East London
NHS Foundation Trust

IN-PATIENT ALCOHOL DETOXIFICATION GUIDELINES

Version number :	3.0
Consultation Groups	Service managers and consultants of ELFT Specialist Addictions Services
Approved by (Sponsor Group)	Substance misuse clinical governance group, Medicines Committee, Healthcare Assurance Committee
Ratified by:	Medicines Committee
Date ratified:	10th November 2021
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Services	Applicable
Trustwide	X
Mental Health and LD	
Community Health Services	

Version Control Summary

Version	Date	Comments / changes
1.0	December 2017	
2.0	April 2018	Revised with changes to reflect current practice
3.0	July 2021	Combined two existing protocols and updated with latest practice. Added decision algorithm about when to detox and when not to.

INTRODUCTION

These guidelines may be used for any service users requiring in-patient alcohol detoxification. However, some parts of the guideline may not be applicable in emergency mental health admissions where alcohol detoxification may be required e.g. monitoring before admission, post-discharge follow up or medication to prevent relapse.

Hospital admissions are a good opportunity to counsel patients about their alcohol use and its impact on health and to plant seeds of change in the patient's lifestyle choices. At the end of this guideline there are links for further education around delivering alcohol identification and brief advice in the hospital setting through e-learning for health. There are also useful resources for patients to help shift their thinking from pre-contemplative to contemplative and eventually action.

PURPOSE

To provide guidance on the management of alcohol detoxification on inpatient units.

DEFINITIONS

CIWA-Ar - Clinical Institute Withdrawal Assessment Scale, Revised

NICE

DUTIES

Medicines Management Committee

Will approve and review these guidelines

Medical Director

Is responsible for the dissemination of this guideline to their Clinical Directors and Clinical Tutors

Clinical Directors

Are responsible for the dissemination and implementation of the guideline in their service areas

Heads of Service

Are responsible for the dissemination and implementation of the guideline in their service areas

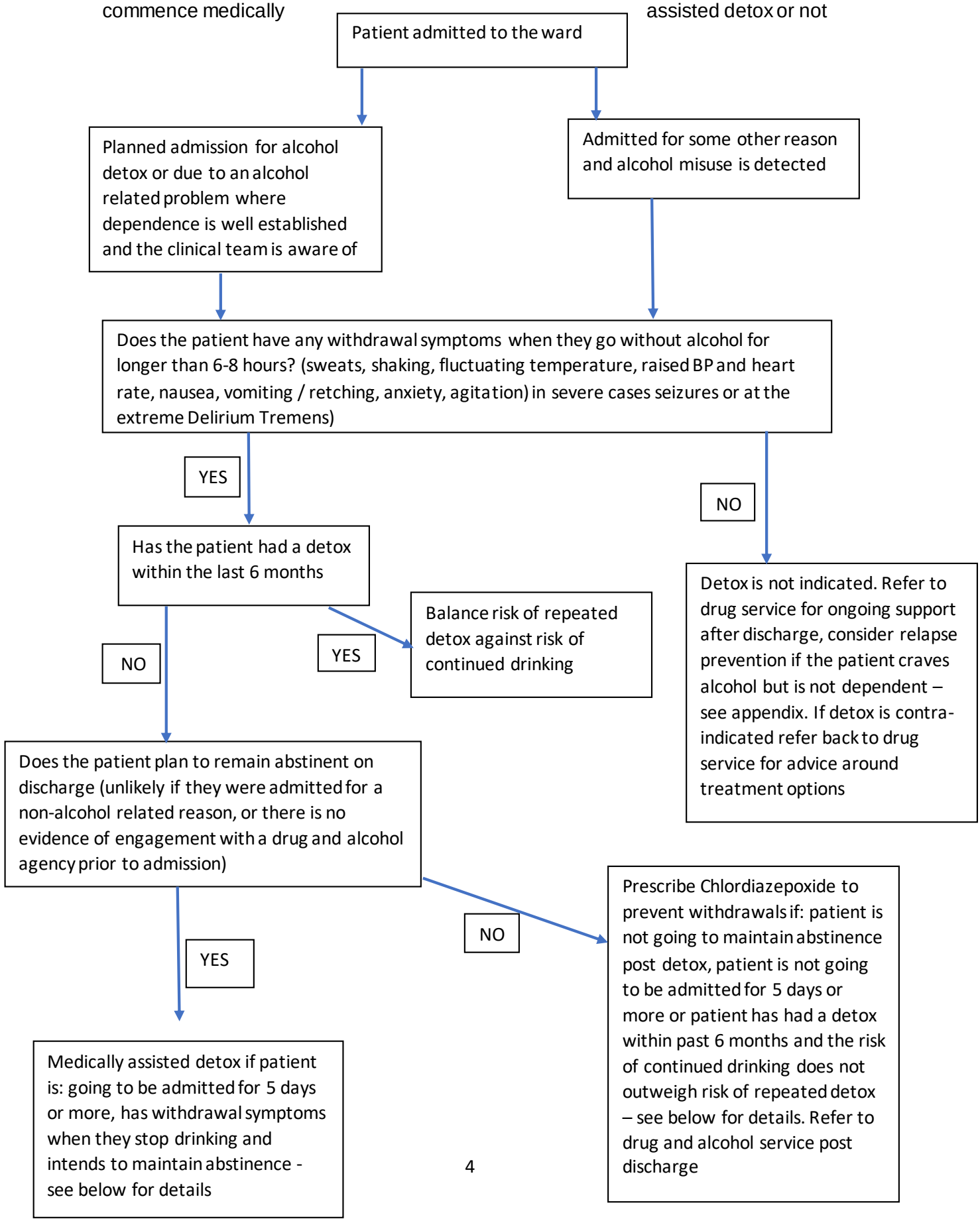
Doctors

Are responsible for reviewing the patient prescribing detoxification treatment and vitamin supplementation

Inpatient Nursing Staff

Are responsible for monitoring CIWA-Ar scores and for signs of withdrawal

Flow chart describing decision to commence medically assisted detox or not



Steps in Medically Assisted Detox.

