A Protocol for the Management of Alcohol Withdrawal in Temporary Homeless Hotels during the COVID-19 Outbreak

Authors	Dr Emmert Roberts, Dr Michael Kelleher

Version Control

Version	Date	Comments/Change
1.0	20 March 2020	
2.0	23 March 2020	Added caution about using > 1 sedative agent – (i.e. methadone for opioid dependence and chlordiazepoxide for alcohol withdrawal)
3.0	25 March 2020	Added note about cessation of breathalyser use, hotels will allow alcohol use on-site, purchasing of alcohol by support staff and medically assisted alcohol detoxification should only be commenced in exceptional circumstances
4.0	29 March 2020	Added information about safe reduction regimens for alcohol consumption
5.0	7 April 2020	Added comments from Iain Armstrong and Hazel Jordan. Amended daily cutting down safely advice

Table of Contents

1. Introduction 3

2. Aims and Objectives 3

3. Assessment for Potential Alcohol Withdrawal on Admission to Hotel 3-4

4. Management of People at Risk of Alcohol Withdrawal 4

5. Alcohol Detoxification Medication Chart 5

6. Overall Flow Chart 6

7. Appendices 7

7.1 The Alcohol Use Disorders Identification Test - C (AUDIT-C) 7

7.2 ICD-10 Criteria for Alcohol Dependence 8

7.3 Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA-Ar) 9

7.4 Calculating Units of Alcohol Intake 10

1. Introduction

It is vital to remember throughout any decision pertaining to alcohol dependence treatment:

UNTREATED ALCHOL WITHDRAWAL CAN BE LIFE THREATENING

This document reflects National Institute of Health and Care Excellence (NICE) Clinical Guideline CG115; Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence, and CG100 Alcohol-use disorders: diagnosis and management of physical complications.

The average pattern of alcohol misuse is likely to alter when an individual becomes unwell or enters a temporary homeless hotel. Although, clinicians should regard alcohol misuse management in temporary homeless hotels as equivalent to any other setting, there are some particular differences they will need to take into account:

- Reduced availability of alcohol during the outbreak, leading to a risk of intermittent intoxication and unanticipated withdrawal
- A potential change in drinking behaviour, and potentially much higher risk behaviours due to the scarcity of available alcohol and risk of infection
- The high volume and frequency of movement of people. At times with limited clinical information available
- The risk of rapid reinstatement of drinking on leaving the temporary homeless hotel
- Limited continuous access for clinicians and therefore difficulty monitoring treatment
- Significant levels of co-morbidity

2. Aims and Objectives

- To reduce alcohol-related harm
- To reduce or prevent withdrawal symptoms
- To support wider recovery

3. Assessment for Alcohol Withdrawal on Admission to the Homeless Hotel

When someone reports use of alcohol upon admission to the homeless hotel the main question is: Is this person at risk of alcohol withdrawal?

People can be screened with the simple self-administered questionnaire the Alcohol Use Disorders Identification Test - C (AUDIT-C) (See appendix 7.1).

Men scoring ≥ 4 and women scoring ≥ 3 on the AUDIT-C should be further questioned about their alcohol use and assessed for risk of going into alcohol withdrawal

Given the risk of COVID-19 transmission breathalysers should NOT be routinely used

The first signs of withdrawal normally commence within hours after an alcohol dependent individual's last drink and peak within 24-48 hours of the last drink.

Common features of alcohol withdrawal are: Restlessness; Sweating; Tremor; Anxiety; Nausea; Vomiting; Loss of appetite; Insomnia; Systolic hypertension; Tachycardia

More serious complications include: Severe shaking and very heavy sweating; Seizures; Delirium tremens (DTs); Confusion as to time and place; Poor coordination and unsteadiness on the feet

It is important to get an accurate history of current alcohol use to know who may be at risk of alcohol withdrawal.

a) Does the person meet ICD-10 criteria for alcohol dependence? (See Appendix 7.2)

b) What is the type and strength of alcohol consumed in a typical 24-hour period over the past week, if possible with calculation of the number of units;

Units = % alcohol by volume (ABV) x volume in litres

c) The time of their most recent drink

d) Have they had any previous withdrawal symptoms? In particular have they had any previous seizures or episodes of delirium tremens (DTs)?

4. Management of People at Risk of Alcohol Withdrawal

It is appropriate to reduce harm to allow people to keep drinking, to source alcohol and bring it into the hotel for them.

