

Outpatient Alcohol Withdrawal Management:

A Tool for
Global Practice Settings
2022

Guidelines

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CONTRIBUTORS

Outpatient Alcohol Withdrawal Management: A Tool for Global Practice Settings was developed by the following volunteer group of subject matter experts:

Moses Audu, M.B., B.S., FWACP

Professor of Psychiatry

University of Jos, Nigeria

Director, Quintessential Healthcare Centre Jos (UNODC Model Drug Dependent Treatment Centre for North Central Nigeria)

Alex Baldacchino, MD, MPhil, PhD, FISAM, FRCPsych, FRCP(E)

Professor of Medicine, Psychiatry, and Addictions

University of St. Andrews School of Medicine

Fife, Scotland, United Kingdom

Linda Frazier, M.A., RN, MCHES

Director, Addictions Initiatives

Advocates for Human Potential, Inc.

Boston, Massachusetts

Darius Rastegar, MD, FASAM

Associate Professor of Medicine

Johns Hopkins University School of Medicine

Baltimore, Maryland

Audra Stock, LPC, MAC

Clinical Director, Substance Use Disorder Clinical Programs, European Region

U.S. Army Medical Command

Landstuhl, Germany

Editing and Design:

Editing and content development: Maureen Fitzgerald

Madison, Wisconsin

Graphic Design: Susann Ely

Madison, Wisconsin

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INTRODUCTION

When COVID erupted in the spring of 2020, the developers of this tool grew concerned about the convergence of several crisis points:

- A reduction in staffing as psychiatrists, nurse practitioners, and addiction-trained counselors would be pulled away to assist with COVID-related patient care AND/OR become sick and unable to work.
- A reduction in substance use disorder treatment services with the cancellation of outpatient face-to-face services (e.g., group therapy), and shutting down or limiting referrals to residential treatment programs.
- Limited or no Wi-Fi capabilities and problematic virtual connectivity.
- Increased alcohol consumption with increased stressors (e.g., social distancing, limited movement, general isolation of individuals/families) and decreased access to healthy alternatives.
- Even in the best of times, non-addiction trained medical professionals do not feel comfortable treating alcohol/drug-related concerns.

All of which led to a sense of urgency to create the following tool.

This tool aims to summarize as simply and accurately as possible the must do's for assessing and treating patients at risk of alcohol withdrawal across global practice settings.

Outpatient Alcohol Withdrawal Management: A Tool for Global Practice Settings was developed by a small group of volunteer subject matter experts who witnessed a sharp increase in the number and severity of alcohol use disorders (AUD) and alcohol withdrawal syndrome corresponding with the COVID epidemic. The volunteers spanned four time zones and three countries. They met during lunch hours, early mornings, and after work hours. They brainstormed how to develop an easy-to-use tool that summarizes the best practices for managing alcohol withdrawal in an outpatient setting. This tool is not intended to be a comprehensive guide; rather, an easy-to-apply tool that can be used in any practice setting in the world.

Developing *Outpatient Alcohol Withdrawal Management: A Tool for Global Practice Settings* was truly an international collaboration of public service. The developers recommend using this tool to start conversations and work groups in any global practice settings (Africa, Asia, South America) and that those practice settings adapt this tool to make it work for them.

PURPOSE

Outpatient Alcohol Withdrawal Management: A Tool for Global Practice Settings provides a clinical decision tool for managing alcohol withdrawal syndrome (AWS) across diverse outpatient practice settings.

Use this tool as written or modify it to fit your unique practice setting and guide your clinical operating procedures.

Mild to moderate alcohol withdrawal syndrome can be managed safely on an outpatient basis



If you are a prescribing clinician, use this tool to guide clinical decisions about managing AWS.



If you are a non-prescribing clinician (master's level counselor, psychologist, nurse, behavioral health technician/assistant, etc.), use this tool with a prescribing provider to develop a localized protocol.



If you are a program manager (non-clinician), use this tool to improve your alcohol withdrawal management protocol. Start by assessing current clinic practices, identifying gaps and strengths of current practice, then develop clinic specific protocols to manage mild to moderate AWS.



If you are a member of the community or a person with lived experience, use this tool to build support for bringing essential alcohol withdrawal treatment services to your community.



Recommended Procedures for Alcohol Withdrawal Management

Prescribing clinicians can manage treatment for mild to moderate alcohol withdrawal effectively on an outpatient basis.

Individuals assessed to be at risk of severe alcohol withdrawal need to be medically monitored or admitted to an inpatient setting.

PATIENT ASSESSMENT

A person who consumes large quantities of alcohol over a consistent period of time and then stops abruptly may experience mild, moderate, or severe withdrawal symptoms within 6 to 24 hours after the last drink.

**AWS appear
6 to 24 hours after
last drink**

Alcohol treatment guidelines classify alcohol withdrawal syndrome (AWS) into three stages of **mild**, **moderate**, and **severe** (Hays, L.R, 2010):

Three Stages of Alcohol Withdrawal Syndrome (AWS)		
Severity	Symptoms	Treatment Setting
Mild	Anxiety, tremor, insomnia, headache, palpitations, gastrointestinal disturbances	Outpatient
Moderate	Mild symptoms AND <ul style="list-style-type: none">• Sweating (diaphoresis)• Increased systolic blood pressure• Abnormally rapid breathing (tachypnea)• Increased heart rate (tachycardia)• Increased body temperature (mild hyperthermia)	Outpatient
Severe	Moderate symptoms AND <ul style="list-style-type: none">• Disorientation• Impaired attention• Visual and/or auditory hallucinations• Seizures• Severe agitation	<i>Must be medically monitored</i> Requires inpatient hospitalization

Use Validated Instruments to Assess the Severity of AWS*

- **Brief Alcohol Withdrawal Scale (BAWS):** A five-item scale, with agitation, sweats, tremor, orientation, and hallucinations each graded 0–3. Typically administered by a trained professional in a clinical setting to determine treatment dosing and frequency to manage AWS.
- **Clinical Institute Withdrawal Assessment for Alcohol-Revised (CIWA-Ar):** A list of 10 signs and symptoms, with a range of scores in each category. High scores indicate increased risk for severe alcohol withdrawal, seizures, and delirium. Typically administered by a trained professional.
- **SAWS (Short Alcohol Withdrawal Scale):** A 10-item scale that an individual can self-administer. If necessary, a family or community member (regardless of medical training), can help an individual complete the SAWS to monitor severity of symptoms.

