<table>
<thead>
<tr>
<th>NAME OF DOCUMENT</th>
<th>Ambulatory Management of Alcohol Withdrawal</th>
</tr>
</thead>
<tbody>
<tr>
<td>TYPE OF DOCUMENT</td>
<td>Procedure</td>
</tr>
<tr>
<td>DOCUMENT NUMBER</td>
<td>SESLHDPR/439</td>
</tr>
<tr>
<td>DATE OF PUBLICATION</td>
<td>November 2015</td>
</tr>
<tr>
<td>RISK RATING</td>
<td>High</td>
</tr>
</tbody>
</table>
| LEVEL OF EVIDENCE         | NSQHS Standard 4 – Medication Safety and 5 – Patient Identification and Procedure Matching  
EquiP Standard 12 – Provision of Care |
| REVIEW DATE               | November 2017                                |
| FORMER REFERENCE(S)       | Drug and Alcohol Service Clinical Business Rule 2011_18 |
| EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR | Dr Greg Stewart  
Director of Operations, Ambulatory and Primary Health Care |
| AUTHOR                    | Professor Nicholas Lintzeris                 |
| POSITION RESPONSIBLE FOR THE DOCUMENT | Professor Nicholas Lintzeris,  
Director, Drug and Alcohol Services  
Nicholas.Lintzeris@sesiahs.health.nsw.gov.au |
| KEY TERMS                 | Alcohol, withdrawal management, medicated withdrawal elective admission, detox, detoxification |
| SUMMARY                   | This procedure describes the assessment, referral and management of patients suitable for supervised alcohol withdrawal in an ambulatory (outpatient) setting, and identifies risk factors which make them unsuitable for ambulatory management and indicated for referral to inpatient withdrawal management. |

COMPLIANCE WITH THIS DOCUMENT IS MANDATORY
This Procedure is intellectual property of South Eastern Sydney Local Health District. Procedure content cannot be duplicated.

Feedback about this document can be sent to seslhdexecutiveservices@sesiahs.health.nsw.gov.au
1. POLICY STATEMENT

NSW Health has published guidelines for the management of alcohol withdrawal in a range of settings. The procedure details the management of people who are able to undertake alcohol withdrawal in an outpatient setting.

The aim of this document is to guide staff on the care of this group of patients presenting to ambulatory D&A settings in SESLHD for alcohol withdrawal.

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

- Guidelines for the Treatment of Alcohol Problems Commonwealth of Australia, 2009
- NSW Drug and Alcohol Withdrawal Clinical Practice Guidelines 2007 (NSW Health GL2008_011)
- Clinical Guidelines for Nursing and Midwifery Practice in NSW: Identifying and Responding to Drug and Alcohol Issues 2007 (NSW Health GL2008_001)

2. BACKGROUND

The appropriate management of alcohol withdrawal is important to ensure patient safety and to avoid major medical complications. Most patients experiencing alcohol withdrawal can be safely managed in an outpatient setting.

Some patients may benefit from the additional psychosocial support that can be provided in residential settings.

Patients who are prone to complications may require inpatient management electively, while those who are admitted for other conditions may incidentally also require withdrawal management (refer to SESLHDPR/238 – D&A – Alcohol – Inpatient Management of Alcohol Withdrawal Procedure).

Definitions

ATOP: Australian Treatment Outcomes Profile

Withdrawal Management: Withdrawal management describes the management of withdrawal from a substance in someone who is 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 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.

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% or 22mmol/L) in severely dependent drinkers. The prevalence of alcohol-withdrawal seizures is estimated at between 2 and 9 per cent of alcohol dependent people. People who have experienced 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 and 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 the continuing drinker. It is characterised by ataxia, ophthalmoplegia, nystagmus and global memory impairment. Untreated, it can progress to Korsakoff’s psychosis, which may result in permanent cognitive damage. It can be prevented in heavy or dependent alcohol users by good nutrition and by the early routine use of thiamine in all patients undergoing withdrawal. The classic triad of 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.

### 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 District Managers/ Service Managers will:
Provide support to staff in the implementation of this procedure as required.

#### 3.4 Medical staff will:
All medical officers will comply with this procedure.
4. PROCEDURE

4.1 Comprehensive Drug and Alcohol Assessment

A standardised SESLHD assessment is to be completed for every patient if this is their first presentation. If the patient has a current treatment episode, a comprehensive assessment should be done. See appendix 2.

For suitability criteria for ambulatory management and other forms of management, including residential and both acute and elective inpatient refer to Appendix 1. If a patient is homeless, or has limited support but no medical admission criteria, referral to a residential withdrawal management unit in a non-government service should be discussed with the patient.

4.1.1 Medicated withdrawal management – Commencement and monitoring

Not all patients will need to be, or request to be, medicated during withdrawal. Thorough assessment and daily monitoring including supportive interventions ensure patient safety and can assist patients through uncomplicated mild alcohol withdrawal.

