Humber Teaching
NHS Foundation Trust

Alcohol Withdrawal Management on Mental Health Inpatient Units

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CHANGE RECORD

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3.02	*28/3/13*	*Reviewed with minor changes*
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4.02	*3/07/17*	*Minor amendments following DTC meeting*
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4.04	*12/01/2024*	*Rreferences updated* *Relevant Trust Policies/Procedures, etc., section 5 added* *NICE CG133 superseded by NICE NG 225* *HERPC updated to HAPC* *Approved at DTG (25 January 2024).*

Contents

1. INTRODUCTION

Around 25% of adults in England are excessive drinkers with 6% of adult males and 2% adult females being alcohol dependent (defined by ICD-10). Approximately 40% of community mental health patients report harmful alcohol use and 85% of patients in alcohol services have a past year history of psychiatric disorder with over half this group having 'multiple comorbidities' (co-occurrence of a number of psychiatric disorders or substance misuse problems). Studies of acute psychiatric inpatients suggest that 50% have an alcohol use disorder and over 20% are alcohol dependent. Historically detection of alcohol problems by generic teams in the community and on inpatient wards is poor leading to poor treatment outcome.

The majority of patients being admitted to psychiatric wards are admitted urgently. Those with coexisting alcohol misuse including alcohol dependence are likely to be at high risk of medical and mental health problems. Patients with alcohol dependence who present for unplanned treatment present with a complexity of problems which need to be fully assessed and explored. Unexplained symptoms might be assumed to be directly related to alcohol withdrawal and minimised, however it must be remembered that the complications of acute alcohol intoxication and chronic alcohol use have potentially fatal consequences. Similarly, patients with alcohol use disorders can develop other medical complications that mimic other diagnosis.

Excluding differential diagnosis is essential to providing holistic care to these patients. Physical observations need to be maintained at regular intervals according to the individual needs of the patient and are essential part of maintaining the safety of the patient.

The following guidance is offered as a guide to safe and effective alcohol detoxification. It is primarily aimed at patients admitted for planned alcohol detoxification to any of the acute inpatient psychiatric units however the principles should be applied for those following unplanned care.

2. SCOPE

This guideline is primarily intended to assist in the medical management of alcohol dependent patients admitted to psychiatric inpatient units. These guidelines should be followed by all clinical staff and be considered by managers of inpatient units when considering resources needed to support and treat patients accessing Humber Teaching NHS Foundation Trust wards.

3. PROCEDURES

3.1. Criteria for Planned In-Patient Detoxification

The aims of alcohol detoxification are:

- To allow the patient to withdraw from alcohol with minimal discomfort
- To prevent complications of acute alcohol withdrawal
- To allow prompt treatment of complications
- To link patients up with community aftercare following successful detoxification

The majority of patients with an alcohol problem, including withdrawal from alcohol, can be managed in the community but if the patient meets one or more of the following criteria inpatient detoxification should be considered (NICE, CG115). They:

- drink over 30 units of alcohol per day
- have a score 31 or more on the SADQ
- have a history of epilepsy or experience of withdrawal-related seizures or delirium tremens during previous assisted withdrawal programmes
- need concurrent withdrawal from alcohol and benzodiazepines

- regularly drink between 15 and 20 units of alcohol per day and have:
  - significant psychiatric or physical co-morbidities (for example, chronic severe depression, psychosis, malnutrition, congestive cardiac failure, unstable angina, chronic liver disease) or
  - a significant learning disability or cognitive impairment.
- Consider a lower threshold for inpatient assisted withdrawal in vulnerable groups, for example, homeless and older people.

Patients with a serious concurrent physical illness should be detoxified on a medical ward. It must be remembered that serious concurrent physical illness are not always apparent and therefore adequate screening and assessment on admission of any patient admitted onto a psychiatric ward is essential to identify complications of chronic alcohol misuse.

Those patients who request, or are referred for in-patient detoxification when they are under the influence of alcohol are less likely to benefit from in-patient detoxification. However, it must be remembered that alcohol detoxification maybe required to ensure an adequate assessment of mental health, cognitive, neurological problems or risk (NICE NG 225). Such patients should not normally be admitted without consultation or advice from a specialist.

Compulsory admission under the Mental Health Act (1983) is not permissible when alcohol dependence is the sole diagnosis. However, in patients with neuropsychiatric complications of alcohol abuse such as alcoholic hallucinosis, Wernicke – Korsakoff syndrome or delirium tremens compulsory admission may be appropriate.

3.1.1. Out-of-Hours Procedures

Problems sometimes arise when patients are referred for admission late at night or over weekends when specialist services are not available for advice. Those assessing patients sometimes feel pressurised to admit patients who are in crisis but do not meet the criteria for admission described above. It must be remembered that improved outcomes for patients are found when alcohol treatment is planned and involves psychological support being immediately available on completion of alcohol detoxification. Normally patients presenting in an intoxicated state should be offered an appointment for further assessment the following day providing they attend relatively sober.

Alternatives to admission should be considered and if appropriate arrangements made for referral to another service. This might include referral for a specialist assessment to allow for the development of a full recovery plan. However there may be occasions when intoxicated patients require urgent psychiatric admission due to acute mental illness/risk issues. Whilst outcomes may be reduced in these circumstances the patient's needs should be fully assessed due to the complications of chronic alcohol misuse. Attempts to engage the patient in specialist treatment should be promoted in all cases.

3.2. Assessment of Alcohol Use

3.2.1. Screening

All patients should be asked about how many units of alcohol they drink per day and in a typical week (Table 1) and complete the Alcohol Use Disorders Identification Test (AUDIT questionnaire) (see Appendix A: Identification of Alcohol Misuse – Humber Teaching NHS Foundation Trust Care Pathway).

Table 1: Units of Alcohol

1 unit of alcohol	=	½ pint of ordinary strength beer or lager (3.5%)
	=	1 small glass (125ml) of table wine (8%)
	=	1 pub measure (25cl) of spirits (40%)
	=	1 small glass (50ml) of sherry (17.5%)

$$\text{no. of units of alcohol} = \frac{\text{volume (ml)} \times \text{\% alcohol by volume}}{1000}$$

500ml can of 9% lager	=	4.5 units
75cl bottle of 12% wine	=	9 units
70cl bottle of 15% sherry	=	10.5 units
2L bottle of 7.5% cider	=	15 units
70cl bottle of 40% spirits	=	28 units

3.2.2. Scoring and Interpretation of the Audit

The 10-item questionnaire takes about two minutes to complete and covers alcohol consumption, drinking behaviour and alcohol-related problems.