- Is medically assisted detox indicated?
- If the patient has had a detox within the last 6 months. repeated detoxes are associated with an increase in the risks of complications developing – even if the patient is on medication. There is increased risk of seizures and delirium tremens occurring. this is part of the phenomenon known as Kindling
- Repeated detox is also associated with long term deficits in brain function. People who have had several medically assisted detoxes perform worse on cognitive tests.

Assessment –

- Define the problem. what were they drinking, how often, how much in 24 hours?
- What happens when they do not drink for prolonged periods?
- Do they have withdrawals in the morning? If they do are they so bad they must drink first thing in the morning?
- To start prescribing we need to know the severity of dependence.
- We can get this from doing the severity of alcohol dependence questionnaire and also working out the number of units they drink per day or per week.
- The two should correlate so a dependent drinker would be expected to be drinking a high number of units of alcohol per day or week.

The table below correlates SADQ score and alcohol unit consumption

Severity of dependence	**Number of units per day**	**SADQ score**	**Chlordiazepoxide (initial starting dose)**
Moderate	15 - 30	15 - 30	15 - 30 mg qds
Severe	30 - 40	31 - 45	30 - 40 mg qds
Very severe	> 40	> 45	> 40 mg qds

See appendix for the SADQ and how to use it.

The Detox -

- Detox should take between 5 to 10 days. Any less than 5 days and the risk period of developing complications has not been covered, thereby defeating the purpose of the detox. Any more than 10 days and there is a risk of developing a new dependence on chlordiazepoxide.
- Detox with chlordiazepoxide or diazepam (if a quicker onset is desired, but bear in mind diazepam is more likely to be abused). If there is liver impairment or in the elderly oxazepam is an alternative.
- Initially the dose will be four times a day and this will reduce over 5 to 10 days.
- The table below gives an example regime for a patient with moderate alcohol dependence
- Use the CIWA-ar score to guide the detox. The scale is done every day and gives a validated score of how severe the patients withdrawal is and is useful

to detect if the dose of chlordiazepoxide is high enough to cover the patient's withdrawal symptoms.

- If the CIWA-ar score is worsening, then the dose of chlordiazepoxide may need to be held or increased.
- Blood pressure pulse, temperature and respiratory rate should all be monitored regularly during detox.
- Medically assisted detoxes should be completed in 5 to 10 days. high risk period is the first 5 days so discharging before 5 days is dangerous as the patient could still develop severe withdrawal symptoms, even when detox is still happening.
- Detox is successful when patient has no moderate or severe withdrawal symptoms when they have no medication or alcohol.

	Morning	Midday	Early Evening	Bedtime
Day 1	20mg	20mg	20mg	20mg
Day 2	15mg	15mg	15mg	15mg
Day 3	10mg	10mg	10mg	10mg
Day 4	5mg	5mg	5mg	5mg
Day 5	5mg	0	5mg	5mg
Day 6	5mg	0	0	5mg
Day 7	0mg	0mg	0mg	5mg
Day 8	STOP			

- A typical regime for moderate dependence, with an estimated average daily use of 20 units of alcohol, may require an initial dose of chlordiazepoxide 20 mg QDS on day 1, with a gradual reduction over the next 5 to 7 days.
- A patient may stay on the same dose for a day or two depending on clinical need and therapeutic response. An additional small dose of chlordiazepoxide could be given in the first 48 hours if required.
- Doses in excess of 40 mg four times a day should be prescribed only if there is clear evidence of very severe alcohol dependence.
- Such doses are rarely necessary in women and children and never in older people or if there is liver impairment.
- Seek advice from an addiction specialist in cases like this

As the detox progresses the patient's observations should all improve. Often you will see improved gait and the patient is more steady on their feet.
Patients requiring medically assisted detox should also be started on a course of Pabrinex at the thiamine deficiency prophylaxis dose – ampoule 1&2 once a day for 3 days.

Management during detoxification

The following are to be monitored:

- Blood pressure, pulse and respiratory rate every 6 hours for the first three days and then daily: Diastolic blood pressure and/or heart rate above 100 may indicate the need to administer higher doses of benzodiazepines.
- Withdrawal symptoms every 6 hours for the first 3 days, using the attached checklist (Appendix 1), if CIWA-AR scores remain below 8 at all times. If CIWA-AR scores are above 8, further monitoring and further doses of chlordiazepoxide may be required.
- In case of over-sedation, the next dose of chlordiazepoxide may be missed and the regime needs to be reviewed.
- Random breathalyser and urine drug tests may be carried out at the discretion of nursing staff. Positive tests should be documented as this may result in the cessation of detoxification. Ward staff to liaise with the drug services when necessary.

