GUIDELINES FOR COMMUNITY ALCOHOL DETOXIFICATION IN SHARED CARE

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Community based alcohol detoxification is a safe and effective option for the majority of alcohol dependent patients. Alcohol detoxification should not occur in isolation but should be part of an integrated treatment package that includes assessment, engagement with services, specific therapy and aftercare. (Lingford-Hughes et al., 2004)

Individuals with mild to moderate dependence can be offered a detoxification from alcohol in the community by their GP, providing that there is appropriate support at home and the GP is able to see them regularly during the course of the detoxification.

Preparation for detoxification

This stage is key to a successful detoxification

- Consider the most suitable setting for the detoxification. (Raistrick, 2007)
- Carry out liver function tests to determine suitability for community detoxification, as opposed to inpatient detoxification and to guide prescription of medications during detoxification
- Physical examination to identify any untreated co-morbid physical illness, blood pressure, pulse.
- Help build motivation
- Discuss goals of treatment, and the patient’s concerns should be addressed. Discussion points may include severity of withdrawal symptoms, medication given during detoxification and life without alcohol. This is an opportunity to plan positive alternatives to drinking.
- Concomitant use of illicit drugs may predict severe withdrawal symptoms during alcohol detoxification. There may be a resultant increase in the use of illicit drugs. In these cases we suggest referral to our service for alcohol detoxification.
- Give accurate information about what to expect during detoxification. Map out a timetable in some detail for the week of detoxification. Consider practical issues e.g. time off work, childcare arrangements, support from family and friends etc.
• Discuss post detoxification relapse prevention strategies e.g. support from family, alternative activities available in the community, Alcoholics Anonymous, drop-in centres, and the relapse prevention groups jointly run by the Fitzwilliam Centre.

• Give the patient contact details for use in the event that problems are encountered during detoxification.

• Discuss the importance of discontinuing the detoxification regime should the patient resume drinking during the detoxification process.

• Discuss potential physical complications of alcohol detoxification, for example, the need for hospitalisation if there is evidence of a severe withdrawal syndrome during the detoxification such as delirium tremens, withdrawal seizures and Wernicke’s encephalopathy. Discuss potential physical complications of alcohol detoxification.

Inpatient detoxification should be considered in the following situations:

1. Severe dependence as indicated by withdrawal seizures, or delirium tremens.
2. Patients with alcohol dependence and unstable polydrug misuse.
3. Medical illnesses including severe hypertension, ischaemic heart disease, severe liver disease, renal disease, diabetes, and organic brain damage.
4. Psychiatric illness including a history of self harm.
5. Social factors e.g. homelessness, lack of social support, childcare problems.
6. Previous multiple unsuccessful community detoxification
7. Patients on significant benzodiazepine script

Protocol for community detoxification

• Ensure contact with a trained health professional who assesses severity of withdrawal symptoms and monitors for complications daily during the first 3 days, then one week later. Suitable scales for monitoring withdrawal symptoms include the Short Alcohol Withdrawal Scale (S.A.W.S.) This is a self –completion questionnaire that rates symptoms over the preceding 24 hours. Scores above 12 indicate the need for medication. (Taylor et al., 2005-2006).

• Integration in GP surgery of brief motivational and coping skills into the detoxification process improve outcome.

• Prescribe benzodiazepines. Chlordiazepoxide is long acting and is the drug of choice when compared to Diazepam due to its lower dependence and abuse potential (Heather et al., 2006). The dose will depend on the severity of alcohol dependence, and the severity of withdrawal symptoms. A typical regimen for uncomplicated , moderate alcohol dependence is:
Chlordiazepoxide 20mg 4 times/ day on day one
Reduce by 10mg a day, and prescribe for 7 days
(See Appendix I for typical regime)

**NB: Never prescribe Chlormethiazole or related drugs for alcohol detoxification as they may cause respiratory failure if used in combination with alcohol.**

- Decide a day with the patient/family when the detoxification should commence. Individuals should not consume any alcohol from the first day of detoxification and commence Chlordiazepoxide on this day. Most detoxifications last between 5 and 10 days. Do not prescribe for longer than 14 days
- For safety reasons, do not issue all the medication at once. It is recommended that the medication is not given for longer than 4 days at a time.

**NB: In cases with severe liver disease Lorazepam is the drug of choice. Suggest referral to Specialist Services**

**Vitamin supplementation**

Vitamin deficiency is common in alcoholism. There is a particular need to replenish thiamine, a deficiency of which can lead to Wernicke’s encephalopathy and Korsakoff’s psychosis.

Recommended doses during detoxification:
   Thiamine 100mg 3 times/day
   Vitamin B Co-strong 30mg/day

Continue vitamin supplementation after detoxification if there is evidence of cognitive impairment or of poor dietary intake. Oral absorption of vitamin B is poor therefore consider parenteral supplementation (as an inpatient or in a clinical setting where appropriate resuscitation facilities are available) if Wernicke’s encephalopathy is suspected. (Royal college of physicians, 2001)

The classical signs of this condition are:

- disturbed gait (ataxia)
- gaze abnormalities (ophthalmoplegia/nystagmus)
- confusion
- memory disturbance
- low blood pressure
- low temperature

Wernicke’s encephalopathy is a medical emergency. In the event that a patient develops the above symptoms, urgent referral to hospital is indicated as it is a medical emergency with significant mortality.
Relapse Prevention

- Discuss psychosocial interventions e.g. social skills training, support groups, drop-in centres, Alcoholics Anonymous, and referral to the relapse prevention groups run by Specialist Services at the Fitzwilliam Centre or drop-in run by SAAS
- Consider prescription of Acamprosate, which can be used safely during medicated withdrawal, or started as soon as possible after detoxification. (See guidelines for prescribing Acamprosate)

Further detoxifications in the event of relapse

Successive episodes of alcohol withdrawal are associated with an increase in the severity of the withdrawal syndrome and in the rate of complications. There is also an increase in cognitive impairment (Duka et al., 2003). It is therefore advised that in the event of a relapse patients are not routinely offered another detoxification in quick succession. In this situation referral to Specialist Services at the Fitzwilliam Centre is advised.

Do’s

1. Ensure regular contact with a health professional during detoxification. Two to three contacts during the detoxification are recommended with emphasis on the initial few days of the detoxification period.
2. Assess severity of withdrawal symptoms to guide prescription of medication.
3. Prescribe chlordiazepoxide.
4. Supplement with vitamins.
5. Follow up with relapse prevention work.

Don’ts

1. Start benzodiazepines if patient intoxicated.
2. Prescribe benzodiazepines long term.
3. Give medication all at once.
4. Continue benzodiazepine in the event of relapse
5. Continue outpatient detoxification in the event of Delirium tremens, withdrawal seizures, or Wernicke’s encephalopathy.
6. Prescribe benzodiazepines other than chlordiazepoxide e.g Chlormethiazole or diazepam. (If this is considered, refer to Specialist Services at the Fitzwilliam Centre)
References

## Proposed 80 mg chlordiazepoxide reduction regime

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