# ALCOHOL AND OTHER DRUG WITHDRAWAL:

# PRACTICE GUIDELINES

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# CHAPTER 14: CANNABIS WITHDRAWAL

# 14 CANNABIS

***These Guidelines provide a comprehensive approach to withdrawal care. The use of prescribing guidelines outlined below will be supported by a comprehensive clinical assessment.***

Cannabis is the most widely used illicit drug worldwide (AIHW, 2007). It is estimated that around ten per cent of people who ever use cannabis will become dependent at some time in their lives (Copeland et al., 2006). Cannabis can be smoked (generally mixed with tobacco) in a pipe, a joint, or a water-pipe (bong). Cannabis can also be ingested with food.

In delivering cannabis withdrawal services to clients, clinicians should consider:

- Setting
- Withdrawal syndrome and potential complications
- Assessment
- Withdrawal care planning
- Withdrawal care
- Planning for post-withdrawal
- Special needs groups

Each of these considerations is examined below.

## 14.1 Cannabis withdrawal syndrome

The existence of a cannabis withdrawal syndrome is now well established. The nature of the withdrawal syndrome is not life threatening and is suited to community-based withdrawal settings.

Cannabis dependence is often seen in clients with polydrug dependence (alcohol, opioid, benzodiazepine and/or tobacco dependence). The cannabis withdrawal syndrome is generally longer than the syndrome for these other substances.

Adverse effects of cannabis intoxication can include anxiety and depression, paranoia, increased appetite and sedation. In users who have a psychiatric predisposition, acute drug-induced psychosis can occur from the ingestion of toxic levels of cannabis and during cannabis withdrawal. Agitation is associated with cannabis withdrawal and management of this condition should be carefully considered in withdrawal care planning.

While benzodiazepines are commonly used for symptomatic relief during cannabis withdrawal, there is currently no data to support this approach (NSW Department of Health, 2008a; Palmer, 2001).

## 14.2 Cannabis withdrawal settings

***The most appropriate setting for an individual seeking cannabis withdrawal will be informed by a thorough clinical assessment.***

The nature of the cannabis withdrawal syndrome is not life threatening and, in most cases, withdrawal can occur in the community. On occasion, cannabis withdrawal warrants an inpatient setting. The most appropriate setting should be determined via a thorough clinical assessment.

***The best withdrawal care facilitates step-up and step-down care, according to client need.***

Stepped care allows clients whose needs warrant greater withdrawal care to be transferred to a more intensive withdrawal setting. Alternately, stepped care allows those for whom risk/need is reducing to be stepped down to less intensive care.

## 14.3 Cannabis withdrawal syndrome

The extent to which withdrawal symptoms occur in light or non-daily cannabis users remains unclear (Budney & Hughes, 2006). However, the presence of a cannabis withdrawal syndrome in heavy or daily cannabis users who cease use has been established. The most common symptoms for these clients are:

- Anger, aggression, irritability
- Anxiety/nervousness
- Agitation
- Decreased appetite or weight loss
- Nausea and vomiting
- Restlessness
- Sleep difficulties including strange dreams

Less common symptoms include:

- Chills
- Depressed mood
- Stomach pain/physical discomfort
- Shakiness
- Sweating

Most symptoms emerge on day one to two of abstinence and peak between days two and six. Most symptoms abate within two to three weeks (Budney & Hughes, 2006; Kouri & Pope, 2000). Figure 1 below, shows the symptoms and duration of cannabis withdrawal.

