PART
TWO

# Child Health BC Provincial Substance Intoxication and Withdrawal Guidelines

## Children & Youth in the Emergency/Urgent Care Settings

*(children & youth ages 0 days of age to 19 years of age less a day)*

## Practical Summary and Tools

NOVEMBER 29, 2019

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Child Health BC Vancouver, BC: Child Health BC, September 2018.

Child Health BC acknowledges the contribution of the Provincial Substance Intoxication and Withdrawal Working Group. See Part 1, Appendix A for a list of representatives.

# Substance Intoxication and Withdrawal Guideline: Children & Youth in the Emergent / Urgent Care Settings
# Age 0 Days of Age – 19 Years of Age Less 1 Day

## Purpose

To provide guidance and direction to physicians, nurse practitioners, nurses and other health care providers on the management of children & youth ages 0 days of age to 19 years of age less a day who present in emergency/urgent care settings in hospitals in BC with presentations related to substance use including:

- Alcohol
- Opiates
- Benzodiazepines
- Nicotine
- Other

To ensure that the principles of consent are applied appropriately and consistently in practice.

To ensure that management of children and youth is provided a manner that is child/youth and family centred, supports trauma-informed practice, is culturally sensitive and based on the principles of harm reduction.

## Principles

### Trauma Informed Practice

Trauma-informed practice takes into account an understanding of trauma in all aspects of service delivery and places priority on the individual's safety, choice and control (Harris & Fallot, 2001). A key aspect of trauma-informed services is to create an environment where service users do not experience trauma or further re-traumatization. This is supported, in part, through awareness of the wide-ranging impacts of trauma on an individual. This includes the ways in which trauma changes an individual's neurobiology and capacity for adaptive social functioning and emotional regulation.

### Recovery Oriented

A model that emphasizes hope, autonomy and engagement in order for a child/youth experiencing mental illness and/or substance use to live a satisfying, meaningful and purposeful life despite the constraints of his/her illness. A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

## Cultural Competence

Cultural competence refers to the ability to recognize and respect cultural difference and diversity. In the context of delivering care, cultural competence is necessary to facilitate effective communication between patients and providers; to ensure a system of care that responds to a variety of culturally-dependent beliefs, needs and practices; to ensure that care is trauma-informed; and to improve patient outcomes and provider experiences by reducing power imbalances that result from systemic inequality, discrimination, stigma, and/or stereotypes.

Clinicians and staff should undertake cultural safety training to improve their ability to establish positive partnerships with Indigenous clients seeking care. The San'yas Indigenous Cultural Safety Training Program, developed by the Provincial Health Services Authority (PHSA) Aboriginal Health Program, is an online training program designed to increase knowledge, enhance self-awareness, and strengthen the skills of those who work both directly and indirectly with Aboriginal people, and is an excellent resource for clinicians seeking to build their cultural competency. Please refer to the San'yas program website for more information.

## Child/Youth Centered Care

A philosophy that focuses on providing care according to the individual's understanding of well-being and quality of life. Treatment that emphasizes collaboration between clinicians and individuals receiving care, prioritizes individualized child/youth-specific care, and involves child/youth whenever possible as active agents in clinical decision-making.

## Family/Caregiver Centered

A family-focused approach that recognizes and supports families in their key role of providing ongoing care and support to children and youth. Client-centered and family-focused approaches are based on a philosophy that service delivery involves a partnership between those using and those providing services.

## Harm Reduction

Harm reduction aims to keep people safe and minimize death, disease and injury from high-risk behaviour. Harm reduction involves a range of support services and strategies to enhance the knowledge, skills, resources, and supports for individuals, families and communities to be safer and healthier.

For more information on principles, please refer to: Trauma Informed Practice Guide http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf This Guide was developed on behalf of the BC Provincial Mental Health and Substance Use Planning Council in consultation with researchers, practitioners and health system planners across British Columbia.

## Key Recommendations

### Consent

Obtain consent and authorization from child/youth or substitution decision maker where possible. In British Columbia, children and youth under 19 years of age do not need parental consent to receive treatment. Capacity to consent is determined based on the capacity to fully understand the treatment, the possible consequences of treatment and the *possible consequences of declining recommended treatment. A patient under 19 seeking treatment who is determined able to understand the treatment and give consent should not require parental (or substitute decision-maker) permission or notification. Informed consent and discussion of rationale for treatment should be documented.

Similarly, if a youth is deemed capable of making healthcare decisions we should also be respectful of their wishes in relation to who is given information about their situation (e.g. if a youth is deemed capable and requests that their parents or guardians are not informed of their health information, this information should not be disclosed). There may be certain circumstances in which breaching their privacy may be justified however these incidences are rare. Disclosure of personal information without consent is only justified in circumstances in which there is a significant risk of imminent harm to themselves or others, and clear indication that breaching privacy would significantly diminish that risk. If there were circumstances in which healthcare providers consider contacting parents against a youth's wishes they should: be very clear about the level of risk to the youth (or others) they are seeking to prevent; explore the youths' reasons for keeping information private; understand if there are other ways that are more palatable to the youth to decrease this risk; inform the youth in advance of the circumstances in which they are obligated to inform parents/ guardians of information.