Scores for each question range from 0 to 4, with the first response for each question (e.g. never) scoring 0, the second (e.g. less than monthly) scoring 1, the third (e.g. monthly) scoring 2, the fourth (e.g. weekly) scoring 3, and the last response (e.g. daily or almost daily) scoring 4.

For questions 9 and 10, which only have 3 responses, the scoring is 0, 2, and 4 (from left to right).

- A score of 8 or more in men and 7 or more in women indicates a strong likelihood of hazardous or harmful alcohol consumption and should be followed by a detailed assessment.
- A score of 16 or more is indicative of significant alcohol-related harm/dependence – patients who score 16 or more are more likely to experience symptoms of alcohol withdrawal which may require medication.
- A score of 20 or more is indicative of probable alcohol dependence and patients are highly likely to experience symptoms of alcohol withdrawal.

AUDIT Scores	Definition	Intervention	Evidence
0-7	No Alcohol Use Disorder	None required	NICE 2010 (PH24)
8 or more	8 or more presence of an Alcohol Use Disorder		NICE 2010 (PH24)
8-15	Hazardous drinking	Inform patient of risks associated to hazardous drinking and discuss reduction of drinking Issue patient with leaflet	NICE 2010 (PH24)
16-19	Harmful drinking (possible	Inform patient of risks	NICE 2010 (PH24)

AUDIT Scores	Definition	Intervention	Evidence
	alcohol dependence)	associated to harmful drinking Brief lifestyle counselling Issue patient with leaflet Consider comprehensive assessment of Alcohol Use Disorder (section 3.2.3) Monitor for signs of alcohol withdrawal if consuming 15 or more alcohol units/day (section 3.2.4)	NICE 2011 (CG115)
20 or more	Probable alcohol dependence	Conduct comprehensive assessment of Alcohol Use Disorder (section 3.2.3) Assessment for Assisted Alcohol Withdrawal (section 3.2.4) Issue patient leaflet regarding alcohol dependence	NICE 2011 (CG115)

3.2.3. Comprehensive Assessment of an Alcohol Use Disorder: Specialist Team (HULL (ReNew) and ERP (East Riding Partnership))

Those patients who score 16 or more on the AUDIT or who are suspected of experiencing complex alcohol misuse should receive a comprehensive assessment of their alcohol misuse by a trained healthcare professional. The comprehensive assessment should consider multiple areas of need, be structured in a clinical interview, use relevant and validated clinical tools, and cover the following areas:

- alcohol use, including: consumption: historical and recent patterns of drinking (using, for example, a retrospective drinking diary), and if possible, additional information (for example, from a family member or carer)
- dependence, including history of:
  - evidence of tolerance (needing more alcohol over time to get the same effect)
  - withdrawal symptoms (nausea, tremor, sweats, anxiety, delirium tremens, seizures, sleep problems and may make use of the Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar))
  - strong desire/compulsion to take alcohol (i.e. craving/urge to drink), inability to control the use of alcohol
  - preoccupation with the obtaining, using and recovery from alcohol – other activities/priorities diminished
  - persistent use of alcohol despite evidence of harmful consequences and problems
  - Supplement the assessment with the use of the Severity of Alcohol Dependence Questionnaire (SADQ)
- alcohol-related problems (using, for example, Alcohol Problems Questionnaire (APQ))
- other drug misuse, including over-the-counter medication
- physical health problems; particularly attention should be paid to a history of recent falls, head injuries, possible neurological problems, nutrition and dietary intake
- psychological and social problems
- cognitive function (using, for example, the Mini-Mental State Examination (MMSE))
- readiness and belief in ability to change.

3.2.4. Assisted Alcohol Withdrawal

Consider the need for assisted alcohol withdrawal for those who drink > 15 units of alcohol per day and/or scores ≥ 20 on AUDIT. An assessment will determine delivery of a **community-based assisted withdrawal, or management in an inpatient setting**.

3.2.5. Inpatient Setting

Consider inpatient or residential assisted withdrawal if a patient meets one or more of the following criteria. They:

- drink over 30 units of alcohol per day
- have a score of more than 30 on the SADQ
- have a history of epilepsy or experience of withdrawal-related seizures or delirium tremens during previous assisted withdrawal programmes
- need concurrent withdrawal from alcohol and benzodiazepines
- regularly drink between 15 and 30 units of alcohol per day and have:
  - significant psychiatric or physical comorbidities (for example, chronic severe depression, psychosis, malnutrition, congestive cardiac failure, unstable angina, chronic liver disease) or
  - a significant learning disability or cognitive impairment

The inpatient setting selected should account for the clinical needs of the patient, the likely treatments required and the competence and skills of the staff to meet these requirements.

3.2.6. Community-Based Assisted Withdrawal

Consider community-based interventions if the service user does not meet the inclusion criteria for inpatient care. They:

- drink less than 30 units of alcohol per day
- have a score of less than 31 on SADQ
- no history of epilepsy or experience of withdrawal-related seizures or delirium tremens
- no concurrent significant psychiatric or physical comorbidities or substance misuse

3.2.7. Taking a Brief Alcohol History

A comprehensive assessment should be undertaken that covers, as a minimum:

- Consumption in units of alcohol per day/week
- Drinking pattern daily/continuous or episodic/binge drinking
- Drinking behaviour in the last week and the last six months
- When did the patient have the last drink?
- Is there a history of withdrawal symptoms (e.g. sweating, tremor, nausea, vomiting, anxiety, insomnia, seizures, hallucinations or delirium tremens?)
- Is there a history of morning/relief drinking, change in tolerance, strong compulsion to drink, continued drinking despite problems, priority of drinking over other important pursuits/activities? (all indicative of dependence syndrome)
- History of alcohol-related problems (medical, psychiatric, social, relationship, occupational, financial, legal etc.)
- Consider impact on any co-morbid psychiatric issues

3.2.8. Severity of Alcohol Dependence Questionnaire (SADQ; Stockwell et al, 1979)

The Severity of Alcohol Dependence Questionnaire (SADQ) is self-administered and a reliable instrument to measure the severity of alcohol dependence. The SADQ is a 20 item tool with a 4-point scale for each item; scoring 0, 1, 2, or, 3 for each question GIVING a maximum score of 60.

