Rotherham Alcohol Guidelines

These guidelines have been developed for use in Primary Care by general practitioners and practice nurses. They are written to complement the documents Rotherham Alcohol Pathway, Identification and Brief Intervention Toolkit, the Rotherham Alcohol Strategy, and the Disulfiram Shared Care Protocol.

The Service Level Agreement of the Rotherham Primary Care Alcohol Service outlines the LES including training requirements.

**BASICS:**
- The maximum recommended weekly limits are 21 units for a man and 14 units for a woman, with a daily recommended limit of 4 units for a man and 3 units for a woman, and two alcohol free days a week
- A binge is defined as drinking twice the recommended daily limits in one session
- 30% men have had more than 8 units and 25% women have had more than 6 units during one day in the past week

**What is a Unit of Alcohol?**

A unit of alcohol is 10mls of pure alcohol or 8gms. This translates as:
- A pint of ordinary strength (3.5%) lager, beer, or cider - 2 units
- A pint of strong (5.6%) lager, cider or bitter - 3 units
- A 175ml glass of red wine - 2 units
- A pub measure of spirits - 1 units
- An alcopop - around 1.5 units

A simple calculation allows anyone to determine the number of units they are drinking, and helps health professionals when dealing with clients:

\[
\% \text{ Alcohol by volume} \times \text{Volume (mls)} / 1000 = \text{number of units}
\]

E.g. half pint of beer at 4.2% 
\[
4.2 \times 280\text{mls} = 1.176/1000 = 1.176 \text{ or 1.2 units}
\]
**Current Concepts**

An important element of contemporary thinking surrounding alcohol has been to move away from focusing on ‘alcoholism’ as the main problem. It’s thought helpful to view alcohol misusers in different categories. (Models of Care for Alcohol Misusers 2006).


Hazardous drinkers are drinking at levels over the sensible drinking limits either in terms of regular excessive consumption or less frequent sessions of heavy drinking. They have so far avoided significant alcohol related problems, but may benefit from brief advice about their alcohol use.

Harmful drinkers are typically drinking at higher levels than most hazardous drinkers and show clear evidence of some alcohol related harm, though they may not appreciate this. They are typically drinking 50 units a week if a man or 35 units a week if a woman.

Dependent drinkers can be viewed as moderate or severely dependent. Moderate dependence is a broad category characterised by an increased drive to use alcohol, a raised level of tolerance, and difficulty controlling its use despite negative consequences, but probably not experiencing physical withdrawal.

Severely dependent drinkers are what used to be thought of as ‘chronic alcoholics’ and drink to avoid withdrawal, often with habitual significant daily alcohol use.

Drinks with complex needs include those with a co-existing problem such as mental health, drug misuse, homelessness etc.

More recently the Department of Health has changed its clarification slightly and introduced the terms Lower Risk, Increasing Risk, and Higher Risk. These roughly equate to Sensible, Hazardous, and Harmful. It was thought there was potential confusion around the use of the words Hazardous and Harmful. Several of the identification tools, particularly AUDIT, still use the old terms.

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**Definition of Alcohol Dependence**

ICD 10 criteria for alcohol dependence. Three or more of the following have been present together during the previous year:

- A strong desire or sense of compulsion to drink alcohol
- Difficulty in controlling drinking in terms of its onset, termination, or level of use
- A physiological withdrawal state (e.g. tremor, sweating, rapid heart rate, anxiety, insomnia or less commonly seizures, disorientation, hallucinations) when drinking has ceased or reduced or drinking to relive or avoid such a withdrawal state
- Evidence of tolerance such as that increased doses of alcohol are required in order to achieve effects originally produced by lower doses
- Progressive neglect or alternative pleasures or interests because of drinking, and increased amounts of time necessary to obtain or take alcohol or to recover from its effects
- Persisting with alcohol use despite awareness of overtly harmful consequences

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**Pyramid Model**

- Severely dependent drinkers (0.1%)
- Moderately dependent drinkers (0.4%)
- Harmful drinkers (4.1%)
- Hazardous drinkers (16.3%)
- Low-risk drinkers (67.1%)
- Non-drinkers (12.0%)

NTA - More treatment, better treatment, fairer treatment

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**Alcohol and Inequalities in Health**

Drinking over the recommended limits is more prevalent in areas of high deprivation. The Department of Health analysis of data indicates that alcohol-related deaths are 45% higher in areas of high deprivation. The rate for males in the most deprived areas is five times that of the least deprived, for women it is three times.

