Withdrawal Management

Protocols/Guidelines and Services

Government of Saskatchewan

The College of Family Physicians of Canada

College of Physicians and Surgeons of Saskatchewan

Complied by the Addictions Medical Advisory Committee
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Introduction

The following are the general treatment guidelines and suggested withdrawal management protocols for alcohol, benzodiazepines, opiates and cocaine. This document is meant to serve as a reference for physicians' use in treating detoxification resulting from chronic substance use.

These guidelines should be implemented only after appropriate clinical assessment has taken place including history, physical examination, laboratory investigations and toxicology screens. One should be cautioned that the history regarding the substance(s) used may not always be accurate. Once stabilised, patients are encouraged to attend local Alcohol and Drug Services (Please refer to Appendix D).

The protocols have been developed by the Addictions Medicine Advisory Committee, the members of which represent Family Medicine, Pharmacology, Psychiatry, Saskatchewan Health and Alcohol and Drug Services across the province. This committee was established in 1997 in order to fulfill an obligation to clients to keep current in the medical aspects of chemical dependency and to begin to establish medical protocols/guidelines in chemical dependency treatment. In addition, this committee acts as a consultative resource for health districts and health professionals.

Definitions

Substance Withdrawal: The signs and symptoms experienced when the use of a substance is ceased. These tend to be the opposite of the effects of the drug itself**.**

Treatment Context / Setting: Guidelines for treatment within the following treatment settings will be referred to throughout this document.

- **Outpatient** - indicated when there is good family support or other support systems in place.
- **Residential Social (Non-hospital) Detoxification Program** - indicated for individuals with an inadequate support system.
- **Inpatient Medical** - indicated where medical complications are present or anticipated.
- **Inpatient Psychiatric** - indicated for individuals with concurrent unstable psychiatric disorders.

1. Alcohol

1.1 Alcohol Withdrawal Symptoms

Withdrawal Status	Signs and Symptoms
Stage I **Mild Withdrawal**	• Slight tremors • Sweating • Feelings of apprehension • Slight increase in heart rate, blood pressure and respiration • Decreased appetite
Stage II **Moderate Withdrawal**	• Coarse tremor • Increased heart rate, blood pressure and respiration • Sweating • Gastrointestinal tract distress • Agitation • Insomnia
Stage III **Severe Withdrawal**	• Marked agitation • Tremor • Elevation of vital signs and autonomic activity • Alcoholic hallucinosis • Seizures • Insomnia • Sensory distortion
Stage IV **Acute Medical**	• Uncontrollable agitation • Gross tremulousness • Anxiety • Severe autonomic activity • Disorientation, delirium • Seizures • Delirium tremens • Death

**Based on information provided by, and used with the permission of, the Province of Nova Scotia "Treatment and Rehabilitation Manual."*

1.2 Management of Alcohol Withdrawal

Protocol

I. Benzodiazepines

Indications

- May be used during any withdrawal phase, as required. Caution should be exercised with repeated use due to the frequency of poly-substance abuse.

Note: Benzodiazepines may potentiate respiratory depression produced by alcohol, barbiturates and opiates. DO NOT COMMENCE within 12 hours of the last drink. Use prn for 7 days.

a) ***Diazepam*** *- Drug of choice*

Advantages

- Long half-life
- Rapid absorption
- Small dosage numbers
- Wide use - most family physicians are familiar with it
- Anti-seizure effects
- Can be used alone

Dosage

Outpatient

- Diazepam - patient weight: 76 kgs or less, 20 mgs per hour po for the first 3 hours
  76 to 90 kgs, 20 mgs per hour po for the first 4 hours
  over 90 kgs, 20 mgs per hour po for the first 5 hours

N.B. This is the maximum recommended dosage.

Residential Social Detoxification

- Diazepam - exactly the same as Outpatient protocol. Other anti-convulsants are generally not necessary.

Inpatient Medical

- Diazepam - 0.1 mg per kg IV, give the first dose slowly over 3 to 5 minutes.
- Then give 5 to 10 mg IV q 1 hr prn, reverting to oral recommendations as above.
- Treat GI symptoms as necessary.

Inpatient Psychiatric

- Diazepam - 10 to 20 mgs po q 1-2 hrs prn [HR >100 and diastolic B/P >100 are often used as objective measures of withdrawal].

