SKILL GUIDE · MENTAL HEALTH

Substance Withdrawal: What's Actually Dangerous

The Mental Health chapter's Tier 2 names increased substance use during the disillusionment phase as a real, well-documented pattern, not a moral failing. This guide covers what happens when access to that substance disappears anyway: which withdrawal is actually life-threatening, which only looks that way, and what to do without assuming medical care is reachable.

WARNING

Severity and danger are not the same thing, and the instinct here is backwards

Someone in opioid withdrawal looks far worse than someone in the first hours of alcohol withdrawal: doubled over, sweating, vomiting, miserable. It's the person who just looks shaky and anxious who needs closer attention. Alcohol and benzodiazepine withdrawal can escalate to seizures and a genuine medical emergency; opioid withdrawal, despite how it looks, rarely becomes life-threatening on its own.

Alcohol and benzodiazepines: the ones that can actually kill

Roughly 3–5% of people going through alcohol withdrawal progress to **delirium tremens** (DTs), its most severe form: severe confusion, hallucinations, dangerously elevated heart rate and blood pressure, and a real risk of prolonged seizures. Untreated, DTs carries a mortality rate as high as 37%; with real medical treatment, that drops to around 2%. That gap, not the withdrawal itself, is the entire reason this section exists.

Timeframe after the last drink	What typically happens
6–48 hours	Seizure risk window, peaking around 24 hours
48–72 hours	Delirium tremens onset, if it's going to happen
4–5 days	Peak DT intensity, when it occurs
Up to 8 days	Symptoms can persist even in a survived, treated case

Benzodiazepines (prescription anti-anxiety medications like diazepam or alprazolam) carry the same real seizure and delirium risk on withdrawal as alcohol does, for the same underlying reason, and the two are

frequently discussed together in clinical withdrawal guidance for exactly that reason.

Recognizing a real emergency

Any of these means get to real medical care immediately, regardless of tier: a seizure, severe confusion or disorientation, hallucinations (visual, auditory, or a crawling sensation on the skin), a dangerously fast heartbeat, or a high fever. This isn't something to manage at home past this point.

> **What clinicians actually use to judge severity**
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> The CIWA-Ar is the real, standard 10-item scale hospitals use to score alcohol withdrawal severity, covering things like tremor, sweating, anxiety, and orientation. A score under 10 is mild; 11 to 15 is moderate; 16 or higher is severe and strongly indicates a real medical response is needed. This isn't a tool for self-diagnosis at home, but the categories it's built from are the same real signs worth watching for.

Opioids: severe, but rarely fatal on their own

Opioid withdrawal is genuinely miserable, nausea, vomiting, gooseflesh skin, and an intense crawling discomfort that can last around 10 days, but it's not usually life-threatening by itself the way alcohol or benzodiazepine withdrawal can be. The real risk with opioids runs the other direction: a return to use after a period of abstinence, when tolerance has already dropped, is what actually kills people, from an accidental overdose at what used to be a normal dose.

If a seizure actually happens

This is real, safely-taught first aid for the seizure itself, arranging emergency transport at the same time, not instead of it.

1. Clear away anything nearby they could strike, and put something soft (a folded jacket, a pillow) under their head.
2. Turn them onto their side, mouth toward the ground, so saliva or vomit doesn't block the airway.
3. **Never put anything in their mouth** and never try to hold them still; both cause real injury and don't stop the seizure.
4. Time it from start to finish. A seizure lasting 5 minutes or longer, or a second one starting before they've regained consciousness from the first, is its own emergency on top of the withdrawal itself.

5. Stay with them until they're fully alert; confusion for a while afterward is normal, but get to real care regardless of how quickly they seem to recover.

What supportive care can and can't do without medical backup

- **Can help:** hydration, a calm and safe environment, monitoring for the danger signs above, reassurance, and simply not leaving someone in moderate-to-severe withdrawal alone. Thiamine (vitamin B1), an over-the-counter supplement, is genuinely worth giving to anyone withdrawing from heavy, sustained alcohol use, it's low-risk and real medical guidance recommends it for exactly this population, to prevent a separate serious complication called Wernicke's encephalopathy. Give it before any sugary food or drink if you can, a large carbohydrate load in someone thiamine-deficient can actually trigger the complication it's meant to prevent.
- **Can't safely substitute for medical care:** managing a real seizure risk, administering benzodiazepines to treat someone else's withdrawal without training and real dosing knowledge, or assuming supportive care alone is enough once any real emergency sign above has appeared.

Tapering ahead of a predictable disruption

If a disruption to supply is foreseeable, evacuating ahead of a hurricane, a known pharmacy closure, a planned move, a gradual, deliberate reduction is real harm reduction and meaningfully safer than an abrupt stop. It's not universally safe to do without guidance, though: heavy daily drinkers, anyone with a prior withdrawal seizure, or anyone with a significant medical condition should be evaluated by a clinician before attempting any reduction plan, not guess at a schedule alone.