Contraindications to commencing the regime are those relating to the medications of diazepam, (some examples include prolonged sedation, older patients over 65, recent head injury, liver failure or respiratory failure), thiamine (e.g. allergy) or the giving of parenteral injections (e.g. bleeding disorder).

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 4.7.

The following is a suggested regime for ambulatory alcohol withdrawal management. Treatment may be tailored to the patient’s presentation in consultation with the medical officer. Should more than 120 mg diazepam over 7 days be prescribed, the rationale must be discussed with a specialist D&A medical officer and documented (see below for regime).

<table>
<thead>
<tr>
<th>Oral diazepam dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1 10 mg four times a day</td>
</tr>
<tr>
<td>Day 2 10 mg three times a day</td>
</tr>
<tr>
<td>Day 3 10 mg twice a day</td>
</tr>
<tr>
<td>Day 4 5 mg twice a day</td>
</tr>
<tr>
<td>Day 5 5 mg at night</td>
</tr>
</tbody>
</table>

If patients are assessed as benefiting from diazepam but do not require this full regime the rationale for prescribing less diazepam should be documented.
• Thiamine 100mg – 300mg IMI daily for 3 to 5 days *(where available)*, depending on the patient’s nutritional status.
In the event it is not possible to administer IMI thiamine (eg none available, patient refuses injection, bleeding disorder) and the patient is at low risk of Wernicke’s Encephalopathy, the following regime may be administered:
  ▪ Thiamine 100mg PO TDS (three times a day) for 5 days.

In the event the patient is at risk of Wernicke’s encephalopathy (poor nutrition), has a past history of Wernicke’s or has any of the features of Wernicke’s (nystagmus, ataxia, confusion), medical assessment is essential and admission for inpatient treatment may be indicated.

4.1.2 Telephone medication orders
A telephone order for the above medication regime may be requested by DAS RNs, based on their assessment, from the MOs in their service.

Note: NSW Health Policy Directive PD2013_043 Medication Handling in NSW Public Health Facilities, sections 4.8.4 and 7.3 to be adhered to.

4.2 Special Populations

4.2.1 Pregnancy
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.

Up to 20 weeks of pregnancy: Ambulatory management is reasonable if a woman is judged to be at low risk (no history of seizures, supportive family and housing stable). However there is a lower threshold for admission to a D&A inpatient setting than for the general population. Daily antenatal input or monitoring is not required during the procedure.

Over 20 weeks of pregnancy: Inpatient management in an antenatal setting is highly recommended. However, some women (eg. 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).

*It is preferable that CUPS/SUPPS staff be involved in the cross-service co-ordination of management of pregnant women.*

4.2.2 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), 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. Oxazepam has an onset of action within 2 hours, half-life of 5 to 10 hours; and 15 to 30 mg oxazepam is approximately equipotent to 5 – 10 mg diazepam. Doses should be titrated according to clinical effect, and requires close monitoring by clinicians and carers, and assessment of falls-risk should also be included. Ambulatory management of alcohol withdrawal using oxazepam must first be discussed with a D&A staff specialist. Residential withdrawal setting may be required if close monitoring is unavailable. A sample oxazepam regime is described:

<table>
<thead>
<tr>
<th>OXAZEPAM</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td>15-30 mg four times a day</td>
</tr>
<tr>
<td>Day 2</td>
<td>15-30 mg three times a day</td>
</tr>
<tr>
<td>Day 3</td>
<td>15-30 mg twice a day</td>
</tr>
<tr>
<td>Day 4</td>
<td>15 mg twice a day</td>
</tr>
<tr>
<td>Day 5</td>
<td>15 mg at night</td>
</tr>
</tbody>
</table>

4.2.3 Patients with concurrent anxiety and depression

Many alcohol dependent patients have concurrent features of depression and anxiety. There should be careful co-ordination between all relevant service providers in planning and managing alcohol withdrawal in patients with mental health co-morbidity. Patients require regular assessment of their mental health and risk assessment regarding self-harm prior to and during the management of alcohol withdrawal. Patients considered at high-risk of suicidal behaviour may require residential withdrawal setting, due to the stress and anxiety associated with alcohol withdrawal, based on assessment of risks and supports for the patient. A patient attempting ambulatory withdrawal may require referral to the Mental Health Line if the clinical condition deteriorates.

During alcohol withdrawal, any existing medications such as antidepressants should be continued, however these medications should generally not be initiated during the first few days of alcohol withdrawal due to the potential for side effects and subsequent confusion regarding symptom aetiology. Furthermore, for many patients, anxiety and dysphoria symptoms resolve following cessation of alcohol use and withdrawal, making antidepressants and anxiolytics unnecessary.

Features of mood disturbance, anxiety and impaired sleep may persist for 1-2 weeks following alcohol withdrawal, and tends to resolve for many patients. Persistent and/or severe features of depression, anxiety or sleep disturbance require specific management, and co-ordination between relevant service providers is required.
4.2.4 Patients with concurrent drug use
Benzodiazepine dependence complicates the management of alcohol withdrawal due to the increase in seizure risk.

