SESLHD PROCEDURE COVER SHEET

Health
South Eastern Sydney
Local Health District

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EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Director, Population and Community Health
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FUNCTIONAL GROUP(S)	Drug and Alcohol Medicine
KEY TERMS	Withdrawal management, inpatient, alcohol, detox, detoxification, Alcohol Withdrawal Scale, AWS, thiamine, nutrition, Wernicke's encephalopathy
SUMMARY	This procedure provides guidance for hospital staff, specifically nurses and doctors, regarding the inpatient management of alcohol withdrawal, both elective and incidental to other treatments.

Drug and Alcohol – Inpatient Management of Alcohol Withdrawal

SESLHDPR/238

1. POLICY STATEMENT

NSW Health has published guidelines for the management of alcohol withdrawal in a range of settings. This procedure details the management of hospital inpatients undertaking alcohol withdrawal within South Eastern Sydney Local Health District (SESLHD).

The aim of this document is to ensure that patients admitted into hospital experiencing alcohol withdrawal or at risk of alcohol withdrawal are managed appropriately by hospital staff with the support from the SESLHD Drug & Alcohol Consultation Liaison Services where required.

This procedure has been developed by SESLHD Drug and Alcohol Service staff and is based on the following documents:

- Guidelines for the Treatment of Alcohol Problems Commonwealth of Australia, 2021
- Clinical Guidance for Withdrawal from alcohol and other drugs, 2022
- NSW Health Policy Directive PD2020_032 - Nursing and Midwifery Management of Drug and Alcohol us in the Delivery of Health Care
- Handbook for Nurses and Midwives: Responding effectively to people who use alcohol and other drugs

2. BACKGROUND

The appropriate management of alcohol withdrawal is important to ensure patient safety and to avoid major medical complications. Refer to Appendix 1 - Admission Criteria for Different Withdrawal Settings. Most people experiencing withdrawal can be safely managed in an outpatient setting. A small proportion of people may benefit from additional social support that can be provided in residential settings.

People who are prone to complications may require inpatient management and a number of people who enter hospital for other treatments may experience withdrawal from alcohol in the course of their hospital stay. This procedure is intended to guide the care of these two patient groups.

Definitions

Withdrawal Management: Withdrawal management describes the management of withdrawal from a substance in someone who is physically dependent on that substance. Withdrawal management was previously known as ‘detox’ or ‘detoxification’.

Elective Admission: Refers to the management of those patients assessed by the SESLHD D&A Service clinicians as being at ‘high risk’ of complicated alcohol withdrawal (such as having a history of seizures) and as such require hospital admission to provide safe management. Elective Inpatient Withdrawal Management will be planned and the timing of admission will depend on bed availability.

Non-elective Admission: Refers to those persons requiring admission to hospital for any reason and as a consequence of this admission they experience alcohol withdrawal.

Alcohol Withdrawal Seizures are usually generalised (tonic-clonic) seizures that occur as blood alcohol falls, typically within 6 to 48 hours after the last drink is consumed. These seizures can occur even if the blood alcohol level is high (e.g. greater than 0.10 g% / 22mmo/l) in people with alcohol dependence.

The prevalence of alcohol-withdrawal seizures is estimated at between 2 and 9 per cent of people with alcohol dependence. People who have experienced an alcohol withdrawal seizure are more

likely to experience further seizures in subsequent withdrawal episodes. The risk of recurrence within 6 to 12 hours is estimated at between 13 and 24 per cent in untreated people.

Alcohol Withdrawal Delirium ('the DTs'): Alcohol withdrawal delirium is an organic brain syndrome characterised by confusion, disorientation, perceptual disturbances, agitation, hyperactivity and tremor. Alcohol withdrawal delirium typically commences 2 to 3 days after ceasing drinking, and usually lasts for a further 2 to 3 days, although it can persist for weeks.

Alcoholic Hallucinosis is an organic psychotic disorder, most commonly with hallucinatory features, that can be difficult to differentiate from other causes of psychosis. Hallucinosis occurs in about 25 per cent of untreated hospitalised patients who have been drinking heavily for at least 10 years. Unlike alcohol withdrawal delirium, the patient will have a clear sensorium during alcoholic hallucinosis; but typically, they will experience auditory hallucinations (also possible visual hallucinations and misperceptions) and persecutory delusions while they are drinking. Such hallucinations may persist during withdrawal and can be mistaken for alcohol withdrawal hallucinations.

