

DETOXIFICATION PROTOCOLS AND WITHDRAWAL SCALES

A: EXAMPLE PROTOCOL FOR COMMUNITY ALCOHOL DETOXIFICATION WITH CHLORDIAZEPOXIDE

1. CLINICAL CONDITION TO WHICH THE PROTOCOL APPLIES

Medication as described in this protocol is for use in planned community alcohol detoxification of patients who are under the care of the specialist team consultant.

The inclusion criteria are a diagnosis of alcohol dependence syndrome and a pre-detoxification assessment which supports the indication of community alcohol detoxification on clinical grounds.

Exclusion criteria for treatment under the protocol are:

A: Chlordiazepoxide specific exclusion criteria

- A history of respiratory depression or acute pulmonary insufficiency.
- Severe hepatic impairment.
- Sleep apnoea syndrome.
- Myaesthesia Gravis.
- Concurrent pregnancy or breast feeding.
- Concomitant prescription of medication other than described in this protocol.
- Concomitant use of illicit substances or any CNS depressant drug (including alcohol) during detoxification.

B: General exclusion criteria

- Inadequate degree of social support (a responsible adult will need to be present on a 24 hour basis with the client for the duration of the detoxification).
- A history of repeated failure to complete community detoxification.
- Severe concurrent medical or psychiatric illness, or potential for detoxification-induced relapse of such illness.
- A history of Delirium Tremens or alcohol withdrawal fits.
- Concurrent suicidal risk.
- Cognitive deficits.

The consultant should be contacted to advise on an appropriate alcohol detoxification regime if any of these exclusion criteria are present.

Patients will be fully assessed by their key-worker/care-coordinator in the Community Drug and Alcohol Team (CDAT) before community detoxification. Patients not wishing to receive chlordiazepoxide, or other medications named in this protocol, will be offered alternative means of planned detoxification if this is clinically feasible. The consultant should be contacted in case of patients refusing to comply with care as stated in the protocol after detoxification has commenced.

2. CHARACTERISTICS OF STAFF AUTHORISED TO TAKE RESPONSIBILITY FOR THE SUPPLY OR ADMINISTRATION OF MEDICINES UNDER THE PROTOCOL

- A qualified medical doctor will be required to prescribe all medication as described in this protocol.
- A qualified nurse will be required to monitor and advise the patient and carer regarding the correct use of medication according to the terms of the protocol. The patient will be responsible for their medication, and for following advice given. The consultant should be contacted in case of patients refusing to comply with care as stated in the protocol after detoxification has commenced.

3. DESCRIPTION OF TREATMENT AVAILABLE UNDER THE PROTOCOL

- Chlordiazepoxide.
- Metoclopramide.
- Zopiclone.
- Diazepam.
- Pabrinex.
- Acamprosate.
- Disulfiram.

4. PAPER WORK REQUIREMENTS

Before detoxification

- Patients should have received a full assessment at CDAT, including a risk assessment.
- A CDAT detoxification assessment package must be completed.

During detoxification

- CDAT community alcohol detoxification monitoring package must be completed.

After detoxification

- Outcome monitoring sections of detoxification assessment package must be completed.

5. CLINICAL MONITORING REQUIREMENTS

- A responsible adult must be living with the patient for the duration of the detoxification. This person must be educated by the detoxification nurse as to means of accessing help in the case of acute deterioration of the patient's clinical state, both within and out of working hours.
- Detoxification should always be commenced on a Monday morning.
- The patient should be visited by the CDAT detoxification nurse on a twice daily basis for the first five days of detoxification. A once daily visit will be sufficient in most cases on days 8 and onwards.
- The CDAT consultant should be informed of the patient's clinical presentation on a Friday as a routine, and at any other time there is concern. In cases where there is marked concern on a Friday, following discussion with the consultant, arrangements will be made either for admission to hospital, or for home visits by a CDAT staff member to occur over the weekend.
- Each set of observations should include:
 - Alcohol withdrawal scale (CIWA-Ar).
 - Alcometer reading.
 - Observation of level of consciousness and orientation.
 - Pulse, blood pressure and temperature.
 - Observation for nystagmus & ophthalmoplegia & ataxia.
 - Observation for dehydration & marked tremor.

- Observations should be performed as follows:

Day 1, 2 & 3

AM: For one hour following Pabrinex injection (continuous observation).

PM: 4 to 5 hours later.

Days 4 & 5

AM: At some point in the morning.

PM: 4 to 5 hours later.

Days 8 onwards

Once or more daily as indicated by clinical progress.

** The CIWA-Ar should be completed as if the observation was occurring immediately before the most recently taken dose of chlordiazepoxide.

*** The client's key-worker should visit the client at home on at least one occasion during the detoxification.

6. ADJUNCTIVE MEDICATION

Pabrinex.

One pair of IM High Potency ampoules of Pabrinex should be given IM on each of the first three days of detoxification. Pabrinex injections should be administered by the CDAT detox nurse in the patient's GP's surgery, with prior agreement of the GP, or at the CDAT base. The only contraindication to administration of Pabrinex is a past history of severe allergic reaction to Pabrinex.

As Required Medication to alleviate specific withdrawal symptoms

Metoclopramide	10mg tds po (IM in severe vomiting)	For vomiting
Diazepam	10mg PR	For fits
Zopiclone	7.5 to 15mg nocte	For insomnia

Medication to prevent relapse.

Acamprosate: This will be commenced as a routine on day 2 of all alcohol detoxes, as long as the patient has given informed consent for this. Dosage will be 666mg tds, unless weight is less than 60kg in which case the dose will be 666mg mane and 333mg bd.

Disulfiram: This will be commenced only if specifically identified as appropriate by the consultant during the detoxification assessment process.

7. CHLORDIAZEPOXIDE REGIMES

Baseline regime.

SADQ	Units/week (if SADQ unavailable)	Baseline regime
<20	<150 units	20mg qds decreasing to zero over 7 days
20 to 30	150-200 units per week	30mg qds decreasing to zero over 7 days
30 to 40	200-250 units per week	40mg qds decreasing to zero over 8 days
40 to 50	250-300 units per week	50mg qds decreasing to zero over 9 days
50 to 60	>300 units per week	60mg qds decreasing to zero over 10 days

A baseline regime will be agreed before commencement of detoxification with the consultant, according to the above criteria. This should be based on a SADQ score wherever possible, but if this is not available may be estimated from the reported number of units of alcohol used weekly.

Commencing detoxification.

If the alcometer reading is positive, then the first dose of chlordiazepoxide on the first day of detoxification should only be taken if the CIWA-Ar is > 15.

Altering the baseline regime during detoxification.

i) Over-medication.

If the patient appears **over-sedated** on a particular regime, or if the sedation scale reads 13 or below, then the next dose of chlordiazepoxide should be omitted.

If the **CIWA-Ar remains below 9 for both readings on a single day**, then the planned regular dosage for the following day should be replaced by that of the day after. This will have the effect of shortening the duration of detoxification by one day. For example, if the CIWA-Ar is 8 on both of Tuesday's readings, then the schedule planned for Thursday should be administered on Wednesday, the schedule planned for Friday should be administered on Thursday etc.etc.

ii) Under-medication.

If the **CIWA-Ar is > 15**, then the next dose of chlordiazepoxide given should be 50% greater than the planned dose (up to a maximum of 60mg in a single dose).

If the **CIWA-Ar is > 29**, then the next dose of chlordiazepoxide should be 100% greater than the planned dose (up to a maximum of 60mg in a single dose).

If the **CIWA-Ar is > 39**, the consultant should be contacted to discuss the case, or if he is unavailable, the client should be taken to A&E for assessment.

