NHS Grampian

Guidance For The Planned Detoxification Of Alcohol Dependent Patients In Community Or Outpatient Settings

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	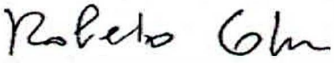	
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Across NHS Boards	Organisation Wide	Directorate	Clinical Service	Sub Department Area
	Yes			

Lead Author/Co-ordinator: Substance Misuse Pharmacist
Subject Guidance

Key word(s): Guidance, community, alcohol, detoxification, detox, chlordiazepoxide, dependant, patients, thiamine

Policy application: NHS Grampian – Substance Misuse

Purpose: This guidance provides best practice guidance to clinicians undertaking outpatient or community based alcohol detoxification in alcohol dependent patients.

Responsibilities for implementation:

Organisational: Operational Management Teams
Sector: General managers, medical leads and nursing leads
Departmental: Clinical Leads
Area: Line managers

Policy statement: It is the responsibility of individual health care professionals and their line managers to ensure that they work within the terms laid down in this guidance and to ensure that staff are working to the most up to date version. By doing so, the quality of the services offered will be maintained, and the chances of staff making erroneous decisions which may affect patient, staff or visitor safety and comfort will be reduced.

Review: This policy will be reviewed at least every three years or sooner if current treatment recommendations change.

Responsible for review of this document:	Substance Misuse Pharmacist
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Revision History:

Date of change	Approval date of guidance that is being superseded	Summary of Changes (Descriptive summary of the changes made)	Section Heading
June 2022	May 2017	Updated References throughout document and contact details to nhs.scot	
June 2022	May 2017	Section 2 :Thiamine supplementation added link to NHS Grampian parenteral thiamine, added choice and medication leaflet for importance of thiamine supplementation	Page 6
June 2022	May 2017	Added info on Maudsley recommendations for assessing problem drinking	Page 7
June 2022	May 2017	Added info on chlordiazepoxide regimes from Maudsley as nice link to example regimes no longer available	Page 9
September 2022	May 2017	Title changed to include “planned”	Throughout
September 2022	May 2017	Added information on psychological aspects of care – specifically ambivalence and motivational work	Section 3.
September 2022	May 2017	Added UKTIS statement relating to updated Librium SmPC in pregnancy/family planning	Section 4.1.
September 2022	May 2017	Reworded section 5 re dosing to encourage tailoring of dose to symptoms. NICE sample regimens has been withdrawn	Section 5.
September 2022	May 2017	Clarified section 6 on relapse prevention to highlight need for specialist support for options other than acamprosate.	Section 6.

Guidance For The Planned Detoxification Of Alcohol Dependent Patients In Community Or Outpatient Settings

Contents **Page No**

Guidance for the Detoxification of Alcohol Dependent Patients in Community Settings

1. Introduction

This guidance aims to provide consistency of practice across Grampian for clinicians and services undertaking planned outpatient or community based detoxification of alcohol dependent individuals (adult). Medically supported withdrawal from alcohol should not be considered a treatment in isolation, but merely one component of a more involved process. Referral to specialist clinical services within the NHS (for GP this is via scistore) and/or local voluntary sector services (supported or self-referral) is the preferred model of care. Where this is not a feasible option, the relevant specialist service may be contacted for advice and support as follows:

Integrated Alcohol Service, Aberdeen	Telephone: 01224 557845 Email: gram.macrappointment@nhs.scot
South/Central Aberdeenshire Clinical Substance Misuse Service	Telephone: 01467 532833 Email: gram.southcentralsms@nhs.scot
North Aberdeenshire Substance Misuse Service, Kessock Clinic, Fraserburgh	Telephone: 01346 585160 Email: gram.kessockclinic@nhs.scot
Moray Integrated Drug and Alcohol Service, Elgin	Telephone: 01343 552211 Email: gram.midasadministration@nhs.scot

NICE Clinical Knowledge Summaries provide a good reference source for those seeking more information on problem alcohol use (http://cks.nice.org.uk/alcohol-problem-drinking#!topicsummary).