*See Forms and Templates

When to Refer to Inpatient Level of Care

Severe alcohol withdrawal syndrome requires inpatient medical withdrawal management. [The U.S. Department of Veterans Affairs Department of Defense Clinical Practice Guidelines, Management of Substance Use Disorders](#) lists the following factors for inpatient care:

Severe alcohol withdrawal is a medical emergency that requires hospitalization

Criteria for Inpatient Withdrawal Management

AWS should be managed in an inpatient setting if any one of the following symptoms is present:

	History of alcohol withdrawal delirium or withdrawal seizures
	Active psychosis or severe cognitive impairment
	Co-occurring medical conditions that pose serious risk for outpatient withdrawal management (e.g., severe coronary artery disease, congestive heart failure, liver cirrhosis)
	Current symptoms of severe alcohol withdrawal assessed using a validated instrument (See Forms and Templates)
	Inability to tolerate oral medication
	Laboratory results or physical evidence of significant liver (hepatic) impairment
	Medical conditions that could complicate withdrawal management (e.g., pregnancy, nephrotic syndrome, cardiovascular disease, lack of medical support system)
	Recurrent unsuccessful attempts at alcohol withdrawal management
	Risk of withdrawal from other substances in addition to alcohol (e.g., sedative hypnotics, unknown psychoactive or illicit substances)
	Social barriers to completing withdrawal management (e.g., homelessness)

See Forms and Templates for a summary of the “must-do’s” for screening, assessment, and treatment for management of AWS.

Managing Stabilization and Withdrawal in an Outpatient Setting

Outpatient treatment is appropriate for individuals with mild or moderate AWS symptoms if there are no contraindications.

Use predetermined fixed dosing when access to care is limited

When you have clinically determined that an individual's AWS can be managed in an outpatient setting, and they would benefit from medication, consider one of the following pharmacotherapy strategies:

- **A predetermined fixed-dose medication tapering** schedule with additional medication as needed. A predetermined fixed-dosage tapering schedule is preferable when access to care, resources for ongoing monitoring, and pharmacotherapy formularies are limited or unpredictable.
- **A symptom-triggered therapy** where individuals are given medication only when signs or symptoms of withdrawal occur (e.g., as needed dosing).

See Form: Example of a community-based outpatient alcohol withdrawal management protocol.

- Assess individuals frequently (e.g., have plan to assess every 4–6 hours) during the withdrawal period using a validated instrument (Williams, D. 2001). *See Forms and Templates for examples of validated instruments and recommended frequency.*
- Determine frequency of reassessment by individual risk level based on symptom severity, degree of support in the living environment, medical stability, and history of adherence.
- When developing an outpatient withdrawal management plan with the individual, emphasize the **importance of not returning to drinking** if/when withdrawal symptoms reoccur.

Choice of Medication

Oral Medications Used to Treat Alcohol Withdrawal Syndrome

Benzodiazepines are intended for managing withdrawal symptoms only. Addiction experts consistently warn against using benzodiazepines for ongoing AUD treatment (Kramer et al., 2003; Lindsay et al., 2020; Malcolm et al., 1989; Myrick et al., 2009).

Benzodiazepines are the medication of choice when the patient has adequate monitoring.

Benzodiazepines reduce:

- withdrawal severity
- risk of delirium
- seizures

Benzodiazepines are generally well-tolerated, although some sedation can occur.

Benzodiazepines Commonly Used to Treat AWS Include

Generic Name	U.S. Brand Name
Chlordiazepoxide	Librium
Diazepam	Valium
Lorazepam	Ativan

Anticonvulsants: For managing mild to moderate alcohol withdrawal in individuals for whom risks of benzodiazepines outweigh benefits (e.g., inadequate monitoring available, risk of misuse, or allergy/adverse reactions), consider using the following anticonvulsants as alternatives.

Anticonvulsants are effective for mild to moderate AWS

Anticonvulsants Used to Treat AWS

Generic Name	U.S. Brand Name
Carbamazepine	Tegretol
Gabapentin	Neurontin
Oxcarbazepine	Trileptal
Valproic acid	Depakene

Alpha-adrenergic agonist: The developers of this tool advise that clonidine/Catapres only be used as an adjunctive (supplemental) agent, not as a primary agent for treatment of withdrawal. Clonidine/Catapres does not reduce the risk of seizures or delirium.



*Using alcohol as an agent for medically supervised withdrawal **is not recommended.***

Dosing Regimen Considerations

The National Health Service (NHS) developed *Guidance for the Identification, Assessment, and Management of Harmful Drinking and Alcohol Dependence* (February 2011).

- There is not a single set dosing regimen that is considered safe and adequate in all situations, as each individual is different and needs to be assessed accordingly.
- Medication and dose selection are influenced by many variables, including medical illness severity, age, other substance-related and behavioral conditions, amount and duration of alcohol consumption, motivation, mental status, lab findings, vital signs, degree of ongoing support, and ability to return to medical care if needed.

Chlordiazepoxide (Librium) is the preferred benzodiazepine for outpatient management of AWS unless testing determines liver/hepatic impairment.

- Using a symptom-triggered chlordiazepoxide schedule for the first 24 hours is associated with lower doses of benzodiazepines and a shorter duration of treatment with no increase in the incidence of alcohol withdrawal-related seizure or alcohol withdrawal delirium.
- Observations: A health care provider or trusted support person should observe the individual every 4–6 hours for the first 24 hours using a validated instrument to measure withdrawal symptoms, blood pressure, heart rate, and respiratory rate. After the initial 24 hours of direct observation and monitoring, telephone contact may be used to continue monitoring for the next 24–48 hours.
- If a health care provider or trusted observer cannot monitor observations at least every 4 hours, use a fixed-dose chlordiazepoxide schedule.
- The prescriber must review medication every 24 hours for 5 days.
- Assess alcohol use at every visit. If breathalyzer or other biological methods for detecting use are not possible, use a person-centered interviewing approach to determine alcohol use.
- If an individual has been drinking, review care plan and consider stopping benzodiazepines.
- Start withdrawal management on the first or second day of the work week to allow monitoring through the period of highest risk.
- Do not begin treatment if the individual remains intoxicated.

Wernicke's Encephalopathy

Wernicke's encephalopathy (WE) is an acute illness, precipitated by alcohol withdrawal, which is often undertreated or missed. It should be suspected and treated in any patients undergoing alcohol withdrawal management who develop confusion, memory problems, or difficulties with their gait or coordination.

All patients presenting in alcohol withdrawal should be considered at risk of developing Wernicke's encephalopathy

Korsakoff's psychosis is a preventable dementia, described as an amnesic syndrome with impaired recent memory, and relatively intact intellectual function. It occurs after one or more inadequately treated episodes of Wernicke's encephalopathy.

Both conditions are due to brain damage caused by acute lack of vitamin B1, a common vitamin deficiency among people with AUD.

Symptoms of Wernicke's Encephalopathy	
	Acute confusion
	Ataxia/unsteadiness (loss of muscle control, leg tremors)
	Decreased consciousness
	Memory disturbance
	Ophthalmoplegia/Nystagmus (vision changes or abnormal eye movements)
	Unconsciousness/coma
	Unexplained hypotension with hyperthermia

Prevention and Treatment of Wernicke's Encephalopathy

For patients with **moderate dependence** with no complex needs or **severe dependence** and complex needs, alcohol withdrawal may cause Wernicke's encephalopathy. All patients with AWS should receive a prophylactic dose and those with symptoms receive a treatment dose of thiamine (vitamin B1).