I. Benzodiazepines (con't)

b) ***Lorazepam*** - *Drug of second choice*

Advantages

- Multiple routes of administration
- Ease of administration
- Speed of onset
- Useful in elderly and in hepatic complications
- Dosage of lorazepam would be approximately 0.2 x that of diazepam

c) ***Chlordiazepozide*** - *Drug of third choice*

Aspects

- Variable absorption
- Dosage of chlordiazepozide would be approximately 2 x that of diazepam

II. Beta Blockers

Indications
- Used in Stage II through Stage IV for tremors and tachycardia.
- Tend to be used in conjunction with benzodiazepines.

a) ***Atenolol***

Advantages
- Has been shown to have advantages over other beta-blockers in alcohol withdrawal treatment.

Contraindications
- Congestive heart failure, diabetes and asthma **must** be ruled out.

Dosage

Outpatient
- Atenolol - 50 mg po od for 7 days.

Residential Social Detox
- Atenolol - 50 mg po od for 7 days.

Inpatient Medical
- Propranolol - 1 mg IM or IV can be administered every 15 minutes up to a maximum of 4 mg during the Acute Medical Stage. **Vital signs must be monitored.** Switch back to oral atenolol as soon as possible if a beta-blocker still needed.

Inpatient Psychiatric
- Beta-blockers - same protocol as Inpatient Medical.

III. Neuroleptics (Major Tranquilizers)

Indications
- For treatment of anticipated Stage III and Stage IV symptoms of alcohol withdrawal.
- Used in conjunction with benzodiazepines.

a) ***Haloperidol***

Advantages
- Does not lower the seizure threshold as much as other neuroleptics have been shown to do

Disadvantages
- Potential extrapyramidal side effects
- Dystonia
- These can usually be reversed with Cogentin® or Benadryl® respectively

Dosage

Inpatient Medical
- Haloperidol - 2 to 10 mg q 12 h po IM or IV.
- May be combined with benzodiazepines.

Inpatient Psychiatric
- Same as Inpatient Medical.
- Other psychiatric medications as indicated.

IV. Nutrition and Hydration

Make sure independent assessment is completed by health care personelle.

Outpatient
- Multi-vitamins.
- Thiamine 100 mg po od.

Residential Social Detoxification
- Multi-vitamins.
- Thiamine 100 mg po od.

Inpatient Medical
- IV fluid as indicated.
- Glucose 25 g IV prn .
- Multi-vitamins.
- Thiamine 100 mg IV or po od.

Inpatient psychiatric
- Same as Inpatient Medical.
- Thiamine 100 mg IV or IM x1, then 100 mg po od.

2. Benzodiazepines

2.1 High Dose Benzodiazepine Withdrawal Signs and Symptoms

Withdrawal Status	Signs and Symptoms
Stage I **Minor Withdrawal**	• Anxiety • Insomnia • Tremor of the hands and fingers • Dilated pupils • Progressive weakness • Dizziness • Visual illusions • Nausea/vomiting • Weight loss • Orthostatic hypertension
Stage II **Major Withdrawal**	• Tonic clonic seizures • Delirium • Confusion • Disorientation • Agitation • Markedly elevated vital signs • Visual hallucinations

**Based on information provided by, and used with the permission of, the Province of Nova Scotia "Treatment and Rehabilitation Manual*

2.2 Management of Benzodiazepine Withdrawal

Protocol

- If the patient is using short half-life benzodiazepines (see conversion table page 12), switch to long half-life benzodiazepines (diazepam) and withdraw slowly (decrease by 10% of the dose per week or every other week).

- For example: If a patient is using alprazolam at 5 mg per day then begin with diazepam at 50 mg per day (10 x 5 mg : conversion factor times daily dose) and reduce by 5 mg per day for the next 1 - 2 weeks, then 4 - 5 mgs per day for 1 to 2 weeks and so on with 10% stepped reductions. At 15 mgs per day decrease at 1 mg per day for 1 to 2 weeks until finished.

- Most patients will have difficulty controlling their use. Dispense weekly, or, if the pharmacist and patient are willing, every one to three days to provide a measure of external control.

- Highly motivated individuals could be withdrawn more rapidly once converted to a diazepam equivalent regimen.

- An SSRI can be used to treat a pre-existing mood disorder, and can be initiated at any time during the withdrawal process.