- Avoid carbohydrate loads where possible (e.g. IV Dextrose) in chronic alcohol use as this will deplete thiamine reserves and may precipitate Wernicke's encephalopathy.
- Always administer parenteral Pabrinex before administering glucose in all patients with altered mental state.
- Always consider the risk of re-feeding syndrome and monitor appropriately.
- Carefully monitor for electrolyte imbalances and especially for sodium, potassium, calcium, phosphate and magnesium levels.
- Consider an ECG and early referral to a medical ward when significant abnormalities are detected.

- In people with alcohol withdrawal seizures, consider offering a quick-acting benzodiazepine (such as lorazepam) to reduce the likelihood of further seizures.
- If alcohol withdrawal seizures develop in a person during treatment for acute alcohol withdrawal, review their withdrawal drug regimen.
- Those who have a seizure for the first time should be investigated to rule out an organic disease or structural lesion.
- Do not offer phenytoin to treat alcohol withdrawal seizures. Carbamazepine (inpatient setting only, see also SPC) may also be considered.
- Many mental health units use PR diazepam for emergency seizure control.
- Staff in an inpatient setting should be familiar with administration of rectal diazepam should a withdrawal seizure occur. Rectal diazepam should be prescribed to be used PRN.
- Diazepam is also advocated as benzodiazepine of choice for medically assisted alcohol withdrawal in those with a previous history of seizures (Taylor et al. 2012).

- If delirium tremens develops in a patient during treatment for acute alcohol withdrawal, review their withdrawal drug regimen.
- In people with delirium tremens, oral lorazepam should be offered as first line treatment.

- If symptoms persist or oral medication is declined, consider parenteral lorazepam, haloperidol or olanzapine and exclude comorbid acute medical conditions.
- Consider an antipsychotic (caution required due to lowering seizure threshold) in a patient with delirium who is distressed or considered a risk to themselves or others and if verbal and non-verbal de-escalation techniques are ineffective. This should normally be for a short-term only (usually for 1 week or less).
- Use antipsychotic drugs with extreme caution or not at all for people with conditions such as Parkinson's disease or dementia with Lewy bodies (DLB).
- The usual recommended starting dose for haloperidol in liver units, (i.e. in patients with underlying liver disease) is 1.5 – 2mg TDS, although treatment with benzodiazepines should be the priority.

Patients suspected of having Delirium Tremens or Wernicke's should be transferred to an acute medical hospital. Mental Health wards do not have the facilities for administering IV fluids and these conditions are often associated with inter-current illnesses such as electrolyte imbalances and infections.

What to do if the patient is not suitable for medically assisted detox?

- If the patient is alcohol dependent but they are not suitable for a medically assisted detox (see flow chart above) the treatment will be about managing withdrawal symptoms.
- In this situation the SADQ is taken and the patient is given doses of chlordiazepoxide to prevent withdrawal while on the ward as an inpatient.
- The scenario here is that the patient is not going to be admitted for long enough to complete a detox, or a detox is contraindicated (for example they have recently had a detox and relapsed) or the patient is not in treatment with a drug and alcohol service so has done no preparatory work for abstinence and is unlikely to maintain abstinence when they are discharged, or a frequent flier).
- They are given chlordiazepoxide at a dose high enough to prevent withdrawal.
- Doses are given up to four times a day.
- Doses are adjusted in line with the presence of withdrawal symptoms.
- If the patient is going to be kept in long enough to complete a detox they should be detoxed and plans put in place for them to be managed in the community.
- If they are not willing to engage with community drug services, then do not detox and manage withdrawal until they are discharged.
- The dose in withdrawal management would remain the same, it could reduce if they were an inpatient for a long time.
- Doses would be around 20mg to 30mg at a time. Higher if indicated by the SADQ score
- Withdrawal management should not continue for longer than 5 days.

Vitamin supplementation

- On admission, all patients should preferably commence the following prophylactic treatment:

- Pabrinex® intramuscular injections one pair daily for 3 - 5 days

followed by:

- Thiamine tablets100mg three times daily
- Vitamin B Compound Strong is no longer recommended.

Pabrinex is also available as an Intravenous High Potency Injection.

- Therefore, before administration ensure that both the Summary of Product Characteristics and ampoule labels refer to the INTRAMUSCULAR injection.
- The contents of one ampoule number 1 and one ampoule number 2 of Pabrinex Intramuscular High Potency (total 7ml) are drawn up into a syringe to mix them just before use.

- Potentially serious allergic adverse reactions such as anaphylactic shock may occur rarely during, or shortly after, parenteral administration of Pabrinex Intramuscular, it is a very rare occurrence and should not preclude the use of Pabrinex Intramuscular in patients who need treatment by this route of administration**.**
- **Initial warning signs of a reaction to Pabrinex Intramuscular are sneezing or mild asthma, and those treating patients need to note that the administration of further injections to such patients may give rise to anaphylactic shock.**
- Facilities for treating anaphylactic reactions should be available whenever Pabrinex Intramuscular High Potency is administered.
- The patient's consent should be obtained before administration and they should be informed of the risk of anaphylaxis.
- The number of actual anaphylaxis incidents is low and has been quoted as 1 per 5 million with intramuscular injections. (McIntosh et al 2005).

- Treatment for a presumptive diagnosis of Wernicke's consists of 2-3 pairs of Pabrinex IV ampoules administered three times a day for at least two days.
- Treatment may continue with 1 pair of Pabrinex IV ampoules for 3-5 days or for as long as clinical improvement continues.
- This treatment should always be administered in a general hospital setting.

