Outpatient Alcohol Withdrawal Treatment: Best-Evidence and Updates from Literature

Zachary Sartor, MD, FAAFP
Ryan Laschober, MD, FAAFP
Natalie Fjellanger, LCSW-S

ASAM 56th Annual Conference, April 25, 2025

Disclosure Information

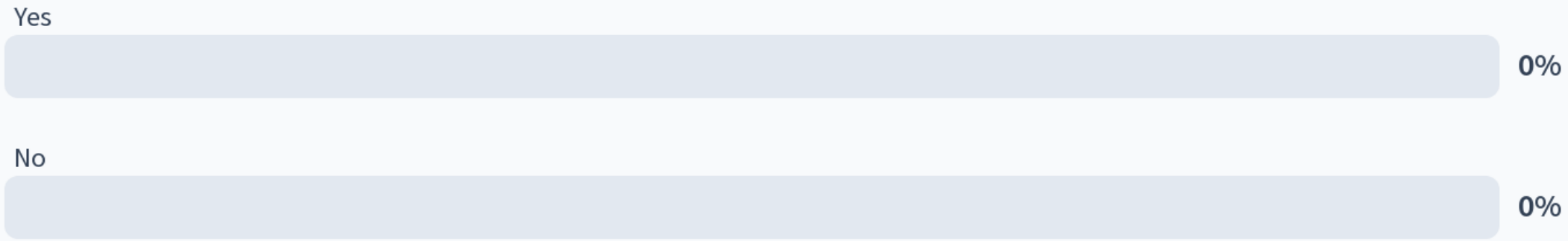
- Zachary Sartor, MD, FAAFP
  - No disclosures
- Ryan Laschober, MD, FAAFP
  - No disclosures
- Natalie Fjellanger, LCSW-S
  - No disclosures

Learning Objectives

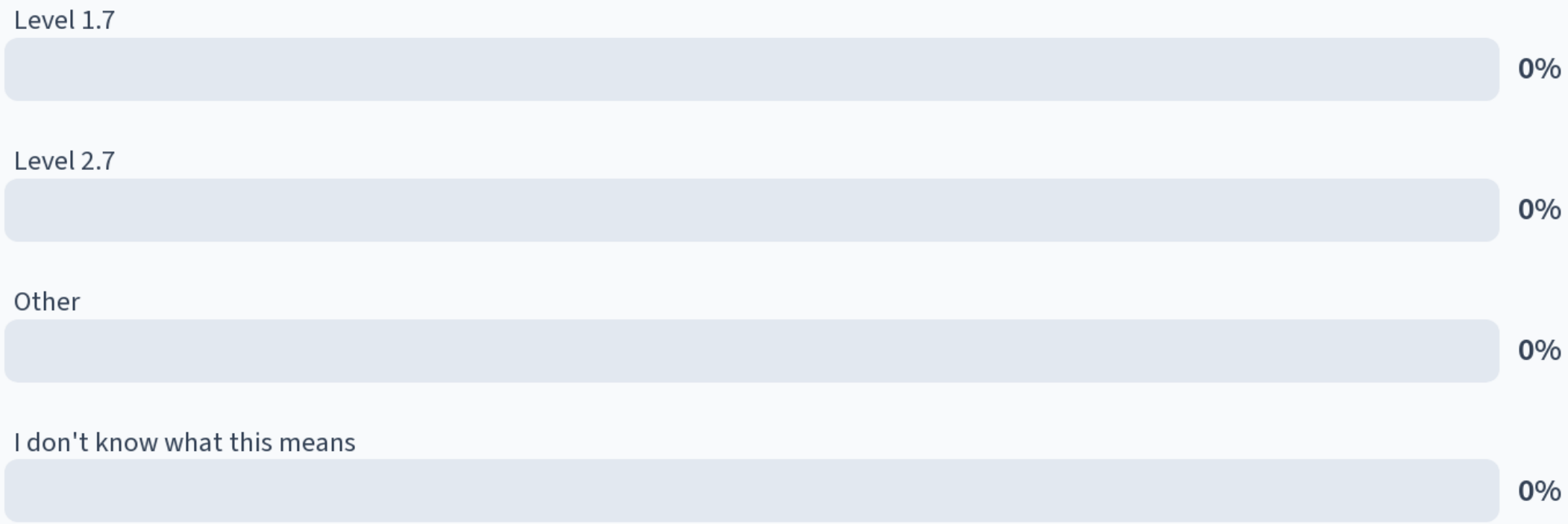
Upon completion of this focus session, learners will be able to:

- Evaluate evidence for outpatient alcohol withdrawal management.
- Synthesize a multidisciplinary approach to managing alcohol withdrawal by incorporating holistic treatment strategies and fostering interprofessional collaboration.
- Create clinical protocols for outpatient alcohol withdrawal treatment for their specific patient population

Do you provide alcohol withdrawal treatment in an outpatient context?



At what level of service do you provide withdrawal services?



Learning Objectives

Upon completion of this focus session, learners will be able to:

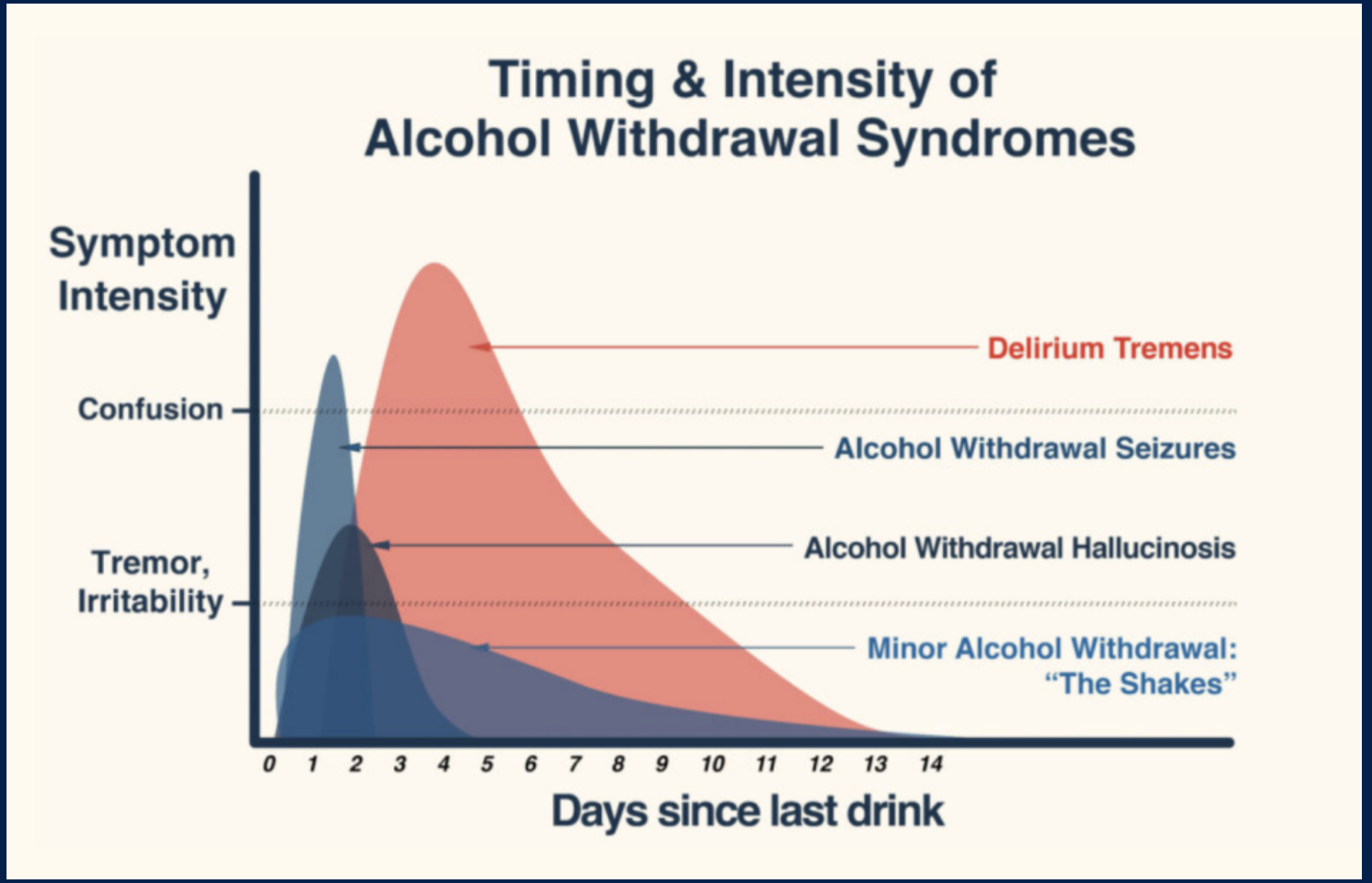
- **Evaluate evidence for outpatient alcohol withdrawal management.**
- Synthesize a multidisciplinary approach to managing alcohol withdrawal by incorporating holistic treatment strategies and fostering interprofessional collaboration.
- Create clinical protocols for outpatient alcohol withdrawal treatment for their specific patient population

Alcohol Use Disorder in the United States **28.9 million** people in 2023

SAMSHA. 2023 NSDUH.

15.3% of people with unhealthy alcohol use experience AWS

Levine et al. Alcohol Clin Exp Res. 2022.



Adapted from Stonegate Center. 2020.

Need for withdrawal treatment depends **individual** treatment goals

The ASAM

CLINICAL PRACTICE GUIDELINE ON

Alcohol Withdrawal Management

ASAM. Journal of Addiction Medicine. 2020.

ASAM Recommendations: Predicting Withdrawal

- Withdrawal most likely for patients drinking "recently, regularly, and heavily"
- AUDIT-PC score of ≥4 may predict withdrawal
  - Sensitivity 91%
  - Specificity 90%

Pecoraro et al. J Gen Intern Med. 2014.

AUDIT - PC

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

ASAM Recommendations: Assessing Risk and Severity

- Assess for risk of severe withdrawal
  - The ASAM Criteria
  - Other risk assessment tools not intended for an outpatient context
- Use a validated scale to assess symptom severity
  - CIWA-Ar
  - Short Alcohol Withdrawal Scale (SAWS)

Adult Medically Managed Program Types

Level 1.7:
Medically Managed Outpatient Treatment

Level 2.7:
Medically Managed Intensive
Outpatient Treatment

Level 3.7:
Medically Managed Residential Treatment

Level 3.7 BIO:
Medically Managed Biomedically
Enhanced Residential Treatment

Level 4:
Medically Managed Inpatient Treatment

ASAM Criteria 4th Edition
(2024)

The ASAM Criteria Dimensions and Subdimensions

Dimension 1 – Intoxication, Withdrawal, and Addiction Medications

- **Intoxication and associated risks**
- **Withdrawal and associated risks**
- **Addiction medication needs**

Dimension 2 – Biomedical Conditions

- **Physical health concerns**
- **Pregnancy-related concerns**
- Sleep problems

Dimension 3 – Psychiatric and Cognitive Conditions

- **Active psychiatric concerns**
- **Persistent Disability**
- Cognitive Functioning
- Trauma exposure and related needs
- Psychiatric and cognitive history

Dimension 4 – Substance Use Related Risks

- **Likelihood of risky substance use**
- **Likelihood of risky SUD-related behaviors**

Dimension 5 – Recovery Environment Interactions

- **Ability to function in current environment**
- **Safety in current environment**
- **Support in current environment**
- Cultural perceptions of substance use

Dimension 6 – Person-Centered Considerations

- Patient preferences
- Barriers to care
- Need for motivational enhancement

Preview of Coming Attractions: Concise Outpatient Withdrawal Criteria

Patients with prior withdrawal seizures or delirium tremens are not candidates for outpatient withdrawal treatment

Additionally, presence of any of the following alone or in combination may preclude outpatient withdrawal treatment
- Long-duration of or heavy use of alcohol (e.g., more than 8 standard drinks daily)
- Aged 65 and over
- Physiological dependence on benzodiazepines
- Significant medical comorbidity that are uncontrolled (e.g., hypertensive urgency)

Most ambulatory centers function at Level 1.7, therefore that is the focus of this session

Alcohol Withdrawal Symptom Scales

CIWA-Ar

- Clinical Institute Withdrawal Assessment, Revised
- 10 item
- Clinically-administered
- Appropriate in any setting

SAWS

- Short Alcohol Withdrawal Scale
- 10-item instrument, rated from 0 (none) to 3 (severe)
- Self-administered by patients,
- Validated in ambulatory settings

TABLE 1. Alcohol Withdrawal Severity.