Wernicke's encephalopathy: This acute neurological syndrome due to thiamine deficiency can complicate withdrawal or present in people who continue to drink alcohol. Untreated, Wernicke's encephalopathy can progress to Korsakoff's psychosis, which may result in permanent cognitive damage. It can be prevented in people who drink alcohol by good nutrition and by the early routine use of thiamine in all patients with a history of heavy and regular alcohol consumption, and especially for those undergoing withdrawal. The classic triad of clinical signs in Wernicke's encephalopathy is:

- Confusion or mental impairment (estimated to occur in 80% of cases)
- Ataxia (approximately 20 to 25% of cases)
- Eye signs such as nystagmus or ophthalmoplegia (approximately 30% of cases).

Alcohol Withdrawal Monitoring: In SESLHD, the Alcohol Withdrawal Scale (AWS) is the tool used to monitor alcohol withdrawal. Validation of the AWS has not been published; however, it has been widely used in Australian context and is considered acceptable for use.

3. RESPONSIBILITIES

3.1 Employees will:

All employees of SESLHD will act in accordance with this procedure.

3.2 Line Managers will:

Ensure this procedure is followed by all relevant staff.

3.3 Network Managers/ Service Managers will:

Provide support to staff in the implementation of this procedure as required.

3.4 Medical Staff will:

All medical officers working in hospital wards and emergency departments and all Drug and Alcohol Service medical officers will comply with this procedure.

3.5 Nursing Staff will:

All nursing staff working in hospital wards and emergency departments and all clinical staff working in the Drug and Alcohol Service will comply with this procedure.

4. PROCEDURE

4.1 Treatment Matching

Inpatient hospital treatment for alcohol withdrawal is required for those patients with a history of withdrawal complications (such as delirium or seizures) and/or clinically significant medical comorbidity. See Appendix 1 for Admission Criteria for Different Withdrawal Settings.

Alcohol withdrawal may be an elective admission to hospital for a planned withdrawal or a non-elective admission to hospital resulting in an unplanned withdrawal. As with any treatment planning, a clinical assessment is required to identify clinical risks and appropriate treatment matching. The key features of a comprehensive Drug and Alcohol assessment and detailed in Appendix 2.

4.1.1 Elective Admission

Assessment for an elective admission for alcohol withdrawal is undertaken by appropriate Drug and Alcohol Service staff. See Appendix 2 for Key Elements of a Comprehensive Drug and Alcohol Assessment. If a patient presents to hospital intoxicated or with Blood Alcohol Level (BAL) higher than 0.1% please contact D&A staff before transfer to the ward.

The criteria for an elective planned withdrawal admission are as follows:

- High likelihood of severe withdrawal complications (risk of alcohol withdrawal seizures, alcohol withdrawal delirium, alcoholic hallucinosis)
- Outpatient withdrawal management has failed or should not be attempted due to significant medical or psycho-social complexity (including pregnancy, co morbidity and homelessness)

NOTE: Consult with the Hospital Drug and Alcohol Consultation Liaison team (business hours) OR SESLHD Drug & Alcohol Medical Officer on call via Sydney Hospital Switchboard: 9382 7111 (after hours).

4.1.2 Non-elective Admission

Incidental alcohol withdrawal following discontinuation of alcohol use resulting from hospitalisation tends to be most severe. This may occur in a variety of settings including the emergency department, wards etc. A careful substance use history (See Appendix 2, Key Elements of a Comprehensive Drug and Alcohol Assessment) may indicate a risk of withdrawal that should be monitored. In general, patients who are identified as exhibiting signs of alcohol withdrawal should be managed according to this procedure.

NOTE: A referral should also be made to the Hospital Drug and Alcohol Consultation Liaison team by submitting an eOrder in eMR to assist in the management and discharge planning (business hours) OR SESLHD Drug & Alcohol Medical Officer on call via Sydney Hospital Switchboard: 9382 7111 (after hours).