- A score of 0-14 indicates no or mild dependence
- 15-30 moderate dependence
- 31-60 severe dependence (see Appendix B).

The SADQ is a useful guide to prescribing detoxification regimes as it can be used to help predict the severity of withdrawal symptoms and therefore helps in rationalising detoxification medication (see later). It is of limited use in patients who are acutely intoxicated or who present in acute withdrawal.

Guidance to consider in using the SADQ:

- Caution should be applied to scores which seem incongruent to the clinical history and typical levels of alcohol consumed.
- In the dependent drinker there is an established relationship between typical units of alcohol consumed on a daily basis and the level of dependence experienced, which can be used to guide judgement. A dependent drinker who reports drinking approximately 30 units of alcohol daily tend to score around 30 on the SADQ (range 25-40) (see section 3.4.1).
- Commonly patients may omit to score questions 17-20 on the SADQ either because they cannot imagine being alcohol free for 2 weeks as requested by the survey or they did not realise there were further questions on the rear of the questionnaire. With a small amount of arithmetic a full score for the SADQ can be used. This avoids asking the patient to repeat the questionnaire.
  - The SADQ is structured into five sets of questions. The last set of questions is 17-20. As there is a strong relationship between these sets of questions a total score can be generated using the score from the remaining questions (i.e. 1-16)
  - The maximum score that can be reached for questions 1-16 is 48
  - If the patient scores 16 out of 48 we can determine the maximum score using the following:
    - 16/48 = 0.33 (one third of the score)
    - One third of the total score = 20/60

3.2.9. Examination

- Look for tremor, sweating, and signs of liver disease, e.g. spider naevi, liver palms, hepatomegaly etc.
- Is the patient intoxicated, in withdrawal, confused, psychotic, depressed, or suicidal?
- Consider other possible organic causes for the patient's clinical presentation and conduct a neurological examination, e.g. head injury, hypoglycaemia, concurrent infection, other drugs etc.

3.2.10. Investigations

Full Blood Count (FBC), Liver Function Tests (LFTs), Gamma GT, blood/urine/breath for alcohol, urine/mouth swab for other drugs. Other investigations may be necessary depending on differential diagnoses or concurrent conditions. It is recommended that in the patient who reports significantly poor dietary intake or unintentional weight loss in the past 3-6 months are monitored for being at risk of refeeding syndrome (NICE CG32, 2017) (see section below) and consider; potassium, magnesium and phosphate levels.

3.3. Alcohol Withdrawal Syndrome

Not all heavy drinkers will experience withdrawal phenomena. Predicting who may experience alcohol withdrawal symptoms is made difficult by levels of alcohol intoxication, other medicines or drug use. However, there is a wide range of severity of withdrawal symptoms and in some cases withdrawal may be life-threatening. It is therefore important to recognise complications early and treat them appropriately.

3.3.1. Early Withdrawl Symptoms

Occur up to 12 hours after the last drink and peak at 12 hours. Signs and symptoms include tremor, sweating, anorexia, nausea, insomnia and anxiety. In moderate withdrawal the signs are more marked and transient auditory hallucinations in clear consciousness may also occur.

3.3.2. Withdrawl Fit ("Rum Fits")

Occurs in 8-15% of individuals withdrawing from alcohol. Can occur at 12 to 48 hours post-withdrawal and are more likely if there is a previous history of withdrawal fits or epilepsy. Fits tend to be single, generalised (if focal suspect head injury) and may occur in bouts. 30% of cases are followed by delirium tremens (DTs).

3.3.3. Delerium Tremens (DTs)

Delerium Tremens is uncommon occurring in less than 5% of individuals withdrawing from alcohol (less in planned admissions) but is associated with significant morbidity and mortality. Symptoms begin within hours of withdrawal, peak at 48 hours and subside over 3-4 days. DTs usually occur in heavy drinkers who have withdrawn unexpectedly, minimised their consumption or been inadequately treated during withdrawal. Patients consuming more than 16 units per day (half to a bottle of spirits per day or equivalent) are particularly at risk. In addition to the classical symptoms of withdrawal, the characteristic symptoms of DT's are agitation, apprehension, confusion, disorientation in time and place and visual and auditory hallucinations. Insomnia, nausea, vomiting, motor coordination and paranoid ideation may be present. Fever is common. Poor concentration, intermittent disorientation and agitation may continue for 1-2 weeks before recovery.

3.3.4. Protracted Withdrawal Symptoms

(Not an official diagnosis) has been noted in many alcohol dependent patients. This is a disorder characterised by irritability, emotional lability, insomnia and anxiety that persist for weeks to months after alcohol withdrawal. It is due to the residual effects of alcohol on the central nervous system. It generally clears spontaneously after prolonged abstinence.

3.4. Management of Alcohol Withdrawal

All those in acute alcohol withdrawal should be assessed immediately on admission to hospital by a health care professional skilled in the management of alcohol withdrawal.

Consideration should be given as to the need for immediate doses (stat) of chlordiazepoxide medication recognising that; alcohol withdrawal symptoms may intensify quickly, the assessment may take some time and the peak effect of chlordiazepoxide (usual medication of choice) may take 1-2 hours after administration.

The severely alcohol dependent patient is at risk of seizures and providing stat medication at the earliest opportunity may help ameliorate some of the risk associated with the patient suddenly stopping drinking due to their admission to hospital.

Those patients with severe dependence, who have repeatedly experienced alcohol withdrawal symptoms, may begin to experience severe withdrawal symptoms early in their admission, even when there is evidence of alcohol intoxication. Hence there is a need for close observation of the severely alcohol dependent patient even whilst they are in receipt of medication for alcohol withdrawal as the risk of seizures is not eliminated only lessened in these circumstances.