If the **CIWA-Ar remains >15 for both readings on a single day** then the planned dosage for the following day should be replaced by that of the day on which the readings took place. This will have the effect of lengthening the duration of detoxification by one day. For example, if the CIWA-Ar is 16 on both of Tuesday's readings, then the schedule for Tuesday should be administered on Wednesday, the schedule planned for Wednesday should be administered on Thursday etc.etc.

iii) Drinking during detoxification.

If the **alcometer reads positive** during detoxification, then the next dose of chlordiazepoxide should only be given if the CIWA-Ar is > 15.

If the client **drinks on 2 concurrent days during detoxification, then the detoxification** should cease. In such a case, the client should be advised to continue drinking at a level of approximately 75% of their regular consumption in the week immediately preceding detoxification, and then to cut down slowly over a period of several weeks.

**** The CIWA-Ar should be completed as if the observation was occurring immediately before the most recently taken dose of chlordiazepoxide.**

MANAGING ADVERSE OUTCOMES

a. Managing confusion and disorientation (delirium).

Confusion and disorientation can occur during detoxification as a result of several different complications of alcohol dependency. The differential diagnosis includes:

- Severe alcohol intoxication.
- Delirium tremens (severe alcohol withdrawal).
- Alcohol withdrawal seizure (ictal/post-ictal).
- Wernicke's Encephalopathy.
- Hepatic encephalopathy.
- Head injury.
- Hypoglycaemia.

All of these conditions are potentially life-threatening and the occurrence of acute confusion in the detoxifying alcoholic should be treated as a **medical emergency**. The CDAT nurse should arrange for immediate transfer of the patient to A&E.

Wernickes Encephalopathy.

A presumptive diagnosis of Wernicke's Encephalopathy should be made if any of the following supervene during detoxification: ataxia, confusion, memory disturbance, hypothermia and hypotension, ophthalmoplegia or nystagmus, coma/unconsciousness.

Hepatic Encephalopathy.

Hepatic encephalopathy occurs in the context of hepatic failure. As such, if this is the cause of the confusional state there will usually be evidence of liver failure evident on examination. Findings in liver failure may include liver palms, spider naevi, gynaecomastia, jaundice, ascites, oedema, cyanosis, clubbing, hepatic foetor. Blood tests may demonstrate grossly elevated liver enzymes, reduced albumin and clotting abnormalities.

The acute onset of hepatic encephalopathy is otherwise hard to differentiate from the other causes of acute

confusion, although the presence of a coarse flapping tremor which occurs when the arms are outstretched and the wrists extended is indicative, although not pathognomic.

Delirium Tremens.

Delirium Tremens is merely an especially severe alcohol withdrawal syndrome. However, it is also potentially fatal, and should be managed as such. The classical triad of symptoms include confusion, vivid hallucinations and illusions affecting any sensory modality and marked tremor. Prodromal symptoms include insomnia, tremulousness and fear. Onset may also be preceded by withdrawal convulsions.

Head injury.

Acute extradural haematoma and chronic subdural haematoma are both more commonly occurring in alcohol dependency and both lead to the development of acute confusion which is then likely to progress to coma and death if untreated.

• Acute extradural haematoma.

The usual history is of recent head injury, with a lucid interval of some hours, followed by the development of headache and drowsiness, followed by development of signs of acutely increased intracranial pressure; the latter include raised blood pressure, bradycardia (50–60bpm), slow & deep respiration, seizures, progressing to coma and fixed, dilated pupils. The bradycardia may be replaced by a tachycardia when approaching the terminal phase.

• Chronic subdural haematoma.

The usual history is one of signs of chronically raised intracranial pressure which slowly increase in severity. The original head injury may have occurred weeks or months ago and have seemed trivial – as such there is often no recollection of the injury. Early signs are **headache** which is worse in the morning, throbbing in character and accentuated by exertion and **vomiting** which usually occurs at the peak of the headache. This progresses in due course to confusion, papilloedema, and false localising signs such as 6th nerve palsies, 3rd nerve palsies and extensor plantar responses.

Severe intoxication.

Levels of alcohol above 0.1mg/dL on breathalyser readings (>200mg/dL blood level) **may be** responsible for the occurrence of acute confusion. However, in the alcohol dependent patient levels in this region are unlikely to be the only cause, and the index of suspicion for the above causes should remain high. Levels of alcohol equivalent to > 300mg/dL should trigger referral to A&E for observation.

Hypoglycaemia.

Hypoglycaemia may be responsible for the development of acute confusion, especially in the early stages of detoxification. The treatment for hypoglycaemia is to administer a glucose load which should usually be administered in A&E. **It is essential that parenteral thiamine is given before administration of the glucose load to prevent precipitation of acute Wernicke's encephalopathy by the glucose.**

b. Managing withdrawal convulsions.

Withdrawal convulsions are likely to occur over the first 72 hours of detoxification. The best predictor of likely occurrence is a past history of withdrawal convulsions. Withdrawal convulsions occurring in the community should be treated with **diazepam 10mg PR**. The patient should be transferred to A&E immediately following administration of diazepam.

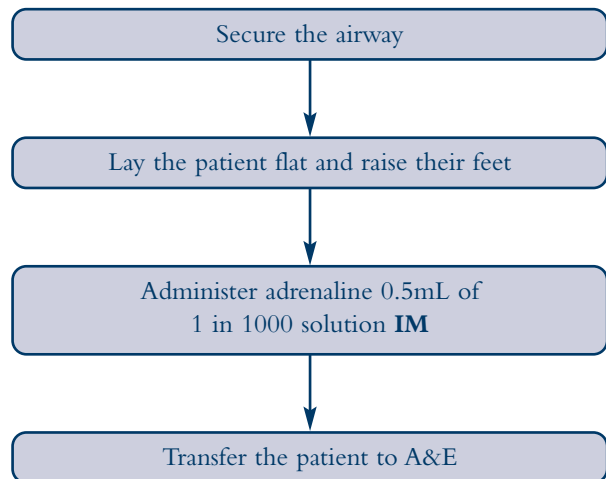
c. Managing alcohol use during detoxification.

- The patient should always be requested to have their last drink on the night before detoxification commences.
- If the alcometer reading is positive immediately before detoxification is due to commence, then the first dose of chlordiazepoxide should only be administered if the CIWA-Ar is > 15.

- If the alcometer reads positive at any time after detoxification has commenced, then a history of recent drinking should be obtained from the patient, and the case discussed with the consultant before continuing with the detoxification. Due to the dangers of combining CNS depressant drugs, it may be necessary to stop the detoxification in some cases. Equally, cessation of detoxification poses its own risks. If it is agreed to cease detoxification, then the patient should always be advised to resume drinking at a level of approximately 75% of their daily pre-detoxification intake, following which they may reduce their intake slowly day-by-day.

d. Management of anaphylaxis induced by administration of Pabrinex.

Anaphylaxis is characterised by the rapid onset of hypotension, tachycardia, and collapse. There may also be bronchospasm and laryngeal oedema.



- Chlorpheniramine 10-20mg IV, given slowly over 1 minute, can be a useful adjunct, but should only be given after adrenaline has already been given.

B. EXAMPLE PROTOCOL FOR IN-PATIENT ALCOHOL DETOXIFICATION WITH CHLORDIAZEPOXIDE

1. CLINICAL CONDITION TO WHICH THE PROTOCOL APPLIES

Chlordiazepoxide as described in this protocol is for use in planned in-patient alcohol detoxification.

The inclusion criteria are a diagnosis of alcohol dependence syndrome and a pre-admission assessment which supports the indication of in-patient alcohol detoxification on clinical grounds.