Food supplements may be considered if dietary intake is inadequate, after advice from a dietitian.

Use of Thiamine in Alcohol Harmful Use / Dependence (NICE-CG100/115)	
Prophylactic oral thiamine:	• if they are malnourished or at risk of malnourishment **or** • if they have decompensated liver disease (development of jaundice, ascites, bruising or abnormal bleeding and/or hepatic encephalopathy) **or** • if they are in acute withdrawal **or** • before and during a planned medically

	assisted alcohol withdrawal
Prophylactic parenteral thiamine followed by oral thiamine:	• if they are malnourished or at risk of malnourishment **or** • if they have decompensated liver disease **and in addition** • they attend an emergency department **or** • are admitted to hospital with an acute illness or injury
Therapeutic parenteral thiamine followed by oral thiamine:	• Offer to people with suspected Wernicke's encephalopathy. • Maintain a high level of suspicion for the possibility of Wernicke's encephalopathy, particularly if the person is intoxicated. • Parenteral treatment should be given for a minimum of 5 days, unless Wernicke's encephalopathy is excluded. • Oral thiamine treatment should follow parenteral therapy.

Wernicke – Korsakoff Syndrome

- The Wernicke-Korsakoff syndrome develops in problem drinkers who are thiamine deficient.
- However, other as yet unidentified factors must be important in its genesis as thiamine deficiency is not invariably associated with the development of this syndrome.
- **Wernicke's encephalopathy** comprises a triad of global confusion, eye signs and ataxia; the confusional state is accompanied by apathy, disorientation and disturbed memory, but drowsiness and stupor are uncommon. The ocular abnormalities include nystagmus, gaze palsies and ophthalmoplegia, while the ataxia affects the trunk and lower extremities.
- The clinical abnormalities may develop acutely or evolve over several days.
- **Korsakoff's psychosis** is an amnesic state in which there is profound impairment of both retrograde and anterograde memory but relative preservation of other intellectual abilities; confabulation may be a feature. Korsakoff's psychosis generally develops after an acute episode of Wernicke's encephalopathy.
- However, some patients develop a combined syndrome, from the outset, with memory loss, eye signs and unsteadiness but without confusion; others do not develop either the eye signs or ataxia.

- Post-mortem analysis has demonstrated that Wernicke's encephalopathy may occur in as many as 12.5% of chronic alcohol misusers.

- The discrepancy between the pathological findings and the clinical recognition of the syndrome may be explained by the fact that the classical presentation is seen in only 10% of patients.
- A **presumptive diagnosis** of the Wernicke-Korsakoff's syndrome should therefore be made in patients with a history of hazardous or harmful drinking and one or more of the following otherwise unexplained symptoms: ataxia, ophthalmoplegia, nystagmus, confusion, memory disturbance, comatose/unconscious, hypotension, and or hypothermia.

Any patient presenting with the above signs should be immediately transferred to the local General Hospital.

Preventing relapse

- After a successful withdrawal of people with moderate and severe alcohol dependence, consider offering acamprosate, disulfiram or oral naltrexone in combination with an individual psychological intervention (cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) focused specifically on alcohol misuse.
- Before starting treatment with acamprosate, oral naltrexone or disulfiram, conduct a comprehensive medical assessment (baseline urea and electrolytes and liver function tests including GGT). In particular, consider any contraindications or cautions (see the SPC), and discuss these with the service user.

Acamprosate

- Acamprosate has been shown to increase abstinence rates.
- It should be initiated as soon as possible after abstinence has been achieved.
- Acamprosate should be avoided in severe hepatic impairment or in serum creatinine greater than 120 micromol/litre.
- Relevant tests should be performed prior to initiation.
- Avoid in those who are pregnant or breastfeeding. Refer to BNF/SPC for full details

- Acamprosate is usually prescribed at a dose of 1998mg (666mg three times a day) unless the service user weighs less than 60 kg, and then a maximum of 1332mg should be prescribed per day (666mg in the morning and 333mg at midday and at night).
- Acamprosate should usually be prescribed for up to 12 months, or longer for those benefiting from the drug who want to continue with it.
- It should be stopped if drinking persists for 4–6 weeks whilst taking the medication.
- Service users taking acamprosate should stay under supervision, at least monthly, for 6 months, and at reduced but regular intervals if the drug is continued after 6 months.

Do not use blood tests routinely, but consider them to monitor for recovery of liver function and as a motivational aid for service users to show improvement.

Naltrexone

- Naltrexone is a non-selective opioid antagonist, commonly used in opioid dependence post detoxification.
- It should not be started in patients known or suspected of being dependent on opioids including heroin, methadone or buprenorphine and analgesia such as tramadol, codeine or other opioid containing agents.
- Naltrexone will precipitate acute withdrawal in these patients.

- Naltrexone is thought to reduce cravings for alcohol, reduce the number of drinking days and the amount of alcohol consumed.
- Begin treatment after assisted withdrawal.
- Start prescribing at a dose of 25 mg per day and aim for a maintenance dose of 50 mg per day.
- Naltrexone should not be stopped if drinking resumes.
- Draw the service user's attention to the information card that is issued with oral naltrexone about its impact on opioid-based analgesics.
- Informed consent should be obtained and documented for its use.

- Oral naltrexone should usually be prescribed for up to 6 months or longer for those benefiting from the drug who wish to continue with it.
- It should be stopped if drinking persists 4–6 weeks after starting the medication.