2. Supplementation With Thiamine

Alcohol dependent individuals are at high risk of developing Wernicke's encephalopathy during detoxification, especially in those who are malnourished, at risk of malnourishment or who have decompensated liver disease. In particular, recent weight loss, diarrhoea, vomiting or peripheral neuropathy should be noted. Clinical features of Wernicke's encephalopathy include confusion, ataxia (loss of coordination), ophthalmoplegia (eye paralysis), nystagmus (involuntary eye movements), memory disturbance, hypothermia, hypotension, and coma. Absence of any of the "classical triad" of symptoms (ophthalmoplegia, ataxia and confusion) does not rule out a diagnosis of Wernicke's encephalopathy. If staff have concerns they should seek urgent medical assessment. When suspected or considered a risk, administration of parenteral thiamine is required and these patients should be referred for inpatient treatment. Guidance for prophylaxis of patients considered at risk of developing Wernicke's can be found here (NHS Grampian guidance for vitamin supplementation during in-patient admission (mental health) for alcohol withdrawal).

Thiamine should be initiated at the earliest opportunity in the period of preparation for community detoxification and compliance should be checked. In community settings oral thiamine is recommended at the doses below:

- 100mg three times a day
- Where compliance is an issue a single dose of 300mg daily
- Where swallowing is an issue, the 100mg tablets can be halved on score line.

The crucial importance of taking this supplement should be strongly emphasised by staff. A "Choice and Medication" patient information leaflet can be accessed here to support these discussions. It should be continued on completion of detoxification until abstinence and a healthy diet are well established. Where indicated, this should be initiated by primary care prior to referral to a specialist service. There is no compelling evidence to support the prescription of vitamin B compound strong and it is not recommended.[1],[2],[4]

3. Assessment And Preparation For Detoxification

As a solitary intervention, pharmacological detoxification is unlikely to be successful in supporting long term abstinence. A comprehensive, holistic, bio-psycho-social assessment that informs a treatment plan for ongoing support should be in place before commencing the course. Recurrent prescribing of short courses of a benzodiazepine is not appropriate in the management of alcohol dependent patients.

Detoxification regimens may not be necessary for patients who are diagnosed with milder dependence, approximated as a reported daily consumption of less than 15 units for males and 8 units for females. A commitment to maintaining abstinence, at least in the medium term (3 - 6 months), is required prior to considering detoxification.

Clinicians should determine the degree of alcohol problem using the Alcohol Use Disorders Identification Test (AUDIT) scale (Appendix 1). Alcohol dependence is more likely where a score of 20 or more is achieved. The Severity of Alcohol Dependence Questionnaire (SADQ) (Severity of Alcohol Dependence Questionnaire (SADQ) Calculator (mdapp.co) will give a measure of the severity of alcohol dependence:

Mild dependence	A score of 15 or less
Moderate dependence	A score or 15 - 30
Severe dependence	A score of 31 or more

The patient's level of motivation to change and their personal goals for their drinking behaviour should also be understood. Exploring any ambivalence and readiness to change is important alongside an understanding of the function of the person's alcohol use. Use of drink diaries may be helpful to support motivational conversations and support regular attendance and engagement with the service. A drink diary (NHS Health Scotland leaflet is available from NHS Grampian's Health Information Resources Service) Your guide and record to success (healthscotland.scot) and ideally a reduction in alcohol consumption from baseline. Many patients are able to reach their goal, whether controlled drinking or abstinence, by gradual reduction with support.

Medical detoxification may be indicated for alcohol dependent patients who are unable to do so. Patients should be strongly advised to avoid sudden cessation or rapid reduction in alcohol consumption as this may precipitate complications associated with severe alcohol withdrawal.

General advice would be to start with a 10% reduction in drinking per day. For example, if you normally drink 20 units a day, try reducing this to 18 units a day. Keep drinking at this reduced level for four days, then try to cut down by another 10%. If individuals start to have any withdrawal symptoms, it means they're cutting down too fast. The Shaap leaflet has good tips for heavy drinkers shaap-heavy-drinking-pamphlet-2022-a5-web.pdf

Maudsley recommends that "where consumption above recommended levels has been identified, a more detailed clinical assessment is required. Depending on the context, this could include the following:

- History of alcohol use, including daily consumption and recent patterns of drinking
- History of previous episodes of alcohol withdrawal
- Time of the most recent drink
- Collateral history from a family member or carer
- Other drug (illicit and prescribed) use
- Severity of dependence and of withdrawal symptoms
- Coexisting medical and psychiatric problems
- Physical examination, including cognitive function
- Breathalyser: absolute breath alcohol level and whether rising or falling (take at least 20 minutes after last drink to avoid falsely high readings from the mouth, and 1 hour later)
- Laboratory investigations: full blood count (FBC), urea and electrolytes (U&E), liver function tests (LFTs), international normalised ratio (INR), prothrombin time (PT) and urinary drug screen.