Exclusion criteria for treatment under the protocol are:

- Acute, severe medical illness, in particular respiratory depression or acute pulmonary insufficiency.
- Severe hepatic impairment.
- Sleep apnoea syndrome.
- Myaesthesia Gravis.
- Concurrent pregnancy or breast feeding.
- Concomitant prescription of medication other than described in this protocol.
- Concomitant use of illicit substances or any CNS depressant drug (including alcohol) during detoxification.

The responsible consultant psychiatrist for the patient should be contacted to advise on an appropriate alcohol detoxification regime if any of these exclusion criteria are present.

Patients will be assessed by the Community Drug and Alcohol Team before admission. Patients not wishing to receive chlordiazepoxide will be offered alternative means of planned detoxification if this is clinically feasible. The ward doctor should be contacted in case of patients refusing to comply with care as stated in the protocol after detoxification has commenced.

2. CHARACTERISTICS OF STAFF AUTHORISED TO TAKE RESPONSIBILITY FOR THE SUPPLY OR ADMINISTRATION OF MEDICINES UNDER THE PROTOCOL

- A qualified medical doctor will be required to prescribe chlordiazepoxide as described in this protocol.

- A qualified nurse will be required to administer chlordiazepoxide as described in this protocol.

3. DESCRIPTION OF TREATMENT AVAILABLE UNDER THE PROTOCOL

- Chlordiazepoxide.
- Metoclopramide.
- Zopiclone.
- Lorazepam.
- Diazepam.
- Pabrinex.
- Acamprosate.

4. PAPER WORK REQUIREMENTS

- Patients should have received a full assessment at CDAT, including a risk assessment.

5. CLINICAL MONITORING REQUIREMENTS

Observations should be performed:

- On admission immediately before the start of the detoxification.
- six hourly throughout the detoxification until the CIWA-Ar score has been < 9 for 24 hours.
- AND ADDITIONALLY at 1 hour after the last dose of chlordiazepoxide administered.

Each set of observations should include:

- Alcohol withdrawal scale (CIWA-Ar).
- Alcometer reading.
- Observation of level of consciousness and orientation.
- Pulse, blood pressure and temperature.
- Observation for nystagmus & ophthalmoplegia & ataxia.
- Observation for dehydration & marked tremor.

6. ADJUNCTIVE MEDICATION

Pabrinex.

One pair of IM High Potency ampoules of Pabrinex should be given IM on each of the first three days

of detoxification. The first dose of Pabrinex must ALWAYS be given before commencement of detoxification, as soon as possible following admission of the patient. The only contraindication to administration of Pabrinex is a past history of severe allergic reaction to Pabrinex.

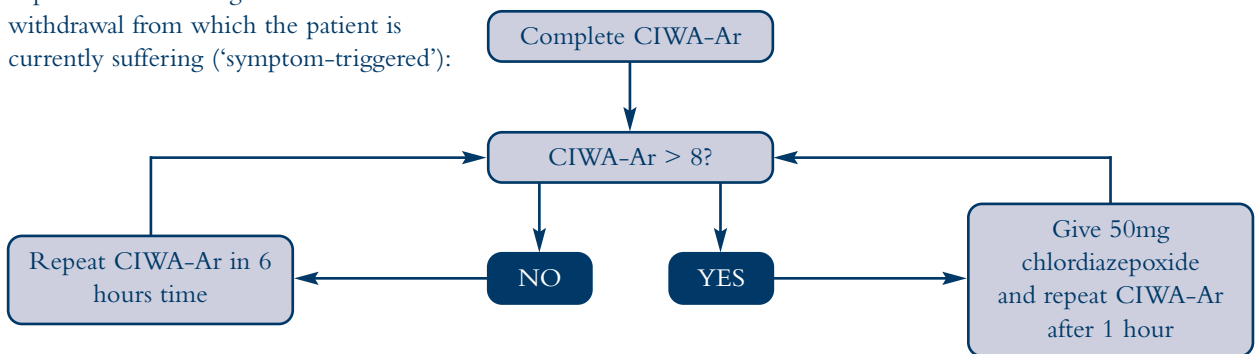
As Required Medication to alleviate specific withdrawal symptoms.

Metoclopramide	10mg tds po (IM in severe vomiting)	For vomiting
Lorazepam	4mg IV	For fits
Diazepam	10mg PR	For fits
Zopiclone	7.5-15mg nocte	For insomnia

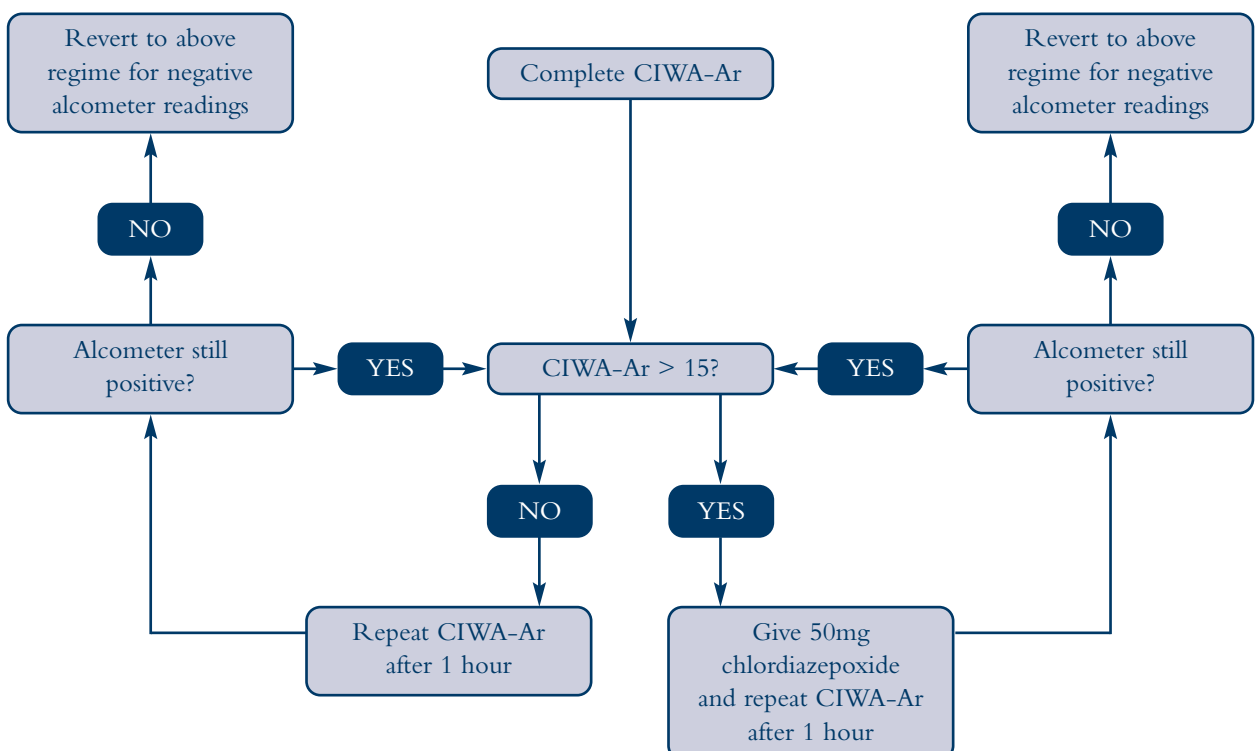
7. CHLORDIAZEPOXIDE REGIMES

The dose of chlordiazepoxide administered will be dependent on the degree of alcohol withdrawal from which the patient is currently suffering ('symptom-triggered'):

If the alcometer reading is negative the following regime should be followed, until the CIWA-Ar has remained less than 9 for a continuous period of 24 hours:



In the presence of a positive alcometer reading, chlordiazepoxide should only be administered if withdrawal symptoms are significant (i.e. CIWA-Ar of more than 15):



8. MANAGING ADVERSE OUTCOMES

a. Managing acute confusion and disorientation (delirium).