4.2 ALCOHOL WITHDRAWAL MANAGEMENT

In all SESLHD inpatient facilities, alcohol withdrawal is to be managed according to this procedure, regardless of point of entry for treatment (elective admission or non-elective admission).

4.2.1 Monitoring during alcohol withdrawal

All patients in alcohol withdrawal, or who are considered at risk of alcohol withdrawal should be monitored regularly, as listed below.

Monitoring frequency Required 2nd hourly for the first 12 hours and then 4 to 6 hourly for 48 hours. More frequent monitoring may be necessary if clinically indicated, appropriate to the relevant clinical setting.

General observations Temperature, pulse, respiratory rate and blood pressure, as well as the Alcohol Withdrawal Scale (Appendix 3).

Physical signs Level of hydration, level of consciousness (especially if medicated), severity of alcohol withdrawal and general progress during withdrawal (i.e. patient's level of motivation and response to medication(s) and patient's concerns and difficulties) should be assessed and documented.

Severity of alcohol withdrawal The Alcohol Withdrawal Scale (AWS) is not a diagnostic tool as other organic or mental health causes may increase the scoring of the scale (false positives). For example, infection can cause raised temperature, perspiration and agitation, or an underlying anxiety disorder can result in persistent high AWS scores. The AWS should be used to guide treatment, and to help clinicians communicate more objectively about the severity and management of alcohol withdrawal. Clinicians need to be aware of the importance of objective clinical signs of alcohol withdrawal i.e. tachycardia, hypertension, low grade temperature, clammy – sweaty skin. These objective signs give clear evidence to the patients increasing discomfort.

4.2.2 Supportive Care

Withdrawal management that provides good supportive care is beneficial to patients and assists staff in the management of these patients and consists of patient information, modification of environment and support, diet and nutrition, including the routine use of thiamine to prevent Wernicke's encephalopathy.

A. Patient Information
   - Communicate the likely nature, severity and duration of symptoms, the role of medication
   - Use a slow, steady, non-threatening approach
   - Explain all interventions clearly
   - Speak slowly and distinctly in a friendly manner
   - Maintain eye contact when speaking
   - Avoid confrontations and arguments
   - Regularly re-orient the patient with his/her environment
   - Offer a night light to reduce the likelihood of perceptual errors and exacerbation of anxiety and psychotic phenomena at night

B. Environment and Support
   - Use low lighting, low stimulation
   - Offer supportive strategies for coping with symptoms and craving
   - Monitor patients for risk of falls

C. Diet, nutrition and rehydration
   - Monitor for dehydration, fluid intake and urine output. Intravenous fluids may be necessary
   - Nutritional state should be monitored as patient may experience nausea and/or diarrhoea during withdrawal
   - Electrolyte and blood abnormalities are common in patients in alcohol withdrawal. Urea, electrolytes, creatinine, full blood count, liver function tests and coagulation profile should be routinely monitored throughout the admission

D. Prophylactic and routine use of thiamine to prevent Wernicke's Encephalopathy
   - Prophylactic thiamine administration is recommended as soon as possible and prior to any carbohydrate load (e.g. intravenous glucose), as glucose intake in the presence of thiamine deficiency can precipitate Wernicke's encephalopathy. Thiamine should initially be given parenterally, as oral thiamine is poorly absorbed through the gastro-intestinal mucosa in people who drink alcohol.
   - Administer thiamine 300mg IV tds (diluted in saline over 30 minutes) for 3 days then change to oral 100mg TDS with meals for at least 5-7 days. Patients with chronic poor

nutrition or did not complete 3 days of IV thiamine may benefit from extended periods of oral thiamine doses following discharge.

- In the event of poor intravenous access that prevents the recommended regimen, alternative approaches to thiamine dosing should be used. This may include:
  - a single intravenous (e.g. 300mg) and high oral doses (e.g. 500mg TDS) for three days
  - once daily intramuscular (e.g. 100mg) dose and high oral doses (e.g. 500mg TDS) for three days
  - further advice can be sought from the Drug and Alcohol Consultation Liaison team (business hours) via eReferral OR SESLHD Drug & Alcohol Medical Officer on call via Sydney Hospital Switchboard: 9382 7111 (after hours).

