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**Project Leader**

Joanne MacMillan, Senior Policy Analyst, Mental Health and Substance Use, Integrated Primary and Community Care, Ministry of Health

**Researchers/Writers**

Tracy Byrne, PhD, Director, InsideOut Policy Research

Samantha Morris, BSN, MA, Senior Associate, InsideOut Policy Research

**Steering Committee Members**

*First Nations Health Authority (FHNA)*

Jodie Millward, Regional Mental Wellness Advisor, Regional Teams

Erika Mundel, Senior Policy Analyst, Mental Wellness and Substance Use

*Fraser Health Authority (FH)*

Kevin Letourneau, Manager, Clinical Programs, Mental Health & Substance Use Services

Sherry Mumford, Director, Clinical Programs, Mental Health & Substance Use Services

*Interior Health Authority (IH)*

Tara Mochizuki, Mental Health & Substance Use Practice Lead, Community Integrated Health Services

Rae Samson, Manager, Mental Health and Addiction Services, Kamloops Community Integrated Services

*Island Health (VIHA)*

Sharon Ali, Coordinator, Withdrawal Management Services, Mental Health and Substance Use Services

Paula Beltgens, Manager, Youth and Family Substance Use Services, Mental Health and Substance Use Services

Michelle Dartnall, Regional Manager, Youth & Family Substance Use Services, Mental Health & Substance Use Services
Kerry Hammell, Youth Withdrawal Management Coordinator, John Howard Society of North Island

Gordon Harper, Executive Director, Umbrella Society for Addictions and Mental Health, Victoria

Janet James, Area Manager, Mental Health & Addictions, Oceanside, Port Alberni & West Coast

Northern Health Authority (NH)

Aaron Bond, NI Mental Health & Addiction Services Manager, Acute Regional Services

Julie Dhaliwal, Manager, Adult Acute Regional Services

Julie Odynak, Team Leader, Nechako Centre Adult Withdrawal Management Unit and Methadone Maintenance Programs, Prince George

Provincial Health Services Authority (PHSA)

Denise Bradshaw, Program Director, Heartwood Centre and the Provincial Youth Concurrent Disorders Program

Vancouver Coastal Health Authority (VCH)

Lorraine Grieves, Manager, Mental Health & Addictions - Youth Addictions, Harm Reduction, Prism & Transgender Health Information Program

Mary Marlow, Addiction Knowledge Exchange Lead

Nicki McGregor, Coordinator, Family Services of Greater Vancouver, Youth Withdrawal Management

Cathy Nelson, Program Manager, Directions Youth Detox, Family Services of Greater Vancouver

Ministry of Health (MoH)

River Chandler, Manager, Harm Reduction Policy

Elizabeth Hartney, PhD, Registered Psychologist

Jesse Lecoy, Intern, Healthy Minds Healthy People Ten Year Plan

Kathleen Perkin, Manager, Harm Reduction Policy

Kelly Veillette, A/Manager, Mental Health and Substance Use
**Reviewers**

B.C. Centre on Substance Use

Dr. Charl Els, Clinical Associate Professor, University of Alberta

Mathew Milen, MSW, RSW, Assessment & Treatment Services, Office of Dr. Charl Els

Clients of Charlford House Society for Women, supported by Trish LaNauze, Executive Director, and Linda Shaw, Program Director

Staff with the Umbrella Society, Victoria

Bill Bullock, MD, CCFP

Caroline Ferris, MD, CCFP, FCFP
   Clinical Assistant Professor, UBC Department of Family Practice
   Site Faculty, Surrey South Fraser Family Practice Residency Program
   Director, Surrey-North Delta Division of Family Practice

Dianne Almond, Withdrawal Management Supervisor, Phoenix Centre, Kamloops

Christine Westland, BSN M(C), Adolescent Mental Health Consultant for First Nations Health Authority

Elizabeth Driver, Registered Psychiatric Nurse, Team Leader, Clearview Detox, Nanaimo

**Consultations**

Provincial Youth Concurrent Disorders Network

BC Substance Use Network

Provincial Mental Health and Substance Use Planning Council

Provincial Emergency Services Advisory Committee (ESAC)

The Island Health Authority Youth Withdrawal Management/Supportive Recovery Working Group
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1. Introduction

1.1 Problematic substance use in British Columbia

Substance use occurs along a spectrum that includes beneficial use, casual or non-problematic use, and problematic use. At the beneficial end of the spectrum, substance use has positive health, social and/or spiritual effects. Problematic use, however, confers a wide range of risks and harms to individuals as well as to their families, friends, and communities, and society as a whole. These may include: interference with the person’s ability to maintain employment; legal and financial problems; impacts on the safety and wellbeing of members of the individual’s family or social circle; compromised physical health; involvement in illegal activities; and social isolation.

Problematic substance use can affect people of all ages and from all social groups. It is an issue that touches all British Columbians either directly or indirectly. Accurate data on the prevalence of problematic substance use are not readily available and estimates tend to vary. One frequently cited estimate is that as many as 400,000 British Columbians are living with some form of problematic substance use, in any given year. Of these, a proportion will meet the specific criteria for a substance use disorder. For example, in 2013, Statistics Canada reported that an estimated 173,690 individuals in B.C. (4.7% of adult British Columbians) meet the criteria for a substance use disorder per year, with one in four (25%) experiencing a substance use disorder at some time in their lives.

Concurrent disorders are common across diagnostic groups, but prevalence estimations are difficult to determine. Studies suggest that more than half of those seeking help for substance use also have a mental health issue, and 15 to 25% of those seeking help from mental health

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1 See the Glossary for a definition of “problematic substance use”
2 BCMA, 2009
3 Cited in BC Ministry of Health, 2015
services are also living with problematic substance use.\textsuperscript{4} The pervasiveness of trauma in the histories of people presenting for substance use treatment is also well recognized.\textsuperscript{5}

Individuals living with a substance use problem – whether or not they meet the criteria for a substance use disorder – experience personal suffering and interference with personal goals. Stigma and discrimination are significant barriers for many and present obstacles to education, employment, housing and appropriate health and social services. Families affected by problematic substance use often experience emotional turmoil, reduced quality of life, and financial challenges.

Helping individuals to change their problematic substance use requires a variety of services that are capable of responding to the specific characteristics and preferences of each person seeking help. Withdrawal management is one such service.

1.2 What is withdrawal management?

Withdrawal management is a service that provides assistance with withdrawal from alcohol and/or other drugs for individuals who are seeking help for their substance use issues. A planned withdrawal supports the individual to go through the process of withdrawing from substances in a safe and effective manner with medical and personal care provided as needed. For many people, withdrawal management will be the first step on a long-term journey of recovery and wellness.

Withdrawal management is the preferred name for the process that is often referred to as “detoxification” or “detox”. Detoxification is only one component of the withdrawal process and refers to the body ridding itself of the chemical effects of the substance(s) that have been used. Withdrawal management, however, implies a more holistic and comprehensive approach to helping someone through withdrawal – one that provides the necessary care during the “detox” process, as well as ongoing supports after the chemical effects of the substance(s) have worn off, to assist the individual to stabilize physically and psychologically, and to connect them with appropriate substance use treatment and other health and social services.

Withdrawal management is sometimes regarded as the only step necessary for dealing with problematic substance use. This is not the case. Withdrawal management alone is insufficient for overcoming the effects of problematic substance use, though it may be an important first point of engagement in clinical care on the journey to recovery and wellness. Withdrawal management is most effective when it is integrated into a long-term recovery process.\textsuperscript{6} The absence of a recovery plan should not preclude people from accessing withdrawal management, but it is strongly recommended that a plan be developed. Indeed, development of a long-term wellness plan is a major theme of these guidelines. (See, in particular, Guideline 8: Recovery / Wellness Planning.)

\textsuperscript{4} CCSA, 2009
\textsuperscript{5} British Columbia, BC Provincial Mental Health and Substance Use Planning Council, 2013
\textsuperscript{6} CSAT, 2006; SCAN, 2006
Note: With respect to the medical management of withdrawal, the evidence for specific withdrawal syndromes and connection into ongoing treatment and care vary across and between substances (e.g. opioids vs. alcohol vs. stimulants) as well as for people who use multiple substances. Treatment plans should address the individual’s needs as they pertain to substance(s) being used. Following completion of withdrawal management, individuals may be linked into ongoing support services that may include a combination of psychosocial treatment interventions, psychosocial supports, residential treatment and pharmacotherapies.

1.3 Why biopsychosocialspiritual guidelines for withdrawal management services?

The guidelines for adult withdrawal management services presented in this document align with and promote a biopsychosocialspiritual model of care. The biopsychosocialspiritual model of care is the accepted substance use practice model in British Columbia. It has been developed to explain the complex interaction between the biological, psychological, social and spiritual aspects of problematic substance use. It is the model that is widely endorsed by researchers and clinicians.

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

Crucially, the biopsychosocialspiritual model asks healthcare professionals to see and to care for the whole person and to recognize the impact that all aspects of our lives and experience have on our health and wellbeing. In this regard it reflects the holistic approach to health and wellbeing that is fundamental to Indigenous perspectives. The 2012 publication, *A Path Forward: BC First Nations and Aboriginal People’s Mental Wellness and Substance Use 10 Year Plan* (2013), describes such perspectives as a shift from a “medical model” of healthcare to a “wellness model”:

*There is a clear connection between health, food, work, play, culture, family, community and achieving a level of personal and collective wellness. [...] Culture, language, values, traditions, spirituality, world views, and the environment are essential elements for the promotion of health and well-being.*

Achieving balance within and across the physical, spiritual, mental, cultural, emotional, and social domains of life is central to being well and healthy.  

An evidence-informed model

The literature on effective substance use services (including withdrawal management) strongly endorses and recommends the provision of comprehensive and coordinated supports that address the diverse biopsychosocialspiritual needs of individuals as a key component of substance use treatment and sustained recovery. A number of beneficial outcomes are associated with this approach, including: enhanced motivation to embark upon and to continue with the wellness journey; increased optimism about the possibility of a successful recovery; increased rates of retention in withdrawal management (and subsequent treatment); and the acquisition of skills (life skills, harm reduction skills, and skills to cope with the cravings and triggers associated with substances) that also promote wellness. These potential benefits and the evidence for them are discussed in more detail in Part 4 of this document, *The Evidence that Informs the Guidelines.*

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7 FHNA, 2013, pp. 6 & 16  
8 Health Canada, 2011; FNHA, 2013  
9 NTA, 2006; UK Department of Health, 2007; NCAT, 2008; NCCMH, 2008; New Zealand, 2008; Amato, et al., 2011; Stein, Anderson & Bailey, 2015
### 1.4 How were the guidelines developed?

Development of the *Provincial Biopsychosocialspiritual Guidelines for Adult Withdrawal Management Services* was led by a working group of specialists in withdrawal management and substance use treatment from the B.C. Ministry of Health, the Provincial Health Services Authority, and the five regional health authorities. The working group also included allied health professionals, withdrawal management service providers, and staff from non-profit agencies that support people with problematic substance use. Input from staff with the First Nations Health Authority was also gathered and incorporated.

The approach to creating the guidelines was evidence-informed and highly collaborative. Research included a review of recent clinical and grey literature on withdrawal management and substance use treatment with an emphasis on psychosocial services and supports. In addition, a scan of withdrawal management services in British Columbia was conducted to identify existing best practice as well as service challenges across the province. The findings from the scan and, in particular the insights and experience shared by service providers who participated in the process, have helped to shape these guidelines.

Various drafts of the guidelines were shared with working group members throughout the development process. A draft was also circulated among groups of general practitioners, Emergency Department professionals, service providers, and service users across the province. In addition, the BC Centre on Substance Use reviewed the draft document. Feedback from all of these experts/stakeholders was used to refine the final version of the guidelines.

### 1.5 What are the goals of the guidelines?

The overall goal of the guidelines is to enhance the ability of withdrawal management services in British Columbia to deliver safe and comprehensive holistic supports to individuals receiving withdrawal care. In so doing, the guidelines promote the implementation of an evidence-informed, patient-centred biopsychosocialspiritual model across substance use services.

In addition, the guidelines seek to support the increased integration of withdrawal management with primary care. To this end, specific guidelines addressing transitions to withdrawal management services from Emergency Departments and the role of general practitioners with respect to their patients’ withdrawal care needs are included. These have been developed with the input of general practitioners and Emergency Department professionals.

Finally, the guidelines include a specific focus on home/mobile withdrawal management with the intention of increasing the numbers of people in British Columbia who are able to access such services. Home/mobile withdrawal management programs are defined by the fact that service providers go to where the individual requiring service is – whether this be the individual’s home, the home of a family member or friend, a shelter, a supportive recovery facility, or (in the case of services for youth) the home of a family who is participating in a family home care model of withdrawal management. Home/mobile withdrawal services
represent a safe and effective option for the majority of individuals who are seeking help to withdraw from substances. Increasing the availability and uptake of home/mobile services will enhance the accessibility of withdrawal care for all British Columbians.

The guidelines do not include specific guidance for the medical or pharmacotherapeutic aspects of withdrawal management. The development of clinical standards or guidelines for the medical management of withdrawal from substances is undertaken through various health system partners, such as the BC College of Physicians and Surgeons, the Guidelines and Protocols Advisory Committee, and the BC Centre on Substance Use. The biopsychosocialspiritual supports captured in the guidelines are intended to complement the medical management of withdrawal where such management is indicated.

1.6 What other initiatives and policies do the guidelines align with?

The Biopsychosocialspiritual Guidelines for Withdrawal Management Services align with and reflect the philosophy and principles of care that underpin the following provincial and national health policy and service documents:

- *Setting Priorities for the B.C. Health System* (British Columbia, 2014)
- *Trauma-Informed Practice Guide* (British Columbia, 2013)
- *A Path Forward: BC First Nations and Aboriginal People’s Mental Wellness and Substance Use 10 Year Plan* (British Columbia, 2013)
- *Service Model and Provincial Standards for Adults/Youth Residential Substance Use Services* (British Columbia, 2011)
- *Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia* (British Columbia, 2010)
- *A Systems Approach to Substance Use in Canada: Recommendations for a National Treatment Strategy* (Ottawa, 2008)
- *Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use and Addiction* (British Columbia, 2004)

Of particular note, there is congruence between the guidelines’ emphasis on involving family in an individual’s treatment and recovery process and the purpose of *Families at the Centre*, which is to increase understanding of a family-centred service orientation with the goal of equipping all members of the family to thrive. *Families at the Centre* calls for greater collaboration between all systems that touch and influence the lives of families affected by mental health and substance use issues. The Provincial Biopsychosocialspiritual Guidelines for Adult Withdrawal Management Services recognize that increased linkages and coordination...
between agencies that play a role in supporting the biopsychosocialspiritual wellbeing of people seeking withdrawal management are crucial to effective service.

In addition, the guidelines align with the Setting Priorities vision of patient-centred, family-centred, multidisciplinary health services within a model of integrated primary and community care. In the context of services for individuals with moderate to severe substance use (and/or mental health) issues, this means enhancing practices around: outreach to vulnerable populations; prompt access to services; effective referral, intake and assessment processes; effective and comprehensive care/recovery planning; coordination of care; strong linkages across the continuum of services (to connect people to more intensive supports as required and to step people down as they recover); and (wherever safe to do so) supporting people to recover at home. The Provincial Biopsychosocialspiritual Guidelines for Adult Withdrawal Management Services reflect these actions and priorities.

1.7 How will the guidelines be used?

The Provincial Biopsychosocialspiritual Guidelines for Adult Withdrawal Management Services are intended to support and inform health authorities and health authority-funded direct and contracted service providers. In view of the regional diversity in British Columbia with regard to geography and populations served, the guidelines are necessarily and intentionally broad in nature. They provide a foundation and framework for effective and consistent withdrawal management care across B.C. while allowing the flexibility that is required to meet the distinct needs of individuals and communities in different regions of the province.

Many of the evidence-informed approaches and supports captured in the guidelines are already in place in withdrawal management programs across the province. Others will involve a process of ongoing dissemination and implementation for health authorities and withdrawal management services. The Ministry of Health is committed to supporting health authorities and withdrawal management services with implementing the guidelines over the longer term.
2. Withdrawal Management within the Continuum of Substance Use Services and Supports in British Columbia

Substance use services in British Columbia are provided along a continuum from health promotion and prevention through harm reduction and treatment and supportive recovery. Ideally, every person who engages with this spectrum of services will receive seamless and coordinated care for their problematic substance use and associated mental and physical health needs.

This service model is informed by the work of the National Treatment Strategy (NTS) Working Group, which was established in 2007 with the mandate of improving the quality, accessibility, and range of options to address harmful substance use. In 2008, the working group published *A Systems Approach to Substance Use in Canada: Recommendations for a National Treatment Strategy*. This report recommends that provinces work to develop a continuum of services based on a tiered model in which the tiers represent different levels of service according to the acuity, chronicity and complexity of the substance use and associated problems. The following diagram illustrates a tiered model for the planning and delivery of substance use services in British Columbia.

![Tiered Framework for Substance Use (and Mental Health) Service Planning](image)

Figure 2: Tiered Framework for Substance Use (and Mental Health) Service Planning

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10 National Treatment Strategy Working Group, 2008
The model articulates various levels of service that correspond to need, and the various system supports that are required to operationalize and monitor the success of the treatment system.

In British Columbia, withdrawal management happens across Tiers 3, 4 and 5 of this model and in a variety of settings. The specific characteristics of withdrawal management services available across the province vary in accordance with regional demands, circumstances and populations. However, they may all be defined by the fact that they provide support for people to withdraw safely from the use of alcohol and other drugs. Services may include:

- Medical approaches (sometimes referred to as “medically managed” or “medically monitored” services). These are typically provided in specialized withdrawal management facilities as a residential service, but they may also be provided in inpatient hospital settings;

- Non-medical or minimally medical approaches, such as home/mobile and day programs, which can be offered within communities or in a home. Depending on the individual’s symptoms, these may involve the use of medication and regular support from/check-ins with primary care staff; and

- Stabilization supports for people requiring or wishing to access ongoing treatment and psychosocial services after withdrawing from a substance. This may involve ongoing monitoring, assessment, case management, and wellness planning and can be provided in a variety of settings, including stabilization and recovery units, residential treatment facilities, and community-based outpatient programs.12

Depending on the substance(s) involved, the majority of people seeking to withdraw from substances will be able to do so safely by following a planned outpatient withdrawal process (i.e. a day program or home/mobile service). Only a small proportion of people will require more intensive medically monitored or medically managed services to ensure that they withdraw from substances safely. Generally, this would comprise people who have unstable concurrent medical or psychiatric issues, are using more than one substance, and/or those who have a history of or are deemed at risk for complicated withdrawal syndromes. As previously noted, withdrawal from opioids without a plan for longer-term treatment has been associated with elevated rates of HIV and hepatitis C infection, higher rates of fatal overdose (in comparison with providing no treatment), and almost universal relapse.

However, there may be psychosocial reasons why an individual would want to access a residential withdrawal management program even though their medical or mental health assessment does not indicate that it is necessary. An individual may, for example, feel a need to be away from their community during withdrawal in order to have a break from an environment that is associated with using substances and to avoid triggers to substance use. Conversely, there may be reasons why a person who is considered to be at risk of a complicated withdrawal would nevertheless want to access home/mobile or day services. For example, an individual may have particular cultural needs and preferences that may be more

12 Adapted from Health Canada, 2011
readily met within a non-residential service. In such cases, additional and more intensive supports may be provided as part of a home/mobile or day program.

It is important that the screening process for withdrawal management take into consideration not only the substance(s) used but also the specific psychosocial/spiritual circumstances and preferences of each individual seeking service (as well as their medical profile) so that they can be matched to the least intrusive service that best meets the entirety of their needs.
Spotlight on Home / Mobile Withdrawal Management

- As its name suggests, home/mobile withdrawal management programs bring the services and supports to the individual – whether that be in the individual’s home, the home of a family member or friend, a shelter, a supportive recovery facility, or in the case of youth, the home of a family that is participating in the family home care model of withdrawal management.

- Services are provided under the oversight of a GP or Nurse Practitioner and with the support of a nurse and/or substance use service provider.

- A review of literature by Fraser Health Authority found that approximately 20 – 40% of individuals in need of withdrawal management services require a residential setting such as a specialized withdrawal management centre or hospital unit. Approximately 60 – 80% of people can benefit from a home/mobile service.

- Inclusion criteria for people seeking home/mobile withdrawal services typically comprise:
  - A safe and quiet “home” environment that is free from substance use;
  - Strong social supports, including the commitment of someone trusted and reliable who can give support through the withdrawal process;
  - No or low-risk of severe or complicated withdrawal;
  - No medical complications that require close observation or treatment in a hospital setting;
  - Psychiatric symptoms can be managed safely in a community setting; and
  - Commitment to the withdrawal process.

- Documented benefits of home/mobile withdrawal services include:
  - Enhanced service capacity – enables a prompt response to a request for withdrawal care;
  - Increased accessibility and flexibility of service provision – in particular, the uptake of withdrawal management by populations that are harder to reach, including older adults, women with children, Indigenous individuals, and people with medical issues and disabilities;
  - Reduced costs – the cost of home/mobile services is approximately 48% of the cost of an inpatient withdrawal in a specialized facility or hospital unit. In addition, home/mobile withdrawal services tend to facilitate reaching people at an earlier stage and therefore reduces costs further along the treatment continuum;
  - Less stigma and labelling for people entering the programs;
  - Increased privacy and ability to tailor care to each individual’s needs;
  - Increased involvement of and support to the individual’s circle of care;
  - Improved relationships between the individual undergoing withdrawal and her/his family members/circle of support; and
  - Increased program completion and use of after-care services and supports.