Wernicke's Encephalopathy	Patient History	Thiamine Dosage
Prophylaxis	AUD or current treatment for AWS no symptoms of Wernicke's encephalopathy.	Oral thiamine 100 mg 3 times daily. Ongoing, indefinite prophylactic dosing for AWS.
Preventive Treatment	AWS and moderate risk for Wernicke's encephalopathy. Treat for moderate risk if a patient has any diarrhea, vomiting, weight loss, or physical illness.	Intravenous (IV) or intramuscular (IM) thiamine 200-500 mg once daily for 3-5 days.
Treatment for Acute/ Severe Risk	AWS and severe risk for Wernicke's encephalopathy. Treat for severe risk if the patient has any of the symptoms listed on page 12.	Intravenous (IV) thiamine 200-500 mg 3 times daily (every 8 hours) for 2 days. Monitor response after 72 hours: Response – continue IV or IM thiamine one time daily for 5 days or until improvement stabilizes. No Response – review diagnosis and consider adding IV magnesium.

There is a small risk of anaphylaxis (allergic reaction) with intravenous administration. Facilities to manage anaphylaxis must be available.

See *Forms and Templates (page 16 of 16)* for detailed prophylaxis and treatment flowchart.

CRITICAL COMPONENTS OF A COMPREHENSIVE CARE PLAN

Engage the whole person

Treatment for AWS represents an opportunity to start the treatment journey. From the first encounter, consider the bigger picture above and beyond stabilizing the immediate AWS condition. Think about how your approach and service planning can alter the individual's progression towards health and recovery.

Consider asking:

- What does the individual want?
- Why now?
- What other services does the person need? (Mee-Lee, 2013)

Timely treatment and dosing of pharmacotherapy combined with nonjudgmental, supportive counseling and recovery support increase the likelihood of recovery from an AUD.

Develop a comprehensive care plan

Treatment goals need to be holistic when managing AWS and should also include the following (SAMHSA, 2015):

- Reducing withdrawal symptoms
- Preventing alcohol withdrawal-related seizure or alcohol withdrawal delirium, and death
- Pharmacotherapy
- Preparing for long-term abstinence from alcohol use
- Follow-up visits
- Participation in evidence-based and culturally sensitive counseling services
- Engaging with psychosocial and recovery-oriented supports and/or mutual-help groups

Include family, community, and recovery support systems

Active involvement with family members, support systems, and/or other community resources is strongly recommended, while respecting individuals' rights to privacy and confidentiality (SAMHSA, 2015).

Consider biological and psychological concerns

Assess and manage co-occurring mental health and nutritional concerns on an ongoing basis (SAMHSA, 2015).

Individualize duration of treatment

Evidence suggests (SAMHSA, 2015) that pharmacotherapy treatment should continue for at least 6 to 12 months. However, some patients may benefit from treatment with medication over shorter periods to help through stressful situations.

Others may need a longer, more consistent duration of medications for addiction treatment. In addition, relapse prevention agents such as naltrexone and acamprosate may help reduce the probability of a return to drinking after withdrawal.

Develop a comprehensive care plan

Treatment goals managing AWS as a part of a comprehensive care plan need to include (SAMHSA, 2015):

- Reducing withdrawal symptoms
- Preventing alcohol withdrawal-related seizure or alcohol withdrawal delirium, and death
- Pharmacotherapy
- Preparing for long-term abstinence from alcohol use
- Follow-up visits
- Participation in evidence-based and culturally sensitive counseling services
- Engaging with psychosocial and recovery-oriented supports and/or mutual-help groups

RESOURCES

Alvanzo, A., Kleinschmidt, K., & Kmiec, J. A. (2020). [The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management.](#)

Screening Tools Links

Tool	Acronym	Description
Alcohol Use Disorders Identification Test	AUDIT	The Alcohol Use Disorders Identification Test (AUDIT) is a 10-item screening tool developed by the World Health Organization (WHO) to assess alcohol consumption, drinking behaviors, and alcohol-related problems.
	AUDIT Translations	
Severity of Alcohol Dependence Questionnaire	SADQ	The SADQ is a short, easy-to-complete, self-administered, 20-item questionnaire designed to measure severity of dependence on alcohol as formulated by Edwards & Gross (1976) and Edwards (1978). There are five subscales with four items in each: Physical Withdrawal, Affective Withdrawal, Withdrawal Relief Drinking, Alcohol Consumption, and Rapidity of Reinstatement. Each item is scored on a 4-point scale, ranging from “Almost Never” to “Nearly Always,” resulting in a corresponding score of 0 to 3. Thus the total maximum score possible is 60 and the minimum is 0.
Stages of Change Readiness and Treatment Engagement Scale	SOCRATES <i>(see Forms and Templates)</i>	SOCRATES is an experimental instrument designed to assess readiness for change in individuals who use alcohol. The instrument yields three factorially-derived scale scores: Recognition (Re), Ambivalence (Am), and Taking Steps (Ts). It is a public domain instrument and may be used without special permission.

Validated Withdrawal Screening Instruments

Instrument	Acronym	Description
Brief Alcohol Withdrawal Scale	BAWS	A five-item instrument. Agitation, sweats, tremor, orientation, and hallucinations are each graded on a 0–3 scale. Typically administered by a trained professional in a clinical setting to determine treatment dose and frequency to manage AWS.
Clinical Institute Withdrawal Assessment for Alcohol Scale, Revised	CIWA-Ar	The Clinical Institute Withdrawal Assessment for Alcohol-Revised is a reliable, valid, and reproducible tool to measure alcohol withdrawal severity in communicative patients once a diagnosis has been made.
Short Alcohol Withdrawal Scale	SAWS	Tool to assess the severity of alcohol withdrawal. Patients indicate how they have felt in the previous 24 hours. Mild withdrawal < 12 points; moderate to severe withdrawal ≥ 12 points.

See Forms and Templates to download copies of these forms.

GLOSSARY

All glossary definitions (unless otherwise noted with an*) are taken from [The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management](#), 2020.