For youth who lack capacity, it is essential to understand whether this lack of capacity is transient and may be restored (e.g. if they are stabilized). If lack of capacity is not transient, involving parents/ guardians for youth who lack capacity is warranted as it is these individuals who act as substitute decision makers and who should consent for treatment on a youth's behalf. Nevertheless if a minor is strongly against involving/ informing parents about certain information then further conversation with the youth to understand these concerns is warranted and to build the therapeutic relationship.

### Principles

Treatment approaches with children and youth should be developmentally-appropriate, child and youth-centered, trauma-informed, culturally appropriate, confidential, promote recovery, and include family involvement when appropriate.

### Screening

All children and youth who present with substance intoxication or withdrawal symptoms should be screened for mental health substance use disorders. The HEARTSMAP screening tool is recommended.

### Assessment

All children and youth who present with substance intoxication or withdrawal symptoms should undergo a thorough medical assessment including a substance use history.

Emergent presentations can include intoxication, withdrawal, an interaction between substances and medications or an exacerbation of mental illness in the context of substance use.

## Management

The Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) is recommended for managing alcohol withdrawal. The Clinical Opiate Withdrawal Scale (COWS) is recommended for opioid withdrawal management. Follow Health Authority standards for withdrawal management.

## Disposition

Patients who appear to have stabilized after being intoxicated should be further assessed for any possibility of withdrawal - early identification and treatment for withdrawal can prevent potentially life-threatening complications.

Information and referral to take-home naloxone programs and other harm reduction services should be routinely offered to patients and, when appropriate, friends and family members as part of standard care for opioid use disorder.

## Scope

This document applies to all staff working in Emergency/Urgent Care settings who work with children & youth ages 0 days of age to 19 years of age less a day who present intoxicated or undergoing withdrawal symptoms.

# 1.0 Procedure

## 1.1 Informed Consent & Certification

### 1.1.1 Consent to treatment:

Health care providers must seek valid consent to health care before providing treatment:

- In British Columbia, youth under 19 years of age do not need parental consent in order to receive treatment. Capacity to consent for youth under 19 is determined based on the capacity to fully understand the treatment and possible consequences of treatment. A patient under 19 seeking treatment who is determined able to understand the treatment and give consent should not require parental permission or notification. Informed consent and discussion of rationale for treatment should be documented. For more information on determining capacity to provide consent in those under 18, refer to guidance from the Canadian Medical Protective Association and Royal College of Physicians and Surgeons of Canada.
- The Infant Act applies to youth under the age of 19 (under the age of majority)
- Health care providers are encouraged to involve children and youth in the discussions involving their health and treatment.
- Where it is clear that the child or youth is competent to consent to treatment and that the treatment is in his/her best interest, as outlined in the Infants Act, the health care provider will obtain informed consent from the patient. **Infants Act: Consent of infants to medical treatment, Section 17.**
- http://www.bclaws.ca/civix/document/id/complete/statreg/96223_01
- If the minor is incapable of providing informed consent, the health care provider must obtain informed consent from the minor's parent or legal guardian.
- If patient/family/substitute decision maker is not able/available to give consent, an explanation with rationale should be provided as soon as possible after the event. It is important that the patient/family/caregiver receive an explanation as to why the treatment is necessary and they should be given the opportunity to respond to alternative methods when appropriate and safe.

### 1.1.2 Consent to medical care:

In a medical emergency, consent may not be needed to treat a child/youth — it depends on the situation. If a person's life or health is seriously threatened, and it appears that the person isn't capable of making healthcare decisions, healthcare providers may be justified in treating the person without consent.

- Because they are dealing with a medical emergency, they may be able do whatever is necessary to try and save the person's life or health.
- Common law also recognizes that, in an emergency, where a person's life is at risk or where there may be serious harm to the person's health and where the individual is incapable of consenting to treatment, emergency treatment may be provided to a person of any age without that person's consent. Common law suggests that these emergency powers include the restraint of a person who is likely to cause serious harm to themselves or others.

### 1.1.3 Certification

When a child/youth requires immediate treatment necessary to avert serious health consequences and/or risk of death, the patient can be admitted involuntarily to a designated facility and treated under the Mental Health Act if they meet specific criteria.[1]

The Mental Health Act authorizes involuntary psychiatric admission to a designated facility for people who meet ALL four of the following criteria:

1. is suffering from a mental disorder that seriously impairs the person's ability to react appropriately to his or her environment or to associate with others;
2. requires psychiatric treatment in or through a designated facility;
3. requires care, supervision and control in or through a designated facility to prevent the person's substantial mental or physical deterioration or for the person's own protection or the protection of others; and
4. is not suitable as a voluntary patient.

One Medical Certificate (Form 4) is required to provide legal authority for an involuntary admission for a 48-hour period. A Medical Certificate is completed by a physician who examines a person and finds that the person meets the involuntary admission criteria of the Mental Health Act. A second Medical Certificate by a different physician must be completed within 48 hours of admission, otherwise the patient must be discharged or admitted as a voluntary patient.