(O’Donaghey, n.d.; Cooper, 1995; Fleeman, 1997; Roche, Watt & Fischer, 2001; Fraser Health, 2013)
3. The Principles that Inform the Guidelines

The following fundamental principles of effective withdrawal management services were identified by service managers and providers across British Columbia during the process of developing these guidelines. They complement the guiding concepts of the National Treatment Strategy and support the implementation of a biopsychosocialspiritual model of care.

Embedding these principles in the delivery of withdrawal management services helps to create a safe, supportive environment that will facilitate positive outcomes for individuals.

Withdrawal management services and supports in British Columbia are:

- **Person centred**

People seeking withdrawal management services and supports come from diverse backgrounds and life situations. They present with different personal, health, and social needs and a unique set of challenges and strengths. No two people will have the same journey through treatment and recovery. People accessing withdrawal management supports will have varying levels of readiness to change their substance use. Some may be ready to complete this early step towards longer-term recovery and wellness; others may simply be seeking a few days respite.

Withdrawal management programs, therefore, have the flexibility to tailor supports to each individual. The individual is supported to determine their personal goals for service. This may include accommodating for longer service stays as required.

Person-centred care is fostered and sustained by ongoing collaboration and relationship building between program staff and the individual receiving service. Services and supports that are responsive to the particular circumstances and preferences of individuals facilitate retention and good outcomes.

- **Accessible**

Reducing barriers to accessing care and supports is fundamental to ensuring that people who are seeking to change their substance use can get the support they need. Barriers may be individual (e.g. transportation needs, childcare requirements) and systemic (e.g. program hours of operation, waits for service, admission criteria). Effective systems of services and supports actively seek to address such issues.

An individual’s motivation to change comes and goes. Services and supports that are available when the window of motivation is open are more likely to be effective.

In the context of withdrawal management supports, providing home/mobile withdrawal services enhances service capacity and is key to reaching people who might otherwise not be served. Low barrier screening procedures and admission criteria, walk-in referral services, 24/7 intake, and active outreach increase service accessibility and help to ensure that those most in need of support receive it.
Respectful

Effective care and treatment occurs within a culture of mutual respect. Individuals receiving service are treated with dignity and respect throughout all stages of the withdrawal management process. Program staff members are friendly, welcoming and caring, and engage individuals using a non-judgmental, supportive and empathic approach. Service providers demonstrate respect for and understanding of each individual’s needs, challenges, fears and goals, and foster a sense of hope, self-worth, accomplishment and expectation of recovery. Withdrawal management services provide individuals with a positive experience that facilitates completion of withdrawal and participation in ongoing treatment and supports.

Culturally safe and culturally centred

Cultural safety is an approach to service planning and delivery that supports an environment free of racism and discrimination where people feel safe receiving care. The approach includes recognizing the role of history and past trauma in shaping individuals’ health and healthcare experiences. It requires service providers to reflect upon their own assumptions and positions of power within the healthcare system and to acknowledge themselves as life-long learners when it comes to understanding another person’s experience. Service providers recognize that each individual is the expert on their own unique experience.

In addition, service providers offer care that is respectful and inclusive of traditional healing and cultural practices around wellness and healing.

Recovery oriented and wellness focused

Recovery is the goal of helping people with substance use issues. It involves overcoming the negative impacts of substance use and building a satisfying and meaningful life. There are many paths to recovery. The process and the time needed to achieve wellness will vary from person to person. At the centre of the recovery process is the individual’s own definition of what constitutes “a meaningful life”. This may or may not involve complete abstinence from substances. Creating a sense of hope and confidence in the possibility of change, both in the individual receiving service and their network of support, is vital to recovery.

Recovery oriented and wellness-focused services encourage people to see themselves as integral and active agents in their healing and build people’s capacity to support their own recovery and wellbeing. Services understand that positive health and participation in society are as central to recovery as gaining control over substance use and they support all aspects of an individual’s wellbeing.

Trauma informed

There is a strong association between violence, trauma and substance use, as well as between trauma and concurrent mental health and substance use problems. Given this association, it is crucial that substance use services are trauma informed.
Trauma-informed practice concerns the overall essence of the approach to providing services. It is fundamentally about the way of being in relationship with people who are accessing substance use supports. In trauma-informed services, all policies, procedures and service components are designed with an understanding of trauma in mind and with the goal of creating a culture of non-violence, mutual learning, and collaboration. Priority is placed on the individual’s safety, choice, and control.

Services strive to create an environment where people do not experience further traumatization or re-traumatization and where they can make decisions about their treatment and support needs at a pace that feels safe to them.

**Strengths based**

Strengths-based practice rests on the firm conviction that every person has potential and that it is a person’s strengths and capabilities, and not their limitations that will shape their evolving journey through life. Concentrating on strengths, rather than deficits, promotes resilience and healthy change. It recognizes the positive qualities that each individual can draw from and build upon during their journey.

In strengths-based services, practitioners purposefully draw out each individual’s strengths, hopes, interests, goals, and skills in order to foster self-efficacy, support empowerment, and build resiliency. They do this in the context of striving to create warm and authentic relationships with the people accessing services.

A strengths-based approach is informed by an understanding that capacity building is a collaborative and dynamic process that occurs over time. Service providers place value on what is important to the person accessing service and support the change process by starting with what that person already knows.

**Informed by the principles of harm reduction**

Services that are informed by the principles of harm reduction focus on reducing the adverse health, social and economic impacts of substance use that are experienced by individuals, families, communities and society. Harm reduction focuses on supporting people’s immediate safety and seeks to minimize death, disease and injury from high-risk behaviours.

Pragmatism is an important principle in harm reduction. Services and supports focus on what the individual is prepared to do “now” (i.e. current stage of change), with priority given to realistic and achievable goals. In this way, harm reduction may help to move a person from a state of chaos to a state of control over their own life and health.

In view of the rates of relapse following withdrawal for opioid use disorder, the provision of harm reduction education and supports as well as linkages to opioid agonist therapy (where appropriate) are key components of withdrawal management services.
Committed to reducing stigma

The stigma associated with substance use operates on three levels: social, institutional and self. Stigma marginalizes people with substance use issues, reduces their sense of self-worth, and creates barriers to accessing services.

Addressing stigma, discrimination and marginalization is a vital component of building and delivering effective substance use services and supports. Effective services challenge the stereotypes that marginalize people who use substances, and seek to enhance individuals’ sense of self-worth and self-efficacy. Service providers see the people who access their services as whole individuals. They treat them with dignity and respect and they use accurate and sensitive language at all times.

Family centred

People seeking support for substance use issues exist in a system of relationships with family, peers, community members, and others. When substance use services engage an individual’s support network in care planning and delivery, positive outcomes are realized.

With the permission of the individual, withdrawal management services involve supportive family members and others in the individual’s recovery journey. By doing so, service providers acquire a better understanding of the context of an individual’s substance use and develop relationships that enhance collaboration with the individual’s support network. Withdrawal management services also provide assistance for individuals to strengthen their supportive ties as this will help them through the withdrawal process and on into post-withdrawal treatment and services.

Part of a continuum of integrated care

Ideally, withdrawal management services exist within a seamless continuum of prevention, early intervention, treatment, and recovery support. Individuals are able to access a range of flexible and individualized services across this continuum that are linked through some form of coordination and case management. Effective case management helps to ensure that the full range of biopsychosocialspiritual needs that an individual has are appropriately addressed. Individuals with concurrent disorders receive collaborative care for both their substance use and mental health issues.

To ensure the most comprehensive and seamless experience possible for individuals accessing service, there is a commitment from all service providers to collaborate with each other to address the often complex and multiple needs of individuals. Withdrawal management services develop and sustain strong links and partnerships with other health and social services and community supports. There is sufficient integration of services such as sobering centres, withdrawal management units, and stabilization/supportive recovery beds to ensure the smooth and timely transition of individuals between services.
4. The Evidence that Informs the Guidelines

This section offers a succinct, high-level summary of the academic and grey literature reviewed for the development of the Guidelines. In the interests of reader-friendliness, citations to the source material are footnoted at the end of each paragraph of the summary. Service providers are encouraged to consult the original sources for more detailed and specific information.

Research on substance use services and supports shows that appropriate, evidence-based treatment works.13 It is helpful in reducing problematic substance use, improving health and social wellbeing, and reducing the risk of death due to overdose and other medical consequences of substance use disorders. It is also associated with reductions in substance-related crime and other social harms.14 Therefore, people who use substances, their families, communities, and society at large all benefit from effective and evidence-based substance use treatment and services.

What is meant by “effective” in the context of withdrawal management services? What evidence supports the application of a biopsychosocialspiritual model when helping people to withdraw from substances? Evidence from national and international clinical research, policy and practice-based experience, as well as consultations with service providers and service users in British Columbia, offers some robust guidance on what constitutes effective approaches to withdrawal management program design and delivery.

The information in this section provides a high-level summary of this evidence. It brings together key findings from material that is specific to withdrawal management and it also draws on sources that address the role of psychosocial services and supports in substance use treatment more broadly. Where evidence indicates the effectiveness of particular approaches or considerations for supporting specific population groups, this information is highlighted in text boxes.

4.1 Withdrawal management as part of a continuum of services

Withdrawal management is most effective when it is understood as an early step in a longer recovery / wellness process

It is important to highlight that withdrawal management is not a “treatment” for problematic substance use nor is it the only step required in overcoming problematic substance use. It is an early step on the path to wellness and is most beneficial to people when integrated with longer-term recovery programs and supports, such as stabilization, rehabilitation and maintenance activities. It is crucial for service providers to ensure that individuals seeking withdrawal management understand this and to encourage them to incorporate this perspective into their personalized withdrawal program.

There is emerging (albeit limited) research to suggest that active preparation for withdrawal

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13 National Treatment Strategy Working Group, 2008
14 Ministry of Health, 2011
management may be beneficial. This may include supporting the individual to identify their goals for recovery, to recognize their triggers for substance use, and in some cases to participate in cognitive behavioural therapy (CBT) sessions.

Individuals who engage with withdrawal management as part of a long-term and integrated wellness plan may be more likely to experience sustained recovery.15

Withdrawal management provides an opportunity to begin the process of behaviour change and engage individuals in longer-term recovery / wellness

Withdrawal management presents an opportunity for program staff to encourage individuals to make changes that will support their recovery and promote their overall health and wellbeing. To this end, program staff should aim to build positive therapeutic relationships with people accessing withdrawal management services. The therapeutic relationship is crucial for enhancing people’s motivation to engage with longer-term treatment and supports. Even though withdrawal management is a relatively short process (typically 4 – 7 days), it is often an individual’s first point of entry into the specialized substance use service system and sets the tone, therefore, for the system as a whole.

Women

- On average, women are more likely to experience a greater intensity and range of negative medical, psychological and social impacts associated with their substance use.
- The majority of women seeking help for their substance use will have experienced physical or sexual violence at some point in their lives. In addition, a significant proportion will have been sexually or physically harassed while participating in a treatment program. Staff must be aware of the risks of such harassment in residential withdrawal programs and the requirement to ensure safety.
- Most experts in the field of substance use treatment agree that women-only services increase participant retention. Where women-only services are not available, programs should offer women-only groups and activities. Some qualitative research has found that women participating in women-only group therapy report feeling safer, more supported and more able to express themselves openly.
- Research suggests that the combination of issues such as parental obligations, unemployment, poverty, and housing insecurity present a particularly significant challenge to women in the first stages of recovery. Withdrawal management presents an opportunity to start connecting women with the social supports that can help to address these issues.

(National Drug & Alcohol Research Centre, Australia, 2003; Callaghan, et al, 2006; Greenfield, et al., 2006; Sun, 2006; WHO, 2009b; Greenfield, et al., 2013; Lee et al., 2014)

Work on establishing a therapeutic relationship should begin upon admission to ensure that people feel safe, welcomed and supported, and motivated to continue on their recovery journey. Withdrawal management services should offer a range of proven and innovative

15 CSAT, 2006; SCAN, 2006; Kouimtsidis & Kolli, 2014; Croxford, et al., 2015
approaches aimed at helping the large proportion of people to continue the process of behaviour change.\textsuperscript{16}

**Individuals should be connected with appropriate post-withdrawal treatment and supports**

After completing withdrawal management, individuals should be linked to the services that will best support their ongoing recovery and wellness. Individuals who are connected to psychosocial support services (e.g. housing, health care, employment, financial assistance, childcare, and transportation) during and after withdrawal are more likely to be engaged with their recovery, stay in treatment for a longer period of time, and experience better outcomes. Aftercare treatment and supports following withdrawal management reduce the risk of relapse.\textsuperscript{17} These may include but are not limited to: combinations of agonist treatment with pharmacotherapies (for example, buprenorphine/naloxone [Suboxone\textsuperscript{®}]); medications such as naltrexone or acamprosate for alcohol relapse prevention; supportive residential services; and psychosocial treatment interventions.

### Indigenous women

- Experts in Indigenous women’s health and substance use services recommend that culturally appropriate models of care must address gender and race as central to providing withdrawal management support. In particular, issues around childcare, how to provide for family members, fear of child protection involvement, and feelings of shame regarding substance use need to be taken into consideration.

- Indigenous women experience particularly high rates of family violence, sexual harassment, inequality, sexual exploitation and poverty, and are more likely to be single parents. It is vital therefore that substance use services, including withdrawal management programs, work to address these broader psychosocial challenges and issues.

- Research has shown that participation in culturally-relevant Indigenous women’s groups, as part of the recovery and wellness process, helps to enhance social and cultural connectedness, sense of hope and mutual support, and overall health. It also helps to reduce stigma.

- Regular involvement of Indigenous staff and community members has been shown to enhance cultural identity and is associated with better psychosocial outcomes for Indigenous women.

(Callahan et al. 2006; Health Canada 2011; Lee, Dawson & Conigrave 2013; Lee et al. 2014)

Strong linkages between withdrawal management programs and post-withdrawal services are essential to sustaining successful outcomes and reducing repeated entry into withdrawal management services or serious harms (such as fatal overdose in the case of opioid withdrawal). Smooth and timely transitions to the most appropriate services following withdrawal management help to support continuity of care and minimize disruptions to treatment and recovery. It is important not to miss the potential “window of opportunity”

\textsuperscript{16} Schillinga, Maresb & El-Bassel, 2004; CSAT, 2006; NCCMH, 2008; NorthWestern Mental Health, 2011; Gholab & Magor-Blatch, 2013; Timko, et al., 2015

\textsuperscript{17} Saskatoon, n.d.; WHO, 2009b; New Zealand, 2010c; Carlebach, et al., 2011
that follows the completion of withdrawal management. In particular, withdrawal management provides the opportunity to link individuals with an opioid use disorder to opioid agonist therapy and other treatments/supports.

4.2 The benefits of applying a biopsychosocialspiritual model of care to withdrawal management

People who experience patterns of problematic substance use often struggle with other concurrent health issues as well as with a range of psychological, social and emotional challenges. They are more likely, for example, to have mental health problems, strained relationships with family and friends, unemployment, and homelessness. Individuals who initiate help for withdrawing from a substance may do so as a result of a personal crisis.

In order to support people adequately and promote their long-term recovery and wellness, specialized substance use services should have a strong psychosocialspiritual component and incorporate a range of services that address the diverse needs of people who are seeking help for their problematic substance use. These services should include family, cultural, gender-specific and peer-based approaches.

Parents of dependent children

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

- Service providers should make space for parents to articulate their own understanding of how their substance use is affecting their parenting, and how they prioritize their needs. Such needs may include broader socioeconomic supports, including, for example, access to housing.

- It is vitally important that withdrawal management staff and allied service providers work with the individual to ensure that the children have a safe place to stay while their parent is participating in withdrawal management. This may involve helping the individual to identify family members and/or friends who can provide temporary childcare or linking the individual with the appropriate social services.

- Program staff members need to be sensitive to the potential anxiety that a parent may feel about their children’s safety and wellbeing. Parents may require support for dealing with this anxiety during the withdrawal management process. It may also be appropriate to include linkages to parenting and childcare services in a parent’s recovery plan.

- Wherever possible, withdrawal management services should help parents of dependent children to access parenting education classes/support.

(Conners et al., 2004; Schillinga, Maresb & El-Bassel, 2004; Poole & Dell, 2005; CSAT, 2006; Baird, 2008; US...)

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18 Saskatoon, n.d.; Bischof, et al., 2003; Stein, Anderson & Bailey, 2015; Timko, et al., 2015
Psychosocialspiritual supports encompass a wide range of activities from supportive counselling and complementary therapies to practical assistance with social programs (such as housing, education and income benefits). While some people may feel very unwell during the withdrawal process (especially in the first few days), many will be able to take part in active psychosocialspiritual activities and programming. Psychosocial supports should be routinely offered to individuals accessing withdrawal management services, though participation should never be mandatory or a barrier to accessing medical treatment.

It is important to highlight that the current evidence base for psychosocial interventions in opioid agonist therapy (OAT) can be interpreted both positively and negatively. Steering a path between overly optimistic or pessimistic interpretations of the value of psychosocial treatment in OAT may be the most pragmatic approach.20

During withdrawal management, the provision of biopsychosocialspiritual supports will likely confer a range of benefits, including: alleviating the unpleasant symptoms of withdrawal; enhancing motivation and optimism; supporting people to stay in the program; promoting people’s overall health and wellbeing; and encouraging individuals to start addressing any underlying psychological, emotional or social issues that they may be experiencing.21 These in addition to other important benefits are discussed in more detail later in this section.

<table>
<thead>
<tr>
<th>Individuals with problematic polysubstance use</th>
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<tbody>
<tr>
<td>➢    Problematic polysubstance use is associated with a higher incidence of concurrent mental health issues, more complicated and severe withdrawal experiences, and increased challenges for recovery in general.</td>
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<tr>
<td>➢    Because of the risk of complicated withdrawal severity (including changes in withdrawal onset and duration), the service provider should:</td>
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<tr>
<td>▪    Carefully consider, with the individual, an evidence-based treatment plan for withdrawal and/or linkages into maintenance/relapse prevention treatment for each different substance; and</td>
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<tr>
<td>▪    Ensure that the individual is closely monitored during withdrawal. This may mean that inpatient withdrawal is the most appropriate option.</td>
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<tr>
<td>➢    Individuals should be made aware of the possible impacts that eliminating the use of one substance may have on their physical and psychological relationship with the other substance(s) that they are using. They should be provided with a range of coping skills and strategies to reduce the risk that their use of the other substance(s) will become more problematic.</td>
</tr>
<tr>
<td>➢    Research suggests that smoking cessation reduces the risk of relapse for other substances. Therefore, smoking cessation support (such as Nicotine Replacement Therapy and other pharmacotherapies such as varenicline) should be offered to individuals in withdrawal management who use tobacco.</td>
</tr>
</tbody>
</table>

20 NTA, 2006; UK Department of Health, 2007; Day & Mitcheson, 2017
21 NTA, 2006; NCCMH, 2008; Amato et al., 2011; Day & Mitcheson, 2017
Women and pregnancy

- Research shows that substance use during pregnancy cuts across socioeconomic strata. However, women who face social and economic vulnerabilities are more likely to experience compounded sources of stress during pregnancy.

- For many women, pregnancy represents an opportunity to make changes in their lives. Given the potential effects of substance use on fetal development, pregnancy may motivate women to start to change their substance use patterns. Research has found that pregnancy is a primary motivator for seeking withdrawal services.

- Pregnant women with problematic substance use face additional stigma, including self-stigma, which may be a barrier to accessing prenatal care and/or substance use treatment. Service providers should be particularly mindful of recognizing a pregnant woman’s strength and courage in accessing treatment rather than perpetuating such stigma. In addition, programs should recognize women’s resiliency, and work with a strengths-based approach to enhance feelings of self-worth and value.

- Recommendations for withdrawal management for pregnant women include:
  - Policies and procedures for priority admission;
  - Opportunities for an extended stay as necessary;
  - Provision of necessary prenatal care;
  - Education about the impact of substance use on pregnancy and fetal development; and
  - Staff who are informed about all possible complications associated with pregnancy and substance use and withdrawing and/or other evidence-based pharmacotherapies for treatment during pregnancy.

- Withdrawal management programs should also provide:
  - Transportation to and from the service;
  - Supportive counselling and case management;
  - Help to connect with a primary care provider and/or community public health services;
  - Help with accessing substance-use free, safe, affordable housing; and
  - Support with legal, nutritional and other social service needs, including services for new mothers. Making such links is crucial and must be part of the woman’s recovery plan.

- With the woman’s consent, the withdrawal management service should support the involvement of her partner in the woman’s substance use treatment and prenatal care. If the partner is using substances, service providers should try to engage them in taking steps towards recovery.

- The woman must be supported to address the psychosocial issues that may have a negative effect on her pregnancy or contribute to the baby being removed from the mother’s care. This includes helping her to prepare mentally, as well as practically, for being a parent.