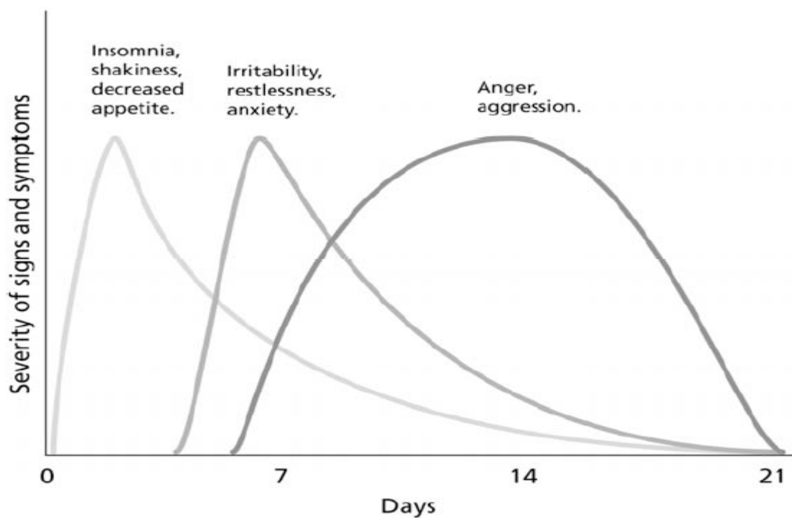


**Figure 1: Symptoms and duration of cannabis withdrawal**
Source: NSW Health (2008, p.44)

## 14.4 Cannabis withdrawal assessment

***Clinicians should be familiar with the general principles of assessment (refer section*** *Error! Reference source not found.* ***).***

***During withdrawal assessment, clinical staff will be alert to signs of client impairment.***

A thorough assessment of cannabis-dependent clients is critical in determining the most appropriate withdrawal care. Assessment is, however, largely dependent on the capacity of clients to provide relevant information. Recent cannabis use may limit clients' capacity to share and absorb accurate assessment information.

For impaired clients, all services should:

- As soon as possible, identify the most recent drug type, dose and time consumed (to inform medical intervention in the event of an overdose)

- Implement regular clinical observations of the client at frequent intervals at first then decreasing over time as evidence of impairment subsides
- Revisit the assessment when acute impairment has passed

A cannabis assessment should explore AOD use, including:

- Cannabis dependence as determined by DSM-IV and ICD-10 (see section **Error! Reference source not found.**: **Error! Reference source not found.**)
- Quantity, potency, frequency of cannabis use, and route of administration
- Polydrug use/dependence
- Physical health issues
- Mental health issues, including symptoms of depression and/or psychosis
- Pregnancy
- The severity of any previous withdrawal symptoms (Cruickshank & Dyer, 2006; Cruickshank et al., 2008; Dyer & Cruickshank, 2005; McKetin et al., 2005; McKetin et al., 2008)

Assessment of these domains will inform the likely severity of the current withdrawal syndrome and contribute to appropriate withdrawal care planning.

## 14.5 Cannabis withdrawal care planning

***Information obtained during assessment will inform the withdrawal care plan.***

The withdrawal care plan documents:

- Likely severity of withdrawal based on previous history of complicated withdrawal
- Risks associated with substance use, such as overdose history
- The client's motivation for withdrawal care, where this is a planned withdrawal presentation
- The client's goals during withdrawal care i.e. withdrawal, maintenance, reduction or substitution
- Potential barriers that may impact on achieving the client's withdrawal goals
- Available support to enhance the likelihood of success
- A post-withdrawal plan, including relapse prevention and linkages to external support networks to address the client's psychosocial needs
- Inclusion of family/significant others where appropriate
- Care plan for agitation management

The use of self-help booklets can be helpful, such as: *Mulling it over,* available at:

http://www.adf.org.au/store/article.asp?ContentID=product_33212

## 14.6 Cannabis withdrawal care

Although no medications have proven to be successful in cannabis withdrawal, benzodiazepines such as diazepam are commonly used to treat some symptoms of cannabis withdrawal, such as anxiety and insomnia (NSW Department of Health, 2008a; Palmer, 2001). Benzodiazepine dosing during cannabis withdrawal is based on ongoing assessment and monitoring. The efficacy of benzodiazepines in human cannabis withdrawal has not been empirically determined.