Diazepam Conversion Table

DRUG NAME (®originator)	ACTIVE METABOLITES	PLASMA HALF-LIFE (Hours)	TOTAL HALF-LIFE **(A)** (Hours)	DIAZEPAM CONVERSION FACTOR **(B)**
alprazolam ®Xanax	yes	10 to 14	20 to 28	10
bromazepam ®Lectopam	no	8 to 19	8 to 19	0.83
chlordiazepoxide ®Librium	yes	7 to 13	85 to 185	0.5
clobazam ® Frisium	yes	10 to 30	45 to 75	0.5
clonazepam ® Rivotril	no	18 to 28	18 to 28	5
clorazepate ®Tranxene	yes	1 to 3	45 to 115	0.66
diazepam ®Valium	yes	30 to 56	75 to 170	1
flumazenil ® Anexate **(C)**	no	**1 (i.v.)**	1	n.a.
flurazepam ® Dalmane	yes	first pass	50 to 100	0.33
lorazepam ® Ativan	no	9 to 19	9 to 19	5
nitrazepam ® Mogadon	no	23 to 29	23 to 29	1
oxazepam ® Serax	no	6 to 10	6 to 10	0.33
temazepam ® Restoril	no	5 to 17	5 to 17	0.33
triazolam ® Halcion	no	2 to 4	2 to 4	20

(A) elimination half-life of parent drug plus half-lives of any active metabolites

(B) daily dose of the drug multiplied by diazepam conversion factor gives equivalent dose of diazepam

(C) flumazenil reverses the actions of the other benzodiazepines and may be used in benzodiazepine overdose. Caution: may precipitate seizures

**Based on the Benzodiazepine Equivalent table noted in the 2000 CPS p.188*

3. Opiates

3.1 Opiate Withdrawal Symptoms

Withdrawal Status	Signs and Symptoms
Stage I *Onset*: within hours of last dose *Peak*: 36 to 72 hours	• Craving for the drug • Tearing • Running nose • Yawning • Sweating • Dysphoria
Stage II *Onset*: about 12 hours *Peak*: 72 hours	• Mild to moderate sleep disturbances • Dilated pupils • Loss of appetite • Piloerection • Irritability • Tremor
Stage III *Onset*: about 24 to 36 hours *Peak*: about 72 hours	• Severe insomnia • Violent yawning • Weakness • Nausea, vomiting, diarrhea • Chills, fever • Muscle spasms, especially in the lower extremities • Flushing • Spontaneous ejaculation • Abdominal pain

**Based on information provided by, and used with the permission of, the Province of Nova Scotia "Treatment and Rehabilitation Manual."*

3.2 Management of Opiate Withdrawal

Protocol

a) Codeine, or Acetaminophen plus Codeine

Indications
- Appropriate at Stage I, II or III to reduce symptoms.

Contraindications
- Since one can not determine the amount of acetaminophen the patient might have on board prior to commencing treatment, codeine 60 mg may be preferable to acetaminophen plus codeine.

Dosage
- Codeine - 30 mg x 2 po qid, and reduce by 30 mg every 24 hours until completed.
- Dimenhydrinate (®Gravol) for nausea.

b) Clonidine

Indications
- Can be used alone, or in combination with either codeine or methadone, to reduce symptoms.

Dosage
- Clonidine - 0.1 mg qid for 3 to 4 days, then discontinue. May be used up to 8 days in some settings, decreasing by 0.1 mg per day q1-2 days.
- Dimenhydrinate for nausea as needed .
- Non-steroidal anti-inflammatories for pain as needed.

c) Methadone

Indications
- Appropriate at Stage I, II or III, to reduce symptoms.

N.B. Special licensing required.

Dosage
- Low dose therapy.
- Methadone - 10 mg tid for three days then taper by 10 mg per day (Methadone related deaths have occurred, almost exclusively at doses in excess of 30 mgs per day. Reference Ball and Ross).
- 5 mg on final day.
- ®Gravol for nausea.

4. Cocaine

4.1 Cocaine Withdrawal Symptoms

Withdrawal Status	Signs and Symptoms
Stage I Crash Begins within hours and lasts four days	• Agitation • Marked dysphoria • Fatigue • Hypersomnolence • Hyperphagia • Anorexia • Dysphoria
Stage II Begins after four days and lasts 1 to 10 weeks	*First Week:* • Normal sleep • Euthymia • Little anxiety • Minimal cocaine craving *The following can be anticipated in subsequent weeks* • Anhedonia • Increasing anxiety • Panic • Depression • Loss of energy • Extreme cocaine craving • Relapse is likely to occur during this period
Stage III Begins after 1 to 10 weeks May last for months to years	• Cocaine craving with reminders of past cocaine use • Desire for cocaine abates with time

**Based on information provided by, and used with the permission of, the Province of Nova Scotia "Treatment and Rehabilitation Manual."*

4.2 Management of Cocaine Withdrawal

- Management of cocaine withdrawal consists of dealing with the symptoms presented in the stages of withdrawal. Appropriate medications for the treatment of symptoms can be used as felt necessary, however, **prolonged benzodiazepine use, as with alcohol use, may induce euphoric recall and/or reduce impulse control resulting in relapse.**

- Pharmacological intervention is not routinely required for acute symptoms unless associated with cardiovascular complications. (Cocaine is rapidly metabolized and acute cardiac ischemia, cardiac failure, hypertension or tachycardia from acute intoxication may be present in immediate "withdrawal.")