3.5. Benzodiazipines

Alcohol dependent patients exhibiting or at risk of developing withdrawal (based on their previous history) should be prescribed a benzodiazepine, usually chlordiazepoxide. Chlormethiazole and chlorpromazine should not be used in alcohol detoxification. There are a number of regimens defined therefore the guidance is not prescriptive. Dosage should be individually titrated against severity of withdrawal symptoms and signs and is ultimately a matter of clinical judgement which considers presentation, history consumption and severity of dependence. NICE CG115 (2011) states that fixed-dose regimens can be used, particularly where a unit may not have sufficient resources or expertise in symptom-triggered regimens. Humber Teaching NHS Foundation Trust suggested prescribing guidelines similar to those specified by NICE (CG115) for inpatients are as follows (see table on page 12).

BNF Guidelines November 2023 state:

- Treatment of alcohol withdrawal in moderate dependence 10–30 mg 4 times a day, dose to be gradually reduced over 5–7 days, consult local protocols for titration regimens.
- Treatment of alcohol withdrawal in severe dependence 10–50 mg 4 times a day and 10–40 mg as required for the first 2 days, dose to be gradually reduced over 7–10 days, consult local protocols for titration regimens; maximum 250 mg per day.

Doses in excess of 40mg q.d.s should only be prescribed where there is clear evidence of very severe alcohol dependence. Such doses are rarely necessary in women and never in the elderly or where there is liver impairment.
Doses in the elderly should be 50% less than stated above.
Patients who self-discharge from the alcohol detoxification process should not normally be provided with supplies of chlordiazepoxide to go home with.

As required (prn) doses of chlordiazepoxide should not be needed if the patient has been adequately assessed. If clinically necessary small doses of prn chlordiazepoxide may be prescribed for the first 48hrs of the detoxification. If withdrawal symptoms become more severe after this then the patient should be reassessed by a doctor (see section 3.6 Special Situations).

Daily alcohol Intake			Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10
15-25 Units	SADQ score	Daily Total Dose Times	60mg	40mg	20mg	10mg						
	15	09:00	15mg	10mg	5mg	5mg						
		13:00	15mg	10mg	5mg	-						
		18:00	15mg	10mg	5mg	-						
		22:00	15mg	10mg	5mg	5mg						
	SADQ score	Daily Total Dose Times	80mg	60mg	40mg	20mg	10mg					
	20	09:00	20mg	15mg	10mg	5mg	5mg					
		13:00	20mg	15mg	10mg	5mg	-					
		18:00	20mg	15mg	10mg	5mg	-					
		22:00	20mg	15mg	10mg	5mg	5mg					
	SADQ score	Daily Total Dose Times	100mg	80mg	60mg	40mg	20mg	10mg				
	25	09:00	25mg	20mg	15mg	10mg	5mg	5mg				
		13:00	25mg	20mg	15mg	10mg	5mg	-				
		18:00	25mg	20mg	15mg	10mg	5mg	-				
		22:00	25mg	20mg	15mg	10mg	5mg	5mg				
26-40 Units	SADQ score	Daily Total Dose Times	120mg	100mg	80mg	60mg	40mg	20mg	10mg			
	30	09:00	30mg	25mg	20mg	15mg	10mg	5mg	5mg			
		13:00	30mg	25mg	20mg	15mg	10mg	5mg	-			
		18:00	30mg	25mg	20mg	15mg	10mg	5mg	-			
		22:00	30mg	25mg	20mg	15mg	10mg	5mg	5mg			
	SADQ score	Daily Total Dose Times	140mg	120mg	100mg	80mg	60mg	40mg	20mg	10mg		
	35	09:00	35mg	30mg	25mg	20mg	15mg	10mg	5mg	5mg		
		13:00	35mg	30mg	25mg	20mg	15mg	10mg	5mg	-		
		18:00	35mg	30mg	25mg	20mg	15mg	10mg	5mg	-		
		22:00	35mg	30mg	25mg	20mg	15mg	10mg	5mg	5mg		
	SADQ score	Daily Total Dose Times	160mg	140mg	120mg	100mg	80mg	60mg	40mg	20mg	10mg	
	40	09:00	40mg	35mg	30mg	25mg	20mg	15mg	10mg	5mg	5mg	
		13:00	40mg	35mg	30mg	25mg	20mg	15mg	10mg	5mg	-	
		18:00	40mg	35mg	30mg	25mg	20mg	15mg	10mg	5mg	-	
		22:00	40mg	35mg	30mg	25mg	20mg	15mg	10mg	5mg	5mg	
41-45 Units	SADQ score	Daily Total Dose Times	180mg	160mg	140mg	120mg	100mg	80mg	60mg	40mg	20mg	10mg
	45	09:00	45mg	40mg	35mg	30mg	25mg	20mg	15mg	10mg	5mg	5mg
		13:00	45mg	40mg	35mg	30mg	25mg	20mg	15mg	10mg	5mg	-
		18:00	45mg	40mg	35mg	30mg	25mg	20mg	15mg	10mg	5mg	-
		22:00	45mg	40mg	35mg	30mg	25mg	20mg	15mg	10mg	5mg	5mg
46-50 Units	SADQ score	Daily Total Dose Times	200mg	180mg	160mg	140mg	120mg	100mg	80mg	50mg	30mg	10mg
	>45	09:00	50mg	45mg	40mg	35mg	30mg	25mg	20mg	15mg	10mg	5mg
		13:00	50mg	45mg	40mg	35mg	30mg	25mg	20mg	10mg	5mg	-
		18:00	50mg	45mg	40mg	35mg	30mg	25mg	20mg	10mg	5mg	-
		22:00	50mg	45mg	40mg	35mg	30mg	25mg	20mg	15mg	10mg	5mg

3.5.1. Vitamins

Most patients admitted for inpatient care will be more severely alcohol dependent than those treated in a community setting. Hence inpatients are at greater risk of complications, e.g. withdrawal seizures, Wernicke's Encephalopathy (confusion, ataxia, ophthalmoplegia) etc.

If patients at high risk of Wernicke's Encephalopathy are given treatment early, their symptoms will improve and they may make a complete recovery (NICE, CG100). However, if treatment is not given, or is not given in time, their condition may become life-threatening and irreversible brain damage can occur, severely affecting short-term memory.

People who drink heavily over a long period of time are at risk of Wernicke's due to low levels of thiamine (vitamin B1) being absorbed in the body. This can be because they have poor eating habits and may often vomit. It can also be because alcohol can damage the stomach lining, affecting its ability to absorb vitamins from food, or because it damages the liver where the thiamine is processed.