- Service users taking oral naltrexone should stay under supervision, at least monthly for 6 months and at reduced but regular intervals if the drug is continued after 6 months.

- Do not use blood tests routinely, but consider them for older people, for people with obesity, for monitoring recovery of liver function and as a motivational aid for service users to show improvement.
- If the service user feels unwell, advise them to stop the oral naltrexone immediately.

Disulfiram – used second line only after failed treatment on acamprosate and naltrexone. Initiated under specialist supervision

- Disulfiram inhibits the aldehyde dehydrogenase, leading to acetaldehyde accumulation after drinking alcohol which can cause unpleasant physical effects.
- Continued drinking can lead to arrhythmias, hypotension and collapse.
- Disulfiram appears to reduce the number of drinking days but not to increase abstinence. Supervised consumption may improve efficacy.
- Contra-indications for using disulfiram include cardiac failure, coronary artery disease, and history of cerebrovascular accident, hypertension, psychosis, severe personality disorder and suicide risk. Disulfiram should not be continued for more than six months without a review. Refer to BNF/SPC for full details.
- After a successful withdrawal for people with moderate and severe alcohol dependence, consider offering disulfiram in combination with a psychological intervention to service users who have a goal of abstinence but for whom

acamprosate and oral naltrexone are not suitable, or prefer disulfiram and understand the relative risks of taking the drug

- If using disulfiram, start treatment at least 24 hours after the last alcoholic drink consumed.
- Usually prescribe at a dose of 200 mg per day. For service users who continue to drink, if a dose of 200 mg (taken regularly for at least 1 week) does not cause a sufficiently unpleasant reaction to deter drinking, consider increasing the dose in consultation with the service user.
- Before starting treatment with disulfiram, test liver function, urea and electrolytes to assess for liver or renal impairment.
- Check the SPC for warnings and contraindications in pregnancy.

- Make sure that service users taking disulfiram stay under supervision, at least every 2 weeks for the first 2 months, then monthly for the following 4 months.
- If possible, they should have a family member or carer, who is properly informed about the use of disulfiram, to oversee the administration of the drug.
- Service users on disulfiram should be medically monitored at least every 6 months after the initial 6 months of treatment and monitoring.

Warn service users taking disulfiram, and their families and carers, about:

- The interaction between disulfiram and alcohol (which may also be found in food, perfume, mouthwash etc.), the symptoms of which may include flushing, nausea, palpitations and, more seriously, arrhythmias, hypotension and collapse.

- The rapid and unpredictable onset of the rare complication of hepatotoxicity; advise service users that if they feel unwell or develop a fever or jaundice that they should stop taking disulfiram and seek urgent medical attention.

Discharge from hospital

- Alcohol detoxification regime should have been completed. A week's supply of acamprosate, naltrexone or disulfiram, if prescribed, could be issued from pharmacy.
- Vitamin supplementation should be reviewed and continued as deemed appropriate.
- GPs may prescribe oral thiamine 50 mg per day (as a single dose) during the maintenance stage following withdrawal, and for as long as malnutrition may be present.
- If the person has chronic alcohol dependence, oral thiamine may need to be continued indefinitely.

Referral to the local Drug and Alcohol services for follow up is a priority. Post-discharge support could be initiated during the in-patient stay if required and available locally.

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Alcohol Withdrawal Assessment Scoring Guidelines (CIWA-Ar)

Nausea/Vomiting – Rate on scale 0 – 7
0 – None
1 – Mild nausea with no vomiting
2
3
4 – Intermittent nausea
5
6
7 – Constant nausea and frequent dry heaves and vomiting

Tremors – have patient extend arms & spread fingers. Rate on scale 0 - 7
0 – No tremor
1 – Not viable, but can be felt fingertip to fingertip
2
3
4 – Moderate, with patient's arms extended
5
6
7 – severe, even w/arms not extended

Anxiety – Rate on scale 0 – 7
0 – no anxiety, patient at ease
1 – mildly anxious
2
3
4 – moderately anxious or guarded, so anxiety is inferred
5
6
7 – equivalent to acute panic states seen in severe delirium or acute schizophrenia reactions

Agitation - Rate on scale 0 – 7
0 – normal activity
1 – somewhat normal activity
2
3
4 – moderately fidgety and restless
5
6
7 – paces back and forth, or constantly thrashes about

Paroxysmal Sweats – Rate on Scale 0 – 7
0 – no sweats
1 – barely perceptible sweating, palms moist
2
3
4 – beads of sweat obvious on forehead
5
6
7 – drenching sweats

Orientation and clouding of sensorium – Ask, "What day is this? Where are you? Who am I?" Rate scale 0 – 4
0 – Orientated
1 – cannot do serial additions or is uncertain about date
2 – disorientated to date by no more than 2 calendar days
3 – disorientated to date by more than 2 calendar days
4 – disoriented to place and/or person

Tactile disturbances – Ask, "Have you experienced any itching, pins & needles sensation, burning or numbness, or a feeling of bugs crawling on or under your skin?"
0 – none
1 – very mild itching, pins & needles, burning, or numbness
2 – mild itching, pins & needles, burning, or numbness
3 – moderate itching, pins & needles, burning, or numbness
4 – moderate hallucinations
5 – severe hallucinations
6 – extremely severe hallucinations
7 – continuous hallucinations