- Research suggests that when parenting classes are offered in conjunction with substance use treatment, better outcomes are seen with respect to a woman’s confidence as a parent, parent-infant attachment, and child development.
The provision of biopsychosocialspiritual supports as part of a withdrawal management program enhances the quality of the therapeutic environment, facilitates warm and supportive interactions between program participants and staff and, as a result, promotes positive treatment outcomes. Enhancing the experience and outcomes of withdrawal helps individuals to challenge any expectations or fears of “failure” as well as to address the likelihood of relapse during their individual path to recovery and wellness. Program participants can feel more optimistic about their recovery and more motivated to continue making changes towards increased health and wellbeing.22

People with physical or sensory disabilities

- Individuals with physical and/or sensory disabilities face barriers of access to residential withdrawal management facilities, especially when these facilities are in older buildings that were not purpose built or have not been adapted to accommodate people with disabilities. These barriers may be overcome, at least for some individuals, through the provision of appropriately supported home-based withdrawal management.
- Individuals with physical and/or sensory disabilities may also require special assistance with overcoming psychological barriers to accessing withdrawal management services.
- There is some evidence to suggest that individuals with physical disabilities experience higher rates of co-occurring problematic substance use and PTSD. Therefore, it is particularly important to take a trauma-informed approach to withdrawal management and subsequent treatment and supports.
- Withdrawal management programs should be able to accommodate the particular communication needs of individuals with physical or sensory disabilities. Clear communication and understanding between program participant and staff is crucial for the delivery of effective care.

(CSAT, 2006; Anderson, Ziedonis & Najavits, 2014)

Providing individuals with biopsychosocialspiritual supports helps them to complete the withdrawal program

Recent studies have demonstrated that providing psychosocial supports during withdrawal management helps people to complete treatment and improves treatment outcomes. Psychosocial supports can assist people with clarifying their treatment and wellness goals and developing a sense of optimism for their recovery, which increases the likelihood that they will remain in the program and complete the withdrawal process. Helping people to begin to address specific issues in their personal lives (including previous trauma) will also support

22 NCCMH, 2008; Australian Government, Department of Health and Ageing, 2009
their retention in the withdrawal program and encourage their participation in ongoing treatment and services.²³

### Indigenous individuals

- Mental, physical, emotional, and spiritual balance is at the core of Indigenous worldviews and ways of life. The movement towards balance in all four of these quadrants underpins the path forwards for reduced problematic substance use. Substance use treatment, including withdrawal management supports, can be more congruent with Indigenous values by following a “wellness model” rather than a “medical model” of care.
- Recent research in Australia shows that intervention models that are effective in non-Indigenous communities need to be adapted to Indigenous settings and not simply transferred. Such adaptation needs to be done in a context of respectful collaboration with Indigenous communities, that promotes ownership of the intervention.
- Withdrawal management service providers must be trained and supported to provide culturally appropriate and safe treatment and care for Indigenous people. Wherever possible, services should involve Indigenous staff and/or community members. Some individuals will prefer to be supported by Indigenous staff, whereas others will prefer to keep some distance from staff that they know personally. In any case, services should be mindful of the need to prevent personal information from becoming known to other community members.
- It may be both appropriate and helpful to incorporate an understanding of Indigenous worldviews, cultural practices and traditions, and the history of intergenerational trauma into the development of a person’s recovery plan. This needs to be driven and guided by the person receiving care.
- Involving family in a person’s wellness planning and care is recognized as being fundamental to good outcomes. For many Indigenous communities, definitions of family go beyond the “nuclear” family and embrace extended family members, clan members and the wider community. It is crucial that program staff members are aware of this and facilitate the involvement of a person’s family network as the person chooses to define it.
- Withdrawal management services should support the use of traditional medicines, practices and initiatives.
- Given the challenging and traumatic historical relationship between Indigenous peoples and government institutions, home-based withdrawal may offer a more comfortable and beneficial environment for withdrawal (where this is a safe option). In addition, supporting the uptake of home-based withdrawal may help to address significant barriers that Indigenous people often face with accessing supports because of geographic location, jurisdictional complexities, and the lack of culturally appropriate services.
- Research highlights the importance of addressing social supports, and in particular housing, in the context of withdrawal management, in order to promote treatment retention and completion

Taking a biopsychosocialspiritual approach to withdrawal management promotes people’s overall health and wellbeing

Supportive, person-centred care is crucial during withdrawal management. This includes attending to the program participant’s physical and emotional comfort and safety. The withdrawal environment should be as comfortable and as free from stressors as possible and program staff should do all they can to help individuals to re-establish healthy sleeping, eating, leisure and social patterns. Activities and supports that help to decrease people’s anxiety, offer reassurance and a sense of hope, provide opportunities for people to learn functional coping skills, and increase people’s social connectedness are important components of an effective withdrawal management program.24

Program participants indicate a higher level of satisfaction with withdrawal management services when biopsychosocialspiritual supports are included

Some researchers have noted that people appreciate the opportunity to take part in psychosocial activities and programming during the withdrawal process. In the context of residential withdrawal management facilities in particular, the provision of such activities can relieve the boredom experienced by many individuals. Clinicians who have piloted and studied the provision of innovative psychosocial supports and complementary therapies in withdrawal management programs observe that participants want such activities and appreciate the emotional and social benefits that they offer.25

4.3 Evidence of the effectiveness of specific supports and activities

The kinds of services and supports that are offered within a biopsychosocialspiritual model of care are varied and diverse. They include, but are not limited to, different forms of counselling and psychotherapy, complementary therapies that can increase people’s physical and emotional comfort, opportunities for mental and physical activity, and assistance with social needs such as relationships, housing, employment, financial benefits, education and legal problems.26 These services and supports are captured throughout the guidelines and in particular in Guideline 10: Provision of Biopsychosocialspiritual Supports.

What follows is a summary of recent evidence on the effectiveness of a limited number of psychosocial approaches about which there is a significant and/or growing body of research and practice-based literature.

Psychological support

Offering supportive counselling during withdrawal management is an effective way to provide individuals with strategies to cope with unpleasant withdrawal symptoms and cravings, maintain motivation during withdrawal, learn functional coping skills, and facilitate connections to post-withdrawal supports. The psychological component of withdrawal can be more challenging and longer lasting than the physiological component and therefore

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24 Australian Government, Department of Health and Ageing, 2009; New Zealand, 2010a; Saskatchewan, 2012
25 Silverman, 2010
26 SCAN, 2006; WHO, 2009b
counselling is a key component of treatment and recovery. Supportive counselling has been demonstrated to reduce problematic substance use in the long-term and increase overall health and wellbeing.\textsuperscript{27}

Motivational Interviewing (MI) and Motivational Enhancement Therapy (MET) (delivered either as a group-based or as an individual intervention) are well suited for individuals in a withdrawal management program. They help to create a supportive and non-judgmental relationship between the program participant and staff, as well as promote the establishment of a therapeutic alliance. Furthermore, MI and MET help individuals to understand the negative impacts associated with continuing problematic substance use. Such outcomes increase the likelihood that an individual will engage with ongoing and long-term treatment and supports. Studies indicate that even one session of Motivational Interviewing during withdrawal is effective at promoting wellbeing. However, three or more sessions have been demonstrated to lead to better outcomes for individuals. Recent research also shows that MI is an effective tool for helping people prepare for withdrawal management because it increases personal motivation, which in turn supports treatment retention and completion.\textsuperscript{28}

Various forms of Cognitive Behavioural Therapy (CBT), including coping and skills training, relapse prevention, and behavioural couples therapy have been shown to be effective in treating problematic substance use. How CBT is delivered may vary according to the substance(s) that each individual is/has been using. It is helpful for withdrawal management programs to provide individuals with opportunities to develop problem solving, stress management, and communication skills, and to enhance their understanding of the patterns and triggers associated with problematic substance use. Group CBT has been shown to help

Survivors of intimate partner violence

- Research reveals that the concurrent incidence of intimate partner violence (IPV) and problematic substance use is high. Recovery plans need to address both issues simultaneously. Trauma-informed care is particularly pertinent in this context.
- If an individual discloses a history of IPV, withdrawal management staff must work with the individual and other allied professionals to create a long-term safety plan and make referrals to appropriate services and supports. The plan must address access to safe accommodation.
- It may be important for the individual to avoid communicating with their abuser while in withdrawal management.
- Survivors of IPV may need to access counselling. Linkages to longer-term counselling support should be made during withdrawal care.
- Parents who are survivors of IPV may require help securing supports such as childcare and family counselling. Withdrawal management providers should be familiar with local resources and help connect the individual with them.

(\textsuperscript{27} Government of Australia, Treatment of Alcohol Problems, 2009; New Zealand, 2010c; Rong, et al., 2016\textsuperscript{28} CSAT, 2006; Berman, et al., 2010; Johnson, J., 2012; Saskatchewan, 2012; Glassman, et al., 2013; Vederhus, J. et al., 2014; Frielink, et al., 2015; Timko, et al., 2015)
individuals to feel supported, to foster a sense of belonging, and to develop a positive outlook with respect to realistic goals for recovery. Australian research has shown the importance of cultural adaptation of CBT for Indigenous individuals.\textsuperscript{29}

There is emerging (albeit limited) evidence that Developmental Counselling and Therapy (DCT) is a promising approach for relapse prevention. It is important for the individual to have a relapse prevention plan in place before starting DCT.\textsuperscript{30}

**Complementary therapies**

Complementary therapies, such as massage, acupuncture, homeopathy, reflexology, herbal therapy, and art and music therapy, may be effective supports during withdrawal management. Although the evidence base supporting these therapies is limited, they may contribute to enhance wellbeing and help alleviate symptoms of withdrawal. Complementary therapies may be provided as part of a holistic and comprehensive approach to treating problematic substance use and supporting health and wellbeing.\textsuperscript{31}

**Acupuncture**

Acupuncture is a safe, simple, and inexpensive therapy for individuals during withdrawal, and is one of the most commonly used alternative therapies in withdrawal management programs. It has been shown to help restore healthy sleeping patterns, reduce cravings, reduce anxiety, and improve the mood and wellbeing of individuals during withdrawal. More specifically, studies have demonstrated that acupuncture helps reduce the severity of symptoms of withdrawal, such as muscle aches, nausea, sweating, gastrointestinal issues, shakes, heart palpitations, hallucinations, and suicidal thoughts.

Overall, individuals have described feeling calmer, more relaxed and content, and have been more open to practices of mindfulness after acupuncture treatment. In addition to having therapeutic value for people during withdrawal, it has been shown to help individuals complete the withdrawal management program and continue to be engaged in the treatment and recovery process. By alleviating withdrawal symptoms, acupuncture helps create a window of opportunity for individuals to start making healthier lifestyle choices. Acupuncture is most effective for managing withdrawal when it is offered as part of a suite of supports and therapies.\textsuperscript{32}

When offered in combination with tobacco cessation education, acupuncture has been demonstrated to be effective at significantly reducing tobacco smoking.\textsuperscript{33} There is some evidence to suggest that acupuncture may help treat some psychiatric disorders, such as anxiety and depression.\textsuperscript{34}

\textsuperscript{29} NCAT, 2008; Government of Australia, Treatment of Alcohol Problems, 2009; Saskatchewan, 2012; Bennet & Babbage, 2014; Croxford, et al., 2015
\textsuperscript{30} Clarke & Myers, 2012
\textsuperscript{31} NTA, 2006; Kenny, P. et al., 2009
\textsuperscript{32} Janssen, Demorest & Whynot, 2005; CSAT, 2006; Shi et al., 2006; Alster, 2010
\textsuperscript{33} Alster, 2010
\textsuperscript{34} Janssen, Demorest & Whynot, 2005; Boyuan, et al., 2014
Art and music therapy

The use of art and music therapy aligns well with approaches to substance use treatment that emphasize participant engagement and motivation.

Research suggests a number of benefits of art therapy for people in substance use treatment. These include: increased openness to treatment; facilitating self-expression and

People with cognitive disabilities

- There is strong evidence to show that individuals with cognitive disabilities face significant barriers to accessing withdrawal management and other substance use services. They are also more likely to have a negative experience with mainstream services.
- Past trauma and physical or sexual abuse increase the risk of problematic substance use for people with cognitive disabilities. It is crucial, therefore, that services take a trauma-informed approach and connect individuals with appropriate counselling/therapy as needed.
- The assessment process in withdrawal management should include an initial evaluation of an individual’s cognitive functioning. If significant cognitive challenges are suspected, a more comprehensive assessment by a qualified professional may be arranged. It may be appropriate to defer this assessment until the physical and psychological process of withdrawal is complete.
- Program staff should carefully consider whether group-based models of care are the most appropriate option for the individual with cognitive disabilities. When possible, one-on-one approaches may be more effective.
- Individuals with cognitive disabilities may need help with self-care, coping strategies, communication, learning, social skills, and planning and decision-making. Withdrawal management programs may need to work with an expert on cognitive disabilities to better understand the needs of an individual with cognitive disabilities, including which challenges derive from substance use and which are a result of the disability.
- Since people with cognitive disabilities often experience social isolation, it may be helpful for additional supports to focus on increasing an individual’s social inclusion.
- It may be necessary for program staff to adapt their style and forms of communication with people who have a cognitive disability. Communication should be as simple and clear as possible. Information may need to be repeated several times. It is important to be sure that the service provider and the person receiving service understand what each is saying to the other.
- Some individuals with cognitive disabilities may have difficulty with changes to patterns of thought and behaviour. The service provider should not mistake this for a denial of the substance use problem or a refusal to change. It may be necessary to try different approaches to engage the person with treatment.
- Individuals with cognitive disabilities will benefit from a more active approach to referral and follow-up to support their ongoing treatment engagement and/or connect with relevant community supports (including, for example, social workers).

(National Drug and Alcohol Research Centre, 2003; CSAT, 2006; Australian Department of Health and Ageing, 2009; Day et al., 2016)
communication; reducing feelings of shame; and increased motivation to change. Art therapy complements MI and MET, as it uses similar cognitive processes.

Music therapy is associated with positive emotional change (i.e. reduction in anger, anxiety and stress) for individuals in substance use treatment. Recent research has demonstrated that individuals who participate in music therapy during withdrawal management experience slightly less severe symptoms of withdrawal than those who engage in verbal psychotherapy. Music therapy has also been shown to increase participants’ internal locus of control. For some individuals, music may help to distract them from the unpleasant symptoms of withdrawal.35

**Traditional Chinese Medicine**

Traditional Chinese Medicine (TCM) has been shown to have significant effects on the unpleasant symptoms associated with withdrawal, including helping to alleviate pain, discomfort, insomnia, cravings, and fatigue. TCM can also help restore normal body functions after a prolonged period of problematic substance use, including improving immune function, increasing metabolism, and enhancing memory. In addition, TCM has been demonstrated to be effective for increasing retention in treatment, and helping to prevent relapse. The literature recommends that TCM be offered where possible to individuals as part of a holistic and comprehensive wellness plan for withdrawal.36

**Spiritual Support**

There is a growing body of evidence demonstrating that offering supports and activities that enhance people’s spiritual wellbeing is an important component of holistic care and may have a significant impact on an individual’s recovery and wellness.

Incorporating spirituality into withdrawal management must be done in a respectful and person-centred way. Supports should always reflect the individual’s preferences and wishes. By adopting a definition of spirituality that encompasses the full range of cultural and religious beliefs and values, and that focuses on personal empowerment, withdrawal management programs can help to facilitate and support the spiritual journeys of individuals during the withdrawal management process.37

For some individuals, feeling engaged with religious or spiritual beliefs helps to foster hope, decrease distress, and increase motivation to continue with their recovery journey. Individuals who look to their religious or spiritual practices for support, guidance, or strength may be more open to certain treatment and recovery options.

By contrast, negative religious coping, such as bearing anger towards or feeling let down by a higher power or some form of faith or religious practice, may be a risk factor for poor outcomes. Use of negative religious coping can increase feelings of hopelessness, loneliness,
and powerlessness. Helping individuals to reduce their use of negative religious coping can reduce barriers to wellness, increase motivation, and enhance coping skills.38

Lesbian, gay, bisexual, two-spirit, transgender or questioning (LGB2STQ) individuals

- There is a limited body of research exploring the needs and experiences of lesbian, gay, bisexual, two-spirit, transgender or questioning (LGB2STQ) individuals with respect to substance use treatment, even though it is known that LGB2STQ people are at a disproportionate risk for problematic substance use, often because of experiences of stigma and discrimination related to sexual orientation and gender identity.
- Some research indicates that LGB2STQ individuals entering treatment for problematic substance use may have greater mental and physical health needs. A recent study found that there is a significantly higher rate of co-occurring mental health issues among the LGB2STQ population than among the general population. Such findings suggest that additional screening, outreach, service provider training and service delivery integration (particularly between MH and SU services) are needed to facilitate effective care.
- Withdrawal management services must become LGB2STQ-responsive. This involves:
  - Revising policies and procedures to be inclusive of LGB2STQ people;
  - Having openly LGB2STQ individuals on staff and among volunteers;
  - Ensuring that staff receive training on culturally appropriate care for LGB2STQ individuals; and
  - Including representations of LGB2STQ people in any advertising or outreach materials.
- As part of their recovery planning and journey, LGB2STQ people may need to explore their feelings about their sexuality and/or gender identity and their experiences of homophobia and heterosexism. However, it is important for service providers to be aware that not all LGB2STQ people will want to focus on these issues. The person receiving withdrawal care should decide what is important for them to work on.
- Taking a trauma-informed approach to service delivery will help to ensure that LGB2STQ individuals who have experienced discrimination, harassment and violence receive appropriate and supportive care.
- Research highlights the following components of holistic care for LGB2STQ individuals:
  - Working on “personal capital”, including self-esteem, problem solving, self-confidence, sense of purpose/spiritual connections and interpersonal skills; and
  - Developing “family and social capital”, including enhancing relationships with family or origin and/or family of choice, and creating a network of social support.
- The literature notes that, at the broader social/community level, efforts are required to reduce stigma, improve awareness of the needs of the LGB2STQ community with respect to substance use treatment, and increase the safety of services for LGB2STQ people.

(Eliason, 2009; Boon, 2010; Rowan, Jenkins & Parks, 2013; Klein & Ross, 2014; Taliaferro, et al., 2014; Flentje, et al., 2015)

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38 Puffer, et al., 2012
The Guidelines
A word about the guidelines

There are sixteen guidelines. They are organized into three sections that together reflect the individual’s (ideally) seamless pathway into withdrawal management and on to the next stages of treatment and recovery. The sections are:

1. Preparing for and accessing withdrawal management services;
2. During withdrawal management; and
3. Preparing for ongoing recovery after withdrawal management.

Each guideline includes an overarching statement and suggested elements.

Where appropriate, notes and examples provide further context and guidance on how to put the guidelines into practice. As necessary, considerations for specific service settings are also described.

These notes and examples do not constitute comprehensive practice guidance and do not take the place of appropriate staff training and clinical supervision. Further, they do not take the place of clinical guidelines/standards for the medical management of specific withdrawal syndromes.

While many of the evidence-informed practices captured here are already in place across the province, others will involve a process of ongoing implementation for health authorities and withdrawal management services.

Current recommendation for treating Opioid Use Disorder

Withdrawal management alone (i.e., detoxification without immediate transition to long-term substance use treatment) is not recommended for treating Opioid Use Disorder, as this approach has been associated with elevated rates of relapse. Withdrawal management alone often leads to high rates of rapid relapse post-treatment, which in turn increases the risk of HIV and hepatitis C transmission, illness and death.

If withdrawal management is pursued, it can be provided more safely in an outpatient rather than inpatient setting. During withdrawal management, patients should be immediately transitioned to long-term substance use treatment to assist with preventing relapse and associated harms.

Best evidence indicates opioid agonist treatment (medication assisted therapy) for Opioid Use Disorder. The first line treatment is Suboxone®, a combination of buprenorphine/naloxone. The second line treatment is methadone.

Psychosocial treatment interventions and supports should be routinely offered in conjunction with opioid agonist treatment.
Preparing for and accessing withdrawal management services

This group of guidelines focuses on reducing barriers to accessing withdrawal management services, enhancing transitions from primary care and emergency services into withdrawal management, and supporting people while they are waitlisted for withdrawal management programs.

In order to ensure that people receive appropriate treatment, services must be visible and accessible. For many people, the decision to seek help with their substance use represents an act of significant courage and a time-sensitive opportunity to make a change. Therefore, admission procedures should be as efficient as possible and completed with sensitivity, compassion and warmth.

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

When an individual is required to wait to access withdrawal management services, it is important that service providers make appropriate connections for that person with the community-based supports that can meet their immediate needs and help to sustain their engagement with the recovery/wellness process.
Guideline 1: Accessibility of Services

Health authorities, allied service providers and direct service providers work to enhance the visibility and accessibility of withdrawal management services.

Suggested Elements

1.1 Health authorities and service providers use information dissemination and outreach strategies to increase the visibility and to promote public awareness of the withdrawal management programs and supports available, and their role within the continuum of substance use services.

1.2 Services build strong relationships with other health and social service providers in their community/region and ensure that such service providers are aware of the withdrawal management programs that are available.

1.3 Services have in place multiple access points and tools by which an individual can connect with withdrawal management supports.

1.4 Health authorities and services have policies and practices in place to address potential barriers to service.

1.5 Wherever possible, services follow-up with an individual after they have made the initial contact expressing an interest in getting help for their substance use.

1.6 Health authorities and service providers use targeted outreach strategies, including peer outreach, to increase reach to people who are experiencing barriers to service.

1.7 Services have no-barrier or low-barrier admission procedures and policies to facilitate prompt access to the appropriate level of withdrawal management service. Wherever possible, admission is based on a brief screening process.