Real help

SAMHSA's National Helpline, **1-800-662-4357**, is free, confidential, available 24/7/365, and reachable as long as phone service is up, independent of whether local treatment facilities are open. It's a real referral and information line, not a hotline that requires an active crisis to call.

Sources

- Alcohol withdrawal timeline, delirium tremens risk, and mortality with and without treatment: StatPearls/NIH; Cleveland Clinic
- Opioid versus alcohol withdrawal, severity-versus-danger distinction: NorthStar; NJ Addiction Centers

- CIWA-Ar scale, items, and severity scoring: Clinical Institute Withdrawal Assessment for Alcohol; MDCalc
- Tapering safety and who shouldn't self-taper: Alina Lodge
- SAMHSA National Helpline: SAMHSA
- Seizure first aid technique and when it's an emergency: Epilepsy Foundation; Mayo Clinic Health System
- Thiamine supplementation in alcohol withdrawal and Wernicke's encephalopathy prevention: Alcohol Treatment Guidelines

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Safety Planning When Home Isn't Safe

Every other guide on this site assumes home is the place you're trying to protect, and that everyone in the household is on the same side of the plan. For a household living with domestic violence or intimate partner violence, neither assumption holds: the danger is a person you live with, not a hazard outside, and a shared family communication plan or an obvious go-bag can be turned into a warning sign for an abuser rather than a safety measure. This guide is a different kind of planning, sourced directly to the organizations built specifically for it, not adapted from the rest of this manual.

If you're in immediate danger, call 911

Everything below is for planning ahead, before a crisis moment, or for situations where calling 911 isn't the safest immediate option. If you or someone else is in danger right now, call 911. This guide doesn't replace that judgment call, it's what to have in place before you need to make it.

The real hotline, and why it matters more than anything on this page

The **National Domestic Violence Hotline** is free, confidential, and available 24/7: call **1-800-799-7233**, text **START to 88788**, or chat at thehotline.org, in English, Spanish, and over 200 languages through interpretation services. Their advocates build a real, personalized safety plan with you, specific to your actual situation, your abuser's actual behavior, and your actual resources, which is something a general guide like this one genuinely cannot do. Their own interactive safety planning tool walks through this step by step. Everything below is a starting point for that conversation, not a substitute for it.

A go-bag that doesn't tip off an abuser

The core difference from every other go-bag on this site: it can't live somewhere obvious in your own home, and packing it can't look like packing.

- **Store it somewhere else entirely**, ideally at a trusted friend or neighbor's home, not next door, not a close mutual friend or family member an abuser would think to check first.
- **Pack it gradually, or keep a duplicate set** of documents and essentials rather than visibly emptying a drawer at once. Photocopies of documents work if the originals can't be removed without being noticed.

- **What actually goes in it:** cash, a spare debit or credit card, identification (driver's license, passport, Social Security card, green card or work permit if applicable), birth certificates for you and any children, a spare phone or a prepaid phone, a change of clothes, any daily medication, and a copy of any protective order already in place.

Know your way out before you need it

Identify which door, window, stairwell, or exit actually offers the fastest way out of your home, and mentally walk through it, the same rehearsal logic this site uses for every other emergency reflex, applied here to a very different kind of emergency.

Agree on a code word with a trusted friend, relative, or neighbor, one ordinary-sounding word or phrase you can say or text that means "call for help" or "come get me now" without an abuser who overhears or reads it realizing what it means.

Technology can be turned into surveillance

WARNING

Shared accounts and devices can reveal a safety plan before it's used

Location sharing on a shared phone plan, a shared cloud or email account, a smart-home app, or a car's own built-in tracking can all let an abuser see where you are or what you've been searching, sometimes without you realizing the feature is even on. If you suspect a device or account is being monitored, using it to research leaving or to contact help can itself be a risk. Where it's safe to do so, use a device the abuser doesn't have access to, a public library computer, a trusted friend's phone, and clear browser history afterward if you have to use a shared device. The National Network to End Domestic Violence's Safety Net Project covers this in real depth, specific to phones, apps, and smart-home devices, and is worth reading before you assume any device is safe to use for this.

Why the rest of this site's plan can work against you here

A family communication plan built for a storm or an earthquake assumes everyone benefits from everyone knowing the meeting point and the out-of-area contact. Here, that same information in the wrong hands is exactly what lets an abuser find you. Keep your own safety plan, your own contact, and your own meeting point separate and known only to people you trust, not shared as part of a household-wide plan the abuser is also part of.

Sources

- National Domestic Violence Hotline, contact methods and interactive safety planning tool: TheHotline.org; MNADV
- Go-bag contents, storage location, and gradual-packing guidance: Women Against Abuse; Illinois Legal Aid Online
- Escape route identification and code-word planning: Illinois Coalition Against Domestic Violence; Domestic Violence Crisis Center
- Technology-facilitated abuse and device/account safety: National Network to End Domestic Violence, Safety Net Project