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APPENDIX A
BENZODIAZEPINES

The benzodiazepines are a large family of compounds that act as agonists on specific receptors on cell membranes. Although the endogenous compound that stimulates these receptors has not yet been identified, the receptors themselves have been quite well characterized. So far, two subtypes of benzodiazepine receptors, referred to as BZ-1 and BZ-2, have been shown to be part of the GABA-A receptor. GABA is the major inhibitory neurotransmitter in the brain. Activation of the GABA-A receptor opens a chloride ion channel in the nerve membrane, which allows negatively charged chloride ions to enter the neuron. This increases the negative charge inside the neuron and reduces or blocks the transmission of action potentials. Stimulation of the BZ receptors increases the affinity of the GABA receptors for GABA and increases the amount of time the chloride channel stays open. Thus, the benzodiazepines potentiate GABA's inhibitory control over nerve impulse traffic. Clinical situations in which augmenting GABA inhibition can be beneficial include anxiety, insomnia and epilepsy.

Continuous exposure of a receptor to its agonist results in a reduction in the number of those receptors. When the receptors have been downregulated, the agonist has less of an effect and, if that agonist was being used for its therapeutic action, we say that the patient has developed tolerance to the direct drug effect. In general, it takes about three weeks for maximal receptor downregulation/tolerance to develop. Conversely, if the drug is withdrawn after tolerance has developed, it takes two to three weeks for the receptors to return to their pre-drug state. During withdrawal, the person experiences the exact opposite of the direct drug effects. Since the benzodiazepines reduce anxiety, produce sleep and reduce seizures, the benzodiazepine withdrawal syndrome includes increased anxiety, insomnia and convulsions. When a person stops taking a drug, that drug is cleared from the body over a period of time corresponding to 3 to 5 times the plasma clearance half-life of that drug. Since it takes several weeks for the receptors to return to their predrug state, but less than 1 day for short half-life drugs to be completely eliminated from-lives than with drugs having long half-lives. When a person who has developed tolerance to a short half-life drug, such as triazolam or oxazepam, is to be withdrawn from that drug, substituting a long half-life drug, such as diazepam, from the same family will reduce the severity and the risks of withdrawal.

APPENDIX B
OPIOID ANALGESICS

Formerly known as narcotic analgesics, the opioid analgesics are compounds that act as agonists on the receptors for the endorphin family of neurotransmitters. The four endorphin neurotransmitters are endorphin, leucine-enkephalin, methionine-enkephalin and dynorphin. These endorphin neurotransmitters, also referred to as the endogenous opioid neuropeptides, are the products of 3 separate genes. To date, 3 classes of opioid receptors, called mu, delta and kappa, have been characterized, and each class has several subtypes. The endogenous opioid neuropeptides are inhibitory neurotransmitters and they reduce impulse traffic in neural pathways involved in anxiety and in the processing of pain sensory information. Most of the older narcotic analgesics, such as morphine, codeine and their synthetic relatives diamorphine, meperidine and methadone, are predominantly mu agonists but also stimulate delta and kappa receptors as well. Butorphanol, nalbuphine and pentazocine stimulate kappa receptors but block mu receptors, and so are mixed agonist/antagonist analgesics. Among the consequences attributed to mu receptor stimulation are euphoria, analgesia, respiratory (and cough) suppression, and constipation. Delta and kappa stimulation produce analgesia and 'depersonalization,' a mind-body separation that results in an 'out of body' experience.

Continuous exposure of a receptor to its agonist results in a reduction in the number of those receptors. When the receptors have been downregulated, the agonist has less of an effect and, if that agonist was being used for its therapeutic action, we say that the patient has developed tolerance to the direct drug effect. In general, it takes about three weeks for maximal receptor downregulation/tolerance to develop. Conversely, if the drug is withdrawn after tolerance has developed, it takes two to three weeks for the receptors to return to their pre-drug state. During withdrawal, the person experiences the exact opposite of the direct drug effects. Since the opioids reduce anxiety and pain, and produce euphoria and a sense of relaxed well being, the opioid withdrawal syndrome includes increased anxiety, hyperalgesia, dysphoria and agitation. When a person stops taking a drug, that drug is cleared from the body over a period of time corresponding to 3 to 5 times the plasma clearance half-life of that drug. Since it takes several weeks for the receptors to return to their predrug state, but less than 1 day for short half-life drugs to be completely eliminated from the body, the symptoms of withdrawal are much more severe with drugs having short half-lives than with drugs having long half-lives. When a person who has developed tolerance to a short half-life drug, such as morphine or heroin, is to be withdrawn from that drug, substituting a long half-life drug from the same family, such as methadone, will reduce the severity and the risks of withdrawal.

