COMMUNITY ASSISTED ALCOHOL WITHDRAWAL

(for Specialist Addiction Services)

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1.0	*28/03/2024*	*New protocol. Approved at Drugs and Therapeutics Group (28 March 2024).*

Contents

1. Introduction

2. Scope

This guideline is primarily intended to assist in the medical management of alcohol dependent patients within a community setting.

3. Procedures

3.1. Criteria for planned community detoxification.

The aims of alcohol detoxification:

- To assist patients in commencing their recovery from alcohol dependence and enter a full package of care aimed at abstinence from alcohol.
- To allow the patient to withdraw from alcohol with minimal discomfort.
- To prevent complications of acute alcohol withdrawal

Most patients with alcohol problems can be managed in the community. The specific inclusion criteria for this are:

- Aged 18 or over and wishing to pursue a goal abstinence from alcohol.
- Those willing to engage in psychological treatment with/without medications to support recovery from alcohol.
- Drinking daily with a typical drinking day being 10-30 units of alcohol and/or experiencing mild/moderate alcohol dependence[1].
- The presence of a reliable family member or friend to supervise the taking of medication and seek help if necessary (or exceptional circumstances when clinically appropriate and risk assessment completed, consideration of the patient taking medication unassisted with daily face to face contact from the addictions team).
- No history of epilepsy or withdrawal related seizure or delirium tremens
- No concurrent significant psychiatric or physical co-morbidity or poly-substance misuse[2]

Specific exclusion criteria for community detoxification and upon which you would seek inpatient care.

3.2. Community Detoxification – Exclusion Criteria

- Those who would intend to continue to consume alcohol after the programme.
- Evidence of severe alcohol dependence (SADQ score >30)
- Evidence or prediction of severe withdrawal symptoms
- Unstable or unsupportive living circumstances

[1] A clinical assessment might be supplemented by use of the Severity of Alcohol Dependence Questionnaire (see Appendix 1) which identifies mild dependence (4-15), moderate dependence (16-30) and severe dependence (31 or more).

[2] In some circumstances concomitant substance misuse might be managed in community treatment programs.

- Those unable or unwilling to engage in post-detoxification treatment.
- Those experiencing withdrawal fits, delirium tremens in previous detoxification programmes.
- History of hallucinations upon alcohol withdrawal
- Patient with significant mental health conditions where it is anticipated would deteriorate because of the community detoxification programme.
- Chaotic poly-substance misuse, who would require either an in-patient setting for detoxification or stabilisation.
- A history of previous failed community detoxification with no substantial change in environmental, psychological, or physical pre-disposing factors
- Significant memory impairment
- Present or history of Wernicke's encephalopathy or confused state.

3.3. Assessment of Alcohol Use

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 AUDIT Questionnaire (see Appendix 2).

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%)
Calculating units of alcohol from size and strength of reported drink		
Number of units of alcohol	=	$\frac{\text{Volume (ml) x \% alcohol by volume}}{1000}$
500ml can of 9% lager 75cl bottle of 12% wine 70cl bottle of 15% sherry 2L bottle of 7.5% cider 70cl bottle of 40% spirits	= = = = =	4.5 units 9 units 10.5 units 15 units 28 units

3.3.1. Screening and Assessment of Alcohol Misuse

Aims

The aim of screening and assessment of alcohol misuse is to:

- Identify the presence and 'type' and severity of alcohol problem the patient is experiencing.
- The potential risk of alcohol withdrawal symptoms
- Help make clinical decisions regarding the interventions to be offered.

NHS professionals should focus screening on groups that may be at an increased risk of harm from alcohol and those with and alcohol-related condition. This includes:

- People with relevant physical conditions (such as hypertension and gastrointestinal or liver disorders)

- People with relevant mental health problems (such as anxiety, depression, or other mood disorder)
- People who have been assaulted
- People at risk of self-harm
- People who regularly experience accidents or minor traumas
- People who regularly attend GUM clinics or repeatedly seek emergency contraception.