The hotels have confirmed alcohol use will be tolerated on-site, and staff all have permission to purchase and deliver alcohol to people at risk of alcohol withdrawal. Aim to purchase and deliver the same number of units of alcohol/day as the person is currently drinking

If people wish to reduce their intake they should do so gradually, cutting down by no more than 10% of their total units per day

For those people drinking more than 30 units per day ideally, they should **not attempt to cut down without medical supervision**. If people start to experience withdrawal symptoms, they are likely cutting down too rapidly.

All people screening positively on the AUDIT-C should be prescribed the following for a minimum of 1 month:

Thiamine 100mg PO tds
Vitamin B Complex Strong 2 tablets PO od

As alcohol should be able to be sourced and delivered, medically assisted alcohol withdrawal should only be considered in exceptional circumstances. If the person goes into alcohol withdrawal and requires a medical detoxification the decision as to what to prescribe should be based on the Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar) scale to assess the severity of their withdrawal. (See Appendix 7.3)

The CIWA-Ar is a clinician rated scale with 10 items and a maximum score of 67. Those people scoring:

< 8 — No clear evidence of withdrawal; There is no indication for medication

8-15 — Evidence of moderate withdrawal; Start the detox protocol (see below) at an initial dose of 120mg Chlordiazepoxide (Librium™) daily in divided doses, reducing to zero over 7 days

>15 — Evidence of severe withdrawal; Start the detox protocol (see below) at an initial dose of 160mg Chlordiazepoxide (Librium™) daily in divided doses, reducing to zero over 10 days. In addition, these people should receive Pabrinex Ampoules I & II intramuscular (IM) injections once daily for 5 days

Cholordiazepoxide (Librium™) should be prescribed as described in section 5

Caution is advised if prescribing > 1 sedative agent i.e. methadone for opioid dependence and chlordiazepoxide for alcohol withdrawal

5. Alcohol Detoxification Chlordiazepoxide Medication Chart

Day	Date	Total Daily Dose	am	Nurse Sign	midday	Nurse sign	pm	Nurse Sign	nocte	Nurse Sign	Doctor's Signature
SEVERE dependence start on DAY 1 CIWA-Ar SCORES > 15											
1		160mg	40		40		40		40		
2		140mg	40		30		40		30		
LOW-MODERATE dependence start on DAY 3 CIWA-Ar SCORES BETWEEN 8-15											
3		120mg	30		30		30		30		
4		100mg	25		25		25		25		
5		80mg	20		20		20		20		
6		60mg	20		10		20		10		
7		40mg	10		10		10		10		
8		30mg	10		5		10		5		
9		20mg	5		5		5		5		
10		10mg	5		-		-		5		

6. Overall Flow Chart

UNTREATED ALCHOL WITHDRAWAL CAN BE LIFE THREATENING

Person at admission says they use alcohol

Screen for alcohol misuse : AUDIT - C

SCREEN POSTIVE: MEN ≥ 4 OR WOMEN ≥3
CONDUCT ASSESSMENT FOR POSSIBLE WITHDRAWAL

SCREEN NEGATIVE: MEN <4 OR WOMEN <3
NO FURTHER ALCOHOL QUESTIONS

All people screening positive should be prescribed:

Thiamine 100mg PO tds
Vitamin B Complex Strong 2 tablets PO od

Conduct Assessment for Risk of Possible Alcohol Withdrawal

a) Does the person meet ICD-10 criteria for alcohol dependence?
b) Type and strength of alcohol consumed in a typical 24-hour period over the past week
Calculate units/day: **Units = % alcohol by volume (ABV) x volume in litres**
c) What was the time of their most recent drink
d) Any previous withdrawal symptoms; Previous seizures or episodes of delirium tremens (DTs)?

Assess the need for medically assisted alcohol detoxification:
1. It is appropriate to allow people to keep drinking, to source alcohol and bring it into the hotel. Aim to provide similar number of units/day as the person is currently drinking
2. Only consider medically assisted alcohol withdrawal in exceptional circumstances. If person requires detoxification/is in alcohol withdrawal assess with the CIWA-Ar

ADVICE ON HOW TO SAFELY CUT DOWN

In general if people wish to reduce their intake they should do so gradually, cutting down by no more than 10% of their total units per day

For people drinking > 30 units per day, they should not attempt to cut down without medical supervision

If people start to experience withdrawal symptoms, they are likely cutting down too rapidly

CIWA-Ar: Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised

Score	Action
<8	No clear evidence of withdrawal; No indication for medication
8-15	Evidence of moderate withdrawal; Start the detox protocol at an initial dose of 120mg Chlordiazepoxide (Librium™) daily in divided doses, reducing to zero over 7 days
>15	Evidence of severe withdrawal; Start the detox protocol at an initial dose of 160mg Chlordiazepoxide (Librium™) daily in divided doses, reducing to zero over 10 days. In addition these people should receive Pabrinex Ampoules I & II intramuscular (IM) injections once daily for 5 days