Confusion and disorientation can occur during detoxification as a result of several different complications of alcohol dependency. The differential diagnosis includes:

- Severe alcohol intoxication.
- Delirium tremens (severe alcohol withdrawal).
- Alcohol withdrawal seizure (ictal and post-ictal).
- Wernicke's Encephalopathy.
- Hepatic encephalopathy.
- Hypoglycaemia.
- Head injury.

All of these conditions are potentially life-threatening and the occurrence of acute confusion in the detoxifying alcoholic should be treated as a **medical emergency**. The on-call psychiatric SHO should be asked to make an immediate assessment, following which referral to the medical on-call team should almost always be made.

Wernickes Encephalopathy.

A presumptive diagnosis of Wernicke's Encephalopathy should be made if any of the following supervene during detoxification: ataxia, confusion, memory disturbance, hypothermia and hypotension, ophthalmoplegia or nystagmus, coma/unconsciousness.

Hepatic Encephalopathy.

Hepatic encephalopathy occurs in the context of hepatic failure. As such, if this is the cause of the confusional state there will usually be evidence of liver failure evident on examination. Findings in liver failure may include liver palms, spider naevi, gynaecomastia, jaundice, ascites, oedema, cyanosis, clubbing, hepatic foetor. Blood tests may demonstrate grossly elevated liver enzymes, reduced albumin and clotting abnormalities.

The acute onset of hepatic encephalopathy is otherwise hard to differentiate from the other causes of acute confusion, although the presence of a coarse flapping tremor which occurs when the arms are outstretched and the wrists extended is indicative, although not pathognomic.

Delirium Tremens.

Delirium Tremens is merely an especially severe alcohol withdrawal syndrome. However, it is also potentially fatal, and should be managed as such. The classical triad of symptoms include confusion, vivid hallucinations and illusions affecting any sensory modality and marked tremor. Prodromal symptoms include insomnia, tremulousness and fear. Onset may also be preceded by withdrawal convulsions.

Head injury.

Acute extradural haematoma and chronic subdural haematoma are both more commonly occurring in alcohol dependency and both lead to the development of acute confusion which is then likely to progress to coma and death if untreated.

• Acute extradural haematoma.

The usual history is of recent head injury, with a lucid interval of some hours, followed by the development of headache and drowsiness, followed by development of signs of acutely increased intracranial pressure; the latter include raised blood pressure, bradycardia (50-60bpm), slow & deep respiration, seizures, progressing to coma and fixed, dilated pupils. The bradycardia may be replaced by a tachycardia when approaching the terminal phase.

• Chronic subdural haematoma.

The usual history is one of signs of chronically raised intracranial pressure which slowly increase in severity. The original head injury may have occurred weeks or months ago and have seemed trivial – as such there is often no recollection of the injury. Early signs are **headache** which is worse in the morning, throbbing in character and accentuated by exertion and **vomiting** which usually occurs at the peak of the headache. This progresses in due course to confusion, papilloedema, and false localising signs such as 6th nerve palsies, 3rd nerve palsies and extensor plantar responses.

Severe intoxication.

Levels of alcohol above 0.1mg/dL on breathalyser readings (>200mg/dL blood level) **may be** responsible for the occurrence of acute confusion. However, in the alcohol dependent patient levels in this region are unlikely to be the only cause, and the index of suspicion for the above causes should remain high. Levels of alcohol equivalent to > 300mg/dL should trigger referral to A&E for observation.

Hypoglycaemia.

Hypoglycaemia may be responsible for the development of acute confusion, especially in the early stages of detoxification. The treatment for hypoglycaemia is to administer a glucose load which should usually be administered in A&E. It is essential that parenteral thiamine is given before administration of the glucose load to prevent precipitation of acute Wernicke's encephalopathy by the glucose.

b. Managing withdrawal convulsions.

Withdrawal convulsions are likely to occur over the first 72 hours of detoxification. The best predictor of likely occurrence is a past history of withdrawal convulsions. Withdrawal convulsions should be treated with IV lorazepam 4mg stat, as first choice drug. Diazepam 10mg IV, by slow injection, is a valid alternative but has a shorter duration of action than lorazepam. If intravenous access cannot be obtained, then diazepam 10mg PR should be administered. The patient should be transferred to A&E immediately following administration of lorazepam or diazepam.

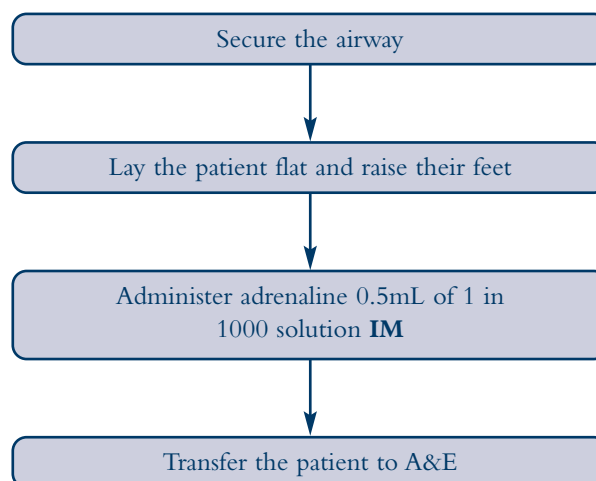
c. Managing alcohol use during detoxification.

- The patient should always be requested to have their last drink on the night before detoxification commences.
- If the alcometer reading is positive immediately before detoxification is due to commence, then the first dose of chlordiazepoxide should only be administered if the CIWA-Ar is > 15.

- If the alcometer reads positive at any time after detoxification has commenced, then a history of recent drinking should be obtained from the patient, and the case discussed with the consultant. It will usually be necessary to discharge the patient at this point. However, cessation of detoxification poses its own risks. If it is agreed to cease detoxification, then the patient should always be advised to resume drinking at a level of approximately 75% of their daily pre-detoxification intake, following which they may reduce their intake slowly day-by-day.

d. Management of anaphylaxis induced by administration of Pabrinex.

Anaphylaxis is characterised by the rapid onset of hypotension, tachycardia, and collapse. There may also be bronchospasm and laryngeal oedema.



- Chlorpheniramine 10-20mg IV, given slowly over 1 minute, can be a useful adjunct, but should only be given after adrenaline has already been given.

C. EXAMPLE PROTOCOL FOR COMMUNITY OPIATE DETOXIFICATION WITH LOFEXIDINE

Lofexidine as described in this protocol is for use in planned community opiate detoxification.

The inclusion criteria are a diagnosis of opiate dependence syndrome and a pre-detoxification assessment which supports the indication of community opiate detoxification on clinical grounds.

Exclusion criteria for treatment under the protocol are:

A: Lofexidine specific exclusion criteria

- A history of sensitivity to lofexidine or other imidazole derivatives (e.g. clotrimazole).
- A history of cardiovascular disease.
- A history of cerebrovascular disease.
- A history of renal impairment.
- Concurrent pregnancy or breast feeding.
- Concomitant prescription of medication other than described in this protocol.
- Concomitant use of illicit substances or any CNS depressant drug (including alcohol) during detoxification.

B: General exclusion criteria.

- Inadequate degree of social support (a responsible adult will need to be present on a 24 hour basis with the client for the duration of the detoxification).
- A history of repeated failure to complete community detoxification.
- Severe concurrent medical or psychiatric illness, or potential for detoxification-induced relapse of such illness.
- Concurrent suicidal risk.
- Cognitive deficits.

