The principles of ambulatory alcohol withdrawal in response to COVID-19 are no different from withdrawal under usual circumstances. However, less frequent attendance at clinics for face-to-face consultations is appropriate, as is less frequent dispensing of medications in order to facilitate reduced social contact. Carer engagement and consumer written information regarding withdrawal management are of heightened importance under the circumstances.

**Typical alcohol use features of individuals with alcohol dependence**:

* High intake of alcohol (more than a bottle of wine, six pack of beer or ½ a bottle of spirits per day)
* Few or no alcohol free days
* Drinking commences before noon
* Continued drinking despite significant associated medical features (cirrhosis, pancreatitis, peptic ulcer, peripheral neuropathy)
* Continued drinking despite significant psychosocial consequences e.g. relationship / employment problems, DUI charges (esp if multiple)

**Assessment may include:**

1. Alcohol use history with daily alcohol consumption, time of day of 1st drink, history of complicating features (including past of current other substance use problems or complex withdrawal experience such as seizures).
2. Focused examination – features of chronic liver disease or other health conditions related to overuse of alcohol.
3. Investigations e.g. FBP, LFT, U&E, liver ultrasound

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| **Aspects of management** | **Preferred withdrawal management features** |
| Setting and supports | Stable housing, a supportive carer (preferably nondrinker, available and willing to support the client, including overseeing medications) |
| Nutrition: meals and fluids | Regular meals, nutritious meals (i.e. some fruit, vegetables, some meat, minimal sweets). Plenty of fluids – water, tea, coffee, fruit juice |
| Medication | See below. Supervision of medication by an adult non-drinker is recommended. |

**Diazepam based withdrawal management**

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| Day 1: 5mg to 10mg qidDay 2: 5mg to 10mg qidDay 3: 5mg to 10mg tdsDay 4: 5mg to 10mg bdDay 5: 5mg and cease | Important 1. Cease diazepam after 5 to 7 days
2. Review patient (eg 2nd to 3rd daily)
3. Advise - stop diazepam if drinking continues
4. Give advice regarding when to present to ED
 |

Note – prescribe only the amount estimated to be required e.g. maximum 25 tablets

Consider addition of metaclopramide (Maxalon) or similar.

**Recommend thiamine:** 100mg tds for 7 days, then 100mg daily for 3 weeks.

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|  **Prescribing diazepam is higher risk when:** 1. There is a history of substance misuse or dependence (other than alcohol)
2. There is evidence of intravenous drug use
3. There is co-existing mental health problem (e.g. anxiety, depression, suicidal ideation, psychosis, personality disorder)
4. The patient is homeless
5. The patient is reporting a chronic pain condition and seeking medication
6. The patient becomes hostile / aggressive if requests for medication are unmet

**Refer for specialist assessment and management when:*** Previous complex withdrawal (e.g. hallucinations, delirium, seizure)
* Multiple substance use issues, past history of substance dependence (especially benzodiazepine abuse or dependence)
* Significant physical illness e.g. cirrhosis
* Significant mental health problems e.g. uncontrolled anxiety, depression or psychosis
* Unsupportive home environment, previous failed home withdrawal attempt

**Note**: If use of diazepam for alcohol withdrawal is assessed as high risk, and/or if there are significant co-occurring medical complications, continued use of alcohol together with an urgent referral to Next Step may be appropriate. |

**Initiate anticraving therapy:** aim for minimum 4 to 6 months duration

* Naltrexone: ½ tablet 4 days, then 1 tablet (50mg) daily,
* Acamprosate: 2 tablets tds.
* Disulfiram: 200mg daily, must be alcohol free minimum 5 days, is expensive, potentially higher risk if co-exisitng medical conditions present.
* Monitor LFT to ensure no evidence of deterioration in liver health
* Response is likely to be enhanced when patient also engages in counselling therapy

**Further action:**

* Wherever possible, increase engagement with carers in the management of amber tree withdrawal.
* Provide the consumer and client with written information regarding withdrawal management, in lieu of regular clinic attendance.
* Consider referral to the local **Community Alcohol and Drug Service** (web link below)
* Consider involving the **Drug and Alcohol Withdrawal Network** - DAWN (tel 9382 6049, metro only)

**Resources:**

A brief guide to the Assessment and Treatment of Alcohol Dependence <https://www.mhc.wa.gov.au/media/1171/dependence-brochure-2014v8web.pdf>

Community Alcohol and Drug Services

<https://www.mhc.wa.gov.au/getting-help/community-alcohol-and-drug-services/>

Drug and Alcohol Withdrawal Network (**DAWN**) – tel: 9382 6049, metro only <https://www.sjog.org.au/our-services/community-and-youth-services/dawn>

Drug and Alcohol Clinical Advisory Service (**DACAS**) – tel: 6553 0520

* Access to an Addiction Medicine Consultant for clinical advice

Alcohol and Drug Support Service (**ADSS**): 9442 5000 – After-hours support for patients

Alcohol and Your Health: Australian Alcohol Guidelines

<https://alcoholthinkagain.com.au/Alcohol-Your-Health/Online-tools/Australian-Alcohol-Guidelines>

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