1.8 Health authorities offer home/mobile services to those individuals for whom such services are safe and appropriate.

Notes and Examples

1.1 Health authorities and service providers should provide accurate descriptions of the range of withdrawal management services available. This information may be written or audio-visual. It may take the form of brochures, DVDs, CDs, and/or websites. The information should be made available at appropriate locations in the community (e.g. doctors’ offices, health clinics, emergency departments, community centres). Depending on the needs of the community, information may be available in languages other than English.

1.2 Individuals accessing withdrawal management programs are more likely to complete withdrawal and move on to longer-term treatment and recovery when they are also connected with mental health and other health and social services that they need (e.g.
medical care, housing assistance, childcare, legal counselling, vocational and educational support). 39

1.3 Access points and tools may include: 24/7 phone line; 24/7 facility intake; active outreach; walk-in referrals; and centralized intake. Offering a “walk-in referral” service (i.e. accompanying a person to the withdrawal management service when their appointment comes up) is an important tool for increasing the accessibility of services and ensuring that those who need it most receive the appropriate help.

1.4 Common barriers include: language and cultural needs; gender identity and sexual orientation; ethnicity; cognitive ability; mobility and other physical limitations; service hours of operation; and transportation to and from the service. Resources permitting, services should do whatever they can to mitigate these barriers for individuals.

1.6 Where outreach organizations exist, withdrawal management services should develop strong relationships with them. Active outreach may also involve withdrawal management program staff meeting individuals in the community at the places that they frequent and feel comfortable in. Outreach facilitates building relationships with people and reaching them before their health becomes severely compromised.

1.7 See the guideline on screening below.

Health authorities in B.C. use different electronic information management systems, and the screening tools in use differ in length and complexity. The ability of service providers to meet this guideline will therefore depend upon the screening processes that are in place in each region. People conducting screening for withdrawal management services are nevertheless encouraged to do what they can to make the process as simple and straightforward as possible.

The screening process for individuals with complex needs (e.g. someone with significant psychiatric issues) may need to be more comprehensive in order to identify the type and range of supports that they will require.

1.8 Most people will be able to withdraw safely and effectively through a planned outpatient withdrawal process. Home/mobile withdrawal management services are key to meeting individuals where they are at and reaching people who would otherwise not receive supports.

39 Simmons et al., 2008
Guideline 2: Screening

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

Suggested Elements

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

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

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

- Accurate identification of the individual;
- Substance use history, including: recent substance use (e.g. type of substance(s), quantity, time and duration of last use), history of withdrawal syndromes related to substance(s) used, previous treatment experiences, implications for the withdrawal management approach of any polysubstance use;
- Current physical and mental health;
- Any recent completion of a screening and/or assessment process;
- Current psychosocial supports; and
- Suitability for safe withdrawal in a non-medical or minimally medical service (e.g. community-based, home/mobile withdrawal).

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

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

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

2.7 If the individual wishes to have a member of their family or social support network participate in the brief screening process, this is facilitated.
Notes and Examples

2.1 Individuals seeking withdrawal management supports are likely to be impaired or already in withdrawal, and may not be able to participate in a lengthy screening process. The depth and breadth of the screening should balance the need to gather information with the need to be respectful of the individual’s level of motivation and wellbeing. The priority should always be to meet the individual’s immediate needs and to gather the minimum amount of information necessary to match them with a withdrawal management program.

It may be helpful for staff to use a motivational interviewing approach to engage the individual in the brief screening process. The provision of information and education, reassurance and, where possible, counselling may help to reduce an individual’s discomfort and anxiety at pre-admission.

The screening process may flag issues and areas for deeper consideration later in the continuous assessment. More comprehensive assessment and the gathering of detailed and sensitive personal information should take place once staff members have developed a relationship with the individual and the individual is ready to discuss such information.

When determining the appropriate level and setting for withdrawal management care, it is important to match each individual with the least intrusive service that can safely meet their needs and preferences. (If an individual’s degree of need or risk increases during the withdrawal process, they should be transferred to a more intensive level of care).

Ideally, there will be a range of withdrawal management settings available to individuals, including mobile and home-based withdrawal. However, in some regions and communities the choices may be more limited.

2.2 Individuals must provide written consent for service. They must also provide written consent for the disclosure of personal and health information, and such consent must specify to whom the personal and health information may be disclosed and how it may be used. Participants must also be informed of the limitations to an individual’s right to confidentiality.

2.3 Given the estimated prevalence of concurrent mental health and substance use disorders, universal screening for both MH and SU is recognized as best practice.

2.4 Factors that may be considered include: the individual’s expectations of withdrawal; the individual’s supports for withdrawal management; the individual’s recovery goals; and potential barriers to successful withdrawal.

Certain psychosocial factors are important when determining a person’s suitability for home/mobile withdrawal. See Service Setting Considerations below.

As appropriate, these issues will be explored more fully as part of the ongoing assessment once the individual is in withdrawal management.
2.7 With the individual’s permission, family members and supportive others should be involved wherever possible as they will be providing ongoing support to the individual throughout their recovery journey.

Family members may find it helpful to connect with a counselling service and/or a family support group in the community to get information and skills to support the individual effectively during and after withdrawal.

Service Setting Considerations

Home / Mobile Withdrawal Management

Health authorities will have preferred validated assessment tools for determining whether someone is suitable for home/mobile withdrawal management. Psychosocial factors to consider when screening someone for home/mobile withdrawal include:

- Does the individual have access to a safe and quiet “home” environment that is free from substance use?
- Does the individual have adequate social supports, including a trusted and reliable friend or family member who can provide support through the withdrawal process?
- If the individual has psychiatric symptoms, can these be managed safely in a community setting?
- What are the individual’s withdrawal management and treatment goals? Is the individual committed to the withdrawal process?
Guideline 3: Primary Care Providers

Wherever possible, the individual’s primary care provider plays a central role in the individual’s withdrawal management care and ongoing recovery journey.

Suggested Elements

3.1 When a primary care provider recognizes that an individual is ready to make a change with respect to their substance use, they:
   - Consult the relevant substance-specific guidelines for the treatment of problematic use; and
   - Consult a substance use expert in their region and/or the provincial Rapid Access to Addiction Consultative Expertise (RACE) supports. ([http://www.raceconnect.ca/](http://www.raceconnect.ca/)).

3.2 When the primary care provider determines that withdrawal management is appropriate, they work with the individual to:
   - Determine the individual’s readiness to begin withdrawal management;
   - Identify the least intensive and most appropriate withdrawal management approach and setting that can safely and effectively meet the individual’s needs; and
   - Transition the individual into the most appropriate withdrawal management supports.

The primary care provider remains actively involved in the individual’s withdrawal management and ongoing recovery journey.

3.3 When the individual accessing the withdrawal management program is already connected to a primary care provider, program staff members involve the provider in the individual’s withdrawal management care. Program staff members engage the primary care provider in the assessment, wellness planning and transition planning processes.

3.4 When the individual accessing the withdrawal management program is not connected to a primary care provider, program staff members facilitate such a connection within the individual’s community, wherever possible.

Notes and Examples

3.1 Primary care providers are in an advantageous position to identify and initiate treatment and supports for problematic substance use early on, through screening, brief intervention, and in-office treatment and support as well as referrals to the appropriate services and supports. As noted above, the primary care provider should access substance-specific evidence-based guidelines, when available, and contact the RACE line for support in managing addiction in primary care ([http://www.raceconnect.ca/](http://www.raceconnect.ca/)).
3.2 When problematic substance use has been identified, individuals are likely to have different levels of readiness or willingness to change. The primary care provider should engage with the individual in a manner that respects the individual’s readiness to change. Using a motivational interviewing approach can help to enhance a person’s readiness to change their substance use.

Establishing rapport and trust with the individual before the discussion of withdrawal management and/or substance use treatment can be key to developing the kind of provider-patient relationship that can ultimately support the individual to complete withdrawal management and participate in ongoing substance use treatment/supports.

Primary care providers should be familiar with evidence-based treatments for substance use disorders as well as the range of substance use services and supports (including withdrawal management) that are available to their patients. They should be able to provide patients with accurate, up-to-date information on these services.

Provincial resources exist to support primary care providers to treat Opioid Use Disorder and low-risk alcohol withdrawal in an office-based setting.

3.3 A working relationship between withdrawal management staff and the individual’s primary care provider helps to foster an effective provider-patient relationship, and helps to ensure continuity of care throughout the individual’s ongoing recovery journey.

Establishing a strong provider-patient relationship and involving the primary care provider in the assessment, transition and wellness planning processes are particularly important for individuals who are high-risk or who have complex needs.

Whenever possible, the primary care provider is invited to meet with the individual and staff at the withdrawal management facility during the recovery planning process. Alternatively, withdrawal management staff could take the program participant to the primary care provider’s office to facilitate the provider’s involvement.

Service Setting Considerations

Home / Mobile Withdrawal Management

If it is determined that home/mobile withdrawal management support is the most appropriate option for the individual, the primary care provider may take a leading role in monitoring the individual’s withdrawal and providing the necessary supportive care. The primary care provider may also choose to provide support for home/mobile withdrawal in collaboration with other allied health care professionals. A lay carer – usually someone who is a trusted and supportive family member or friend of the individual undergoing withdrawal – is also a key part of the support team.

Support includes:

- Working with the individual to develop a recovery/wellness plan (including details and goals of the withdrawal process);
• Monitoring the individual’s withdrawal symptoms via in-person visits and telephone calls; and

• Helping the individual to manage medications and potential side effects (as appropriate).
Guideline 4: Supporting Transitions from Emergency Departments

Health Authorities work with the Emergency Departments in their region to facilitate the smooth and timely transition of individuals from the Emergency Department to the appropriate withdrawal management service.

Suggested Elements

4.1 Health authorities coordinate with withdrawal management services to ensure that Emergency Department staff members have ready access to current and accurate information about the available withdrawal management services and supports in their region.

*Note: Emerging evidence regarding treatment for people with Opioid Use Disorder suggests taking a history of substance(s) used and initiating opioid agonist treatment (buprenorphine/naloxone) in the Emergency Department setting.*

4.2 Health authorities develop processes and protocols to facilitate the timely sharing of patient information between Emergency Departments, substance use treatment services, hospitals, and withdrawal management services and supports (including primary care providers). These processes and protocols ensure that the necessary information is shared while protecting patient privacy.

4.3 Health authorities work with hospitals, substance use treatment services and withdrawal management services in their region to develop protocols for effective care planning and transitioning the patient to the ongoing care that they require in the community or in the hospital. Such strategies may include outreach and in-reach activities.

4.4 When an individual is referred by the Emergency Department to withdrawal management and the withdrawal management service is unable to admit the individual promptly, the withdrawal management service connects the individual with appropriate community-based supports, their primary care provider, and/or substance use treatment services.

4.5 Whenever possible and appropriate, the individual’s family and/or circle of support is involved in the decision to transition the individual to the appropriate withdrawal management service.

Notes and Examples

4.1 Health authorities and service providers are responsible for providing Emergency Departments in their region with accurate and up-to-date descriptions of the withdrawal management services available. At minimum, this information is made available on

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40 D’Onofrio, et al., 2015
health authority websites (public sites and the intranet) for easy access in Emergency Departments.

In addition to web-based information, details about withdrawal management services and programs may take the form of brochures, posters, DVDs, and/or CDs. Depending on the needs of the community, information may be available in languages other than English.

4.2 At minimum, the withdrawal management service intake screening and/or assessment tools should ask if the person has visited an Emergency Department in the past 48 hours, and request consent for obtaining the relevant medical records from that visit. On the basis of informed patient consent, Emergency Department staff will provide withdrawal management intake services with the necessary patient visit information.

4.3 It is anticipated that such strategies will be specific to each health authority and able therefore to reflect regional differences in system structure and service provision.

Approaches to outreach and in-reach will depend on the resources and structures available in each region. It may be possible, for example, to use a Mental Health and Substance Use intake team or a Drug and Alcohol Recovery Team (DART) to provide coordination support. Some hospitals in B.C. have a liaison person/service for Mental Health and Substance Use Services in their Emergency Department, an inpatient addiction medicine consult service, and/or a connected outpatient low-barrier substance use treatment service. Others have social workers as the designated liaison support between the hospitals and substance use services.

4.4 See Guideline 5: Community Supports for more details regarding supporting people who are waiting to access withdrawal management.
Guideline 5: Community Supports

When the individual is on a waiting list for withdrawal management support they are provided with community resources that can assist them with meeting immediate needs, preparing for withdrawal, and establishing linkages that will be helpful after withdrawal.

Suggested Elements

5.1 The individual waiting to access withdrawal management support is connected to a community substance use counsellor (if they do not already have one).

5.2 The individual is connected with appropriate health and social services, such as mental health services, a primary healthcare practitioner, housing, income support, and childcare.

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

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

5.5 If the individual decides not to access the service or does not present when a space is available, wherever possible the withdrawal management service uses assertive follow-up and re-evaluates any treatment/recovery decisions made during the initial screening process in accordance with the individual’s current goals and motivation.

Notes and Examples

5.1 Ideally, there will be no waiting period between identifying that withdrawal management is the appropriate approach for an individual and that individual accessing the service. However, this ideal is not always achievable.

A waiting period may provide an opportunity for individuals seeking withdrawal management services to start developing a therapeutic relationship with a community support (e.g. a primary care provider). Some people will already have such a contact; some will need to be connected with one. Making such contacts before beginning withdrawal management will help to ensure successful completion of withdrawal and entry into ongoing treatment for longer-term recovery and wellness.

Where making a connection with a long-term community support is not possible, the individual should be encouraged to maintain telephone contact with the person who conducted the screening process until a withdrawal management place becomes available for them.
5.3 While individuals are waiting, it is crucial to provide supports and strategies for maintaining their motivation to change their substance use, and to prepare for withdrawal management and subsequent treatment. Evidence suggests that the following strategies are effective:

- Offering tangible incentives;
- Encouraging the support of family members;
- Introducing the individual to the withdrawal facility and staff;
- Harm reduction education;
- Encouraging the individual to identify their goals for recovery and how these will be achieved;
- Motivational Interviewing and/or group CBT;
- Self-care advice; and
- Relaxation techniques to manage anxiety.\(^{41}\)

During this time, it is also important to take the opportunity to provide harm reduction education, including (as appropriate):

- Safer injecting and smoking practices;
- Healthy food, adequate hydration, and sufficient sleep;
- Personal care and hygiene;
- Safer sex;
- Possible risks to the fetus if pregnant;
- The effect of substance use on everyday activities (such as driving);
- The risks of polysubstance use;
- How to recognize an escalating problem;
- Reduced tolerance to substances after completion of withdrawal (i.e. increased risk of overdose); and
- Education about take-home naloxone and where to access it. If the withdrawal management program is a distribution site for B.C.’s Take Home Naloxone Program, staff should offer this service. Otherwise, staff should ensure that the individual, and their family members, know where to access appropriate training and kits for take-home naloxone.

Where appropriate, individuals may also be given harm reduction supplies. See Guideline 15: Reducing Risks for more information regarding harm reduction education.

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\(^{41}\) CSAT, 2006; Australia, Department of Health and Ageing, 2009; Kenny et al., 2009; Brett, et al., 2014; Kouimtsidis & Kolli, 2014; Croxford, et al., 2015; Frielink, et al., 2015; Timko et al., 2015; Priester, et al., 2016
and supplies. See also Best Practice Recommendations for Canadian Harm Reduction Programs that Provide Service to People Who Use Drugs and Are At Risk for HIV, HCV, and Other Harms: Parts 1 & 2 (2013), developed by the Working Group on Best Practice for Harm Reduction Programs in Canada.

5.4 Not every person will be easily contactable by telephone, and therefore the withdrawal management service should be creative and flexible about how it remains in contact with an individual who is waiting for supports. When the individual has a cellphone, consider texting as well as phoning. Try to identify a community support person through whom the individual can be reached, for example an outreach worker or substance use counsellor. Wherever possible, contact the individual the day before their place is available to remind them of the appointment and commitment to attend.
During withdrawal management

Making the decision to participate in a withdrawal management program is a significant milestone. Services providers should understand that individuals who engage in withdrawal management services have varying degrees of motivation and readiness to change. Across program settings, service providers should do all they can to ensure that the withdrawal experience meets each individual’s needs and is as comfortable and safe as possible.

Although an individual’s time in withdrawal management is relatively short, and the individual may be feeling quite unwell at the beginning of the process, withdrawal management nevertheless provides an opportunity for substance use professionals to engage a person in a longer-term recovery/wellness journey. This includes undertaking a more detailed and holistic assessment of the individual’s situation and starting the collaborative process of developing a recovery/wellness plan that details the ongoing services and supports that the person will access after withdrawal.

Assessment is a continuous and cumulative process that creates an increasingly detailed and comprehensive picture of an individual’s substance use and their holistic needs, strengths, goals and preferences. It marks the beginning of the recovery journey and, when done sensitively and with the individual’s active participation, can initiate healing.

Withdrawal management is not just a medical or physical process. Effective programs are aligned with the biopsychosocialspiritual model of care and provide supports that address the broader health, social, psychological, and spiritual issues underlying a person’s substance use and/or resulting from it.

Withdrawal management exists within a continuum of substance use services and supports. It is an early step in a longer-term recovery process. As such, it is important to start working with the individual on a personal recovery/wellness plan as soon as they are ready in order to set goals and prepare for what will come after withdrawal management.
Guideline 6: Orientation

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

Suggested Elements

6.1 Orientation to the program includes (as appropriate to the service setting):
   - A tour of the facility;
   - Introductions to program staff and to other participants;
   - A review of the program’s rules and policies, including:
     - The individual’s rights and responsibilities;
     - Visits and other forms of contact with family and friends;
     - Instances of when the individual might have to be stepped up to a higher level of withdrawal management care and/or transferred to hospital;
     - Reasons why the individual may be asked to leave the program; and
     - An opportunity to speak with a health care provider regarding evidence-based approaches to withdrawal management and treatment initiation and maintenance (targeted by substance(s) used).

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

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

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

Notes and Examples

6.1 Orientation is part of the program admission process and takes place within 24 hours of the individual entering the program. Program rules should be reviewed with the individual as soon as they are able to participate. It is helpful to have program rules and other program information available in a variety of formats (e.g. written, audiovisual, infographic). Wherever possible, when the individual’s first language is not English, information is provided in the appropriate language.

6.2 Individuals will begin the withdrawal management program with varying capacities to participate in conversations and retain information. An appropriate balance should be
struck between the need to provide the individual with important information and their readiness and willingness to take on that information.

6.4 It is helpful to provide individuals with substance-specific information on the typical withdrawal process so that they know what to expect. This may ease participants’ anxiety, increase their comfort, and help to enhance their capacity to complete the withdrawal process. Program staff should reassure the individual that they will receive the supports necessary to ensure their safety and to minimize their discomfort throughout the process.

People in withdrawal management are initially likely to feel worse than usual, especially in the early stages of withdrawal. They will need to be informed about and prepared for this. Appropriate support may need to be put in place to manage a withdrawal-related decline in their emotional and mental state of wellbeing.
Guideline 7: Assessment

The individual participates in a continuous assessment process that is tailored to their particular circumstances, needs, and preferences.

Suggested Elements

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

7.2 The assessment process is:
   - Dynamic and ongoing;
   - Aligned with the biopsychosocialspiritual model of care; and
   - Conducted collaboratively between the individual, program staff and, where appropriate, supportive family members and others.

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

7.4 The person conducting the assessment uses a culturally appropriate and trauma-informed care practice approach throughout the assessment process.

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

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

7.7 As appropriate, and with the individual’s consent, other health and social service professionals may be involved in the continuous assessment process in order to ensure that it is comprehensive. Wherever possible, the individual’s primary care provider is involved in the assessment.

7.8 The assessment includes determining the level of regular monitoring that is required to ensure the individual’s safety and wellbeing.

7.9 Evidence-based assessment tools supported by the health authority are used to guide the service provider in conducting an assessment.

7.10 With the individual’s written and informed consent, relevant aspects of the assessment are shared with any other substance use or mental health service or program to which they are referred.
Notes and Examples

7.1 It is important to determine and to respect the individual’s readiness for participating in a more comprehensive assessment process. A thoughtfully paced assessment will help to establish a positive and trusting relationship between the program participant and staff and allow the participant to reflect on their situation and goals. It may be appropriate to conduct the assessment as a series of informal conversations at various points during the individual’s participation in the withdrawal management program. Participants should never feel pressured to provide information.