The Mental Health Act provides for compulsory treatment of all involuntary patients. The director may authorize treatment for patients who are mentally incapable of making a consent decision about the proposed treatment. Prior to treatment of involuntary patients, the Consent for Treatment (Involuntary Patient) form (Form 5) must be completed and signed.

http://www2.gov.bc.ca/gov/content/health/health-forms/mental-health-forms.

For further guidance regarding the Mental Health Act, see the Guide to the Mental Health Act at:
http://www.health.gov.bc.ca/library/publications/year/2005/MentalHealthGuide.pdf

[1] A designated facility is a provincial mental health facility designated under the *Mental Health Act*, a public hospital or part of it, designated by the Minister of Health.

## 2.0 Background

The assessment and management of patients presenting with acute intoxication and withdrawal or toxicity can be demanding and sometimes safety issues can present. Patients can rapidly deteriorate or may become extremely agitated, aggressive or violent. Young people may conceal or deny substance use because of potential parent/guardian responses. Patients may also have experienced trauma and a trauma informed approach to practice is critical.

Emergent presentations can include intoxication, withdrawal, an interaction between substances and medications or an exacerbation of mental illness in the context of substance use. It is important to note that a person's physiological, psychological and behavioural reaction to a drug depends on:

- Characteristics of the individual (e.g. age, size, gender, health state, mood etc.)
- Pharmacology of the drug/s used
- Pharmacokinetics of drug/s used
- Dosage and route of the drug/s taken
- Side effects or unwanted effects of the drug/s used
- The environment in which the drug/s were used (Where? How it was provided? Who was the source?)
- Drug/s used in combination with other substances (including medicines, inhalants, herbal preparations)
- Previous experience with the drug/s used
- Lack of awareness of what substances have been ingested

Determining which substances have been used and in what time frame, monitoring vital signs, and gaining collateral are all necessary.

## 3.0 Assessment

Common symptoms and signs of intoxication include:

- Slurred speech
- Poor concentration
- Altered perception
- Agitation
- Confusion
- Disorientation
- Unstable mood
- Unstable gait
- Vomiting, diarrhea, incontinence
- Unresponsiveness
- Diaphoresis

1. Exclude possible medical or biological reasons for the presentation (e.g. head injury, acute infection, electrolyte imbalance, cerebrovascular accident, stroke, hypoglycemia, psychosis, severe liver disease etc.).
2. Take a substance use history. Enquire about substance use on the day of presentation and the time and quantity and route of administration of recently consumed substances. Enquire about using practices e.g. access to safe needles. If the patient is unwilling or unable to provide a substance use history, attempt to identify collateral sources for obtaining information i.e. companions, parents, family, guardians etc. Indications for psychosocial screening include but are not limited to: chronic unexplained problems; drug and alcohol presentations; mental health concerns; history of previous exposure; frequency of previous admissions or medical interventions.
3. Drug-drug interactions can be looked up on the Drug Cocktails website or www.drugbank.ca.
4. All children and youth should be screened for substance use disorders including co-occurring mental health disorders. For those youth who present with a co-occurring substance use disorders, severe psychiatric disorder, or other diagnoses that may require specialist referral, referrals can be made to Foundry in communities where Foundry Centres exist, child and youth mental health and substance use services in each health authority, or the Compass Program at BC Children's Hospital.
5. Examine for physical signs of drug use such as puncture marks, cellulitis, phlebitis, skin abscesses, nasal erosion, irritation or rash around nostrils, septum or mouth, evidence of rectal damage, dehydration, rapid weight loss.
6. Undertake a urine drug screen.
7. All children and youth should be screened with HEARTSMAP http://heartsmap.ca/
8. Clinicians are encouraged to call the Rapid Access to Consultative Expertise (RACE) line to speak with an addiction medicine specialist if they have any questions or concerns: Rapid Access to Consultative Expertise Vancouver Area: 604-696-2131 Toll Free: 1-877-696-2131 Hours of operation are Monday to Friday, 0800-1700. http://www.raceconnect.ca/

# 4.0 Management

## 4.1 General:

- Create a simple, quiet, and safe environment - remove unnecessary equipment.
- Always treat the patient with respect.
- Approach in a quiet, calm and confident manner.
- Speak clearly and slowly.
- Ask them what they preferred to be called and their preferred pronoun.
- Always explain who you are and what you are doing.
- Acknowledge the patient's feelings and concerns.
- Provide frequent reassurance. Brief and frequent attendances will assist with this and may avoid unnecessary agitation.
- Protect the patient from accidental harm (e.g. do not leave them unattended on a bed without safety guards. Lower the bed as close to the floor as possible).
- Ensure child/youth's physical and psychological needs are met.
- Provide comfort items- could include: fidgets, ear plugs, warm drink, sleep masks, aroma therapy mist, Kleenex, lip balm, paper and pencils, snacks, books, comic books, relaxation techniques on cue cards, playing cards, greeting cards, blanket, stuffed animal etc.
- Sensory modulation (arts and crafts, music or sound therapy e.g. ipods, dvds) can be helpful.
- Encourage walking, talking, writing, resting, crying, deep breathing.
- Time alone and/or spiritual practice may be helpful.
- Minimize the number of staff attending the patient.
- For the confused/disoriented patient, keep an object familiar to them in view (e.g. a bag or an item of clothing).
- Correct perceptual errors and tell the patient what is real in a respectful manner.
- Accompany the person to and from places (e.g. toilet).
- In the case of aggressive patients – refer to CHBC Provincial Least Restraint guideline, April 2018.
- Refer to Learning Links education module for more information on managing safety concerns. https://learninglinksbc.ca/