In outpatient settings, tapered or reducing benzodiazepine dosing may be used in conjunction with psychosocial interventions. There are numerous strategies to consider for outpatient cannabis reduction, including:

- Gradually limiting the quantity used per day
- Gradually reducing the frequency of use per day in conjunction with a smaller quantity
- Setting weekly reduction goals

Severity of cannabis withdrawal symptoms is dependent on a number of key factors such as:

- Method of ingestion
- Potency
- Quantity used per day
- Comorbid mental health conditions
- Polydrug dependence, including tobacco
- Current engagement in an outpatient or inpatient treatment setting

All withdrawal care is predicated on ongoing and objective monitoring in the initial stages of a client's presentation to withdrawal care. Monitoring should then occur at regular intervals, the frequency of which is dependent on the severity of the withdrawal syndrome.

### 14.6.1 Symptomatic medications

***A range of symptomatic medications is appropriate for use in cannabis withdrawal.***

Symptomatic medications are also useful in managing cannabis withdrawal symptoms, as outlined in Table 17 below.

**Table 1: Symptomatic medications for use in cannabis withdrawal (as at March 2009)**

| Symptoms | Symptomatic medication |
|---|---|
| Stomach cramps | Hyoscine (Buscopan®)[a]<br>Belladonna Herb (Atrobel®)[a] |
| Nausea | Promethazine (Phenergan®)[a]<br>Metoclopramide (Maxolon®)[a] |
| Physical pain and/or headaches | Paracetamol[a]<br>Non-steroidal anti-inflammatory drugs (NSAIDS)[a] such as ibuprofen (Brufen® or Nurofen®) |
| Sleep problems/ sleep disturbances | Short-acting benzodiazepines may be helpful for sleep problems (in small, controlled doses in the initial few days)[b]<br>Temazepam 10 mg tablets: one or two at night as required for up to seven days<br>Zolpidem (Stilnox®) or zopiclone (Imovane®) or sedating antihistamines such aspromethazine (e.g. Phenergan®) may also be of some value |
| Anxiety/restlessness/irritability | If anxiety symptoms predominate, a longer acting benzodiazepine may be of more value e.g.<br>Diazepam 5 mg tablets: up to 20 mg daily (in divided doses) initially, reducing the doses over three to seven days (maximum of 10 days duration)[b]<br>Outpatient regimens might be:<br>• 7 days of diazepam 5 mg four times daily,<br>• Zopiclone 7.5 mg at night<br>• NSAIDs/hyoscine butylbromide (Buscopan®) as needed;<br>or<br>• 7 days of zolpidem 7.5 mg at night[a] |
| Sedation | Tricyclic antidepressants (TCAs)<br>Doxepin 50–75 mg at night for up to seven days[b] |
| Note:<br>Do not mix benzodiazepines - use one or the other<br>Dosages and prescribing schedules for symptomatic relief will most effectively be decided upon only after thoroughly exploring the individual patient's symptom profile and circumstances | |

a) NSW Department of Health (2008a)
b) Murray et al. (2002)

General principles and guidelines for coping with, and relaxing during, cannabis withdrawal may also assist some clients (Appendix 5).

### 14.6.2 Cannabis withdrawal scales

At present, there are no validated cannabis withdrawal scales. However, the Cannabis Withdrawal Assessment Scale (CWAS)(Appendix 11) is currently used in some Australian AOD settings and is a useful tool for assessment purposes. The CWAS is a nine-item scale that assesses the domains of restlessness/agitation, fear, racing thoughts, drowsiness, mood changes, hunger, feelings of unreality and amount of sleep, on a scale of zero to seven (de Crespigny et al., 2003).

**Note:** Withdrawal scales should not be solely relied upon to monitor complicated withdrawal as they may lack the sensitivity to detect progression to serious illness. Withdrawal monitoring should always include close clinical observation and judgement.