APPENDIX C
OPIOID ANALGESICS
APPROXIMATE ANALGESIC EQUIVALENCES [1]

Drug	Equivalent Dose(mg) **(A)** (compared to 10 mg morphine IM)		Duration of Action (hours)
	Parenteral	**Oral**	
Strong Opioid Agonists			
morphine (single dose)	10	60	3-4
(chronic dose)	10	20-30**(B)**	3-4
fentanyl	0.1-0.2	None	.5-2 hours
hydromorphone	1.5-2	6-7.5	2-4
anileridine	25	75	2-3
levorphanol	2	4	4-8
meperidine **(C)**	75	300	1-3
oxymorphone	1.5	5(rectal)	3-4
methadone **(D)**			
heroin	5-8	10-15	3-4
Weak Opioid Agonists			
codeine	120	200	3-4
oxycodone	5-10	10-15	2-4
propoxyphene	50	100	2-4
Mixed Agonist-Antagonists (E)			
pentazocine	60	180	3-4
nalbuphine	10		3-6
butorphanol	2		3-4

A Most of these data were derived from single-episode, acute pain studies and should be considered an approximation for selection of doses when treating chronic pain.

B For acute pain, the oral dose of morphine is 6 times the injectable dose. However, for chronic dosing, this ratio becomes 2 to 3 times, possibly due to the accumulation of active metabolites.

C This drug is not recommended for the management of chronic pain.

D Extremely variable equianalgesic dose. Patients should undergo personalized titration starting at a dose equivalent to 10% of the morphine dose.

E Mixed agonist-antagonists can precipitate withdrawal in patients on pure agonist opioids.

(1) Compendium of Pharmaceuticals and Specialties Thirty-Fifth Edition 2000 p 980

APPENDIX D

ADDICTION RESEARCH FOUNDATION CLINICAL INSTITUE WITHDRAWAL ASSESSMENT FOR ALCOHOL

Patient: _____Date_____Time: _____.(24 hr)

Pulse or heart rate, taken for one minute: _____Blood pressure: _____

Nausea and Vomiting: Ask "Do you feel sick to your stomach? Have you vomited?" Observation: 0 no nausea and no vomiting 1 mild nausea with no vomiting 2 3 4 intermittent nausea with dry heaves 5 6 7 constant nausea, frequent dry heaves and vomiting	**Tactile disturbances** Ask "have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation: 0 none 1 very mild itching, pins and needles, burning or numbness 2 mild itching, pins and needles, burning or numbness 3 moderate itching, pins and needles, burning or numbness 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations
Tremor Arms extended and fingers spread apart. Observation: 0 no tremor 1 not visible, but can be felt fintertip to fingertip 2 3 4 moderate, with patient's arms extended 5 6 7 severe, even with arms not extended	**Auditory disturbances** Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation: 0 not present 1 very mild harshness or ability to frighten 2 mild harshness or ability to frighten 3 moderate harshness or ability to frighten 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations
Paroxysmal Sweats Observation: 0 no sweat visible 1 barely perceptible sweating, palms moist 2 3 4 beads of sweat obvious on forehead 5 6 7 drenching sweats	**Visual Disturbances** Ask, "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there? Observation: 0 not present 1 very mild sensitivity 2 mild sensitivity 3 moderate sensitivity 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations
Anxiety Observation: 0 no anxiety 1 mild anxious 2 3 4 moderately anxious, or guarded, so anxiety is inferred 5 6 7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions	**Headache, fullness in head** Ask, "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity. 0 not present 1 very mild 2 mild 3 moderate 4 moderately severe 5 severe 6 very severe 7 extremely severe
Agitation Observation: 0 normal activity 1 somewhat more than normal activity 2 3 4 moderate fidgety and restless 5 6 7 paces back and forth during most of the interview, or constantly thrashes about	**Orientation and clouding of sensorium** Ask, "What day is this? Where are you? Who am I? 0 oriented and can do serial additions 1 cannot do serial additions or is uncertain about date 2 disoriented for date by no more than 2 calendar days 3 disoriented for date by more than 2 calendar days 4 disoriented for place/or person

Total: CIWA-Ar Score _____Rater's Initials _____Maximum possible score: 67. The maximum score is 67 (see instrument). Patients scoring less than 10 do not usually need additional medication for withdrawal.