## 4.2 Stabilization:

- Patients presenting as intoxicated or in withdrawal should be observed and monitored closely as they are at risk of medical complications.
- Based on the substance identified use the scoring tool CIWA-AR (Appendix 1) for alcohol or COWS (Appendix 2) for opioids. Follow withdrawal care plan based on the score as per health authority standard.
- Note that alcohol withdrawal can occur with a zero-blood alcohol reading.
- Seizures may be an indication of alcohol withdrawal, benzodiazepine withdrawal or stimulant intoxication.
- You may not be able to determine substance and/or the patient may have ingested more than one substance. In addition, sometimes the patient may not be aware of other substances that may have been ingested.

## 5.0 Intoxication and Substance Withdrawal Symptoms and Management:

| INTOXICATION SYMPTOMS | | |
|---|---|---|
| **STIMULANTS (two or more of the symptoms listed below)** | **OPIOIDS (Constricted pupils and one or more of the symptoms listed below)** | **ALCOHOL (one or more of the symptoms listed below)** |
| Tachycardia/ | Impairment in attention/memory | Slurred speech |
| Dilated pupils | Drowsiness/coma | Incoordination |
| High/low blood pressure | Slurred speech | Unsteady gait |
| Sweating/chills | | Nystagmus |
| Nausea/vomiting | | Impaired attention or memory |
| Muscle weakness | | Stupor or coma |
| Evidence of weight loss | | |
| Psychomotor agitation or retardation | | |
| Respiratory depression | | |
| Chest pain or cardiac arrhythmias | | |
| Confusion | | |
| Seizures | | |
| Abnormal movements (dyskinesias or dystonias) | | |
| Coma | | |
| **WITHDRAWAL SYMPTOMS** | | |
| **STIMULANTS (Dysphoric mood and two or more of the symptoms listed below within a few hours/days)** | **OPIOIDS (cessation or reduction in opioid use that has been heavy and prolonged and three or more of the symptoms listed below)** | **ALCOHOL (2 or more of the symptoms listed below within several hours/days after cessation of drinking)** |
| Fatigue | Dysphoric mood | Autonomic hyperactivity |
| Vivid unpleasant dreams | Nausea/vomiting | Increased hand tremor |
| Insomnia or hypersomnia | Muscle aches | Insomnia |
| Increased appetite | Lacrimation/rhinorrhea | Nausea/vomiting |
| Psychomotor retardation or agitation | Dilated pupils | Transient hallucinations |
| Seizures | Sweating | Agitation |
| | Piloerection (goosebumps) | Anxiety |

| WITHDRAWAL SYMPTOMS (continued) | | |
|---|---|---|
| | Diarrhea | Generalized tonic-clonic seizures |
| | Yawning | |
| | Fever | |
| | Insomnia | |
| | Described as 'the worst flu of my life' | |
| **TREATMENT AND MANAGEMENT CONSIDERATIONS** | | |
| Cardiac/Respiratory monitoring | Cardiac/Respiratory monitoring | Cardiac/Respiratory monitoring |
| Protect airway | Protect airway | Protect airway |
| Cool | IV hydration | Largely supportive |
| | Consider Suboxone Induction if in Opioid withdrawal | Determine if ethylene glycol or methanol ingestion |

**NOTE:** for all of the above, DSM has a criteria that "clinically problematic behaviour or psychological changes developed during or shortly after the alcohol/substance ingestion" and it's not better explained by another mental health disorder including intoxication from another substance

## 5.1 SUBSTANCE USE DISORDER CRITERIA:

Not all youth presenting with intoxication or withdrawal symptoms will have a formal substance use disorder, but many will. These criteria are very helpful in assessing youth:

A problematic pattern of ____ leading to clinically significant impairment or distress, manifested by at least 2 of the following, occurring within a 12 month period

1. Substance taken in larger amounts for longer than intended
2. Persistent desire or unsuccessful efforts to cut down or control use
3. Great deal of time spent obtaining, using or recovering from substance
4. Cravings
5. Recurrent use results in failure to fulfill obligations at home/work/school
6. Ongoing use despite social or interpersonal problems caused or exacerbated by the effects of ___
7. Important activities given up or reduced because of ___
8. Recurrent use in situations where it is physically hazardous
9. Continued use despite knowing that a persistent physical or psychological problem is being made worse by it (sometimes more noticeable to family members)
10. Tolerance (need more to achieve an effect or diminished effect from same amount)
11. Withdrawal (as above)

## 6.0 Disposition

Patients who require further treatment may require admission. Consult psychiatry and follow local Child Youth Mental Health Substance Use (CYMHSU) Emergency Department Guidelines.

Patients who appear to have stabilized after being intoxicated should be further assessed for any possibility of withdrawal - early identification and treatment for withdrawal can prevent potentially life-threatening complications.

