MAT and Withdrawal Management

This 'lower acuity site' guidance was developed for emergency shelters for people experiencing homelessness (which have, sporadically, a nurse on site, but not reliably nor with reasonable patient to nurse ratios).

ALCOHOL USE DISORDER MANAGEMENT

For all patients with alcohol use disorder (including those who are actively drinking) and for those patients experiencing alcohol withdrawal:

1. Screen for any opioid use (ask if the patient is using any heroin, fentanyl, or narcotic pain medications from any source). If they are, *do not start naltrexone*. If they don't:
2. Screen for severe cirrhosis characterized by significant jaundice and/or ascites. If they have this, *do not start naltrexone*. If they don't:
3. Start oral naltrexone (25mg daily x3d, then increase to 50mg daily) since this can help patients reduce their alcohol consumption or sustain alcohol abstinence in QI sites. Start naltrexone as soon as is feasible and concurrently with withdrawal management.
4. Do not give naltrexone to patients who are using or withdrawing from opioids and do not give naltrexone to patients with severe cirrhosis characterized by significant jaundice and/or ascites unless directed by the MAT consultation line or the addiction medicine consultation service.

ALCOHOL / BENZODIAZEPINE / BARBITURATE WITHDRAWAL MANAGEMENT

Provide the following for alcohol / sedative withdrawal management, if the patients reports experiencing alcohol / sedative withdrawal. Any clinicians, providers, or staff member unfamiliar with alcohol and sedative withdrawal can find the symptoms of this withdrawal here, but a formal SAWS or CIWA does not need to be administered or completed prior to offering patients alcohol / sedative withdrawal management.

For mild-to-moderate[1] and low-risk[2] patients with alcohol /sedative withdrawal syndrome:

Gabapentin is first line; carbamazepine can be used in patients who do not tolerate gabapentin. Escalate from gabapentin to chlordiazepoxide or lorazepam if the patient exhibits severe withdrawal symptoms that are not addressed by the gabapentin protocol below.

In QI sites, the patient can be furnished the entire taper of gabapentin (#30 of the 600mg tabs) or carbamazepine (#30 of the 200mg) with instructions on how to take it.

Gabapentin is dosed as 600mg PO TID plus an additional 600mg prn once daily for the first week, followed by a 300mg taper after the first week

Taper schedule:

Days	Gabapentin Monotherapy (fixed schedule dosing)
1	1,200mg BID plus 1,200mg x1 prn
2-7	600mg TID plus 600mg x1 prn

8	300mg TID
9	300mg BID
10	300mg qday

How to write the prescription:
Rx: Gabapentin 600mg tabs, take as directed, #30, NR

Verbalized or printed instructions for the patient:
Day 1: Take 2 tabs twice daily plus an additional 2 tabs if needed the first day
Days 2-7: Take 1 tab three times daily plus an additional 1 tabs if needed
Day 8: Take ½ tab three times daily
Day 9: Take ½ tab twice daily
Day 10: Take ½ tab once at bedtime

Carbamazepine is dosed 200mg PO QID x 72º followed by a 200mg reduction q72º

Taper schedule:

Days	Carbamazepine Monotherapy (fixed schedule dosing)
1-3	200mg QID
4-6	200mg TID
7-9	200mg BID
10-11	200mg qHS

How to write the prescription:
Rx Carbamazepine 200mg tabs, take 1 QID x3d, then 1 TIDx3d, then 1 BID x3d, then 1 qHS x3d, #30, NR

Verbalized or printed instructions for the patient:
Days 1-3: Take 1 four times throughout the day
Days 4-6: Take 1 three times throughout the day
Days 7-9: Take 1 twice a day
Days 10-11: Take 1 at bedtime

For patients with a history of severe alcohol/sedative withdrawal and in patients that do not respond to gabapentin or carbamazepine, refer the patient to a higher

acutity site or, if the patient is in active and significant distress, to a hospital.