Term	Definition
Abstinence	Intentional and consistent restraint from the pathological pursuit of reward and/or relief that involves the use of substances and other behaviors. These behaviors may involve, but are not necessarily limited to substance use, gambling, video gaming, or compulsive sexual behaviors. Use of FDA-approved medications for the treatment of substance use disorder is consistent with abstinence.
Acamprosate (Campral)	Acamprosate calcium delayed-release tablets are indicated for the maintenance of abstinence from alcohol in patients with alcohol dependence who are abstinent at treatment initiation. Treatment with acamprosate calcium delayed-release tablets should be part of a comprehensive management program that includes psychosocial support. Acamprosate is used to help maintain sobriety in alcohol-dependent adults who no longer drink alcohol. Acamprosate is used with behavioral therapy or counseling support to help prevent an urge to drink again. Acamprosate will not treat or prevent alcohol withdrawal symptoms. (drugs.com)
Adjunct therapy	Adjunct therapy (see also monotherapy) - A pharmaceutical drug used together with a primary pharmaceutical drug whose purpose is to assist the primary treatment.
Alcohol use disorder (AUD)	A problematic pattern of alcohol use leading to clinically significant impairment or distress as manifested by at least two of the 11 DSM-5 criteria within a 12-month period.
*Withdrawal syndrome	The onset of predictable constellation of signs and symptoms following the abrupt discontinuation of, or rapid decrease in dosage of a psychoactive substance. (ASAM definition from the <i>ASAM Criteria, 3rd Edition</i> , 2013)
*Benzodiazepine	A class of agents that work in the central nervous system and are used for a variety of medical conditions. Benzodiazepines act on specific receptors in the brain, called gamma-aminobutyric acid-A (GABA-A) receptors. Benzodiazepines attach to these receptors and make the nerves in the brain less sensitive to stimulation, which has a calming effect. Benzodiazepines may be used to treat alcohol withdrawal, anxiety, panic disorder, seizures, and can be used as a muscle relaxant. (drugs.com)

GLOSSARY

Term	Definition
*Breath alcohol concentration (BAC)	The percent of alcohol (ethyl alcohol or ethanol) in a person's blood stream. A BAC of .10% means that an individual's blood supply contains one part alcohol for every 1000 parts blood. (Stanford.edu)
*Brief Alcohol Withdrawal Scale (BAWS)	A five-item instrument developed by Rastegar, et al. Agitation, sweats, tremor, orientation, and hallucinations are each graded on a 0–3 scale. Typically administered by a trained professional in a clinical setting to determine treatment dosing and frequency to manage AWS.
*Carbamazepine (Tegretol)	Carbamazepine (Tegretol) is an anticonvulsant. It works by decreasing nerve impulses that cause seizures and pain. Carbamazepine is used to treat certain types of seizures (partial, tonic-clonic, mixed.) It is also used to treat nerve pain such as trigeminal neuralgia and glossopharyngeal neuralgia. (drugs.com)
*Chlordiazepoxide (Librium)	Chlordiazepoxide is a benzodiazepine that is used to treat anxiety disorders. Chlordiazepoxide may also be used short-term to treat symptoms of alcohol withdrawal, or anxiety before a surgery. (drugs.com)
Clonidine (Catapres)	<p>Clonidine (Catapres) is an alpha agonist used to treat high blood pressure (hypertension). It is effective when used alone or with other high blood pressure medications. Clonidine is also used for *alcohol, nicotine, or benzodiazepine (tranquilizer) withdrawal; migraine headaches, smoking cessation, Tourette's syndrome, narcotic/methadone detoxification, premenstrual tension, diabetic diarrhea, ulcerative colitis, and to diagnose pheochromocytoma. (drugs.com)</p> <p>The developers of this tool advise that clonidine/Catapres only be used as an adjunctive (supplemental) agent; not as a primary agent for treatment of alcohol withdrawal. Clonidine/ Catapres does not reduce the risk of seizures or delirium.</p>

GLOSSARY

Term	Definition
Clinical Institute Withdrawal Assessment for Alcohol-Revised (CIWA-Ar)	Clinical Institute Withdrawal Assessment for Alcohol-Revised, is a reliable, valid, and reproducible tool to measure alcohol withdrawal severity in communicative patients once a diagnosis has been made.
Delirium tremens (now referred to as alcohol withdrawal delirium)	Delirium and seizure. Alcohol withdrawal-related seizure or alcohol withdrawal delirium.
*Diazepam (Valium)	A benzodiazepine. It is thought that benzodiazepines work by enhancing the activity of certain neurotransmitters in the brain. Diazepam is used to treat anxiety disorders or alcohol withdrawal symptoms. (drugs.com)
Dosing regimens	The schedule of doses of a therapeutic agent per unit of time, including: the time between doses (e.g., every 6 hours) or the time when dose(s) are to be given (e.g., 8 a.m. and 4 p.m. daily), and the amount of a medicine (e.g., number of capsules) to be given at each specific time. (https://medical-dictionary.thefreedictionary.com/dosage+regimen).
Fixed dosing regimen	A predetermined dose is administered at fixed intervals according to a schedule.
*Folic acid	A type of B vitamin that is normally found in foods such as dried beans, peas, lentils, oranges, whole-wheat products, liver, asparagus, beets, broccoli, brussels sprouts, and spinach. (drugs.com)
*Gabapentin (Neurontin)	An anti-epileptic drug, also called an anticonvulsant. It affects chemicals and nerves in the body that are involved in the cause of seizures and some types of pain. Gabapentin is used together with other medicines to treat partial seizures in adults and children at least 3 years old. (drugs.com)
Inpatient withdrawal management	Inpatient Withdrawal Management: Alcohol withdrawal management that occurs in inpatient settings, including hospitals. The defining feature of inpatient settings for the purposes of this document is that patients are on site 24/7. Level of clinical expertise and frequency of monitoring vary widely within various inpatient withdrawal management settings. For the purposes of this document, residential facilities without continual medical monitoring are considered inpatient settings.

GLOSSARY

Term	Definition
Lorazepam (Ativan)	Lorazepam is one of the benzodiazepines used to manage AWS. Drug class: benzodiazepine. Benzodiazepines (also called “benzos”) are a class of agents that work in the central nervous system and are used for a variety of medical conditions. They act on specific receptors in the brain, called gamma aminobutyric acid-A (GABA-A) receptors. Benzodiazepines attach to these receptors and make the nerves in the brain less sensitive to stimulation, which has a calming effect. (drugs.com)
*Naltrexone	Naltrexone hydrochloride, an opioid receptor antagonist, competitively binds to such receptors and may block the effects of endogenous opioids. Opioid antagonists have been shown to reduce alcohol consumption by animals, and naltrexone hydrochloride has been shown to reduce alcohol consumption in clinical studies. (drugs.com)
*Outpatient treatment	An organized service, delivered in a variety of settings, in which treatment staff provide professionally directed evaluation and treatment of substance-related, addictive, and mental disorders. This also includes the services of an individual licensed practitioner. (ASAM, 2013)
Pharmacotherapy	Therapy (medical treatment) using pharmaceutical drugs.
Predetermined fixed-dose medication tapering	In a fixed-dose regimen, a predetermined dose is administered at fixed intervals according to a schedule. Doses usually decrease in a gradual taper over several days. A fixed-dose schedule can be refined by choosing an initial dose according to withdrawal severity as assessed by a withdrawal symptom severity scale. When fixed-doses are given, allowances should be made to provide additional medication if the fixed-dose should prove inadequate to control symptoms.
*Short Alcohol Withdrawal Scale (SAWS)	Short Alcohol Withdrawal Scale
Symptom-triggered dosing regimen	An approach whereby patients are monitored through the use of a structured assessment scale and given medication only when symptoms cross a threshold of severity.