Those patients most at risk of Wernicke's Encephalopathy experience:

- Poor dietary intake
- Significant weight loss
- Evidence of cognitive impairment
- Vomiting
- Neurological symptoms

Symptoms include uncontrollable eye movements (these can be side-to-side, up-and-down or rolling movements), problems with walking and coordination, confusion and memory loss. However, some people may not show all of these symptoms, which can sometimes make it difficult for doctors to recognise it. The following sign/symptoms occurring during alcohol withdrawal should be taken as indication of a presumptive diagnosis of Wernicke's Encephalopathy and must be treated immediately with parenteral thiamine if this has not commenced (Note: absorption of oral thiamine is inadequate in such circumstances).

- Confusion (not due to intoxication)
- Memory disturbance
- Ophthalmoplegia (paralysis of eye muscles)
- Nystagmus
- Hypothermia (low body temperature)
- Hypotension (low blood pressure)
- Coma/unconsciousness (not due to intoxication)

In addition parenteral thiamine should be used in the following circumstances

- Alcohol withdrawal fits
- Delirium tremens
- Patients who are malnourished or obviously physically unwell
- Acute peripheral neuritis (inflammation of the nerves)

3.5.2. Dosage of Thiamine

If a healthcare professional thinks a patient is experiencing Wernicke's Encephalopathy, or they think that the patient is at high risk of developing it, they should be offered thiamine. Local policy and national guidance indicates that those at high risk should receive thiamine injections (e.g. Pabrinex) when admitted to hospital. The amount of thiamine, type of injection and length of treatment may vary depending on the risk or evidence of neurological symptoms.

Doses should be given towards the upper end of the British National Formulary (BNF) range.

Prophylaxis
Patients experiencing alcohol withdrawal are at increased risk of developing neurological impairment irrespective of the presence of alcohol withdrawal symptoms and therefore all patients should be prescribed parenteral thiamine as follows:

- one pair of Pabrinex IM High Potency ampoules daily for five days
- treatment should commence on the first day of alcohol abstinence

Treatment
Patients should be transferred to the acute hospital for emergency treatment if Wernicke's encephalopathy is suspected – as IV medication cannot be safely administered on the ward due to lack of experience.

Patients experiencing alcohol withdrawal who present with signs/symptoms indicating Wernicke's Encephalopathy (see above), or with severe poor dietary intake, weight loss or vomiting should be considered for the treatment schedule of parenteral thiamine. This patient group are likely to have other complications and be in need of treatment doses of parenteral thiamine which should be administered by IV infusion, necessitating the transfer of the patient to a clinical environment which can support and manage IV treatment:

- two to three pairs Pabrinex IV High Potency ampoules by IV infusion three times daily for two days
- treatment should commence on the first day of the emergence of signs and symptoms indicative of Wernicke's Encephalopathy

then

- if improvement occurs one pair Pabrinex IV High Potency ampoules by IV infusion or one pair of Pabrinex IM High Potency ampoules daily for 5 days or as long as improvement continues
- if no response after two days of Pabrinex IV High Potency ampoules by IV infusion, discontinue treatment

For patients with:

- enduring ataxia
- polyneuritis
- memory disturbance

one pair of ampoules daily for as long as improvement continues

The normal administration of Pabrinex on a psychiatric ward is intramuscular. Anaphylaxis is a rare but recognised complication. Anaphylactic and serious allergic reactions are more severe and more frequent with the intravenous route. If given IV Pabrinex should be diluted in 50 to100mls of normal saline or 5% dextrose and given over 15 to 30 minutes. Facilities for treating anaphylactic reactions must be readily available whenever parenteral thiamine is used. Whenever parenteral thiamine is given on a psychiatric ward an anaphylaxis pack must be available (see the Trust anaphylaxis policy).

3.5.3. Assesment of Withdrawal Signs and Symptoms

The severity of withdrawal symptoms can be measured by using Clinical Institute Withdrawal Assessment for Alcohol revised version (CIWA-Ar, see Appendix C), which is a very sensitive instrument and can be used as a guide to dose reduction and to alert the clinician to possible alcohol withdrawal symptoms. NEWS should also be used to monitor for signs of deterioration in the patient.

Patients undergoing planned or unplanned alcohol withdrawal are at risk of withdrawal phenomena

including alcohol withdrawal seizures, even when in receipt of medication. The risk is highest over the first 48 hours. Patients may also experience idiosyncratic responses to benzodiazepines placing them at risk of falls, confusion. Patients may begin to exhibit signs of cognitive impairment and neurological complications at the early stages of withdrawal which need to be responded to promptly.

It is recommended that:

- Throughout the admission staff should use techniques such as positive engagement to help the patient participate in their care. However, **over the first 48 hours** the frequency of observation of the patient needs to be regular due to the specific risk outlined above. Therefore **staff need to be aware of the patient every 30-60 minutes** – using a policy of supportive engagement would mean that these observations are meaningful and designed to engage the patient in their care. At times visible observations of the patient will be acceptable.
- Assessment of alcohol withdrawal using the **CIWA-Ar and NEWS2 prior to each dose of medication in the first 24 hours**.
- **A total CIWA-Ar score of 15 or more on one occasion indicates that further medical review is needed.**
- Following the first 24 hours the **CIWA-Ar should be assessed twice daily for the remaining three days** due to the risk of delirium tremens that may emerge independently of seizures over a 72 hour period.
- The frequency of the NEWS2 will be determined by the NEWS2 scores over the first 24 hours but should be maintained on a daily basis unless otherwise indicated.
- **Observation levels and frequency of NEWS2 should be increased where the patient is thought to be deteriorating**, i.e. reporting falls, confusion or exhibiting features that maybe related to alcohol withdrawal or complications such as Wernicke's.

3.6. Treatment of Common Symptoms During Alcohol Withdrawal

Many of these symptoms are normal in withdrawal. Reassure the patient they will improve during detoxification. Avoid unnecessary pharmacological treatment and only treat if severe.