NOTE: If there is a clinical suspicion of Wernicke's Encephalopathy (e.g. one sign such as confusion, or ataxia or eye signs; or a history of poor nutrition), then treatment with high dose parenteral thiamine (500mg IV TDS) should be administered as though a diagnosis of Wernicke's is confirmed (see Section 5 – Treating Complications).

4.2.3 Withdrawal Medication

Diazepam

Diazepam, a long-acting benzodiazepine, is the pharmacotherapy of choice in alcohol withdrawal. Diazepam is well absorbed orally, has a rapid onset of action (within one hour) and has prolonged duration of effects (up to several days).

For information on the management of Special Populations (pregnant women, older patients and patients with concurrent drug use) see Section 7.

Loading Dose Therapy

Loading dose regimens quickly administer high doses of benzodiazepines in the early stages of alcohol withdrawal and are indicated in:

- patients with a history of withdrawal complications (seizures, delirium),
- patients presenting in clinically significant alcohol withdrawal (AWS ≥ 8) and/or with withdrawal complications (delirium, hallucinations, following an alcohol withdrawal seizure).

Alcohol withdrawal seizures can occur following the cessation of drinking and before the onset of clinically significant alcohol withdrawal features. Hence, diazepam loading should commence in patients with alcohol dependence with a history of alcohol withdrawal seizures prior to the development of withdrawal symptoms.

NOTE: Some patients may begin to experience withdrawal whilst still recording a breath or blood alcohol level. For these patients, treatment with diazepam may commence once the BAL is < 0.1.

The suggested diazepam loading-dose regimen is 20mg orally every 2 hours until reaching 60-80 mg or the patient is sedated. Medical review should occur if the patient remains agitated after 80 mg and other causes of agitation should be excluded. Further doses of diazepam may be required and advice should be sought from the Drug and Alcohol Consultation Liaison team (business hours) OR SESLHD Drug & Alcohol Medical Officer on call via Sydney Hospital Switchboard: 9382 7111 (after hours).

The dose of 80mg diazepam will have significant sedative effects for several days and generally no further doses of diazepam will be needed. Further tapering doses of diazepam may be required for individuals who demonstrate ongoing significant withdrawal symptoms for 1-3 days. If there are concerns, further advice should be sought from the Drug and Alcohol Hospital Consultation Liaison team (business

hours) OR SESLHD Drug & Alcohol Medical Officer on call via Sydney Hospital Switchboard: 9382 7111 (after hours).

Fixed-Schedule Regimen

Fixed schedule regimens usually involve reducing doses over a 3 to 4 day period, and is generally initiated once the patient scores ≥ 5 on the AWS. Regular clinical review is required (minimum daily) to ensure the patient is not over or under-medicated.

A fixed dose regimen using diazepam is recommended for hospitalised patients who do not meet indications for loading dose therapy (see above) yet have signs and symptoms of alcohol withdrawal. Patients should ideally be reviewed daily by specialist drug and alcohol clinicians.

A fixed dose regimen using oxazepam is recommended when diazepam is contraindicated (i.e., liver failure, prolonged sedation, older patients, recent head injury, or respiratory failure).

Fixed schedule regimen may be supplemented with additional diazepam or oxazepam as needed for people with low tolerance of withdrawal discomfort or those exhibiting severe or prolonged withdrawal.

NOTE: In the event that additional benzodiazepines may be required after a medical review, further advice should be sought from the Drug and Alcohol Consultation Liaison team (business hours) OR SESLHD Drug & Alcohol Medical Officer on call via Sydney Hospital Switchboard: 9382 7111 (after hours).

Example of a Fixed Schedule Regimen is as follows:

***DIAZEPAM* - FIXED SCHEDULE REGIMEN**	
Day 1	10 mg four times a day
Day 2	10 mg three times a day
Day 3	5 mg three times a day
Day 4	No diazepam or 5 mg nocte

DIAZEPAM is recommended for hospitalised patients in alcohol withdrawal with an AWS score ≥ 5.