'Types' (Definitions) of Alcohol Problems

There are various diagnostic codes for mental and behavioural presentation related to alcohol use. However, under the World Health Organisation's International Classification of Mental Disorders, 10th Revision (ICD-10; WHO, 1992) the main disorders are classified as either *harmful alcohol use* or *alcohol dependence*.

Harmful use is defined as – "*a pattern or psychoactive substance use that is causing damage to health. The damage may be physical (e.g., hepatitis) or mental (e.g., depressive episodes secondary to heavy alcohol intake). Harmful use commonly but not invariable, has adverse social consequences; social consequences in themselves, however, are not sufficient to justify a diagnosis of harmful use".*

Alcohol Dependence is defined as – *"A definite diagnosis of dependence should usually be made only if **three or more** of the following have been present together at some time **during the previous year:***

a) A strong desire or sense of compulsion to take the substance.
b) Difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use.
c) A physiological withdrawal state when substance use has ceased or been reduced, as evidenced by the characteristic withdrawal syndrome for the substance; or use of the same (or closely related) substance with the intention of relieving or avoiding withdrawal symptoms.
d) Evidence of tolerance, such as the increased doses of the psychoactive substances are required to achieve effects originally produced by lower doses (clear examples of this are found in alcohol- and opiate-dependent individuals who may take daily doses sufficient to incapacitate or kill non-tolerant users).
e) Progressive neglect of alternative pleasures or interests because of psychoactive substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects.
f) Persisting with substance use despite clear evidence of overtly harmful consequences such as harm to the liver through excessive drinking, depressive mood states consequent to periods of heave substance use, or drug-related impairment of cognitive functioning; efforts should be made to determine that the user was, or could be expected to be, aware of the nature and extent of the harm".

Additionally, **hazardous alcohol use** has been defined as drinking above the recommended daily drinking units (i.e., 2-3 units) or weekly units (i.e., 14 units) without experiencing harmful effects.

The presence and severity of each disorder may require specific care and management. The intention of this guideline is to highlight the initial management only. Patients who are alcohol dependent, and those who experience harmful drinking that do not respond to interventions, may require a comprehensive assessment by specialist clinicians.

The aim of this assessment is to identify the:

1. Presence of an alcohol use disorder "Case Identification"
2. Need for management of alcohol withdrawal (inpatient settings)
3. Severity of any alcohol use disorder and need for further help.

3.3.2. 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 following by a detailed assessment.

A score of 16 or more is indicative of significant alcohol related harm/dependency and indicates the need for comprehensive assessment.

Table 2

AUDIT Score	Definition	Intervention	Evidence
0-7	No Alcohol Use Disorder	None required	NICE 2010 (PH24)
8 or more	8 or more indicates the 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 with a patient leaflet	NICE 2010 (PH24)
16-19	Harmful drinking (possible alcohol dependence	• Inform patient of risks associated to harmful drinking • Brief lifestyle counselling • Issue patient with leaflet • Consider comprehensive assessment of Alcohol Use Disorder • Monitor for signs of alcohol withdrawal if consuming 15 or more alcohol units per day	NICE 2010 (PH24) NICE 2011 (CG115)
20 or more	Probable alcohol dependence	• Conduct comprehensive assessment of Alcohol Use Disorder	NICE 2011 (CG115)

		• Assessment for Assisted Alcohol Withdrawal • Issue patient with leaflet regarding alcohol dependence	

3.3.3. Comprehensive Assessment of an Alcohol Use Disorder

A comprehensive assessment should assess multiple areas of need, be structured in a clinical interview, use relevant and validated clinical tools, and cover the following areas: -

- Alcohol use, including:
  - Consumptions: historical and recent patterns of drinking (using, for example, a retrospective diary), and if possible, additional information (for example, from a family member or carer)
  - Dependence (using, for example, Severity of Alcohol Dependence Questionnaire (SADQ))
  - Alcohol related problems (using, for example, Alcohol Problems Questionnaire (APQ) – Appendix 3)
- Other drug misuse, including over-the-counter medication
- Physical health problems
- Psychological and social problems
- Cognitive function (using, for example, the Mini-Mental State Examination [MMSE])
- Readiness and belief in ability to change.
- 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 – for example 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? (Indicative of dependence syndrome)

3.3.4. The Use of the Severity of Alcohol Dependence Questionnaire (SADQ; Stockwell et al, 1979) (Appendix 1)

The Severity of Alcohol Dependence Questionnaire (SADQ) (Appendix 1) is a 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 0-3 = no dependence, 4-15 = mild dependence, 16-30 = moderate dependence, and 31+ = severe dependence (CG115, pg121).