Symptom	Possible Treatment
Sleep difficulties:	Sleep hygiene Do not prescribe hypnotics If severe consider loading the total daily dose of chlordiazepoxide towards the evening or increasing night time dose for 1-2 days or extending the period of detoxification
Poor appetite	Encourage diet. If severe nutritional and vitamin supplements
Nausea	Metoclopramide 10 mg oral or intramuscular
Diarrhoea	If severe loperamide 2-4 mgs prn
Heartburn	Gaviscon 10 ml prn
Itching	Check for signs of liver disease
	If necessary chlorpheniramine 2-4 mg tds
Headache	Paracetamol with caution in severe liver disease
Anxiety	Very common in withdrawal, usually resolves after 3-4 days. May unmask pre-existing anxiety which will need assessing in its own right
Depression	Very common. Monitor for severe persistent symptoms and suicidal ideation. Treat if necessary once the withdrawal is over. NICE recommends that for a formal diagnosis of depression to be made the patient should be alcohol-free for 3-4 weeks (NICE, CG115)

3.7. SPECIAL SITUATIONS

3.7.1. Breakthrough Withdrawal

With adequate dosing there is no need for PRN chlordiazepoxide or other benzodiazepines. However, where a patient presents with breakthrough withdrawal either clinically or if scores 15+ on CIWA-Ar, they should be reassessed to rule out concurrent physical illness. If necessary, repeat the previous day's chlordiazepoxide dosing regimen before resuming the sliding scale.

3.7.2. Previous Benzodiazepine Perscription

Some patients will have been prescribed long-term benzodiazepines prior to detoxification. In this case continue their long-term prescription unaltered and do not take the long-term dose into account when deciding on the dosage schedule for a withdrawal regimen.

3.7.3. Acute Presentation

Patients presenting in acute withdrawal should be prescribed chlordiazepoxide on a flexible dosage regimen over a 24-hour period following **four-hourly clinical assessments of withdrawal signs and symptoms**. It may occasionally be necessary to extend the flexible period to 48 hours, e.g. if seizures or delirium tremens occur. At the end of the flexible prescribing period a standard reducing regimen should be used. If it is not possible to offer the flexible dosage regimen, consider using typical drinks per dinking day and the guidelines set out above to support clinical judgement. Regular clinical assessment of withdrawal symptoms and vital signs will be required to ensure appropriate response (i.e. four-hourly assessments).

3.7.4. Nausea/Vomiting/Dehydration

Patients who are nauseous or vomiting should be monitored especially carefully and may need an anti-emetic, e.g. metoclopramide 10mg oral or IM injection. Patients in severe withdrawal and unable to tolerate oral medication should be assessed with a view to transfer to a medical ward for intravenous therapy.

3.7.5. Liver Disease

Special caution is necessary in the case of severe liver impairment or decompensated liver disease (jaundice, ascites), as the metabolism of benzodiazepines may be reduced and lead to over sedation.

3.7.6. Severe Withdrawal

Additional doses of chlordiazepoxide orally (5 to 15mg) may be necessary initially. If the patient is very drowsy or over sedated the dosage may need to be reduced. Symptoms of breakthrough withdrawal or features of delirium tremens (especially whilst on high dose regimen) should prompt an immediate medical review and possible urgent transfer to a medical ward where management may involve intravenous sedation. In these circumstances high levels of observation should be maintained whilst nursing the patient in a low stimulus environment and encouraging hydration till transfer can be arranged. Where a patient becomes confused, agitated, etc. sensitive management will also include advising the patient not to leave the unit.

3.7.7. Withdrawal Fits or Status Epilepticus

Adjunctive treatment with carbamazepine should be used in the planned prophylactic treatment of alcohol withdrawal seizures. This is recommended for those patients with a past history of withdrawal seizures or epilepsy of any cause. Ideally carbamazepine should be commenced three days prior to admission at a dose of 200 mgs bd. and on admission increased to 600 to 800 mg bd. for four to five days. Phenytoin does not prevent alcohol withdrawal seizures.

If a withdrawal seizure does occur treatment should be with Buccal Midazolam 10mg (or 10mg Rectal Diazepam) as prescribed. Repeat after 10 minutes if the seizure continues. Any patient developing a withdrawal seizure should be prescribed prophylactic parenteral thiamine and be assessed with a view to increasing the dose of chlordiazepoxide.

3.7.8. Severe Behavioural Disturbance

Rule out delirium tremens. If necessary give lorazepam 2mg IM injection.

Patients who do not respond to benzodiazepines or experience a paradoxical effect with benzodiazepines can be given haloperidol 5-10mg p.o. (syrup) or IM injection. This should not be regarded as a treatment of choice in alcohol withdrawal and should only be used when delirium tremens has been excluded.

3.7.9. Delirium Tremens

General measures:

- Ensure adequate levels of medical and nursing staff
- Treat the patient in a well-lit area away from other patients
- Keep external stimuli especially noise to a minimum
- Use a friendly understanding but firm approach
- Be aware of the possibility of withdrawal fits

Medical measures:

- Ensure the patient is adequately hydrated and correct any electrolyte imbalance
- Give high dose parenteral thiamine (see previous)
- Give sufficient chlordiazepoxide to induce a light sleep without impairing vital functions
- Maximum doses of chlordiazepoxide may be needed for 36-48 hours
- The detoxification regimen will need to be extended to 7-10 days
- Up to 50% of patients with DTs have a secondary infection or evidence of trauma especially head injury which must be actively excluded.

3.7.10. Indications for Urgent Medical Assessment

The following are some situations when urgent medical assessment is important:

- The patient has consumed potentially toxic amounts of alcohol or alcohol plus other drugs
- Hallucinations
- Confusion or delirium
- Severe agitation
- Severe tremor
- Rapid heart rate (>120/min)
- Fever (>38ºC)
- Evidence of injury especially head injury
- Coma or semi-coma

3.7.11. Refeeding Syndrome

The refeeding syndrome is increasingly recognised (NICE CG32, updated 2017). It is a serious change in electrolytes when nutrition is reintroduced to malnourished patients. Refeeding syndrome is a potentially lethal condition in chronically malnourished patients undergoing re-nutrition. The syndrome is under- recognised and undertreated. Chronic alcohol abuse and dependence are risk factors for refeeding syndrome.