Men over 35 who are unemployed, or working in unskilled or manual employment, are at highest risk of being admitted to hospital with an alcohol related problem.

Half of homeless people are dependent on alcohol.

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**Identifying Problematic Drinkers**

In general practice it is recommended that the routine identification of problematic drinking is performed at new patient registration and during consultations for a condition known to be related to alcohol.
Examination may be unremarkable but some indicators of alcohol misuse are:

- Hypertension
- Dilated facial capillaries
- Blood shot eyes
- Hand or tongue tremor
- Cognitive impairment

Biological markers are unreliable. They have a lower specificity and sensitivity than questionnaires but can be used as an adjunct to them. They can be useful for confirming self-reports, for providing motivational feedback on health status and in the monitoring of progress following treatment:

- Liver function tests - particularly GGT ALT AST may be raised
- Raised MCV
- Raised Uric Acid

Several identification tools have been developed for use in Primary Care. It is suggested that AUDIT is used. It is specific and sensitive and can be completed in less than two minutes. There are several versions of AUDIT. AUDIT-C uses the first three questions only. A score of 5 or more would prompt completion of the full questionnaire.

It can be completed by the client alone but is best done with a health professional. It is not appropriate for using to assess alcohol dependent patients. Simply ticking the boxes is unlikely to maximise the potential of the identification tool.

### Alcohol Users Disorders Identification Test (AUDIT)

<table>
<thead>
<tr>
<th>Questions</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Your Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often do you have a drink?</td>
<td>Never</td>
<td>Monthly or less</td>
<td>2 - 4 times per month</td>
<td>2 - 3 times per week</td>
<td>4+ times per week</td>
<td></td>
</tr>
<tr>
<td>How many standard alcoholic drinks do you have on a typical day when you are drinking?</td>
<td>1-2</td>
<td>3-4</td>
<td>5-6</td>
<td>7-8</td>
<td>10+</td>
<td></td>
</tr>
<tr>
<td>How often do you drink alcohol if you have had a drink?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
<td></td>
</tr>
<tr>
<td>How often during the last year have you had three or more drinks on one occasion?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
<td></td>
</tr>
<tr>
<td>How often in the last year have you felt guilty or ashamed about your drinking?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
<td></td>
</tr>
<tr>
<td>How often in the last year have you been concerned about your drinking?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
<td></td>
</tr>
<tr>
<td>How often in the last year have you been able to remember what happened when you were drinking?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
<td></td>
</tr>
<tr>
<td>Have you been injured as a result of your drinking?</td>
<td>No</td>
<td>Yes, but not in the last year</td>
<td>Yes, during the last year</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SCORING:**

- 0-7 = Sensible drinking
- 8-19 = Hazardous drinking
- 16-19 = Harmful drinking
- 20+ = Possible dependence
Cognitive function is known to decline with prolonged alcohol use. This is not easy to test for in the early stages, and early referral to psychology or neuropsychologist may be appropriate. Vitamin B supplementation should be started early. Details are given in the prescribing section.

Mental health problems are more common in harmful drinkers. Some will have a psychotic illness which they are self-medicating with alcohol. It is important to remember to assess for depression, which is common among those who misuse alcohol.

A number of people whose use alcohol also misuse other substances. Questions about illicit drugs should be part of the initial assessment.

**Safeguarding**

If a primary care worker identifies in their judgement a significant level of alcohol use then the practitioner must carry out a risk assessment relating to vulnerable adults or children in accordance with safeguarding procedures.

**Prescribing for Alcohol Related Problems in Primary Care**

‘Pharmacological therapies are most effective when used as enhancements to psychological therapies as part of an integrated programme of care ‘(Models of Care for Alcohol Misusers).

There are three main areas of pharmacological treatment for alcohol related problems. Unlike heroin addiction there is no substitute medication available:

- Medication for detoxification
- Relapse prevention medications - sensitising agents and Anti-craving agents
- Nutritional supplements

**Detoxification**

Safe and effective alcohol detoxification is possible in community settings with appropriate patient selection and good quality support. Cessation of drinking is likely to be uncomplicated in milder dependence and does not always need medication. The patient should be assessed using the Severity of Alcohol Dependency Questionnaire.