APPENDIX E
Alcohol and Drug Services

Saskatchewan offers a full range of recovery services for individuals and their families who have problems because of alcohol and/or other drug use. Outpatient services are available in each of Saskatchewan's 32 health districts as well as through a number of community-based organizations located throughout the province. Inpatient, detoxification and long term residential facilities are also available in several health districts.

Services available include:

- **Outpatient Service**

  Outpatient service agencies are the starting point for families and individuals concerned about their own, or others', use of alcohol or other drugs. Most people with substance use problems can be adequately helped on an outpatient basis. Outpatient services are available in every health district. Qualified addictions rehabilitation counselors provide a wide range of services, including assessments, intensive one on one and group counseling, education and support. Clients that attend outpatient appointments carry on with their day to day activities, such as working, school and caring for the family.

- **Detoxification Services**

  For people with more severe substance use problems, recovery often begins in a detoxification facility. Staff at these facilities work to provide a safe and comfortable environment in which the client is able to undergo the process of alcohol and other drug withdrawal and stabilization. Usually, detoxification lasts seven to ten days. During this time, clients may be required to attend self-help groups such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA), and participate in activities held at the facility.

Inpatient Services

Some people may require inpatient services. These programs offer activities similar to those of outpatient services, but on a more structured and intensive basis, with the client actually living at the facility. These programs usually last about four weeks, but may be longer depending on individual needs.

Long Term Residential Services

Many people with substance use problems require assistance in other life areas as well. Long term residential facilities provide services for a more extended period to individuals recovering from chemical dependency and addiction. These facilities offer counseling, education and relapse prevention in safe and supportive environment. Life skills training, which allows clients to further develop and enhance the skills needed for successfully building recovery, is also an important service offered at such facilities.

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OUTPATIENT SERVICES

Assiniboine Valley Health District
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Fax: (306) 563-5134

Battlefords Health District
Battlefords District Addictions Services
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Central Plains Health District
George Bailey Centre*
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Phone: (306) 822-2020
Fax: (306) 822-2441

Living Sky Health District
Addictions Services
Box 1060
Lanigan, Saskatchewan
S0K 2M0
Phone: (306) 365-1438
Fax: (306) 365-2099

Lloydminster Health District
Walter A. "Slim" Thorpe Recovery Centre
4204 - 54th Avenue
Lloydminster, Alberta
T9V 2R6
Phone: (780) 875-8890
Fax: (780) 875-2161

Mamawetan - Churchill River
Alcohol and Drug Programs
Box 6000
La Ronge, Saskatchewan
S0J 1L0
Phone: (306) 425-4840
Fax: (306) 425-8514

CADAC Outpatient Centre*
Alcohol and Drug Programs
Box 760
Creighton, Saskatchewan
S0P 0A0
Phone: (306) 688-8291
Fax: (306) 688-3784

Sandy Bay Outpatient Centre*
Alcohol and Drug Programs
Box 40
Sandy Bay, Saskatchewan
S0P 0G0
Phone: (306) 754-2050
Fax: (306) 754-2048

Midwest Health District
Alcohol and Drug Services
Box 1300
Rosetown, Saskatchewan
S0L 2V0
Phone: (306) 882-6413
Fax: (306) 882-6474

Moose Jaw/Thunder Creek Health District
Addictions Services
#116 - 110 Ominica Street
Moose Jaw, Saskatchewan
S6H 6V2
Phone: (306) 691-6495
Fax: (306) 691-6499

Moose Mountain Health District
Moose Mountain Alcohol and Drug Outpatient Centre*
Box 699
Kipling, Saskatchewan
S0G 2S0
Phone: (306) 736-2363
Fax: (306) 736-2271

North Central Health District
Addictions Services
Box 1480
Melfort, Saskatchewan
S0E 1A0
Phone: (306) 752-8747
Fax: (306) 752-8711

North-East Health District
Alcohol and Drug Services
Box 340
Nipawin, Saskatchewan
S0E 1E0
Phone: (306) 862-0760
Fax: (306) 862-2277

Pine Island Out-Patient Crisis Centre*
Box 218
Cumberland House, Saskatchewan
S0E 0S0
Phone: (306) 888-2155
Fax: (306) 888-4633

North Valley Health District
Saul Cohen Centre*
Box 164
Melville, Saskatchewan
S0A 2P0
Phone: (306) 728-2629
Fax: (306) 728-5569

Northwest Health District
Robert Simard Centre*
#3, 711 Centre Street
Meadow Lake, Saskatchewan
S9X 1E6
Phone: (306) 236-1540
Fax: (306) 236-4409