The principal biochemical hallmark of refeeding syndrome is severe, acute hypophosphatemia that usually occurs within 3-4 days of refeeding. This is often associated with hypokalaemia, hypomagnesaemia, sodium and fluid retention, thiamine deficiency and hyperglycaemia. Electrolyte levels (Potassium, magnesium and phosphate) should be initially monitored in at-risk patients, as acute, profound hypophosphatemia may develop even in asymptomatic patients.

Those most at risk of refeeding syndrome include:

A patient who experiences any one of the following:

- BMI<16kg/m2
- Weight loss of >15% over 3-6 months
- Little or no nutritional intake for 10 days
- Low electrolytes **or**

A patient who experiences any two of the following:

- BMI<18.5kg/m2
- Weight loss >10% over 3-6 months
- Little or no nutritional intake for five days
- History of excess alcohol or medications such as insulin, chemotherapy, antacids and diuretics

Where the patient is at risk of refeeding syndrome refer immediately for medical advice and consider transferring the patient to acute medicine ward for care and management. **Note**: parenteral thiamine is beneficial to the support of refeeding syndrome.

3.8. General Management

During detoxification all patients, and in particular those with severe withdrawal need:

- close observation (see above)
- monitoring of vital signs (see above)
- correction of dehydration or electrolyte imbalance
- treatment of concurrent conditions, e.g. infection, hypoglycaemia, hepatic failure, gastrointestinal bleeding etc.

Patients should be orientated and reassured that any distressing symptoms will settle. Patients should be given an explanation of their symptoms and their relationship to excessive consumption. Although directive counselling during the detoxification can enhance patient's motivation to continue treatment, many patients have subtle cognitive deficits during detoxification, therefore therapy is best kept simple.

During withdrawal patients often have alcohol craving and are vulnerable to relapse. Patients should not have leave for the first few days of the detoxification. Following this any unaccompanied leave from the ward should be carefully considered and patients should be advised not to go into pubs or places where alcohol is available when on leave.

3.9. Planning Aftercare

Discharge Planning

Those in need of care under this protocol are likely to require ongoing specialist treatment for alcohol dependence. Staff should engage local alcohol services to support continued treatment and management of alcohol use disorders.

All patients having a medical alcohol detoxification should have a biopsychosocial aftercare plan developed with the ward, patient, their family/carers (where appropriate) and the community addictions service (where appropriate). This should include appropriate psychological and social interventions, which should be intensified on discharge.

In terms of pharmacological aftercare, all patients who complete an alcohol withdrawal should be prescribed thiamine on discharge (100mg t.d.s). In some situations, for patients abstinent from alcohol with a diagnosis of alcohol dependence, it may be worth considering whether relapse

prevention medications (acamprosate, naltrexone or disulfiram) are clinically indicated. Please always discuss this request with the community addiction services and see the Humber Area Prescribing Committee (HAPC) prescribing frameworks on the Trust intranet.

If the patient is discharged before detoxification is finished, there should be clear instructions on discharge medication and if necessary arrangements for on-going medical supervision (e.g. by the GP). Providing the most recent blood test results, including LFT to the GP within the discharge letter is recommended.

As per the transition of care from community to inpatient and vice versus NICE guidelines (NG53) recommends that any discharge should be planned in advance with the relevant services. Patients with alcohol dependence and mental health disorders will need input from a variety of services so clear communication and liaison with appropriate services is essential to support the complex needs.

A local up to date list of agencies can be found through NHS Choices or see below for information on Hull and East Yorkshire addictions services.

Local Community Specialist Alcohol Treatment providers

EAST RIDING PARTNERSHIP: for all East Riding residents

East Riding – East Riding Partnership (three Community Hubs)
The Central Hub (Cottingham, Beverley, Withernsea, Hedon, Anlaby areas)
7 Baker Street
Hull
HU2 8HP
Please telephone to ensure that your referral has been received: Tel: 01482 336675
Referrals via email: Hnf-tr.erphull@nhs.net

The West Hub (Goole, Pocklington, Brough, Howden, Hessle, South Cave areas)
100 Boothferry Road
Goole
DN14 6AE
Please telephone to ensure that your referral has been received Tel: 01405 608210
Email: Hnf-tr.erpgoole@nhs.net

The East Hub (Bridlington, Driffield, Hornsea areas)
Becca House
27 St John's Avenue
Bridlington
YO16 4ND
Please telephone to ensure that your referral has been received Tel: 01262 458200
Email: Hnf-tr.erpbridlington@nhs.net

ReNEW: for all Hull residents
Hull – ReNew
Trafalgar House
43-45 Beverley Road
Hull HU3 1XH
Please telephone to ensure that your referral has been received: Tel: 01482 620013
Email: earlyhelp.hull@cgl.org.uk

4. REFERENCES

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- NICE (2011) Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence – clinical guideline 115 (CG 115). National Institute for Health and Clinical Excellence: London
- NICE (2016) Transition between inpatient mental health settings and community or care home settings – national guideline 53 (NG 53). National Institute for Health and Clinical Excellence: London
- NICE (2017) Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition – clinical guideline 32 (CG 32). National Institute for Health and Clinical Excellence: London
- NICE (2017) Alcohol-use disorders: diagnosis and management of physical complications – clinical guideline 100 (CG 100). National Institute for Health and Clinical Excellence: London
- NICE (2022) Self-harm: assessment, management and preventing recurrence - NICE guideline 225 (NG225 formerly NICE clinical guideline 133 (CG 133). National Institute for Health and Clinical Excellence: London
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- Sullivan, J. T., Sykora, K., Schneiderman, J., Naranjo, C. A. & Sellers, E. M. 1989. Assessment of alcohol withdrawal: the revised clinical institute withdrawal assessment for alcohol scale (CIWA-Ar). Br J Addict, 84, 1353-7
- Rotherham Doncaster and South Humber NHS Foundation Trust, 2020. Inpatient Alcohol Detoxification Policy. October 2020

5. RELEVANT TRUST POLICIES/PROCEDURES/PROTOCOLS/GUIDELINES

Community Assisted Alcohol Withdrawal (for Specialist Addiction Services) – Protocol 536 (2024) To be available from https://intranet.humber.nhs.uk/document-library/clinical-policies-procedures-sops.htm?AccessLetter=C

Deteriorating Patient Protocol (2022)
https://intranet.humber.nhs.uk/Policies/Clinical%20Policies/Clinical%20Protocols/Deteriorating%20Patient%20Protocol%20Prot527.pdf