Best practice evidence indicates that the person conducting the assessment should:

- Explain the assessment process, the reasons why certain questions are being asked, and what will be done with the information that the participant provides;
- Be non-judgmental, empathic and respectful;
- Listen and clearly identify and acknowledge the individual’s needs and preferences, and incorporate these into assessment and treatment;
- Use motivational interviewing techniques;
- Encourage the individual to participate actively in identifying their goals for recovery and preferred treatment options;
- Communicate clearly, and allow time for the individual to gain an understanding of what supports are being recommended and the reasoning behind this; and
- Be aware of when it is necessary to take a break from the assessment, with a mind to resuming the process when the individual is ready.42

7.2 Biopsychosocialspiritual assessments incorporate the following domains:

- Needs and preferences. “Needs” may include family responsibilities, and the types of supports the person requires in order to improve their situation (both substance related and other). “Preferences” includes matters relating to cultural background, spiritual beliefs, sexual orientation, and gender identity that may be critical to recovery and wellness;
- Desired withdrawal management and longer-term wellness goals and outcomes;
- Readiness to look at the impact of their substance use and associated issues, risks and harms;
- Personal strengths and resources. May include qualities such as optimism, determination, and hopefulness. It may also include positive and supportive

42 Kenny, P. et al., 2009; WHO, 2009; Pilling, Hesketh & Mitcheson, 2010; Saskatchewan, 2012
relationships with significant others, spiritual beliefs, and healthy community ties;

- Potential barriers to successful withdrawal (e.g. current living situation, financial problems, work commitments, care of children and current legal issues);
- Assessment of risk: in particular, suicide risk, self harm, or danger to others;
- Current and previous substance use (including underlying reasons for substance use), and treatment history;
- Current physical health and medical history (including dental health);
- Current mental health (including, as appropriate, psychiatric diagnosis) and associated history. Concurrent mental health and substance use issues are common among individuals seeking or entering withdrawal management services. Researchers and practitioners generally recommend that individuals seeking service be screened for concurrent disorders as part of the screening and assessment processes, and on an ongoing basis (especially following withdrawal);
- Experience of sexual or physical violence, including whether the individual is currently experiencing intimate partner violence;
- Physical, developmental and cognitive abilities;
- Current medication use and medication history;
- Social and economic situation (including whether or not the individual is working);
- Language and literacy abilities;
- Family situation, supports and significant others;
- Sexual orientation and gender identity;
- Involvement with any other programs or counsellors;
- Involvement, if any, with the child welfare system; and
- Involvement, if any, with the criminal justice system.

Some researchers suggest that incorporating an assessment of the participant’s quality of life (e.g. using a standardized tool) can help to gauge the positive outcomes of the withdrawal process on the individual’s overall wellbeing.43

7.3 See note 2.2 on confidentiality under Guideline 2: Screening.

7.4 Trauma may be linked to a single experience, or to ongoing or repeated events. Traumatic events have a profound and lasting impact on how an individual sees

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43 Picci, et al., 2014
themself, other people, and the world. Such experiences can overwhelm an individual’s ability to cope or to integrate the thoughts and feelings associated with those experiences. Trauma-informed services are, broadly speaking, characterized by the following features:

- An understanding of trauma is integrated throughout all service components;
- Policies and procedures are designed with an understanding of trauma in mind; and
- Priority is placed on trauma survivors’ safety, choice, and control.

Health authorities should support staff to access training on how to work with people who have suffered trauma.

For more information regarding trauma-informed practice, see the British Columbia Trauma-Informed Practice Guide (as referenced in the Appendix).

7.7 The primary care provider is in a position to provide consistent and continuous general care for an individual dealing with problematic substance use and should have an ongoing role in the individual’s recovery journey. Where an individual is participating in a home/mobile withdrawal management program, the support of the primary care provider is particularly important. (See the guideline on the role of the primary care provider in Section 3.1 for guidance regarding the primary care provider role in home/mobile withdrawal management). If an individual is not connected to a primary care provider, the withdrawal management service facilitates making such a connection.

7.8 Regular monitoring should occur throughout withdrawal care in order to respond to the individual’s needs as they arise. The frequency of monitoring will be dependent on symptom severity and the withdrawal care setting.

7.9 While formal assessment tools have been developed specifically for the substance use treatment sector, the evidence also supports taking a less structured, narrative approach to assessment. Assessment tools should guide (not dominate) the conversation. It may be appropriate to record the information after, rather than during, the conversation.
Guideline 8: Recovery / Wellness Planning

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

Suggested Elements

8.1 The information from the continuous assessment process informs the development and revision of the recovery/wellness plan.

8.2 The personal recovery/wellness plan addresses supports and goals for withdrawal management, transition from the withdrawal management program and ongoing, longer-term treatment.

8.3 Work on developing the personal recovery/wellness plan begins as soon as the individual feels ready to participate. The process is a collaborative one between the participant, program staff, supportive family members, and other relevant health care professionals. Care is taken to ensure that the individual understands and is engaged with the content of their recovery/wellness plan.

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

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

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

8.7 If the individual wishes to have family or other external supports participate in the recovery/wellness planning process, this is facilitated.

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

8.9 As well as focusing on substance use, the recovery/wellness plan addresses the biopsychosocialspiritual domains covered by the continuous assessment process and incorporates the available supports detailed in the guideline for Provision of Biopsychosocialspiritual Supports (below), as appropriate to the individual’s needs, preferences, strengths, culture and goals.
8.10 The individual receives a copy of the recovery/wellness plan and takes it with them on leaving the withdrawal management program.

Notes and Examples

8.2 While the generally short (7-10 day) duration of a withdrawal management program does not allow for the full development of a recovery/wellness plan, withdrawal management does provide the opportunity to start working with program participants on a longer-term plan for their care and recovery. In addition to identifying some longer-term goals and treatment options, the details developed during the individual’s participation in withdrawal management must cover the goals for withdrawal management and the process of transitioning from the withdrawal management program to ongoing community-based supports or residential treatment.

There is significant variation in symptoms and duration of withdrawal from one individual to the next. The portion of the recovery/wellness plan that deals with withdrawal management must be tailored to the individual’s specific situation, including paying particular attention to any concurrent mental health issues.

It is intended that each individual will take a copy of the plan with them on leaving the withdrawal management program and that the plan will be reviewed and updated in collaboration with their primary care provider and staff at the other services and supports that the individual accesses throughout their recovery journey.

8.3 Engaging individuals in the development of their recovery/wellness plan supports their willingness and capacity to complete withdrawal management and to continue with ongoing treatment and supports. With the individual’s permission, every effort should be made to include in the planning process other health and social care professionals with whom the individual is connected.

The pace of the process should be appropriate to the individual’s level of wellbeing and willingness to participate. Program staff should strive to develop warm, honest and open professional and therapeutic relationships with the individual receiving services. As part of this, the individual’s thoughts and feelings about the service and supports that they are receiving are listened to and inform ongoing recovery/wellness planning.

People often experience difficulties with concentration and memory during withdrawal and may be limited in their ability to retain information. It may be necessary therefore to provide important programming information more than once and in a variety of formats (e.g. verbal, written, audio-visual).

Some individuals may not be ready to engage with recovery/wellness planning during their stay in withdrawal management. In these instances, it may be more appropriate to work on the plan for longer-term treatment and recovery when the individuals are in stabilization or supportive recovery services.

8.4 The primary care provider is in a position to provide consistent and continuous general care for an individual dealing with problematic substance use and should have an
ongoing role in the individual’s recovery journey. Where an individual is participating in a home/mobile withdrawal management program, the support of the primary care provider is particularly important.

8.5 Participants’ needs and goals may change as they progress through the withdrawal management program and these changes need to be reflected in the personal recovery/wellness plan. Regular monitoring should occur throughout withdrawal care in order to respond to individuals’ needs as they arise. The frequency of such monitoring will be dependent on symptom severity and the withdrawal care setting. Broadly, as part of the regular monitoring process, program staff should:

- Check the individual’s general health (e.g. level of consciousness, vital signs, pain, self-report);
- Check the individual’s environment (e.g. calm, quiet, low lighting, supportive persons, self-report);
- Reassure the individual (e.g. allay concerns and fears, give positive encouragement, offer information);
- Orientate the individual (e.g. to time, place, person);
- Offer fluids; and
- Check the individual’s physical comfort (e.g. ambient temperature, bedding, need for pain relief).44

If anything occurs that is beyond the scope of the withdrawal program to address effectively then the individual should be transferred to an appropriate health care facility. See note 10.2 for examples of symptoms that require immediate emergency medical and/or psychiatric intervention.

An individual’s ability to follow the recovery/wellness plan that they have developed with program staff may be affected adversely by other health issues and by broader social, emotional and spiritual factors. As much as possible within the context of withdrawal management, and in accordance with the individual’s readiness and willingness, these issues should be explored and taken into account when developing a plan and goals for recovery.

8.8 Some people accessing withdrawal management services may believe that withdrawing from the substance(s) they are using is all that is necessary to overcome their problematic substance use. However, research and practice evidence indicates that withdrawal should be approached as an early step in a longer recovery process. Withdrawal management presents an opportunity for service providers to inform program participants about the full spectrum of substance use services and to encourage

44 Kenny, et al., 2009
them to make decisions and changes in support of their longer-term health and recovery.\textsuperscript{45}

8.9 In order to address the biopsychosocialspiritual needs of program participants, withdrawal management providers should be familiar with the available public sector and community social, economic, and cultural supports such as: legal assistance; parenting groups and childcare services; employment assistance; education and training programs; interpreters; spiritual and cultural groups; housing assistance; recreation; and dental and other health care services. \textit{Guideline 10: Provision of Biopsychosocialspiritual Supports} addresses the full range of such services and supports in detail.

\textsuperscript{45} Schillinga, Maresb & El-Bassel, 2004; CSAT, 2006; SCAN, 2006; NCCMH, 2008; Stein, Anderson & Bailey, 2015
Guideline 9: Retention

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

Suggested Elements

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

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

9.3 Appropriate strategies are used to engage the individual with the program and to enhance their motivation to stick with the program.

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

9.5 Program staff members make every effort to engage with and support an individual who is exhibiting challenging behaviour and ensure their continued participation in the program.

9.6 Staff members are provided with training on how to deal effectively and respectfully with the challenging behaviour of individuals at the service.

9.7 If the individual receiving service chooses to leave before completing the withdrawal management program or achieving their goals, this is managed in a sensitive and respectful way. It is made clear to the individual that they will be able to return to the program when they are ready. Service providers support the prompt readmission of any individual wishing to return to the program.

9.8 If an individual is asked to leave the withdrawal management program early, this is also managed with sensitivity and respect. The individual understands why they are being asked to leave and what needs to happen before they can be readmitted into the program. As appropriate, service providers support the readmission of the individual or facilitate their admission into an alternative program.

9.9 An individual who chooses to leave, or who is asked to leave, the withdrawal management service early is provided with a written plan to support their ongoing care. The individual is also given active assistance to connect with their primary care provider and appropriate community-based services and agencies.

9.10 When an individual is asked to leave the service before completing the withdrawal process, this is documented. The program reviews all such incidences regularly and, if
necessary, reviews and adjusts its discharge policies to ensure that the program is working to retain people.

9.11 An individual who chooses to leave, or who is asked to leave, the withdrawal management service early is provided with harm reduction supplies and education as appropriate (e.g. take home naloxone for patients with an Opioid Use Disorder).

**Notes and Examples**

9.1 People accessing withdrawal management will have different levels of motivation and readiness to change. It is usual for people to attempt withdrawal several times before feeling able to continue with their wellness plan and goals. It is necessary therefore for the program to take a person-centred approach and meet individuals where they are at with respect to their readiness to address their substance use.

9.2 Information about policies and rules includes:

- Contact with family members, friends and significant others;
- Smoking restrictions; and
- Reasons why a participant may be asked to leave the program.

Should an individual use substances while in the withdrawal management program, any decision to ask them to leave should be made on a case-by-case basis. Issues to consider include (but are not limited to):

- The impact that the individual’s substance use has had on the other program participants;
- The intentions of the individual with respect to their substance use and participation in the withdrawal management program; and
- The willingness of the individual to discuss the matter with program staff.

9.3 Strategies that have been shown to improve retention in substance use services and treatment include:

- Using motivational interviewing techniques such as: rolling with resistance in a non-confrontational method; reflective listening; asking open-ended questions; affirming change-related statements; and listening to and building upon self-motivational statements; ⁴⁶
- Focusing on the individual’s rather than the program’s concerns;
- Educating the individual about the withdrawal process and what to expect;
- Engaging with individuals in an objective, caring, and respectful manner;
- Offering choice and flexibility with respect to the program elements;

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• Developing realistic goals that reflect the individual’s stage of change;
• Offering hope and demonstrating empathy;
• Focusing on the individual’s strengths;
• Recognizing small steps towards achieving goals;
• Providing feedback; and
• Engaging with the individual’s family and/or network of support.

9.8 There are a small number of circumstances that might necessitate an individual being excluded from the service for a period of time because it would be deemed unsafe to have them remain in the program. These circumstances include (but are not necessarily limited to):

• When an individual has physically or sexually assaulted another person (staff member or program participant);
• When an individual has been found dealing substances in the unit; and
• When a person has been found attempting to recruit other program participants into illegal and/or harmful activities (e.g. sex trade participation, gang membership).

Any incident such as these should be documented in the individual’s file along with a clear plan for what needs to happen before they will be readmitted and any safety precautions that would need to be in place to minimize the risk of reoccurrence as well as the consequences of the behaviour. If necessary, alternative arrangements should be made for the individual to address their withdrawal management needs at another facility/in another program. All recorded information about the incident should be communicated to the withdrawal management service that is receiving the individual.

In cases of violence towards another person by an individual receiving service, charges should be made.
**Guideline 10: Provision of Biopsychosocialspiritual Supports**

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

**Suggested Elements**

10.1 The individual has access to a calm and comfortable physical environment. This includes:
   - Sufficient personal/private space;
   - Enough space to move around freely;
   - A comfortable ambient temperature;
   - Access to outdoor space;
   - Access to natural light; and
   - Limited noise pollution (e.g. from vacuum cleaners, radios, televisions, other clients, etc.).

10.2 The service provides each participant with access to physician and nursing care as appropriate to their level of need.

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

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

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

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

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

10.8 The program provides educational sessions and/or presentations on a range of topics related to problematic substance use, including (but not limited to):
   - Evidence-based pharmaceutical and psychosocial treatment intervention
options for each substance used;

- Public health;
- Harm reduction strategies;
- Community-based substance use resources and supports;
- Peer support;
- Self-help groups;
- Residential treatment options;
- Mental health and concurrent disorders;
- Indigenous and traditional approaches to healing;
- Tobacco cessation; and
- Stages of Change model.

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

10.10 The program provides access to a range of evidence-informed alternative therapies that have been shown to have beneficial impacts on an individual’s physical, emotional and spiritual wellbeing. Such therapies may include, for example: massage therapy; art and music therapy; meditation and mind/body-based therapies; homeopathy; Chinese medicine; and auricular acupuncture.

10.11 Participants have access to a range of exercise activities that promote general wellness and a healthy mind/body connection and that are suitable to their needs and capacity. Such activities may include for example: daily walks; stretching; yoga; and swimming.

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

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

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

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

10.1 It is important that people undergoing withdrawal have access to an environment that reduces stress and stimulation, and supports their comfort. Ideally, participants will have private rooms with attached bathrooms and good natural light. During withdrawal, people often experience unpleasant gastrointestinal symptoms. Not having access to a private bathroom can cause additional distress to the individual who is suffering from such symptoms, as well as to other program participants, and undermines the individual’s dignity.

The suitability of the home environment is a crucial consideration in determining whether home-based withdrawal management will be the most appropriate option for an individual. See information below under Service Setting Considerations.

10.2 The program has policies and procedures in place that determine the appropriate level of medical support and access to medical professionals in accordance with the service setting and the individual participant’s need.

The following presenting symptoms (the list is not exhaustive) require immediate emergency medical/psychiatric intervention:

- Decreased level of consciousness;
- History of recent head injury with symptoms of concussion;
- Severe respiratory depression or difficulties;
- Significant/profuse bleeding;
- Vomiting with blood;
- Acute chest pain with a history of cardiac problems;
- Repeated seizures;
- Suspected acute fractures/dislocations;
- Acute psychotic behaviour (hallucinations/extreme paranoia); and
- Suicidal thoughts with intent.

After-hours staff in withdrawal management settings that do not have access to 24-hour medical support may call the 8-1-1 HealthLink BC line or the RACE line (http://www.raceconnect.ca/) when they need advice on the best management of an individual’s symptoms.

10.3 It is good practice to help participants to develop regular sleep practices as soon as they are able; however, staff should be aware that it is common for individuals to need extra sleep during the first few days of withdrawal management. Literature about sleep and relaxation techniques should be available to participants.

In order to address disturbed sleep, individuals should be encouraged to:

- Avoid caffeinated drinks during the day and especially after 2:00 pm;
• Eat regular meals and avoid eating heavy meals late at night;
• Avoid napping during the day;
• Exercise regularly;
• Use relaxation techniques; and
• Have a bath before bed.

When appropriate, the program may provide participants with supportive counselling for sleep hygiene.

10.4 The withdrawal process is stressful to the body and, consequently, program participants may require increased nutrients. During the first few days, it may be appropriate to ensure that individuals have access to a range of healthy foods that they may eat as needed. Consuming fresh fruits, vegetables and other whole foods can contribute to the individuals’ health and wellbeing. Nutritional supplements may be provided to participants on an as needed basis. Deficiencies that are common in people undergoing withdrawal include: B complex vitamins, vitamin C, folic acid, zinc, and magnesium.

Staff should encourage individuals to drink plenty of fluids (water and/or fruit juice). It is good practice to offer program participants beverages that are free of caffeine and refined sugars.

Malnutrition can interfere with the withdrawal process. Where the individual’s assessment indicates poor nutritional or hydration status, program staff should, with the individual’s consent, monitor the individual’s food and fluid intake.

Withdrawal management should include efforts to address the individual’s nutritional wellbeing and provide support for improved eating habits. It may be appropriate to talk with the individual about their eating habits and desire to change them. Access to a specialist dietician service is helpful in delivering nutritional education.

10.5 Health Canada approved nicotine replacement therapies (such as the nicotine patch, gum, inhaler and lozenge) should be made available to individuals who use tobacco. Health Canada also approves non-nicotine prescription medications for smoking cessation. Where appropriate, staff should support individuals in accessing that medication. In the research literature, tobacco use is correlated with relapse. Addressing tobacco use as part of the withdrawal management process improves outcomes.47

10.6 Acupuncture, which has been shown to be effective for several symptoms of substance withdrawal, can help to alleviate discomfort. Other approaches include: physical exercise; massage; and therapeutic heat and/or cold. While not all of these approaches are supported by research evidence, clinicians and program participants have reported their effectiveness. Muscle cramps and aches can be alleviated by taking a bath, using a heat rub or hot pack, doing gentle exercise, or massage. Sweating/hot and cold flashes can be alleviated by taking a shower or bath.

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47 Stuyt, 2015; Rolland et al., 2016
10.7 Common psychological symptoms of withdrawal include (but are not limited to):

- Agitation or irritability;
- Moodiness, mood swings, or feeling low in mood;
- Anxiety and worries;
- Restlessness and inability to sleep;
- Difficulty concentrating and fidgetiness;
- Tiredness and feeling low in energy; and
- Cravings or strong urges to use substances.48

**Easing anxiety/promoting relaxation** – Anxiety may usually be managed with a combination of education, reassurance and use of the following strategies:

- Relaxation exercises, such as deep breathing, muscle relaxation and listening to relaxing music or relaxation tapes;
- Mindfulness and meditation;
- Access to a quiet, private room;
- Having a bath;
- Doing gentle exercise;
- Massage; and/or
- Reducing or eliminating caffeine intake.

Using a night-light can reduce anxiety during the night. The program could recommend that an individual use a night-light and/or provide the individual with a night-light, as appropriate.

If anxiety does not subside as the withdrawal process progresses, or if it is associated with depression or suicidal thinking, the appropriate medical and psychiatric help should be sought. Expert psychiatric help should be sought for any person experiencing psychotic symptoms.

**Dealing with cravings** – Supportive counselling and strategies for helping individuals to deal with cravings may include:

- Reassuring the individual that cravings will become easier to deal with and will eventually pass;
- Removing “cues” or reminders of substance use;
- Encouraging and supporting the individual to keep busy (e.g. watch a movie; do some exercise; engage in recreational activities such as cooking, playing games, going for a walk);

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48 Christie & Temperton, 2008
• Mindfulness and meditation techniques; and
• Identifying ways in which the individual can reward themself in a positive way each time they make it through a period of craving.

**Maintaining motivation** – Program staff can take the opportunity to enhance an individual’s motivation to complete the withdrawal process and access ongoing treatment and supports by taking a motivational interviewing approach to conversations with the individual. The withdrawal service may also consider introducing contingency management to promote participants’ engagement with the withdrawal program and longer-term recovery and wellness.

10.8 Such sessions and presentations may be delivered by program staff or by other professionals/community-based support people with whom the program has a relationship.

10.9 Supportive counselling during withdrawal management can usefully include a focus on skill building. Individuals accessing substance use services are likely to benefit from help to develop or enhance the following skills (not exhaustive): problem solving; coping/stress management; boundary setting; decision making; relationship building and management; emotion identification and stability; and navigating social and economic service systems (e.g. health, education, training, financial supports).

10.10 There is a growing body of research that demonstrates the beneficial outcomes of music therapy, Chinese herbal medicine, and acupuncture in the context of withdrawal management. Program participants and clinicians also report the effectiveness of alternative therapies as an adjunct to core withdrawal treatment and care. (See the Glossary and Evidence sections of these guidelines for more information.)

The range of alternative therapies and supports available will depend to some extent on the service setting. Programs should consider partnering with community resources such as post-secondary schools and colleges to support the free or low-cost provision of services such as music therapy, art therapy, acupuncture, and/or massage therapy by students or community members.

10.11 Gentle physical activity is an important part of the healing and recovery process and can play a positive role in supporting participants’ engagement with the withdrawal management program. It is widely accepted that exercise has beneficial impacts on a person’s emotional and psychological wellbeing, as well as physical health. In the context of substance use treatment, the benefits of exercise for relapse prevention, reducing cravings, and enhancing psychological wellbeing are clinically admitted but have yet to be empirically corroborated.