GLOSSARY

Term	Definition
Substance use disorder (SUD)	Substance use disorder is marked by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use alcohol, nicotine, and/or other drugs despite significant related problems. Diagnostic criteria are given in the DSM-5. Substance use disorder is the new nomenclature for what was included as substance dependence and substance abuse in the DSM-4.
*Thiamine	Thiamine (vitamin B1), found in cereals, whole grains, meats, nuts, beans and peas, helps process carbohydrates. Thiamine deficiency is common among people with alcohol dependence and may lead to cognitive impairment and Wernicke's encephalopathy. Thiamine is used to treat or prevent vitamin B1 deficiency in people with alcohol dependence. (drugs.com)
Treatment plan	A therapeutic strategy that may incorporate patient education, drug therapy, and the participation of health professionals. Treatment plans are especially important in the optimal management of complex or chronic illnesses such as SUDs.
*Valproic acid (Depakene)	Part of the drug class: Fatty acid derivative anticonvulsants. Used to treat various types of seizure disorders. Valproic acid is sometimes used together with other seizure medications. (drugs.com)
Wernicke's encephalopathy	A severe complication resulting from thiamine (B1) deficiency. Characterized by an often-reversible acute confusional state. Patients consuming large volumes of alcohol are at an increased risk of developing Wernicke's encephalopathy due to inadequate nutrition as well as biological interactions between cellular functioning and alcohol.
Withdrawal management	This term has replaced the formerly used "detoxification." Withdrawal management refers to the medical and psychological care of patients who are experiencing withdrawal symptoms as a result of ceasing or reducing their substance use. Withdrawal management includes reducing the physiological and psychological features of withdrawal and interrupting the momentum of habitual compulsive use in person with SUD.

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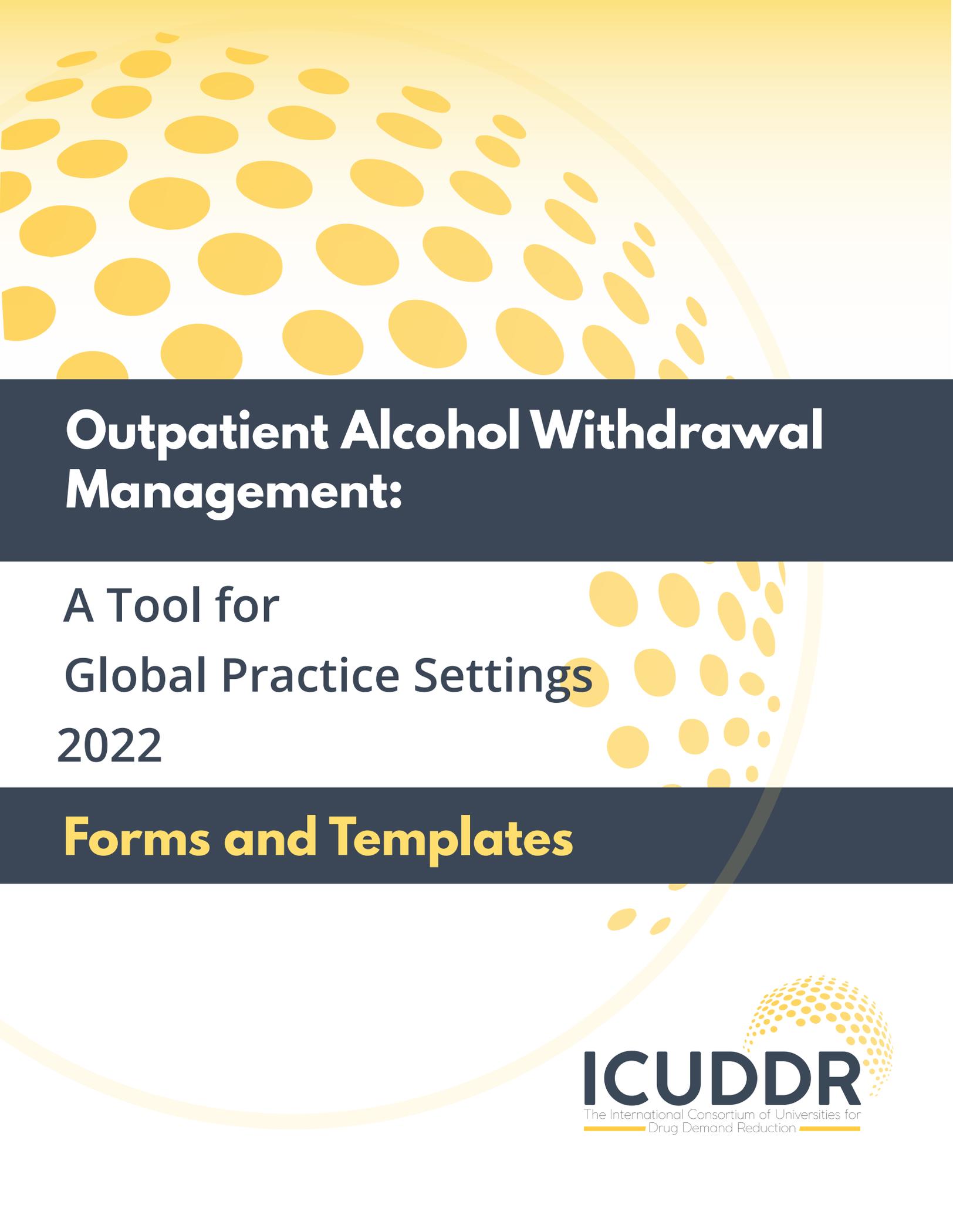
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Outpatient Alcohol Withdrawal Management:

A Tool for
Global Practice Settings
2022

Forms and Templates

CONTRIBUTORS

Outpatient Alcohol Withdrawal Management: A Tool for Global Practice Settings 2022, Forms and Templates was developed by the following volunteer group of subject matter experts:

Moses Audu, M.B., B.S., FWACP

Professor of Psychiatry

University of Jos, Nigeria

Director, Quintessential Healthcare Centre Jos (UNODC Model Drug Dependent Treatment Centre for North Central Nigeria)

Alex Baldacchino, MD, MPhil, PhD, FISAM, FRCPsych, FRCP(E)

Professor of Medicine, Psychiatry, and Addictions

University of St. Andrews School of Medicine

Fife, Scotland, United Kingdom

Linda Frazier, M.A., RN, MCHES

Director, Addictions Initiatives

Advocates for Human Potential, Inc.

Boston, Massachusetts

Darius Rastegar, MD, FASAM

Associate Professor of Medicine

Johns Hopkins University School of Medicine

Baltimore, Maryland

Audra Stock, LPC, MAC

Clinical Director, Substance Use Disorder Clinical Programs, European Region

U.S. Army Medical Command

Landstuhl, Germany

Editing and Design:

Editing and content development: Maureen Fitzgerald

Madison, Wisconsin

Graphic Design: Susann Ely

Madison, Wisconsin

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How to Use Forms and Templates

Outpatient Alcohol Withdrawal Management: A Tool for Global Practice Settings

Our goal for the *Outpatient Alcohol Withdrawal Management: A Tool for Global Practice Settings* is to provide overall guidance as well as forms and templates to assist clinicians and clinics in developing and improving their capacity and confidence in assessing and treating alcohol withdrawal in an outpatient setting.