Auditory Disturbances – Ask "Are you more aware of sounds around you? Are they harsh? Do they startle you? Do you hear anything that disturbs you or that you know isn't there?"
0 – not present
1 – Very mild harshness or ability to startle
2 – mild harshness or ability to startle
3 – moderate harshness or ability to startle
4 – moderate hallucinations
5 – severe hallucinations
6 – extremely severe hallucinations
7 – continuous hallucinations

Visual disturbances – Ask "Does the light appear to be too bright? Is its colour different than normal? Does it hurt your eyes? Are you seeing anything that disturbs you or that you know isn't there?"
0 – not present
1 – very mild sensitivity
2 – mild sensitivity
3 – moderate sensitivity
4 – moderate hallucinations
5 – severe hallucinations
6 – extremely severe hallucinations
7 – continuous hallucinations

Headache – Ask, "Does your head feel different than usual? Does it feel like there is a band around your head?" Do not rate dizziness or light headiness.
0 – not present
1 – very mild
2 – mild
3 – moderate
4 – moderately severe
5 – severe
6 – very severe
7 – extremely severe

Procedure:

1. Assess and rate of each of the 10 criteria of the CIWA scale. Each criterion is rated on a scale from 0 to 7, except for "Orientation and clouding of sensorium" which is rated on scale 0 to 4. Add up the scores for all ten criteria. This is the total CIWA-Ar score for the patient at that time. Prophylactic medication should be started for any patient with a total CIWA-Ar score of 8 or greater (i.e. Start on withdrawal medication). If started on scheduled medication, additional PRN medication should be given for a total CIWA-Ar score of 15 or greater.
2. Document vitals and CIWA-Ar assessment on the Withdrawal Assessment Sheet.
3. The CIWA-Ar scale is the most sensitive tool for assessment of the patient experiencing alcohol withdrawal. Nursing assessment is vitally important. Early intervention for CIWA-Ar score of 8 or greater provides the best means to prevent the progression of withdrawal.

Assessment Protocol a. Vitals, Assessment Now. b. If initial score ≥ 8 repeat q1h x 8hrs, then if stable q2h x 8 hrs, then if stable q4h. c. If initial score < 8, assess q4h x 72 hrs. If score < 8 for 72 hours, d/c assessment. If score ≥ 8 at any time, go to (b) above. d. If indicated, (see indications below) administer pm medications as ordered and record on MAR and below.	**Date**												
	Time												
	Pulse												
	RR												
	O_2 sat												
	BP												

Assess and rate each of the following (CIWA-Ar Scale):	**Refer to reverse for details instructions in use of the CIWA-Ar scale.**											
Nausea/vomiting (0 – 7) 0 – none, 1 – mild nausea no vomiting; 4 – intermittent nausea; 7 – constant nausea, frequent dry heaves and vomiting												
Tremors (0 – 7) 0 – no tremor, 1 – not viable but can be felt; 4 – moderate w/arms ex tended, 7 – severe even w/arms not extended												
Anxiety (0 – 7) 0 – none, at ease; 1 – mildly anxious; 4 – moderately anxious or guarded; 7 – equivalent to acute panic state												
Agitation (0 – 7) 0 – normal activity; 1 – somewhat normal activity; 4 – moderately fidgety/restless; 7 – paces or continuously thrashes about												
Paroxysmal Sweats (0 – 7) 0 – no sweats; 1 – barely perceptible sweating, palms moist; 4 – heads of sweat obvious to forehead; 7 – drenching sweat												
Orientation (0 – 4) 0 – orientated; 1 – uncertain about date; 2 – disorientated to date by no more than 2 days; 3 – disorientated by > 2 days; 4 – disorientated to place and/or person												
Tactile Disturbances (0 – 7) 0 – none; 1 – very mild itch, P&N, numbness; 2 – mild itch, P&N, burning, numbness; 3 – moderate itch, P&N, burning, numbness; 4 – moderate hallucinations; 5 –severe hallucinations; 6 – extremely severe hallucinations; 7 – continuous hallucinations												
Auditory Disturbances (0 – 7) 0 – not present; 1 – very middle harshness/ability to startle; 2 – mild harshness/ability to startle; 3 – moderate harshness/ ability to startle; 4 – moderate hallucinations; 5 severe hallucinations; 6 – extremely severe hallucinations; 7 – continuous hallucinations												
Visual Disturbances (0 – 7) 0 – not present; 1 – very mild sensitivity, 2 – mild sensitivity; 3 – moderate sensitivity; 4 – moderate hallucinations; 5 – severe hallucinations; 6 – extremely severe hallucinations; 7 – continuous hallucinations												
Headache (0 -7) 0 – not present; 1 – very mild; 2 – mild; 3 – moderate; 4 – moderately severe; 5 – severe; 6 – very severe; 7 – extremely severe												
Total CIWA-Ar score:												

Scale for Scoring: Total Score:= 0 – 9: absent or minimal withdrawal 10 – 19: mild to moderate withdrawal more than 20: severe withdrawal	**Indication for PRN medication:** a. Total CIWA- AR score 8 or higher if ordered PRN only (Symptom triggered method) b. Total CIWA-Ar score 15 or higher if on Scheduled medication. (Scheduled + pm method)

Assessment of response (CIWA-Ar score 30-60 minutes after medication administered)												
Assessor initials												

Patient Identification (Addressograph)

The CIWA-Ar is a validated tool to assess the severity of withdrawal during detoxification. It can be used as a guide to the administration of 'PRN' or 'as required' chlordiazepoxide and

to alert clinicians to problems. It is not a substitute for clinical judgement but a guide to inform clinical decisions.