As with the AUDIT SADQ may help indicate those who could benefit from structure alcohol withdrawal programmes. There is evidence from the Adult Psychiatric Morbidity Survey (2007) that identifies alcohol dependence being missed with a cut-off score of AUDIT 16+. Therefore, it is recommended that AUDIT & SADQ are used together and a score of SADQ 10 or more would also indicate the need for an assessment for alcohol withdrawal. The SADQ is a useful guide to prescribing

detoxification regimes as it can be used to predict the severity of withdrawal symptoms and therefore helps in rationalising detoxification medication. It is or limited use in patients who are acutely intoxicated or who present in acute withdrawal.

3.3.5. 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, e.g., head injury, hypoglycaemia, concurrent infection, other drugs etc.

3.3.6. Investigations

FBC, LFTS, GGT, Enhanced liver Fibrosis (ELF) blood test, blood/urine/breath for alcohol urine/mouth swab for other drugs. Other investigations may be necessary depending on differential diagnoses or concurrent conditions.

3.4. Alcohol Withdrawal Syndrome

Not all heavy drinkers will experience withdrawal phenomena. 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.

3.4.1. Early Withdrawal Symptoms

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

3.4.2. Withdrawal Fit ('Rum Fits')

Occurs in between 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.

3.4.3. Delirium Tremens (DT's)

Delirium 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 (1/2 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.

3.4.4. Protracted Withdrawal Symptoms

Protracted withdrawal symptoms (not an official diagnosis) have 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 nervous system. It generally clears spontaneously after prolonged abstinence.

3.5. Community Alcohol Withdrawal

We offer community alcohol withdrawal across the locality. Those with alcohol dependence may experience dependence across a continuum of severity and will need differing levels of social, emotional, and medical support. Therefore, all patients are treated individually.

Inclusion criteria for community detoxification:

- Aged 18 or over and wishing to pursue a goal abstinence from alcohol.
- Those willing to engage in psychological treatment with/without medications to support recovery from alcohol.
- Drinking daily with a typical drinking day being 15-30 units of alcohol and/or experiencing moderate alcohol dependence (SADQ Score 16-30).
- For mild dependence (drinking 10-15 units daily or SADQ 10-15), a community alcohol detoxification could be considered in exceptional circumstances where a gradual self-reduction has not been successful or there are other reasons to consider a pharmacological detoxification.
- The presence of a reliable family member or friend to supervise the taking of medication and seek help if necessary or in exceptional circumstances when clinically appropriate and risk assessment completed, the consideration of the patient taking medication without a carer and having daily face to face contact from the addictions team.
- No history of epilepsy or withdrawal related seizure or delirium tremens
- No concurrent significant psychiatric or physical co-morbidity or substance misuse (in some circumstance concomitant substance misuse may not exclude the patient from clinic-based interventions but result in greater attendance rate)
- Patient should be willing to attend clinic during the phase of medication for support and monitoring (i.e., up to daily attendance).