Providing access to exercise activities may involve giving participants passes for recreation centres and passes or prepaid tickets for public transit. The range of exercise activities available will depend to some extent on the service setting.

10.12 In addition to being enjoyable, recreational activities can help program participants to develop social skills and make connections with other people. The program should be
responsive to the cultural needs of participants. Activities such as music and singing, art, and cooking and eating provide opportunities for cultural responsiveness and inclusivity.

The range of recreational activities available will depend to some extent on the service setting.

10.13 Supportive counselling and education for strengthening personal and social supports may be done individually or in a group setting. The program should have active connections with community organizations that serve diverse people (e.g. LBGT2S, Indigenous, developmentally disabled). In studies, withdrawal management participants have reported that social support networks play an important role in sustaining their ongoing wellness.49

The involvement of supportive family members in an individual’s recovery journey contributes significantly to successful outcomes. It allows for the demystification of the treatment and recovery process and provides an opportunity to encourage support for the individual to make changes in their behaviour and lifestyle. Family involvement enhances an individual’s engagement with and retention in treatment, reduces the risk of relapse, and improves family functioning. Research shows that involvement in positive family/social activities during the post-withdrawal management period significantly reduces the likelihood of relapse. Conversely, negative family/social experiences (such as interpersonal conflict, exposure to others’ problematic substance use) increase the risk of relapse.50

Having a well-informed personal circle of support (family members or others) is important to the individual’s ongoing wellbeing and their ability to capitalize on the gains made during withdrawal management. A trauma-informed approach to educating family members and supportive others will facilitate their understanding of what is helpful and unhelpful when supporting someone who is in recovery. Broadly speaking, members of the individual’s support network need to be aware that enabling, coercive, and confrontational behaviours and actions are unhelpful.

It may also be appropriate to refer individuals to local family support groups and organizations.

As appropriate, and with the individual’s permission, programs should also involve Indigenous Elders and community members to help build the individual’s social and community connectedness. Working with Indigenous advisors/liaisons can also help enhance communication and engagement between the withdrawal program staff and Indigenous families.

Participants should have the opportunity to make personal phone calls in a suitably private space.

49 Khan, et al., 2014
50 Khan, et al., 2014
Evidence shows that peer support programs for people with problematic substance use are associated with a number of beneficial outcomes, including:

- Increased engagement with treatment and motivation to change;
- Increased sense of self-efficacy;
- Enhanced social support, networks and functioning;
- Increased ability to cope with stress;
- Improvements in practical outcomes (e.g. employment, housing, finances);
- Enhanced ability to navigate services and communicate with service providers; and
- Reduced mortality rates, particularly with regard to suicide.\(^{51}\)

Peer support programs are important because they offer a link to the shared experience of recovery. In addition, they represent a constant connection for people as they move between the various points on the continuum of care.

Spiritual experiences are integral to the recovery and wellness process for many individuals, and the appropriate spiritual care and supports should be part of the withdrawal management program. These may take the form of:

- Providing information about spiritual groups and access to spiritual guidance;
- Offering group sessions where participants can explore broad spiritual issues;
- Having spiritual leaders visit a participant (as requested by the participant);
- Accommodating spiritual rites and practices (e.g. prayer, smudging, attendance at religious meetings); and
- Developing and sustaining active connections with religious and spiritual groups and organizations that reflect the spiritual and religious affiliations of program participants.

Program staff should be aware of and knowledgeable about Indigenous spiritual and cultural practices, especially as they pertain to healing and wellness. The program should have a strong link with an Indigenous cultural liaison/advisory person.

**Service Setting Considerations**

**10.1 Home-based withdrawal:**

Having an appropriate home environment is a crucial component of effective home-based withdrawal management. The process of assessing an individual’s suitability for withdrawing at home should include assessing their home environment and, as necessary, helping the individual to create a suitable home environment for withdrawal. Broadly, the individual should have access to a safe, supportive and stable place in...
which to undertake withdrawal. Ideally, the environment will have the following characteristics:

- Quiet;
- Low lighting;
- Appropriate space for bed rest; and
- Free from substance use (does not have to include tobacco, but should be considered).

10.4 For residential withdrawal management programs, the provision of regular meals consisting of healthy foods that are attractively presented is an important consideration. Individuals accessing home/mobile or day withdrawal programs should receive the necessary support to eat healthy meals during withdrawal care.
Guideline 11: Prescription Medication

The withdrawal management service ensures that individuals are able to continue taking physician-prescribed medications that are supportive of their health and wellbeing, and that will facilitate the achievement of their withdrawal management goals.

Suggested Elements

11.1 All participants receive an assessment of their health status and use of medications related to their physical, psychiatric and substance use needs.

11.2 As appropriate, a medication plan is developed for the individual and this is reviewed on an ongoing basis.

11.3 All decisions taken as a result of medication reviews are recorded in the personal recovery plan.

11.4 The program has policies and procedures in place to ensure that all medications are stored, dispensed, and administered according to accepted standards and applicable policies, legislation, and regulations.

Notes and Examples

11.1 The withdrawal management service strives to compile the best possible medication history from as many sources as reasonably possible. The health status and medication use assessment takes place as soon as reasonably possible. The assessment is carried out by: a physician or a nurse practitioner attached to the program; by the person’s own primary care provider; or by a local walk-in clinic that the program has established a relationship with. A registered nurse may carry out the initial assessment and then consult with a physician.

Withdrawal management can also be a time to address potentially harmful medication use (e.g. benzodiazepine tapering).

11.2 Any decision-making related to prescription medications has to be made by a physician. When individuals already have a primary care provider, or have an existing prescription from a doctor, then consultation with that physician must occur.

11.3 A significant number of people accessing withdrawal management supports will require prescribed medications for a variety reasons. Medications may also form part of an individual’s withdrawal process. Examples of concurrent conditions requiring medication include physical conditions such as: asthma; diabetes; arthritis; hepatitis; and HIV/AIDS. Mental health conditions requiring medication may include: schizophrenia; anxiety and mood disorders; eating disorders; and other mental health problems with a biochemical basis.

The treatment of problematic substance use may require medication for withdrawal,
stabilization, or agonist treatment or relapse prevention. There is abundant and conclusive evidence that opioid agonist treatments such as Buprenorphine/Naloxone (also known as Suboxone®) and Methadone, can help individuals to participate in treatment, reduce their illicit substance use, and improve their overall health.


Vancouver Coastal Health has also created easy to read overviews of these medications for patients:


11.4 At a minimum, written medication management policies and procedures should include:

- Procedures for managing medication errors and adverse medication reactions;
- Procedures for controlling access to medications;
- The practice of highlighting known medication allergy information in the participant’s record;
- The practice of administering all medications with the authority of a physician;
- A policy establishing under what circumstances self-medication by the participant is permitted; and
- Specific routines for the administration of medications, including standardization of abbreviations and dose schedules.

Services that are licensed under the Community Care and Assisted Living Act are required to follow regulations governing medication in that Act. Detailed requirements for medication storage and administration can be found in the Residential Care Regulation (RCR) (as referenced in the Appendix).

Services that are accredited under the Commission on Accreditation of Rehabilitation Facilities (CARF) are required to follow standards governing medication in the latest edition of the Behavioral Health Standards Manual (as referenced in the Appendix).

The Community Care and Assisted Living Act supersedes CARF. If there is any discrepancy, agencies that are licensed must follow the legislation.
Guideline 12: Continuous Program Improvement

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

Suggested Elements

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

12.2 Participants are given formal and informal opportunities to provide feedback on program activities and supports. Upon leaving the program, each participant is invited to fill out a satisfaction survey.

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

12.4 Withdrawal management service providers participate with health authorities in regular program and outcomes-based evaluations. In addition, programs delivered by third-party providers participate in regular contract monitoring and reporting procedures with their health authority.

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

Notes and Examples

12.1 “Evidence” includes both research evidence (from clinical trials and health and social science studies) and practice-based evidence (from clinicians’, participants’, and programs’ experiences and knowledge).

The most fundamental components of what we know to be effective substance use treatment and supports include:

- Recognition that withdrawal management is an important first point of contact for many and that this approach alone is not considered treatment. Patients must be connected into comprehensive and ongoing treatment and care post-withdrawal management.
- Providing evidence-based care and access to evidence-based treatments, including but not limited to pharmacotherapies, psychosocial treatment interventions, peer support and recovery oriented systems of care.
- Providing person-centred care that addresses the needs of the whole person through the provision of a range of biopsychosocial/spiritual supports that are tailored to the circumstances and preferences of each individual;
- Taking a culturally-appropriate and trauma-informed approach to all aspects
of treatment and care;

- Treating each individual with sensitivity and respect and in a way that preserves their dignity and reduces the stigma associated with substance use;
- Providing help and support for any concurrent mental health issues;
- Involving the individual’s family and supportive others in recovery planning, and providing the individual with help and tools to strengthen their personal circle of support; and
- Developing and maintaining strong links and relationships between providers across the spectrum of substance use supports, and between substance use services and providers of other health and social services to facilitate the delivery of “wrap around” services for each individual.

As the body of evidence with respect to leading practices in the substance use services field is constantly being added to and revised, it is desirable for health authorities to have mechanisms in place that facilitate service providers’ ongoing access to the latest research and practice-based guidance.

12.2 Participant feedback may include verbal as well as written feedback. Seeking such feedback supports inclusivity and collaboration between program staff and participants. It allows program staff to make modifications to activities and supports in order to best meet individual and group needs. The satisfaction survey is a more formal way to seek participants’ input and impressions on the quality of service that they received and how well the program met their needs.

12.4 Each program should have a health authority approved process to measure participant outcomes. Ideally, and with the participant’s consent, this includes follow up with the participant after they have left the program.

In addition to participating in health authority evaluations, residential withdrawal management services that are licensed under the Community Care and Assisted Living Act will take part in the inspection process required under the Act. Refer to the Appendix for the web link to the Act.

Residential withdrawal management services that are accredited under the Commission on Accreditation of Rehabilitation Facilities (CARF) will participate in that organization’s regular survey and review process.
Guideline 13: Staff Qualifications and Experience

Withdrawal management supports offered by the program are delivered by appropriately qualified staff.

Suggested Elements

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

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

13.3 Program staff members meet the Canadian Centre on Substance Abuse (CCSA) competencies for their specific roles.

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

13.5 The program has policies in place that clearly designate which member of staff is responsible at any given time for approving the key decisions about each participant’s care.

13.6 All staff have appropriate training, supervision and support to carry out the work that they do safely and effectively.

Notes and Examples

13.2 At a minimum, volunteers are familiar with the program’s rules, policies and procedures, and receive the necessary supervision to put these into practice.

13.3 Employees should receive recognition and credit for their experience and demonstrated capabilities, and should be supported in accessing further training or developmental opportunities, where possible, in order to stay current with leading practice.


Each component of the *Competencies for Canada’s Substance Abuse Workforce* provides comprehensive guidance on which of the competencies apply to which roles and/or professionals within the substance use workforce. They also describe how individual staff members may demonstrate each competency. Refer to the Appendix for a web link to the CCSA’s competencies guide.

Agencies providing withdrawal management services are responsible for ensuring that all staff members meet the CCSA competencies.
All health authority direct and contracted staff members have the opportunity to participate in the Core Addiction Practice Training or similar health authority approved training package.

Ongoing staff training and development may be delivered in a number of ways. Possible approaches include: health authority-led workshops; online learning; mentoring programs; and knowledge and best practice exchange through multi-agency workshops, symposia and communities of practice.

13.5 Such decisions would include (but are not necessarily limited to):

- When to seek the advice or input of a physician;
- Issues related to medication(s) that an individual is taking;
- When it is necessary to transfer an individual to hospital for medical supports that are not available within the program; and
- A determination to ask an individual to leave the program early.

Who the designated staff member is will vary according to the service setting and program type.
Preparing for ongoing recovery after withdrawal management

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

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

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

All individuals leaving withdrawal management must be actively and meaningfully supported. Successful transitions from withdrawal management rely on strong linkages and relationships between residential and community-based substance use services, and other health and social service agencies.
Guideline 14: Transition Planning

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

Suggested Elements

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

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

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

14.4 As appropriate, the plan includes provision for the individual to access a supportive recovery facility on leaving withdrawal services to help maintain and sustain their wellness.

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

14.6 With the individual’s consent, members of their support circle are involved in transition planning, and are informed about how best to support the individual during their ongoing recovery.

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

- Ongoing substance use treatment and supports (residential and community-based);
- Connection to a primary care provider and/or addiction medicine specialist;
- Mental health services and supports;
- Other health and medical supports;
- Pharmacotherapy (including, as appropriate, Opioid Agonist Treatment, alcohol relapse prevention medications);
- Residential or supportive recovery oriented systems of care;
- Psychosocial treatment interventions;
- Support for healthy diet and nutrition;
• Life skills;
• Stress management skills;
• Relapse prevention skills and education about Post Acute Withdrawal Syndrome;
• Harm reduction;
• Relationships with family;
• Personal and social supports (including community groups);
• Safety from violence and abuse, including intimate partner violence (IPV);
• Income support;
• Employment, education and/or vocational training;
• Housing;
• Legal services;
• Child protection services;
• Parenting skills;
• Spiritual and cultural practices and preferences; and
• Recreational interests (e.g. arts, sports, social activities).

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

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

14.10 The individual receives a copy of their transition plan and with the individual’s written consent the plan is shared with the appropriate health and social services and supports.

Notes and Examples

14.1 Having a plan for ongoing treatment and supports is associated with better outcomes for individuals who are trying to change their substance use. Wellness and transition planning helps to engage people in their longer-term recovery journey and increases their awareness of the support services that are available to them. Further, identifying and linking individuals with the supports that best meet their post-withdrawal needs and preferences helps to ensure continuity of services.

14.4 Ideally, a residential treatment and/or supportive recovery bed would be available for every person who needs and wants one immediately on leaving withdrawal management. However, where resources are limited, it may be necessary to prioritize access to these beds to people who:
• Have declined opioid agonist treatment and are at risk for opioid overdose due to decreased tolerance;
• Are at high risk of relapse if only outpatient supports are provided;
• Are homeless;
• Live alone;
• Have experienced or are experiencing a violent or abusive relationship;
• Would be returning to a home situation where there is ongoing substance use;
• Are survival sex trade workers; and/or
• Have a persistent substance-use induced mental health problem (e.g. psychosis, risk of suicide).

14.6 Having a well-informed personal circle of support (family members or others) is important to the individual’s ongoing wellbeing and their ability to capitalize on the gains made during withdrawal management. A culturally appropriate and trauma-informed approach to educating family members and supportive others will facilitate their understanding of what is helpful and unhelpful when supporting someone who is in recovery. Broadly speaking, members of the individual’s support network need to be aware that enabling, coercive and confrontational behaviours and actions are unhelpful. The individual’s support circle (e.g. family members, significant others, friends) may require additional support during the transition planning process (e.g. through referrals and linkages to the appropriate support services).

14.7 The transition plan should address all of the biopsychosocialspiritual domains. In particular, program staff should be aware that many people leaving withdrawal management services are homeless or have no safe or stable home to return to. The transition plan must address the individual’s need for safe shelter. It must also consider the individual’s level of safety from violence and abuse following their transition to post-withdrawal supports. The development of a safety plan that reflects the individual’s circumstances may be necessary. This is a particularly important consideration for individuals who have experienced, or may still be experiencing, intimate partner violence (IPV).

Where an individual needs to be connected with income assistance (or other government income supplement programs), it is important to begin this process promptly as there may be a delay of some weeks between applying for assistance and receiving the first payment. It would also be useful to help individuals to develop a plan for how they will manage (e.g. food, housing) until income assistance starts coming in.

While residential treatment and/or supportive recovery facilities may represent the appropriate next step for some people leaving withdrawal management, in reality capacity issues mean that these services are not always available to everyone who needs and wants them. During transition planning, withdrawal management program staff
may need, therefore, to take a creative and flexible approach to identifying the substance use services that are readily available and that will provide adequate support for the individual.

Appropriate substance use services may include:

- Primary care and/or addiction medicine specialist;
- Individual counselling;
- Self-help and peer support groups;
- Post-withdrawal support groups;
- Outreach support;
- Outpatient programs; and
- Residential treatment.
Guideline 15: Reducing Risks

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

Suggested Elements

15.1 The withdrawal management program provides participants with the opportunity to learn about the risk of relapse after withdrawal and to develop strategies to prevent relapse. This includes education on the neurobiology and neurochemistry of addiction as a chronic relapsing brain condition as well as rates of relapse for each substance used.

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

15.3 The program provides participants with:

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

Notes and Examples

15.1 Relapse is a common challenge for individuals who are addressing their substance use. Program staff must be aware of the evidence on rates of relapse and potential risks. It is important that program participants understand the risk of relapse and do not regard it as a personal failure or as a failure of treatment.

When an individual relapses, they often experience shame and this can increase the risk of a full relapse. Program staff should take a nonjudgmental and accepting approach to help sustain the individual’s engagement.

The literature suggests that certain situations or states of mind are often associated with relapse, including:

- Negative emotional states (e.g. frustration, anger, anxiety, depression or anger);
- Interpersonal conflict (e.g. relationships with partner, work colleagues, friends); and
- Direct or indirect social pressure to use substances.52

Relapse prevention education can be individual or group-based. A relapse prevention program usually includes the following:

- Enhancing the individual’s motivation to capitalize on the gains made in withdrawal management by exploring the consequences of continuing to use substances as well as the consequences of discontinuing substance use;

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52 Australian Government, Department of Health and Ageing, 2009
• Identifying high-risk situations and triggers for craving;
• Developing strategies to limit exposure to high-risk situations and to deal positively and confidently with inevitable risk. This may include developing an “emergency plan” for coping with high-risk situations when other skills are not working;
• Developing skills to manage cravings and other painful emotions without using substances;
• Learning to cope with lapses or ‘slips’. This may include strategies for analyzing and understanding the context of the lapse and reducing feelings of failure, shame, guilt and hopelessness about the lapse.
• Learning how to recognize, challenge, and manage unhelpful thoughts about using substances; and
• Identifying pleasurable and rewarding activities that are not associated with substance use, and that can contribute to increased wellbeing and happiness.

In addition, the treatment of any underlying health condition, mental health issue, or substance-use related mental health issue, is important for helping to prevent relapse.

There is some emerging (limited) evidence to suggest that Developmental Counselling Therapy (DCT) is a promising approach for preventing relapse. A relapse prevention plan needs to be in place before using DCT.53

15.2 Addiction to substances involves both the physical and psychological domains. After the physical process of withdrawal has been completed, people still have to work on their psychological desire and “need” for the substance(s) they have been using. This puts them at risk of Post Acute Withdrawal Syndrome (PAWS).

Symptoms of PAWS are common to almost all people recovering from problematic substance use. It is crucial therefore, that withdrawal management staff members are aware of PAWS symptoms and effective treatments and supports.

PAWS symptoms often start around 7 to 14 days after stopping substance use and peak over the following 3 to 6 months. Common symptoms include:

• Inability to think clearly;
• Memory problems;
• Heightened or excessive emotions and/or feelings of numbness;
• Insomnia and other sleep problems;
• Problems with physical coordination; and/or
• Particular sensitivity to stress.54

53 Clarke & Myers, 2012
54 Gorski, 2013
Awareness of PAWS is a fundamental component of supporting the individual’s ability to cope with the symptoms. Other effective strategies and supports include: individual counselling; recovery support groups; massage; biofeedback therapy; emotional intelligence coaching; music therapy; acupuncture; healthy eating and exercise habits; and adequate hydration.55

15.3 Harm reduction education includes providing information about: relapse and relapse prevention; risk of overdose and how to recognize and reverse an overdose; safer sex practices; safer substance consumption practices; reducing use; and treatments such as opioid agonist therapy. It may also include information on services available in certain areas, such as needle exchanges or supervised injection sites.

Harm reduction supplies include (but are not limited to): sterile needles and syringes; swabs; tourniquets; sharps containers; sterile water; vitamin C/acidifier sachets; crack pipe mouthpieces and screens; and condoms. For more information, see the Toward the Heart website: www.towardtheheart.com. To access supplies, service providers should contact their local health authority.

Individuals who have been using opioids must receive education about take home naloxone and where to access appropriate training and supplies. All withdrawal management programs should be a distribution site for B.C.’s Take Home Naloxone Program and provide a kit to all patients who use opioids on discharge. Staff should ensure that the individual has a take home naloxone kit and access to training on how to use it.

For more information on best practices for harm reduction, see Best Practice Recommendations for Canadian Harm Reduction Programs that Provide Service to People Who Use Drugs and Are At Risk for HIV, HCV, and Other Harms: Parts 1 & 2 (2013), developed by the Working Group on Best Practice for Harm Reduction Programs in Canada.

55 Davis, n.d.; Bergdahl, Berman & Haglund, 2012
Guideline 16: Ongoing Treatment and Supports

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

Suggested Elements

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

16.2 The withdrawal management program facilitates connections between participants and self-help/peer supports such as SMART Recovery and 12-Step groups, as appropriate.

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

Notes and Examples

16.1 Linking individuals with other services is associated with better treatment outcomes. Without adequate support, post-withdrawal recidivism rates are high. The goal is to ensure that progression from withdrawal management to other substance use treatment services and supports is timely and responsive to the individual’s needs. In this way, the risk of relapse is reduced and individuals are supported in building on the gains that they have made during withdrawal management.