Clinicians should consult the Rapid Access to Consultative Expertise (RACE) line and/or refer to addiction physicians with experience treating youth and refer to specialty care targeted at youth as available and appropriate. Vancouver Area: 604-696-2131 Toll Free: 1-877-696-2131 Hours of operation are Monday to Friday, 0800-1700. http://www.raceconnect.ca/

Determine need for additional referrals to child youth mental health services based on HEARTSMAP http://heartsmap.ca/

Provide NARCAN training and Take Home Naloxone Kit if required and available. See http://towardtheheart.com/

***Discharge Steps:***

- Assess patient's readiness for discharge and provide education or consider appropriate referrals (youth detox, residential treatment etc.)
- Identify if there is a further risk of overdose and determine urgency for referral based on assessment.
- If possible, discharge into the care of a responsible adult or with MCFD in attendance.
- Address any education requirements for harm reduction.
- Address child/youth & family/guardian questions.
- Explain discharge follow-up.
- Complete Discharge Communication Plan & HEARTSMAP report. Fax to:
    - Child Youth Mental Health (CYMH) as an urgent referral
    - Addiction Services
    - General Practitioner
- Complete Emergency Department Safety Plan at Discharge with child/youth & family/guardian.
- Connect with MCFD social worker on-call if any protection or neglect concerns exist

## 7.0 Documentation

Follow site procedures for documentation of event including monitoring, assessment, and interventions.

## 8.0 Resources

1. The Kelty Mental Health Resource Centre
   http://www.keltymentalhealth.ca/

2. FamilySmart Resources:
   http://www.familysmart.ca/resources/

3. Learning Links
   https://learninglinksbc.ca/

4. Comprehensive Trauma Informed Practice Guide:
   http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

5. Healing Families, Helping Systems: A Trauma-Informed Practice Guide for working with children, youth and families
   http://www2.gov.bc.ca/assets/gov/health/child-teen-mental-health/trauma-informed_practice_guide.pdf

6. Mental Health Act: Guide to the Mental Health Act of BC is available @
   http://www.health.gov.bc.ca/library/publications/year/2005/MentalHealthGuide.pdf

7. Mental Health Act Forms
   http://www2.gov.bc.ca/gov/content/health/health-forms/mental-health-forms

8. Infants Act: The Infants Act of BC is available @
   http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96223_01

9. San'yas program website

10. http://foundrybc.ca/

11. Drug and Alcohol Referral Line: Lower Mainland: 604-660-9382, BC: 1-800-663-1441, Yukon: 1-866-980-9099

12. BCCH Provincial Youth Concurrent Disorders Program:
    http://www.bcchildrens.ca/health-professionals/refer-a-patient/youth-concurrent-disorders-referral

13. Teen Drug Abuse:
    https://teens.drugabuse.gov/

14. Drug Cocktails for Youth: Provides information on drug/medication combinations: http://drugcocktails.ca/

15. From Grief to Action: When addiction hits home: http://fgta.ca/

16. Provincial Harm Reduction Program (includes Take Home Naloxone Resources): http://towardtheheart.com/

17. British Columbia Drug and Poison Information Centre (BC DPIC): http://www.dpic.org/

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## CIWA-Ar: Withdrawal Assessment- Alcohol

(Score CIWA-AR on second page)

Patient Label

**NAUSEA and VOMITING:** Ask: Do you feel sick to your stomach? Have you vomited? Observation:

**0** no nausea and no vomiting
**1** mild nausea with no vomiting
**2**
**3**
**4** intermittent nausea with dry heaves
**5**
**6**
**7** consistent nausea, frequent dry heaves and vomiting

**TACTILE DISTURBANCES** - Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation:

**0** none
**1** very mild itching, pins and needles, burning or numbness
**2** mild itching, pins and needles, burning or numbness
**3** moderate itching, pins and needles, burning or numbness
**4** moderately severe hallucinations
**5** severe hallucinations
**6** extremely severe hallucinations
**7** continuous hallucinations

**AUDITORY DISTURBANCES** - Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation:

**0** not present
**1** very mild harshness or ability to frighten
**2** 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

**TREMOR** - Arms extended and fingers spread apart. Observation:

**0** no tremor
**1** not visible, but can be felt fingertip to fingertip
**2**
**3**
**4** moderate, with patient's arms extended
**5**
**6**
**7** severe, even with arms not extended

**PAROXYSMAL SWEATS** – Observation:

**0** no sweat visible
**1** barely perceptible sweating, palms moist
**2**
**3**
**4** beads of sweat obvious on forehead
**5**
**6**
**7** drenching sweats

**VISUAL DISTURBANCES** -Ask "Does the light appear to be too bright? color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation:

**0** not present
**1** very mild sensitivity
**2** mild sensitivity
**3** moderate sensitivity
**4** moderately severe hallucinations
**5** severe hallucinations
**6** extremely severe hallucinations
**7** continuous hallucinations

Patient Label

**HEADACHE, FULLNESS IN 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.

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

**ANXIETY** -Ask "Do you feel nervous?" Observations:

**0** no anxiety, at ease
**1** mild anxious
**2**
**4** moderately anxious, or guarded, so anxiety is inferred
**5**
**6**
**7** equivalent to acute panic states as seen in severe delirium or acute Schizophrenia 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

