MAT) may help to reduce cravings or manage withdrawal symptoms for those with alcohol or opioid use disorder.

Cognitive Behavioral Intervention may help you learn to:

- Move away from doing things that are harmful to you
- Change addictive thoughts into healthy thoughts
- Make healthy decisions
- Handle setbacks and stress
- Deal with feelings such as depression or low self-esteem
- Recognize the cues and habits that lead to opioid use

If you believe you may have a Substance Use Disorder and wish to seek treatment, you can fill out a CDCR 7362, Health Care Services Request Form.
¿Qué es la intoxicación?

La intoxicación ocurre cuando una persona consume una sustancia en exceso, la cual cambia su humor y sus capacidades físicas o mentales.

Las fases de la intoxicación pueden ir desde leve hasta mortal. Una intoxicación leve puede dar como resultado somnolencia, problemas para hablar, falta de equilibrio y dificultad para concentrarse; mientras que una intoxicación severa puede resultar en vómitos y desmayos. En una situación mortal puede ocurrir la pérdida del conocimiento y de las funciones vitales, lo que puede llevar a la muerte.

El uso continuo de drogas podría ser señal de un Trastorno de Abuso de Sustancias (Substance Use Disorder, SUD) subyacente, conocido comúnmente como una adicción, el cual puede causar secuelas físicas duraderas, incluyendo daño cerebral. Su proveedor tiene más información disponible sobre el Trastorno de Abuso de Sustancias, y quizá quiera discutir las opciones de tratamiento con él.

ApoYO EN CASO DE UNA ADICCIÓN

¿Está listo para lidiar con su adicción a las drogas? Tome la decisión de cambiar.

El Departamento Correccional y de Rehabilitación de California (California Department of Corrections and Rehabilitation, CDCR)/los Servicios de Salud Correccional de California (California Correctional Health Care Services, CCHCS) tienen un programa de Tratamiento Integrado para el Trastorno de Abuso de Sustancias (Integrated Substance Use Disorder Treatment, ISUDT).

El consumo excesivo de drogas crea cambios en el cerebro, causa fuertes compulsiones y una necesidad de consumir que hace ver la sobriedad como una meta imposible. **Pero la recuperación nunca está fuera del alcance**, sin importar cuán desesperada parezca su situación ni cuantas veces haya intentado, y fallado, antes. Con el tratamiento adecuado, motivación, apoyo y con el compromiso a cambiar, puede superar su adicción y retomar el control de su vida.

**Empiece su camino hacia la recuperación:** llene un formulario 7362 y déjenos ayudarlo. Se le programará una evaluación y será remitido para el tratamiento que necesita.

¿A dos años de ser liberado? Ofrecemos exámenes, evaluaciones y tratamientos para aquellos que están cerca de cumplir su sentencia, para ayudarlos a hacer más fácil y segura su transición a la vida en la comunidad.

Los tratamientos son personalizados y pueden incluir intervenciones cognitivo conductuales, así como medicamentos y seguimiento a largo plazo para ayudar a evitar las recaídas y a mantener su sobriedad, ya sea dentro del CDCR o a medida que hace su transición a la vida en la comunidad.

**El paso más difícil hacia la recuperación es el primero: reconocer que tiene un problema y decidirse a cambiar.**
### RESUMEN

La intoxicación por sustancias y la abstinencia y los difíciles síntomas que vienen con ellas se pueden evitar al reducir o detener el consumo de sustancias. Esto podría ayudar con el tratamiento a largo plazo.

Aquellos que sufren una intoxicación o abstinencia podrían padecer un Trastorno de Abuso de Sustancias y deberían buscar tratamiento para reducir su consumo y deseo de consumir.

### Estrategias de prevención

La intoxicación por sustancias y la abstinencia y los difíciles síntomas que vienen con ellas se pueden evitar al reducir o detener el consumo de sustancias. Esto podría ayudar con el tratamiento a largo plazo.

Aquellos que sufren una intoxicación o abstinencia podrían padecer un Trastorno de Abuso de Sustancias y deberían buscar tratamiento para reducir su consumo y deseo de consumir.

### ¿Qué es el Trastorno de Abuso de Sustancias?

El Trastorno de Abuso de Sustancias (SUD) es una enfermedad tratable que puede ser causado por el uso frecuente de sustancias. Se le conoce comúnmente como “adicción.”

