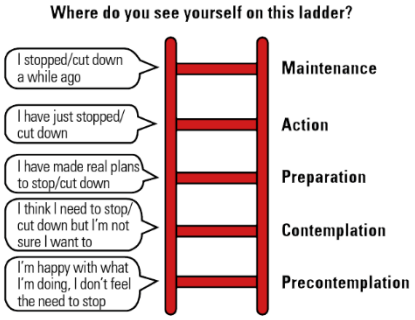
Home-based GP-led Alcohol Withdrawal: All patients will differ on why they seek out a withdrawal. Abstinence may be a goal of care, but equally so stabilising a substance use disorder so a patient can pursue respite, goal setting, stabilise comorbidities, 'controlled' drinking, a period of abstinence or abstinence are all valid goals of care.

Who

Stage of change? Action or preparation
Is the patient **1. Ready, 2. Willing and 3. Able?**

*Is the patient **'low risk'** for a home based alcohol withdrawal, do they have any concerning risk factors?*

- *Appropriate support person*
- *A home that is safe and free from violence*
- *No concurrent drug use*
- *No severe physical or mental health issues*
- *Willing to present for medical review*
- *Kidney function is normal, Liver function not more than >3-4x normal*
- *No severe symptoms of withdrawal: seizures, delirium*
- *24/7 telephone emergency support access*



Determine what a typical day looks like, is the substance use disorder mild, moderate or severe? Use the **AUDIT-C, SADQ** and **K10** to determine SUD severity and comorbid mental health. Mild to moderate SUD may be suitable for a home-based withdrawal. Severe SUD, multiple withdrawal attempts, women who are pregnant or breastfeeding should be referred to a specialist service for further management

Prepare

- Review the patient's domains of **Whole Person Care; Biomedical, Body-mind, Lifestyle, Connection & Relationships, Activities & Responsibilities.** A chronic disease care plan can be made with these domains. Review and optimise to address **Readiness**, **Willingness** and **Ability**
- Explain the course of withdrawal. Prescribe oral thiamine 300mg/day for at least 2 weeks prior to withdrawal to prevent Wernicke-Korsakoff syndrome. Perform a full blood panel. Mild withdrawal typically lasts 5-7 days. Onset is 6-24 hours from last consumed alcohol. Use the **CIWA-Ar or AWS** scoring system to determine withdrawal severity. **Review** the patient daily for the first 3-4 days, face-to-face or via telehealth. Educate on the risk of withdrawal seizures, highest in the first 6-24hours, delirium tremens can start 2-3 days after last alcohol- if these or **complicated symptoms** patient is to call an **ambulance** and attend emergency. Provide first aid advice on seizures. Agree no driving whilst on benzodiazepines. **Cravings management:** delay, distract, decide, positive self talk, relaxation and imagery

Withdrawal experience	Symptoms and signs of autonomic hyperactivity	Gastrointestinal symptoms and signs	Cognitive and perceptual symptoms and signs
Uncomplicated withdrawal	Sweating, tachycardia, hypertension, tremor, fever (generally lower than 38°C)	Anorexia, nausea, vomiting, dyspepsia	Poor concentration, anxiety, psychomotor agitation, disturbed sleep
Complicated withdrawal	Dehydration and electrolyte imbalances	As above	Seizures, hallucinations or perceptual disturbances (visual, tactile, auditory), delirium

Source: Guidelines for the treatment of alcohol problems[4]

Withdrawal

- Start at the beginning of the working week
- Regular **thiamine TDS** throughout
- **Benzodiazepines**=cross tolerant with alcohol, reduce withdrawal symptoms, prevent severe withdrawal
- Staged supply of diazepam - pharmacy or trusted support person. Qty only for the **withdrawal week**
- Perform **clinical assessment** for dose changes
- Perform **withdrawal scale** at every review and consider- Is the patient still **appropriate for home** or do they need inpatient admission?

Day	*Mild withdrawal (outpatient)- suggested regimen, individualise as per the patient's withdrawal symptoms*
1	10mg four times per day
2	10mg three times a day
3	10mg twice a day
4	5mg twice a day
5	5mg at night as needed

Follow up

- A **structured aftercare program** is essential; Utilise chronic disease care plans and mental health care plans
- **Pace** the timing of the reviews to the patient's preferences
- **Anti-craving medicines** can increase lengths of abstinence
  - Acamprosate is divided daily dosing, some patients appreciate the consistent reminder throughout the day.
  - Naltrexone is a once a day tablet and is started at a half dose as nausea and dizziness are commonly cited side effects. Avoid naltrexone in patients who have moderate to severe liver disease and monitor LFTs
  - Disulfiram has significant risk of toxicity and low adherence, it is advisable to discuss prescribing with an AOD specialist
- **12 step programs** such as Alcoholics Anonymous and Narcotics Anonymous maintain patients in long term abstinence when compared with CBT. SMART Recovery addresses connection separate to the AA/NA 12 step framework.
- The maintenance phase is when a patient is in recovery. Use a **whole-person care** approach and engage in **relapse prevention planning**: Review the **'positive reinforcers'** of their new behaviour and/or identity by using the **CHIME** acronym, Connectedness, Hope and optimism about the future, Identity, Meaning in life and Empowerment
- Review potential **'triggers'** and high-risk scenarios.
- Develop a **crisis plan**, who to call and how to reengage in treatment

https://www.racgp.org.au/afp/2012/september/motivational-interviewing-techniques
https://www.racgp.org.au/afp/2011/august/problem-drinking-management
https://adis.health.qld.gov.au/sites/default/files/resource/file/qh_detox_guide.pdf
https://alcoholtreatmentguidelines.com.au/pdf/guidelines-for-the-treatment-of-alcohol-problems.pdf

*Extra links and resources to click out to e.g. CIWA etc