Severity Category	Associated CIWA-Ar Range*	Symptom Description
Mild	CIWA-Ar < 10	Mild or moderate anxiety, sweating and insomnia, but no tremor
Moderate	CIWA-Ar 10-18	Moderate anxiety, sweating, insomnia, and mild tremor
Severe	CIWA-Ar ≥19	Severe anxiety and moderate to severe tremor, but not confusion, hallucinations, or seizure
Complicated	CIWA-Ar ≥19	Seizure or signs and symptoms indicative of delirium – such as an inability to fully comprehend instructions, clouding of the sensorium or confusion – or new onset of hallucinations

*Throughout this document, we provide examples for withdrawal severity using the CIWA-Ar, although other scales can be used. Regardless of the instrument used, there is a wide variety in the literature and in practice as to which scores best delineate mild, moderate and severe withdrawal. Classification of withdrawal severity is ultimately up to the judgment of clinicians and the choice of reference range may be based on their particular patient population or capabilities.

Short alcohol withdrawal scale (SAWS)

Score each symptom based on the following scale:

None = 0 Mild = 1 Moderate = 2 Severe = 3

Symptom	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:
Anxious					
Feeling confused					
Restless					
Miserable					
Problems with memory					
Tremor (shakes)					
Nausea					
Heart pounding					
Sleep disturbance					
Sweating					
TOTAL					

ASAM Recommendations: Withdrawal Pharmacotherapy

- Consider pharmacotherapy for mild symptoms
- Prescribe pharmacotherapy for moderate symptoms
- Longer-acting benzodiazepines are preferred
  - Anticonvulsants alternatively for mild withdrawal
  - Anticonvulsants adjunctively for moderate withdrawal
- Symptom triggered or fixed-dose in either Level 1.7 or 2.7
- Thiamine 100 mg daily + MVI

AWS Treatment Regimens

- Fixed-dose benzodiazepines prevent seizures
- Diazepam prevents DTs
- Low to moderate evidence that carbamazepine reduces CIWA-Ar score
  - Has a higher dropout rate compared to other agents
- Moderate level of evidence that gabapentin reduces CIWA-Ar
- High risk of bias and heterogeneity in data

Ghosh et al. Alcohol Alcohol. 2021.
Bahji et al. Addiction. 2022.

Alcohol and Alcoholism Vol. 46, No. 3, pp. 318–323, 2011
Advance Access Publication 17 March 2011

doi: 10.1093/alcalc/agr020

TREATMENT

Alcohol Withdrawal Syndrome: Symptom-Triggered versus Fixed-Schedule Treatment in an Outpatient Setting

Bjarne Elholm[1], Klaus Larsen[2], Nete Hornnes[2], Finn Zierau[1] and Ulrik Becker[3,4,*]

[1]Alcohol Unit, Copenhagen University Hospital, Hvidovre, Capital Region, Copenhagen, Denmark, [2]Clinical Research Centre, Copenhagen University Hospital, Hvidovre, Capital Region, Copenhagen, Denmark, [3]Department of Medical Gastroenterology, Copenhagen University Hospital, Hvidovre, Capital Region, Copenhagen, Denmark and [4]National Institute of Public Health, University of Southern Denmark, Copenhagen, Denmark

*Corresponding author: Department of Medical Gastroenterology, 439, Hvidovre Hospital, DK-2650 Hvidovre, Denmark. Tel: +45-36-32-22 89; E-mail: ulrik.becker@hvh.regionh.dk

(*Received* 14 *September* 2010; *in revised form* 12 *February* 2011; *accepted* 15 *February* 2011)

Elholm et al. Alcohol Alcohol. 2011.

Study Characteristics

- Randomized-control trial in Denmark
- Stratified selection less than or more than 20 daily drinks
- Randomized to fixed dosing or symptom-triggered dosing
  - Chlordiazopoxide
  - N=143
- Daily assessment with SAWS

Elholm et al. Alcohol Alcohol. 2011.

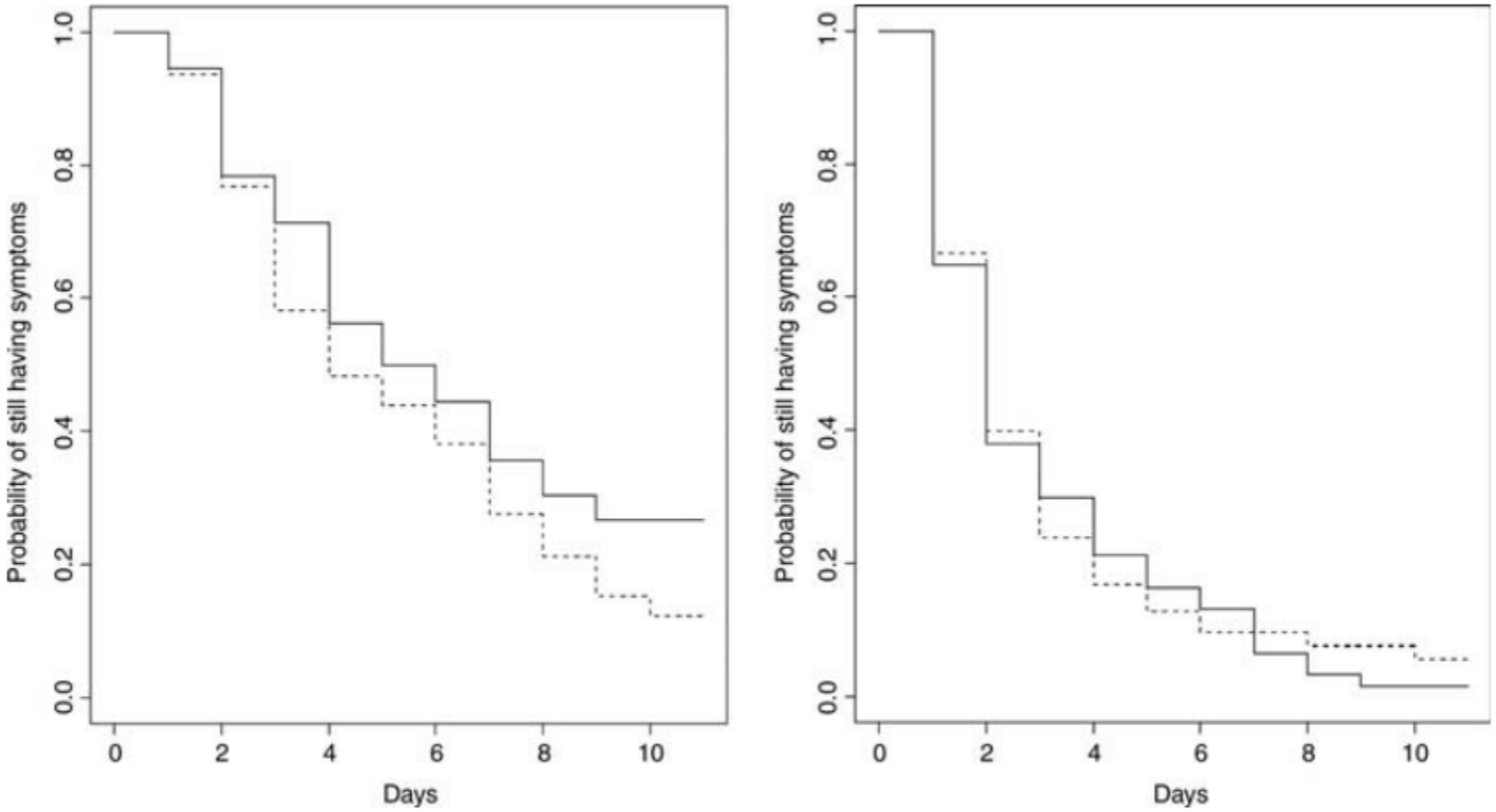


Fig. 2. Kaplan–Meier analysis of time to SAWS ≤ 6 (left panel) and ≤ 12 (right panel) for individuals assigned to symptom-triggered treatment schedule (solid) and fixed-schedule treatment (dashed). Time to SAWS ≤ 6; hazard ratio 1.38, $P = 0.09$ (log-rank test) and time to SAWS ≤ 12; hazard ratio = 0.98, $P = 0.92$.

Elholm et al. Alcohol Alcohol. 2011.

ASAM Recommendations: Front Loading

- Higher, more frequent doses of medication
  - Diazepam 20 mg every 1-2 hours to achieve control of withdrawal symptoms and light sedation
  - Typical total dose diazepam 80 mg
- Long-lasting effect
- Achieves rapid control of symptoms
- Requires monitoring for over sedation

ASAM. Journal of Addiction Medicine. 2020.

Medication	Regimen	Description, Examples
Benzodiazepines *(doses in Chlordiazepoxide)*	Typical single dose	Mild withdrawal (CIWA-Ar < 10): 25–50 mg PO Moderate withdrawal (CIWA-Ar 10–18): 50–100 mg PO Severe withdrawal (CIWA-Ar ≥19): 75–100 mg PO
	Symptom-triggered	25–100 mg PO q4–6h when CIWA-Ar ≥10. Additional doses PRN.
	Fixed-dose	Taper daily total dose by 25–50% per day over 3–5 days by reducing the dose amount and/or dose frequency. Additional doses PRN. Day 1: 25–100 mg PO q4–6h Day 2: 25–100 mg PO q6–8h Day 3: 25–100 mg PO q8–12h Day 4: 25–100 mg PO at bedtime (Optional) Day 5: 25 to 100 mg PO at bedtime
	Front loading	*Symptom-triggered:* 50–100 mg PO q1–2h until CIWA-Ar < 10. *Fixed-dose:* 50–100 mg PO q1-2h for 3 doses.
Phenobarbital	Typical single dose	10 mg/kg IV infused over 30 minutes or 60-260 mg PO/IM.
	Monotherapy	*Symptom-triggered in the ICU:* 130 mg IV q30m to target a RASS score of 0 to -1. *Fixed dose in the ED:* Loading dose 260 mg IV, then 130 mg IV q30m at physician's discretion. *Fixed dose in ambulatory management:* Loading dose 60–120 mg PO. Then 60 mg PO q4h until patient is stabilized. Then 30–60 mg PO q6h tapered over 3–7 days. Additional doses PRN.
	Adjunct therapy	*Single dose in the ED:* 10 mg/kg IV infused over 30 minutes. *Escalating dose in the ICU:* After maximum diazepam dose (120 mg), if RASS ≥1, escalating dose of 60 mg → 120 mg → 240 mg IV q30m to target RASS score of 0 to -2.
Carbamazepine (Tegretol)	Monotherapy	600–800 mg total per day tapered to 200–400 mg/d over 4–9 days.
	Adjunct therapy	200 mg q8h or 400 mg q12h.
Gabapentin (Neurontin)	Monotherapy	Loading dose 1200 mg, then 600 mg q6h on Day 1 or 1200 mg/d for 1–3 days, tapered to 300–600 mg/d up to 4–7 days. Additional doses PRN.
	Adjunct therapy	400 mg q6–8h.
Valproic acid (Depakene)	Monotherapy	1200 mg/d tapered to 600 mg/d over 4–7 days or 20 mg/kg/d.
	Adjunct therapy	300–500 mg q6–8h.