For patients with concurrent drug use, further advice should be sought from a specialist D&A medical officer.

MANAGEMENT ADVICE AND SUPPORT
Business hours, contact your local Drug and Alcohol Service.
After hours, contact the SESLHD Drug and Alcohol Medical Officer on call via Sydney Hospital Switchboard: 9382 7111

5. DOCUMENTATION
Client Medical Record including electronic and/or paper as per local requirements
Drug and Alcohol Assessment Form
Alcohol Withdrawal Scale
Drug and Alcohol Review form
Medication Chart with prescription to be followed by R.N’s dispensing the medication, missed doses and takeaways are also documented on the medication chart.
Clinical notes entered into electronic medical records after each encounter with client.

6. AUDIT
Standard documentation and medication chart audits will ensure this procedure is complied with.

7. REFERENCES
Nursing & Midwifery Clinical Guidelines - Identifying & Responding to Drug & Alcohol Issues


NSW Health PD2009_060 Clinical Handover – Standard Key Principles


NSW Drug and Alcohol Withdrawal Clinical Practice Guidelines 2007 (NSW Health GL2008_011)

Health Care Records – Documentation and Management (NSW Health PD2012_069)
8. **REVISION AND APPROVAL HISTORY**

<table>
<thead>
<tr>
<th>Date</th>
<th>Revision No.</th>
<th>Author and Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2015</td>
<td>1</td>
<td>Ashley Cochrane transferred BR to Procedure template as medications involved.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reviewed by Withdrawal Services Clinical Governance Working Group and Director, Nicholas Lintzeris.</td>
</tr>
<tr>
<td>August 2015</td>
<td>1</td>
<td>Application to Development endorsed by Executive Sponsor.</td>
</tr>
<tr>
<td>August 2015</td>
<td>1</td>
<td>On Draft for Comment until 28 September 2015</td>
</tr>
<tr>
<td>November 2015</td>
<td>1</td>
<td>Approved by Clinical &amp; Quality Council 11 November 2015 for publishing.</td>
</tr>
</tbody>
</table>
## Admission criteria for different withdrawal settings

<table>
<thead>
<tr>
<th></th>
<th>Ambulatory</th>
<th>Community residential</th>
<th>Inpatient hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Predicted alcohol withdrawal severity</strong></td>
<td>Mild-moderate</td>
<td>Moderate-severe</td>
<td>Moderate-severe</td>
</tr>
<tr>
<td><strong>Likelihood of severe withdrawal complications</strong></td>
<td>No</td>
<td>Withdrawal complications (seizures, hallucinations)</td>
<td>Withdrawal complications (delirium, seizures with unclear cause)</td>
</tr>
<tr>
<td><strong>Medical or psychiatric co-morbidity</strong></td>
<td>Minor co-morbidity</td>
<td>Minor co-morbidity</td>
<td>Significant co-morbidity</td>
</tr>
<tr>
<td><strong>Other substance use</strong></td>
<td>No heavy use of other drugs (licit and illicit)</td>
<td>Heavy or unstable use of other drugs</td>
<td>Heavy or unstable use of other drugs</td>
</tr>
<tr>
<td><strong>Social environment</strong></td>
<td>Alcohol-free home environment Daily monitoring by reliable support people Good access to health care service</td>
<td>Unsupportive home environment</td>
<td>Unsupportive home environment</td>
</tr>
<tr>
<td><strong>Previous attempts</strong></td>
<td>No recent repeated failure at ambulatory withdrawal</td>
<td>Repeated failure at ambulatory withdrawal</td>
<td>Repeated failure at ambulatory withdrawal</td>
</tr>
</tbody>
</table>

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

A full standardised SESLHD drug and alcohol assessment is to be completed for every patient.

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

- Patient’s reasons for presentation.
- Patient’s expectations and goals.
- A comprehensive history of current alcohol intake:
  - frequency of consumption
  - amount (documented in standard drinks/grams)
  - duration of consumption at current level
  - the time of last consumption of alcohol (this is important for estimating when withdrawal symptoms may occur)
  - time of first alcohol consumption of the day
  - where and with whom the consuming of alcohol is done
  - previous periods of alcohol abstinence or non-problematic alcohol consumption.
- Other drug use of the previous month, both licit and illicit. Prior problematic drug use.
- Past treatment if any, and outcomes
- History of withdrawal symptoms from alcohol or any other substance and withdrawal-related complications and their treatment.
- Past history of Wernicke’s encephalopathy, delirium or hallucinations and their treatment.
- Past seizure history. Staff should attempt to verify any account of seizures and differentiate from blackouts, e.g. witnessed, hospital admission or medical treatments, investigations and hospital discharge summaries.
- Observations:
  - Blood alcohol level (BAL) using an alcometer (breathalyser).
  - Pulse, blood pressure.
  - Temperature
  - O2 levels
  - Alcohol Withdrawal Scale (AWS)
- Lifestyle and social supports.