- El Trastorno de Abuso de Sustancias es una condición crónica y nadie sabe exactamente por qué algunas personas sufren de SUD y otras no.
- Sus genes juegan un papel y generalmente, el SUD tiene antecedentes familiares.
- Su estilo de vida y su entorno pueden incrementar el riesgo de SUD.
- El SUD no se puede curar, sin embargo, se puede manejar con asesoramiento, medicamentos y el apoyo de familiares y amigos.
- La recuperación requiere de un compromiso para toda la vida, un día a la vez.

Los síntomas incluyen:

- Fuertes ansias por consumir.
- Sentirse incapaz de detenerse o reducir el uso de sustancias.
- Tener problemas en el trabajo, la escuela, legales o familiares causados por su abuso de sustancias.
- Con el tiempo, necesitar más y más de la sustancia para tener el mismo efecto.
- Sentirse enfermo después de detener o minimizar el consumo.

### ¿Cómo se trata?

El Trastorno de Abuso de Sustancias puede ser tratado con una combinación de terapia y medicamentos, lo cual puede ser apropiado en algunos casos. El apoyo de amigos y familiares también puede ser crucial para el éxito del tratamiento.

El Tratamiento Asistido por Medicamentos (Medication Assisted Treatment, MAT) podría ayudar a reducir las ansias o a manejar los síntomas de la abstinencia para aquellas personas con trastornos de abuso de alcohol u opioides.

La intervención cognitiva conductual podría ayudarlo a aprender cómo:

- Alejarse de las cosas que son dañinas para usted.
- Convertir los pensamientos adictivos en saludables.
- Tomar decisiones saludables.
- Manejar los contratiempos y el estrés.
- Lidiar con sentimientos como la depresión o la baja autoestima.
- Reconocer señales y los hábitos que llevan al uso de opioides.

Si siente que podría tener un Trastorno de Abuso de Sustancias y desea buscar tratamiento, puede llenar un formulario 7362 del CDCR (Formulario de Solicitud de Servicios de Salud).
### Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

**Patient's Name:** ____________________________

**Date and Time:** _____________ (24 hr. midnight = 00:00)

**Pulse or heart rate, taken for one minute:**

**Blood Pressure:**

#### Nausea and vomiting
- Ask: "Do you feel sick to your stomach? Have you vomited?" Observation.
- 0: no nausea and no vomiting
- 1: mild nausea and no vomiting
- 2:
- 3:
- 4: intermittent nausea with dry heaves
- 5:
- 6:
- 7: constant nausea, frequent dry heaves and vomiting

#### Tremor
- Arms extended and fingers spread apart. Observation.
- 0: no tremor
- 1: not visible, but can be felt fingertip to fingertip
- 2:
- 3:
- 4: moderate, with patient’s arms extended
- 5:
- 6:
- 7: severe, even with arms not extended

#### Anxiety
- Ask: "Do you feel nervous?" Observation.
- 0: no anxiety, at ease
- 1: mildly anxious
- 2:
- 3:
- 4: moderately anxious, or guarded, so anxiety is inferred
- 5:
- 6:
- 7: equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

#### Agitation
- Observation.
- 0: normal activity
- 1: somewhat more than normal activity
- 2:
- 3:
- 4: moderately fidgety and restless
- 5:
- 6:
- 7: paces back and forth during most of the interview, or constantly thrashes about

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

#### Orientation and clouding of the sensorium
- Ask "What day is this? Where are you? Who am I?"
- 0: oriented and can do serial additions
- 1: cannot do serial additions or is uncertain about date
- 2: disoriented for date by no more than 2 calendar days
- 3: disoriented for date by more than 2 calendar days
- 4: disoriented in place/or person

#### Auditory disturbances
- Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things that are not there?" Observation.
- 0: not present
- 1: very mild harshness or ability to frighten
- 2: mild harshness or ability to frighten
- 3: moderate harshness or ability to frighten
- 4: moderately severe hallucinations
- 5: severe hallucinations
- 6: extremely severe hallucinations
- 7: continuous hallucinations or muscle twitching is difficult

---

### Visual disturbances
Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things that you know are not there?" Observation

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>not present</td>
</tr>
<tr>
<td>1</td>
<td>very mild sensitivity</td>
</tr>
<tr>
<td>2</td>
<td>mild sensitivity</td>
</tr>
<tr>
<td>3</td>
<td>moderate sensitivity</td>
</tr>
<tr>
<td>4</td>
<td>moderately severe hallucinations</td>
</tr>
<tr>
<td>5</td>
<td>severe hallucinations</td>
</tr>
<tr>
<td>6</td>
<td>extremely severe hallucinations</td>
</tr>
<tr>
<td>7</td>
<td>continuous hallucinations</td>
</tr>
</tbody>
</table>

### Headache, fullness in the head
Ask "Does your head feel different? Does it feel like there is a band around your head?"