CIWA-Ar, Clinical Institute Withdrawal Assessment for Alcohol, Revised; ED, Emergency Department; h, hour(s); ICU, Intensive Care Unit; IM, intramuscularly; IV, intravenously; m, minute(s); mg, milligrams; PO, by mouth; PRN, as needed; q, every; RASS, Richmond Agitation Sedation Scale.

ASAM Recommendations: Daily Assessments

- Daily check-in with a qualified health professional
- Use a validated scale to assess symptom severity changes
  - CIWA-Ar
  - Short Alcohol Withdrawal Scale (SAWS)
- Telehealth options acceptable alternatives

ASAM Recommendations: Medications for AUD (MAUD)

- Initiate at any point during assessment or treatment
- Naltrexone and acamprosate, specifically, can be started concurrently with withdrawal treatment if not before
- Gabapentin for mild withdrawal symptoms ideal if planning to continue after withdrawal treatment

ASAM. Journal of Addiction Medicine. 2020.

MAUD During Withdrawal Treatment

- Acamprosate: historically not recommended due to mechanism of action
- Safety and signal of efficacy demonstrated in RCT
- Gabapentin for mild withdrawal symptoms ideal if planning to continue after withdrawal treatment

ASAM. Journal of Addiction Medicine. 2020.

BRIEF REPORT

Outpatient Alcohol Withdrawal Management in a Substance Use Disorder Bridge Clinic: An Opportunity for Low-barrier Engagement and Shared Decision-making

Alyssa F. Peterkin, MD, Jordana Laks, MD, MPH, Natalija Farrell, PharmD, Karrin Weisenthal, MD, MHS, and Jessica L. Taylor, MD

Peterkin et al. Journal of Addiction Medicine. 2025.

Study Characteristics

- 46 patients between 2021 and 2023
  - 28.3% with history of withdrawal seizure
  - 4.3% with history of DTs
- Daily office visits or telehealth, alternatively
- Medications on site (ASAM Criteria Level 2.7)

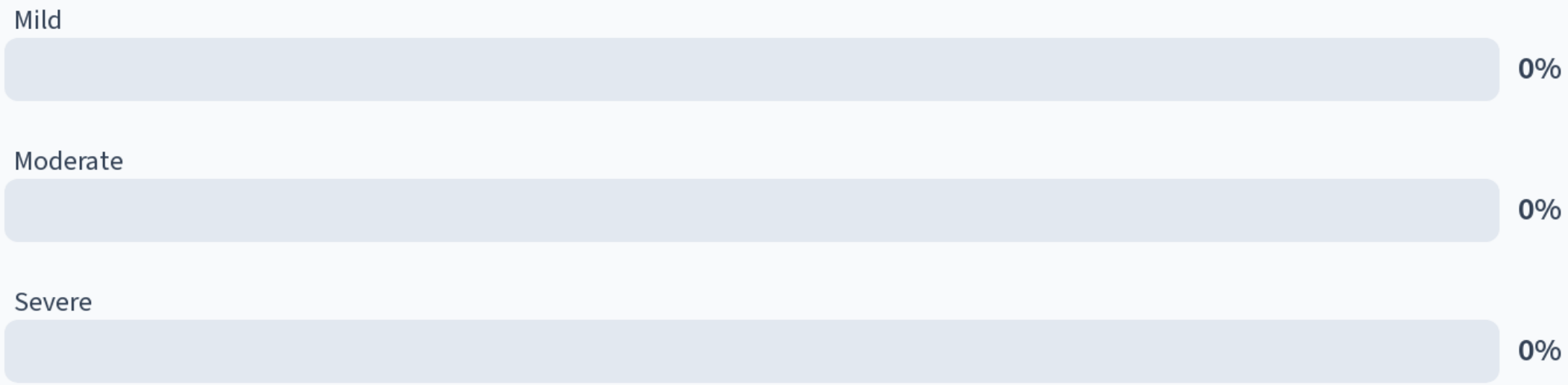
Peterkin et al. Journal of Addiction Medicine. 2025.

Study Findings

- 41% completed a benzodiazepine taper
- One patient had a seizure who declined initial recommendation of an inpatient level of care
- Adjunctive treatment
  - 52.2% prescribed MAUD
  - 23.9% linked to recovery coaches

Peterkin et al. Journal of Addiction Medicine. 2025.

A patient with a CIWA-Ar score of 14 has what severity of withdrawal?



Which of the following pharmacological options would be appropriate for a patient with known cirrhosis to treat withdrawal?

Diazepam 0%

Lorazepam 0%

Carbamazepine 0%

Gabapentin 0%

Either B or D 0%

A 45-year-old males who drinks 12 standard drinks daily has no history of DTs and lives alone but has friends nearby. Which level of care would be appropriate for withdrawal management?

Level 1.7 — 0%

Level 2.7 — 0%

Residential or inpatient (level 4.7 or 4) — 0%

Either A or B — 0%

Learning Objectives

Upon completion of this focus session, learners will be able to:

- Evaluate evidence for outpatient alcohol withdrawal management.
- **Synthesize a multidisciplinary approach to managing alcohol withdrawal by incorporating holistic treatment strategies and fostering interprofessional collaboration.**
- Create clinical protocols for outpatient alcohol withdrawal treatment for their specific patient population

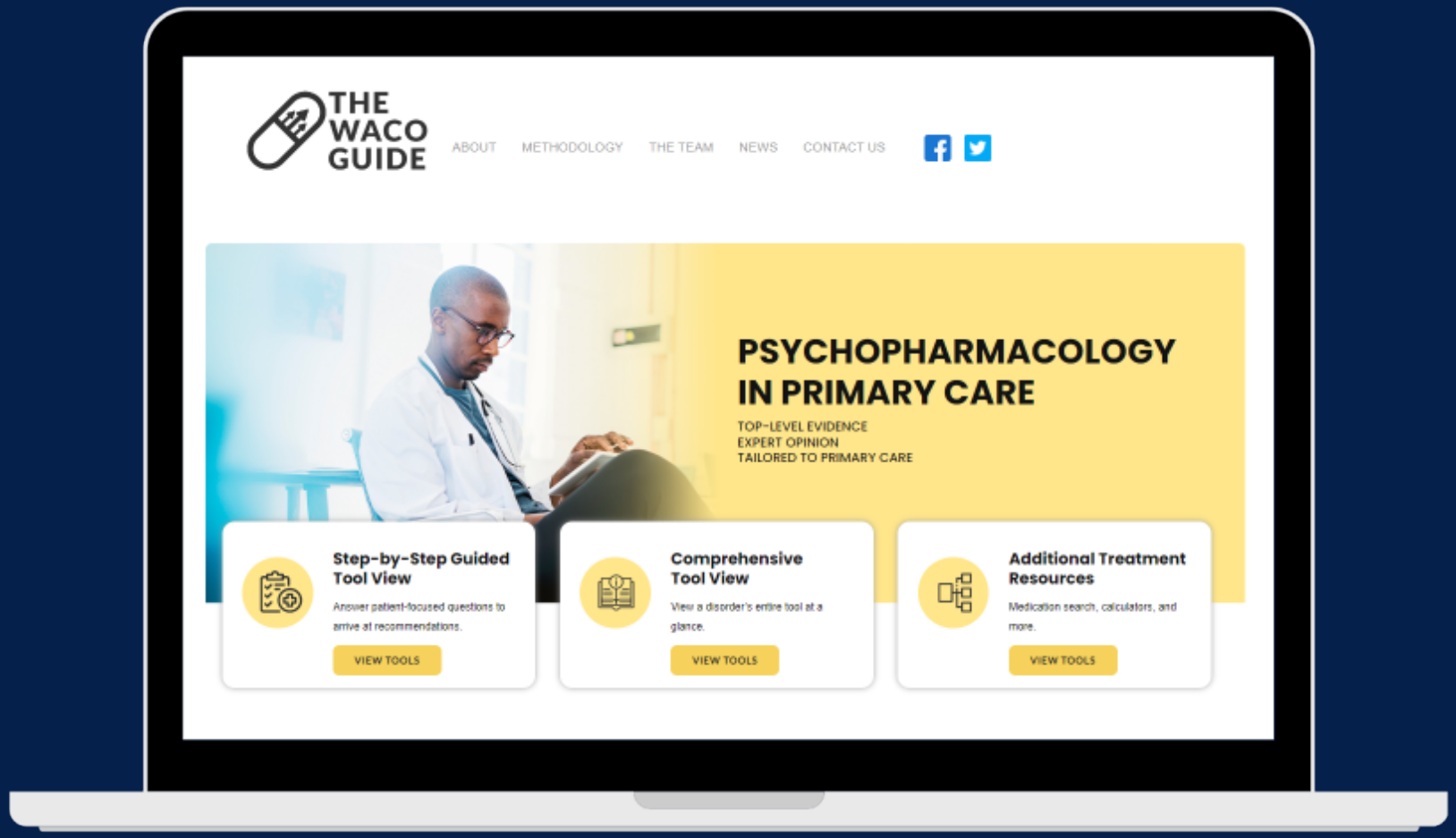
Alcohol withdrawal in **appropriate patients** can be safely managed in an **ambulatory setting**

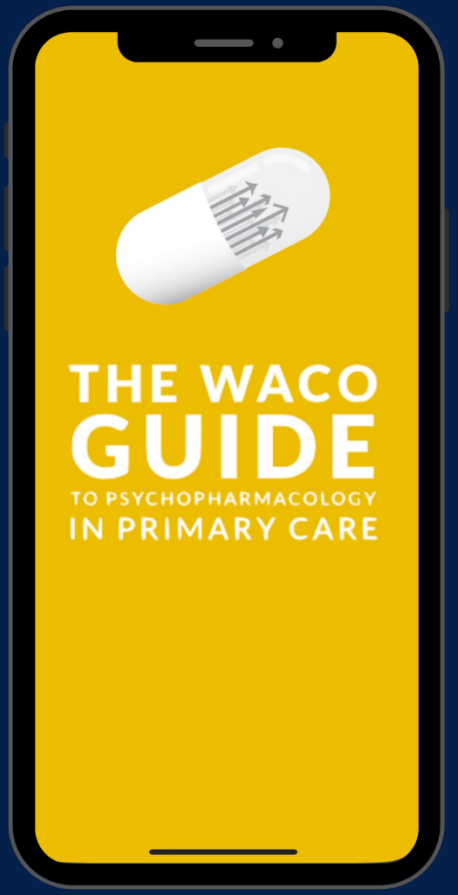
ASAM. Journal of Addiction Medicine. 2020.

What **resources and clinical tools** are needed to succeed in providing withdrawal services?

ASAM. Journal of Addiction Medicine. 2020.