Ensuring timely access to the services and supports identified in the individual’s transition plan may be challenging, and staff may need to be flexible and creative about finding the means to meet the needs of the individual. It may be necessary to link an individual to lower tier supports when there are wait periods to access higher tier treatment services. Telephone support (and other telehealth or web-based services) may provide a beneficial, short-term solution when there are waits for accessing in-person treatment and services.

The withdrawal management program should take an active role in connecting and engaging the individual with the ongoing treatments and supports identified in their recovery/transition plan. Face-to-face interaction between the program participant and providers of ongoing services supports relationship building and helps to provide for effective follow-up after withdrawal management. Generally speaking, the more real links and connections an individual has on leaving the withdrawal management service the better.
When an individual is being referred to supportive residential services, the withdrawal program should help to prepare them for entering this program. If there is a wait period between leaving withdrawal management and entering residential treatment, the withdrawal management program should link the individual to harm reduction services and appropriate community-based services that can provide adequate support during the wait time.

16.2 Attendance at self-help/peer support groups may be an important component of ongoing recovery and wellness for many people. Withdrawal management services can support people to make connections with these groups by inviting organizations to come into the service to talk to participants and providing information on meeting times/locations in their area.

16.3 At a minimum, individuals should be given up-to-date and accurate telephone numbers, contact names, email addresses and websites for ancillary services in their communities.

Access to stable and affordable housing is a concern for many individuals receiving substance use services and supports. The withdrawal management program should connect participants who are homeless with services that can assist them in finding housing.

It is crucial that the individual is connected with a primary care provider who can help to coordinate ongoing care and treatment. Individuals with other chronic medical conditions and those in need of follow-up medical care should have an appointment made with the appropriate health care professional before leaving the withdrawal management program.
Additional Information about Older Adults and People with Concurrent Disorders
Considerations for Older Adults

An aging population is associated with higher rates of problematic substance use among older adults and an increase in the number of older adults seeking help and treatment for problematic substance use. The literature on treatment for problematic substance use in older adults is, however, limited and there is a recognized need for more research on the challenges of treating older adults with substance use issues, as well as on the effectiveness of approaches to prevention, identification, and treatment.\(^{56}\)

This chapter provides a synthesis of the available research and offers some guidance with respect to: risk factors for problematic substance use among older adults; barriers to treatment; emerging promising practices for substance use treatment in general; and specific considerations for supporting older adults through withdrawal.

Risk Factors for Problematic Substance Use among Older Adults

In older adults, the aging process is often accompanied by a complex range of biological, psychological, and social factors that may contribute to or trigger problematic substance use patterns. These “stress” factors include: death of a spouse, close friend or family member; chronic health issues; loss of identity, status or self-worth following retirement; isolation, reduced mobility, and diminished social supports; a history of psychiatric disorders; and financial difficulties.\(^{57}\)

In addition to having a unique set of stress factors or triggers for substance use, older adults are also more at-risk for the harmful effects of problematic substance use. The decreased capacity of older adults to cope with stress, reduced body and organ function, changes in body composition (lower water stores and higher fat stores), co-occurring health problems, poor diet, and increased use of medications for existing health concerns represent some of the factors that increase the harmful effects of substance use in older adults. Problematic substance use patterns in older adults are also associated with poor physical and psychological health, and may represent many years (or a life-time) of substance use.\(^{58}\)

Potential Barriers to Treatment and Care

Studies suggest that older adults face a number of challenges and barriers with respect to accessing and completing treatment for problematic substance use. Two systemic issues represent particular challenges for this population. Firstly, problematic substance use in older

\(^{56}\) Australian Government, Department of Health and Ageing, 2009; Kalapatapu, 2010; Andrews, Reddy & Whelan, 2011; Moy et al., 2011; Pawsey, Logan & Castle, 2011
\(^{57}\) Health Canada, 2002; Moy, et al., 2011; Ayres, et al., 2012
\(^{58}\) Seeking Solutions, 2004a; CNSAAP, 2007; Australian Government, Department of Health and Ageing, 2009; Kalapatapu, 2010; Moy, et al., 2011; Ayres, et al., 2012
adults tends to go undetected. There are a number of reasons for this: a) lack of reliable screening instruments for this population; b) symptoms of substance use often mimic problems associated (stereotypically) with aging (e.g. sleep issues, memory loss, falls, increased social isolation, a decline in self care); and c) symptoms may be subtle or atypical and therefore go undiagnosed. Secondly, problematic substance use in older adults can have the effect of restricting access to other necessary health and social services. These issues may prevent older adults with problematic substance use from receiving the full range of services and supports that they need to maximize their health and wellbeing.59

Other barriers to treatment (including withdrawal management care) that are noted in the literature on older adults include:

- **Stigma, shame and denial:** Older adults may experience particularly strong feelings of embarrassment and shame about their substance use. They may also be reluctant to acknowledge that they have a problem. These feelings of shame and denial may prevent them from seeking support.

  Similarly, the families and care providers of older adults may also be reluctant to acknowledge when there is a problem with substance use. They may be hesitant about encouraging their loved one to seek support or disinclined to find and to make contact with the appropriate services.

Studies show that older adults with problematic substance use face significant stigma from the general public as well as from their family members and care providers.

- **The age of other program participants:** Older adults may be reluctant to receive treatment alongside younger people. They may be apprehensive of being judged or feeling intimidated by younger people. Older participants may also feel alienated from programs and facilities where the majority of individuals are younger and are dealing with their use of illegal street drugs.

- **Co-existing health and medical issues:** Older people are more likely to have co-existing medical conditions, psychiatric issues, cognitive impairments and decline, issues with sensory perception, and reduced mobility. These factors can make it difficult for older adults to access treatment facilities and can make it difficult for individuals to benefit from the group format of many activities and meetings.

• **Other psychosocial challenges:** Other issues that are more likely to affect older adults and that may have a negative impact on their ability to access and complete treatment include: limited access to transportation; financial constraints; diminished social supports and family networks; and responsibilities in a caregiving role (e.g. for a spouse, a relative, a friend, grandchildren).\(^6^0\)

**Barriers specific to accessing and completing withdrawal management**

The small body of literature on older adults and withdrawal management identifies some important barriers and concerns that may inhibit older adults from seeking and receiving the withdrawal care that they need. These include:

• **Previous experiences of withdrawal:** Older adults may have had previous unpleasant, and physically and emotionally difficult withdrawal experiences. They may be apprehensive that withdrawal becomes more difficult with age.

• **Fears about the pace of the withdrawal process:** Older adults may worry that they will feel too much pressure during withdrawal, and that the withdrawal and recovery process will move at too fast a pace.

• **Location of withdrawal management services:** Withdrawal management services may be located in an area that is unfamiliar to the older adult and in which they do not feel comfortable or safe. Even if the individual is familiar with the area, they may find the environment of the withdrawal management facility (and the absence of familiar visual cues) confusing and disorientating.\(^6^1\)

These barriers need to be considered when assessing older people for substance use treatment generally and for withdrawal management specifically. They should also be addressed, as appropriate to each individual’s circumstances, as part of the recovery/wellness planning process. The promising practices for withdrawal management and substance use treatment take into consideration the main barriers to care facing older adults.

**Promising Practices for Substance Use Treatment for Older Adults**

Older adults have particular and (often) complex health and social needs. The recognition of the age-specific biological, psychological, social, and spiritual realities of older adults is the foundation of effective treatment. This includes being sensitive to the values, attitudes, beliefs, and fears of older adults, and incorporating these into the recovery/wellness plan. Comprehensive assessment should also explore the older adult’s family context, including whether involvement of a spouse and/or family members will be conducive to supporting recovery. It may be beneficial to incorporate family-based services and supports into the recovery/wellness plan.

Effective treatment is supportive and non-confrontational, and takes a person-centred, flexible, collaborative, holistic, strengths-based, and harm reduction approach. There is some

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\(^6^0\) Seeking Solutions, 2004a; CNSAAP, 2007; CARBC, 2008; Kalapatapu, 2010; Ayres, et al., 2012; Holland, et al., 2016

\(^6^1\) Seeking Solutions, 2004a; CNSAAP, 2007; CARBC, 2008; Kalapatapu, 2010; Ayres, et al., 2012
evidence that cognitive-behavioural and self-management interventions are effective with older adults.62

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

- Being mindful of the physiological and social characteristics that are associated with the aging process, while taking care not to generalize these to all older adults;
- Acknowledging that, despite the unique challenges and losses that older adults may face, many older adults are strong and resilient;
- Treating the older adult with dignity and respect, and building rapport and trust;
- Establishing a supportive, non-judgmental relationship with the older adult, and remaining optimistic in terms of treatment outcomes;
- Exploring the least intensive treatment options first, and taking an educational approach to treatment;
- Being sensitive to the fact that older adults may have physical and/or sensory limitations (e.g. mobility, hearing, vision), and ensuring that any limitations do not have an adverse effect on communication, comprehension, or success of recovery;
- Adjusting the pace of treatment to suit the older adults’ needs;
- Having the capacity to manage cognitive impairments associated with age and/or long-term substance use;
- Accommodating transportation challenges and offering outreach services to facilitate assessment and recovery planning;
- Prioritizing the needs that the individual feels are the most pressing or the most important, and ensuring that their basic living needs (e.g. housing, nutrition, access to medical services) are met;
- Helping individuals to manage cravings and difficult emotions (such as those associated with loss) that may trigger substance use, and increasing their capacity to deal with difficult life changes;

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• Taking an approach to assessment and recovery planning that supports the individual to recognize and to build on their strengths, skills, and abilities;

• Helping the older adult to identify and enhance their social support system in order to reduce social isolation (which is a major cause of substance use among older individuals);

• Helping older adults living at home to get connected to necessary health and social services, including the appropriate range of medical and non-medical home supports; and

• Taking a harm reduction approach to treatment and recovery planning.63

Considerations and promising practices for withdrawal management for older adults

Although the literature on withdrawal management for older adults is not extensive, it does offer some fundamental guidance regarding the provision of effective care and support for older people who are withdrawing from substances. This guidance broadly aligns with the philosophy and intent of the withdrawal management guidelines but offers some more nuanced direction and advice for meeting the specific needs of the older adult.

Different withdrawal signs and symptoms:

Studies suggest that older adults do not always show signs of withdrawal (e.g. anxiety, sweating, the shakes) in the same way as younger adults, and the symptoms of withdrawal may be easily confused with other co-occurring medical issues. Furthermore, cognitive impairment may prevent the individual from communicating some symptoms, including how they are feeling during withdrawal. Monitoring vital signs before and during withdrawal is crucial to providing safe and effective treatment, as this helps set a baseline for the individual’s “normal” status.64

A longer, more complex withdrawal process requiring greater intensity of support:

An important consideration that emerges strongly from the literature is that older adults often require more time in withdrawal management, as well as more intensive care and ongoing monitoring than younger adults. Because older adults have an increased risk of having or developing co-occurring medical issues, and because they are more vulnerable to the complications of withdrawal, an older individual may need to undergo withdrawal in a more intensive setting and at a slower pace.

The screening and ongoing assessment processes must be comprehensive and include checking thoroughly for any co-occurring medical issues (e.g. heart disease, respiratory disease, diabetes, dementia, hypertension, anaemia) and any potential risks that may pose a

63 Saskatoon, n.d.; Health Canada, 2002; Seeking Solutions, 2004b; CSAT, 2006; Canadian Centre on Substance Abuse, 2007; CNSAAP, 2007; Drew, Wilkins & Trevisan, 2010; Andrews, Reddy & Whelan, 2011; Malliarakis, 2015; Holland, 2016; Rolland, 2016

64 Health Canada, 2002; Seeking Solutions, 2004a; Addictions Ontario, 2008
threat during and/or after withdrawal. Service providers should also assess the individual’s risk for falls and plan accordingly.

Research suggests that older adults are more likely than their younger counterparts to experience the following during withdrawal:

- Pronounced physiological changes, including nausea, diarrhoea, vomiting, dizziness, and increased heart rate and blood pressure;
- Cognitive impairment;
- Dehydration and nutritional deficiency;
- Complex drug interactions;
- Infections;
- Insomnia and daytime sleepiness; and
- A general sense of weakness.

Program staff should be aware that, during withdrawal, the threshold for medical assistance might be lower for older adults than it is for younger adults.

In addition, programs need to be flexible with regard to the pace of withdrawal management and the provision of biopsychosocialspiritual supports to allow more time for older adults to adjust to the withdrawal process and deal with any anxieties or fears that they may have. It may be necessary to slow the pace of support to meet the comfort level and capacity of the individual.65

With respect to group processes (e.g. group therapy/counselling and support groups), some research indicates that older adults have better outcomes when participants are of a similar age, have a similar readiness for change, and are addressing similar types and severity of issues.66

It should be remembered, however, that not all older adults will require intensive, medically managed withdrawal management. Home/mobile and day withdrawal management programs may be suitable (and therefore preferable) for older adults who have no complex co-occurring medical needs and who have a safe “home” environment and sufficient familial or social support.67

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65 Seeking Solutions, 2004a; CSAT, 2006; Addictions Ontario, 2008; Australian Government, Department of Health and Ageing, 2009; Drew, Wilkins & Trevisan, 2010; Kalapatapu, 2010; Ayres, et al., 2012
66 Holland et al., 2016
67 Seeking Solutions, 2004a
Older adults and post-acute withdrawal symptoms:

Older adults may experience the effects of withdrawal for weeks (or months) after the initial period of acute withdrawal. Service providers should continue to provide older adults with support after the initial phase of withdrawal, because the risk of relapse is high during this period of post-acute withdrawal. Post-acute withdrawal symptoms may include confusion and difficulties with processing information. As a result, counselling sessions and/or support meetings should start after the individual’s health has stabilized and they are able to think clearly.68

Other practices for ensuring effective withdrawal management for older adults:

In addition to the considerations described above, effective withdrawal care for older adults includes:

- Taking the time to gain a clear understanding of the reason(s) why the older adult is seeking withdrawal management services;
- Being sensitive to the timing of withdrawal management support and ensuring that the individual is ready;
- Offering older adults a tour of the withdrawal management facility. (Evidence suggests that this helps orientate the older adult to their new surroundings and helps reduce any anxiety they may have about starting treatment);
- Involving family members and friends in the recovery/wellness planning process in accordance with the individual’s wishes. As appropriate, family members and friends should also be supported in accessing counselling for themselves and guidance on how best to help their older loved one;
- Working to normalize the withdrawal process by:
  - Responding appropriately to the older adult’s fears and anxiety about withdrawal and living without substances;
  - Offering emotional support; and
  - Addressing the associated stigmas.
- Offering peer-based group counselling to foster peer support and to combat feelings of loneliness and isolation;
- Providing older adults with opportunities to take on social roles or responsibilities. (Peer-led self-help groups, for example, support individuals to form social relationships and develop a sense of purpose);
- Providing the older adult with written, rather than oral information. Material should be provided to older adults in accessible formats, particularly if the individual is experiencing sensory or cognitive challenges;

68 Seeking Solutions, 2004a
• Prior to completing withdrawal, ensuring that older adults are linked to the appropriate medical supports and specialized services that accommodate their age-related needs; and

• Closely following older adults after they have completed withdrawal management so that help can be provided at the first signs of risk of relapse. (At minimum, this involves placing follow-up outreach calls).69

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69 Health Canada, 2002; Seeking Solutions, 2004a; CSAT, 2006; Kalapatapu, 2010; Van den Berg, et al., 2015
Considerations for People with Concurrent Mental Health and Substance Use Issues

Context

Concurrent disorders present particular challenges for individuals, their families and for services. Concurrent disorders present particular challenges for individuals, their families and for services.70 Having a concurrent disorder is associated with greater challenges than having either a mental health or a substance use issue on its own.71 The biopsychosocialspiritual impacts of a concurrent disorder are often more profound and complex, and individuals may encounter difficulties with navigating mental health and substance use service systems that are not well integrated.

The estimated prevalence of concurrent disorders among the adult population varies, but most studies suggest that around 50% of individuals who are seeking help for problematic substance use are also experiencing issues with mental health. Likewise, between 15 and 25% of people who are receiving support from mental health services have problematic substance use issues. The rates tend to be higher for women and for Indigenous peoples. In British Columbia, an estimated 130,000 people at any one time “meet the criteria” for concurrent mental health and substance use issues.72

Given the prevalence of concurrent disorders, it is recommended that all individuals seeking help for their substance use should be assessed for co-occurring mental health issues. In particular, screening for common conditions such as anxiety and depression should be a routine part of the screening and ongoing assessment process.73

Individuals accessing withdrawal management services are likely to have concurrent mental health issues – such issues may have preceded their substance use, or may have developed as a direct result. It is common for individuals who are accessing withdrawal support and who have concurrent disorders to be in or approaching a medical crisis, particularly as mental health issues can be exacerbated by problematic substance use. It is important to be aware that the withdrawal management process can have a negative effect on an individual’s concurrent mental health issues.

70 British Columbia, 2004
71 Matua Raki, 2008; Morisano, Babor & Robaina, 2014
72 Statistics Canada, 2003; British Columbia, 2004; CCSA, 2009
73 CSAT, 2006; Saskatchewan, 2008; Australian Department of Health and Ageing, 2009; Morisano, Babor & Robaina, 2014; Priester, et al., 2016; Webber, Clark & Kelly, 2016
Likewise, the concurrent mental health issue(s) can have a negative effect on the withdrawal management process.\textsuperscript{74}

Nevertheless, there is also evidence demonstrating that many common concurrent mental health challenges – including severe challenges such as psychosis – can be significantly improved as a result of substance use treatment.\textsuperscript{75}

**Biopsychosocialspiritual Impacts of Concurrent Disorders**

Individuals with concurrent mental health and substance use issues experience more challenges and negative outcomes across the range of medical and psychosocial domains than people who have only a mental health or substance use problem. Research shows that people with a dual diagnosis are more likely to:

- Have involvement with the criminal justice system;
- Perpetrate or experience violence; and
- Experience homelessness.

There is also a higher rate of suicide among people with concurrent disorders. In addition, rates of treatment completion are lower for people with mental health and substance use issues compared with those who have only a mental health problem.\textsuperscript{76}

**Evidence-Informed Practices for Supporting People with Concurrent Disorders**

**Provision of comprehensive, integrated services and supports**

There is a consensus across the literature that an integrated approach to treating mental health and substance use issues is the most effective. Broadly speaking, people with concurrent disorders experience better outcomes when MH and SU services and supports are integrated than they do when services are offered separately. Integrated service delivery is also more cost-effective.

The specific evidence and arguments for integrating mental health and substance use services include:

- The rate of concurrent disorders is sufficiently high to justify the integration of specialist substance use and mental health services.
- The roots of an individual’s mental health and substance use problems are often intertwined. Using substances may be a way of “coping with” a mental health problem or a mental health issue may have

\textsuperscript{74} CSAT, 2006

\textsuperscript{75} Gossop, Marsden & Stewart, 2006

\textsuperscript{76} Addictions Ontario, 2008; Ginieri-Coccosis & Liappas, 2010; Pawsey, Logan & Castle, 2011
arisen as a result of problematic substance use.

- The treatment of problematic substance use can be difficult without appropriate treatment of any concurrent mental health issues. People who are experiencing depression, anxiety, psychosis or mania are not able to participate fully in a substance use program and so may not benefit from that treatment to the extent that they otherwise might. An integrated approach helps to increase participant engagement and establish a more collaborative relationship with the service provider. These are key to the individual’s successful recovery.

- Where mental health and substance use services are offered separately, continuity of care suffers. People with concurrent disorders tend to fall through the cracks. For example, a person who is referred from one service to another may not take up the referral. Furthermore, they may run up against the challenge that different services often have different criteria for eligibility.

- Combining treatment strategies for mental health and problematic substance use provides individuals with the skills and tools to work on both domains.

- Expert substance use care providers are well positioned to help identify mental health symptoms that are likely to improve after withdrawal management and initiation of problematic substance use treatment. They also understand the limitations of some psychoactive medications in the context of substance use treatment and help prevent unsafe psychoactive medication prescribing (e.g. benzodiazepines).

In order to provide continuity of services for people with concurrent disorders, specialist mental health and substance use services need to work closely with each other. Increased communication and collaboration is essential. Coordination to enhance referral and case management across specialisms will help to ensure that people receive the full range of supports that they need to make progress on their recovery journey. Research recognizes the effectiveness of “collaborative clinician/client team model” of care in which ongoing assessment and evaluation of the individual’s wellness journey is a central component.

The provision of integrated services relies on staff receiving the appropriate training to help individuals with concurrent mental health and substance use issues. Such training should be provided not only to the staff of the respective specialized services but also to those working

“A recent qualitative study that examined barriers to client-centred treatment in rural communities found that flexible, community-based, wrap-around services that address substance use, mental health, and basic needs in an integrated way may increase the likelihood of individuals accessing treatment when significant barriers such as transportation, childcare, and geographic proximity to services in resource poor, rural communities are present.”

Priester, et al., 2016
in social service provision and correctional services who frequently encounter and work with individuals with concurrent disorders.  

**Screening and assessment for withdrawal management and ongoing treatment**

Effective treatment begins with screening all individuals who are seeking support for problematic substance use for concurrent mental health issues. Screening individuals at the beginning of the recovery journey helps to identify who will require a more comprehensive assessment for mental health issues.