The forms and templates provided here feature:

- Must-do's in assessing and treating alcohol withdrawal syndrome (AWS)
- Screening tools referred to in the *Outpatient Alcohol Withdrawal Management: A Tool for Global Practice Settings*
- An example of a community-based AWS management approach
- A decision tree for assessing and treating Wernicke's encephalopathy
- An editable sample procedures template

The forms and templates are not to be edited or changed, with one exception: the Sample Template–AWS Management Procedures can and should be adapted to local practice settings.

We welcome your feedback on *Outpatient Alcohol Withdrawal Management: A Tool for Global Practice Settings* and thank you for your important work in improving care for AWS in your community. Please submit your feedback at info@icuddr.org

Alcohol Withdrawal Management in an Outpatient Setting

FORM A

Alcohol Withdrawal Management in an Outpatient Setting. *Adapted from Baldacchio, 2009*

Please do not add or change the following information.

The Must Do's	
	Visit and/or assess home environment to determine risks and suitability of the environment.
	Meet with the caregiver who will provide support and observation. If a direct meeting is not possible, the individual needs to name a specific person you can speak with on the phone.
	Educate the individual and caregiver about the withdrawal process.
	Educate the individual and caregiver about the medication.
	Make a plan with the individual for relapse prevention including psychological support, discussion of relapse prevention medication (if available), and ongoing care plan with referral to appropriate agencies.
	Arrange for withdrawal management medication prescribing.
	Obtain informed consent for withdrawal management services and associated medication.

Withdrawal Management Protocol	
	Start medication on the first or second day of the workweek to allow monitoring through the period of highest risk.
	Do not begin treatment if the patient remains intoxicated.
	Use a fixed-dose chlordiazepoxide (Librium) schedule most of the time.
	Allow for individual symptomatic response, particularly in older patients and patients of low body weight.
	Chlordiazepoxide is contraindicated in severe hepatic insufficiency.
	Monitor withdrawal symptoms using a validated instrument twice on the first day and then as indicated. The care team or prescriber can complete ongoing assessment by telephone or in person as appropriate.
	Review medication every 24 hours for the next 3 to 4 days.
	Monitor breath alcohol concentration (BAC) at every visit. If breathalyzer or other biological methods for detecting use are not possible, use a person-centered interviewing approach to determine alcohol use.
	If the individual has been drinking, stop chlordiazepoxide and review care plan.

Alcohol Withdrawal Management in an Outpatient Setting

Alcohol Withdrawal Management in an Outpatient Setting. *Adapted from Baldacchio, 2009*

FORM A

Please do not add or change the following information.

Consult medical staff urgently if any of the following emerge during withdrawal management:

	Failure to improve despite increased dosing
	Hallucinations that do not respond to clordiazepoxide
	High level of disorientation
	Suicidal ideation
	Other new physical or mental health concerns
	Persistent vomiting

The following symptoms indicate a medical emergency:

	Seizures
	Chest pain
	Signs of Wernicke's encephalopathy
	Impaired level of consciousness
	Active suicidal thoughts

Relapse prevention

	Relapse prevention and care planning should be ongoing. Include individual counseling, group work, referral to self-help groups and recovery supports, and referrals to other appropriate agencies.
--	---

Please do not add or change the following information.

Source	
Family Practice Notebook, 2021	Family Practice Notebook
Alcohol Detoxification in Ambulatory Setting	Home/Mental Health Book/Chemical Dependency Chapter/Alcohol Detoxification in Ambulatory Setting

A. Benzodiazepines	
1.	Administered based on either a symptom-triggered protocol or fixed dose protocols (See below.)
2.	<p>First-line, long-acting benzodiazepines:</p> <ul style="list-style-type: none"> a. Preferred for self-tapering and less addictive b. Diazepam (Valium) 10 mg every 6 hours prn c. Chlordiazepoxide (Librium) 25–50 mg prn <ul style="list-style-type: none"> • Preferred agent overall: Less stimulation of reward system, lower misuse potential • Maximum 300 mg/day • Consider during ED evaluation in patients at risk and with early withdrawal signs <ul style="list-style-type: none"> o Consider single dose of chlordiazepoxide (Librium) 50 mg orally
3.	<p>Short-acting agents. (Higher misuse potential, but preferred in elderly or those with liver dysfunction.)</p> <ul style="list-style-type: none"> • Ativan (Lorazepam) 1–2 mg prn every 6 hours prn

Please do not add or change the following information.

B. Benzodiazepine Alternatives (in patients considered risky for benzodiazepines)

1.	<p>Carbamazepine (Tegretol)</p> <ul style="list-style-type: none"> • Effective in moderate withdrawal • Dosing: 200 mg 4 times daily tapered over 5 days <ul style="list-style-type: none"> o Start at carbamazepine (Tegretol) 800 mg on Day 1 o Finish at 200 mg on Day 5 <p>Reference: Malcolm, R., Myrick, H., Roberts, J., Wang, W., Anton, R. F., & Ballenger, J. C. (2002). The effects of carbamazepine and lorazepam on single versus multiple previous alcohol withdrawals in an outpatient randomized trial. <i>Journal of General Internal Medicine</i>, 17(5), 349-355. Read online</p>
2.	<p>Gabapentin (Neurontin)</p> <ul style="list-style-type: none"> • Potentiates CNS GABA activity and decreases glutamate activity <ul style="list-style-type: none"> o Decreases alcohol craving and depression • Dosing (minimum effective daily dose 900 mg/day) <ul style="list-style-type: none"> o Start 600 mg 3 times daily for 3 days o Then 300 mg 3 times daily for 3 days <p>References:</p> <p>Stock, C. J., Carpenter, L., Ying, J., & Greene, T. (2013). Gabapentin versus chlordiazepoxide for outpatient alcohol detoxification treatment. <i>Annals of Pharmacotherapy</i>, 47(7-8), 961-969. Read online</p> <p>Myrick, H., Malcolm, R., Randall, P. K., Boyle, E., Anton, R. F., Becker, H. C., & Randall, C. L. (2009). A double-blind trial of gabapentin versus lorazepam in the treatment of alcohol withdrawal. <i>Alcoholism: Clinical and Experimental Research</i>, 33(9), 1582-1588. Read online</p>

Please do not add or change the following information.