Parkland Health District
Addictions Services
Box 69
Spiritwood, Saskatchewan
S0J 2M0
Phone: (306) 883-3344
Fax: (306) 883-3329

Pasquia Health District
Hudson Bay and District Assessment and Resource Service*
Box 898
Hudson Bay, Saskatchewan
S0E 0Y0
Phone: (306) 865-4211
Fax: (306) 865-2141

Pasquia District Health Board
Addiction Services
Box 1525
Tisdale, Saskatchewan
S0E 1T0
Phone: (306) 873-3012
Fax: (306) 873-4240

Pipestone Health District
Alcohol and Drug Services
Box 970
Grenfell, Saskatchewan
S0G 2B0
Phone: (306) 697-4000
Fax: (306) 697-2686

Prairie West Health District
Danny Fisher Centre*
Box 1688
111 1st Avenue East
Kindersley, Saskatchewan
S0L 1S0
Phone: (306) 463-4464
Fax: (306) 463-4466

Prince Albert Health District
Addiction Services
101 - 15th Street East
Prince Albert, Saskatchewan
S6V 1G1
Phone: (306) 765-6550
Fax: (306) 765-6554

PACADA Addiction Services*
101-15`" Street East
Prince Albert, Saskatchewan
S6V 1G1
Phone: (306) 765-6550
Fax: (306) 765-6554

Regina Health District
Alcohol & Drug Services
2110 Hamilton Street
Regina, Saskatchewan
S4P 2E3
Phone: (306) 766-7910
Fax: (306) 766-7909

Rolling Hills Health District
Alcohol and Drug Services
Vanguard Health Centre
Box 190
Vanguard, Saskatchewan
S0N 2V0
Phone: (306) 582-2056
Fax: (306) 582-4833

Saskatoon District Health
Addiction Services
8th Floor, 122 Third Avenue North
Saskatoon, Saskatchewan
S7K 2H6
Phone: (306) 655-4100
Fax: (306) 655-4115

South Central Health District
Alcohol and Drug Services
Box 2003
Weyburn, Saskatchewan
S4H 2Z9
Phone: (306) 842-8693
Fax: (306) 842-8692

South Country Health District
Alcohol and Drug Services
Box 1120
Assiniboia, Saskatchewan
S0H 0B0
Phone: (306) 642-5733
Fax: (306) 642-5433

Southeast Health District
Addiction Services
St. Joseph's Hospital
1176 Nicholson Road
Estevan, Saskatchewan
S4A 0H3
Phone: (306) 634-0422
Fax: (306) 634-8785

Southwest Health District
Alcohol and Drug Services
Box 1328
Maple Creek, Saskatchewan
S0N 1N0
Phone: (306) 662-5330
Fax: (306) 662-5349

Swift Current Health District
Addiction Services - Youth Program
350 Cheadle Street West
Swift Current, Saskatchewan
S9H 4G3
Phone: (306) 778-5280
Fax: (306) 778-5408

Addictions Services-Adult Program
429 - 4th Avenue N.E.
Swift Current, Saskatchewan
S9H 2J9
Phone: (306) 778-5280
Fax: (306) 773-9513

Touchwood Qu'Appelle Health District
Community Service Team
Box 1819
Fort Qu'Appelle, Saskatchewan
S0G 1S0
Phone: (306) 332-3305 / 332-3308
Fax: (306) 332-1226

Twin Rivers Health District
Addiction Services
Box 629
Maidstone, Saskatchewan
S0M 1M0
Phone: (306) 893-4850
Fax: (306) 893-4480

Health District and Community Based Organization Detoxification Services

Walter A. "Slim" Thorpe Recovery Centre*
Detox, Outpatient and
Residential Services
4204-54th Avenue
Lloydminster, Alberta
T9V 2R6
Phone: (780) 875-8890
Fax: (780) 875-2161

La Ronge Health Centre
Detox/Hostel Unit
Box 6000
La Ronge, Saskatchewan
S0J 1L0
Phone: (306) 425-3205
Fax: (306) 425-5513

Angus Campbell Centre - Detox Centre*
Box 118
Moose Jaw, Saskatchewan
S6H 4N7
Phone: (306) 693-5977
Fax: (306) 693-0908

Regina Recovery Homes - Detox Centre*
2839 Victoria Avenue
Regina, Saskatchewan
S4T 1K6
Phone: (306) 522-5662
Fax (306) 525-2382

Larson Intervention House - Detox Centre*
201 Avenue 0 South
Saskatoon, Saskatchewan
S7M 2R6
Phone: (306) 655-4195
Fax: (306) 655-4196