Alcohol Detoxification Chlordiazepoxide Medication Chart

CAUTION IF PRESCRIBING > 1 SEDATIVE AGENT (E.G. CHLORDIAZEPOXIDE + METHADONE)

Day	Date	Total Daily Dose	am	Nurse Sign	midday	Nurse sign	pm	Nurse Sign	nocte	Nurse Sign	Doctor's Signature
SEVERE dependence start on DAY 1 CIWA-AR SCORES > 15											
1		160mg	40		40		40		40		
2		140mg	40		30		40		30		
LOW-MODERATE dependence start on DAY 3 CIWA-AR SCORES BETWEEN 8-15											
3		120mg	30		30		30		30		
4		100mg	25		25		25		25		
5		80mg	20		20		20		20		
6		60mg	20		10		20		10		
7		40mg	10		10		10		10		
8		30mg	10		5		10		5		
9		20mg	5		5		5		5		
10		10mg	5		-		-		5		

7. Appendices

Appendix 7.1 **The Alcohol Use Disorders Identification Test - Consumption (AUDIT-C)**

Self-rated scale; 3 items; Maximum Score 12

≥ 4 Men; Positive; Continue assessment for potential alcohol withdrawal
≥ 3 Women; Positive; Continue assessment for potential alcohol withdrawal

AUDIT-C	
Q1: How often did you have a drink containing alcohol in the past year?	
Answer	**Points**
Never	0
Monthly or less	1
Two to four times a month	2
Two to three times a week	3
Four or more times a week	4
Q2: How many drinks did you have on a typical day when you were drinking in the past year?	
Answer	**Points**
None, I do not drink	0
1 or 2	0
3 or 4	1
5 or 6	2
7 to 9	3
10 or more	4
Q3: How often did you have six or more drinks on one occasion in the past year?	
Answer	**Points**
Never	0
Less than monthly	1
Monthly	2
Weekly	3
Daily or almost daily	4

Appendix 7.2: **ICD-10 criteria for alcohol dependence**

≥ 3 of the following 6 criteria in the past 12 months

a) Desire or compulsion to drink alcohol
b) Difficulties to control drinking alcohol
c) Physiological withdrawal
d) Development of tolerance
e) Neglect of other things in favour of alcohol
f) Persistent use despite evidence of harm

Appendix 7.3 **Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised 'CIWA-Ar'**

Clinician rated scale; 10 items; Maximum Score 67

< 8 No clear evidence of withdrawal; No indication for medication
8-15 Evidence of moderate withdrawal;
>15 Evidence of severe withdrawal;

Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

Patient:________________ **Date:** __________ **Time:** __________ (24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute:________________ **Blood pressure:**_____

NAUSEA AND 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

TACTILE DISTURBANCES -- Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your 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

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 not extended

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

PAROXYSMAL 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

VISUAL DISTURBANCES -- Ask "Does the light appear to be too bright? Is its color 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

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 schizophrenic reactions

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 lightheadedness. Otherwise, rate severity.
0 not present
1 very mild
2 mild
3 moderate
4 moderately severe
5 severe
6 very severe
7 extremely severe

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

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
4 disoriented for place/or person

Total CIWA-Ar Score _____
Rater's Initials _____
Maximum Possible Score 67

Appendix 7.4 **Calculating Units of Alcohol Intake**

The formula to calculate units of alcohol is:

Units = % alcohol by volume (ABV) x volume in litres

Beer, Lager & Cider	**Bottle** (330ml)	**Can** (440ml)	**Pint** (568ml)	**Litre**
4%	1.3 units	1.8 units	2.3 units	4 units
5%	1.7 units	2.2 units	2.8 units	5 units
6%	2 units	2.6 units	3.4 units	6 units
'Super Strength' drinks	**Bottle** (330ml)	**Can** (440ml)	**Pint** (568ml)	**Litre**
Beer Lager Cider at 9%	3 units	4 units	5 units	9 units
Spirits (38 - 40%)	**Small measure (25ml)**		**Double measure (50ml)**	
Gin Rum Vodka Whisky	1 unit		2 units	
Wine & Champagne (red, white, rose or sparkling)	**Small glass (125ml)**		**Large glass (250ml)**	**Bottle (750ml)**
10%	1.25 units		2.5 units	7.5 units
12%	1.5 units		3 units	9 units
14%	1.75 units		3.5 units	10.5 units