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<th>NAME OF DOCUMENT</th>
<th>Drug and Alcohol – Alcohol – Inpatient Management of Withdrawal Procedure</th>
</tr>
</thead>
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<tr>
<td>TYPE OF DOCUMENT</td>
<td>Procedure</td>
</tr>
<tr>
<td>DOCUMENT NUMBER</td>
<td>SESLHDPR/238</td>
</tr>
<tr>
<td>DATE OF PUBLICATION</td>
<td>August 2015</td>
</tr>
<tr>
<td>RISK RATING</td>
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</tr>
<tr>
<td>LEVEL OF EVIDENCE</td>
<td>NSQHS Standards 4 – Medication Safety, 5 – Patient Identification and Procedure Matching EQuIP Standard 12 – Provision of Care</td>
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<tr>
<td>REVIEW DATE</td>
<td>August 2016</td>
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<tr>
<td>FORMER REFERENCE(S)</td>
<td>Replaces all site and network based procedures</td>
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<tr>
<td>EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR</td>
<td>Dr Greg Stewart Director of Operations: Ambulatory and Primary Health</td>
</tr>
<tr>
<td>AUTHOR</td>
<td>Prof Nicholas Lintzeris Director, Drug and Alcohol Service <a href="mailto:Nicholas.Lintzeris@sesiahhs.health.nsw.gov.au">Nicholas.Lintzeris@sesiahhs.health.nsw.gov.au</a></td>
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<tr>
<td>POSITION RESPONSIBLE FOR THE DOCUMENT</td>
<td>Prof Nicholas Lintzeris Director, Drug and Alcohol Service</td>
</tr>
<tr>
<td>KEY TERMS</td>
<td>Withdrawal management, alcohol, detox, detoxification, inpatient, Alcohol Withdrawal Scale, AWS</td>
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<tr>
<td>SUMMARY</td>
<td>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.</td>
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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 and 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, 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. 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 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 Drug and Alcohol 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.
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 six to 48 hours after the last drink is consumed. These seizures can occur even if the blood alcohol level is high (eg, greater than 0.10 g% / 22mmol/l) in severely dependent drinkers.

The prevalence of alcohol-withdrawal seizures is estimated at between two and nine 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 six 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 two to three days after ceasing drinking, and usually lasts for a further two to three 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.

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 severe withdrawal complications (such as delirium or seizures of unknown cause), and/or severe medical or psychiatric 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.

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 patient presents to hospital intoxicated or with Blood Alcohol Level (BAL) higher than 0.1% please contact Drug and Alcohol staff before transfer to ward.
The criteria for an elective planned withdrawal admission are as follows:

- Moderate to severe predicted alcohol withdrawal severity
- 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 Drug and Alcohol Consultation Liaison team (business hours) or SESLHD Drug and Alcohol Medical Officer on call via Sydney Hospital Switchboard on 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 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 Drug and Alcohol Consultation Liaison team (business hours) or SESLHD Drug and Alcohol Medical Officer on call via Sydney Hospital Switchboard on 9382 7111 (after hours) to assist in the management and discharge planning.

### 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.

**General observations** Temperature, pulse, respiratory rate and blood pressure, as well as the Alcohol Withdrawal Scale (Appendix 3) are required 2nd hourly for the first 12 hours and then four to six hourly for 48 hours. More frequent monitoring may be necessary if clinically indicated.

**Physical signs** Level of hydration, level of consciousness (especially if medicated), severity of alcohol withdrawal and general progress during withdrawal (ie, 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 causes may increase the scoring of the scale eg, infection causing a raised temperature, perspiration and agitation. It should be used to guide treatment, and
to help clinicians communicate more objectively about the severity and management of alcohol withdrawal.

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.

Prophylactic Thiamine
- Should initially be given parenterally, as oral thiamine has very low bioavailability in heavy drinkers due to poor absorption through the gastro-intestinal mucosa.
- Administer thiamine 300 mg per day (100 mg tds) intravenously (preferably) or intramuscularly for three days.
- Administer thiamine prior to any carbohydrate load (eg, intravenous glucose) as glucose intake in the presence of thiamine deficiency can precipitate Wernicke’s encephalopathy.