Clinical Decision Support





Featured by:

AMA

ACP℠
American College of Physicians
Leading Internal Medicine, Improving Lives

American Society of Addiction Medicine
Founded 1954
ASAM

Waco Guide is **free** for users and was not created nor is maintained with industry funding

Components of Decision Support Tools

Algorithms

Logic to complement medical decision making

Prescribing Info

Dosing, titration schedules, and monitoring parameters

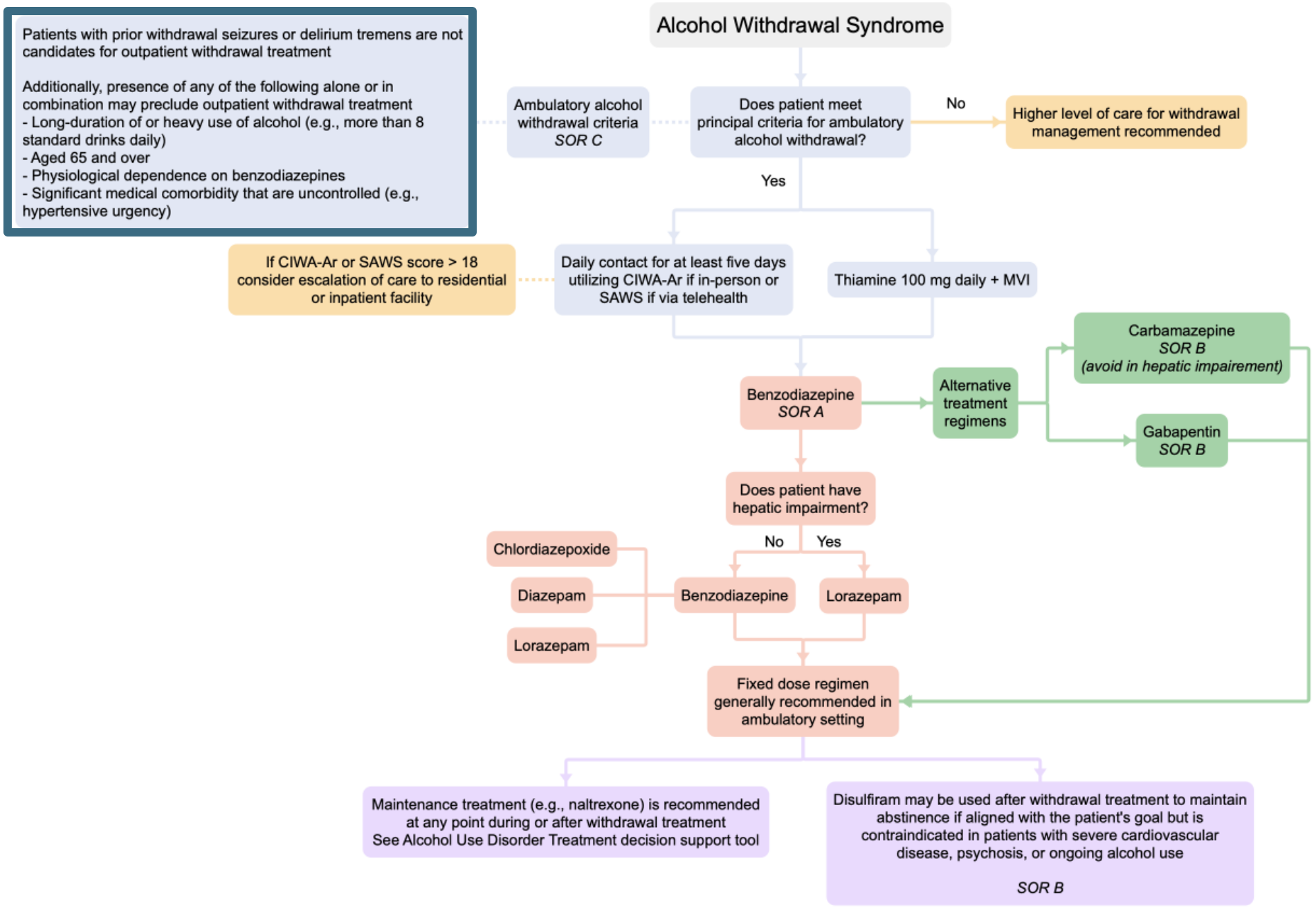
SORT Ratings

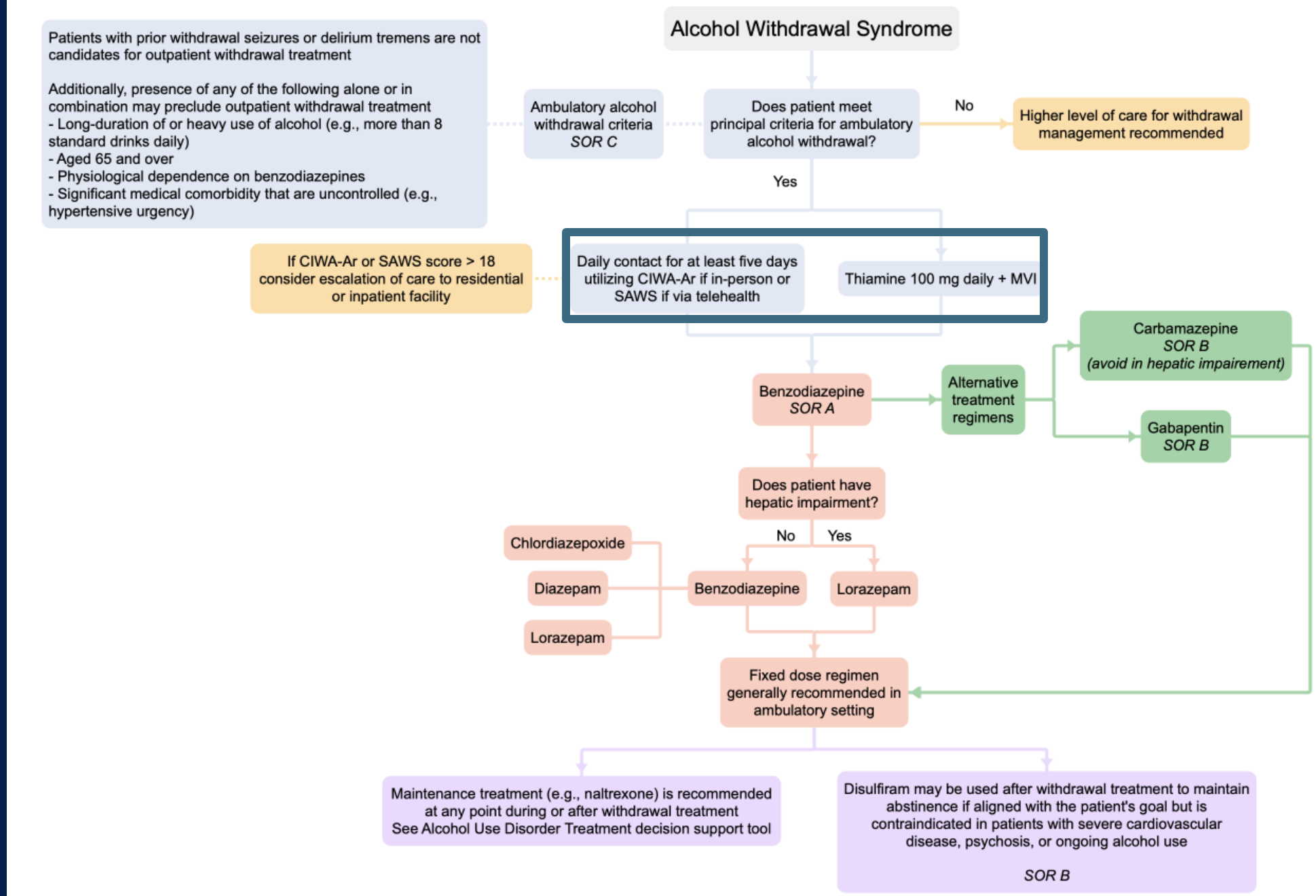
SORT statements with important references