The responsible consultant psychiatrist for the patient should be contacted to advise on an appropriate opiate detoxification regime if any of these exclusion criteria are present. Patients will be fully assessed by their key-worker/care-coordinator in the Community Drug and Alcohol Team, and by the CDAT Senior House Officer before community detoxification. Patients not wishing to receive lofexidine will be offered alternative means of planned detoxification if this is clinically feasible. The CDAT consultant should be contacted in case of patients refusing to comply with care as stated in the protocol after detoxification has commenced.

CHARACTERISTICS OF STAFF AUTHORISED TO TAKE RESPONSIBILITY FOR THE SUPPLY OR ADMINISTRATION OF MEDICINES UNDER THE PROTOCOL

- A qualified medical doctor will be required to prescribe all medication as described in this protocol.
- A qualified nurse will be required to monitor and advise the patient and carer regarding the correct use of medication according to the terms of the protocol. The patient will be responsible for their medication, and for following advice given.

DESCRIPTION OF TREATMENT AVAILABLE UNDER THE PROTOCOL

Legal status of medications

• Lofexidine Hydrochloride	PoM
• Ibuprofen	OTC
• Metoclopramide	PoM
• Loperamide Hydrochloride	PoM
• Zopiclone	PoM

PRESCRIBING REGIMES

A range of doses may be administered depending on several factors. These are

- The amount of opiate drugs (prescribed or/and illicit) used by the patient in the week immediately preceding admission; this will indicate the estimated total dose of lofexidine and the duration of detoxification.
- Indication of dosage requirements from previous in-patient detoxifications.
- The blood pressure and pulse.

- The level of consciousness.
- The severity of the opiate withdrawal syndrome.

Withdrawal symptoms should be monitored by use of the 'Short Opiate Withdrawal Scale'. Additional lofexidine may be administered on an 'as required' basis as stated within the chosen regime (see below), for continued withdrawal symptoms. Dosage of lofexidine should be altered as indicated below under 'managing adverse outcomes' if there is a drop in blood pressure or pulse, or a change in the level of consciousness.

If the patient is on a methadone stabilization regime, this may be continued for the first two days of the detoxification, following discussion with the consultant.

Suggested regimes are as follows.

Regime one. Detoxification from moderate dosages of methadone (20 - 70mg methadone daily)

Lofexidine PO	Mane	12.00 pm	6.00pm	10.00pm	Total dose	PRN
Day 1	0.2mg	0.2mg	0.2mg	0.2mg	0.8mg	
Day 2	0.4mg	0.2mg	0.2mg	0.4mg	1.2mg	
Day 3	0.4mg	0.4mg	0.4mg	0.4mg	1.6mg	
Day 4	0.4mg	0.4mg	0.4mg	0.4mg	1.6mg	0.2mg bd
Day 5	0.4mg	0.4mg	0.4mg	0.4mg	1.6mg	0.2mg qds
Day 6	0.4mg	0.2mg	0.2mg	0.4mg	1.2mg	0.2mg qds
Day 7	0.2mg	0.2mg	0.2mg	0.2mg	0.8mg	0.2mg qds
Day 8	0.2mg			0.2mg	0.4mg	0.2mg qds
Day 9				0.2mg	0.2mg	0.2mg tds
Day 10						0.2mg bd
Day 11						0.2mg od

Regime two: For patients detoxifying from moderate dosages of street heroin 1/4g - 3/4g daily

Lofexidine PO	Mane	12.00 pm	6.00pm	10.00pm	Total dose	PRN
Day 1	0.2mg	0.2mg	0.2mg	0.2mg	0.8mg	
Day 2	0.4mg	0.2mg	0.2mg	0.4mg	1.2mg	
Day 3	0.4mg	0.4mg	0.4mg	0.4mg	1.6mg	
Day 4	0.4mg	0.2mg	0.2mg	0.4mg	1.2mg	0.2mg qds
Day 5	0.2mg	0.2mg	0.2mg	0.2mg	0.8mg	0.2mg qds
Day 6	0.2mg			0.2mg	0.4mg	0.2mg qds
Day 7				0.2mg	0.2mg	0.2mg tds
Day 8						0.2mg bd
Day 9						0.2mg od

Regime three: For patients detoxifying from dosages of methadone >70mg daily

Lofexidine PO	Mane	12.00 pm	6.00pm	10.00pm	Total dose	PRN
Day 1	0.2mg	0.2mg	0.2mg	0.2mg	0.8mg	
Day 2	0.4mg	0.2mg	0.2mg	0.4mg	1.2mg	
Day 3	0.4mg	0.4mg	0.4mg	0.4mg	1.6mg	
Day 4	0.6mg	0.4mg	0.4mg	0.6mg	2.0mg	
Day 5	0.6mg	0.6mg	0.6mg	0.6mg	2.4mg	
Day 6	0.6mg	0.4mg	0.4mg	0.6mg	2.0mg	0.2mg bd
Day 7	0.4mg	0.4mg	0.4mg	0.4mg	1.6mg	0.2mg qds
Day 8	0.4mg	0.2mg	0.2mg	0.4mg	1.2mg	0.2mg qds
Day 9	0.2mg	0.2mg	0.2mg	0.2mg	0.8mg	0.2mg tds
Day 10	0.2mg			0.2mg	0.4mg	0.2mg bd
Day 11				0.2mg	0.2mg	0.2mg od
Day 12						0.2mg od

Regime four: Detoxification from large dosages of street heroin (> 3/4g street heroin daily)

Lofexidine PO	Mane	12.00 pm	6.00pm	10.00pm	Total dose	PRN
Day 1	0.2mg	0.2mg	0.2mg	0.2mg	0.8mg	
Day 2	0.4mg	0.2mg	0.2mg	0.4mg	1.2mg	
Day 3	0.4mg	0.4mg	0.4mg	0.4mg	1.6mg	
Day 4	0.6mg	0.4mg	0.4mg	0.6mg	2.0mg	0.2mg bd
Day 5	0.4mg	0.4mg	0.4mg	0.4mg	1.6mg	0.2mg qds
Day 6	0.2mg	0.2mg	0.2mg	0.2mg	0.8mg	0.2mg qds
Day 7	0.2mg			0.2mg	0.4mg	0.2mg tds
Day 8				0.2mg	0.2mg	0.2mg bd
Day 9						0.2mg od

Regime five: For patients detoxifying from small dosages of methadone <20mg daily

Lofexidine PO	Mane	12.00 pm	6.00pm	10.00pm	Total dose	PRN
Day 1	0.2mg	0.2mg	0.2mg	0.2mg	0.8mg	
Day 2	0.4mg	0.2mg	0.2mg	0.4mg	1.2mg	
Day 3	0.4mg	0.2mg	0.2mg	0.4mg	1.2mg	0.2mg bd
Day 4	0.4mg	0.2mg	0.2mg	0.4mg	1.2mg	0.2mg bd
Day 5	0.2mg	0.2mg	0.2mg	0.2mg	0.8mg	0.2mg qds
Day 6	0.2mg			0.2mg	0.4mg	0.2mg qds
Day 7				0.2mg	0.2mg	0.2mg tds
Day 8						0.2mg bd
Day 9						0.2mg od

Regime six: For patients detoxifying from dosages of street heroin <1/4g daily

Lofexidine PO	Mane	12.00 pm	6.00pm	10.00pm	Total dose	PRN
Day 1	0.2mg	0.2mg	0.2mg	0.2mg	0.8mg	
Day 2	0.4mg	0.2mg	0.2mg	0.4mg	1.2mg	
Day 3	0.4mg	0.2mg	0.2mg	0.4mg	1.2mg	0.2mg bd
Day 4	0.2mg	0.2mg	0.2mg	0.2mg	0.8mg	0.2mg qds
Day 5	0.2mg			0.2mg	0.4mg	0.2mg qds
Day 6				0.2mg	0.2mg	0.2mg tds
Day 7						0.2mg bd
Day 8						0.2mg od

ADJUNCTIVE MEDICATION

To be prescribed as prn medication for all regimes.