C. Adjunctive Medications in All Patients		
1.	See Alcohol Withdrawal	Family Practice Notebook/Alcohol Withdrawal
2.	Vitamin deficiency is common: Vitamins A, C, B1, B3, B6, B9, B12	Family Practice Notebook/Vitamin Deficiency/Vitamin Deficiency in Alcoholism
3.	See Alcohol Dependence	Family Practice Notebook/Alcohol Abuse
4.	Thiamine • 100 mg orally daily	Family Practice Notebook/Thiamine
5.	Folic Acid • 1 mg daily	Family Practice Notebook/Folic Acid

D. Adjunctive Adrenergic Symptom Control to Consider as Needed:

The developers of this guide advise that clonidine/Catapres only be used as an adjunctive (supplemental) agent, not as a primary agent for treatment of withdrawal. Clonidine/Catapres does not reduce the risk of seizures or delirium.

Please do not add or change the following information.

Management: Symptom-Triggered Regimen

- A. Brief Alcohol Withdrawal Scale (BAWS)
 - 1. Assess every 4 to 6 hours, depending on severity of symptoms
- B. Clinical Institute Withdrawal Assessment for Alcohol Withdrawal Scale (**CIWA-Ar**)
 - <https://www.mdcalc.com/ciwa-ar-alcohol-withdrawal>
 - 1. Initially assess 4 times daily
- C. **Short Alcohol Withdrawal Scale (SAWS)**
 - <https://fpnotebook.com/Psych/Exam/ShrtAlchWthdrwlSci.htm>
 - 1. Patient completes 4 times daily
- D. **Benzodiazepine** dose indication
 - 1. **CIWA-Ar** Score >9 points OR
 - 2. **SAWS** Score 12 or more OR
 - 3. BAWS score of 3 or more (*see page 12*)
- E. **Chlordiazepoxide** (Librium) Protocol (with prn based on indications listed above)
 - 1. Prescribe Chlordiazepoxide 25 mg tabs (#11-22)
 - 2. Day 1: Librium 25-50 every 4 hours prn
 - 3. Day 2: Librium 25-50 every 6 hours prn
 - 4. Day 3: Librium 25-50 every 6 hours prn
 - 5. Day 4: Librium 25-50 every 12 hours prn
 - 6. Day 5: Librium 25-50 every 12 hours prn
- F. **Diazepam** (Valium) Protocol (with prn based on indications listed above)
 - 1. Prescribe Diazepam 10 mg tabs (#18)
 - 2. Day 1: Valium 10 mg every 4 hours prn
 - 3. Day 2: Valium 10 mg every 6 hours prn
 - 4. Day 3: Valium 10 mg every 6 hours prn
 - 5. Day 4: Valium 10 mg every 12 hours prn
 - 6. Day 5: Valium 10 mg every 12 hours prn
- G. **Lorazepam** (Ativan) Protocol (with prn based on indications listed above)
 - 1. Prescribe Lorazepam 1 mg tabs (#15)
 - 2. Day 1: Ativan 2 mg every 6 hours prn
 - 3. Day 2: Ativan 2 mg every 6 hours prn
 - 4. Day 3: Ativan 1 mg every 8 hours prn
 - 5. Day 4: Ativan 1 mg every 12 hours prn
 - 6. Day 5: Ativan 1 mg every 12 hours prn

Please do not add or change the following information.

Management: Fixed-Dose Protocol

- A. Reduce dosage if over-sedation occurs
- B. Monitoring by reliable friend or family member
- C. [Chlordiazepoxide \(Librium\)](#) Protocol (preferred agent)
 - 1. Prescribe [Chlordiazepoxide \(Librium\)](#) 25 mg tabs (#11–22)
 - 2. Option 1:
 - a. Day 1: Librium 25-50 mg every 6 hours scheduled
 - b. Day 2: Librium 25-50 mg every 8 hours scheduled
 - c. Day 3: Librium 25-50 mg every 12 hours scheduled
 - d. Day 4: Librium 25-50 mg at bedtime scheduled
 - e. Day 5: Librium 25-50 mg at bedtime scheduled
 - 3. Option 2:
 - a. Day 1: Librium 50 mg every 6–12 hours
 - b. Day 2: Librium 25 mg every 6 hours
 - c. Day 3: Librium 25 mg every 12 hours
 - d. Day 4: Librium 25 mg at night
 - 4. Option 3
 - a. [Librium](#) 25–50 mg every 8 hours for 3 days
 - b. Consider for emergency department discharge (lower risk)
 - c. Patient follow-up with primary care or addiction medicine
- D. [Diazepam \(Valium\)](#) Protocol
 - 1. Prescribe [Diazepam](#) 10 mg tabs (#11)
 - 2. Day 1: Valium 10 mg every 6 hours scheduled
 - 3. Day 2: Valium 10 mg every 8 hours scheduled
 - 4. Day 3: Valium 10 mg every 12 hours scheduled
 - 5. Day 4: Valium 10 mg at bedtime scheduled
 - 6. Day 5: Valium 10 mg at bedtime scheduled
- E. [Lorazepam \(Ativan\)](#) Protocol
 - 1. Prescribe [Lorazepam](#) 1 mg tabs (#18)
 - 2. Day 1: Ativan 2 mg every 8 hours scheduled
 - 3. Day 2: Ativan 2 mg every 8 hours scheduled
 - 4. Day 3: Ativan 1 mg every 8 hours scheduled
 - 5. Day 4: Ativan 1 mg every 12 hours scheduled
 - 6. Day 5: Ativan 1 mg at bedtime scheduled

You can adapt this to your practice. Please see the introduction for more information.

Assessment Protocol

Name of Clinic/Outpatient Program: _____

Effective Date of (AWM) Standard Operating Procedure: _____

Name of primary screener/ assessor: _____

Will assess the individual at risk of alcohol withdrawal using the following:

Pattern of consumption: AUDIT	AUDIT
Severity of dependency: SADQ	SADQ
Readiness to Change (SOCRATES)	SOCRATES
Withdrawal symptoms	CIWA-Ar, BAWS, or SAWS: See forms following
Physical and/or mental comorbidity	
Cognitive function	
Drug or other substance use	
Home environment	
Risk of harm to self and others	
Urgency of treatment	
Physical examination and biological tests when available: <ul style="list-style-type: none"> • FBC (inc MCV) • U&Es • LFTs (inc yGT) • Glucose + drug screen 	
Breath Alcohol Concentration	
Other:	

You can adapt this to your practice. Please see the introduction for more information.

Caregiver Name/Contact Information: _____

Preferred pharmacotherapy approach. Medication Formulary (what is accessible/available):

Benzodiazepine: _____

Anticonvulsant: _____

Dosing Regimen:

Fixed Dose: _____

Symptom-Triggered Dosing: _____

Monitoring Plan:

Validated instrument: CIWA-Ar, BAWS-if self-monitoring, SAWS

Reliable/present person who can monitor: _____

Self-monitoring plan:

Emergency Services Protocol:

In case of emergency, call: _____

Nearest location for inpatient medical monitoring: _____

Relapse Prevention Referral and Planning: _____

Standardized screening tool used to assess AWS.