Health District and Community Based Organization Inpatient Services

Northwest Alcohol and Drug Abuse Centre
Box 129
Ile- a -la- Crosse, Saskatchewan
S0M 1C0
Phone: (306) 833-2462
Fax: (306) 833-2330

Walter A. "Slim" Thorpe Recovery Centre*
Detox, Outpatient and Residential Services
4204 54th Avenue
Lloydminster, Alberta
T9V 2R6
Phone: (780) 875-8890
Fax: (780) 875-2161

La Ronge Health Centre
Detox/Hostel Unit
Box 6000
La Ronge, Saskatchewan
S0J 1L0
Phone: (306) 425-3205
Fax: (306) 425-5513

Pine Lodge Treatment Centre*
Box 457
Indian Head, Saskatchewan
S0G 2K0
Phone: (306) 695-2251
Fax: (306) 635-2514

Calder Centre (Adult and Adolescent Programs)
2003 Arlington Avenue
Saskatoon, Saskatchewan
S7J 2H6
Phone: (306) 655-4500
Fax: (306) 655-4545

St. Louis Alcoholism Rehabilitation Centre (Impaired Driver Training Program)*
Box 220
St. Louis, Saskatchewan
S0J 2C0
Phone: (306) 422-8533
Fax: (306) 422-8488

Metis Addictions Council of Saskatchewan Incorporated (MACSI)

MACSI Regina
329 College Avenue East
Regina, Saskatchewan
S4N 0V9
Phone: (306) 352-9601
Fax: (306) 347-7902

MACSI Saskatoon
419 Avenue E South
Saskatoon, Saskatchewan
S7M 1S4
Phone: (306) 652-8951
Fax: (306) 665-0703

MACSI Prince Albert
334 19th St. East
Prince Albert, Saskatchewan
S6V IJ7
Phone: (306) 953-8250
Fax: (306) 953-8261

Long-Term Residential Services

Hopeview Recovery Home
1891 96th St.
North Battleford, Saskatchewan
S9A 0J1
Phone: (306) 446-7370
Fax: (306) 445-0424

Regina Recovery Home
2825 Victoria Avenue
Regina, Saskatchewan
S4T 1K6
Phone: (306) 522-55763
Fax: (306) 525-2382

METIS ADDICTION COUNCIL OF SASKATCHEWAN INCORPORATED (MACSI)

Since 1969, MACSI has been providing rehabilitation, education and prevention services to persons who are affected by substance use. Rehabilitation services include inpatient, detoxification, and outpatient and field services for adults and youth. You should contact the centre nearest you for specific information regarding what services are available. While the majority of MACSI clients are of Indian or Metis ancestry, services are available to all members of the population. MACSI services are a vital component of alcohol and drug recovery services in Saskatchewan.

MACSI services in Saskatchewan:

MACSI Regina
329 College Avenue East
Regina, Saskatchewan
S4N 0V9
Phone: (306) 352-9601
Fax: (306) 347-7902
(Inpatient, Outpatient, Youth Field Worker)

MACSI Saskatoon
419 Avenue E South
Saskatoon, Saskatchewan
S7M 1S4
Phone: (306) 652-8951
Fax: (306) 665-0703
(Inpatient, Outpatient, Adult Field Worker)

MACSI Prince Albert
334 - 19th St. East
Prince Albert, Saskatchewan
S6V IJ7
Phone: (306) 953-8250
Fax: (306) 953-8261
(Detox, Inpatient, Outpatient)

Other Alcohol and Drug - related Services not funded by Saskatchewan Health or Health Districts

- National Native Alcohol and Drug Abuse Program (306) 780-7449
- Methadone Programs: Private physicians in some areas provide methadone services, in cooperation with pharmacists and community services, for opiate addicted individuals who meet the criteria.

MACSI North Battleford
Adult and Youth Field Workers
Box 1752
North Battleford, Saskatchewan
S9A 3W2
Phone: (306) 445-3319
Fax: (306) 445-6004

MACSI Fort Qu'Appelle
Adult Field Worker
Box 1188
Fort Qu'Appelle, Saskatchewan
S0G 1S0
Phone: (306) 332-4771
Fax: (306) 332-1869

MACSI Archerwill
Adult Field Worker
Box 158
Archerwill, Saskatchewan
S0E 0B0
Phone: (306) 323-4232
Fax: (306) 323-4520

MACSI Yorkton
Youth Field Worker
212 Myrtle Avenue
Yorkton, Saskatchewan
S3N 1R2
Phone: (306) 783-8755
Fax: (306) 783-6780

**Based on information provided by, and used with the permission of, Saskatchewan Health.*