NOTE: For patients with possible/confirmed Wernicke’s encephalopathy, refer to Section 5 – Treating Complications.

Patient Information
- Communicate the likely nature, severity and duration of symptoms, the role of medication
- 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
- Reacquaint the patient with his environment
- A night light to reduce the likelihood of perceptual errors and exacerbation of anxiety and psychotic phenomena at night.

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

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.

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 severe withdrawal complications (seizures, delirium)
- patients presenting in severe alcohol withdrawal (AWS ≥8) and/or severe withdrawal complications (delirium, hallucinations, following an alcohol withdrawal seizure).

Alcohol withdrawal seizures can occur following the cessation of drinking and before the onset of severe alcohol withdrawal features. Hence, diazepam loading should commence in alcohol dependent patients 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 20 mg orally every two 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 and Alcohol Medical Officer on call via Sydney Hospital Switchboard on 9382 7111 (after hours).

The dose of 80 mg diazepam will have significant sedative effects for several days and generally no further doses of diazepam will be needed. Further doses of diazepam (eg, 10mg nocte) may be used for symptomatic management for the following two to three days. If there are concerns, further advice should be sought from the Drug and Alcohol Consultation Liaison team (business hours) or SESLHD Drug and Alcohol Medical Officer on call via Sydney Hospital Switchboard on 9382 7111 (after hours).

Fixed-Schedule Regimen

Fixed schedule regimens usually involve reducing doses over a three to five 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 (ie, prolonged sedation, older patients, recent head injury, liver failure or respiratory failure).
Fixed schedule regimen may be supplemented with additional diazepam or oxazepam as needed for people with low tolerance of withdrawal discomfort.

**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 and Alcohol Medical Officer on call via Sydney Hospital Switchboard on 9382 7111 (after hours).

Example of a Fixed Schedule Regimen is as follows:

<table>
<thead>
<tr>
<th><strong>DIAZEPAM - FIXED SCHEDULE REGIMEN</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td>10 mg four times a day</td>
</tr>
<tr>
<td>Day 2</td>
<td>10 mg three times a day</td>
</tr>
<tr>
<td>Day 3</td>
<td>10 mg twice a day</td>
</tr>
<tr>
<td>Day 4</td>
<td>5 mg twice a day</td>
</tr>
<tr>
<td>Day 5</td>
<td>5 mg at night</td>
</tr>
</tbody>
</table>

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

4.2.4 **Contraindications to Diazepam**

Shorter acting benzodiazepines eg, oxazepam should be used where there is concern about the following:

- Prolonged sedation, such as in older patients
- Recent head injury
- Liver failure
- Respiratory failure

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

<table>
<thead>
<tr>
<th><strong>OXAZEPAM - FIXED SCHEDULE REGIMEN</strong></th>
<th></th>
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</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>

**OXAZEPAM** is recommended where diazepam is contraindicated (eg, prolonged sedation, older patients (over 65), recent head injury, liver failure or respiratory failure). (15 to 30 mg oxazepam is approximately equipotent to 5 to 10 mg diazepam)

Midazolam by intravenous bolus or infusion is preferred where rapid, but easily reversible, sedation is required (for example, in a patient who has had a seizure and has a suspected head injury).

**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 and Alcohol Medical Officer on call via Sydney Hospital Switchboard on 9382 7111 (after hours).
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 and Alcohol Medical Officer on call via Sydney Hospital Switchboard on 9382 7111 (after hours).

Wernicke’s Encephalopathy: Many cases of Wernicke’s encephalopathy may be subclinical and signs and symptoms may not be present. See Definition Section of this document for further information.

The recommended treatment is as follows:
- Parenteral doses of at least 500 mg per day thiamine (intramuscular or intravenous diluted in saline over 30 minutes) should be administered for at least three to five days, and subsequent doses of at least 300 mg (oral or parenteral) per day for one to two weeks. The intramuscular route should not be used for patients with coagulopathy.
- Correct any electrolyte disturbances, including hypomagnesaemia.
- Thiamine should be given before any carbohydrate load (eg, intravenous glucose).