Do not rate for dizziness or lightheadedness. Otherwise, rate severity.

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>not present</td>
</tr>
<tr>
<td>1</td>
<td>very mild</td>
</tr>
<tr>
<td>2</td>
<td>mild</td>
</tr>
<tr>
<td>3</td>
<td>moderate</td>
</tr>
<tr>
<td>4</td>
<td>moderately severe</td>
</tr>
<tr>
<td>5</td>
<td>severe</td>
</tr>
<tr>
<td>6</td>
<td>very severe</td>
</tr>
<tr>
<td>7</td>
<td>extremely severe</td>
</tr>
</tbody>
</table>

**Total CIWA-Ar Score:**

**Rater's Initials:**

**Maximum Possible Score:** 67
Clinical Opiate Withdrawal Scale (COWS) ¹⁰

<table>
<thead>
<tr>
<th>Patient’s Name: ___________________________</th>
<th>Date and Time: __________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for this assessment:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resting Pulse Rate: ___ beats/min</th>
<th>GI Upset: Over last ½ hour</th>
<th>Total Score: _______</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measured after patient is sitting or lying for 1 minute</td>
<td>0 no GI symptoms</td>
<td>The total score is the sum of all 11 items</td>
</tr>
<tr>
<td>0 pulse rate 80 or below</td>
<td>1 stomach cramps</td>
<td>Initial of person completing assessment: ______________________</td>
</tr>
<tr>
<td>1 pulse rate 81-100</td>
<td>2 nausea or loose stool</td>
<td></td>
</tr>
<tr>
<td>2 pulse rate 101-120</td>
<td>3 vomiting or diarrhea</td>
<td></td>
</tr>
<tr>
<td>4 pulse rate greater than 120</td>
<td>5 multiple episodes of diarrhea or vomiting</td>
<td></td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Sweating: Over past ½ hour not accounted for by room temperature or patient activity</th>
<th>Tremor: Observation of outstretched hands</th>
<th>Score 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 subjective report of chills or flushing</td>
<td>1 tremor can be felt, but not observed</td>
<td><a href="https://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf">https://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf</a></td>
</tr>
<tr>
<td>2 flushed or observable moistness on face</td>
<td>2 slight tremor observable</td>
<td></td>
</tr>
<tr>
<td>3 beads of sweat on brow or face</td>
<td>4 gross tremor or muscle twitching</td>
<td></td>
</tr>
<tr>
<td>4 sweat streaming off face</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Restlessness: Observation during assessment</th>
<th>Anxiety or Irritability</th>
<th>Initial of person completing assessment: ______________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 able to sit still</td>
<td>0 none</td>
<td>The total score is the sum of all 11 items</td>
</tr>
<tr>
<td>1 reports difficulty sitting still, but is able to do so</td>
<td>1 patient reports increasing irritability or anxiousness</td>
<td></td>
</tr>
<tr>
<td>3 frequent shifting or extraneous movements of legs/arms</td>
<td>2 patient obviously irritable or anxious</td>
<td></td>
</tr>
<tr>
<td>5 unable to sit still for more than a few seconds</td>
<td>4 patient so irritable or anxious that participation in the assessment is difficult</td>
<td></td>
</tr>
</tbody>
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<tr>
<th>Bone or Joint Aches: If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored</th>
<th>Gooseflesh Skin</th>
<th>Score 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 mild diffuse discomfort</td>
<td>3 piloerection of skin can be felt or hairs standing up on arms</td>
<td></td>
</tr>
<tr>
<td>2 patient reports severe diffuse aching of joints/muscles</td>
<td>5 prominent piloerection</td>
<td></td>
</tr>
<tr>
<td>4 patient is rubbing joints or muscles and is unable to sit still because of discomfort</td>
<td></td>
<td></td>
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</tbody>
</table>

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<tr>
<th>Runny nose or tearing: Not accounted for by cold symptoms or allergies</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 nasal stuffiness or unusually moist eyes</td>
<td>3 piloerection of skin can be felt or hairs standing up on arms</td>
<td></td>
</tr>
<tr>
<td>2 nose running or tearing</td>
<td>5 prominent piloerection</td>
<td></td>
</tr>
<tr>
<td>4 nose constantly running or tears streaming down cheeks</td>
<td>The total score is the sum of all 11 items</td>
<td><a href="https://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf">https://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf</a></td>
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