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**SADQ Questionnaire**

**The Severity of Alcohol Dependence Questionnaire**

<table>
<thead>
<tr>
<th>NAME</th>
<th>AGE</th>
<th>SEX</th>
</tr>
</thead>
</table>

Have you drunk any alcohol in the past six months? **YES / NO**

During the past six months:

1. Indicate below physical symptoms you have experienced 1st thing in the morning during typical periods of heavy drinking

**The day after drinking alcohol, I woke up feeling sweaty**

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Nearly Always</td>
</tr>
</tbody>
</table>

**The day after drinking alcohol my hands shook first thing in the morning**

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Nearly Always</td>
</tr>
</tbody>
</table>

**The day after drinking alcohol, my whole body shook first thing in the morning**

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Nearly Always</td>
</tr>
</tbody>
</table>

**The day after drinking alcohol, I woke up absolutely drenched in sweat**

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Nearly Always</td>
</tr>
</tbody>
</table>

2. The following statements refer to moods and states of mind you may have experienced during these periods of heavy drinking

**I dreaded waking up in the morning**

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Nearly Always</td>
</tr>
</tbody>
</table>

**I was afraid of meeting people first thing in the morning**

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Nearly Always</td>
</tr>
</tbody>
</table>
### I felt at the edge of despair when I first woke up

<table>
<thead>
<tr>
<th>0</th>
<th>Almost Never</th>
<th>1</th>
<th>Sometimes</th>
<th>2</th>
<th>Often</th>
<th>3</th>
<th>Nearly Always</th>
</tr>
</thead>
</table>

### I felt very frightened when I woke up

<table>
<thead>
<tr>
<th>0</th>
<th>Almost Never</th>
<th>1</th>
<th>Sometimes</th>
<th>2</th>
<th>Often</th>
<th>3</th>
<th>Nearly Always</th>
</tr>
</thead>
</table>

### 3. The following statements refer to a degree of alcohol consumption during the recent period of heavy drinking and periods like it

#### I liked to have a morning drink

<table>
<thead>
<tr>
<th>0</th>
<th>Almost Never</th>
<th>1</th>
<th>Sometimes</th>
<th>2</th>
<th>Often</th>
<th>3</th>
<th>Nearly Always</th>
</tr>
</thead>
</table>

#### I always gulped my first few morning drinks down as quickly as possible

<table>
<thead>
<tr>
<th>0</th>
<th>Almost Never</th>
<th>1</th>
<th>Sometimes</th>
<th>2</th>
<th>Often</th>
<th>3</th>
<th>Nearly Always</th>
</tr>
</thead>
</table>

#### I drank in the morning to get rid of the shakes

<table>
<thead>
<tr>
<th>0</th>
<th>Almost Never</th>
<th>1</th>
<th>Sometimes</th>
<th>2</th>
<th>Often</th>
<th>3</th>
<th>Nearly Always</th>
</tr>
</thead>
</table>

#### I had a very strong craving for a drink when I woke up

<table>
<thead>
<tr>
<th>0</th>
<th>Almost Never</th>
<th>1</th>
<th>Sometimes</th>
<th>2</th>
<th>Often</th>
<th>3</th>
<th>Nearly Always</th>
</tr>
</thead>
</table>

### 4. The following statements refer to a degree of alcohol consumption during the recent period of heavy drinking and periods like it

#### I drank more than a quarter of a litre bottle of spirits per day i.e. 4 doubles or 1 bottle of wine or 4 pints of beer / lager

<table>
<thead>
<tr>
<th>0</th>
<th>Almost Never</th>
<th>1</th>
<th>Sometimes</th>
<th>2</th>
<th>Often</th>
<th>3</th>
<th>Nearly Always</th>
</tr>
</thead>
</table>

### I drank more than half a litre bottle of spirits per day or 2 bottles of wine or 8 pints of beer / lager

<table>
<thead>
<tr>
<th>0</th>
<th>Almost Never</th>
<th>1</th>
<th>Sometimes</th>
<th>2</th>
<th>Often</th>
<th>3</th>
<th>Nearly Always</th>
</tr>
</thead>
</table>

### I drank more than one bottle of spirits per day or 4 bottles of wine or 15 pints of beer / lager

<table>
<thead>
<tr>
<th>0</th>
<th>Almost Never</th>
<th>1</th>
<th>Sometimes</th>
<th>2</th>
<th>Often</th>
<th>3</th>
<th>Nearly Always</th>
</tr>
</thead>
</table>

### I drank more than two bottles of spirits per day or 8 bottles of wine or 30 pints of beer / lager

<table>
<thead>
<tr>
<th>0</th>
<th>Almost Never</th>
<th>1</th>
<th>Sometimes</th>
<th>2</th>
<th>Often</th>
<th>3</th>
<th>Nearly Always</th>
</tr>
</thead>
</table>

### 5. Imagine the following situations. You have been completely off drink for a few weeks and you then drink very heavily for two days. How would you feel the morning after those two days of heavy drinking?