6. DETERIORATING PATIENTS

6.1 PACE
In the event that a patient’s condition deteriorates, regardless of cause, the PACE protocol is to be followed as described in SESLHDPR/283: Patient with Acute Condition for Escalation (PACE): Management of the Deteriorating ADULT and MATERNITY Inpatient.

7. SPECIAL POPULATIONS

7.2.1 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. FACS notification may be necessary – Keep Them Safe (NSW Health PD2011_057 ‘Child Protection and Wellbeing – Information Exchange’)

- 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 a Drug and Alcohol 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 (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 Drug and Alcohol 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 and Alcohol Medical Officer on call via Sydney Hospital Switchboard on 9382 7111 (after hours).

7.2.2 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 (ie, 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.

7.2.3 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 the Drug and Alcohol Consultation Liaison team (business hours) or SESLHD Drug and Alcohol Medical Officer on call via Sydney Hospital Switchboard on 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 withdrawal episode. Clinicians, with the assistance of the local drug and alcohol consultation liaison team
should facilitate links to post-withdrawal treatment services during the withdrawal treatment.

Discharge options include the following:

- Primary care
- Refer to Drug and Alcohol Consultation and Liaison Service for ongoing treatment planning and co-ordination
- Provision of information to the patient (or carer)
  - Alcohol and Drug Information Service (ADIS) 9361800/1800 422 599
  - Local Drug and Alcohol Service
  - Educative material
- Counselling links (eg, relapse prevention)
- Residential rehabilitation
- Self-help services
- Medication for relapse prevention (acamprosate, naltrexone, disulfiram)

10. DOCUMENTATION

- SESIAHS Drug and Alcohol Assessment Form
- SESIAHS Inpatient Alcohol Withdrawal Scale (AWS) Form

11. AUDIT

Drug and Alcohol Consultation Liaison Nurses will regularly audit the files to ensure this procedure is complied with.

12. REFERENCES

Clinical Guidelines for Nursing and Midwifery Practice in NSW: Identifying and Responding to Drug and Alcohol Issues 2007 (NSW Health GL2008_001)

Clinical Handover – Standard principles (NSW Health PD2009_060)


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


Health Care Records - Documentation and Management

SESI AHS PD209 Prevention, Diagnosis and Management of Delirium in Older People in Acute & Sub Acute Care 2009


13. REVISION AND APPROVAL HISTORY

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<td>Draft</td>
<td>Drug and Alcohol Consultation Liaison Working Group</td>
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<td>0</td>
<td>Endorsed by Area Patient Safety and Clinical Quality Committee Noted by Area Clinical Council</td>
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<td>August 2015</td>
<td>3</td>
<td>Drug and Alcohol Consultation Liaison Working Group Drug and Alcohol Executive. Endorsed by Executive Sponsor.</td>
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### Admission Criteria for Different Withdrawal Settings

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<th>Ambulatory</th>
<th>Community residential</th>
<th>Inpatient hospital</th>
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<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, unclear cause of seizures)</td>
</tr>
<tr>
<td><strong>Medical or psychiatric comorbidity</strong></td>
<td>Minor comorbidity</td>
<td>Minor comorbidity</td>
<td>Significant comorbidity</td>
</tr>
<tr>
<td><strong>Other substance use</strong></td>
<td>No heavy drug use</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’</td>
<td>Unsupportive home environment</td>
<td>Unsupportive home environment</td>
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<tr>
<td></td>
<td>Daily monitoring by reliable support people</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Good access to health care service</td>
<td></td>
<td></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 assessment is to be completed for every client.

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.
- 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

<table>
<thead>
<tr>
<th>MONITORING THE PATIENT</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temp, Pulse, Respirations, BP and AWS 2nd hourly for 12 hours, then 4 - 6 hourly for 48 hours</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 37.0°C
- 1 – Temperature of 37.1°C to 37.5°C
- 2 – Temperature of 37.6°C to 38.0°C
- 3 – Temperature of 38.1°C to 38.5°C
- 4 – Temperature above 38.5°C

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 orientated in person but not sure where he/she is or time
- 2 – Oriented in person but disorientated 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

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.