Figure 1

Essential Steps in the Management of Alcohol Withdrawal

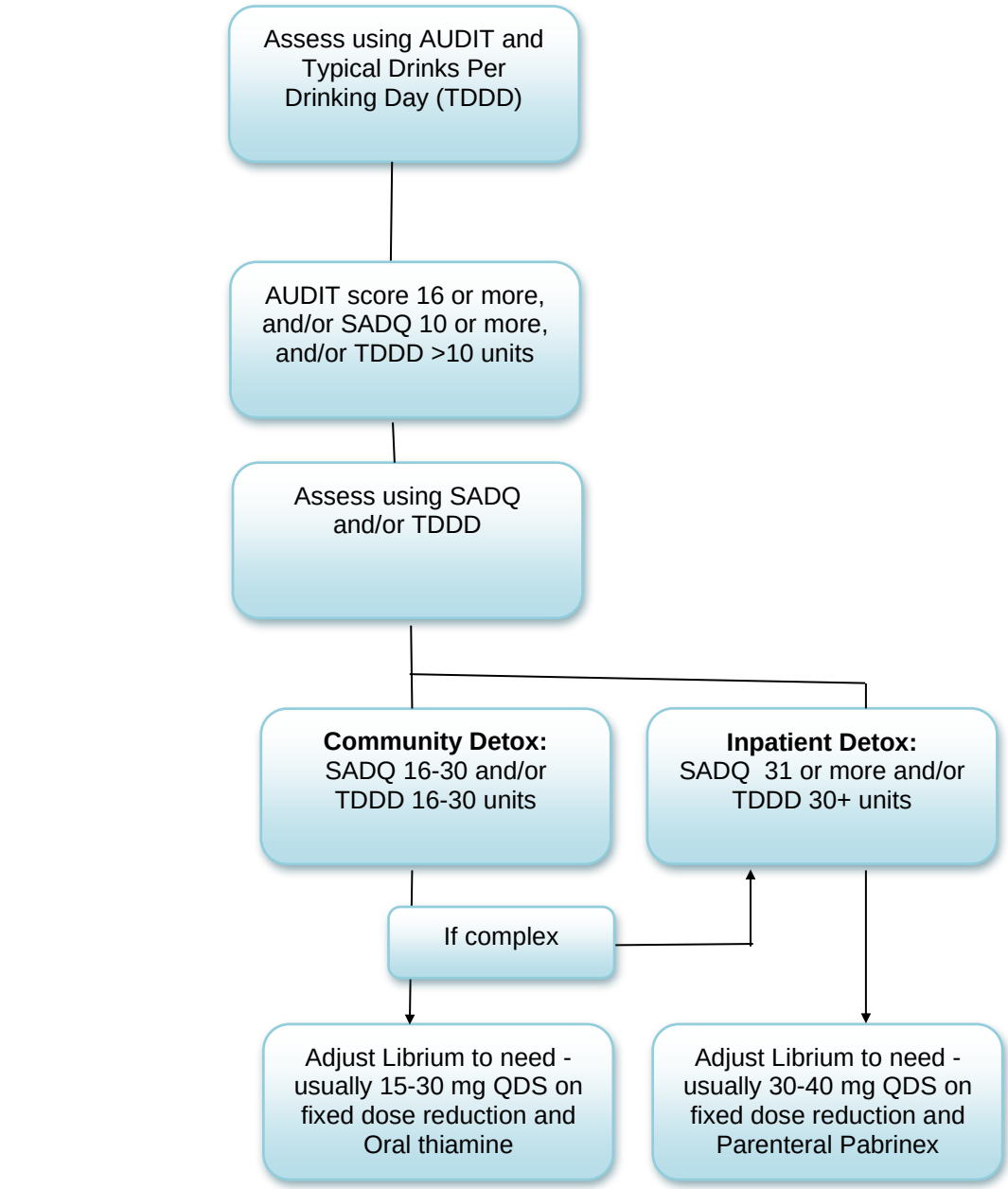