Anxiety and depression are common issues, and should be routinely addressed as part of the assessment process. With the individual’s consent, service providers should review the individual’s mental health history. It may be helpful to include supportive family members and friends in this process.

A comprehensive assessment process should also seek to identify whether the concurrent mental health issues are a result of problematic substance use, or whether they represent a separate issue. Some sources also recommend that people with concurrent disorders should be regularly assessed and monitored for risk of suicide.

**Challenges for diagnosis**

The relationship between mental health issues and substance use issues presents a set of challenges for accurate diagnosis, particularly in the context of withdrawal. A key dilemma for assessment is determining whether the mental health problems that a person is experiencing are an effect of their substance use or a separate issue. Research and practice-based evidence shows that concurrent mental health issues (especially common problems such as anxiety and depression) can be a direct effect of substance use.

In addition, symptoms of a mental health disorder may also be an outcome of withdrawal. The acute effects of alcohol withdrawal, for example, can cause anxiety and depression. Studies suggest that withdrawal-associated symptoms abate after three weeks of abstinence. Experts generally recommend a period of two to four weeks abstinence before attempting to diagnose a psychiatric disorder.

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77 Saskatoon, n.d.; Matua Raki, 2008; Australian Department of Health and Ageing, 2009; Pani, et al., 2010; Lader, 2011; Pawsey, Logan & Castle, 2011; McCallum, et al., 2013; Morisano, Babor & Robaina, 2014; Priester, et al., 2016; Walton, et al., 2016; Webber, Clark & Kelly, 2016

78 Saskatchewan, 2011; Morisano, Babor & Robaina, 2014; Priester, et al., 2016; Webber, Clark & Kelly, 2016

79 Australian Department of Health and Ageing, 2009

80 CSAT, 2006; Australian Department of Health and Ageing, 2009
Psychosocial treatment and supports for people with concurrent mental health and substance use issues

The research on effective psychosocial treatment and supports for people with concurrent disorders yields some mixed conclusions. For example, a 2008 Cochrane Review of 25 randomized controlled trials on psychosocial interventions for people with concurrent severe mental health and substance use disorders concluded that there was no compelling evidence to support any one psychosocial treatment over another to reduce substance use by people with serious mental illnesses or to improve their mental wellbeing. In a 2009 review of the existing evidence on treating people with concurrent alcohol and mental health problems, the Australian Department of Health and Ageing notes that the research literature is limited in size and quality, in spite of the prevalence of concurrent disorders among people with problematic alcohol use. The authors of the review conclude that while a number of clinical trials demonstrate that psychological interventions do reduce anxiety and depression in people with concurrent disorders, there is an insufficient amount of research to demonstrate that such interventions lead to reductions in substance use or prevent relapse.

In spite of these cautions, the literature identifies a number of psychosocial interventions that have been demonstrated to have positive results for people with concurrent mental health and substance use issues. These are:

- Motivational Interviewing (MI) – has been shown to help engage and retain people in treatment and to have a positive effect on treatment outcomes generally as well as on individuals’ ability to stick with their prescribed course of medication;
- Cognitive Behavioural Therapy (CBT) – has demonstrated effectiveness in treating depression and anxiety/panic;
- Dialectical Behaviour Therapy (DBT) – has shown positive results with individuals with concurrent disorders and in particular those with borderline personality disorder;
- Behavioural Activation (BA) – has shown promising results in the treatment of depression for people with problematic substance use;
- Brief interventions – have proven effective in addressing mild forms of depression;
- Guided or facilitated self help (including the use of computer-delivered CBT) – has been shown to be effective in addressing mild

81 Cleary et al., 2008
82 Australian Department of Health and Ageing, 2009
forms depression; and

- A stepped approach using various psychosocial interventions such as self-help manuals or CBT has been proven effective for general anxiety disorder and panic disorder of variable severity.\(^{83}\)

In addition to offering or facilitating access to the interventions listed above, it has been demonstrated that providing information, support, and treatment to family members is a crucial component of care for a person with concurrent substance use and mental health issues.

As part of a broad biopsychosocialspiritual model of care for people with concurrent MH and SU challenges, service providers should help individuals to identify meaningful life goals that may provide them with a sense of reward and self-worth. Such goals may include:

- Developing new habits or coping skills;
- Working on improving social relationships and family connections;
- Establishing goals for education and/or employment; and
- Enhancing diet and nutrition and/or physical fitness.

Celebrating the small and incremental “wins” made by the individual is important. Person-centred approaches, involving a flexible combination of treatments and supports that match the severity of the individual’s challenges, help to maximize engagement and recovery.\(^{84}\)

**Psychosocial treatment and supports in the context of withdrawal management**

Since the typical stay in a withdrawal management program is four to seven days, withdrawal management is not the appropriate service through which to provide people with a full course of CBT or DBT. Nevertheless, there is a growing body of evidence suggesting that “low-intensity” interventions are effective at reducing anxiety and mild to moderate depression.\(^{85}\) Low-intensity interventions can be delivered by staff members providing routine care in substance use service settings. Such interventions typically involve less than six hours of contact time with the individual receiving treatment and are suitable therefore for delivery in the context of the withdrawal management process.\(^{86}\)

In addition, withdrawal care provides an opportunity for service providers to connect people who have a concurrent disorder with the appropriate longer-term mental health services and supports. It is crucial that the recovery/wellness plan for someone with a concurrent disorder

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\(^{83}\) CNSAAP, 2007b; UK Department of Health, 2007; Pilling, Hesketh & Mitcheson, 2010; Pawsey, Logan & Castle, 2011; Glassman, et al., 2013; Morisano, Babor & Robaina, 2014

\(^{84}\) CNSAAP, 2007b

\(^{85}\) There is no consensus definition of “low-intensity intervention”. However, the literature broadly understands the term to encompass psychological/psychosocial interventions that are: unsupported (i.e. self-help); supported, but not involving highly qualified MHSU professionals; and/or involving qualified MHSU professionals but with less than six hours of contact time per client (Rodgers, et al., 2012).

\(^{86}\) Pilling, Hesketh & Mitcheson, 2010; Rodgers, et al., 2012
includes integrated treatment and supports for both the mental health and substance use challenges that the person is experiencing.
Glossary

Acupuncture:

Acupuncture is the practice of using needles to stimulate specific sites on the skin, mucous membranes, or subcutaneous tissues of the body. Acupuncture aims to promote, maintain, or improve a person’s health, as well as alleviate pain. Acupuncture includes: manual, mechanical, thermal, and electrical stimulation using acupuncture needles; the use of laser acupuncture, magnetic therapy and acupressure; and the use of moxibustion and suction cups.

Art therapy:

Art therapy is a creative therapeutic process that combines visual art and psychotherapy as a foundation for self-exploration and understanding. Art therapy uses imagery, colour, and shape to help individuals express thoughts and feelings that may be difficult to articulate using words. The creative process of art therapy helps individuals to address their feelings, and to re-experience, resolve, and integrate any inner conflicts.

Behavioural Activation:

A formal therapy for depression, behavioural activation focuses on activity scheduling to encourage individuals to approach activities that they are avoiding and on analyzing the function of cognitive processes (e.g. rumination) that serve as a form of avoidance. In this way, the therapy refocuses individuals on their goals and directions in life.

Biopsychosocialspiritual model:

The biopsychosocialspiritual model has been developed to explain the complex interaction between the biological, psychological, social and spiritual aspects of problematic substance use. It is the model that is most widely endorsed by researchers and clinicians. The model promotes an approach to assessment that seeks to capture the full range of underlying causes of an individual’s substance use, including (but not limited to): genetic predisposition; learned behaviour; social factors, such as relationships with family, peers and the larger community; and feelings and beliefs about problematic substance use. Wellness plans developed from such assessments seek to address the impacts of substance use on an individual’s physical and mental health, social support circle, and spiritual or moral values.

Case management:

Case management is a collaborative, client-centred process that involves assessing an individual’s needs, linking them with the appropriate supports and services, monitoring their progress, and adjusting the recovery/wellness plan as necessary. Collaboration
with the individual’s primary care physician and other health care professionals is essential for successful case management. Case management helps people reach treatment goals or objectives in a complex health, social, and fiscal environment.

**Cognitive Behavioural Therapy (CBT):**

A type of psychotherapy that helps individuals to change the way that they think and behave in certain situations. It is a widely accepted therapy that can be used to treat any distressing or harmful practice or habit, and is commonly used to treat problematic substance use. CBT is a goal-orientated process, and treatments range from a few weeks to a few months in duration.

**Complementary therapies:**

Refers to a broad range of non-medical, alternative therapies that are often used to supplement or enhance conventional medical treatments and interventions, and promote overall wellbeing. Examples of such therapies include: massage, acupuncture, Tai Chi, aromatherapy and yoga.

**Concurrent Disorders:**

A person who is experiencing problematic substance use has a higher risk of having a mental health issue (and vice-versa). People who have combined substance use and mental health issues are said to have concurrent disorders. Concurrent disorders are also referred to as dual disorders, dual diagnosis, and co-occurring substance use and mental health issues.

**Contingency Management:**

Contingency management is a therapeutic tool used in substance use treatment. Contingency management reinforces (or rewards) the positive changes that an individual makes to their behavioural patterns, or to their patterns of substance use. The magnitude of the reward received by individuals typically increases with the length of time that a behaviour change is sustained.

**Developmental Counselling and Therapy (DCT):**

Focuses on supporting individuals to understand the cognitive-emotional origins of their substance use patterns and the way in which they think, perceive and remember information. It helps individuals to make sense of their relapse triggers and patterns, and how their personal history contributes to their substance use. It is a promising approach for relapse prevention.

**Dialectical Behaviour Therapy (DBT):**

A comprehensive, evidence-based, cognitive-behavioural treatment for borderline personality disorder (BPD). The standard DBT treatment package consists of weekly
individual therapy sessions (approximately 1 hour), a weekly group skills training session (approximately 1.5–2.5 hours), and a therapist consultation team meeting (approximately 1–2 hours).

**Evidence-informed:**

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

**Family:**

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

**Primary Care Providers:**

Primary care providers, which may include general practitioners (also called “family doctors” and “family physicians”) and/or nurse practitioners, assume responsibility for the provision of continuing and comprehensive medical care to individuals, families and communities.

**Harm reduction:**

Harm reduction refers to policies, programs, and practices that aim to reduce the adverse health, social, and economic consequences of substances for people who are unable or unwilling to stop using immediately. Harm reduction is a pragmatic response that focuses on keeping people immediately safe and minimizing death, disease, and injury from high-risk behaviour. It involves a range of strategies and services to enhance the knowledge, skills, resources, and supports for individuals, families and communities to be safer and healthier.

**Holistic:**

Holistic refers to the concept that promoting, protecting or restoring health requires understanding the individual as an integrated system—including physical, mental, emotional and spiritual aspects—which cannot be reduced to one or more separate parts.

**Home/mobile withdrawal management:**

Home/mobile withdrawal management programs are defined by the fact that service providers go to where the individual requiring service is located. This may be the
individual’s home, the home of a family member or friend, a shelter, a support recovery facility, or (in the case of services for youth) the home of a family who is participating in a family home care model of withdrawal management.

**Homeopathy:**

Homeopathy is a natural system of medicine that uses highly diluted doses of substances to stimulate the body’s own healing mechanism to promote health. The use of homeopathic remedies is based on the premise that natural substances are capable of curing the same symptoms that they can cause.

**Integrated care:**

Integrated care refers to the coordination of personal support networks (including family and community) with components of the health care system (such as case management). Integrated care may include multi-disciplinary teams of supporters and care providers that can facilitate collaboration among various types or levels of services in a way that promotes cultural safety and improves health outcomes.

**Limits of confidentiality:**

Confidentiality between a healthcare or social service professional and a person receiving service is not absolute. There are a number of exceptions to the obligations of confidence. In British Columbia, the legal limitations on an individual’s right to confidentiality include:

- If the individual is planning to harm themselves or others;
- If the person providing service is subpoenaed by a judge to testify in court; and
- If the individual is endangering or neglecting a child or knows of someone who is.

**Massage therapy:**

In massage therapy, a trained professional with an understanding of anatomy and physiology uses assessment and a variety of manual (e.g. kneading, rubbing, stretching) techniques to work with an individual to achieve optimum health. This includes reducing the individual’s pain and stress and increasing their range of motion.

**Mind-body therapies:**

Mind-body therapies are based on the belief that the mind is able to affect the body. They emphasize the ability of the mind to enhance body function and health. Examples of mind-body approaches include: biofeedback; creative therapies such as art or music; hypnosis; visualization; meditation; relaxation; and yoga.
Motivational Interviewing:

Motivational Interviewing (MI) is a directive, client-centred counselling style for enhancing intrinsic motivation to change by identifying and resolving ambivalence. It has been developed over the past 30 years or so by William Miller and Stephen Rollnick. Although originally developed for people with problematic alcohol use, MI has been used with a wide range of behaviours and populations, including substance use in general, eating disorders, smoking, mental health issues, criminal justice populations, and couples counselling.

Music therapy:

Music therapy is the use of music and musical elements by an accredited music therapist to promote, maintain, and restore mental, physical, emotional, and spiritual health. Music has nonverbal, creative, structural, and emotional qualities. These are used in the therapeutic relationship to facilitate contact, interaction, self-awareness, learning, self-expression, communication, and personal development.

Pharmacotherapy:

The treatment of disease through the administration of drugs.

Polysubstance use:

Polysubstance use is defined as the use of different substances on the same or different occasion. Polysubstance use is common, with many people using alcohol, tobacco and cannabis in some combination or along with other illicit substances.

Post-Acute Withdrawal Syndrome:

There are two stages of withdrawal: the acute stage (which lasts at most for a few weeks) and the post-acute stage (which can last for two years). Most people experience some post-acute withdrawal symptoms. The most common symptoms are: mood swings; anxiety; irritability; tiredness; variable energy; lack of enthusiasm; variable concentration; and disturbed sleep.

Prescribed medication:

A medication that has been prescribed by an authorized physician or nurse practitioner for a client.

Peer mentoring:

Mentoring is a relationship between an experienced person and a less experienced person for the purpose of helping the one with less experience. Peer mentoring assigns mentees to someone with experience who is comparable to them in a number of possible realms, including: age; personal experiences; substance use history; social background; treatment goals; and preferences.
Primary care:

Primary care involves the widest scope of health care, including all ages of patients, patients of all socioeconomic and geographic origins, patients seeking to maintain optimal health, and patients with all manner of acute and chronic physical, mental and social health issues, including multiple chronic diseases. Continuity is a key characteristic of primary care, as patients usually prefer to consult the same practitioner for routine check-ups and preventive care, health education, and when they require an initial consultation about a new health problem. Collaboration among providers is a desirable characteristic of primary care.

Problematic substance use:

Problematic substance use refers to psychoactive substance use that results in or increases risks for physical, psychological, economic, social or other problems for individuals, families/friends, communities or society. The most commonly recognized type of problematic substance use is chronic dependent use, or addiction, but other instances or patterns of use can also be problematic. For example, youth substance use at an early age, substance-impaired driving, substance use during pregnancy, and using a psychoactive medication other than as prescribed by a physician are all types of problematic use. Problematic substance use is not necessarily dependent on the legal status of the substance used, but rather on the amount used, the pattern of use, the context in which it is used and, ultimately, the potential for harm.

Psychosocial treatments:

The term psychosocial refers to an individual’s psychological development in and interaction with their social environment. Psychosocial treatments (interventions) include structured counselling, motivational enhancement, case management, care-coordination, psychotherapy, and relapse prevention.

Recovery / wellness plan:

The recovery/wellness plan is a written document developed collaboratively between a clinician and the individual receiving service for the purpose of informing the individual’s course of treatment. Typically, the recovery planning process involves the identification of short- and long-term goals for treatment and care; the most appropriate interventions to meet the individual’s needs and preferences; and any perceived barriers to treatment. The plan is a living document in which the individual’s progress, as well as their changing needs and situation, are recorded.

Reflective listening:

Reflective listening involves two key steps: listening intently to a speaker and then verbally offering the idea back to the speaker. Reflective listening: ensures that the listener is actively engaged in the conversation; helps the listener and the speaker clarify
their understanding of each other; creates empathy; and builds rapport and a deepening relationship between the speaker and listener.

**Relapse:**

In the context of substance use, relapse refers to the process of returning to the use of alcohol or drugs after a period of abstinence. Relapse is possible no matter how long an individual has been abstinent and is most helpfully interpreted as a normal part of the recovery journey.

**Relapse Prevention:**

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

**Residential Substance Use Treatment:**

Residential treatment facilities provide time-limited treatment in structured, substance-free, live-in environments. Individuals accessing these services are most likely to be those with more complex and/or chronic substance use for whom community-based treatment services have not been effective.

**Self-help groups:**

Self-help group programs provide peer support for people who are seeking to overcome their problematic substance use. They include such step-based programs as 12-step, 16-step, and SMART Recovery.

**Sleep hygiene:**

The habits, practices and environmental factors that are conducive to sleeping well on a regular basis.

**Stages of Change model:**

The Stages of Change model conceptualizes behaviour change as a process that unfolds over time and involves progression through a series of five stages: pre-contemplation, contemplation, preparation, action, and maintenance.

**Stigma:**

Stigma in the domain of mental wellness and substance use refers to the beliefs and attitudes about people living with mental illness and/or problematic substance use that lead to negative stereotyping and prejudice against individuals and their families. These beliefs are often based on ignorance, misunderstanding and misinformation. A related
concept, discrimination, refers to the various ways in which people, organizations, and institutions unfairly treat people living with a mental wellness or substance use problem. Such discrimination is often based on stigmatizing beliefs and attitudes.

**Supportive counselling:**

Supportive counselling is a therapeutic approach aimed at facilitating optimal adjustment either to situations of ongoing stress or to acutely stressful circumstances. Supportive counselling may consist of a large number of regular contacts over a long period of time or a few extended consultations over a relatively brief period. The main practical components of supportive counselling include: empathy; sympathetic listening; encouragement; explanation and education; reassurance; guidance; practical help and sometimes Cognitive Behaviour Therapy.

**Tobacco cessation programs:**

Programs designed to help people stop smoking or using other tobacco products by providing free or subsidized tobacco cessation aids. Such aids include prescription smoking cessation drugs (e.g. bupropion and varenicline) and non-prescription nicotine replacement therapy gum or patches.

**Traditional Chinese medicine:**

Traditional Chinese medicine refers to the application of Chinese medicine theory to promote, maintain, and restore health and wellbeing. Chinese medicine includes the following therapies: Chinese acupuncture, moxibustion, and suction cup; Chinese manipulative therapy; Chinese energy control therapy; Chinese rehabilitation exercises such as Chinese shadow boxing; and prescribing, compounding, or dispensing Chinese herbal formulas and therapeutic food recipes.

**Trauma:**

Trauma is defined as experience that overwhelms an individual’s capacity to cope. Trauma can include events experienced early in life – for example, as a result of child abuse, neglect, disrupted attachment or witnessing violence – or later in life, such as violence, accidents, natural disasters, war, sudden unexpected loss and other life events that are out of one’s control. Trauma can be devastating and can interfere with a person’s sense of safety, self and self-efficacy, as well as the ability to regulate emotions and navigate relationships. Traumatized people may feel terror, shame, helplessness and powerlessness, and may engage in problematic substance use or other unhealthy behaviours as a way to cope. Understanding the roots and effects of trauma is important for health and human service providers to help establish a sense of safety and connection with the people they are serving and supporting.
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Appendix: Resources

A Guideline for the Clinical Management of Opioid Use Disorder (BC Centre on Substance Use, 2017)

A Path Forward: BC First Nations and Aboriginal People’s Mental Wellness and Substance Use 10 Year Plan (British Columbia, 2013)
http://www.fnhc.ca/pdf/FNHA_MWSU.pdf

A Systems Approach to Substance Use in Canada: Recommendations for a National Treatment Strategy (Ottawa, 2008)

Best Practice Recommendations for Canadian Harm Reduction Programs that Provide Service to People Who Use Drugs and Are At Risk for HIV, HCV, and Other Harms: Parts 1 & 2 (Working Group on Best Practice for Harm Reduction Programs in Canada, 2013)

CARF, Behavioural Standards Manual (2016)
Available for purchase at:

CCSA, Competencies for Canada's Substance Abuse Workforce (2014)
http://www.ccsa.ca/Eng/topics/Workforce-Development/Workforce-Competencies/Pages/default.aspx

Community Care and Assisted Living Act (British Columbia)
http://www.bclaws.ca

Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use and Addiction (British Columbia, 2004)

Families at the Centre: Reducing the Impact of Mental Health and Substance Use Problems on
http://www2.gov.bc.ca/assets/gov/health/managing-your-health/mental-health-substance-use/child-teen-mental-health/families_at_the_centre_full_version.pdf

Harm Reduction: A British Columbia Community Guide (British Columbia, 2005)

Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia (British Columbia, 2010)

Residential Care Regulation (RCR) (British Columbia)
http://www.bclaws.ca

Service Model and Provincial Standards for Adult Residential Substance Use Services (British Columbia, 2011)

Setting Priorities for the B.C. Health System (British Columbia, 2014)

Toward the Heart, project of the Provincial Harm Reduction Program (British Columbia)
http://www.towardtheheart.com

Trauma-Informed Practice Guide (British Columbia, 2013)