	0 None	1 Mild	2 Moderate	3 Severe	Score
Tremor	No tremor	Not visible, but can be felt	Moderate, with arms extended	At rest, without arms extended	
Diaphoresis/Sweats	No sweats	Mild, barely visible	Beads of sweat	Drenching sweats	
Agitation	Alert and calm	Restless, anxious, apprehensive, movements not aggressive	Agitated, frequent non-purposeful movement	Very agitated or combative, violent	
Confusion/ Orientation	Oriented to person, place, time	Disoriented to time (e.g., by more than 2 days or wrong month or wrong year) or to place (e.g., name of building, city, state), but not both	Disoriented to time and place	Disoriented to person	
Hallucinations (Visual, auditory, tactile)	None	Mild (Vague report, reality testing intact)	Moderate (More defined hallucinations)	Severe (Obviously responding to internal stimuli, poor reality testing)	
TOTAL					

Please follow the BAWS protocol as follows:

1. Complete BAWS
2. Hold diazepam if patient is sedated or respiratory rate <10.
3. Notify physician if heart rate is > 120, systolic blood pressure > 200, diastolic blood pressure > 120.
4. Notify physician if patient is unable to take oral medications.

BAWS Score	Protocol
< 3	Give diazepam 5 mg orally as needed for mild withdrawal/anxiety: <ul style="list-style-type: none"> - every 4 hours up to 6 doses (Day 1); - then every 6 hours up to 4 doses (Day 2), - then every 8 hours up to 3 doses (Day 3). Reassess BAWS every 4 hours for 24 hours, then every 6 hours.
3-5	Give diazepam 10 mg orally every 4 hours until BAWS is < 3 (up to 10 doses). Reassess BAWS every 4 hours.
6-8	Give diazepam 20 mg orally every 2 hours until BAWS is < 6 (up to 3 doses). (If the patient has not received any benzodiazepines, give an initial dose of 10 mg) Reassess BAWS every 2 hours – notify physician if BAWS is > 5 after 6 hours.
> 8	Give diazepam 20 mg orally and notify physician.

Standardized screening tool used to asses AWS.

Patient _____ Date ____/____/____ Time: ____: ____

Pulse/heart rate taken for one minute: _____ Blood pressure: _____/_____

NAUSEA AND VOMITING

- 0 No nausea and no vomiting
- 1 Mild nausea with no vomiting
- 2
- 3
- 4 Intermittent nausea with dry heaves
- 5
- 6
- 7 Constant nausea, frequent dry heaves & vomiting

TREMOR

- 0 No tremor
- 1 Not visible, but can be felt fingertip to fingertip
- 2
- 3
- 4 Moderate, with arms extended
- 5
- 6
- 7 Severe, even with arms extended

PAROXYSMAL SWEATS

- 0 No sweat visible
- 1 Barely perceptible sweating, palms moist
- 2
- 3
- 4 Beads of sweat obvious on forehead
- 5
- 6
- 7 Drenching sweats

ANXIETY: Ask "Do you feel nervous?" Observation

- 0 No anxiety, at ease
- 1 Mildly anxious
- 2
- 3
- 4 Moderately anxious or guarded. Anxiety inferred
- 5
- 6
- 7 Equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

AGITATION

- 0 Normal activity
- 1 Somewhat more than normal activity
- 2
- 3
- 4 Moderately fidgety and restless
- 5
- 6
- 7 Paces back and forth during the interview or constantly thrashes about

TACTILE DISTURBANCES: Ask: Do you have any itching, burning, or numbness, feel bugs crawling under your skin?

- 0 None
- 1 Very mild itching, pins & needles, burning, numbness
- 2 Mild itching, pins & needles, burning, numbness
- 3 Moderate itching, pins & needles, burning, numbness
- 4 Moderately severe hallucinations
- 5 Severe hallucinations
- 6 Extremely severe hallucinations
- 7 Continuous hallucinations

AUDITORY DISTURBANCES: Ask: "Are you aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing things you know are not there?"

- 0 No tremor
- 1 Very mild harshness or ability to frighten
- 2 Mild harshness or ability to frighten
- 3 Moderate harshness or ability to frighten
- 4 Moderately severe hallucinations
- 5 Severe hallucinations
- 6 Extremely severe hallucinations
- 7 Continuous hallucinations

VISUAL DISTURBANCES: Ask: "Is the light too bright/hurting your eyes? Is the color different? Seeing anything disturbing? Are you seeing things you know are not there?"

- 0 Not present
- 1 Very mild sensitivity
- 2 Mild sensitivity
- 3 Moderate sensitivity
- 4 Moderately severe hallucinations
- 5 Severe hallucinations
- 6 Extremely severe hallucinations
- 7 Continuous hallucinations

HEADACHE, FULLNESS IN HEAD: Ask: "Is the light too bright/hurting your eyes? Is the color different? Seeing anything disturbing? Are you seeing things you know are not there?"

- 0 Not present
- 1
- 2
- 3
- 4
- 5
- 6
- 7

ORIENTATION AND CLOUDING OF SENSORIUM: Ask "What day is this? Where are you? Who am I?"

- 0 Not present
- 1
- 2
- 3
- 4

-----TOTAL CIWA-Ar Score

Maximum possible score: 67

Short Alcohol Withdrawal Scale (SAWS)

SAWS

Standardized screening tool used to assess AWS.

Item	None (0 pts)	Mild (1 pt)	Moderate (2 pts)	Severe (3 pts)
Anxious				
Feeling Confused				
Restless				
Miserable				
Problems with memory				
Tremor (shakes)				
Nausea				
Heart pounding				
Sleep disturbance				
Sweating				

The SAWS tool is used to assess AWS. The SAWS is designed to be filled out by patients to indicate how they have felt in the previous 24 hours.

- Mild withdrawal < 12 points
- Moderate to severe withdrawal \geq 12 points

Prophylaxis and Treatment of Wernicke's Korsakoff Syndrome

Please do not add or change the information.

All in-patients presenting in alcohol withdrawal should be considered for risk of developing Wernicke's encephalopathy.

Patient with history of alcohol misuse and one or more of the following:
Acute confusion
Ataxia/unsteadiness
Decreased consciousness
Ophthalmoplegia/Nystagmus
Memory disturbance
Unconsciousness/coma

NO

YES

Patient with one or more of the following:
Malnourished
Vomiting
Diarrhea
Physical illness

NO

YES

Preventative Treatment for Wernicke's encephalopathy

Administer 200–500 mg intravenous (IV) or intramuscular (IM) thiamine (vitamin B1) ONCE DAILY for 3 to 5 DAYS

Continue indefinitely with **ORAL THIAMINE** 100 mg **THREE** times daily

Treatment of acute/severe Wernicke's encephalopathy

Administer 200–500 mg of intravenous (IV) thiamine (vitamin B1) **THREE TIMES DAILY** for 2 DAYS

No response after 72 hours:

- Review diagnosis.
- Consider augmentation with IV magnesium or
- Discontinue supplementation unless comatose/unconscious

Response – continue with IV or IM thiamine ONCE DAILY for 5 DAYS or for as long as improvement continues



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