Ibuprofen	400mg tds po prn for duration of detoxification
Metoclopramide	10mg tds po prn for duration of detoxification
Loperamide	2mg po after loose stool to a maximum of 16mg daily for 1 week
Zopiclone	7.5-15mg nocte po prn for a maximum of 2 week

All medicines to be administered orally only.

OTHER REQUIREMENTS

1. All patients should have agreed and formulated a coherent aftercare plan with their CDAT care coordinator before commencement of detoxification.
2. The administration of naltrexone may be commenced shortly before completion of detoxification to continue regularly for a duration of six months to one year following discharge. The administration of naltrexone is the subject of a separate protocol.
3. A responsible adult must be living with the patient for the duration of the detoxification. The detoxification nurse should educate this person and the patient about the risks associated with detoxification and the appropriate action to take both within and outside working hours.
4. Detoxification should always be commenced on a Monday morning.

VISITS AND COMMUNICATION

5. The patient should be visited by the CDAT detoxification nurse on a twice daily basis for the first five days of detoxification. A once daily visit will be sufficient in most cases on days 8 and onwards. The CDAT SHO will usually accompany the detox nurse on the first visit of day 1.
6. The CDAT consultant should be informed of any concerns regarding the patient's clinical presentation immediately before the weekend.

CLINICAL MONITORING REQUIREMENTS

7. The CDAT Opiate Detoxification Monitoring Scales should be completed in full by the detox nurse with the patient, on a twice daily basis on days 1 to 5 of detoxification, immediately before the first and third daily

doses of lofexidine. Where a visit cannot occur until late in the morning, monitoring may take place before the second and third daily doses. If visits are occurring on a daily basis from day 8 onwards, then the 'Scales' need only be completed daily. Alterations to the lofexidine regime should be made as directed in 'Managing Adverse Outcomes', or following discussion with the consultant.

8. An on-site urine opiates and methadone screen should be performed on each of days 1 to 5 and day 8 onwards to the completion of the detoxification.

MANAGING ADVERSE OUTCOMES

Increasing lofexidine dosage due to poorly controlled opiate withdrawal symptoms.

The patient should be advised to use 'As required' lofexidine only if their experience of withdrawal is becoming intolerable. Clear advice as to when to avoid the use of 'as required' lofexidine should also be given i.e. if the patient feels drowsy or dizzy on standing.

Decreasing lofexidine dosage due to adverse effects of lofexidine.

1. The regular daily dose of lofexidine should be reduced by 25% in the following circumstances:

- The Sedation Scale reads 14 (out of 15).
- The systolic blood pressure drops by $> 20\text{mmHg}$ either sitting or standing.
- There is a difference of $> 20\text{mmHg}$ between the sitting and standing systolic blood pressure.
- The patient complains of symptoms of postural hypotension.

2. The regular daily dose of lofexidine should be reduced by 50% in the following circumstances:

- The Sedation Scale reads 13.
- The systolic blood pressure drops by $> 30\text{mmHg}$ either sitting or standing.
- There is a difference of $> 30\text{mmHg}$ between the sitting and standing systolic blood pressure.
- The pulse rate drops below 50bpm.

3. Lofexidine should be discontinued if

- The Sedation Scale reads < 13 .
- The systolic blood pressure drops below 80mmHg either sitting or standing.
- The diastolic blood pressure drops below 40mmHg either sitting or standing.
- There is a difference of $> 50\text{mmHg}$ between the sitting and standing systolic blood pressure.
- The pulse rate drops below 40bpm.

The CDAT consultant should be informed in the case of 2 or 3 above, and monitoring arrangements tailored according to the advice received. In the case of 3 above, if for any reason medical advice is not immediately available, the detoxification nurse should stay with the patient until the blood pressure and pulse improve, or arrange for transfer to A&E if there is no improvement or a deterioration.

Illicit drug and alcohol use during detoxification.

Use of any CNS depressant drug during detoxification presents dangers due to the potential for additive CNS depressant effects with lofexidine. Clients and carers should be educated and advised regarding this. The use of heroin on a single occasion during detoxification will not usually lead to termination of the detoxification, but use on two or more occasions should result in the detoxification being terminated. In such cases the detoxification nurse should continue to visit for 24 hours following detoxification to monitor the client's blood pressure, in order to exclude rebound hypertension.

D. EXAMPLE PROTOCOL FOR IN-PATIENT OPIATE DETOXIFICATION WITH LOFEXIDINE

CLINICAL CONDITION TO WHICH THE PROTOCOL APPLIES

Lofexidine as described in this protocol is for use in planned in-patient opiate detoxification.

The inclusion criteria are a diagnosis of opiate dependence syndrome and a pre-admission assessment which supports the indication of in-patient opiate detoxification on clinical grounds. This assessment will be accompanied by agreed documentation.

Exclusion criteria for treatment under the protocol are:

- A history of sensitivity to lofexidine or other imidazole derivatives (e.g. clotrimazole).
- A history of cardiovascular disease.
- A history of cerebrovascular disease.
- A history of renal impairment.
- Concurrent pregnancy or breast feeding.
- Concomitant prescription of medication other than described in this protocol.
- Concomitant use of illicit substances or any CNS depressant drug (including alcohol) during detoxification.

The responsible consultant psychiatrist for the patient should be contacted to advise on an appropriate opiate detoxification regime if any of these exclusion criteria are present.

Patients will be assessed by the Community Drug and Alcohol Team before admission. Patients not wishing to receive lofexidine will be offered alternative means of planned detoxification if this is clinically feasible. The ward doctor should be contacted in case of patients refusing to comply with care as stated in the protocol after detoxification has commenced.

CHARACTERISTICS OF STAFF AUTHORISED TO TAKE RESPONSIBILITY FOR THE SUPPLY OR ADMINISTRATION OF MEDICINES UNDER THE PROTOCOL

A qualified medical doctor will be required to prescribe lofexidine as described in this protocol.

A qualified nurse will be required to administer lofexidine as described in this protocol.

DESCRIPTION OF TREATMENT AVAILABLE UNDER THE PROTOCOL

Names of all medicines to be administered under the protocol.

- Lofexidine Hydrochloride.
- Ibuprofen.
- Metoclopramide.
- Loperamide Hydrochloride.
- Zopiclone.

PRESCRIBING REGIMES

A range of doses may be administered depending on several factors. These are:

- The amount of opiate drugs (prescribed or/and illicit) used by the patient in the week immediately preceding admission; this will indicate the estimated total dose of lofexidine and the duration of detoxification.
- Indication of dosage requirements from previous in-patient detoxifications.
- The blood pressure and pulse.
- The level of consciousness.
- The severity of the opiate withdrawal syndrome.

Withdrawal symptoms should be monitored by use of the 'Short Opiate Withdrawal Scale'. Additional lofexidine may be administered on an 'as required' basis as stated within the chosen regime (see below), for continued withdrawal symptoms.

Dosage of lofexidine should be altered as indicated below under 'monitoring requirements' if there is a drop in blood pressure or pulse.

Dosage of lofexidine should be altered as indicated below under 'monitoring requirements' if there is a change in the level of consciousness.