OPIOID USE DSIORDER AND WITHDRAWAL MANAGEMENT

For opioid use disorder and opioid withdrawal:

Buprenorphine / Naloxone 8mg/2mg, give the patient 1 tab to take sublingually q2H if the patient reports opioid withdrawal. For those with a low opioid habit or low opioid tolerance, okay to split the tab in 1/2 and given 4mg/1mg q2H rather than the full 8mg/2mg. Once the patient stabilizes on a dose, continue to offer them that dose as a maintenance treatment. Buprenorphine / Naloxone is best used as a maintenance medication where the patient takes the dose they need (usually 8mg/2mg, 16mg/4mg or 24mg/6mg) daily.

At QI sites: Dispense #28 of the buprenorphine / naloxone tabs to the patient at one time with instructions on how to take it. Ongoing visits are only needed for opioid withdrawal management if the patient has questions or isn't responding to the treatment, or needs a refill.

If there is a question about whether the patient is in opioid withdrawal, providers, clinicians, and other staff can refer to the SOWS, but a SOWS or COWS not need to be administered or completed prior to offering patients opioid withdrawal management.

TOBACCO USE DISORDER AND NICOTINE WITHDRAWAL

- Nicotine patches 14mg once a day
- Nicotine lozenges 2mg five times daily

The protocol is to assess how much someone is smoking, and match
(1mg of nicotine = 1 cigarette)

The dose of the patches to match the usual number of cigarettes per day. Place the patch in the morning and take off at bedtime, since it can cause nightmares. The lozenges are q1H prn for smoking urges.

At QI sites: Dispense two week's worth of patches (#14 or more for heavy smokers) and two week's worth of lozenges (1 box, typically 72) to each patient with tobacco use disorders who want to accept this treatment. Ongoing visits are only needed for nicotine withdrawal management if the patient has questions or isn't responding to the treatment, or needs a refill.

References:

ASAM Alcohol Withdrawal National Practice Guideline
American Society of Addiction Medicine (2020). ASAM Guideline on Alcohol Withdrawal Management. http://www.asam.org/Quality-Science/quality/guideline-on-alcohol-withdrawal-management - Accessed 3/20/2020

Malcolm, R., Ballenger, J. C., Sturgis, E. T., & Anton, R. (1989). Double-blind controlled trial comparing carbamazepine to oxazepam treatment of alcohol withdrawal. *The American journal of psychiatry*. 1989 May;146(5):617-21 http://www.ncbi.nlm.nih.gov/pubmed/2653057

Barrons, R., & Roberts, N. (2010). The role of carbamazepine and oxcarbazepine in alcohol withdrawal syndrome. *Journal of clinical pharmacy and therapeutics*, *35*(2), 153-167. http://www.ncbi.nlm.nih.gov/pubmed/20456734

Hammond, C. J., Niciu, M. J., Drew, S., & Arias, A. J. (2015). Anticonvulsants for the treatment of alcohol withdrawal syndrome and alcohol use disorders. *CNS drugs*, 29(4), 293-311. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC5759952

[1] SAWS of ≤16 is mild to moderate withdrawal (see http://www.aafp.org/afp/2013/1101/afp20131101p589-f2.gif in http://www.aafp.org/afp/2013/1101/p589.html)

[2] Patients are not appropriate for outpatient alcohol withdrawal management if they have any one of the following characteristics, unless directed by addiction medicine team or attending supervisor:

- History of delirium tremens or withdrawal seizures
- Acute illness that requires inpatient management
- Severe cognitive impairment (acute or chronic) that prevents ability of patient to take medication or follow instructions
- Inability to take oral medications because of vomiting or swallowing issues
- Serious psychiatric condition requiring a higher level of care
- Pregnancy – unless directed by high risk OB team
- Severe alcohol withdrawal symptoms (SAWS > 16 or CIWA-Ar ≥ 20)