Figure 1: Summary Care Pathway for Community Alcohol Detoxification

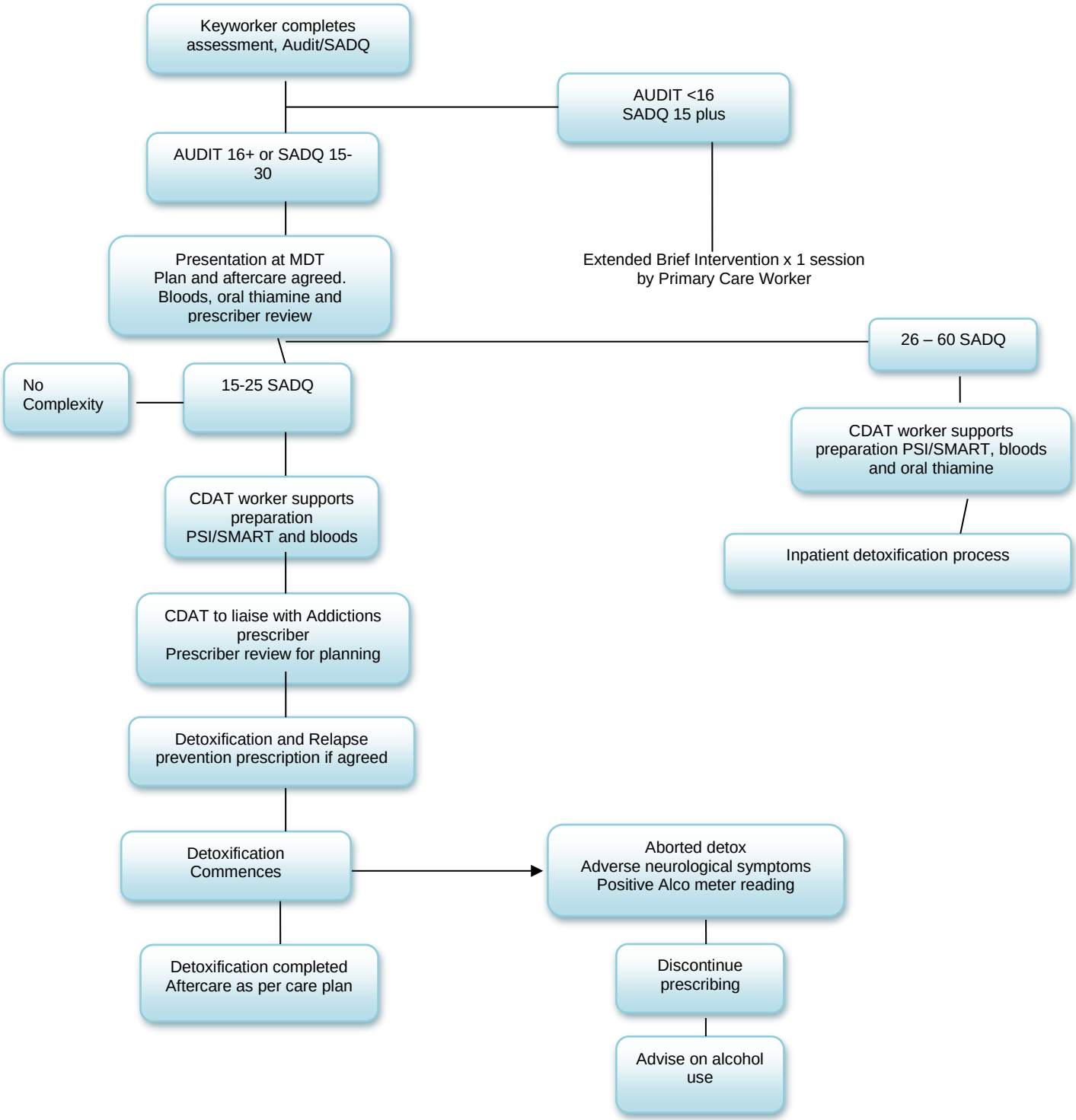
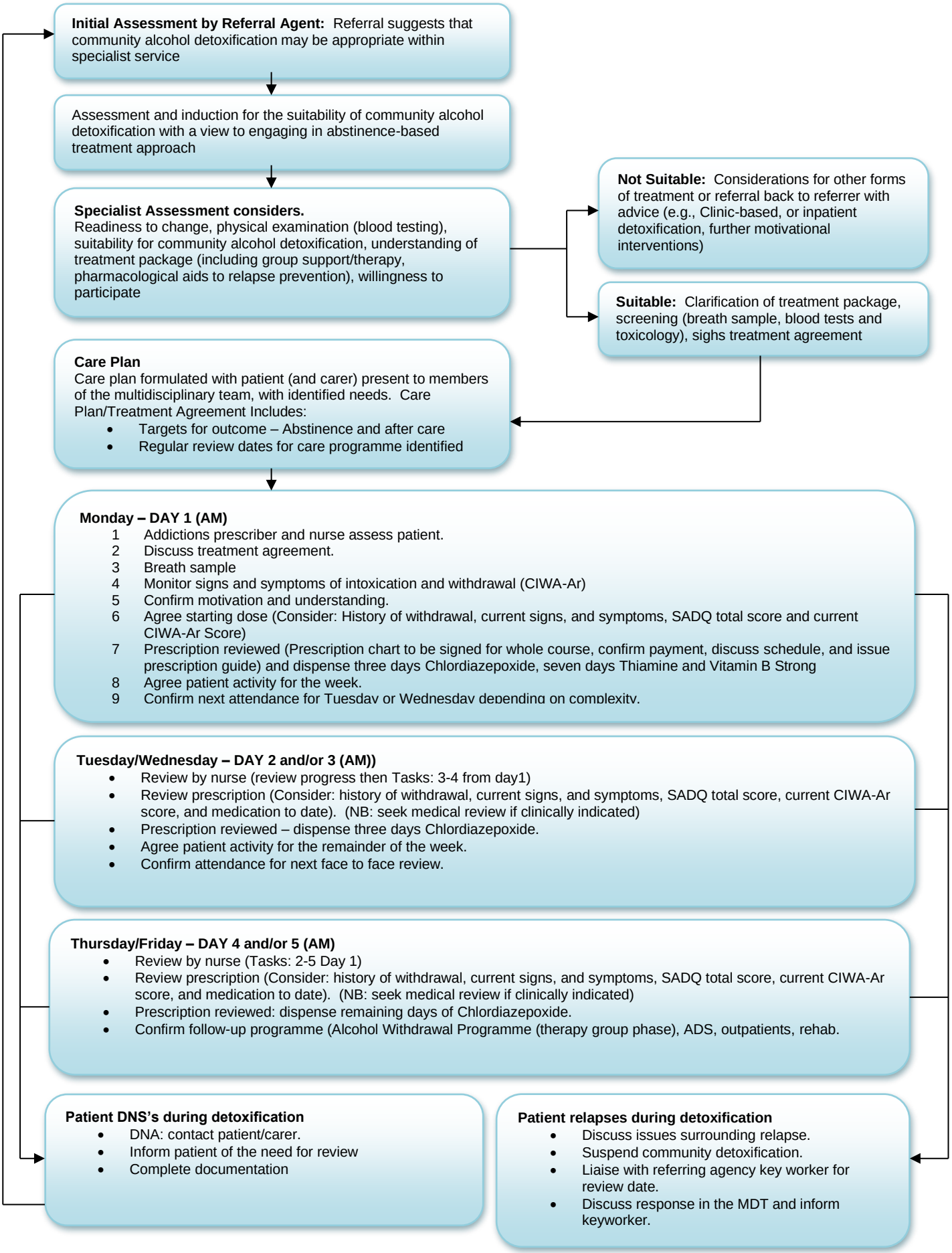