**ORIENTATION AND CLOUDING OF SENSORIUM** - Ask "What day is this? Where are you? Who am I?"

**0** oriented and can do serial additions
**1** cannot do serial additions or is uncertain about date
**2** disoriented for date by no more than 2 calendar days
**3** disoriented for date by more than 2 calendar days
**4** disoriented for place/or person

Patient Label

| SCORING CIWA-AR | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Nausea & Vomiting | Tactile Disturbance | Auditory Disturbance | Tremor | Paroxysmal Sweats | Visual Disturbance | Headache, Fullness in Head | Anxiety | Agitation | Orientation and Sensorium | Pulse/ Heart Rate (taken for 1min) | Blood Pressure | Total score (max 67) | Date |
| | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
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Patient Label

## Clinical Opiate Withdrawal Scale (COWS) -

## Flow-sheet for measuring withdrawal symptoms for Opiate Withdrawal.

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

Patient's Name: _____ Date: _____

| DATE | | | | | | | |
|---|---|---|---|---|---|---|---|
| **TIME** | | | | | | | |
| **Resting Pulse Rate**: (record beats per minute)<br>*Measured after patient is sitting or lying for one minute*<br>0 pulse rate 80 or below<br>1 pulse rate 81-100<br>2 pulse rate 101-120<br>4 pulse rate greater than 120 | | | | | | | |
| **Sweating:** *over past ½ hour not accounted for by room temperature or patient activity.*<br>0 no report of chills or flushing<br>1 subjective report of chills or flushing<br>2 flushed or observable moistness on face<br>3 beads of sweat on brow or face<br>4 sweat streaming off face | | | | | | | |
| **Restlessness** *Observation during assessment*<br>0 able to sit still<br>1 reports difficulty sitting still, but is able to do so<br>3 frequent shifting or extraneous movements of legs/arms<br>5 Unable to sit still for more than a few seconds | | | | | | | |
| **Pupil size**<br>0 pupils pinned or normal size for room light<br>1 pupils possibly larger than normal for room light<br>2 pupils moderately dilated<br>5 pupils so dilated that only the rim of the iris is visible | | | | | | | |

| | Patient Label |
|---|---|

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Bone or Joint aches** *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored*<br>0 not present<br>1 mild diffuse discomfort<br>2 patient reports severe diffuse aching of joints/ muscles<br>4 patient is rubbing joints or muscles and is unable to sit still because of discomfort<br>**Time:** | | | | | | | |
| **Runny nose or tearing** *Not accounted for by cold symptoms or allergies*<br>0 not present<br>1 nasal stuffiness or unusually moist eyes<br>2 nose running or tearing<br>4 nose constantly running or tears streaming down cheeks | | | | | | | |
| **GI Upset**: *over last ½ hour*<br>0 no GI symptoms<br>1 stomach cramps<br>2 nausea or loose stool<br>3 vomiting or diarrhea<br>5 Multiple episodes of diarrhea or vomiting | | | | | | | |
| **Tremor** *observation of outstretched hands*<br>0 No tremor<br>1 tremor can be felt, but not observed<br>2 slight tremor observable<br>4 gross tremor or muscle twitching | | | | | | | |
| **Yawning** *Observation during assessment*<br>0 no yawning<br>1 yawning once or twice during assessment<br>2 yawning three or more times during assessment<br>4 yawning several times/minute | | | | | | | |
| **Anxiety or Irritability**<br>0 none<br>1 patient reports increasing irritability or anxiousness<br>2 patient obviously irritable anxious<br>4 patient so irritable or anxious that participation in the assessment is difficult | | | | | | | |

| Patient Label |
|---|
| |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Gooseflesh skin**<br>0 skin is smooth<br>3 piloerrection of skin can be felt or hairs standing up on arms<br>5 prominent piloerrection | | | | | | | |
| **Score:**<br>**5-12 = mild;**<br>**13-24 = moderate;**<br>**25-36 = moderately severe;**<br>**more than 36 = severe withdrawal**<br><br>**Total scores** | | | | | | | |
| **Observers initials** | | | | | | | |

# HEARTSMAP GUIDE

## HOME

- Is there difficulty or fighting at home between family members?
- How do you get along with [guardian/parents/family]?
- How do you feel about your home environment?

**Assessment Notes**

| No Concerns | Mild Concerns | Moderate Concerns | Major Concerns |
|---|---|---|---|
| 0 | 1 | 2 | 3 |
| | Supportive of youth's difficulties but some conflicts. | Unsupportive (parents at risk for burn out). Frequent conflicts. | Dysfunctional (parental burn out). Homelessness. Major conflicts. |
| ○ | ○ | ○ | ○ |

**Resources:** ○ Social Supports neither requested nor initiated
○ Social Supports Involved (resource requested and services initiated)

## EDUCATION & ACTIVITIES

- How is school going for you?
- Are there any difficulties going to school or staying in class?
- What do you do for fun? Has that changed recently?