It is recommended that a baseline CIWA-Ar score is obtained prior to initiating chlordiazepoxide. The initial CIWA-Ar score should be used in conjunction with the severity of 'Alcohol Dependence Questionnaire' (SADQ) which provides a guide to the regime of chlordiazepoxide required, according to the severity of dependency. Further, CIWA-Ar scores should be obtained one hour after receiving each dose of chlordiazepoxide until 2 consecutive scores of 8 or less are obtained.

The following guidelines highlight the relationship between CIWA-Ar and requirement for 'PRN' chlordiazepoxide.

CIWA-Ar Score AND SEVERITY OF ALCOHOL WITHDRAWAL	ACTION REQUIRED (IF MEDICATION IS GIVEN REPEAT CIWA-Ar IN ONE HOUR)
0-8 (mild)	None
8-10 (mild)	None. If hallucinations or disorientation present, give 10mg chlordiazepoxide.
10-15 (mild)	10mg chlordiazepoxide
16-20 (moderate)	20mg chlordiazepoxide. Total of up to three "prn" doses can be given. Call doctor if CIWA-Ar remains above 10
>20 (severe)	20 mg chlordiazepoxide. Call doctor. May require treatment in general medical ward

No additional intervention is required for a CIWA-Ar score of eight or less

For scores of between eight and ten when the patient is Not experiencing hallucinations or disorientation, no action is required.

For scores between eight and ten in the presence of hallucinations or disorientation, 10mg of chlordiazepoxide should be given and the score checked again after one hour.

If the score is between ten and fifteen, 10mg chlordiazepoxide should be given and the score repeated in an hour

If the score is between sixteen and twenty, give 20mg chlordiazepoxide and recheck the score in an hour. Up to three doses of chlordiazepoxide can be given at hourly intervals if necessary. However, if after the third dose the score remains above ten, seek medical advice if this has not already been done.

Scores of twenty or more indicate severe alcohol withdrawal and a risk of Delirium Tremens and seizures. 20mg chlordiazepoxide should be administered and a doctor called. The patient is likely to need be seen to re-assess the diagnosis and may need to be treated in a general medical ward. The CIWA-Ar score should be repeated after an hour. If the score

remains above ten, it is mandatory for a doctor to see the patient if this has not already happened.

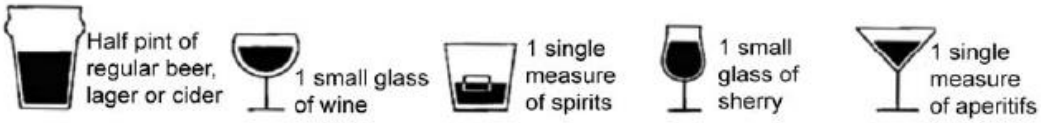
The objective is to obtain two consecutive scores of eight or less. This indicates safe withdrawal.

If a total of 20mg or more chlordiazepoxide has been given as "PRN" doses in any one day, the regular regime of chlordiazepoxide will need to be re-written starting at a lighter dose to prevent re-emergence of symptoms of alcohol withdrawal to the large drop in the daily dose of benzodiazepine which would otherwise occur.

The CIWA-Ar is used to assess the severity of withdrawal during the detox. It can be used to guide doses and to alert clinicians to problems. Again experienced clinicians will be able to cover its domains in interview and will not feel they need the CIWA-Ar. However, many more complex regimes found in many prescribing guidelines rely on the CIWA-Ar scores to guide dosing.

APPENDIX 2: AUDIT Questionnaire

This is one unit of alcohol…



…and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

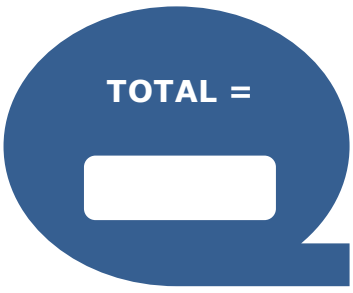
Score from AUDIT- C (other side)

Remaining AUDIT questions

Questions	Scoring system					Your score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence

TOTAL Score equals
AUDIT C Score (above) +
Score of remaining questions



APPENDIX 3: **SEVERITY OF ALCOHOL DEPENDENCE QUESTIONAIRE (SADQ-C)**1

NAME_____AGE_____No._____

DATE: _____

Please recall a typical period of heavy drinking in the last 6 months.

When was this? Month:…….…… Year….…….…….……..

Please answer all the following questions about your drinking by circling your most appropriate response.

During that period of heavy drinking

1. The day after drinking alcohol, I woke up feeling sweaty.

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

2. The day after drinking alcohol, my hands shook first thing in the morning.

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

3. The day after drinking alcohol, my whole body shook violently first thing in the morning if I didn't have a drink.

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

4. The day after drinking alcohol, I woke up absolutely drenched in sweat.

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

5. The day after drinking alcohol, I dread waking up in the morning.

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

6. The day after drinking alcohol, I was frightened of meeting people first thing in the morning.

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

7. The day after drinking alcohol, I felt at the edge of despair when I awoke.

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

8. The day after drinking alcohol, I felt very frightened when I awoke.

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

9. The day after drinking alcohol, I liked to have an alcoholic drink in the morning.

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

10. The day after drinking alcohol, I always gulped my first few alcoholic drinks down as quickly as possible.

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

11. The day after drinking alcohol, I drank more alcohol to get rid of the shakes.

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

12. The day after drinking alcohol, I had a very strong craving for a drink when I awoke.

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

13. I drank more than a quarter of a bottle of spirits in a day (OR 1 bottle of wine OR 8 units of beers).

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

14. I drank more than half a bottle of spirits per day (OR 1.5 bottles of wine OR 15 units of beer).

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

15. I drank more than one bottle of spirits per day (OR 3 bottles of wine OR 30 units of beer).

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

16. I drank more than two bottles of spirits per day (OR 6 bottles of wine OR 60 units of beer)

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

Imagine the following situation:
1. You have been **completely off drink for a few weeks**
2. You then drink **very heavily** for **two days**