4.2.4 Contraindications to Diazepam

Shorter acting benzodiazepines e.g. oxazepam should be used where there is concern about the following:

- Those at risk of prolonged sedation, such as in older patients
- Liver failure (evidence of decompensation – e.g. jaundiced, severe cirrhosis)
- Recent head injury
- Respiratory failure

Oxazepam has an onset of action within 2 hours, half-life of 5 to 10 hours; 15 to 30 mg oxazepam is approximately equipotent to 5 – 10 mg diazepam.

***OXAZEPAM* - FIXED SCHEDULE REGIMEN**	
Day 1	30 mg four times a day
Day 2	30 mg three times a day
Day 3	15 mg three times a day
Day 4	No oxazepam or 15 mg nocte

OXAZEPAM is recommended where diazepam is contraindicated (e.g., liver failure, prolonged sedation, older patients (over 65), recent head injury, or respiratory failure). *(30 mg oxazepam is approximately equipotent to 10 mg diazepam)*

In circumstances where oral medication cannot be used (e.g. strict nil oral intake), intravenous benzodiazepines may be considered, and the treating team may liaise with D&A Consultation Liaison services for advice.

NOTE: In the event the above conditions are present, further advice should be sought from the Drug and Alcohol Consultation Liaison team (business hours) OR SESLHD Drug & Alcohol Medical Officer on call via Sydney Hospital Switchboard: 9382 7111 (after hours).

NOTE: The use of alcohol (e.g. beer, wine, spirits or IV ethanol) for treating alcohol withdrawal in hospital is contraindicated. Patients with alcohol dependence will generally require very high doses of alcohol to prevent or treat withdrawal symptoms, and such doses increase the risk of other health complications.

5. TREATING ALCOHOL WITHDRAWAL COMPLICATIONS

Alcohol withdrawal seizures, alcohol withdrawal delirium and alcoholic hallucinosis - see Definition Section of this document for full definition and explanation of each of the above complications.

NOTE: Treatment advice for the above complications should be sought from the Drug and Alcohol Consultation Liaison team (business hours) OR SESLHD Drug & Alcohol Medical Officer on call via Sydney Hospital Switchboard: 9382 7111 (after hours).

Treatment of Wernicke's encephalopathy: Many cases of Wernicke's encephalopathy may be subclinical and the full triad of signs and symptoms may not be present. See Definition Section of this document for further information. The recommended treatment is as follows:

- IV doses of thiamine 500 mg TDS per day (diluted in saline over 30 minutes) should be administered for at least 5-7 plus days (duration of treatment should depend on clinical response) according to clinical response and subsequent doses of at least 300 mg oral per day for 1 to 2 weeks. The intramuscular route should not be used for patients with coagulopathy.
- Correct any electrolyte disturbances, including hypomagnesaemia.
- **NOTE**: Thiamine should be given before any carbohydrate load (e.g., intravenous glucose).

6. DETERIORATING PATIENTS

If a patient's condition deteriorates, regardless of cause, the management is to be followed as described in SESLHDPR/697 - Management of the Deteriorating ADULT inpatient (excluding maternity).

7. SPECIAL POPULATIONS

7.1 Pregnant Women

A woman's obstetric history must be taken into consideration when determining management options and discussion with the woman about the use of diazepam as a medication should take place. Department of Communities and Justice (DCJ) notification may be necessary as per NSW Health Policy Directive PD2013_007 - Child Wellbeing and Child Protection Policies and Procedures for NSW Health.

- Up to 20 weeks of pregnancy: Ambulatory management is reasonable if a woman is judged to be at low risk of complications (no history of seizures, supportive family and housing stable). However, there is a lower threshold for admission to an inpatient setting than for the general population. Daily antenatal input or monitoring should be considered during the withdrawal period.

- Over 20 weeks of pregnancy: Inpatient management in an antenatal setting is highly recommended. However, some women (e.g., with children in their care) may decline this treatment option and may rather opt for ambulatory treatment. If a woman is assessed as suitable for ambulatory management, there should be close supervision with daily attendance at the D&A ambulatory unit and regular foetal

monitoring as directed by the antenatal team (both assessments may be provided at one site if staffing allows)

NOTE: In cases involving pregnant women, management advice should be sought from the Drug and Alcohol Consultation Liaison team (business hours) OR SESLHD Drug & Alcohol Medical Officer on call via Sydney Hospital Switchboard: 9382 7111 (after hours).