**Assessment Notes**

| No Concerns | Mild Concerns | Moderate Concerns | Major Concerns |
|---|---|---|---|
| 0 | 1 | 2 | 3 |
| | Struggle to maintain. Difficulty attending. Attends more than misses. | Performance decline. Missing classes / activities. Misses more than attends. | Failing / major issues. Not attending. Completely truant (excluding holidays) |
| ○ | ○ | ○ | ○ |

**Resources:** ○ Educational/Activity issues not yet addressed
○ Functional Plan in Place (counselor involved)

## ALCOHOL & DRUGS

- How much is alcohol use a part of your life?
- Do you use any substances like marijuana? How about any others?
- Do you ever use drugs or alcohol to feel better or to make a problem go away?

**Assessment Notes**

| No Concerns | Mild Concerns | Moderate Concerns | Major Concerns |
|---|---|---|---|
| 0 | 1 | 2 | 3 |
| | Infrequent. Mild recreational use. | Regular recreational use. Mild substance misuse. | Binging recreational use. Substance abuse. |
| ○ | ○ | ○ | ○ |

**Resources:** ○ No detox or rehabilitation services suggested yet
○ Substance Use Services in Place (referred and offered)

## RELATIONSHIPS & BULLYING

- How are things going for you with friends and relationships?
- Do you have a close person/group of people that you can rely on?
- Do you feel teased, bullied, or excluded by others?
- Are you sexually active?
- Do you have any struggles with your sexual identity or sexual preference?

**Assessment Notes**

| No Concerns | Mild Concerns | Moderate Concerns | Major Concerns |
|---|---|---|---|
| 0 | 1 | 2 | 3 |
| | Minor conflicts / bullying. Struggle to maintain. | Conflicts / bullying. Negative changes. | Major conflicts / bullying. Lack of relationships. Major dysfunctional relationship. |
| ○ | ○ | ○ | ○ |

**Resources:** ○ No support or resources initiated
○ Educational or Social Plan in Place (school authority or social worker aware and addressing

| | | | | |
|---|---|---|---|---|
| **THOUGHTS & ANXIETY** | • Do you consider yourself someone who worries or thinks a lot about the past or future?<br>• Do you ever experience panic / extreme fear that comes out of the blue?<br>• Do you ever have times where you feel your brain is playing tricks on you?<br>• Do you generally feel safe? | | | |
| **Assessment Notes** | No Concerns | Mild Concerns | Moderate Concerns | Major Concerns |
| | 0 | 1 | 2 | 3 |
| | | Anxiety / odd thoughts (minimal impact). | Moderate anxiety or thought problems (strong, but able to power through). | High anxiety (impairing / insurmountable).<br>Thought disorder / psychosis. |
| | ○ | ○ | ○ | ○ |
| | **Resources:** ○ No psychiatric assessment or services initiated yet (not yet referred or on wait list for initial assessment and no appointment in sight)<br>○ Care plan in place (CYMH, Crisis response team, psychiatrist, or private counselor/psychologist involved or will be involved shortly, and available in the long term irrespective of youth's adherence) | | | |
| **SAFETY** | • Do you sometimes feel hopeless, or that life is not worth living?<br>• In the past few weeks, have you seriously considered ending your life?<br>• Have you ever tried to end your life?<br>• In the past few weeks, have you thought of harming yourself?<br>• In the past few weeks, have you felt that you or your family would be better off if you were dead? | | | |
| **Assessment Notes** | No Concerns | Mild Concerns | Moderate Concerns | Major Concerns |
| | 0 | 1 | 2 | 3 |
| | | Fleeting or improving thoughts.<br>Non-suicidal self injury.<br>Verbal threats to others but no action. | Passive suicidal ideation.<br>Non-lethal gestures to self (suicide practicing) or others. | Formed plan.<br>Lethal gestures to self or others.<br>Attempt. |
| | ○ | ○ | ○ | ○ |
| | **Resources:** ○ No plan for current safety concern<br>○ Safety planning in place AND consistent with previous suicidality/homicidality | | | |
| **SEXUAL HEALTH** | • Are you involved in any sexual activities / not limited to penetration?<br>• Do you use any mode of contraception?<br>• What form of protection against sexually transmitted disease do you use if any?<br>• Do you get any counseling about sexual health from a doctor or nurse? | | | |
| **Assessment Notes** | No Concerns | Mild Concerns | Moderate Concerns | Major Concerns |
| | 0 | 1 | 2 | 3 |
| | | Sexually active and safe practice (contraception and STD protected). | Stable partner but inconsistent use of protection and contraception. | Multiple partners or no use of protection or contraception.<br>Involved in sex trade. |
| | ○ | ○ | ○ | ○ |
| | **Resources:** o Sexual health issues not yet approached with health care professional<br>o Has a primary care provider and issues of sexual health/family planning addressed | | | |

| | | | | |
|---|---|---|---|---|
| **MOOD & BEHAVIOUR** | • How would you rate your mood, with '0' being as low as possible, and '10' being perfectly happy?<br>• Do you feel down or depressed recently?<br>• Do you feel really happy or energetic lately?<br>• How often are you getting into trouble? | | | |
| **Assessment Notes** | No Concerns | Mild Concerns | Moderate Concerns | Major Concerns |
| | 0 | 1 | 2 | 3 |
| | | Mood instability (minor). A few concerning behaviours. | Depression / irritability. Concerning behaviours. | Severe depression / manic. Major behavioral concern. |
| | ○ | ○ | ○ | ○ |
| | **Resources:** ○ No psychiatric assessment or services initiated yet (not yet referred or on wait list for initial assessment and no appointment in sight)<br>○ Care plan in place (CYMH, Crisis response team, psychiatrist, or private counsellor/psychologist involved or will be involved shortly, and available in the long term irrespective of youth's adherence) | | | |