Drug Testing in Addictions (2021)
https://intranet.humber.nhs.uk/Policies/Clinical%20Policies/Clinical%20Guidelines/Drug%20Testing%20in%20Addictions%20Guideline%20G392.pdf

Identification of Alcohol Misuse Policy (N-036) (2013)
https://intranet.humber.nhs.uk/Policies/Clinical%20Policies/C%20Policies/Identification%20of%20Alcohol%20Misuse%20Policy%20N-036.pdf

Prescribing Framework for Acamprosate tablets 333mg in alcohol relapse prevention
https://intranet.humber.nhs.uk/prescribing-framework.htm

Prescribing Framework for DISULFIRAM as an adjunct in the treatment of alcohol dependence
https://intranet.humber.nhs.uk/prescribing-framework.htm

Prescribing Framework for Naltrexone in Alcohol Relapse Prevention
https://intranet.humber.nhs.uk/prescribing-framework.htm

Appendix A: Alcohol Use Disorders Identification Test

Interview Version (Saunders et al, 1993)

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages ***during this past year***." Explain what is meant by "alcoholic drinks" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks" (NB: 1 standard drink in the UK = 8grams ethanol). Place the correct answer number in the box at the right.

Question	0	1	2	3	4	Score
1. How often do you have a drink that contains alcohol?	Never	Monthly or less	2 – 4 times per month	2 – 3 times per week	4+ times per week	
2. How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7, 8 or 9	10 or more	
3. **MEN:** How often do you have **8** or more standard drinks on one occasion? **WOMEN:** How often do you have **6** or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often in the last year have you failed to do what was expected of you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor or health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	
Total AUDIT Score (maximum 40)						

Appendix B: Severity of Alcohol Dependence Questionnaire

(Stockwell et al, 1979)

We would like to recall a recent month when you were drinking in a way, which for you was fairly typical of a heavy drinking period. Please fill in the month and the year:-

MONTH: ……YEAR: …….

We want to know more about your drinking during this time and how often you experienced certain feelings. Please put a tick to show how frequently each of the following statements applied to you during this typical period of drinking

Score	0	1	2	3
	Almost Never	Sometimes	Often	Nearly Always
1) I wake up feeling sweaty				
2) My hands shaking first thing in the morning				
3) My whole body shakes violently first thing in the morning, if I don't have a drink				
4) I wake up absolutely drenched in sweat				
5) I dread waking up in the morning				
6) I am frightened of meeting people first				
7) I feel on the edge of despair when I wake up				
8) I feel very frightened when I wake up				
9) I like to have a morning drink				
10) I always gulp down my morning drink as quickly as possible				
11) I drink in the morning to get rid of the shakes				
12) I have a very strong craving for a drink when I wake up				
13) I drink more than 1/4 bottle of spirits or 4 pints beer or 1 bottle wine per day				
14) I drink more than 1/2 bottle of spirits or 8 pints beer or 2 bottles wine per day				
15) I drink more than 1 bottle of spirits or 15 pints beer or 4 bottles of wine per day				
16) I drink more than 2 bottles of spirits or 30 pints beer or 8 bottles wine per day				

Imagine the following situation:

You have been completely off drink for a few weeks and you then drink very heavily for two days HOW WOULD YOU FEEL THE MORNING AFTER THOSE TWO DAYS OF DRINKING?

Score	0	1	2	3
The morning after	Not at all	Slightly	Moderately	A lot
17) I would start to sweat				
18) My hands would shake				
19) My body would shake				
20) I would be craving a drink				
Totals				
SEVERITY OF ALCOHOL DEPENDENCE QUOTIENT				

Re: Questions 17 – 20

(If the patient has not been abstinent for a period of two weeks then score maximum for Q17–20)

TOTAL SADQ SCORE=

TOTAL SADQ SCORE	SEVERITY OF ALCOHOL DEPENDENCE
0-14	**no dependence or mild dependence**
15-30	**moderate dependence**
31-60	**severe dependence**

Appendix C: CIWA-Ar (Sellers, E. M. 1989)

QUESTION	DATE										
	TIME										
NAUSEA & VOMITING – Ask "Do you feel sick to your stomach? Have you vomited?" Observation.											
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 and vomiting											
TREMOR – Arms extended and fingers spread apart. Observation.											
0 no tremor											
1 not visible, but can be felt fingertip to fingertip											
2											
3											
4 moderate, with patient's arms extended											
5											
6											
7 severe, even with arms extended											
PAROXYMSMAL SWEATS – Observation.											
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 mild anxious											
2											
3											
4 moderately anxious, or guarded, so anxiety is inferred											
5											
6											
7 equivalent to acute panic states as seen in severe delirium or acute schizophrenia reactions											
AGITATION – Observation.											
0 normal activity											
1 somewhat more than normal activity											
2											
3											
4 moderately fidgety and restless											
5											
6											
7 paces back and forth during most of the interview, or constantly thrashes about.											
TOTAL SCORE FOR PAGE ONE											

Name of Person obtaining the information			
Designation/Band			
Signature		Date & Time	

TACTILE DISTURBANCES – Ask “Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under skin?” Observation.										
0 none										
1 very mild itching, pins and needles, burning or numbness										
2 mild itching, pins and needles, burning or numbness										
3 moderate itching, pins and needles, burning or numbness										
4 moderately severe 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 frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?” Observation.										
0 not present										
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 “Does the light appear to be too bright? Is its colour different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?” Observation.										
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 “Does your head feel different? Does it feel like there is a band around your head?” Do not rate for dizziness or light-headedness. Otherwise, rate severity.										
0 not present										
1 very mild										
2 mild										
3 moderate										
4 moderately severe										
5 severe										
6 very severe										
7 extremely severe										
ORIENTATION AND CLOUDING OF SENSORIUM – Ask “What day is this? Where are you? Who am I?”										
0 oriented and can do serial additions										
1 cannot do serial additions or is uncertain about date										
2 disoriented for date by no more than 2 calendar days										
3 disoriented for date by more than 2 calendar days										
TOTAL SCORE FOR PAGE 2										
TOTAL CIWA-Ar SCORE										

Name of Person obtaining the information			
Designation/Band			
Signature		Date & Time	