7.2 Older Patients

Older patients who drink alcohol are at higher risk of alcohol related complications and should be closely monitored. Poor diet, inadequate housing, physical inactivity, and concomitant illness may make older people more vulnerable to complications especially during withdrawal, such as dehydration, nutritional deficiency (risk of Wernicke's encephalopathy), delirium, hypertension or infections.

Older patients should receive adequate thiamine, rehydration and nutritional support, and close monitoring of other conditions (i.e., blood pressure, blood glucose, mental state).

Diazepam has the potential for over-sedation due to the accumulation in older people – over 65 (delayed hepatic clearance of long-acting active metabolite). Shorter acting benzodiazepines, such as oxazepam, should be considered as first line medication for moderate to severe alcohol withdrawal - see section 4.2.4 Doses should be titrated according to clinical effect.

7.3 Patients with concurrent drug use

Benzodiazepine dependence complicates the management of alcohol withdrawal due to the increase in seizure risk. Patients withdrawing from other substances (e.g. opioids, cannabis, amphetamines) are at increased risk of withdrawal complications, and monitoring using withdrawal scales (e.g. AWS, Clinical Opioid Withdrawal Scale (COWS)) is less reliable.

For patients with concurrent drug use, further advice should be sought from the Drug and Alcohol Consultation Liaison team (business hours) OR SESLHD Drug & Alcohol Medical Officer on call via Sydney Hospital Switchboard: 9382 7111 (after hours).

8. REQUIREMENTS FOR ONE-TO-ONE NURSING OF A PATIENT IN ALCOHOL WITHDRAWAL

Under certain circumstances, a patient in alcohol withdrawal may require constant monitoring. Refer to local hospital practice regarding the one-to-one nursing of patients.

9. DISCHARGE PLANNING

Alcohol dependence is a chronic condition and most patients will relapse to regular alcohol use unless they continue in some form of treatment following the withdrawal episode. Clinicians should consult with the local Drug and Alcohol Consultation Liaison team or local D&A Services when possible to facilitate links to community D&A treatment services.

The Discharge Summary should also include information for the General Practitioner (LMO) regarding details of the diagnosis (alcohol dependence), management (withdrawal), and ongoing treatment plans.

Advice regarding provision of benzodiazepines on discharge:

1. once the inpatient benzodiazepine reduction has been completed there is no place for further benzodiazepine prescribing for the management of alcohol use disorders upon discharge.
2. for those patients who are discharged prior to the completion of the planned reduction; please seek advice from the D&A Consultation and Liaison team during working hours, and the on-call D&A team to get a more tailored advice. In principle, if there are alcohol withdrawal symptoms present on discharge and the patient is completing alcohol withdrawal in the community, it is best to liaise with community services – such as a community Drug and Alcohol service or the patient's

GP, with ongoing benzodiazepine reduction completed in a community pharmacy through daily benzodiazepine dispensing (referred to as staged supply). Discharging patients from hospital with a benzodiazepine prescription or take-home supply is generally not recommended without consultation with community treatment providers.

Further information for the patient (and their carers) regarding D&A treatment services is available at the 24-hour confidential telephone service Alcohol and Drug Information Service (ADIS) on (02) 9361 8000 or 1800 422 599 (toll free).

10. DOCUMENTATION

- Inpatient Alcohol Withdrawal Scale (AWS) Form

11. AUDIT

- D&A Hospital Consultation Liaison Services will regularly audit hospital medical records to assess this procedure is complied with.

12. REFERENCES

- NSW Health Policy Directive PD2013_007 - Child Wellbeing and Child Protection Policies and Procedures for NSW Health
- NSW Health Policy Directive PD2012_069 - Health Care Records - Principles for Creation, Management, Storage and Disposal of Health Care Records
- NSW Health Policy Directive PD2020_032 - Nursing and Midwifery Management of Drug and Alcohol use in the Delivery of Health Care
- Handbook for Nurses and Midwives: Responding effectively to people who use alcohol and other drugs (NSW Health 2021)
- Management of Withdrawal from Alcohol and Other Drugs Clinical Guidance and Handbook (NSW Health 2022)
- SESLHDPR/303 - Clinical Handover: Implementation of ISBAR Framework and Key Standard Principles
- SESLHDPR/380 - Falls prevention and management for people admitted to acute and sub-acute care
- SESLHDPR/697 - Management of the Deteriorating ADULT inpatient (excluding maternity)
- SESLHDPR/345 - Prevention, Assessment and Management of Delirium in Older People
- Haber PS, Riordan BC (2021). Guidelines for the Treatment of Alcohol Problems (4th edition)