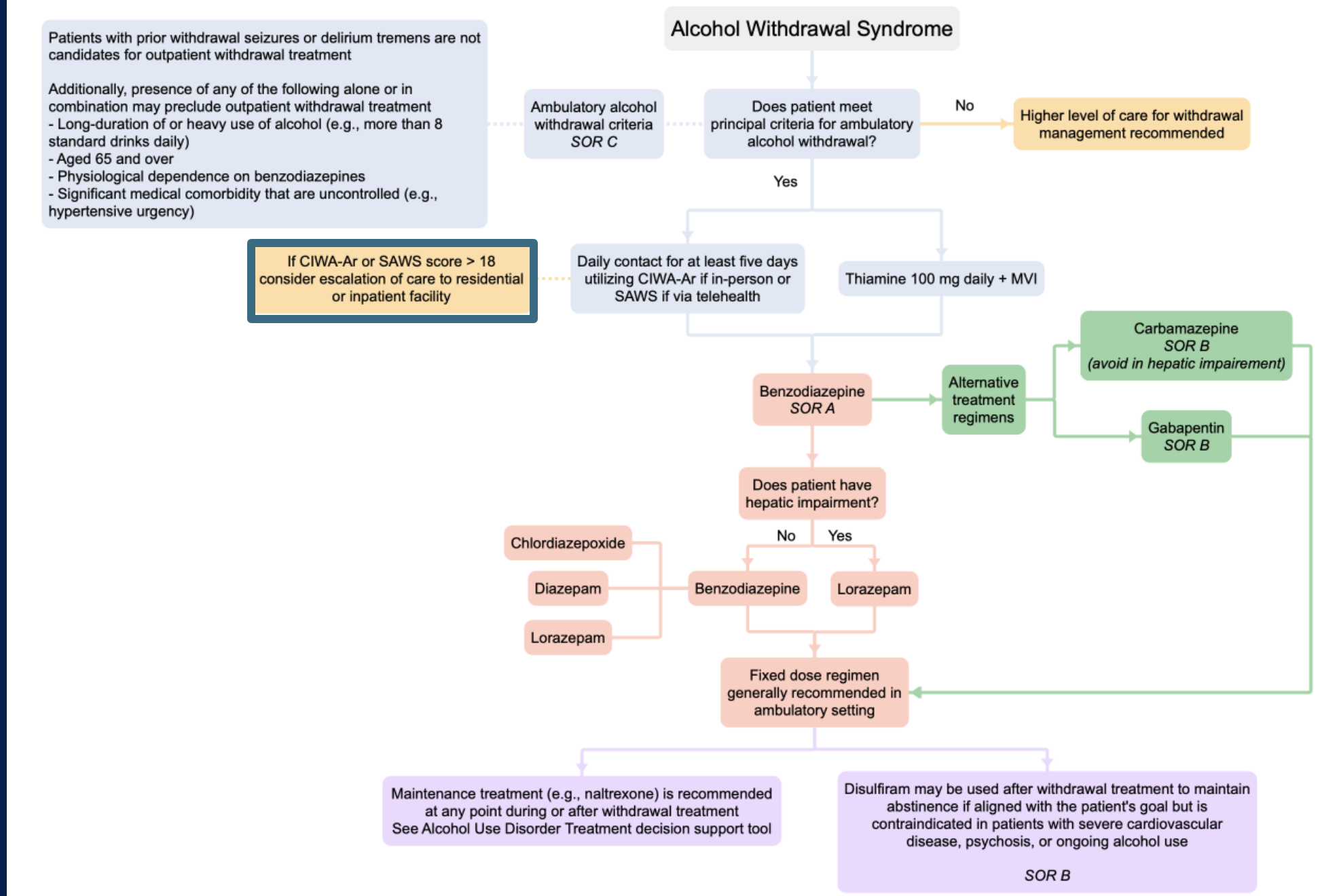
MGH *VISITING*

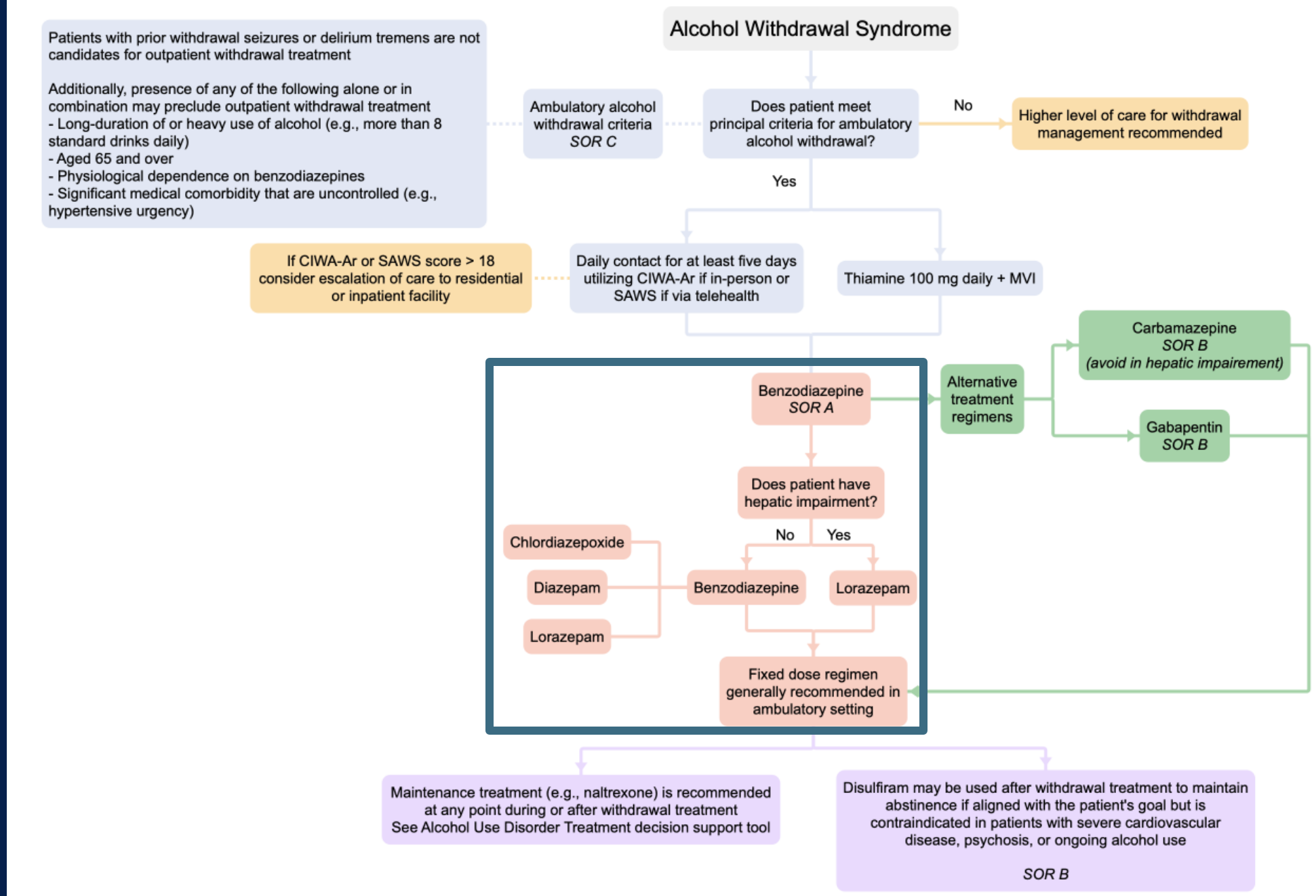
WACO FAMILY MEDICINE

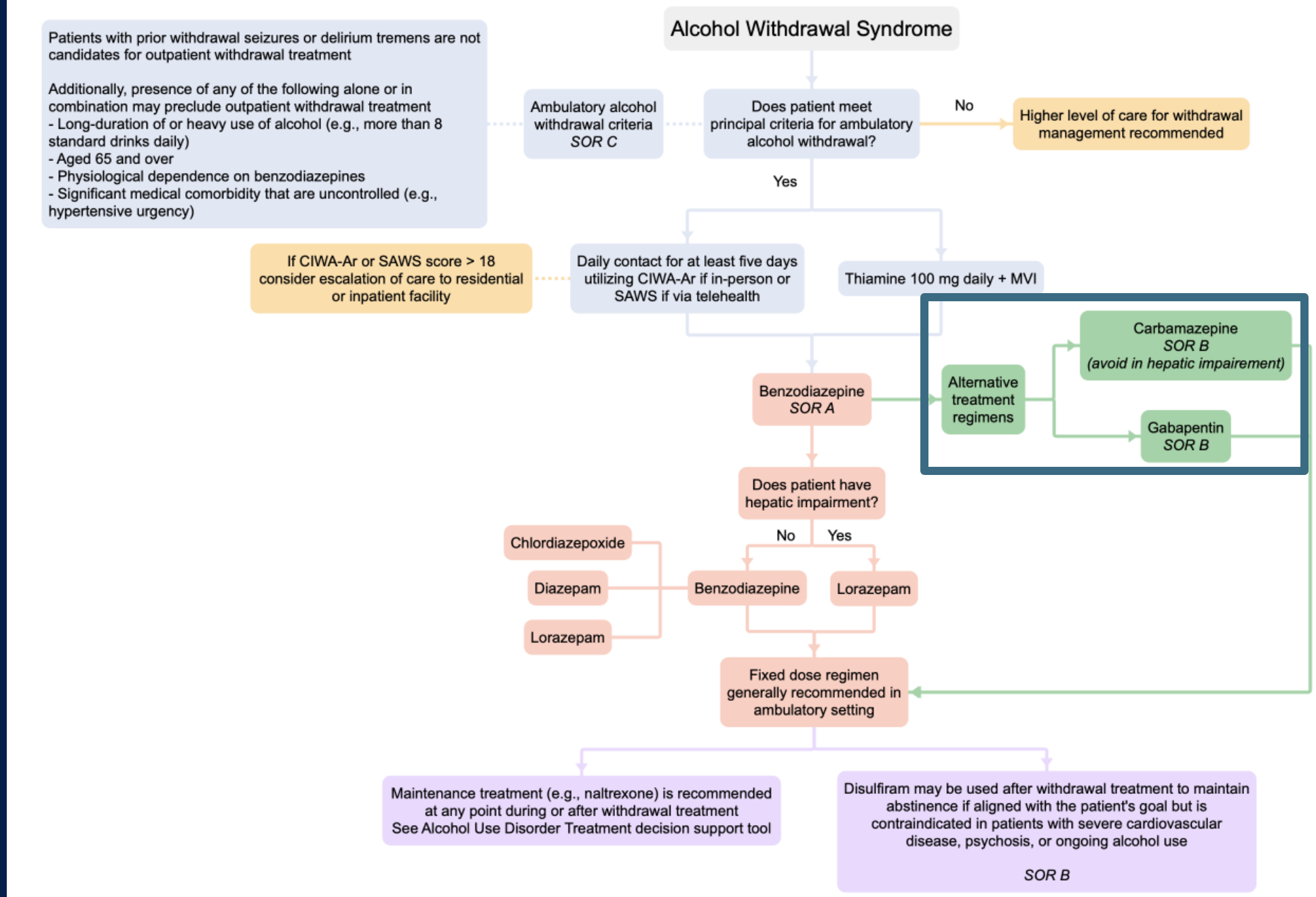
AMERICAN SOCIETY OF ADDICTION MEDICINE
FOUNDED 1954
ASAM

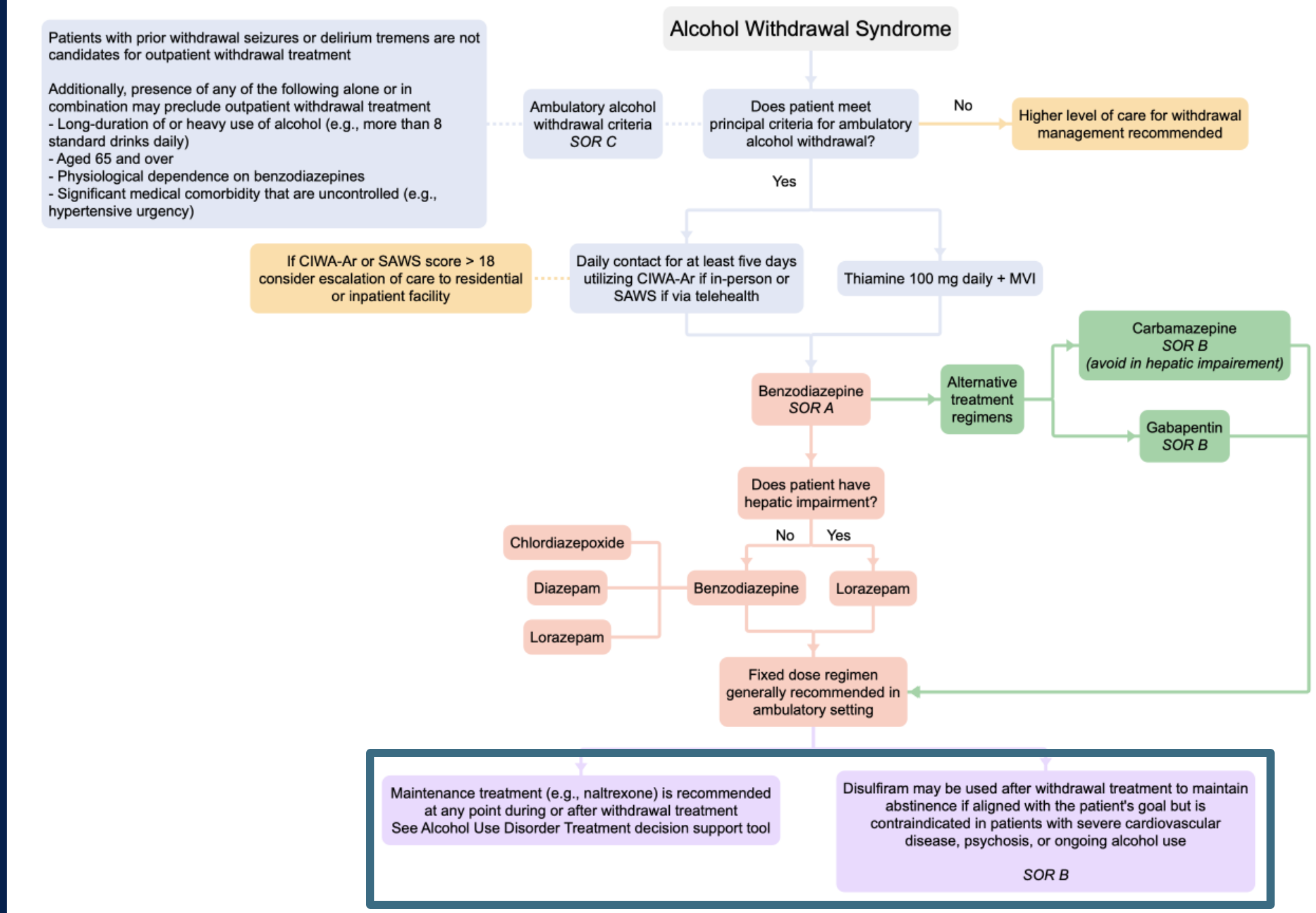

Patients with prior withdrawal seizures or delirium tremens are not candidates for outpatient withdrawal treatment
Additionally, presence of any of the following alone or in combination may preclude outpatient withdrawal treatment
- Long-duration of or heavy use of alcohol (e.g., more than 8 standard drinks daily)
- Aged 65 and over
- Physiological dependence on benzodiazepines
- Significant medical comorbidity that are uncontrolled (e.g., hypertensive urgency)
Alcohol Withdrawal Syndrome
Ambulatory alcohol withdrawal criteria SOR C
Does patient meet principal criteria for ambulatory alcohol withdrawal?
No
Higher level of care for withdrawal management recommended
Yes
If CIWA-Ar or SAWS score > 18 consider escalation of care to residential or inpatient facility
Daily contact for at least five days utilizing CIWA-Ar if in-person or SAWS if via telehealth
Thiamine 100 mg daily + MVI
Benzodiazepine SOR A
Alternative treatment regimens
Carbamazepine SOR B (avoid in hepatic impairement)
Gabapentin SOR B
Does patient have hepatic impairment?
No
Yes
Chlordiazepoxide
Diazepam
Lorazepam
Benzodiazepine
Lorazepam
Fixed dose regimen generally recommended in ambulatory setting
Maintenance treatment (e.g., naltrexone) is recommended at any point during or after withdrawal treatment
See Alcohol Use Disorder Treatment decision support tool
Disulfiram may be used after withdrawal treatment to maintain abstinence if aligned with the patient's goal but is contraindicated in patients with severe cardiovascular disease, psychosis, or ongoing alcohol use
SOR B


Alcohol Withdrawal Syndrome
Patients with prior withdrawal seizures or delirium tremens are not candidates for outpatient withdrawal treatment
Additionally, presence of any of the following alone or in combination may preclude outpatient withdrawal treatment
- Long-duration of or heavy use of alcohol (e.g., more than 8 standard drinks daily)
- Aged 65 and over
- Physiological dependence on benzodiazepines
- Significant medical comorbidity that are uncontrolled (e.g., hypertensive urgency)
Ambulatory alcohol withdrawal criteria SOR C
Does patient meet principal criteria for ambulatory alcohol withdrawal?
No
Higher level of care for withdrawal management recommended
Yes
If CIWA-Ar or SAWS score > 18 consider escalation of care to residential or inpatient facility
Daily contact for at least five days utilizing CIWA-Ar if in-person or SAWS if via telehealth
Thiamine 100 mg daily + MVI
Benzodiazepine SOR A
Alternative treatment regimens
Carbamazepine SOR B (avoid in hepatic impairement)
Gabapentin SOR B
Does patient have hepatic impairment?
No
Yes
Chlordiazepoxide
Diazepam
Lorazepam
Benzodiazepine
Lorazepam
Fixed dose regimen generally recommended in ambulatory setting
Maintenance treatment (e.g., naltrexone) is recommended at any point during or after withdrawal treatment
See Alcohol Use Disorder Treatment decision support tool
Disulfiram may be used after withdrawal treatment to maintain abstinence if aligned with the patient's goal but is contraindicated in patients with severe cardiovascular disease, psychosis, or ongoing alcohol use
SOR B


Alcohol Withdrawal Syndrome
Patients with prior withdrawal seizures or delirium tremens are not candidates for outpatient withdrawal treatment
Additionally, presence of any of the following alone or in combination may preclude outpatient withdrawal treatment
- Long-duration of or heavy use of alcohol (e.g., more than 8 standard drinks daily)
- Aged 65 and over
- Physiological dependence on benzodiazepines
- Significant medical comorbidity that are uncontrolled (e.g., hypertensive urgency)
Ambulatory alcohol withdrawal criteria SOR C
Does patient meet principal criteria for ambulatory alcohol withdrawal?
No
Higher level of care for withdrawal management recommended
Yes
If CIWA-Ar or SAWS score > 18 consider escalation of care to residential or inpatient facility
Daily contact for at least five days utilizing CIWA-Ar if in-person or SAWS if via telehealth
Thiamine 100 mg daily + MVI
Benzodiazepine SOR A
Alternative treatment regimens
Carbamazepine SOR B (avoid in hepatic impairement)
Gabapentin SOR B
Does patient have hepatic impairment?
No
Yes
Chlordiazepoxide
Diazepam
Lorazepam
Benzodiazepine
Lorazepam
Fixed dose regimen generally recommended in ambulatory setting
Maintenance treatment (e.g., naltrexone) is recommended at any point during or after withdrawal treatment
See Alcohol Use Disorder Treatment decision support tool
Disulfiram may be used after withdrawal treatment to maintain abstinence if aligned with the patient's goal but is contraindicated in patients with severe cardiovascular disease, psychosis, or ongoing alcohol use
SOR B


Alcohol Withdrawal Syndrome
Patients with prior withdrawal seizures or delirium tremens are not candidates for outpatient withdrawal treatment
Additionally, presence of any of the following alone or in combination may preclude outpatient withdrawal treatment
- Long-duration of or heavy use of alcohol (e.g., more than 8 standard drinks daily)
- Aged 65 and over
- Physiological dependence on benzodiazepines
- Significant medical comorbidity that are uncontrolled (e.g., hypertensive urgency)
Ambulatory alcohol withdrawal criteria SOR C
Does patient meet principal criteria for ambulatory alcohol withdrawal?
No
Higher level of care for withdrawal management recommended
Yes
If CIWA-Ar or SAWS score > 18 consider escalation of care to residential or inpatient facility
Daily contact for at least five days utilizing CIWA-Ar if in-person or SAWS if via telehealth
Thiamine 100 mg daily + MVI
Benzodiazepine SOR A
Alternative treatment regimens
Carbamazepine SOR B (avoid in hepatic impairement)
Gabapentin SOR B
Does patient have hepatic impairment?
No
Yes
Chlordiazepoxide
Diazepam
Lorazepam
Benzodiazepine
Lorazepam
Fixed dose regimen generally recommended in ambulatory setting
Maintenance treatment (e.g., naltrexone) is recommended at any point during or after withdrawal treatment
See Alcohol Use Disorder Treatment decision support tool
Disulfiram may be used after withdrawal treatment to maintain abstinence if aligned with the patient's goal but is contraindicated in patients with severe cardiovascular disease, psychosis, or ongoing alcohol use
SOR B


Alcohol Withdrawal Syndrome
Patients with prior withdrawal seizures or delirium tremens are not candidates for outpatient withdrawal treatment
Additionally, presence of any of the following alone or in combination may preclude outpatient withdrawal treatment
- Long-duration of or heavy use of alcohol (e.g., more than 8 standard drinks daily)
- Aged 65 and over
- Physiological dependence on benzodiazepines
- Significant medical comorbidity that are uncontrolled (e.g., hypertensive urgency)
Ambulatory alcohol withdrawal criteria SOR C
Does patient meet principal criteria for ambulatory alcohol withdrawal?
No
Higher level of care for withdrawal management recommended
Yes
If CIWA-Ar or SAWS score > 18 consider escalation of care to residential or inpatient facility
Daily contact for at least five days utilizing CIWA-Ar if in-person or SAWS if via telehealth
Thiamine 100 mg daily + MVI
Benzodiazepine SOR A
Alternative treatment regimens
Carbamazepine SOR B (avoid in hepatic impairement)
Gabapentin SOR B
Does patient have hepatic impairment?
No
Yes
Chlordiazepoxide
Diazepam
Lorazepam
Benzodiazepine
Lorazepam
Fixed dose regimen generally recommended in ambulatory setting
Maintenance treatment (e.g., naltrexone) is recommended at any point during or after withdrawal treatment
See Alcohol Use Disorder Treatment decision support tool
Disulfiram may be used after withdrawal treatment to maintain abstinence if aligned with the patient's goal but is contraindicated in patients with severe cardiovascular disease, psychosis, or ongoing alcohol use
SOR B


Alcohol Withdrawal Syndrome
Patients with prior withdrawal seizures or delirium tremens are not candidates for outpatient withdrawal treatment
Additionally, presence of any of the following alone or in combination may preclude outpatient withdrawal treatment
- Long-duration of or heavy use of alcohol (e.g., more than 8 standard drinks daily)
- Aged 65 and over
- Physiological dependence on benzodiazepines
- Significant medical comorbidity that are uncontrolled (e.g., hypertensive urgency)
Ambulatory alcohol withdrawal criteria SOR C
Does patient meet principal criteria for ambulatory alcohol withdrawal?
No
Higher level of care for withdrawal management recommended
Yes
If CIWA-Ar or SAWS score > 18 consider escalation of care to residential or inpatient facility
Daily contact for at least five days utilizing CIWA-Ar if in-person or SAWS if via telehealth
Thiamine 100 mg daily + MVI
Benzodiazepine SOR A
Alternative treatment regimens
Carbamazepine SOR B (avoid in hepatic impairement)
Gabapentin SOR B
Does patient have hepatic impairment?
No
Yes
Chlordiazepoxide
Diazepam
Lorazepam
Benzodiazepine
Lorazepam
Fixed dose regimen generally recommended in ambulatory setting
Maintenance treatment (e.g., naltrexone) is recommended at any point during or after withdrawal treatment
See Alcohol Use Disorder Treatment decision support tool
Disulfiram may be used after withdrawal treatment to maintain abstinence if aligned with the patient's goal but is contraindicated in patients with severe cardiovascular disease, psychosis, or ongoing alcohol use
SOR B

MEDICATIONS

Aldehyde Dehydrogenase Inhibitor

- **Disulfiram** *Aldehyde Dehydrogenase Inhibitor*

Anticonvulsants

- **Topiramate** *Anticonvulsants*

Benzodiazepines

- **chlordiazePOXIDE** *Benzodiazepines*
- **Diazepam** *Benzodiazepines*
- **LORazepam** *Benzodiazepines*
- **Oxazepam** *Benzodiazepines*

GABA Analog

- **Gabapentin (Alcohol Withdrawal Syndrome)** *GABA Analog*
- **Gabapentin (AUD)** *GABA Analog*

Glutamate Multi-Modal

- **Acamprosate** *Glutamate Multi-Modal*

Mood Stabilizers

- **carBAMazepine** *Mood Stabilizers*

Spinal Nerve Conduction Inhibitor

- **Baclofen** *Spinal Nerve Conduction Inhibitor*

mu-Opioid Receptor Antagonist

- **Naltrexone** *mu-Opioid Receptor Antagonist*

Fixed-Dose Regimens with Side Effect and Additional Information

chlordiazePOXIDE *Benzodiazepines*

Class: Benzodiazepines

Brands: Librium

Fixed-Dose Regimen:
Day 1- 50 mg every 6-12 hours
Day 2- 25 mg every 8 hours
Day 3- 25 mg every 12 hours
Day 4 -25 mg nightly
Day 5 -25 mg nightly
Do not use if comorbid hepatic impairment is present

Side effects (common):
Somnolence, ataxia

Side effects (rare/serious):
Anterograde amnesia, paradoxical reaction, increased fall risk, respiratory depression

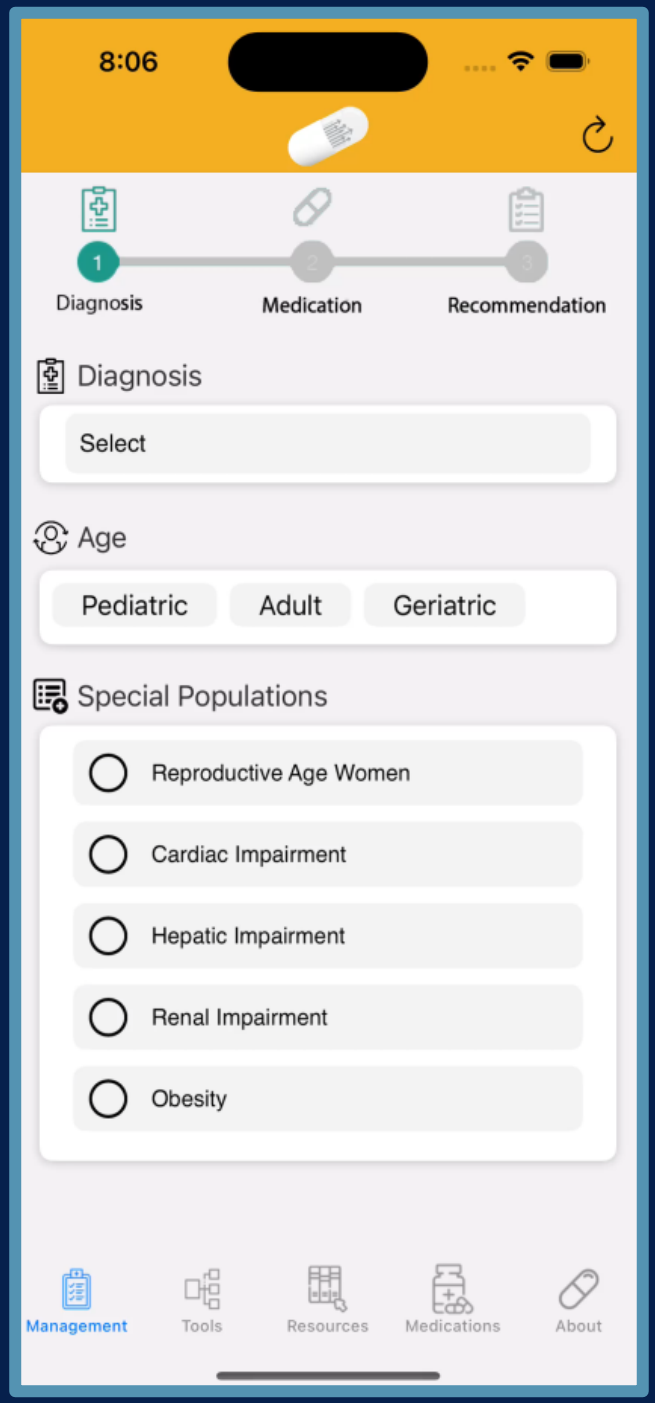
Monitor:
No specific recommendation.

Additional Info:
FDA has issued a Drug Safety Communication requiring an update to the Benzodiazepine Box Warning to include the risks of abuse, misuse, addiction, physical dependence, and withdrawal reactions in order to help improve their safe use.

FDA box warning- Risks from concomitant use with opioids.

https://medlineplus.gov/druginfo/meds/a682078.html

Waco Guide iOS App Demonstration



A 45-year-old male who drinks 12 standard drinks daily has no history of DTs and lives alone but has friends nearby. Which of the following could be part of his treatment plan?

Diazepam for AWS 0%

Naltrexone for MAUD 0%

Treatment receipt at either a Level 1.7 or Level 2.7 facility 0%

Brief CBT 0%

A and C plus B or D if desired/needed 0%

Team-Based Care

Principles of Team-Based Health Care

Shared goals: The team—including the patient and, where appropriate, family members or other support persons—works to establish shared goals that reflect patient and family priorities, and can be clearly articulated, understood, and supported by all team members.

Clear roles: There are clear expectations for each team member's functions, responsibilities, and accountabilities, which optimize the team's efficiency and often make it possible for the team to take advantage of division of labor, thereby accomplishing more than the sum of its parts.

Mutual trust: Team members earn each others' trust, creating strong norms of reciprocity and greater opportunities for shared achievement.

Effective communication: The team prioritizes and continuously refines its communication skills. It has consistent channels for candid and complete communication, which are accessed and used by all team members across all settings.

Measurable processes and outcomes: The team agrees on and implements reliable and timely feedback on successes and failures in both the functioning of the team and achievement of the team's goals. These are used to track and improve performance immediately and over time.

Mitchell et al. Core Principles & Values of Effective Team-Based Care. NASEM. 2012.

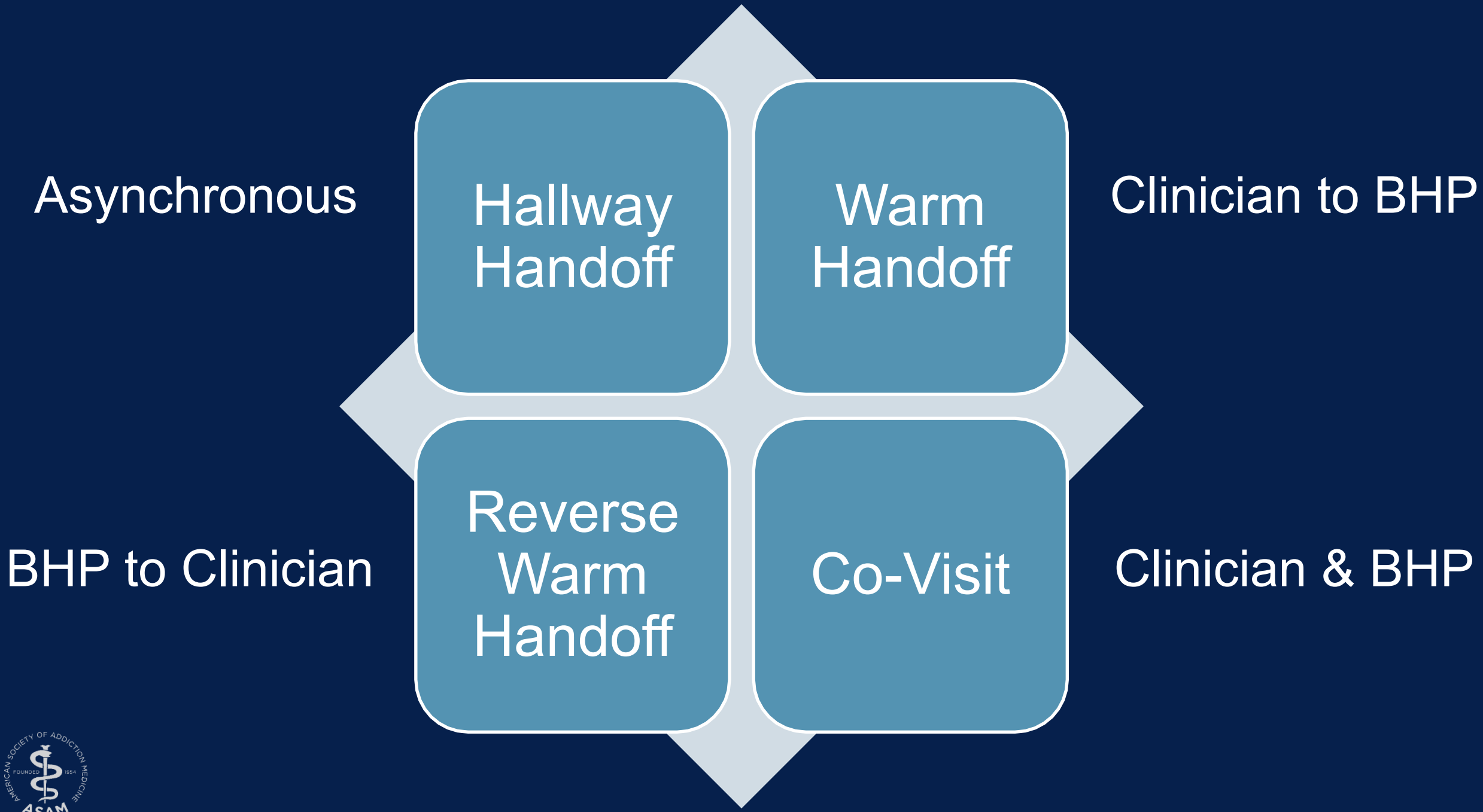
Procedural Best Practices: Intakes

- Direct referral process to prioritize fast access
- Day before appointment: chart review for screening needs (hepatitis, HIV, IPV) or paperwork needs
- Intake appointment: completion of new paperwork, complete CIWA-Ar or SAWS, complete other screening instruments
- Arrange follow-up plan before departure and provide direct contact information

Procedural Best Practices: Follow-ups

- Maintain a list/registry for tracking follow-up
- Find out what modalities for visits work best for your patients (e.g., phone visits after missed in-person appointment)
- Adapt or abandon parts of the follow-up plan based on changing circumstances

Behavioral Interventions


Asynchronous
Hallway Handoff
Warm Handoff
Clinician to BHP
BHP to Clinician
Reverse Warm Handoff
Co-Visit
Clinician & BHP

Brief Behavioral Interventions

Motivational interviewing	• Elicit and enhance behavioral change
Acceptance and Commitment Therapy	• Increase psychological flexibility
Cognitive Behavioral Therapy	• Change unhelpful thinking and behavioral patterns
Solution-Focused Therapy	• Identify and incorporate helpful coping mechanisms
CBT-I	• Co-morbid onset or maintenance insomnia

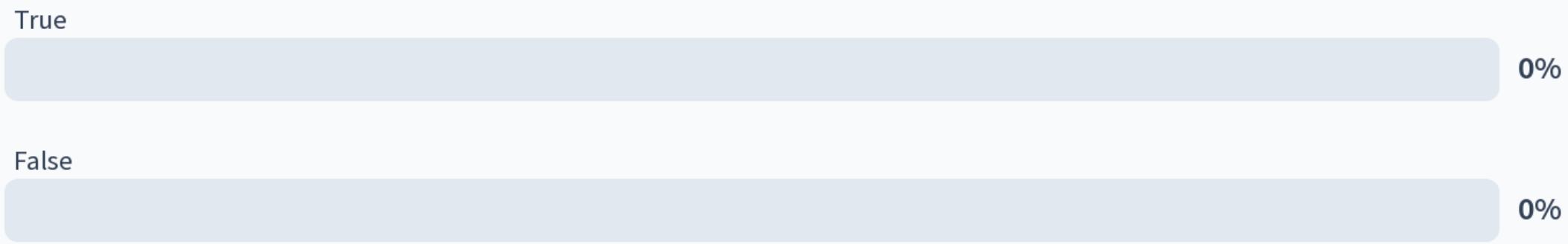
Behavioral Interventions are NOT required for treatment