If the patient is on a methadone stabilization regime, this may be continued for the first two days of the detoxification, following discussion with the consultant.

Regime one. Detoxification from moderate dosages of methadone (20 - 70mg methadone daily)

Lofexidine PO	Mane	12.00 pm	6.00pm	10.00pm	Total dose	PRN
Day 1	0.2mg	0.2mg	0.2mg	0.2mg	0.8mg	
Day 2	0.4mg	0.2mg	0.2mg	0.4mg	1.2mg	
Day 3	0.4mg	0.4mg	0.4mg	0.4mg	1.6mg	
Day 4	0.4mg	0.4mg	0.4mg	0.4mg	1.6mg	0.2mg bd
Day 5	0.4mg	0.4mg	0.4mg	0.4mg	1.6mg	0.2mg qds
Day 6	0.4mg	0.2mg	0.2mg	0.4mg	1.2mg	0.2mg qds
Day 7	0.2mg	0.2mg	0.2mg	0.2mg	0.8mg	0.2mg qds
Day 8	0.2mg			0.2mg	0.4mg	0.2mg qds
Day 9				0.2mg	0.2mg	0.2mg tds
Day 10						0.2mg bd
Day 11						0.2mg od

Regime two. For patients detoxifying from moderate dosages of street heroin 1/4g - 3/4g daily

Lofexidine PO	Mane	12.00 pm	6.00pm	10.00pm	Total dose	PRN
Day 1	0.2mg	0.2mg	0.2mg	0.2mg	0.8mg	
Day 2	0.4mg	0.2mg	0.2mg	0.4mg	1.2mg	
Day 3	0.4mg	0.4mg	0.4mg	0.4mg	1.6mg	
Day 4	0.4mg	0.2mg	0.2mg	0.4mg	1.2mg	0.2mg qds
Day 5	0.2mg	0.2mg	0.2mg	0.2mg	0.8mg	0.2mg qds
Day 6	0.2mg			0.2mg	0.4mg	0.2mg qds
Day 7				0.2mg	0.2mg	0.2mg tds
Day 8						0.2mg bd
Day 9						0.2mg od

Regime three. For patients detoxifying from dosages of methadone >70mg daily

Lofexidine PO	Mane	12.00 pm	6.00pm	10.00pm	Total dose	PRN
Day 1	0.2mg	0.2mg	0.2mg	0.2mg	0.8mg	
Day 2	0.4mg	0.2mg	0.2mg	0.4mg	1.2mg	
Day 3	0.4mg	0.4mg	0.4mg	0.4mg	1.6mg	
Day 4	0.6mg	0.4mg	0.4mg	0.6mg	2.0mg	
Day 5	0.6mg	0.6mg	0.6mg	0.6mg	2.4mg	
Day 6	0.6mg	0.4mg	0.4mg	0.6mg	2.0mg	0.2mg bd
Day 7	0.4mg	0.4mg	0.4mg	0.4mg	1.6mg	0.2mg qds
Day 8	0.4mg	0.2mg	0.2mg	0.4mg	1.2mg	0.2mg qds
Day 9	0.2mg	0.2mg	0.2mg	0.2mg	0.8mg	0.2mg tds
Day 10	0.2mg			0.2mg	0.4mg	0.2mg bd
Day 11				0.2mg	0.2mg	0.2mg od
Day 12						0.2mg od

Regime four. Detoxification from large dosages of street heroin (>3/4g street heroin daily)

Lofexidine PO	Mane	12.00 pm	6.00pm	10.00pm	Total dose	PRN
Day 1	0.2mg	0.2mg	0.2mg	0.2mg	0.8mg	
Day 2	0.4mg	0.2mg	0.2mg	0.4mg	1.2mg	
Day 3	0.4mg	0.4mg	0.4mg	0.4mg	1.6mg	
Day 4	0.6mg	0.4mg	0.4mg	0.6mg	2.0mg	0.2mg bd
Day 5	0.4mg	0.4mg	0.4mg	0.4mg	1.6mg	0.2mg qds
Day 6	0.2mg	0.2mg	0.2mg	0.2mg	0.8mg	0.2mg qds
Day 7	0.2mg			0.2mg	0.4mg	0.2mg tds
Day 8				0.2mg	0.2mg	0.2mg bd
Day 9						0.2mg od

Regime five. For patients detoxifying from small dosages of methadone <20mg daily

Lofexidine PO	Mane	12.00 pm	6.00pm	10.00pm	Total dose	PRN
Day 1	0.2mg	0.2mg	0.2mg	0.2mg	0.8mg	
Day 2	0.4mg	0.2mg	0.2mg	0.4mg	1.2mg	
Day 3	0.4mg	0.2mg	0.2mg	0.4mg	1.2mg	0.2mg bd
Day 4	0.4mg	0.2mg	0.2mg	0.4mg	1.2mg	0.2mg bd
Day 5	0.2mg	0.2mg	0.2mg	0.2mg	0.8mg	0.2mg qds
Day 6	0.2mg			0.2mg	0.4mg	0.2mg qds
Day 7				0.2mg	0.2mg	0.2mg tds
Day 8						0.2mg bd
Day 9						0.2mg od

Regime six. For patients detoxifying from dosages of street heroin <1/4g daily

Lofexidine PO	Mane	12.00 pm	6.00pm	10.00pm	Total dose	PRN
Day 1	0.2mg	0.2mg	0.2mg	0.2mg	0.8mg	
Day 2	0.4mg	0.2mg	0.2mg	0.4mg	1.2mg	
Day 3	0.4mg	0.2mg	0.2mg	0.4mg	1.2mg	0.2mg bd
Day 4	0.2mg	0.2mg	0.2mg	0.2mg	0.8mg	0.2mg qds
Day 5	0.2mg			0.2mg	0.4mg	0.2mg qds
Day 6				0.2mg	0.2mg	0.2mg tds
Day 7						0.2mg bd
Day 8						0.2mg od

ADJUNCTIVE MEDICATION

To be prescribed as prn medication for all regimes.

Ibuprofen	400mg tds po prn for duration of detoxification
Metoclopramide	10mg tds po prn for duration of detoxification
Loperamide	2mg po after loose stool to a maximum of 16mg daily for 1 week
Zopiclone	7.5-15mg nocte po prn for a maximum of 2 weeks

All medicines to be administered orally. Metoclopramide may be administered intramuscularly in the case of severe vomiting.

All patients should have agreed and formulated a coherent aftercare plan with their CDAT care coordinator before admission for in-patient detoxification. The administration of naltrexone may be commenced shortly before completion of detoxification to continue regularly for a duration of six months to one year following discharge. The administration of naltrexone is the subject of a separate protocol.

CLINICAL MONITORING REQUIREMENTS

The Short Opiate Withdrawal Scale (SOWS) should be completed immediately before the administration of each dose.

Sitting and standing blood pressure should be taken immediately before the administration of each dose.

Pulse rate should be taken immediately before the administration of each dose.

The patient's level of consciousness should be immediately before the administration of each dose.

The patient should be questioned about symptoms of postural hypotension immediately before the administration of each dose.

MANAGING ADVERSE OUTCOMES

Increasing lofexidine dosage due to poorly controlled opiate withdrawal symptoms.

1. 'As required' lofexidine should be administered by titrating against the short opiate withdrawal scale (see SOWS for more details).

Decreasing lofexidine dosage due to adverse effects of lofexidine.

1. The regular daily dose of lofexidine should be reduced by 25% in the following circumstances:
 - The Sedation Scale reads 14 (out of 15).

- The systolic blood pressure drops by > 20mmHg either sitting or standing.