Figure 2 – Detailed Care Pathway: Community Alcohol Detoxification Phase



3.6. Assessment of Withdrawal Signs and Symptoms during Detoxification.

3.6.1. The use of the Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar)

To ensure a safe withdrawal and appropriate use of detoxification medication withdrawal symptoms should be monitored daily (initially). The severity of withdrawal symptoms can be measured by using Addiction Research Foundation Clinical Institute Withdrawal Assessment for Alcohol, which is a very sensitive instrument and can be used as a guide to dose reduction and to alert the clinician to possible complications. A total score of>15 on one occasion indicates that further medical review is needed.

3.6.2. Treatment of Common Symptoms during Alcohol Withdrawal

Many of these symptoms are normal in withdrawal. Reassure the patient that they will improve during detoxification. Avoid unnecessary pharmacological treatment and only treat if severe. If withdrawal symptoms become more severe after this, then the patient should be reassessed medically.

Table 3

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. 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 if symptoms persist beyond four weeks post withdrawal

3.7. Implementation

Step by Step Guide to Community Detoxification at a Treatment Hub

Step 1

- Assessment of suitability for community detoxification. Assess for risk and reasonable likelihood of a positive outcome:
    - Previous medical history, sensitivities and/or allergies
    - Previous detox experience and numbers
    - Psychiatric history and current mental health
    - Support network

        - Home environment
        - Acquire SADQ score to determine level of dependence.
        - Laboratory tests required from GP prior to detoxification:
            - U&E's, LFT, FBC, ELF (where available)
        - Drug screen
        - Pregnancy test (for women of childbearing age)
        - Completion of pre-detoxification checklist (see appendix 4)
    - Discuss at Addictions Service MDT, agree aftercare plan and prescriber review for medication prescribing.

Step 2

- Discuss and disseminate information leaflets to patient and carer.
    - Role of medication in detoxification (Appendix 5)
    - Self-care advice leaflet (Appendix 6)
    - Carers leaflet (including important contact details) (Appendix 7)
- Agree commencement date for detoxification (usually a Monday) with prescriber, patient, and carer.
- Complete and sign Community Detoxification Consent Form (see appendix 8) copy to notes, copy to patient, copy to GP.
- Clients told to have last alcoholic drink on the night before commencement of detoxification (no later than 10 pm)

Step 3

- The CDAT nurse to co-ordinate storage of medication with liaison with prescriber.

Step 4

- Commence detoxification process.
- Contact with patient to include:
    - Breath alcohol reading
    - Completion of CIWA-Ar (Appendix 10)
    - Pulse, BP, respiratory rate, and temperature
    - Observation of nystagmus, ophthalmoplegia and ataxia
    - Record contact and observations in client's case notes.
    - Medication Record completed (appendix 11)
- NICE (GG115) recommends that for those receiving an out-patient based assisted withdrawal programme contact between patient and staff should average between 2-4 meetings per week over the first week.
- Most clients will breathalyse positive on the morning of the commencement and Chlordiazepoxide can still safely be given medication dependent on levels of intoxication and whether withdrawal symptoms are present.
- Report back to prescriber any concerns or difficulties arising during and after detoxification.

3.8. Ordering and Dispensing of Medication for Out-Patient Community Detoxification Programme

Prescription generated by prescriber and sent as EPS to be dispensed local community pharmacy.

3.9. Medication in Detoxification

The Role of Benzodiazepines

Heavy and regular alcohol use without periods of abstinence changes the receptor system within the body. The changes in the gamma amino butyric acid (GABA) and the n-methyl-d-aspartate (NMDA) are largely responsible for the alcohol withdrawal symptoms that we observe and the patient reports. It may take a significant amount of time before these systems return to a state of 'normality' and the patient should be informed of this and supported during the after-care phase.

The pharmacological effect of benzodiazepines is like that of alcohol. Being able to control dosage makes benzodiazepines and particularly chlordiazepoxide the drugs of choice in alcohol detoxification. Chlordiazepoxide is the benzodiazepine of choice where there is no known liver impairment.

The principle is to prescribe high enough doses to prevent withdrawal but not over sedation and for long enough to cover peak withdrawal effect.

Community detoxification should follow an individually tailored fixed dose regimes with regular review and dose amendment if required depending on withdrawals. It is important to note that dosage should always be individually titrated against the severity of withdrawal symptoms and is ultimately a matter of clinical judgment. Suggested prescribing guidelines are shown below.

Table 4: Prescribing Guidelines for Community Alcohol Detoxification

Approximate Daily Alcohol Consumption	**10-15 units**		**20-30 units**		
Severity of dependence Starting dose of Chlordiazepoxide	**SADQ Score 10-15** 10-15 mg qds		**SADQ Score 20-30** 20-30 mg qds*		
Day 1 (starting dose)	10 mg qds	15 mg qds	20 mg qds	25 mg qds	30 mg qds
Day 2	10 mg tds	10 mg qds	15 mg qds	20 mg qds	25 mg qds
Day 3	5 mg tds	10 mg tds	10 mg qds	15 mg qds	20 mg qds
Day 4	5 mg bd	5 mg tds	5 mg qds	10 mg qds	15 mg qds
Day 5	5 mg nocte	5 mg bd	5 mg tds	5 mg qds	10 mg qds
Day 6		5 mg nocte	5 mg bd	5 mg tds	5 mg qds
Day 7			5 mg nocte	5 mg bd	5 mg tds
Day 8				5 mg nocte	5mg bd
Day 9					5 mg nocte
Day 10					