13. VERSION AND APPROVAL HISTORY

Date	Version No.	Author and approval notes
May 2010	Draft	D&A Consultation Liaison Working Group
Dec 2010	0	Endorsed by Area Patient Safety & Clinical Quality Committee Noted by Area Clinical Council
Feb 2012	1	D&A Consultation Liaison Working Group
Dec 2012	2	SESLHD D&A Service Patient Safety and Quality Committee
August 2015	3	D&A Consultation Liaison Working Group D&A Executive

October 2016	4	D&A Consultation Liaison Working Group 1. More detailed protocol for prophylactic use of thiamine in alcohol withdrawal 2. Statement about non-use of alcohol to treat withdrawal D&A Executive
April 2018	5	Reviewed by the Drug and Alcohol Service Ambulatory Care Working Group, led by Miriam Van Zanten. Changes to procedure approved by Director, Nicholas Lintzeris: 1. Changes to the Fixed-Schedule Regimen to a 3-4 day regimen as average length of stay for alcohol withdrawal is 3 days. 2. Oxazepam regimen: ranges for oxazepam removed; and replicate the diazepam regimen using the formula 30 mg oxazepam = 10 mg diazepam.
May 2018	5	Major Review - Draft for Comment
Sept 2018		QUM comments received - recommend addition of a recommended dosing schedule for midazolam and advice around provision of benzodiazepines on discharge, e.g. what to do if the reducing dose schedule has not been completed.
Nov 2018		Revised version submitted: • Advice on provision of benzodiazepines on discharge included. • Replaced reference to midazolam with advice on considering intravenous benzodiazepine in cases of strict nil oral intake.
Nov 2019		Procedure reviewed by Hospital D&A Consultation Liaison Working Group and deemed fit for purpose – nil changes required.
February 2020	6	Minor review updating Executive Sponsor. Processed by Executive Services prior to publishing.
March 2020	6	Processed by Executive Services prior to publishing
July 2020	7	Risk rating amended from Extreme to High Risk. Review date amended to align with a High Risk rating. Approved by Executive Sponsor.
14 December 2023	7.1	Minor review. Change to 4.2.2 D – D. *Prophylactic and routine use of thiamine to prevent Wernicke's Encephalopathy* to thiamine 300mg IV tds. Updated references to current versions. Approved at SESLHD Drug and Therapeutics Committee.

Appendix 1

Admission Criteria for Different Withdrawal Settings

	Ambulatory	Community residential	Inpatient hospital
Predicted alcohol withdrawal severity	Mild-moderate	Moderate-severe	Moderate-severe
Likelihood of severe withdrawal complications	No	Withdrawal complications not expected (seizures, hallucinations)	Withdrawal complications (delirium, unclear cause of seizures)
Medical or psychiatric comorbidity	Minor comorbidity	Minor comorbidity	Significant comorbidity
Other substance use	No heavy drug use	Heavy or unstable use of other drugs	Heavy or unstable use of other drugs
Social environment	Alcohol-free 'home' Daily monitoring by reliable support people Good access to health care service	Unsupportive home environment	Unsupportive home environment
Previous attempts	-No recent repeated failure at ambulatory withdrawal	Repeated failure at ambulatory withdrawal	Repeated failure at ambulatory withdrawal

Source: Guidelines for the Treatment of Alcohol Problems. 2009 Australian Government Department of Health and Ageing and Sydney South West Area Health Service p 54.

