Community Alcohol Detoxification

Lothian has walk-in services run in close partnerships of Social Care, Health and third sector agencies for people experiencing problems with substance misuse. People are able to start treatment within weeks of presenting at a HUB or Gateway service. Despite these easily accessible services, people will still present in crisis with alcohol-related problems at their GP practice. This can cause clinical difficulties for the primary care team since sudden alcohol cessation can cause severe withdrawals including hallucinations, convulsions or even death.

There is no evidence on how best to approach these encounters, however, the following may be helpful:

- Intoxicated patients presenting in GP practices requesting detoxification should be given written information about available community walk-in services and mutual aid agencies
- Patients who have stopped drinking ‘cold turkey’, requesting detoxification and who have a known history of alcohol withdrawals can be encouraged to resume alcohol use in the short term to relieve withdrawals before gradually reducing intake (10% every 48 hours) and be given written information about available community walk-in services and mutual aid agencies
- Suicidal ideation or demands for immediate, but undefined, help require more detailed assessment and possible referral to Mental Health Assessment Service (MHAS), or discussion with a sector psychiatric team, or Substance Misuse Directorate (SMD) staff
- Physically threatening behaviour should be dealt with by calling the police.

Referral to specialist services - Consider the walk-in services as a first option. They offer a response to varying levels of alcohol-related needs. Following a brief initial assessment the patient will be allocated/referred to the most appropriate service(s). This will depend on the level of alcohol consumption and other health and social factors. The patient can be supported through a planned detoxification and offered daily monitoring before and after withdrawal. The aim is to reduce the number of alcohol detoxification episodes and promote ongoing recovery for people experiencing problems with alcohol.

ELCA (Edinburgh and Lothian Council on Alcohol) provide 1-1 support and counselling for patients and have drop-in times. Alcoholics anonymous have meetings throughout the Lothians (http://aa-edinburgh.org.uk/).

Community alcohol detoxification that adheres to best practice guidelines is an effective, safe treatment for patients with mild to moderate withdrawal symptoms (http://www.sign.ac.uk/guidelines/fulltext/74/section4.html).

However, alcohol withdrawal does carry risks and requires careful clinical management and should be part of a recovery plan that is drafted between the patient and the clinician. Unplanned, frequent and intermittent short-term prescribing of benzodiazepines for alcohol withdrawal could have negative effects. If there are clinical reasons to offer a community detoxification in primary care, it should be delivered using protocols specifying:

- daily monitoring of the breath alcohol level
- daily monitoring of withdrawal symptoms
- daily assessment of medication/dosage adjustment.

When the patient describes alcohol consumption of less than 15 units/day (male) or 10 units/day (female) and reports neither recent withdrawal symptoms nor recent drinking to prevent withdrawal symptoms, stopping drinking is unlikely to require medication.

Among periodic dependent drinkers, whose last bout was less than one week long, medication is seldom necessary unless drinking was extremely heavy (over 20 units/day).

Benzodiazepines are currently the recommended drugs to control withdrawal symptoms during detoxification. SIGN 74 and the LJF (http://www.ljf.scot.nhs.uk/lothianjointformularies/adult/4.0/4.10/(i)/Pages/default.aspx) outline potential reducing regimes. They can cause temporary cognitive slowing, memory and executive function impairment and have dependence potential. Prescribing should be restricted to a maximum of seven days. The LJF recommends restricting diazepam to inpatient use. Chlordiazepoxide is the first-choice oral agent for outpatients and general practice alcohol withdrawal, because it has less abuse potential and ‘street value’ than diazepam.

If the patient resumes alcohol use or does not understand why benzodiazepines have been prescribed and continues to drink while taking them, serious reactions can result and the benzodiazepines should be stopped.

- The combination of benzodiazepines and alcohol can potentiate depressive effects on mood and increase suicidal ideation
- When benzodiazepines are prescribed immediately before a referral to the specialist services, this may compromise a planned detoxification programme
- Repeated alcohol detoxification leads to an increased severity of withdrawal syndrome and can result in alcohol-related brain damage and cognitive deficits
- Benzodiazepines also share cross-tolerance with alcohol and there is a risk of replacing an alcohol addiction with benzodiazepine dependence or adding another addiction.

Vitamin supplements - Oral thiamine is indicated for less severe cases while receiving detoxification treatment for 5 to 7 days. Patients who resume drinking or continue to drink and are at risk of malnourishment should be given oral thiamine 50mg or 300mg daily, according to local protocol, on a long-term basis.