- There is a difference of > 20mmHg between the sitting and standing systolic blood pressure.

- The patient complains of symptoms of postural hypotension.

2. The regular daily dose of lofexidine should be reduced by 50% in the following circumstances:

- The Sedation Scale reads 13.

- The systolic blood pressure drops by > 30mmHg either sitting or standing.

- There is a difference of > 30mmHg between the sitting and standing systolic blood pressure.

- The pulse rate drops below 50bpm.

3. Lofexidine should be discontinued if

- The Sedation Scale reads < 13.

- The systolic blood pressure drops below 80mmHg either sitting or standing.

- The diastolic blood pressure drops below 40mmHg either sitting or standing.

- There is a difference of > 50mmHg between the sitting and standing systolic blood pressure.

- The pulse rate drops below 40bpm.

Pulse rate, blood pressure and level of consciousness should be monitored on a four hourly basis in the case of (1) above, and on a two hourly basis in the case of (2) above. The medical team, ward doctor on call and consultant psychiatrist on call should be informed in the case of (3) above, and monitoring arrangements tailored according to the advice received.

Resuscitation equipment and emergency medication must be available to the ward in which these detoxifications will take place.

SCALES FOR USE IN DETOXIFICATION

1. GLASGOW COMA SCALE

Date:	Time (24hr):	TOTAL
Action	Response	
Eyes Open	Spontaneously (4)	
	To verbal command (3)	
	To pain (2)	
	No response (1)	
Best Motor Response	Obeys a verbal command (6)	
	Localises a painful stimulus (5)	
	Abnormal or no response (1)	
Best Verbal Response	Orientated and converses (5)	
	Disorientated and converses (4)	
	Inappropriate words (3)	
	Incomprehensible sounds (2)	
	No response (1)	
TOTAL		/15

2. SHORT OPIATE WITHDRAWAL SCALE

	None (0)	Mild (1)	Moderate (2)	Severe (3)	TOTAL
Feeling sick					
Stomach Cramps					
Muscle Spasms/Twitching					
Feelings of Coldness					
Heart Pounding					
Muscular Tension					
Aches and Pains					
Yawning					
Runny Eyes					
Insomnia/Problems Sleeping					
TOTAL					/30

3. SEVERITY OF OPIATE DEPENDENCE QUESTIONNAIRE (SODQ)

Please answer every question by ticking one response only

1. On waking and before my first dose of opiates

My body aches or feels stiff:

Never or almost never Sometimes Often Always or nearly always

I get stomach cramps

Never or almost never Sometimes Often Always or nearly always

I feel sick

Never or almost never Sometimes Often Always or nearly always

I notice my heart pounding

Never or almost never Sometimes Often Always or nearly always

I have hot and cold flushes

Never or almost never Sometimes Often Always or nearly always

I feel miserable or depressed

Never or almost never Sometimes Often Always or nearly always

I feel tense or panicky

Never or almost never Sometimes Often Always or nearly always

I feel irritable or angry

Never or almost never Sometimes Often Always or nearly always

I feel restless and unable to relax

Never or almost never Sometimes Often Always or nearly always

I have a strong craving

Never or almost never Sometimes Often Always or nearly always

Please answer the following questions

I try to save some opiates to use on waking

Never or almost never Sometimes Often Always or nearly always

I like to take my first dose of opiates within two hours of waking up

Never or almost never Sometimes Often Always or nearly always

In the morning, I use opiates to stop myself feeling sick

Never or almost never Sometimes Often Always or nearly always

The first thing I think of doing when I wake up is to take some opiates

Never or almost never Sometimes Often Always or nearly always

When I wake up I take opiates to stop myself aching or feeling stiff

Never or almost never Sometimes Often Always or nearly always

The first thing I do after I wake up is to take some opiates

Never or almost never Sometimes Often Always or nearly always

Please think of your opiate use during a typical period of drug taking when answering the following questions

Did you think your opiate use was out of control?

Never or almost never Sometimes Often Always or nearly always

Did the prospect of missing a fix (or dose) make you very anxious or worried?

Never or almost never Sometimes Often Always or nearly always

Did you worry about your opiate use?

Never or almost never Sometimes Often Always or nearly always

Did you wish you could stop?

Never or almost never Sometimes Often Always or nearly always

How difficult would you find it to stop or go without?

Not difficult Quite difficult Very difficult Impossible

TOTAL SCORE

/63

4. SEVERITY OF ALCOHOL DEPENDENCE QUESTIONNAIRE (SADQ)

1. Please indicate below the physical symptoms that you have experienced first thing in the morning during typical periods of heavy drinking.

- I wake up feeling sweaty.
 Almost Never Sometimes Often Nearly Always
- My hands shake first thing in the morning.
 Almost Never Sometimes Often Nearly Always
- My whole body shakes violently first thing in the morning if I don't have a drink.
 Almost Never Sometimes Often Nearly Always
- I wake up absolutely drenched in sweat.
 Almost Never Sometimes Often Nearly Always

2. The following statements refer to moods and states of mind you may have experienced during these periods of heavy drinking.

- I dread waking up in the morning.
 Almost Never Sometimes Often Nearly Always
- I am afraid of meeting people first thing in the morning.
 Almost Never Sometimes Often Nearly Always
- I feel at the edge of despair when I first wake up.
 Almost Never Sometimes Often Nearly Always
- I feel very frightened when I wake up.
 Almost Never Sometimes Often Nearly Always

3. The following statements refer to morning drinking habits during the recent period when you were drinking heavily, and periods like it.

- I like to have a morning drink.
 Almost Never Sometimes Often Nearly Always
- I always gulp my first few morning drinks down as quickly as possible.
 Almost Never Sometimes Often Nearly Always
- I drink in the morning to get rid of the shakes.
 Almost Never Sometimes Often Nearly Always
- I have a very strong craving for a drink when I wake up.
 Almost Never Sometimes Often Nearly Always

4. The following statements refer to a degree of alcohol consumption during the recent period of heavy drinking and periods like it.

- I drink more than a quarter of a bottle of spirits per day I.E. 4 doubles or 1 bottle of wine or 4 pints of beer/lager.
 Almost Never Sometimes Often Nearly Always
- I drink more than half a bottle of spirits per day or 2 bottles of wine or 8 pints of beer/lager.
 Almost Never Sometimes Often Nearly Always
- I drink more than one bottle of spirits per day or 4 bottles of wine or 15 pints of beer/lager.
 Almost Never Sometimes Often Nearly Always
- I drink more than two bottles of spirits per day or 8 bottles of wine or 30 pints of beer/lager.
 Almost Never Sometimes Often Nearly Always

5. Imagine the following situations.

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 heavy drinking?

- I would start to sweat.
 Not at all Slightly Moderately Quite a lot
- My hands would shake
 Not at all Slightly Moderately Quite a lot
- My body would shake
 Not at all Slightly Moderately Quite a lot
- I would be craving for a drink
 Not at all Slightly Moderately Quite a lot

TOTAL SCORE

/60

CIWA-Ar (ALCOHOL WITHDRAWAL SCALE)

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 not extended

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

Anxiety

Ask "Do you feel nervous?" Observation.

- 0 no anxiety, at ease
- 1 mildly 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

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

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

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 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 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 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

Orientation & clouding of sensorium

Ask "What day is this? Where are you? Who am I?"

- 0 orientated and can do serial additions
- 1 cannot do serial additions or is uncertain about the date
- 2 disorientated for date by no more than 2 calendar days
- 3 disorientated for date by more than 2 calendar days
- 4 disorientated for place and/or person

TOTAL CIWA-Ar SCORE /67

(Max possible score is 67)

Date:

Time (24hr):

Rater's initials: