VI. Statement Rating Table

Identification and Diagnosis

Statements: Identification and Diagnosis	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
1. To diagnose alcohol withdrawal, use a diagnostic criteria such as the DSM-5 diagnostic criteria.	9			
2. To diagnose alcohol use disorder, use diagnostic criteria such as those provided by the DSM-5.	9	x	x	x
3. If a patient is known to be using alcohol recently, regularly, and heavily, clinicians should assess for the risk of alcohol withdrawal even in the absence of symptoms.	9			
4. Universal screening for at-risk alcohol use should be incorporated into medical settings to help identify patients at risk of alcohol use disorders and alcohol withdrawal.	9	x	x	x
5. If a patient has symptoms suggestive of alcohol withdrawal, clinicians should assess the quantity, frequency, and time of day when alcohol is consumed to determine whether the patient could be experiencing alcohol withdrawal.	9			
6. To assess the quantity and frequency of the patient's alcohol use to assist with diagnosis of alcohol withdrawal, tools that screen for unhealthy alcohol use can be helpful.	8.5		Moderate	
7. To assess the quantity, frequency and time of day when alcohol is consumed to assist with diagnosis of alcohol withdrawal, collateral information (i.e. from family and friends) can be helpful.	9		Moderate	
8. For patients who are unable to communicate or otherwise unable to give a history, blood tests, breath tests, and urine tests may help the clinician assess the quantity and frequency of the patient's alcohol use.	7.5		Moderate	
9. To assess a patient's recent heavy use of alcohol to assist with diagnosis of alcohol withdrawal, a laboratory test that provides some measure of hepatic function can be helpful.	8		Moderate	
10. Negative biological tests for alcohol use do not exclude the presence or risk of developing alcohol withdrawal.	9			
11. Clinicians should understand that the CIWA-Ar is not a diagnostic instrument.	9		Moderate	
12. Clinicians should be aware that other serious illnesses can mimic the signs and symptoms of alcohol withdrawal.	9			
13. Clinicians should be aware that the effects of certain medications can mimic the signs of alcohol withdrawal while others can mask them.	9		Moderate	
14. Differential diagnosis of alcohol withdrawal is dependent on the patient’s signs and symptoms.	9			
15. Differential diagnosis of alcohol withdrawal is dependent on the patient's history.	9	x	x	x
16. Clinicians should be aware that a patient with a high blood alcohol level (e.g., 100-200 mg/DL) can be experiencing alcohol withdrawal.	9			
17. The presence of alcohol withdrawal does not exclude co-existing disease, co-occurring substance use disorder, or simultaneous withdrawal from other substances.	9	x	x	x

18. Do not rule in or out a co-occurring disease, co-occurring mental health disorder, co-occurring substance use disorder, or simultaneous withdrawal from other substances even in the presence of alcohol withdrawal.	8.5			
19. For patients experiencing new onset seizures or for patients with a known history of alcohol withdrawal seizures showing a new pattern, an EEG and/or neuroimaging is recommended	7	x	x	x
20. For patients with a known history of alcohol withdrawal seizure who present with a seizure that can be attributed withdrawal, additional neurological testing may not be necessary.	8	x	x	x
21. For patients with a known history of alcohol withdrawal seizure who present with a seizure that can be attributed to withdrawal, a neurology consult may not be necessary.	7.5	x	x	x
22. If a patient has a known history of withdrawal seizures, and the current seizure can be attributed to withdrawal, a full evaluation and additional testing may not be necessary. This includes if the seizure was generalized and without focal elements, if a careful neurological examination reveals no evidence of focal deficits, if there is no suspicion of meningitis and if there is no history of recent head trauma a. stroke	7.5	x	x	x
b. Transient ischemic attack (TIA)	7.8	x	x	x
c. Cerebrovascular accident (CVA)	8	x	x	x
23. Whenever possible in non-emergent situations, obtain consent or a release of information from the patient before: a. speaking to collaterals (e.g., family, friends, caretakers)	8	x	x	x
b. consulting with other health professionals currently caring for a patient	8	x	x	x

Initial Assessment

Statements: Initial Assessment	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
24. The ASSIST can be helpful for characterizing a patient's drug or alcohol use.	9			
25. Measuring BAC with a breathalyzer can be helpful for detecting a patient's recent alcohol use.	9			
26. Conducting urine drug screens can be helpful for detecting a patient's drug or alcohol use.	9			
27. Treatment of a patient with alcohol withdrawal should not be impeded if clinicians don't have breathalyzers or drug tests available.	9			
28. Treatment of a patient with alcohol withdrawal should not be delayed because clinicians are waiting for drug test results.	9			
29. When practical, obtain a complete blood count with differential, blood glucose, calcium, magnesium, phosphorous, anion gap, and renal and hepatic function tests.	7		Moderate	
30. Initial laboratory screening may include testing for viral hepatitis, HIV testing with permission, pregnancy testing and a tuberculin skin test.	8			
31. Treatment of a patient with alcohol withdrawal should not be impeded if clinicians don't have laboratory tests available.	9			

Statements: Initial Assessment	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
32. Treatment of a patient with alcohol withdrawal should not be delayed because clinicians are waiting for laboratory test results.	9			
33. The PHQ-9 can be helpful for identifying a possible psychiatric illness.	7.5			
34. The GAD can be helpful for identifying a possible psychiatric illness	8			
35. Clinicians should measure the severity of alcohol withdrawal symptoms with a validated instrument such as the CIWA-Ar.	8.5		Moderate	
36. A validated instrument should be used to assess the severity of alcohol withdrawal. The Richmond Agitation-Sedation scale (RASS) can be helpful.	5	x	x	x
37. For patients who are able to monitor and score their own symptoms, the SAWS, a validated instrument designed for self-administration, may be used.	7		Moderate	
38. Clinically, the most important information for clinicians to know is whether the patient will develop potentially life-threatening symptoms.	8			
39. Symptoms may indicate risk, but they are not the sole indication.	8			
40. To assess patients for risk of complicated withdrawal, clinicians should use the results of an existing tool combined with an assessment of individual risk factors.	8			
41. Clinicians can determine risk of complicated withdrawal by interviewing family members about the patient's history of alcohol withdrawal, seizures, and delirium.	7		Moderate	
42. One common error when using a withdrawal risk assessment tool is to assess the patient who is clinically intoxicated, which may result in a high withdrawal score and thus lead to treatment of an already intoxicated individual with benzodiazepines.	6*		Moderate	
43. The CIWA-Ar should only be used to measure withdrawal symptoms and indicate risk of complicated withdrawal once the patient has been diagnosed with or is assumed to have alcohol withdrawal.	7.5			
44. Although a high score can indicate high risk, the CIWA-Ar should not be the only information used to predict a patient's risk of complicated withdrawal.	8		High	
45. There are a variety of recommendations about the use of CIWA-Ar score to indicate risk of complicated withdrawal. In general, patients with CIWA-Ar scores greater than 15-19 may be considered at risk of complicated withdrawal.	8		Moderate	
46. There are a variety of recommendations about the use of CIWA-Ar scores to indicate risk of complicated withdrawal. In general, patients with CIWA-Ar scores lower than 8-10 may be considered at low risk of complicated withdrawal.	6*		Low	
47. If the score on the CIWA-Ar is low over the first 24 hours without need for or administration of cross-tolerant medications, there is little or no risk of severe withdrawal subsequently.	6.5*		Low	
48. Clinicians can consider the use of a tool to determine patient risk for alcohol withdrawal such as the ASAM Risk Matrix.	8		Low	

Statements: Initial Assessment	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
49. Among hospitalized patients, the PAWSS can be a helpful tool to assess for the risk of alcohol withdrawal in the absence of signs and symptoms of alcohol withdrawal.	8			Moderate
50. Among hospitalized patients, the AUDIT-PC can be a helpful tool to assess for the risk of alcohol withdrawal in the absence of signs and symptoms of alcohol withdrawal.	7			Low
51. Among hospitalized patients, the LARS (Luebeck Alcohol-withdrawal Risk Scale) can be a helpful tool to assess for the risk of alcohol withdrawal.	7	x	x	x
52. Among hospitalized patients, the Newcastle AWS scale can be a helpful tool to assess for the risk of alcohol withdrawal.	7			Low
53. Among hospitalized patients, the Fast Alcohol Screening Test (FAST) can be a helpful tool to assess for the risk of alcohol withdrawal.	6*			Low
54. Some withdrawal risk assessment scales (e.g. the LARS) rely more on objective signs of withdrawal (autonomic activity) and history that may be found in a patient's chart. Consider the use of these scales if the patient cannot communicate and therefore cannot complete a CIWA-Ar.	8			
55. Existing scales that rely more on objective signs of withdrawal (autonomic activity) and are appropriate to use include a. Richmond Agitation-Sedation scale (RASS)	7.5	x	x	x
b. Newcastle AWS (has pulse, temp, RR)	6.5	x	x	x
56. Clinicians should seek information about the time elapsed since the patient's last alcohol use because knowledge of the timeline for symptom onset and severity helps predict withdrawal complications. For example, the period of seizure risk is 6-48 hours after the reduction or cessation of alcohol use.	8		Low	
57. The following individual factors may increase a patient's risk for complicated withdrawal or complications of withdrawal: a. Increasing age	7.5	Low	Moderate	
b. Comorbid medical or surgical illness	8.5	Low	Moderate	
c. Past history of delirium or alcohol withdrawal seizure	9	Moderate	Moderate	
d. History of having had withdrawal seizure during this current withdrawal state before the assessment	9	Low		
e. Long duration of heavy alcohol consumption	8	Low	High	
f. Numerous lifetime prior withdrawal episodes	9		Moderate	
g. Marked autonomic hyperactivity on presentation	9		Moderate	
h. Concomitant dependence on CNS depressants such as benzodiazepines or barbiturates	9		Moderate	
i. Physiological dependence on GABAergic agents such as benzodiazepines or barbiturates	8	x	x	x
j. Concomitant use of other licit and illicit substances	7.5		Moderate	
k. Elevated blood alcohol level (100-200 mg/DL) without being clinically intoxicated in the context of a diagnosis of alcohol withdrawal	8	Low	Moderate	
58. The presence of multiple risk factors is associated with higher risk of complicated and/or complications of alcohol withdrawal.	7.5		Low	
59. A strong predictor of an incidence of delirium or seizure is a history of a similar event.	9	Moderate	Moderate	

Statements: Initial Assessment	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
60. A strong predictor of an incidence of delirium or seizure is the number of previous withdrawal episodes a patient has experienced.	8		Moderate	
61. A strong predictor of an incidence of delirium or seizure is the occurrence of a seizure during the current withdrawal episode.	7.5			
62. All patients with alcohol withdrawal should receive a history and physical examination as part of the comprehensive assessment process. Clinicians should conduct this examination themselves or, in accordance with the ASAM Standards, ensure that a current physical examination is contained within the patient medical record.	9		Low	
63. Patients should be screened for common chronic conditions that are associated with alcohol use disorders.	9			
64. Patients should be screened for medical conditions that could affect the course of alcohol withdrawal or treatment of alcohol withdrawal.	9			
65. If recent results are not available in a patient's medical record, clinicians should conduct and/or arrange for the following routine laboratory tests:				
a. Albumin	7.5			
b. Electrolytes (and calculation of the anion gap)	8			
c. INR	7			
d. Phosphorus	7.5			
e. Magnesium	8			
f. Complete blood count (platelets, white blood cell count, hemoglobin)	7			
g. Calcium	7.5			
h. Glucose	8			
i. Renal function (creatinine and BUN)	8		Moderate	
j. Liver function tests (AST, ALT)	9	x	x	x
66. In settings with access to laboratory tests, clinicians should conduct and/or arrange for the follow items to assess patient's electrolytes, liver functioning, renal functioning and immune functioning. In setting with limited access to laboratory testing, clinicians should obtain results when practical to assist with treatment planning decisions. Address any nutritional deficiencies detected.				
a. A comprehensive metabolic profile or basic metabolic profile	8		Moderate	
b. A hepatic panel	8		Moderate	
c. A complete blood count with differential	8		Moderate	
67. Clinicians should carefully probe for polysubstance use, utilizing information from collaterals as well as drug screening tests, and be prepared to treat the other potential withdrawal syndromes.	9		Moderate	
68. Clinicians should consider a review of the patient's mental health history. Mental health professionals caring for the client may also be consulted.	8		Moderate	
69. Clinicians should be cautious when diagnosing a new primary mental health disorder during acute withdrawal, being careful to differentiate between substance-induced disorders and primary psychiatric disorders.	9		Moderate	

Statements: Initial Assessment	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
70. Level of care considerations should be based on the patient's level of risk for developing complicated withdrawal and/or complications of withdrawal and current signs and symptoms.	9			
71. Although a high CIWA-Ar score is an indication that a patient is at high risk for complicated withdrawal, clinicians should be aware that the CIWA-Ar has only been validated for tracking the withdrawal management process and not for making level of care decisions.	8		Low	
72. Patients who are at low risk for severe withdrawal syndrome can be treated in an outpatient setting.	9		Low	
73. Patients with risk factors for severe or complicated withdrawal should be treated in a medical setting with 24-hour nursing care.	9		Low	
74. Patients with a risk of withdrawal from other substances in addition to alcohol should be treated in a medical setting with 24-hour nursing care.	6.5*		High	
75. Patients with current seizures or alcohol withdrawal delirium should be treated in a medical setting with 24-hour nursing care.	9		High	
76. Patients with moderate to severe symptoms of alcohol withdrawal should be treated in a medical setting with 24-hour nursing care.	8			
77. Consider continuous medical supervision for patients with symptoms of at least moderate alcohol withdrawal (i.e., CIWA-Ar score ≥10) and any of the following conditions: a. Recurrent unsuccessful attempts at ambulatory withdrawal management	9			
b. Reasonable likelihood that the patient will not complete ambulatory withdrawal management (e.g., due to low recovery capital)	9			
c. Active psychosis or severe cognitive impairment	9			
d. Medical conditions that could make ambulatory withdrawal management problematic, especially with a lack of medical support system	9		High	
78. Consider continuous medical supervision if the patient has recent high levels of alcohol consumption.	7.5		High	
79. Patients with concurrent medical or psychiatric conditions that indicate a need for inpatient treatment should receive inpatient care.	9			
80. Consider inpatient treatment for patients with concurrent conditions that could complicate management of alcohol withdrawal such as difficulty communicating, inability to tolerate oral medication, or congestive heart failure.	9		High	
81. Patients with a significant other or trusted observer at home may be appropriate for outpatient withdrawal management.	8			
82. Patients who receive outpatient care should be assessed on a daily basis, either by telephone or in person.	8			
83. Patients with low recovery capital or an unsafe environment may benefit from a higher level of care than is otherwise indicated.	9		High	

Statements: Initial Assessment	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
84. For patients with a history of withdrawal seizures, it is a reasonable option to provide one of the recommended medications at the time of presentation, regardless of the severity of withdrawal symptoms. Monitoring the patient and providing symptom-triggered therapy is also a reasonable option.	8	High	Moderate	
85. Benzodiazepines should be first line treatment for preventing the development of alcohol withdrawal symptoms.	9			
86. Benzodiazepines should be first line treatment for preventing an alcohol withdrawal seizure in patients at increased risk for experiencing alcohol withdrawal seizure, usually due to prior history of seizure.	9	x	x	x
87. Benzodiazepines should be first line treatment for preventing alcohol withdrawal delirium in patients at increased risk for experiencing alcohol withdrawal delirium, usually due to prior history of delirium.	8.5	x	x	x

Level of Care Determination

Statement – Level of Care Determination	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
88. Clinicians should be aware that most people with alcohol withdrawal can be safely managed in outpatient settings.	9		High	
89. Potential for misuse and sedation with cross-tolerant medication such as benzodiazepines are generally minor considerations during the relatively short period of supervised withdrawal.	7.5		Moderate	
90. The ASAM Risk Matrix can be helpful for determining the appropriate level of care for patients with alcohol withdrawal	9			
At a Level 1-WM setting, for the average patient with:				
91. Symptoms include mild anxiety, sweating and insomnia, but no tremor (generally associated with a CIWA-Ar <10)	9	x	x	x
92. Symptoms include moderate anxiety, sweating and insomnia, but no tremor (generally associated with a CIWA-Ar <10)	8	x	x	x
93. Symptoms include moderate anxiety, sweating, insomnia, mild tremor (generally associated with a CIWA-Ar 10-18)	5.5	x	x	x
94. Symptoms include severe anxiety and moderate to severe tremor, but not confusion or hallucinations and has not experienced a seizure (generally associated with a CIWA-Ar ≥ 19)	3	x	x	x
95. Is not able to fully comprehend instructions, or has clouding of the sensorium or confusion, or new onset of hallucinations, or has experienced a seizure (generally associated with CIWA-Ar ≥19)	1	x	x	x
96. Has difficulty communicating (not fully coherent or unable to comprehend instructions)	1	x	x	x
97. Has difficulty communicating (due to language or hearing / speech difficulty)	3.5	x	x	x
98. Concurrently withdrawing from other substance(s)	5	x	x	x

Statement – Level of Care Determination	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
99. History of complicated alcohol withdrawal within the past year (e.g., alcohol withdrawal delirium or alcohol withdrawal seizures)	3	x	x	x
100. History of complicated alcohol withdrawal more than one year ago (e.g., alcohol withdrawal delirium or alcohol withdrawal seizures)	4*	x	x	x
101. History of severe alcohol withdrawal symptoms within the past year (generally associated with a CIWA-Ar ≥19)	4.5	x	x	x
102. History of severe alcohol withdrawal symptoms more than one year ago (generally associate with a CIWA-Ar>19)	5	x	x	x
103. Consumes over >8 standard drinks of alcohol per day	5	x	x	x
104. Concurrent dependence on benzodiazepine or benzodiazepine use disorder	3	x	x	x
105. Concurrent dependence on opioids or opioid use disorder	4	x	x	x
106. Medical or psychiatric condition that itself needs inpatient treatment	1	x	x	x
107. Moderate, active, and potentially destabilizing medical problems	2.5	x	x	x
108. Moderate to severe active and potentially destabilizing medical problems	2	x	x	x
109. Unstable chronic conditions such as heart disease, congestive heart failure, coronary artery disease, liver disease, hypertension, hepatic or renal impairment	1.5	x	x	x
110. History of seizures within the past year (not alcohol-withdrawal related)	5	x	x	x
111. History of seizures more than one year ago (not alcohol-withdrawal related)	5	x	x	x
112. History of epilepsy	5*	x	x	x
113. Suspected head injury	2.5	x	x	x
114. Older age (>65 years)	5.5	x	x	x
115. Inability to take oral medications	1	x	x	x
116. Clinically significant abnormal laboratory results, once obtained	4	x	x	x
117. Symptoms of a co-occurring psychiatric disorder are mild, reflecting a low level of severity, or a stable as the result of treatment.	8.5	x	x	x
118. Symptoms of a co-occurring psychiatric disorder are active, reflecting a moderate level of severity that is likely to complicate withdrawal management.	4	x	x	x
119. Symptoms of a co-occurring psychiatric disorder are moderate to severe	2	x	x	x
120. Symptoms of a co-occurring psychiatric disorder are severe	1	x	x	x
121. Mild cognitive impairment	4	x	x	x
122. Moderate cognitive impairment	2.5	x	x	x
123. Severe cognitive impairment	1	x	x	x
124. Absence of a caregiver who can watch a patient frequently for at least 72 hours	5	x	x	x
125. Absence of reliable supports (such as family or friends) who are willing to provide monitoring of symptoms	5	x	x	x
126. Absence of any reliable support network	4	x	x	x
127. Unable to come to the treatment setting on a daily basis	5	x	x	x

Statement – Level of Care Determination	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
128. Unable to obtain transportation and access to safe and appropriate housing	2.5	x	x	x
129. Family or friends are not supportive of or oppose the withdrawal management process and will not assist in providing transportation or a safe place to stay.	3	x	x	x
130. Previous failure to benefit from outpatient alcohol withdrawal treatment	5	x	x	x
131. Does not have a high level of commitment to the withdrawal management process and level of cooperation and reliability are questionable	3	x	x	x
132. Is not cooperative or reliable, to an extent that places him or her at imminent risk of harm	1	x	x	x
133. Likelihood of imminent relapse is high	3	x	x	x
134. Significant risk of imminent relapse	2	x	x	x
At a Level 2-WM setting, for the average patient with:				
135. Symptoms include mild anxiety, sweating and insomnia, but no tremor (generally associated with a CIWA-Ar <10)	8.5	x	x	x
136. Symptoms include moderate anxiety, sweating and insomnia, but no tremor (generally associated with a CIWA-Ar <10)	8.5	x	x	x
137. Symptoms include moderate anxiety, sweating, insomnia, mild tremor (generally associated with a CIWA-Ar 10-18)	8.5	x	x	x
138. Symptoms include severe anxiety and moderate to severe tremor, but not confusion or hallucinations and has not experienced a seizure (generally associated with a CIWA-Ar ≥ 19)	5.5*	x	x	x
139. Is not able to fully comprehend instructions, or has clouding of the sensorium or confusion, or new onset of hallucinations, or has experienced a seizure (generally associated with CIWA-Ar ≥19)	1	x	x	x
140. Has difficulty communicating (not fully coherent or unable to comprehend instructions)	1	x	x	x
141. Has difficulty communicating (due to language or hearing / speech difficulty)	5	x	x	x
142. Concurrently withdrawing from other substance(s)	6	x	x	x
143. History of complicated alcohol withdrawal within the past year (e.g., alcohol withdrawal delirium or alcohol withdrawal seizures)	6*	x	x	x
144. History of complicated alcohol withdrawal more than one year ago (e.g., alcohol withdrawal delirium or alcohol withdrawal seizures)	5*	x	x	x
145. History of severe alcohol withdrawal symptoms within the past year (generally associated with a CIWA-Ar ≥19)	6*	x	x	x
146. History of severe alcohol withdrawal symptoms more than one year ago (generally associate with a CIWA-Ar>19)	7	x	x	x
147. Consumes over >8 standard drinks of alcohol per day	5	x	x	x
148. Concurrent dependence on benzodiazepine or benzodiazepine use disorder	6.5	x	x	x
149. Concurrent dependence on opioids or opioid use disorder	7.5	x	x	x
150. Medical or psychiatric condition that itself needs inpatient treatment	1	x	x	x

Statement – Level of Care Determination	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
151. Moderate, active, and potentially destabilizing medical problems	3.5*	x	x	x
152. Moderate to severe active and potentially destabilizing medical problems	2	x	x	x
153. Unstable chronic conditions such as heart disease, congestive heart failure, coronary artery disease, liver disease, hypertension, hepatic or renal impairment	1.5	x	x	x
154. History of seizures within the past year (not alcohol-withdrawal related)	5	x	x	x
155. History of seizures more than one year ago (not alcohol-withdrawal related)	7*	x	x	x
156. History of epilepsy	7	x	x	x
157. Suspected head injury	3.5	x	x	x
158. Older age (>65 years)	7.5	x	x	x
159. Inability to take oral medications	1	x	x	x
160. Clinically significant abnormal laboratory results, once obtained	5	x	x	x
161. Symptoms of a co-occurring psychiatric disorder are mild, reflecting a low level of severity, or a stable as the result of treatment.	8	x	x	x
162. Symptoms of a co-occurring psychiatric disorder are active, reflecting a moderate level of severity that is likely to complicate withdrawal management.	6.5	x	x	x
163. Symptoms of a co-occurring psychiatric disorder are moderate to severe	4.5	x	x	x
164. Symptoms of a co-occurring psychiatric disorder are severe	2	x	x	x
165. Mild cognitive impairment	5	x	x	x
166. Moderate cognitive impairment	5	x	x	x
167. Severe cognitive impairment	1.5	x	x	x
168. Absence of a caregiver who can watch a patient frequently for at least 72 hours	5.5	x	x	x
169. Absence of reliable supports (such as family or friends) who are willing to provide monitoring of symptoms	5.5	x	x	x
170. Absence of any reliable support network	5	x	x	x
171. Unable to come to the treatment setting on a daily basis	5	x	x	x
172. Unable to obtain transportation and access to safe and appropriate housing	3	x	x	x
173. Family or friends are not supportive of or oppose the withdrawal management process and will not assist in providing transportation or a safe place to stay.	3.5	x	x	x
174. Previous failure to benefit from outpatient alcohol withdrawal treatment	6.5	x	x	x
175. Does not have a high level of commitment to the withdrawal management process and level of cooperation and reliability are questionable	5	x	x	x
176. Is not cooperative or reliable, to an extent that places him or her at imminent risk of harm	1	x	x	x
177. Likelihood of imminent relapse is high	5	x	x	x
178. Significant risk of imminent relapse	5	x	x	x

1

1 Management

2 Monitoring Scales

Statements: Monitoring Scales	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
179. The use of a structured withdrawal symptom assessment scale to monitor symptom severity is recommended.	9	High	High	
180. Some symptom assessment scales (e.g. AST) rely more on objective signs of withdrawal (autonomic activity). Consider the use of these scales if the patient cannot communicate and therefore cannot complete a CIWA-Ar.	8			
181. In patients with acute concomitant medical or psychiatric illness, or concurrent withdrawal from other drugs, these scales should be used with caution because they rate signs and symptoms that may be caused by the other condition and not by the alcohol withdrawal.	8	High		
182. Existing scales that are appropriate to use for assessing and monitoring withdrawal symptoms include: a. CIWA-Ar Clinical Institute Withdrawal Assessment for Alcohol, Revised	9		Low	
b. AST (Anxiety, Sweats, Tremors)	6.5		Low	
c. Brief Alcohol Withdrawal Scale (BAWS)	7		Low	
d. Sweating, Hallucination, Orientation, Tremor (SHOT)	6.5		Low	
e. Severity of Ethanol Withdrawal Scale (SEWS)	6.5		Low	
f. Short Alcohol Withdrawal Scale (SAWS)	6.5		Low	
183. In ambulatory settings, existing scales that are appropriate to use for monitoring withdrawal include: a. Brief Alcohol Withdrawal Scale (BAWS)	8	x	x	x
b. Richmond Agitation-Sedation Scale (RASS)	5	x	x	x
c. Newcastle AWS	7.5	x	x	x
184. In inpatient settings (not hospital/ICU), existing scales that are appropriate to use for monitoring withdrawal include: a. Short Alcohol Withdrawal Scale (SAWS)	6.5	x	x	x
b. Richmond Agitation-Sedation Scale (RASS)	4.5	x	x	x
c. Newcastle AWS	6.5	x	x	x
185. For patients being treating in ICU setting for alcohol withdrawal, existing scales that are appropriate to use for monitoring withdrawal include: a. CIWA-Ar	6	x	x	x
b. Brief Alcohol Withdrawal Scale (BAWS)	6.5	x	x	x
c. Newcastle AWS	5	x	x	x
d. Short Alcohol Withdrawal Scale (SAWS)	5	x	x	x

3

4 Monitoring – Ambulatory

Statements: Monitoring – Ambulatory	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
186. Patients should be followed daily by a qualified health providers (peer medical assistant, nurse, etc.) for up to five days after their last drink.	7			
187. Assessment by phone or video on alternating days can be an adequate alternative to daily face-to-face visits for some patients with mild withdrawal	8.5		Moderate	

Statements: Monitoring – Ambulatory	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
188. The severity of alcohol withdrawal symptoms should be reassessed using the same instrument as the initial assessment	9			
189. Assess vital signs, hydration, emotional status, orientation, general physical condition, and sleep at each visit.	9		High	
a. Worsening anxiety	8	x	x	x
b. Suicidal thoughts	8	x	x	x
190. Focus the assessment on the patient's health since the last check-up.	8.5			
191. If available, measuring BAC with a breathalyzer can be helpful for detecting a patient's recent alcohol use.	8.5			
192. In ambulatory setting, typical dosing is 100 mg PO per day for 3-5 days.	7	x	x	x
193. If more severe withdrawal symptoms develop such as persistent vomiting, marked agitation, hallucinations, or confusion, the patient should be transferred to an inpatient setting.	9			
194. If existing medical conditions worsen, the patient should be transferred to an inpatient setting.	8			
195. If existing psychiatric conditions worsen, the patient should be transferred to an inpatient setting.	8		Moderate	
196. If the patient returns to alcohol use, the clinician should provide a referral to an inpatient setting.	8		High	
197. For patients undergoing alcohol withdrawal in an ambulatory setting with infrequent monitoring (Level 1-WM), the following indications would necessitate transfer to a high level of care such as Level 2-WM or an inpatient setting: • Agitation or severe tremor have not resolved despite having received multiple doses of medication, and the patient will not be continually monitored (treatment setting is closing) • More severe signs or symptoms develop such as persistent vomiting, marked agitation, hallucinations, confusion or seizure • Existing medical or psychiatric conditions worsen • Patients appear over-sedated • Patients return to alcohol use	8			
• Syncope, unstable vital signs (low BP, high BP, high HR, low HR)	9	x	x	x
198. At short-term observational settings with continuous monitoring (e.g., Level 2-WM), if certain symptoms (such as agitation or severe tremor) are persistently present at the close of the day's program service hours despite the patient having received multiple doses of medication.	9			

1

2 Monitoring – Inpatient

Statements: Monitoring – Inpatient	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
199. Reassessments with the CIWA-Ar should be performed frequently.	8		Moderate	

Statements: Monitoring – Inpatient	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
200. When possible, the CIWA-Ar should be repeated every 1-4 hours for 24 hours in patients with scores >8-10 or those requiring treatment, as clinically indicated.	8			
201. When possible, once a patient is stable and the CIWA-Ar score is less than 8-10 for 24 hours, monitoring intervals can be extended to every 4-8 hours for 24 hours, as clinically indicated.	8.5			
202. When possible, patients with mild withdrawal symptoms (CIWA-Ar score <8-10) and a low risk of complicated withdrawal should be observed, for a period of up to 36 hours, after which more severe withdrawal symptoms are unlikely to develop.	7.5			
203. In the inpatient setting, when monitoring patients with mild withdrawal and low risk of severe, complicated or complications of withdrawal, a. Re-assess withdrawal at least every 1-4 hours, as clinically needed	5*	x	x	x
b. Re-assess withdrawal at least every 6-8 hours, as clinically indicated	6.5	x	x	x
204. The patient's vital signs should be monitored.	9	Low	Moderate	
205. Included signs to monitor: a. Hydration	8	x	x	x
b. Orientation	8	x	x	x
c. Sleep	8	x	x	x
d. Emotional status	8	x	x	x
e. Worsening anxiety	8	x	x	x
f. Suicidal thoughts	8	x	x	x
206. Fluid intake and output and serum electrolytes should be monitored in hospitalized patients. [Changed to fluid intake only in Expert Panel meeting and approved]	5		Moderate	
207. Sustained elevations in blood pressure and pulse should be considered signs of alcohol withdrawal until proven otherwise.	6*		Low	

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2 Supportive Care – Ambulatory

Statements: Supportive Care – Ambulatory	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
208. Patients/caregivers should be educated about the danger of drug-drug interactions between benzodiazepines and alcohol and the importance of abstinence from alcohol	9			
209. Clinicians should explain the importance of taking medications as prescribed	9			
210. Clinicians should communicate to patients/caregivers that alcohol withdrawal management may necessitate a transfer to an inpatient setting and secure the patient's agreement to go to inpatient treatment if there are indications that outpatient is not safe or effective	9			
211. It may be helpful for patients/caregivers to monitor alcohol withdrawal symptoms with an instrument such as the CIWA-Ar or the SAWS	8.5			

Statements: Supportive Care – Ambulatory	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
212. Patients/caregivers should be educated about serious withdrawal symptoms to watch for and report	9			
a. Worsening anxiety	8	x	x	x
b. Insomnia	8	x	x	x
c. Suicidal thoughts	7.5	x	x	x
213. Patients/caregivers should be instructed to create a low-stimulation, reassuring environment to promote an effective outcome	8.5			
214. If prescribed benzodiazepines, patients should be instructed not to drive or use heavy machinery for the first few days.	8			
215. Patients should be advised to drink non-caffeinated fluids	8		High	
216. Patients should be advised that it may be helpful to take a daily multivitamin	7		Moderate	
217. While not essential, clinicians can offer an oral thiamine supplement	7.5		Moderate	
218. In inpatient settings parenteral thiamine is preferred. Typical dosing is 100mg IV/IM per day for 3-5 days.	8	x	x	x
219. In inpatient settings, oral thiamine can also be offered. Typical dosing is 100 mg PO per day for 3-5 days.	6.5	x	x	x

1

2 Supportive Care – Inpatient

Statements: Supportive Care – Inpatient	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
220. Non-pharmacologic interventions are important in the management of alcohol withdrawal and include frequent reassurance, reality orientation, and nursing care.	8.5	Low	Moderate	
221. To the extent possible, patients with severe alcohol withdrawal should be kept in an evenly lit, quiet room.	7.5		Moderate	
222. All clinicians who have contact with patients in withdrawal should offer hope and the expectation of recovery.	9		Moderate	
223. Clinicians should educate patients about what to expect over the course of withdrawal, including common withdrawal symptoms and how they will be treated.	9		Moderate	
224. Clinicians should assess patients' home/social environment for safety and the presence of alcohol or drugs.	9			
225. Restraints should be avoided; however, they may be used as required (and in compliance with state laws) in order to prevent injuries due to agitation or violence.	9		Low	
226. Supportive care for alcohol withdrawal patients includes adherence to safety measures and protocol (e.g., assess risk for fall/syncope).	8	x	x	x
227. If available, use existing institutional/ hospital-associated delirium protocols for inpatient supportive care of: a. All patients with alcohol withdrawal	4.5	x	x	x
b. Mild alcohol withdrawal	4	x	x	x
c. Moderate alcohol withdrawal	5.5	x	x	x
d. Severe alcohol withdrawal	7.5	x	x	x
e. A recent alcohol withdrawal seizure	6	x	x	x
f. Alcohol withdrawal delirium	9	x	x	x

Statements: Supportive Care – Inpatient	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
g. Alcohol-induced psychotic disorder	7.5	x	x	x
h. Resistant alcohol withdrawal	7.5	x	x	x
i. Hospitalized patients experiencing alcohol withdrawal	5.5	x	x	x
228. Consider a multivitamin for all patients being treated for alcohol withdrawal.	6		Low	
229. Patients should be evaluated for specific nutritional deficiencies based on clinically evident symptoms and available laboratory tests. In this way, clinicians can verify the diagnosis and provide more definitive therapy for isolated nutritional deficiencies, rather than using the low doses of vitamins and minerals provided by a multivitamin.	7*		Low	
230. All hospitalized patients presenting with alcohol withdrawal should receive thiamine to prevent Wernicke's encephalopathy.	8.5	High	High	
231. Thiamine must be given before any intravenous glucose.	5*		Moderate	
232. Thiamine and glucose may be given in any order.	8	x	x	x
233. For hospitalized patients, 100 mg of thiamine daily should be used for prophylaxis of Wernicke's encephalopathy.	7.5	Low	Low	
234. Intravenous or intramuscular administration of thiamine is best if patients have poor nutritional status, if there is any question regarding malabsorption, or severe complications such as Wernicke's encephalopathy.	8		Moderate	
235. Offer prophylactic oral thiamine to people with alcohol use disorder: a. If they are malnourished or of malnourishment	9			
b. If they have decompensated liver disease	9			
c. If they are in acute withdrawal	8			
d. Before and during a planned medically treated alcohol withdrawal	8.5		High	
236. Hospitalized patients with alcohol withdrawal should receive parenteral thiamine: a. If they have decompensated liver disease and in addition are in an emergency department	8			
b. If they are admitted to hospital with an acute illness or injury.	8*		High	
c. All hospitalized patients with alcohol withdrawal	7.5			
237. Consider folate supplementation for critically ill hospitalized patients being treated for alcohol withdrawal.	8	Low	Low	
238. Clinicians should be alert to the possibility of hypomagnesemia, particularly if there is hypokalemia.	9			
239. There is insufficient evidence for magnesium as prophylaxis or treatment for alcohol withdrawal.	9	High		
240. The use of magnesium should be limited to cases of hypomagnesemia.	8	High	High	
241. Magnesium causes little harm when used routinely to treat deficiency, which is common and hard to diagnose, as long as renal insufficiency is excluded.	8		Moderate	
242. Magnesium should not be administered routinely with the exception of patients with cardiac arrhythmias, electrolyte disturbances or previous history of AWS-related seizures.	8		Moderate	
243. All patients with alcohol withdrawal should be assessed for potassium deficiency and receive supplementation if indicated.	9			

Statements: Supportive Care – Inpatient	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
244. Clinicians should be aware that magnesium supplementation is often needed to correct a potassium deficiency.	9			
245. Hypokalemia can be corrected with supplementation, but given the lack of data supporting phosphate replenishment in asymptomatic, moderate hypophosphatemia (1-2 mg/DL), self-correction with proper nutrition is preferred.	8			
246. If phosphorous is < 1 mg/DL, it should be supplemented.	7	Low		

AUD Engagement – Ambulatory

Statements: AUD Engagement – Ambulatory	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
247. Near the end of the withdrawal process, clinicians should ask patients if they have had contact with a behavioral health provider regarding referral for SUD assessment/treatment and, if not, what barriers have prevented this from occurring.	7.5			
248. Near the end of the withdrawal process, clinicians should offer patients information about local support groups, including 12-step groups.	8			
249. Near the end of the withdrawal process, clinicians should educate patients about FDA-approved medications for alcohol use disorder and, if possible, offer to provide ongoing treatment with these medications.	8.5			
250. For patients treated in primary care, regular follow-up visits at least monthly for one year will increase the chances of abstinence	7			
251. When discussing AUD, clinicians should emphasize patient engagement and offer a variety of treatment and support options, even if the patient does not have a current goal of abstinence from alcohol.	8.5			

AUD Engagement – Inpatient

Statements: AUD Engagement – Inpatient	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
252. Clinicians should begin the addiction recovery treatment process concurrently as cognitive status permits, rather than delaying it until the patient's withdrawal management is completed.	7		Low	
253. Although there are no evidence-based practices for addressing AUD as part of alcohol withdrawal management, clinicians should proactively work to educate patients about evidence-based AUD treatment practices and connect them to these resources as seamlessly as possible.	9			
254. At a minimum, clinicians should communicate to the patient that he or she has an alcohol use disorder and explain the range of services available onsite and in the community.	9		High	
255. Clinicians should offer warm handoffs to alcohol use disorder service providers.	9			

Statements: AUD Engagement – Inpatient	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
252. Clinicians should begin the addiction recovery treatment process concurrently as cognitive status permits, rather than delaying it until the patient's withdrawal management is completed.	7		Low	
256. Clinicians should consider offering FDA-approved medications for alcohol use disorder.	9		Moderate	
257. The period of management of alcohol withdrawal presents an opportunity to initiate the treatment recovery process for alcohol use disorder. Clinicians should attempt to engage the patient in continued treatment that may lead to a sustained recovery from addiction.	9			

Co-occurring Opioid Use Disorder

Statements: Co-occurring Opioid Use Disorder	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
258. In ambulatory settings, for patients with concomitant alcohol withdrawal and an opioid use disorder: a. Stabilize opioid use disorder (e.g. with buprenorphine) concomitantly with treating alcohol withdrawal	8	x	x	x
b. Treat alcohol withdrawal before stabilizing a patient's opioid use disorder (e.g. with buprenorphine)	3.5*	x	x	x
259. In inpatient settings, for patients with concomitant alcohol withdrawal and an opioid use disorder: a. Stabilize opioid use disorder (e.g. with buprenorphine) concomitantly with treating alcohol withdrawal	8	x	x	x
b. Treat alcohol withdrawal before stabilizing a patient's opioid use disorder (e.g. with buprenorphine)	4*	x	x	x

Alternative therapies

Statements: Alternative Therapies	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
260. Acupuncture may be considered to help reduce alcohol withdrawal symptoms.	4.5*	Moderate		
261. Massage therapy may be considered to help reduce alcohol withdrawal symptoms.	5.5*		Moderate	

Pharmacotherapy – Inpatient

Statements: Pharmacotherapy – Inpatient	Appropriateness (Median)	Level of Care		
		AMSTAR-2	AACODS	Cochrane ROB
Need for Pharmacotherapy				
262. For those with mild symptoms (for example, CIWA-Ar scores <8-10) and a low risk of complicated withdrawal, a reasonable clinical option is supportive non-pharmacological therapy and continued monitoring.	9	High		Low

Statements: Pharmacotherapy – Inpatient	Appropriateness (Median)	Level of Care		
		AMSTAR-2	AACODS	Cochrane ROB
263. Those with moderate symptoms (e.g., CIWA-Ar scores of 8-16) benefit symptomatically from medication that will also reduce the risk of major complications.	9	High	Moderate	
264. Those with severe symptoms (for example, CIWA-Ar scores greater than or equal to 15) have a significant risk of major complications if untreated. It is recommended that such patients receive benzodiazepines in amounts necessary to control symptoms.	9	High	Moderate	
265. Patients with ASAM Criteria Risk Rating Matrix ratings of 2 or higher should receive pharmacotherapy for alcohol withdrawal syndrome.	9		Low	
266. For patients who have notable comorbid medical illness, medications should be considered even if withdrawal is mild to moderate.	9	High		
267. If waiting for lab test(s) results or if the test(s) are unavailable, use a BZD with less hepatic metabolization if a patient has signs of significant liver disease.	8	x	x	x
268. Benzodiazepines are the first line agents recommended for preventing and treating alcohol withdrawal symptoms.	9	High	High	High
269. Benzodiazepines should be first line treatment for mild-moderate symptoms of alcohol withdrawal.	8	x	x	x
270. Benzodiazepines should be first line treatment for moderate-severe symptoms of alcohol withdrawal.	9	x	x	x
271. Benzodiazepines are effective at preventing the incidence of alcohol withdrawal seizures.	9	High	High	High
272. Benzodiazepines are effective at preventing the incidence of alcohol withdrawal delirium.	9	High	High	
273. Benzodiazepines with adequate monitoring are recommended for treatment of moderate to severe alcohol withdrawal.	9		High	
274. Longer-acting benzodiazepines are generally recommended as the drugs of choice for monotherapy.	9		High	
275. Longer-acting agents may be more effective in preventing withdrawal seizures.	6.5		Moderate	High
276. Longer-acting agents may contribute to a smoother withdrawal with fewer rebound symptoms.	9		Moderate	High
277. Shorter-acting benzodiazepines with rapid onset have greater addictive potential.	9	High	Moderate	
278. There is no data to support the utilization of either short acting or long acting benzodiazepines to reduce the risk of over-sedation in elderly patients.	8			
279. There is no data to support the utilization of either short acting or long acting benzodiazepines to reduce the risk of over-sedation in patients with liver disease.	8			
280. There is no data to support the utilization of either short acting or long acting benzodiazepines to reduce the risk of over-sedation in patients with COPD.	7.5			
281. Benzodiazepines that are not metabolized hepatically (e.g., lorazepam, oxazepam) may be more appropriate for patients with significant liver disease.	9		Moderate	

Statements: Pharmacotherapy – Inpatient	Appropriateness (Median)	Level of Care		
		AMSTAR-2	AACODS	Cochrane ROB
282. Signs of significant liver disease include: • Skin and eyes that appear yellowish (jaundice) • Abdominal pain and swelling (ascites) • Swelling in the legs and ankles (edema) • Itchy skin • Dark urine color • Pale stool color, or bloody or tar-colored stool • Confusion • Chronic fatigue • Nausea or vomiting	8	x	x	x
283. All benzodiazepines appear equally efficacious in reducing signs and symptoms of withdrawal.	9	High	Moderate	High
284. No specific benzodiazepine is preferred for the prevention of alcohol withdrawal seizures.	9			High
285. No specific benzodiazepine is preferred for the prevention of alcohol withdrawal delirium.	9			High
286. Barbiturates such as phenobarbital may be effective in the treatment of withdrawal-related seizures.	7	Low		High
287. Phenobarbital is not generally recommended as the initial agent in place of benzodiazepines.	8	Moderate		
288. Barbiturates can ease withdrawal symptoms but there is no evidence that they prevent seizures.	4.5		Moderate	High
289. Barbiturates can ease withdrawal symptoms but there is no evidence that they prevent alcohol withdrawal delirium.	5		Moderate	Moderate
290. Phenobarbital may be a clinically acceptable alternative to benzodiazepines although the margin of safety for this agent is lower than for benzodiazepines.	9	High		Moderate
291. In an inpatient setting, [for patients with NO contraindication for benzodiazepine use] phenobarbital monotherapy is appropriate for patients experiencing:				
a. Mild withdrawal	3	x	x	x
b. Moderate withdrawal	4.5	x	x	x
c. Severe withdrawal	6	x	x	x
d. Who are risk of developing severe or complicated alcohol withdrawal or complications of alcohol withdrawal	6	x	x	x
292. In an inpatient setting, for patients with a contraindication for benzodiazepine use, phenobarbital monotherapy is appropriate for patients experiencing:				
a. Mild withdrawal	7	x	x	x
b. Moderate withdrawal	8	x	x	x
c. Severe withdrawal	8	x	x	x
d. Who are at risk of developing severe or complicated or complications of alcohol withdrawal	8	x	x	x
293. In an inpatient setting, if close monitoring is available, phenobarbital adjunct to benzodiazepines is an option for patients experiencing:				
a. Mild withdrawal	3	x	x	x
b. Moderate withdrawal	5	x	x	x
c. Severe withdrawal	7	x	x	x
d. Who are at risk of developing severe or complicated or complications of alcohol withdrawal	7	x	x	x

Statements: Pharmacotherapy – Inpatient	Appropriateness (Median)	Level of Care		
		AMSTAR-2	AACODS	Cochrane ROB
294. Because of synergistic effects, there is rationale for the use of barbiturates as an adjunct to benzodiazepines.	7			
295. The combination of phenobarbital and benzodiazepines may lead to favorable additive clinical effects in controlling alcohol withdrawal syndromes; this regimen could be used in settings with close monitoring as a strategy at preventing ICU admission and mechanical ventilation.	7	Moderate	Moderate	
296. Parenteral phenobarbital should only be used in highly supervised settings with hospitalized patients because of overdose risk.	9		Moderate	
297. Anticonvulsants are not recommended as monotherapy for patients at risk of moderate alcohol withdrawal.	6.5*			High
298. Anticonvulsants are not recommended as monotherapy for patients at risk of severe alcohol withdrawal.	8.5			
299. Anticonvulsants are non-inferior to benzodiazepines as monotherapy for the management of alcohol withdrawal.	8	High	Moderate	High
300. Anticonvulsants are non-inferior to benzodiazepines as monotherapy for the prevention of alcohol withdrawal symptoms.	7.5	High	Moderate	
301. Carbamazepine, gabapentin and valproic acid monotherapy are non-inferior to benzodiazepines as monotherapy for both prevention of seizures and treatment of withdrawal.	8			
302. For patients who are at mild to moderate risk of severe alcohol withdrawal, anticonvulsant monotherapy may be used to control symptoms after an initial dose of benzodiazepines.	8			
303. Some anticonvulsants do not have the addictive potential of benzodiazepines, which may be a consideration for patients being treated in outpatient settings.	7		High	
304. For managing mild to moderate alcohol withdrawal for patients for whom risks of benzodiazepines outweigh benefits (e.g, inadequate monitoring available, concerns about misuse, or allergy/adverse reactions), carbamazepine or gabapentin may be considered as alternatives.	9		High	
305. Anticonvulsants may be used as adjunctive medications to benzodiazepines to help control alcohol withdrawal symptoms.	9	High	High	
306. Before anticonvulsants are used as adjunctive medications to benzodiazepines, clinicians should ensure that an adequate dose of benzodiazepines has been administered.	7.5			
307. Some studies have shown that the adjunctive use of anticonvulsants reduces the total dose of benzodiazepines. However, the total dose of benzodiazepine is not a meaningful clinical goal in its own right, or a good measure of the efficacy of anticonvulsants to reduce and prevent alcohol withdrawal symptoms.	8			
308. A limitation of carbamazepine use is its interaction with multiple medications that undergo hepatic oxidative metabolism making it less useful in older patients or those with multiple medical problems.	9		High	
309. Valproic acid may have limited use in patients with acute liver impairment.	8		Moderate	

Statements: Pharmacotherapy – Inpatient	Appropriateness (Median)	Level of Care		
		AMSTAR-2	AACODS	Cochrane ROB
310. Gabapentin may provide therapeutic effect during withdrawal and continued long-term for relapse prevention or harm reduction. It may be a more appropriate choice for alcohol withdrawal symptoms if the clinician plans to use it to treat alcohol use disorder.	8.5		Low	
311. Antipsychotic agents are not recommended as monotherapy because they do not prevent delirium and they lower the seizure threshold.	9	High	Moderate	
312. Antipsychotic agents may be considered an adjunctive therapy to benzodiazepines in the late stage of alcohol withdrawal when delirium and hallucinations are not controlled with benzodiazepines alone.	8	high	Moderate	
313. Antipsychotic agents with less effect on the seizure threshold (such as haloperidol) should be used.	5.5*		Moderate	
314. Beta-blockers can be used as adjunctive treatment to control neuroautonomic hyperactivity.	7	High	High	
315. Beta-blockers have not demonstrated efficacy in prevention of seizure.	9		Moderate	
316. A concern about beta-blockers is their potential to mask the development of worsening withdrawal symptoms, which may lead to seizures and delirium.	5.5			
317. A concern about beta-blockers is their potential to induce delirium, which can make it difficult to determine the cause of the patient's delirium.	5			
318. A2AA can be used as adjunctive treatment to control autonomic hyperactivity.	8		Moderate	
319. A2AA do not prevent seizures or the development of delirium.	9	Low	Moderate	
320. A2AA increase the incidence of bradycardia, which requires close cardiac monitoring.	5*	Low		
321. Alpha2-adrenergic agonists such as clonidine can be used as an adjunct to benzodiazepine therapy to control autonomic hyperactivity and anxiety when symptoms are not controlled by benzodiazepines alone. They should not be used to prevent withdrawal-related seizures or delirium.	7.5	x	x	x
322. Dexmedetomidine has been successfully used in combination with other medications for patients in severe refractory withdrawal.	9	Low		
323. In ICU settings, dexmedetomidine is indicated only for patients with severe alcohol withdrawal who have already received high doses of benzodiazepines.	7.5			
324. Clonidine can be used as adjunctive treatment to control autonomic hyperactivity.	9			
325. Clonidine use should be restricted to patients with substantial increase in blood pressure over baseline or are nearing a hypertensive urgency or emergency (pressure is greater than 180 over 120) and should not be used to treat other general symptoms of alcohol withdrawal syndrome.	4.5*		Low	
326. For patients of severe alcohol withdrawal, other medications can be used in the management of alcohol withdrawal as long as benzodiazepines are already being given.	8		Moderate	

Statements: Pharmacotherapy – Inpatient	Appropriateness (Median)	Level of Care		
		AMSTAR-2	AACODS	Cochrane ROB
327. For patients at low risk of severe alcohol withdrawal, clinicians may utilize many interventions (including medications) to reduce symptoms. However, no other medications are as well-studied or known to prevent seizures and delirium as benzodiazepines.	9			
328. There is insufficient and low quality evidence about the use of baclofen for alcohol withdrawal.	9	High	High	
329. Baclofen should only be considered an adjunctive medication for alcohol withdrawal management.	6		Moderate	
330. Propofol is indicated only for patients with severe alcohol withdrawal who have already received high doses of benzodiazepines.	8			
331. Propofol should only be considered for patients already requiring mechanical ventilation.	8	Low		
332. Because oral or intravenous alcohol has no proven efficacy, no accepted protocols, and known toxicity, it should not be used.	9	High	High	
Dosing Regimens				
333. The indication and tailoring of benzodiazepine treatment should be guided by regular and rigorous clinical surveillance which may be supported by withdrawal symptom evaluation scales.	9		High	
334. Treatment should allow for a degree of individualization so patients can receive large amounts of medication rapidly if needed.	9	High	Moderate	
335. When using shorter-acting agents, medication should be tapered carefully even after AWD resolves to prevent the development of breakthrough symptoms or the occurrence of withdrawal seizures.	9	High		
336. Symptom-triggered dosing is the standard of care for hospitalized patients.	8.5			
337. Symptom-triggered dosing is a best practice for hospitalized patients.	9			
338. Symptom-triggered dosing is preferred because it is as effective as fixed-dose therapy, but leads to the administration of significant less medication and a significantly shorter duration of treatment. Moreover, patients receiving fixed-dose therapy still require monitoring and doses based on symptoms as needed.	9	Low	High	High
339. Symptom-triggered dosing can be used with short, intermediate, and long-acting benzodiazepines.	8		Moderate	
340. A fixed dose schedule is generally not appropriate in a hospital setting.	8.5			
341. Fixed dose schedule offers few advantages over symptom triggered dosing; importantly, it does not obviate the need for monitoring and adjusting doses as necessary.	7			
342. A fixed dose with a gradual taper may be appropriate for patients receiving shorter-acting benzodiazepines in an inpatient setting.	5*			
343. A single loading dose of a benzodiazepine may be appropriate for asymptomatic patients with severe coronary artery disease, when the clinician may want to prevent the development of even minor symptoms of withdrawal.	7.5		Moderate	

Statements: Pharmacotherapy – Inpatient	Appropriateness (Median)	Level of Care		
		AMSTAR-2	AACODS	Cochrane ROB
344. A single loading dose of a benzodiazepine may be given regardless of symptoms or when asymptomatic if a patient has past severe or complicated withdrawal or a patient has acute medical, psychiatric or surgical illness.	8	Low	Moderate	
345. A single loading dose of a benzodiazepine may be given when a patient has withdrawal symptoms at a high (100-150 mc/dL) BAC.	7		Moderate	
346. For patients with severe alcohol withdrawal symptoms or high risk of severe alcohol withdrawal, a repeating or escalating dose of a benzodiazepine can be considered.	8		Low	Low-ob
347. Because of their rapid onset and long half-life, diazepam and chlordiazepoxide are appropriate benzodiazepines for loading doses.	8			
348. After administering a loading dose or doses of a benzodiazepine, clinicians should monitor the patient closely and shift to symptom-triggered dosing.	8	Low		
349. Phenobarbital can be dosed in an inpatient setting using: a. Symptom-triggered treatment	7	x	x	x
b. Fixed dosing with a scheduled taper	6.5	x	x	x
c. Front-loading or loading dose regimen	7	x	x	x
d. Provide additional doses as needed	7	x	x	x
Response to Medication				
350. For patients who do not respond as expected to a typical dose of medication: a. First, consider increasing the dose	9	x	x	x
b. Reassess for appropriate level of care		x	x	x
c. Consider switching to an alternative medication		x	x	x

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3 Pharmacotherapy – Ambulatory

Statements: Pharmacotherapy – Ambulatory	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
Need for pharmacotherapy				
351. If patients are at moderate risk of developing more severe (but still manageable in outpatient) symptoms before their next appointment, prescribe one of the recommended medications regardless of current symptom severity.	8.5			
352. Indications of moderate risk of developing more severe (but still manageable in outpatient) symptoms: a. Previous withdrawal episodes of moderate severity	8.5		Moderate	
b. > 3 standard drinks per day for men and 2 for women	3		Moderate	
c. > 4 standard drinks per day for men and 3 for women	3		Moderate	
d. > 5 standard drinks per day for men and 4 for women	4		Moderate	
e. > 6 standard drinks per day for men and 5 for women	5		Moderate	
f. > 7 standard drinks per day for men and 6 for women	5.5		Moderate	
g. > 8 standard drinks per day for men and 7 for women	6		Moderate	
h. > 9 standard drinks per day for men and 8 for women	6		Moderate	
i. > 10 standard drinks per day for men and 9 for women	6		Moderate	

Statements: Pharmacotherapy – Ambulatory	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
j. > 11 standard drinks per day for men and 10 for women	6		Moderate	
353. If risk is unknown: a. Offer one of the recommended medications for AWS symptoms at the time of presentation.	8			
b. Monitor and reassess frequently over the next 24 hours to determine their need for medication	8.5		Moderate	
Use of Benzodiazepines				
354. Benzodiazepines have some addictive potential, which should not impede their use in withdrawal management. The potential for misuse may be relevant for patients receiving treatment in outpatient settings but generally not of clinical significance during the treatment of acute withdrawal.	8		Moderate	
355. Clinicians should be aware that the use of benzodiazepines is associated with increased risk of excessive sedation, motor and memory deficits, and respiratory depression.	9		Moderate	
356. Patients receiving benzodiazepines in outpatient settings should be advised about the risk of drowsiness and should be told to reduce the dose if this occurs.	9	Low		
357. Patients receiving benzodiazepines in outpatient settings should be advised about the risk of impairment and overdose if combined with alcohol or other CNS depressants.	9			
358. Absolute contraindication for BZD use in outpatient setting indicated by: a. History of adverse events with benzodiazepine use	8.5		High	
b. Current benzodiazepine use disorder	5.5		Moderate	
c. Past benzodiazepine use disorder	4		Moderate	
d. High risk of benzodiazepine diversion (history of previous diversion or another household member with a history of diversion or abuse of benzodiazepines)	8		Low	
359. Relative contraindication for BZD use in outpatient setting indicated by: a. History of adverse events with benzodiazepine use	7.5		High	
b. Current benzodiazepine use disorder	6.5		Moderate	
c. Past benzodiazepine use disorder	6		Moderate	
d. High risk of benzodiazepine diversion (history of previous diversion or another household member with a history of diversion or abuse of benzodiazepines)	8		Low	
Medication choice:				
360. No Medication, Supportive non-pharmaceutical care alone for a patient with: a. BZD Contraindication=No, Symptoms=Mild, Risk=Mild	3			
b. BZD Contraindication=No, Symptoms=Mild, Risk=Mod	1.5			
c. BZD Contraindication=No, Symptoms=Mod	7.5			
d. BZD Contraindication=Absolute, Symptoms=Mild, Risk=Mild	3.5			
e. BZD Contraindication=Absolute, Symptoms=Mild, Risk=Mod	3			
f. BZD Contraindication=Absolute, Symptoms=Mod	7.5			
g. BZD Contraindication=Relative, Symptoms=Mile, Risk=Mild	7.5			

Statements: Pharmacotherapy – Ambulatory	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
h. BZD Contraindication=Relative, Symptoms=Mild, Risk=Mod	3.5			
i. BZD Contraindication=Relative, Symptoms=Mod	3			
361. Long-acting BZD as monotherapy for AWS symptoms for a patient with:				
a. BZD Contraindication=No, Symptoms=Mild, Risk=Mild	6.5			
b. BZD Contraindication=No, Symptoms=Mild, Risk=Mod	8			
c. BZD Contraindication=No, Symptoms=Mod	9			
d. BZD Contraindication=Relative, Symptoms=Mild, Risk=Mild	4.5			
e. BZD Contraindication=Relative, Symptoms=Mild, Risk=Mod	6			
f. BZD Contraindication=Relative, Symptoms=Mod	8			
362. Intermediate-acting BZD as monotherapy for AWS symptoms for a patient with:				
a. BZD Contraindication=No, Symptoms=Mild, Risk=Mild	4			
b. BZD Contraindication=No, Symptoms=Mild, Risk=Mod	7			
c. BZD Contraindication=No, Symptoms=Mod	8.5			
d. BZD Contraindication=Relative, Symptoms=Mild, Risk=Mild	3.5			
e. BZD Contraindication=Relative, Symptoms=Mild, Risk=Mod	6			
f. BZD Contraindication=Relative, Symptoms=Mod	7			
363. Carbamazepine as monotherapy for AWS symptoms for a patient with:				
a. BZD Contraindication=No, Symptoms=Mild, Risk=Mild	8			
b. BZD Contraindication=No, Symptoms=Mild, Risk=Mod	8.5			
c. BZD Contraindication=No, Symptoms=Mod	8.5			
d. BZD Contraindication=Absolute, Symptoms=Mild, Risk=Mild	7.5			
e. BZD Contraindication=Absolute, Symptoms=Mild, Risk=Mod	8.5			
f. BZD Contraindication=Absolute, Symptoms=Mod	8.5			
g. BZD Contraindication=Relative, Symptoms=Mild, Risk=Mild	7.5			
h. BZD Contraindication=Relative, Symptoms=Mild, Risk=Mod	8.5			
i. BZD Contraindication=Relative, Symptoms=Mod	8.5			
j. Plan to use carbamazepine as part of long-term AUD therapy after withdrawal	5.5			
364. Gabapentin as monotherapy for AWS symptoms for a patient with:				
a. BZD Contraindication=No, Symptoms=Mild, Risk=Mild	7			
b. BZD Contraindication=No, Symptoms=Mild, Risk=Mod	8.5			
c. BZD Contraindication=No, Symptoms=Mod	7.5			
d. BZD Contraindication=Absolute, Symptoms=Mild, Risk=Mild	8			
e. BZD Contraindication=Absolute, Symptoms=Mild, Risk=Mod	8.5			
f. BZD Contraindication=Absolute, Symptoms=Mod	8.5			

Statements: Pharmacotherapy – Ambulatory	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
g. BZD Contraindication=Relative, Symptoms=Mild, Risk=Mild	7			
h. BZD Contraindication=Relative, Symptoms=Mild, Risk=Mod	8.5			
i. BZD Contraindication=Relative, Symptoms=Mod	7.5			
j. Plan to use gabapentin as part of long-term AUD therapy after withdrawal	8.5			
365. Valproic acid as monotherapy for AWS symptoms (patient not woman of child-bearing potential) for a patient with:				
a. BZD Contraindication=No, Symptoms=Mild, Risk=Mild	5			
b. BZD Contraindication=No, Symptoms=Mild, Risk=Mod	6			
c. BZD Contraindication=No, Symptoms=Mod	6			
d. BZD Contraindication=Absolute, Symptoms=Mild, Risk=Mild	5.5			
e. BZD Contraindication=Absolute, Symptoms=Mild, Risk=Mod	6			
f. BZD Contraindication=Absolute, Symptoms=Mod	6			
g. BZD Contraindication=Relative, Symptoms=Mild, Risk=Mild	5			
h. BZD Contraindication=Relative, Symptoms=Mild, Risk=Mod	6			
i. BZD Contraindication=Relative, Symptoms=Mod	6			
j. Plan to use valproic acid as part of long-term AUD therapy after withdrawal	4.5			
366. Phenobarbital as monotherapy for AWS symptoms for a patient with:				
a. BZD Contraindication=No, Symptoms=Mild, Risk=Mild	4			
b. BZD Contraindication=No, Symptoms=Mild, Risk=Mod	5			
c. BZD Contraindication=No, Symptoms=Mod	5			
d. BZD Contraindication=Absolute, Symptoms=Mild, Risk=Mild	4.5			
e. BZD Contraindication=Absolute, Symptoms=Mild, Risk=Mod	6.5			
f. BZD Contraindication=Absolute, Symptoms=Mod	7			
g. BZD Contraindication=Relative, Symptoms=Mild, Risk=Mild	4			
h. BZD Contraindication=Relative, Symptoms=Mild, Risk=Mod	5.5			
i. BZD Contraindication=Relative, Symptoms=Mod	6.5			
367. Baclofen as monotherapy for AWS symptoms for a patient with:				
a. BZD Contraindication=No, Symptoms=Mild, Risk=Mild	3			
b. BZD Contraindication=No, Symptoms=Mild, Risk=Mod	3.5			
c. BZD Contraindication=No, Symptoms=Mod	1.5			
d. Plan to use baclofen as part of long-term AUD therapy after withdrawal	4.5			
368. Tiapride as monotherapy for AWS symptoms for a patient with:				
a. BZD Contraindication=No, Symptoms=Mild, Risk=Mild	3			
b. BZD Contraindication=No, Symptoms=Mild, Risk=Mod	3			
c. BZD Contraindication=No, Symptoms=Mod	3			

Statements: Pharmacotherapy – Ambulatory	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
369. Clonidine as monotherapy for AWS symptoms for a patient with:				
a. Rx=CLO, BZD Contraindication=No, Symptoms=Mild, Risk=Mild	3			
b. Rx=CLO, BZD Contraindication=No, Symptoms=Mild, Risk=Mod	1.5			
c. Rx=CLO, BZD Contraindication=No, Symptoms=Mod	1			
370. Carbamazepine after an initial dose of BZD for a patient with:				
a. BZD Contraindication=No, Symptoms=Mild, Risk=Mild	7			
b. BZD Contraindication=No, Symptoms=Mild, Risk=Mod	7			
c. BZD Contraindication=No, Symptoms=Mod	6.5			
d. BZD Contraindication=Relative, Symptoms=Mild, Risk=Mild	5.5			
e. BZD Contraindication=Relative, Symptoms=Mild, Risk=Mod	7.5			
f. BZD Contraindication=Relative, Symptoms=Mod	6.5			
g. Plan to use carbamazepine as part of long-term AUD therapy after withdrawal	6			
371. Gabapentin after an initial dose of BZD for a patient with:				
a. BZD Contraindication=No, Symptoms=Mild, Risk=Mild	6.5			
b. BZD Contraindication=No, Symptoms=Mild, Risk=Mod	7			
c. BZD Contraindication=No, Symptoms=Mod	7			
d. BZD Contraindication=Relative, Symptoms=Mild, Risk=Mild	6.5			
e. BZD Contraindication=Relative, Symptoms=Mild, Risk=Mod	7			
f. BZD Contraindication=Relative, Symptoms=Mod	7			
g. Plan to use gabapentin as part of long-term AUD therapy after withdrawal	7			
372. Valproic acid after an initial dose of BZDs (patient not woman of child-bearing potential) for a patient with:				
a. BZD Contraindication=No, Symptoms=Mild, Risk=Mild	6.5			
b. BZD Contraindication=No, Symptoms=Mild, Risk=Mod	7			
c. BZD Contraindication=No, Symptoms=Mod	6.5			
d. BZD Contraindication=Relative, Symptoms=Mild, Risk=Mild	6			
e. BZD Contraindication=Relative, Symptoms=Mild, Risk=Mod	6			
f. BZD Contraindication=Relative, Symptoms=Mod	6			
g. Plan to use valproic acid as part of long-term AUD therapy after withdrawal	4.5			
373. BZD w/ adjunct carbamazepine for a patient with:				
a. BZD Contraindication=No, Symptoms=Mild, Risk=Mild	4			
b. BZD Contraindication=No, Symptoms=Mild, Risk=Mod	6			
c. BZD Contraindication=No, Symptoms=Mod	7.5			
d. Plan to use carbamazepine as part of long-term AUD therapy after withdrawal	5.5			
374. BZD w/ adjunct gabapentin for a patient with:				
a. BZD Contraindication=No, Symptoms=Mild, Risk=Mild	4			
b. BZD Contraindication=No, Symptoms=Mild, Risk=Mod	7			
c. BZD Contraindication=No, Symptoms=Mod	7.5			

Statements: Pharmacotherapy – Ambulatory	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
d. Plan to use gabapentin as part of long-term AUD therapy after withdrawal	4			
375. BZD w/ adjunct valproic acid (patient not woman of child-bearing potential) for a patient with:				
a. BZD Contraindication=No, Symptoms=Mild, Risk=Mild	6			
b. BZD Contraindication=No, Symptoms=Mild, Risk=Mod	7			
c. BZD Contraindication=No, Symptoms=Mod	4.5			
d. Plan to use as part of long-term AUD therapy after withdrawal	4.5			
376. BZD w/ adjunct clonidine for a patient with:				
a. BZD Contraindication=No, Symptoms=Mild, Risk=Mild	4.5			
b. BZD Contraindication=No, Symptoms=Mild, Risk=Mod	5.5			
c. BZD Contraindication=No, Symptoms=Mod	5.5			
377. BZD w/ adjunct atenolol for a patient with:				
a. BZD Contraindication=No, Symptoms=Mild, Risk=Mild	3.5			
b. BZD Contraindication=No, Symptoms=Mild, Risk=Mod	4			
c. BZD Contraindication=No, Symptoms=Mod	4.5			
378. Transfer to inpatient setting for a patient with:				
a. BZD Contraindication=Absolute, Symptoms=Mild, Risk=Mild	1			
b. BZD Contraindication=Absolute, Symptoms=Mild, Risk=Mod	2			
c. BZD Contraindication=Absolute, Symptoms=Mod	5			
d. BZD Contraindication=Relative, Symptoms=Mild, Risk=Mild	1			
e. BZD Contraindication=Relative, Symptoms=Mild, Risk=Mod	2			
f. BZD Contraindication=Relative, Symptoms=Mod	4.5			
379. Patients with contraindications for benzodiazepine treatment do not require automatic transfer to an inpatient facility because other effective medications are available for the treatment of alcohol withdrawal symptoms in the outpatient setting.	8.5			
380. In ambulatory Level 2-WM setting, for patients whose symptoms include severe anxiety and moderate to severe tremor, but not confusion or hallucinations and has not experiences a seizure (e.g., CIWA-AR≥19):				
a. Provide pharmacotherapy	9	x	x	x
b. Benzodiazepines are first-line treatment	8.5	x	x	x
c. Phenobarbital is also an option	7.5	x	x	x
d. For patients with a BZD contraindication, use phenobarbital	8	x	x	x
e. For patients with a BZD contraindication, use carbamazepine	7	x	x	x
f. For patients with a BZD contraindication, use gabapentin	7	x	x	x
g. For patients with a BZD contraindication, transfer to an inpatient setting.	6.5	x	x	x
381. In ambulatory Level 2-WM setting, for patients who are at risk of developing severe or complicated alcohol withdrawal or complications of alcohol withdrawal:				
a. Provide pharmacotherapy	9	x	x	x
b. Benzodiazepines are first-line treatment	9	x	x	x
c. Phenobarbital is also an option	7	x	x	x

Statements: Pharmacotherapy – Ambulatory	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
d. For patients with a BZD contraindication, use phenobarbital	8	x	x	x
e. For patients with a BZD contraindication, use carbamazepine	5.5	x	x	x
f. For patients with a BZD contraindication, use gabapentin	5.5	x	x	x
g. For patients with a BZD contraindication, transfer to an inpatient setting.	7	x	x	x
Medication Dosing				
382. In the ambulatory setting, a front loading or loading dose regimen is appropriate for patients at high-risk of severe withdrawal syndrome.	8.5	x	x	x
383. In the ambulatory setting, providing at least a single loading dose is appropriate for patients: a. Not experiencing severe withdrawal but who have a history of severe or complicated withdrawal	8.5	x	x	x
b. With a current acute medical, psychiatric or surgical illness	7	x	x	x
c. Who are displaying signs or symptoms of withdrawal concurrent with a positive blood alcohol content	9	x	x	x
384. At settings without continuous monitoring (e.g. Level 1-WM); patients whose symptoms will be reliably monitored a. Symptom-triggered treatment (take medication when needed)	7			
b. Fixed dose + additional as-needed medication	7		High	
c. Fixed dose no additional as-needed medication	2.5		High	
d. Front loading	7		High	
385. At settings without continuous monitoring (e.g. Level 1-WM); patients whose symptoms will NOT be reliably monitored a. Symptom-triggered treatment (take medication when needed)	6			
b. Fixed dose + additional as-needed medication	8		High	
c. Fixed dose no additional as-needed medication	4		High	
d. Front loading	7		High	
386. At short-term observational settings with continuous monitoring (e.g. Level 2-WM) a. Symptom-triggered treatment (take medication when needed)	9		Moderate	
b. Fixed dose + additional as-needed medication	7		High	
c. Fixed dose no additional as-needed medication	2.5		High	
d. Front loading	7.5		High	
387. Phenobarbital can be dosed in an ambulatory setting using: a. Symptom-triggered treatment	4.5	x	x	x
b. Fixed dosing with a scheduled taper	5	x	x	x
c. Front-loading or loading dose regimen	6	x	x	x
d. Provide additional take-home doses	5.5	x	x	x
388. Discontinue benzodiazepines prescribed for alcohol withdrawal a. After withdrawal is complete	8.5		Moderate	
b. If a patient drinks alcohol	2		Moderate	
389. If a patient does not respond to an adequate dose of medication: a. First, consider increasing the dose	9	x	x	x
b. Reassess the patient for appropriate level of care	9		Very Low	

Statements: Pharmacotherapy – Ambulatory	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
c. Consider switching to a different medication	9			
d. Consider adding an adjunct medication	9			
390. In an outpatient setting where it is possible to monitor the patient over a period of hours, symptom-triggered dosing is preferred.	9			
391. A fixed dose with a gradual taper may be appropriate for patients receiving shorter-acting benzodiazepines in an outpatient setting.	7.5			
392. An initial fixed dose with a gradual taper may be suited for outpatient settings when close monitoring is not possible, as long as monitoring is done to assess for needed changes.	7	Low	Low	
393. If initiating a fixed dose in an outpatient setting, clinicians should arrange to follow up with a patient the following day (or arrange for follow-up with another provider) to potentially modify the patient's dose.	8.5			
394. Patients treated in outpatient settings who are prescribed benzodiazepines to treat withdrawal should be provided with as few days' worth of doses as is practically possible given their level of stability and access to follow up evaluation.	8.5			

Addressing Seizures, Delirium and Hallucinosis

Statements: Addressing Seizures, Delirium, Hallucinosis, RAW	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
395. Routine drug therapy for the prevention of seizures is not necessary in patients with no history of withdrawal seizures and mild to moderate symptoms.	6		High	
396. Clinicians should be aware that a seizure may occur in the absence of other clinically prominent alcohol withdrawal symptoms.	8			
397. Following a withdrawal seizure, admit patients to a setting with close monitoring and re-assess at least every 1-2 hours for up to 24 hours.	7.5	x	x	x
398. For patients who present with seizures, only make a diagnosis of alcohol withdrawal seizures if there is a recent change in alcohol use. Clinicians should be aware that seizures often occur 24-48 hours after a decrease or cessation of alcohol use.	8		Moderate	
399. Patients who present with seizures who have no history of seizures should receive a thorough neurological exam to determine its etiology.	9	Low	Moderate	
400. Patients who are known to have a history of withdrawal seizure and who present with a seizure that can be attributed clearly to withdrawal may not require a full repeat evaluation. If the seizure was generalized and without focal elements, if a careful neurologic examination reveals no evidence of focal deficits, if there is no suspicion of meningitis and if there is no history of recent head trauma, additional testing may be safely omitted.	8		Moderate	
401. EEG is recommended in new onset seizures or when showing a new pattern in patients with a known history of alcohol withdrawal seizures.	8		Moderate	

Statements: Addressing Seizures, Delirium, Hallucinosis, RAW	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
402. Patients with a recent alcohol withdrawal seizure should be admitted for 6-24 hours.	5			
403. Patients with a recent alcohol withdrawal seizure should be observed for 6-24 hours.	7.5			
404. Patients with a recent alcohol withdrawal seizure should be admitted for at least 24 hours.	5			
405. Patients with a recent alcohol withdrawal seizure should be observed for at least 24 hours.	8.5		High	
406. Patients experiencing alcohol withdrawal seizures: a. Should be treated with immediate parenteral benzodiazepines to prevent another seizure.	8.5	Low	Moderate	High
b. Phenobarbital is also an option	7	x	x	x
c. For patients with a BZD contraindication, phenobarbital is an option	8	x	x	x
d. If easy and fast to access, IV administration is preferred to IM, but IM administration is also effective.	8	x	x	x
407. For patients who have experienced an alcohol withdrawal seizure in the current withdrawal episode, to prevent another seizure: a. Benzodiazepines should be first line treatment	9			
b. Phenobarbital is also an option	6.5	x	x	x
c. For patients with a BZD contraindication, phenobarbital is an option	7.5	x	x	x
408. The drugs of choice for treatment of alcohol withdrawal seizures are lorazepam and diazepam.	8		High	High
409. The drug of choice for treatment of alcohol withdrawal seizure is lorazepam.	8			High
410. Do not offer phenytoin to treat alcohol withdrawal seizures because it has been shown to be ineffective.	9		High	
411. It is not recommended to use phenytoin to prevent or treat alcohol withdrawal seizures unless treating a concomitant underlying seizure disorder.	7.5	x	x	x
412. All patients with seizures should receive intravenous fluids.	5*		Low	
413. Patients with seizures should be evaluated for the need to receive IV fluid.	7			
414. Someone experiencing an alcohol withdrawal seizure is at greater risk for progressing to alcohol withdrawal delirium. Therefore, a withdrawal seizure warrants closer monitoring for delirium.	8		Moderate	
415. Anticonvulsant treatment should not be given in the long term to prevent alcohol withdrawal seizures.	9			
416. Clinicians should use DSM-5 criteria to diagnose delirium as part of alcohol withdrawal.	8			
417. Regardless of the apparent etiology of the delirium, clinicians should conduct a detailed neurological and medical examination with appropriate testing to rule out other common causes of delirium.	9		Low	
418. It can be difficult to differentiate between treatment-related benzodiazepine intoxication and alcohol withdrawal delirium.	6.5		Moderate	
419. Patients with delirium require close nursing observation and supporting care that frequently necessitates admission to an intensive care unit.	7		Moderate	

Statements: Addressing Seizures, Delirium, Hallucinosis, RAW	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
420. In many cases, continuous, one-to-one observation and monitoring may be required to ensure safe and adequate management of agitated and disoriented patients.	9	High		
421. Vital signs should be monitored regularly in all patients. The appropriate frequency of monitoring depends on the frequency of medication administration, concurrent medical conditions, and the degree of abnormality of the vital signs.	9	High		
422. When high doses of benzodiazepines are needed, or when continuous infusions of medication are used, or when patients have significant concurrent medical conditions, cardiac monitoring and oximetry should be in place and resuscitative equipment should be readily available.	9	High	Moderate	
423. All patients with alcohol withdrawal delirium should have immediate intravenous access for administration of drugs and fluids.	9	Low		
424. Clinicians should utilize a structured assessment scale to monitor symptoms of alcohol withdrawal delirium.	8			
425. Sedation agitation scales are preferred over the CIWA-Ar for monitoring symptoms of alcohol withdrawal delirium.	6*			
426. Due to the subjective reporting of symptoms on the CIWA-Ar, it may be difficult to use for patients with delirium and other scales should be considered.	8.5			
427. The Delirium Detection Scale may be useful for identifying and monitoring patients with alcohol withdrawal delirium.	6.5			
428. The goal of managing alcohol withdrawal delirium is for patients to achieve and maintain light somnolence.	8	High	High	
429. Benzodiazepines are recommended as first-line agents for managing alcohol withdrawal delirium.	8.5			
430. Alcohol withdrawal delirium is best treated with intravenous medications.	7.5			High
431. Clinicians should be aware that both lorazepam and diazepam are stabilized with propylene glycol and repeated high intravenous doses may result in both hyponatremia and metabolic acidosis. Careful monitoring is required to prevent this complication.	8.5		Moderate	
432. As an alternative to benzodiazepines, barbiturates can be considered an option.	8	High		Low
433. Paraldehyde is not recommended for the management of alcohol withdrawal delirium.	9	High		
434. Intermittent IV administrations of long-acting medications and continuous IV infusion of short-acting medications seem effective and are thus acceptable. However, continuous IV infusion is considerably more expensive and there is no existing evidence of therapeutic superiority.	8	High		
435. Symptom-triggered bolus administration is more beneficial than continuous infusion for alcohol withdrawal delirium treatment.	6			
436. Antipsychotic agents may be considered for use in conjunction with benzodiazepines when symptoms are not adequately controlled by benzodiazepine therapy.	8	High		
437. Antipsychotic agents should not be used as monotherapy.	9		Moderate	

Statements: Addressing Seizures, Delirium, Hallucinosis, RAW	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
438. Propofol is an appropriate adjunctive medication when symptoms are not adequately controlled by benzodiazepine therapy.	8	High	Moderate	Moderate
439. Beta-adrenergic antagonists may be considered for use in conjunction with benzodiazepines in selected patients for control of persistent hypertension or tachycardia.	8	High		
440. Haloperidol is an appropriate adjunctive medication when symptoms are not adequately controlled by benzodiazepine therapy.	8			
441. The practitioner should not hesitate to use whatever amounts of benzodiazepines are needed to control the agitation while keeping in mind the possible buildup of long acting metabolites especially in patients with impaired hepatic function or the elderly.	8		Moderate	
442. Clinicians should be aware that very large doses of benzodiazepines are often required to control agitation in alcohol withdrawal treatment, doses that are much higher than typically seen in other patient populations.	9			
443. Although large doses of benzodiazepines are often required to control agitation in alcohol withdrawal treatment, clinicians should keep in mind the possible buildup of long acting metabolites, especially in patients with impaired hepatic function or the elderly.	8.5			
444. Patients with alcohol withdrawal delirium should receive symptom-triggered doses of medication.	7			Moderate
445. For patients with alcohol withdrawal delirium, it may be appropriate to administer an initially larger dose of benzodiazepines (a loading dose) followed by symptom triggered dosing.	8			
446. Clinicians can use an established dosing protocol as a guide, but dosing should be individualized based on symptoms.	9			
447. When light somnolence is achieved and the patient is calm and cooperative, management may be shifted to oral symptom-triggered schedule.	8	Low	Low	
448. In cases where the patient has been delirious more than 72 hours, careful consideration should be given to the diagnosis of benzodiazepine-induced delirium. In such cases, reduction of benzodiazepine dose should be strongly considered.	8		Moderate	
449. If the patient has been delirious longer than 72 hours, assess the patient for benzodiazepine-induced delirium and withdrawal from another GABAergic agent (like gabapentin or soma).	7	x	x	x
450. Clinicians should be aware that it is unlikely that a person already in alcohol withdrawal delirium will then experience a seizure.	7.5		Moderate	
451. Hallucinosis can occur in the absence of other clinically prominent withdrawal symptoms. It should be distinguished from hallucinations that can be part of alcohol withdrawal delirium.	8.5		Moderate	
452. Neither antipsychotics nor benzodiazepines have demonstrated efficacy in the treatment of hallucinosis.	6.5			
453. For hallucinations, diazepam is first-line treatment.	6*		Low	High

Statements: Addressing Seizures, Delirium, Hallucinosis, RAW	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
454. In cases of persistent hallucinosis, low doses of antipsychotics may be prescribed for a period of 1-2 weeks until symptoms remit.	5	Low		
455. The treatment of alcohol-induced psychotic disorder may require consultation with a psychiatrist.	8			
456. The treatment of alcohol-induced psychotic disorder may require addition of antipsychotics	8			

Specific Settings and Populations

Statements: Specific Settings and Populations	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
457. Clinicians should assess all critically ill patients for risk of alcohol withdrawal using screening questions, collateral information from family members and other medical providers, and/or laboratory tests.	9			
458. Patients with a reduced level of consciousness who are for the development of alcohol withdrawal should be monitored for the appearance of alcohol withdrawal symptoms.	9		Moderate	
459. It is important that clinicians ask critically ill patients if they have experienced events such as seizures or delirium tremens during past withdrawal episodes.	9	Low		
460. With patients for whom a complete medical history is not available, (i.e. ED, trauma, ICU) knowing the patient is at high risk of complicated alcohol withdrawal may orient the medical decision toward a more aggressive treatment despite presenting symptoms.	8		Moderate	
461. It is generally appropriate to provide prophylactic treatment of alcohol-dependent patients in the ICU.	7		Moderate	
462. Clinicians should be aware that the effects of some medications may lead to artificially low CIWA-Ar scores and the effects of some medications and some medical conditions (e.g. fever from infection) may confound CIWA-Ar scores.	8	Low	Moderate	
463. Within the ICU, use of the CIWA-Ar may be complicated by lack of patient communication or presence of influential comorbidities. Clinicians should consider alternative scales to assist with dosing including:				
a. Riker Sedation-Agitation Scale	7	Low	Moderate	Low
b. Richmond Agitation-Sedation Scale (RASS)	7*	Low	Moderate	Low
c. Minnesota Detoxification Scale (MINDS)	7*	Low		Low
d. Confusion Assessment Method for ICU Patients (CAM-ICU)	7*	Low	Moderate	
e. Delirium Detection Score (DDS)	5*			Moderate
464. Within the ICU, use of the CIWA-Ar may be complicated by lack of patient communication or presence of influential comorbidities. Clinicians should consider alternative scales to assist with dosing in these patients (e.g., the Richmond Agitation-Sedation Scale, Confusion Assessment Method for ICU Patients, or Minnesota Detoxification Scale).	8			

Statements: Specific Settings and Populations	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
465. For patients admitted to the ICU for alcohol withdrawal symptoms, symptom-triggered dosing using a validated scale is recommended.	8	Low		
466. For patients admitted to the ICU for alcohol withdrawal symptoms, the administration of benzodiazepines via the intravenous route may be preferable because of the rapid onset of action and more predictable bioavailability.	8	Low		
467. For patients admitted to the ICU for alcohol withdrawal symptoms, clomethiazole should not be used in critically ill patients due to its risk of trachaeobronchitis and pneumonia through higher bronchia secretion.	5	Low		
468. In the ICU, implementing an alcohol withdrawal management protocol such as symptom-triggered benzodiazepine therapy is associated with a reduction in benzodiazepine acquisition costs and ICU length of stay.	9	Moderate		
469. For patients admitted for to the ICU for alcohol withdrawal symptoms, those with symptoms that may mimic or mask Wernicke's encephalopathy should be administered thiamine.	9			
470. In the ICU, a worsening clinical condition in a patient with alcohol withdrawal should not always be assumed to be related to withdrawal.	9	Low		
471. It is essential to establish risk for alcohol withdrawal in all patients admitted to the hospital.	8.5		Moderate	
472. Every patient admitted with liver disease must be monitored for signs of alcohol withdrawal.	4.5*		Low	
473. Patients undergoing elective surgery should be screened for alcohol problems and may need to undergo medically managed withdrawal before proceeding with surgery, but this is not always necessary.	8		Moderate	
474. If alcohol withdrawal develops after surgery or trauma, immediate treatment is required.	9			
475. When treating delirium in surgical patients, doses are generally increased compared to those in detoxification units.	5		Moderate	
476. Among general medical/surgical patients, low withdrawal scores can be interpreted with confidence, although patients on beta-blockers and other sympatholytic drugs may have low scores associated with progressive withdrawal. However, high scores have many causes and must be interpreted with caution.	7		Moderate	
477. Hospitalized patients requiring more than small amounts of medication for withdrawal symptoms need individualized assessment by clinicians experienced in the management of withdrawal.	8		Moderate	
478. In the emergency department, patients with alcohol withdrawal require immediate evaluation for delirium as well as for other conditions that mimic withdrawal.	8		Low	
479. Patients with delirium in the emergency department should be assessed for all potential etiologies of the delirium.	8.5			
480. Patients who take sedative-hypnotic medications may have tolerance; thus, treatment of alcohol withdrawal may require adjustments compared to usual treatment.	9			
481. Patients who use other substances may experience concomitant withdrawal syndromes.	9			

Statements: Specific Settings and Populations	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
482. In most cases, the management of the medical condition in the patient with an SUD does not differ from that of any other patient. However, the medication used for withdrawal management and the actual withdrawal management protocol may need to be modified to minimize potentially harmful effects relevant to the co-occurring condition.	9		Moderate	
483. In most cases, the management of alcohol withdrawal for patients on chronic opioid therapy (opioid substitution therapy or opioid analgesic therapy) does not differ from that of any other patient, but caution and close monitoring should be undertaken when benzodiazepines are prescribed.	8.5			
484. For patients with co-occurring medical conditions, consultation with specialists in infectious diseases, cardiology, pulmonary medicine, hematology, neurology, and surgery may be warranted.	9		Moderate	
485. Wernicke's encephalopathy is a neurologic emergency that should be treated by the immediate parenteral administration of thiamine.	9		Moderate	
486. For patients with cardiovascular disorders, underlying cardiac illness could be worsened by the presence of autonomic arousal (e.g., elevated BP, increased pulse). Thus, prompt attention to these findings and aggressive withdrawal treatment is indicated.	9		Moderate	
487. For patients with impaired hepatic function, protocols that use the benzodiazepines should be adjusted to use those specific medications that are minimally hepatically metabolized.	7.5		Moderate	
488. Patients with medical conditions that prevent the use of oral medications should receive intravenous or intramuscular medications, which may impact the appropriate choice of level of care.	9			
489. Before giving any medications to pregnant patients, clinicians should ensure that the patient understands the risks and benefits of the medication, both for herself and the developing fetus.	9		Moderate	
490. Pregnant women who develop withdrawal symptoms following the cessation of alcohol consumption should be managed with the short-term use of a benzodiazepine.	8.5		Moderate	
491. Benzodiazepines have been associated with adverse effects on the developing fetus, but these risks appear to be small, so the use of these medications should be weighed against the risk of possible harm to the fetus should the patient develop severe alcohol withdrawal symptoms.	9	High		
492. Benzodiazepines and barbiturates cross the placenta and are teratogenic, but in view of the risk for fetal alcohol syndrome and consequences of maternal withdrawal, they are still considered the medications of choice in treatment of pregnant patients with alcohol withdrawal.	8.5			
493. Clinicians should understand that the risk of teratogenicity from benzodiazepines and barbiturates is mainly during the first trimester.	8			

Statements: Specific Settings and Populations	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
494. For patients at risk for pre-term delivery, use of a short-acting benzodiazepine is recommended in the late third trimester, given their short onset and offset of action, which minimize the risk for neonatal benzodiazepine intoxication.	7.5			
495. Use of chlordiazepoxide is recommended in the first trimester of pregnancy as the preponderance of evidence points to low teratogenic risk.	5			
496. Because anticonvulsants carry a risk of neural tube defects in addition to teratogenic risks, clinicians should ensure that pregnant patients take folic acid if they are being treated for alcohol withdrawal using anticonvulsants.	6			
497. Barbiturates have been associated with adverse effects on the developing fetus, but these risks appear to be small for short-term use, so the use of these medications should be weighed against the risk of possible harm to the fetus should the patient develop severe alcohol withdrawal symptoms.	8	High		
498. Valproic acid should be avoided for pregnant patients because of teratogenic risk.	8			
499. The use of the CIWA-Ar is recommended to determine the appropriate dose of medication to be administered.	7		Moderate	
500. Inpatient supervised withdrawal is appropriate for patients with at least moderate alcohol withdrawal (i.e, CIWA-Ar scores greater than or equal to 10) who are pregnant.	9		High	
501. Supervised withdrawal should include fetal monitoring appropriate to stage of pregnancy.	8.5			
502. Inpatient care should be considered in the withdrawal management of pregnant women with alcohol dependence.	9		Moderate	
503. In cases of alcohol withdrawal treated close to delivery, clinicians should assess the newborn baby for hypotonia, benzodiazepine intoxication, and fetal alcohol syndrome.	9		Low	
504. If a pregnant patient has been treated with benzodiazepines in the third trimester, clinicians should be aware that the newborn baby may experience benzodiazepine withdrawal as late as after discharge from the newborn nursery, likely because immature hepatic function in newborns leads to prolonged half-life.	6.5		Low	
505. Clinicians offering alcohol withdrawal management to pregnant patients should assume that symptoms such as nausea, headache, anxiety, and insomnia are connected to alcohol withdrawal, and will abate once the alcohol withdrawal has been effectively treated.	7			
506. Medical staff have an ethical and legal obligation to understand state laws regarding definitions of child abuse and neglect, reporting requirements, and plans of safe care for newborns with in utero alcohol exposure.	9		Moderate	
507. Treatment engagement is particularly important for pregnant patients with alcohol withdrawal given the risk of FAS and FASD.	9			

Statements: Specific Settings and Populations	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
508. Pregnant women should be made aware of all wraparound services that will assist them in addressing newborn needs, including food, shelter, medical clinics for inoculations, as well as programs that will help with developmental or physical issues that the newborn baby may experience as a result of substance exposure.	9		Moderate	

Future Directions

Statements: Future Directions	Appropriateness (Median)	Level of Evidence		
		AMSTAR-2	AACODS	Cochrane ROB
509. For young people under 16 years who are in acute alcohol withdrawal, offer admission to hospital for physical and psychosocial assessment, in addition to medical treatment of alcohol withdrawal.	9		High	
510. There is no evidence that the recommendations should change for adolescent populations.	9	High		
511. Medical staff should understand state laws regulating treatment of minors including age of consent for treatment, parental involvement, and administering psychotropic medications.	9			

APPENDIX VI