### 14.6.3 Psychosocial support in cannabis withdrawal

***Psychosocial interventions complement the medical management of cannabis withdrawal symptoms and will be available at all cannabis withdrawal services.***

The overarching principles of supportive care are fundamental to the provision of a holistic model of withdrawal care. Psychosocial interventions should explore:

- Client goals, including any change in these goals over time
- Perceived barriers to achieving an individual's goals of withdrawal care
- An individual's beliefs about withdrawal care
- Appropriate interventions and support services

## 14.7 Planning for post-withdrawal

***Post-withdrawal support is an essential component of the treatment continuum for cannabis-dependent clients.***

Planning for post-withdrawal should:

- Commence at the assessment phase of withdrawal care
- Support the client's goals, which may pertain to accommodation, child protection, domestic violence and legal support
- Support client access to post-withdrawal services that provide ongoing support and advocacy
- Involve family/significant others in post-withdrawal care, as appropriate, to help implement the client's post-withdrawal plan

## 14.8 Special needs groups

### 14.8.1 Pregnant women

There is limited evidence of adverse effects of cannabis consumption on a pregnant woman or foetus. Where polydrug use exists, specialist paediatric consultation should be sought. Cannabis reduction or abstinence should be encouraged among pregnant women and the use of supportive medications should be minimal.

### 14.8.2 Tobacco

Cannabis is commonly mixed with tobacco for smoking and there is some evidence that withdrawal from both nicotine and cannabis at the same time leads to more severe withdrawal symptoms than would be experienced during withdrawal from either substance alone (Vandrey et al., 2008). The role of nicotine replacement therapy (NRT) in residential withdrawal settings should be strongly considered for all clinically dependent on nicotine.

### 14.8.3 Clients with a dual diagnosis

***Clients for whom a psychiatric condition emerges during cannabis withdrawal will receive care that addresses their specific needs.***

Specifically, they will be:

- Linked with appropriate mental health services

- Encouraged to continue to seek mental health support beyond withdrawal care
- Monitored for symptoms such as agitation during withdrawal and managed appropriately.

### 14.8.4 Families/significant others

***Consideration will be given to the needs of family/significant others in contact with a cannabis-dependent person during outpatient withdrawal or reduction.***

Where appropriate, information will be provided to family/significant others regarding the withdrawal process and support services such as Directline and/or Lifeline.

### 14.8.5 Young people

***Young people presenting to AOD services will be linked with youth-specific services, where available.***

As outlined above (section **Error! Reference source not found.**), young people may present with varying psychosocial factors contributing to their drug use which impact upon their long-term plan for recovery. It is important to be mindful of the potential differences in treatment approach and care when commencing withdrawal care. For example, young people have reported an increase in disputes with parents and peers during cannabis withdrawal and a reduction in capacity to undertake school work (Dawes et al., 2006). Ongoing contact with, and adjunct support from, youth-specific workers throughout withdrawal care can promote more positive experiences for the young person.

For further detailed information related to the withdrawal care of young cannabis users, please refer to the YSAS Clinical Practice Guidelines (YSAS, 2008).

## 14.9 Recommended reading

Budney, A. J., & Hughes, J. R. (2006). The cannabis withdrawal syndrome. *Current Opinion in Psychiatry, 19*(3), 233–238.

NSW Department of Health. (2008a). *NSW Drug and Alcohol Withdrawal Clinical Practice Guidelines.* NSW: NSW Department of Health.

Palmer, B. (2001). *Alcohol and Drug Withdrawal: A Practical Approach. A manual for doctors to assist in the treatment of patients withdrawing from alcohol and other drugs.* Mt Lawley: Next Step Specialist Drug & Alcohol Services.

YSAS. (2008). YSAS Clinical Practice Guidelines - Management of alcohol and other drug withdrawal. Melbourne; YSAS.

*'Mulling it over':* A self-help booklet for cannabis users. Available at http://www.adf.org.au/store/article.asp?ContentID=product_33212