#### I would start to sweat

<table>
<thead>
<tr>
<th>0</th>
<th>Not At All</th>
<th>1</th>
<th>Slightly</th>
<th>2</th>
<th>Moderately</th>
<th>3</th>
<th>Quite A Lot</th>
</tr>
</thead>
</table>

#### My hands would shake

<table>
<thead>
<tr>
<th>0</th>
<th>Not At All</th>
<th>1</th>
<th>Slightly</th>
<th>2</th>
<th>Moderately</th>
<th>3</th>
<th>Quite A Lot</th>
</tr>
</thead>
</table>

#### My body would shake

<table>
<thead>
<tr>
<th>0</th>
<th>Not At All</th>
<th>1</th>
<th>Slightly</th>
<th>2</th>
<th>Moderately</th>
<th>3</th>
<th>Quite A Lot</th>
</tr>
</thead>
</table>

#### I would be craving for a drink

<table>
<thead>
<tr>
<th>0</th>
<th>Not At All</th>
<th>1</th>
<th>Slightly</th>
<th>2</th>
<th>Moderately</th>
<th>3</th>
<th>Quite A Lot</th>
</tr>
</thead>
</table>
Notes on the use of SADQ

The Severity of Alcohol Dependence Questionnaire was developed by the Addiction Research Unit at Maudsley Hospital. It is a measure of the severity of dependence.

Patients scoring less than 15 probably do not need detoxification. A significant number of patients can reduce their alcohol intake themselves over the course of 7-10 days.

Patients scoring 15-30 are classed as moderately dependent and suitable for community detoxification. Patients scoring above this may on occasion be suitable but should be assessed by specialist services initially.

A medical assessment should be undertaken. A history of a co-existing severe medical or psychiatric condition, or a past history of epilepsy or delirium tremens, substance misuse, pregnancy child protection involvement would be contraindications to primary care detoxification. The patient should have a stable home environment.

A focused examination should be conducted looking for:

- Signs of liver disease
- Signs of withdrawal - tremor sweating etc
- A mental state examination

Investigations should include:

- LFT
- FBC
- Alcohol breath test

If the decision is made to commence community detoxification this should ideally be done with the support of the primary care alcohol support worker/nurse. A choice of either medically assisted detoxification or a supervised alcohol withdrawal programme should be made after assessment and discussion with the patient.

Withdrawal symptoms should be assessed with an appropriate alcohol withdrawal scale.

Alcohol Withdrawal Scale

<table>
<thead>
<tr>
<th>a) Perspiration</th>
<th>e) Axilla temperature (centigrade)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - No Sweating</td>
<td>0 - 37.0 or less</td>
</tr>
<tr>
<td>1 - Moist palms only</td>
<td>1 - 37.1-37.5</td>
</tr>
<tr>
<td>2 - Moist palms and localised beads of sweat</td>
<td>2 - 37.6-38.0</td>
</tr>
<tr>
<td>3 - Whole body moist</td>
<td>3 - 38.1-38.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>b) Tremor</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - No tremor</td>
<td>4 - Above 38.5</td>
</tr>
<tr>
<td>1 - Positional hand tremor</td>
<td></td>
</tr>
<tr>
<td>2 - Constant tremor of the hand</td>
<td></td>
</tr>
<tr>
<td>3 - Constant marked tremor of the hand</td>
<td></td>
</tr>
<tr>
<td>4 - Full body tremor</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>c) Anxiety</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - Calm, no anxiety</td>
<td>0 - No hallucinations</td>
</tr>
<tr>
<td>1 - Uneasy</td>
<td>1 - Episodes of distortion. Has insight</td>
</tr>
<tr>
<td>2 - Apprehensive, easily startled</td>
<td>2 - Frank hallucinations. Retains reasonable contact with reality</td>
</tr>
<tr>
<td>3 - Anxious and fearful</td>
<td>3 - Frank hallucinations. Tenuous grip on reality</td>
</tr>
<tr>
<td>4 - Uncontrolled anxiety, panic</td>
<td>4 - Disoriented in time place and person</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>d) Agitation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - Normal activity, no agitation</td>
<td>0 - Fully orientated</td>
</tr>
<tr>
<td>1 - Unsettled, fidgety</td>
<td>1 - Orientated place and person. Problems recollecting time.</td>
</tr>
<tr>
<td>2 - Restless, tossing and turning</td>
<td>2 - Oriented in person, patchy orientation in place and time</td>
</tr>
<tr>
<td>3 - Excitable</td>
<td>3 - Patchy orientation in person, distorted in place and time</td>
</tr>
<tr>
<td>4 - Very excitable, unable to settle</td>
<td>4 - Generalised hallucinations. Exists in an illusionary world</td>
</tr>
</tbody>
</table>