How would you feel the **morning after** those two days of drinking?

17. I would start to sweat.

NOT AT ALL SLIGHTLY MODERATELY QUITE A LOT

18. My hands would shake.

NOT AT ALL SLIGHTLY MODERATELY QUITE A LOT

19. My body would shake.

NOT AT ALL SLIGHTLY MODERATELY QUITE A LOT

20. I would be craving for a drink

NOT AT ALL SLIGHTLY MODERATELY QUITE A LOT

SCORE _____

CHECKED BY:

ALCOHOL DETOX PRESCRIBED: YES/NO

NOTES ON THE USE OF THE SADQ

The Severity of Alcohol Dependence Questionnaire was developed by the Addiction Research Unit at the Maudsley Hospital. It is a measure of the severity of dependence. The AUDIT questionnaire, by contrast, is used to assess whether or not there is a problem with dependence.

The SADQ questions cover the following aspects of dependency syndrome:
- physical withdrawal symptoms
- affective withdrawal symptoms
- relief drinking
- frequency of alcohol consumption
- speed of onset of withdrawal symptoms.

Scoring
Answers to each question are rated on a four-point scale:

Almost never	-	0
Sometimes	-	1
Often	-	2
Nearly always	-	3

A score of 31 or higher indicates "severe alcohol dependence".
A score of 16 -30 indicates "moderate dependence"
A score of below 16 usually indicates only a mild physical dependency.
A chlordiazepoxide detoxification regime is usually indicated for someone who scores 16 or over.

It is essential to take account of the amount of alcohol that the patient reports drinking prior to admission as well as the result of the SADQ.

There is no correlation between the SADQ and such parameters as the MCV or GGT.

APPENDIX 4: DOSING REGIMENS - NICE CCG115

Table 1 Example dosing regimen one: fixed dose

Daily alcohol consumption	**15–25 units**		**30–49 units**		**50–60 units**
Severity of alcohol dependence	**Moderate SADQ score 15–25**		**Severe SADQ score 30–40**		**Very severe SADQ score 40–60**
Day 1 (starting dose)	15 mg four times a day	25 mg four times a day	30 mg four times a day	40 mg four times a day[a]	50 mg four times a day[b]
Day 2	10 mg four times a day	20 mg four times a day	25 mg four times a day	35 mg four times a day[a]	45 mg four times a day[b]
Day 3	10 mg three times a day	15 mg four times a day	20 mg four times a day	30 mg four times a day	40 mg four times a day[a]
Day 4	5 mg three times a day	10 mg four times a day	15 mg four times a day	25 mg four times a day	35 mg four times a day[a]
Day 5	5 mg twice a day	10 mg three times a day	10 mg four times a day	20 mg four times a day	30 mg four times a day
Day 6	5 mg at night	5 mg three times a day	10 mg three times a day	15 mg four times a day	25 mg four times a day
Day 7		5 mg twice a day	5 mg three times a day	10 mg four times a day	20 mg four times a day
Day 8		5 mg at night	5 mg twice a day	10 mg three times a day	10 mg four times a day
Day 9			5 mg at night	5 mg three times a day	10 mg four times a day
Day 10				5 mg twice a day	10 mg three times a day
Day 11				5 mg at night	5 mg three times a day
Day 12					5 mg twice a day
Day 13					5 mg at night

SADQ = Severity of Alcohol Dependence Questionnaire

[a] Doses of chlordiazepoxide in excess of 30 mg four times a day should be prescribed only in severe alcohol dependence The patient's response to treatment should always be regularly and closely monitored.

[b] Doses in excess of 40 mg four times a day should be prescribed only if there is clear evidence of very severe alcohol dependence. Such doses are rarely necessary in women and children and never in older people or if there is liver impairment.

This sample regimen was adapted from the dosing regimen in Ghodse H. (1998), by the Guideline Development Group to bring it in line with the recommendations in NICE clinical guideline 115.

Sample chlordiazepoxide dosing regimens for use in managing alcohol withdrawal: alcohol-use disorders: harmful drinking and alcohol dependence 7

Appendix 4
Useful resources:

- https://www.drinkaware.co.uk/
- https://alcoholchange.org.uk/
- http://www.alcohollearningcentre.org.uk
- https://www.e-lfh.org.uk/programmes/alcohol/

Drug and alcohol services in Areas covered by East London Foundation Trust

Bedford and Dunstable – Path 2 Recovery (part of ELFT) - 0333 332 4019
Luton – Resolutions (CGL) - 0800 0546 603
Tower Hamlets – Reset (CGL) - 0203 889 9510
Newham – CGL Newham – 0800 652 3879
Hackney – Turning Point - 0300 303 2611