Other interventions such as

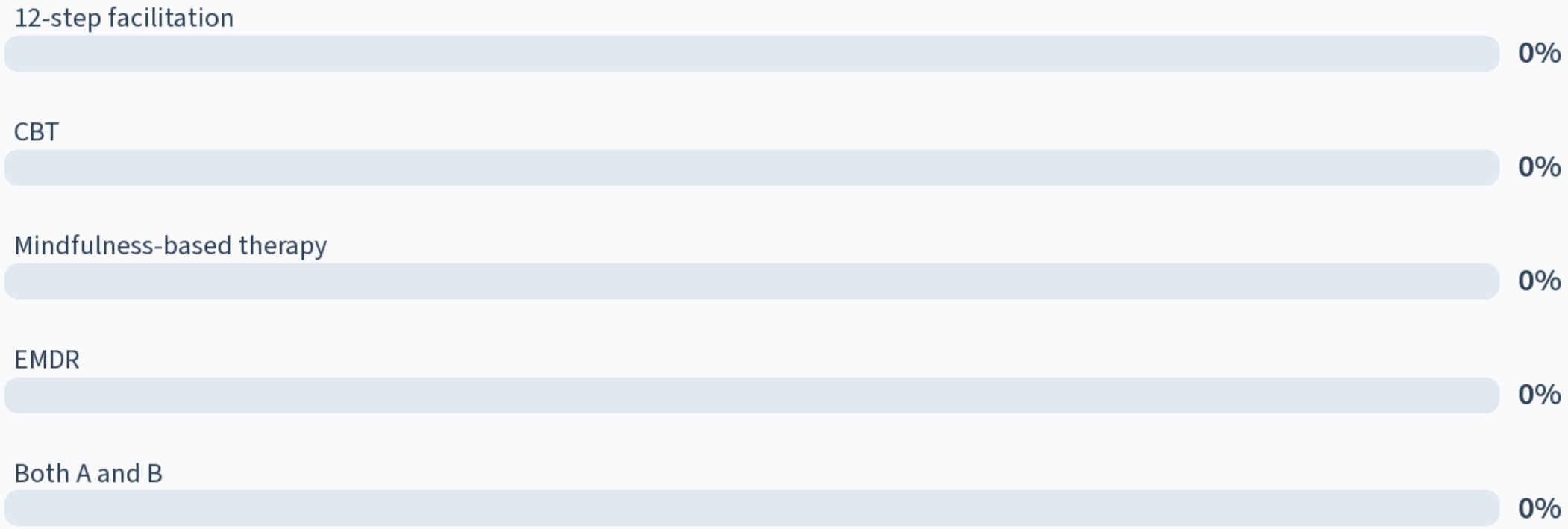
peer support

may be effective if available

True or False: A patient's stage of change is often static during withdrawal treatment.



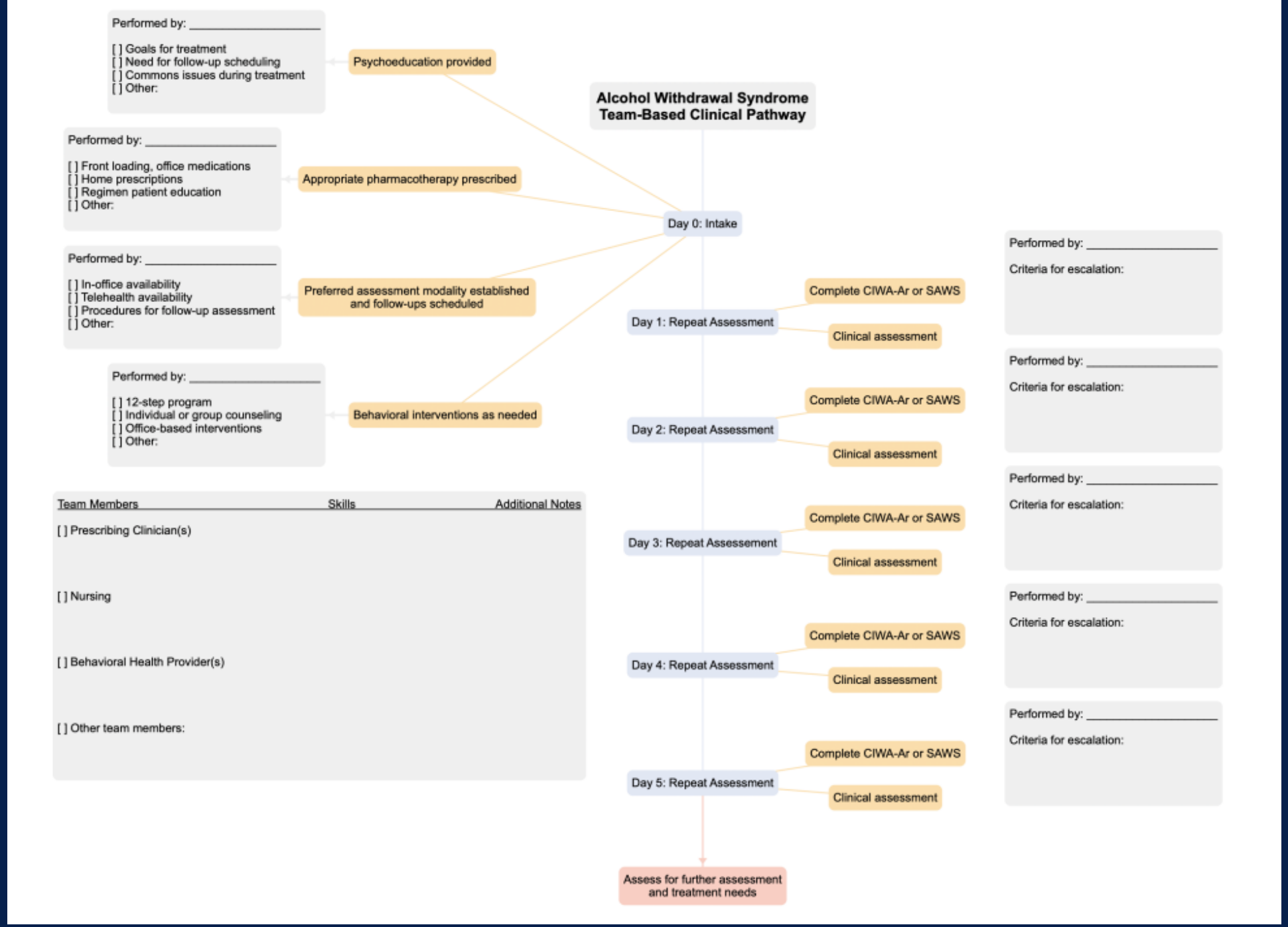
Which of the following behavioral interventions have the strongest empirical support for the treatment of AUD?



Learning Objectives

Upon completion of this focus session, learners will be able to:

- Evaluate evidence for outpatient alcohol withdrawal management.
- Synthesize a multidisciplinary approach to managing alcohol withdrawal by incorporating holistic treatment strategies and fostering interprofessional collaboration.
- **Create clinical protocols for outpatient alcohol withdrawal treatment for their specific patient population.**


Alcohol Withdrawal Syndrome
Team-Based Clinical Pathway
Day 0: Intake
Psychoeducation provided
Performed by: _____
[ ] Goals for treatment
[ ] Need for follow-up scheduling
[ ] Commons issues during treatment
[ ] Other:
Appropriate pharmacotherapy prescribed
Performed by: _____
[ ] Front loading, office medications
[ ] Home prescriptions
[ ] Regimen patient education
[ ] Other:
Preferred assessment modality established and follow-ups scheduled
Performed by: _____
[ ] In-office availability
[ ] Telehealth availability
[ ] Procedures for follow-up assessment
[ ] Other:
Behavioral interventions as needed
Performed by: _____
[ ] 12-step program
[ ] Individual or group counseling
[ ] Office-based interventions
[ ] Other:
Team Members
Skills
Additional Notes
[ ] Prescribing Clinician(s)
[ ] Nursing
[ ] Behavioral Health Provider(s)
[ ] Other team members:
Day 1: Repeat Assessment
Complete CIWA-Ar or SAWS
Clinical assessment
Performed by: _____
Criteria for escalation:
Day 2: Repeat Assessment
Complete CIWA-Ar or SAWS
Clinical assessment
Performed by: _____
Criteria for escalation:
Day 3: Repeat Assessement
Complete CIWA-Ar or SAWS
Clinical assessment
Performed by: _____
Criteria for escalation:
Day 4: Repeat Assessment
Complete CIWA-Ar or SAWS
Clinical assessment
Performed by: _____
Criteria for escalation:
Day 5: Repeat Assessment
Complete CIWA-Ar or SAWS
Clinical assessment
Performed by: _____
Criteria for escalation:
Assess for further assessment and treatment needs

Take **5 minutes** to sketch out a team-based clinical pathway for your context

Alcohol Withdrawal Syndrome Team-Based Clinical Pathway

Performed by: Clinician, M.Esparza

[M] Goals for treatment
[M] Need for follow-up scheduling
[M] Commons issues during treatment
[ ] Other:

Psychoeducation provided

Performed by: Clinician, M.Esparza

[ ] Front loading, office medications
[M] Home prescriptions
[M] Regimen patient education
[ ] Other:

Appropriate pharmacotherapy prescribed

Performed by: M.Esparza

[M] In-office availability
[M] Telehealth availability
[M] Procedures for follow-up assessment
[M] Other: complete treatment plan

Preferred assessment modality established and follow-ups scheduled

Performed by: N.Fjellanger

[M] 12-step program
[ ] Individual or group counseling
[M] Office-based interventions
[ ] Other:

Behavioral interventions as needed

Day 0: Intake

Day 1: Repeat Assessment
- Complete CIWA-Ar or SAWS
- Clinical assessment

Performed by: M.Esparza

Criteria for escalation:
severity scale moderate to severe
over-sedation
questions regarding regimen
(send via EHR message to clinician)

Day 2: Repeat Assessment
- Complete CIWA-Ar or SAWS
- Clinical assessment

Performed by: Clinician

Criteria for escalation:
change enhancement, behavioral needs, follow-up schedule changes

Day 3: Repeat Assessement
- Complete CIWA-Ar or SAWS
- Clinical assessment

Performed by: M.Esparza

Criteria for escalation:
severity scale moderate to severe
over-sedation
questions regarding regimen
(send via EHR message to clinician)

Day 4: Repeat Assessment
- Complete CIWA-Ar or SAWS
- Clinical assessment

Performed by: M.Esparza

Criteria for escalation:
severity scale moderate to severe
over-sedation
questions regarding regimen
(send via EHR message to clinician)

Day 5: Repeat Assessment
- Complete CIWA-Ar or SAWS
- Clinical assessment

Performed by: N.Fjellanger

Criteria for escalation:
severity scale moderate to severe
questions regarding regimen
(send via EHR message to clinician)
other medical concerns

Assess for further assessment and treatment needs

Team Members	Skills	Additional Notes
[ ] Prescribing Clinician(s)		
Zachary Sartor	addiction medicine physician, systems thinking	
Ryan Laschober	medical eduction, MI champion	
[ ] Nursing		
Melissa Esparza	problem-solving, clear communication	
[ ] Behavioral Health Provider(s)		
Natalie Fjellanger	SFT, brief CBT, CBT-I, MI	
[ ] Other team members:		

Alcohol Withdrawal Treatment Plan

Name: _____ DOB: _____

Clinic Contact: _____

My treatment goals:

Day 1

Date: _____

Medication	
Behavioral Support	
Appointment Time	

Day 2

Date: _____

Medication	
Behavioral Support	
Appointment Time	

Final Takeaways

- AWS treatment in outpatient setting is safe and effective
- Fixed-dose benzodiazepines are the most parsimonious treatment regimens for most outpatient clinical settings
- Utilize daily assessments during AWS treatment
- Develop a team-based clinical pathway that leverages extant resources

References

1. SAMHSA, Center for Behavioral Health Statistics and Quality. 2023 National Survey on Drug Use and Health.
2. Alvanzo, A., Kleinschmidt, K., & Kmiec, J. A. (2020). The ASAM clinical practice guideline on alcohol withdrawal management. J Addict Med, 14(3S Suppl 1), 1-72.
3. Miller, S. (2018). The ASAM principles of addiction medicine. Lippincott Williams & Wilkins.
4. The ASAM Criteria. 4th ed.
5. Laschober RD, Kelley LP, Sartor ZR, Johnson S, Griggs JO. Waco Guide to Psychopharmacology in Primary Care. https://wacoguide.org/