Scoring

0-5 = possible alcohol withdrawal
5-6 = severe alcohol withdrawal (risk of DT’s)
over 8 = very severe alcohol withdrawal (high risk of DT’s)
Alcohol Detoxification Using the Alcohol Reduction Programme

The main aim of the programme is for the individual to detoxify from a position of physical dependency on alcohol to become non-alcohol dependent safely and without the use of psychoactive drugs. The approach is used for mild to moderate dependency and is carried out within a community setting usually in the patient’s own home.

“Most community referred ambulatory chronic alcoholics can be detoxified quickly and safely without the use of psychoactive drugs. We believe such detoxification can be done most efficiently in a social setting with the aid of staff who will provide reassurance and reality orientation and who will monitor the patient’s vital signs, general condition and any specific problems.” (JAMA 259 (14) APRIL 1978 WHITFIELD et al)

It is far from new though there is little specific literature on the process.

As with all interventions the safety of the patient remains paramount and as such the following criteria should be observed.

Prior to commencement of a reduction plan the following should be considered:

- Goals of treatment. Does the client want to reduce their alcohol consumption and ultimately stop drinking or are they looking to cut down? Review the cut off point as they progress
- Gold standard for the reduction programme is the safe suppression of withdrawal symptoms leading to a period of abstinence
- Plans should be in place for support once reduction has finished

• Reduction is not a crisis intervention and should be considered in detail before progressing
• Reduction is about treatment choice not a second best option for medicated detox

The suitability of patients with the following history should be considered in greater detail:

• Severe dependence
• History of DT’s and alcohol withdrawal seizures, Poor social support
• Cognitive impairment
• Psychiatric co-morbidity
• Poor physical health - routine blood investigations LFT, FBC, U+E and INR

Reduction Process

“Alcohol withdrawal with alcohol empowers the client because it achieves a desired goal through a process that makes obvious the importance of the client’s own choice to stop drinking”

(Wright and Thompson Alcohol and Alcoholism 37 (4) 344-348)

There must first be agreement between the patient and nurse regarding the objective of the reduction. The patient should provide a detailed drink diary of the previous seven days indicating:

- Daily alcohol intake
- Time span and duration of drinking for each day
- Pattern of consumption within the day e.g. drinking steadily throughout or large amounts followed by sleep followed by further alcohol

An average of the daily consumption should be agreed upon and the amount in units recorded. Ideally a conversion to an alternative form of alcohol should be agreed utilizing weaker drinks e.g. spirits to wine, strong lager / cider to ordinary strength lager, beer or cider. The equivalent amount of the “new” drink in comparable units should be worked out and recorded.

A timetable for drinking the new level of units should be discussed and agreed upon.

The aim of the timetable is to provide a regulated and steady intake of alcohol so providing a blood alcohol level with as few fluctuations as possible.

Once the timetable has been adhered to for 2 days a reduction of no more than 25% should be negotiated with the drinks removed from the middle of the timetable rather than either end. This process should be repeated every 2 days with the reduction being based on the previous day’s intake.

Once the reduction has reached an intake of 4 units daily for 2 days with no signs of withdrawal the patient can stop alcohol consumption safely.

Throughout the process the patient should be visited on a daily basis and the withdrawal symptoms monitored and recorded using agreed withdrawal scale. If there is not a demonstrable reduction in withdrawal symptoms after 2 days reduction should be delayed until this is evident and the process resumed.
**Role of Vitamin Supplements in Detoxification**

Detoxification may precipitate Wernicke’s encephalopathy, which must be treated urgently with parenteral thiamine, in hospital.

Signs of possible Wernicke-Korsakoff syndrome in a patient undergoing detoxification:

- Confusion
- Ataxia, especially truncal ataxia
- Ophthalmoplegia
- Nystagmus
- Memory disturbance
- Hypothermia and hypotension
- Coma

Patients with any sign of above should receive Pabrinex in a setting with adequate resuscitation facilities - ideally an inpatient setting.