Appendix 2

Key Elements of a Comprehensive Drug and Alcohol Assessment

The following items are to be documented as part of the drug and alcohol assessment:

- Client's reasons for presentation.
- Client's expectations and goals.
- A comprehensive history of current alcohol intake:
    - frequency of use
    - amount (documented in standard drinks/grams)
    - duration of use at current level
    - the time of last drink (this is important for estimating when withdrawal symptoms may occur)
    - time of first drink of the day
    - where and with whom drinking is done
    - previous periods of not drinking or non-problematic drinking.
- Other drug use of the previous month, both licit and illicit, especially benzodiazepines as this complicates withdrawal management.
- Past treatment if any and outcomes.
- History of withdrawal symptoms, including alcohol, or any other substance, withdrawal-related complications and treatment.
- Past history of Wernicke's encephalopathy, delirium or hallucinations and treatment.
- Past seizure history. Attempt to verify any account of seizures and differentiate from blackouts, e.g. witnessed, hospital admission or medical treatments, investigations, hospital discharge summaries.
- Current or previous pharmacotherapies used to treat alcohol dependence (eg acamprosate, naltrexone, disulfiram)
- Acute psychiatric issues such as self harm and suicide attempts
- Acute medical issues such as head injury, liver failure, respiratory distress, infections
- Other past medical and psychiatric history
- Observations and Investigations:
    - Alcohol level (BAL) using an alcolmeter (breathalyser) or blood test.
    - Pulse, blood pressure.
    - Alcohol Withdrawal Scale (AWS)
    - Liver function tests, coagulation profile, full blood count
- Lifestyle and social supports.

Appendix 3 – Alcohol Withdrawal Scale

MONITORING THE PATIENT Temp, Pulse, Respirations, BP and AWS 2nd hourly for 12 hours, then 4 - 6 hourly for 48 hours	Date											
	Time											
Perspiration 0 - No abnormal sweating 1 – Moist skin 2 – Localised beads of sweat, e.g., on face, chest 3 – Whole body wet from perspiration 4 – Profuse maximal sweating – clothes, linen are wet												
Tremor 0 – No tremor 1 – Slight tremor 2 – Constant slight tremor of upper extremities 3 – Constant marked tremor of extremities												
Anxiety 0 – No apprehension or anxiety 1 – Slight apprehension 2 – Apprehension or understandable fear, e.g., of withdrawal symptoms 3 – Anxiety occasionally accentuated to state of panic 4 – Constant panic-like anxiety												
Agitation 0 – Rests normally during the day, no signs of agitation 1 – Slight restlessness; cannot sit or lie still; awake when others asleep 2 – Moves constantly; looks tense; wants to get out of bed but obeys request to stay in bed 3 – Constantly restless; gets out of bed for no reason 4 – Maximally restless; aggressive; ignores request to remain in bed												
Temperature 0 – Temperature of 37.0ºC 1 – Temperature of 37.1ºC to 37.5ºC 2 – Temperature of 37.6ºC to 38.0ºC 3 – Temperature of 38.1ºC to 38.5ºC 4 – Temperature above 38.5ºC												
Hallucinations 0 – No evidence of hallucinations 1 – Distortions of real objects; aware these are not real if this is pointed out 2 – Appearance of totally new objects or perceptions; aware that these are not real if this is pointed out 3 – Believes the hallucinations are real but still orientated in place and person 4 – Believes self to be in a totally non-existent environment; preoccupied and cannot be diverted or reassured												
Orientation 0 – Fully orientated in time, place, person 1 – Fully oriented in person but not sure where he/she is or time 2 – Oriented in person but disoriented in time and place 3 – Doubtful personal orientation; disorientated in time and place; may be short periods of lucidity 4 – Disoriented in time, place and person; no meaningful contact can be obtained.												
MAXIMAL POSSIBLE SCORE = 27 **TOTAL SCORE**												

AWS score guide ≤ 4 = mild withdrawal 5 – 7 = moderate withdrawal ≥ 8 = severe withdrawal

THE AWS IS USED TO GUIDE THE COMMENCEMENT OF TREATMENT AND MONITOR THE PATIENT'S PROGRESS.

THE AWS SHOULD NOT BE USED TO DETERMINE MEDICATION DOSES IN PATIENTS WITH SIGNIFICANT MEDICAL OR PSYCHIATRIC COMORBIDITY, OR PATIENTS CONCURRENTLY WITHDRAWING FROM OTHER SUBSTANCES.