| | | | |
|---|---|---|---|
| **ABUSE** | • To child: Has anyone ever hurt you by touching you in a way you didn't like?<br>• To adolescent: Have you ever experienced abuse, either physical, emotional, or sexual?<br>• To caregiver: Do you have any concerns of abuse or mistreatment? | | |
| **Assessment Notes** | No Concerns | Moderate Concerns | Major Concerns |
| | 0 | 2 | 3 |
| | | Concern has been raised and reported to the ministry. Historical concerns. At risk for grooming / victimization. | Current concern of abuse or neglect / not reported. |
| | ○ | ○ | ○ |
| | **Notification has occurred:** o Yes<br>o No | | |

| | | | |
|---|---|---|---|
| **PROFESSIONALS & RESOURCES** | • Do you feel that there are people or places you can go to for help?<br>• Who are the people who are working with you on these issues?<br>• Does the current plan to help make sense to you? | | |
| **Assessment Notes** | No Concerns | Moderate Concerns | Major Concerns |
| | 0 | 2 | 3 |
| | Service plan in place or available. No new outpatient or long term referrals need to be made. | Referred for service, but access delayed (wait- listed). | Longitudinal services unavailable, but necessary. Not yet referred or refusing services/treatment. |
| | ○ | ○ | ○ |

| **PRESCRIBER ORDERS**<br>FOR<br>**ALCOHOL WITHDRAWAL**<br>**IN THE EMERGENCY DEPARTMENT**<br>**AGE 10-18.99** | Patient Identification |
|---|---|

Weight: _____kg Height: _____cm Allergies: _____

***Initial on all lines applicable***

**REFER TO SUBSTANCE INTOXICATION AND WITHDRAWAL GUIDELINE**

**INVESTIGATIONS**

- Urine Drug Screen including Fetanyl
- Blood work for medication screening
- Glucose
- bHCG if female

**MONITORING**

- Initiate Clinical Institute Withdrawal Assessment for Alcohol Use. (CIWA-Ar)
- Assess CIWA-Ar score Q1H and vital signs as per Health Authority guidelines.
- Continue CIWA-Ar until score less than 10 for 3 consecutive measurements, then continue Q6H x 24H

Treatment endpoint is mild sedation (rouses easily and can maintain contact) and CIWA-Ar less than 10.

**Notify physician if:**

- CIWA –Ar score greater than 20 after one dose
- A change in score of greater than 10
- Heart rate greater than 120 BPM; SBP greater than 180 mmHg; or DBP greater than 120 mmH of lorazepam
- HOLD benzodiazepine and call physician if respiratory rate is less than 12/MIN or difficult to rouse (over-sedation)
- O2 sat less than 90% (less than 96% for pregnant women)
- Evidence of delirium
- Patient experiences seizures

Continue CIWA-Ar until scores are within the normal range (0 to 9) WITHOUT the use of medication, discontinued by MRP or patient admitted

**MEDICATIONS**

☐ Thiamine 50-100 mg PO (may give IM if unable to take PO)

*Note: Thiamine 100 mg is a prophylactic dose.*

*Higher doses required for treatment of Wernicke's Encephalopathy*

*ALCOHOL WITHDRAWAL PRN BENZODIAZEPINE ADMINISTRATION GUIDELINE*

| **CIWA-Ar Score** | **LORazepam PRN** | **Reassess CIWA-Ar and Vital Signs** |
|---|---|---|
| 0 to 9 | No medication | Q1H x 4 then Q4H until discontinued by MD or disposition determined |
| 10 to 19 | LORazepam 1 or 2 mg PO/ sublingual Q1H PRN | Q1H until CIWA-Ar score less than 10 or disposition determined |
| 20 or greater | LORazepam 2 mg PO/ sublingual Q1H PRN | Q30 to 45 MIN until CIWA-Ar score less than 20 or disposition determined |

| | | |
|---|---|---|
| _____ | _____ | _____ |
| PHYSICIAN SIGNATURE | PRINT NAME OF PHYSICIAN | DATE & TIME |
| _____ | _____ | _____ |
| NURSE SIGNATURE | PRINT NAME OF NURSE | DATE & TIME |

□ Original Copy – Chart □ Copy to Pharmacy Date: JULY, 2017

## Disclaimer

Child Health BC develops evidence-based clinical support documents that include recommendations for the care of children and youth across British Columbia. These documents are intended to give an understanding of a clinical problem, and outline one or more preferred approaches to the investigation and management of the problem. These documents are for guidance only and not intended as a substitute for the advice or professional judgment of a health care professional, nor are they intended to be the only approach to the management of a clinical problem. Healthcare professionals should continue to use their own judgment and take into consideration context, resources and other relevant factors. Neither Provincial Health Services Authority nor Child Health BC assume any responsibility or liability from reliance on or use of the documents.