Please refer to Appendices 8 (a, b, c, d) – Fixed Dose Regimes

Note:

- **Doses of chlordiazepoxide more than 100 mg daily should only be prescribed following discussion with the patient's consultant or another senior prescriber.**
- **Doses of 30 mg qds or above should only be prescribed in cases where severe withdrawal symptoms are expected and the patient's response to treatment must be regularly and closely monitored.**

- **Doses more than 40 mg qds should only be prescribed where there is clear evidence of very severe alcohol dependence. Patients needing such doses of medication should only be treated in an inpatient setting.**
- **Doses in the elderly should be 50% less than stated above**

Altering a fixed Dose Regime

Over- medication
Patients who appear over-sedated should be advised to omit a dose of medication**.** They should be reviewed, and the dose of medication changed after liaising with the responsible doctor.

Under-medication
If the CIWA- Ar is ≥15, then the next dose of Chlordiazepoxide given should be higher than the planned dose and this will have to be reviewed with the doctor and dose regime changed accordingly for the rest of the detoxification.

The role of Vitamin Replacement Therapy in Community Alcohol Detoxification
Most patients who need medically assisted detoxification will be at a higher risk of vitamin deficiency. Patients will develop deficiency due to reduced vitamin B absorption from the gastrointestinal tract secondary to prolonged heavy alcohol consumption. They also are less likely to have a balanced dietary intake due to the high calorie content in most of the alcoholic drinks.

Patients with severe vitamin deficiency are at high risk of developing Wernicke's encephalopathy and Korsakoff's psychosis. These are medical emergencies and will need treatment with Intravenous high potency vitamin B. Pabrinex is the parenteral high potency vitamin b complex licensed to use in the UK.

In an outpatient setting the recommended treatment is:
- Oral thiamine 100mg three times a day

The role of Relapse Prevention Medication in a Detoxification Programme
Please see the prescribing frameworks for acamprosate, naltrexone and disulfiram
.

3.10. Special Situations

3.10.1. Breakthrough Withdrawals

With adequate dosing there is usually no need for PRN Chlordiazepoxide or other benzodiazepines. However, as a pre-emptive measure for community alcohol detoxification, we recommend providing one extra dose of chlordiazepoxide that could be used if breakthrough withdrawals occurred.

Where a patient presents with breakthrough withdrawals either clinically or if scores 15+ on CIWR-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.

3.10.2. Nausea/Vomiting/Dehydration

Patients who are nauseous or vomiting should be monitored especially carefully and may need an anti-emetic, e.g., Metoclopramide 10 mg oral or intramuscular 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.

3.10.3. 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,

3.10.4. Severe Withdrawal

Additional doses of Chlordiazepoxide orally (5-15 mg). 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 a 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 until transfer can be arranged. Where a patient becomes confused, agitated, etc sensitive management will also include not allowing the patient to leave the unit.

3.10.5. 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 (>38 C)
- Evidence of injury especially head injury
- Coma or semi-coma

4. Appendices

Appendix 1	Severity of Alcohol Dependence Questionnaire (SADQ)
Appendix 2	Alcohol Use Disorders Identification Test (AUDIT)
Appendix 3	Alcohol Problems Questionnaire (APQ)
Appendix 4	Pre-detoxification Checklist
Appendix 5	The Role of Medication (Patients Copy)
Appendix 6	Self-Care Leaflet
Appendix 7	Carers Leaflet
Appendix 8 (a, b, c, d)	Alcohol Withdrawal Prescription Guide for Patients and Carers A B C D
Appendix 9	Community Detoxification Consent Form
Appendix 10	Clinical Institute for Withdrawal from Alcohol