Otherwise for duration of the detox till eating normally:

- At least Thiamine 100mg tds. The local secondary care service prescribes 200mg qds (above BNF), recommended by Royal College of Physicians

- Vit B Co Strong Two daily

Problems may occur during withdrawal. Simple features occurring not uncommonly in the first 24 hours include:

- Tremor
- Nausea / Vomiting
- Anxiety
- Sweating
- Palpitations
- Depression
- Craving

Complicated features occurring within 24-72 hours, and requiring admission include:

- Seizures
- Wernike’s Encephalopathy
- Delirium Tremens characterised by hallucinations, confusion, and marked tremor

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**Medically Assisted Detoxification**

On commencing detoxification the patient will be seen on a daily basis by the primary care worker / Community alcohol team, who will provide support, carry out and record BP, pulse and temp check, and liaise with the prescribing GP as appropriate. Chlordiazepoxide is the drug of choice for alcohol detoxification. It provides sedation, with safety. It is slowly absorbed, has a low abuse potential, and a long half-life.

Before the regimen is begun the patient must have an alcohol breath test. A result greater than 80mgs / 100mls should prompt re-assessment.

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**Table:**

<table>
<thead>
<tr>
<th>Time</th>
<th>Day 1/2</th>
<th>Day 3/4</th>
<th>Day 5/6</th>
<th>Day 7/8</th>
<th>Day 9/10</th>
<th>Day 11/12</th>
<th>Day 13/14</th>
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</thead>
<tbody>
<tr>
<td>8am</td>
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<td>10pm</td>
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* = 1 Can
Relapse prevention support should be offered to every client who has had a detoxification. A variety of strategies may be used. Psychosocial interventions, which are most effectively delivered by a trained professional, may include:

- Behavioural coping strategies
- Assertiveness training
- Relaxation strategies
- Cognitive strategies including Cue exposure
- Alcoholics Anonymous

The pharmacological therapies used in Rotherham are acamprosate and disulfiram:

**Acamprosate** is an anti-craving agent. Its mode of action is unclear. It has relatively few side effects – the main ones being nausea and diarrhoea. It is contra indicated in breast-feeding and pregnancy. It is available in 333mg tablets. In adults over 60kg the dose is two tablets three times a day, those weighing under 60kg should take two in the morning and one lunch at night.

The treatment should start as soon as possible (at least within 28 days) of alcohol withdrawal and continue for 6 months. Treatment should not be stopped during a relapse. It should only be prescribed in conjunction with a programme of psychosocial support. The evidence suggests that it may increase by 50% the number of abstinent days. It is often used with disulfiram.

**Disulfiram** is a sensitising agent. It works by blocking the action of an enzyme in the liver leading to an increase in levels of acetaldehyde. When alcohol is taken it causes unpleasant flushing, tachycardia, sweating, nausea, vomiting, and headache and can lead to hypotension, collapse and even death. It is contra indicated in:

- Cardiac failure
- CHD
- Hypertension
- Pregnancy
- Those with a history of psychosis
- It interacts with metronidazole. The usual dose is 200mg daily.

When disulfiram is delivered in supervised settings with psychosocial support up to 100% abstinence has been reported. The supervision can be done by a relative, friend or alcohol worker.

It should be given for at least 3-6 months. Prescriptions must be reviewed every 6 months.

- Supervision important
- Wait at least 24 hours after last alcohol
- Nothing containing alcohol
- Interactions; potentiates warfarin, benzos, possibly opiates

**Undesirable effects:**

- 1-10% increase in transaminases, bilirubin
- 1/25000: hepatitis (severe) within 2 months
- LFT’s first: safest all normal, safe GGT<200. GPs can prescribe disulfiram with a GGT over 200 following consultation with the local Consultant in Substance Misuse

**Monitoring:**

- Ill health, fever, jaundice
- LFT’s: At 2, 4, 6, 8 and 12 weeks. 6 Monthly thereafter

## Aftercare

Successful detoxification is an important step on the patient’s treatment journey but not the end. Some people will continue to require psychosocial support. 12 step programmes and self-help organisations will be useful for some. The local wrap around / aftercare services should be accessible to all who require them. This can be done individually or as a group. Aftercare can be useful to help early detection of lapses, and prevent them becoming full-blown relapses. It can help to reinforce the new skills and coping strategies that have been learnt from the preparatory sessions before detoxification, and provide booster sessions. It can also deal with the mundane tasks of sorting out housing and benefits.

## References

5. ‘Alcohol Use Disorders Identification Test’, WHO (2001)
Call Wendy Edmondson, Alcohol Development Lead on 01709 304919 for more information.