4. Cautions To Undertaking Alcohol Detoxification In The Community

Where detoxification is indicated, inpatient management is advised if the patient:

- Is confused or has hallucinations
- Has a history of previous complicated withdrawal
- Has epilepsy or a history of fits
- Is malnourished or at risk of malnourishment
- Has severe vomiting or diarrhoea
- Is at risk of suicide
- Has severe dependence (Defined by SADQ as a score of 31 or more)
- Has a previously failed home-assisted withdrawal
- Has uncontrollable withdrawal symptoms
- Has an acute physical or psychiatric illness
- Has multiple substance misuse issues
- Has a home environment unsupportive of abstinence
- Is pregnant
- Needs concurrent withdrawal from alcohol and benzodiazepines.

In vulnerable groups, such as homeless and older people, it may be appropriate to consider inpatient or residential assisted withdrawal. Necessity will be dependent on the individual's personal circumstances.

4.1. Pregnancy and Family Planning

The SmPC for Chlordiazepoxide (Librium®) was updated in 2022 to include information on teratology risk both for women of child bearing age and men who are planning family.

The UK Teratology Information Service (UKTIS) provided guidance advising that:

- The available data suggesting mutagenic effects of chlordiazepoxide are not conclusive, and as such, the recommendations from the manufacturer are considered overly cautious given the benefits of treating alcohol dependency and the risks from delirium tremens and seizures if chlordiazepoxide is withheld.
- Clinicians should not be discouraged from using chlordiazepoxide based on this evidence.
- The benefits of treating pregnant women (at any stage of pregnancy) experiencing acute alcohol withdrawal with chlordiazepoxide likely outweigh the risks.

The full UKTIS statement can be accessed here:
https://www.medicinesinpregnancy.org/bumps/monographs/Librium-SPC-Updates-Opinion-Statement/

5. Pharmacological Interventions

Chlordiazepoxide is the recommended benzodiazepine for use in community settings as it is less toxic in overdose and has lower street value, thus less potential for diversion than diazepam.

5.1. Identification of patients suitable for medication-assisted community detoxification

- Reported daily consumption of more than 15 units for males and 8 units for females
- Unable to reduce alcohol intake gradually
- A commitment to maintaining abstinence at least in the medium term (3-6 months)
- AUDIT score >20
- SADQ >15
- Exclude individuals falling under the categories listed in Section 4.

5.2. Chlordiazepoxide reducing regimens

In a community setting initially a fixed dose regimen using chlordiazepoxide is recommended. A fixed-dose regimen involves starting treatment with a standard dose, not defined by the level of alcohol withdrawal, and reducing the dose to zero over 7 to 10 days according to a standard protocol.

In the Community the full assessment of the patient prior to commencing detox should have identified at what level a patient usually begins to experience withdrawal symptoms after last consumption of alcohol. The recommendation to patients should be to stop drinking, according to their habit, at a time appropriate for them to attend just before the onset of withdrawal symptoms, which, in case of people starting to drink first thing in the morning to relieve the withdrawal symptoms, can be just a few hours after their last drink.

For some heavily dependent drinkers they may experience withdrawal symptoms even with low levels of alcohol still in their system, therefore breathalyser readings should be used alongside alcohol withdrawal scales to inform the safe point to commence medication assisted detox. There has to be a balance between the risk of withdrawal and the risk of over-sedation if alcohol is still in the system.

Breath Alcohol Concentration (BAC) Table can be used to support decisions along with appropriate alcohol withdrawal scales.

The first dose of medication should be given before withdrawal symptoms begin to emerge, which in the case of more severe dependence can be before the breathalyser reads zero. The Clinician supporting the detox (usually the Community Mental Health Nurse (CMHN)) should review the patient daily making use of breathalyser and Short alcohol withdrawal scale (SAWS) and response to the treatment should be monitored and the dose of chlordiazepoxide prescribed adjusted upwards or downwards if needed in the early stages of withdrawal.

When Community detox is undertaken in an inpatient setting, such as a community hospital then an ‘As Required’ dose of chlordiazepoxide can also be prescribed for breakthrough withdrawals.

As a general rule of thumb, the starting dose of chlordiazepoxide can be estimated from current alcohol consumption. For example, if 20 units/day are being consumed, an appropriate starting dose would be around 20mg four times a day with the dose tapered to zero over a period of 5-10 days [Maudsley].

For patients drinking in the region of 30 units daily the maximum dose for the first day will be chlordiazepoxide 30mgs four times a day. An additional 30mgs dose prescribed as required for continued symptoms of withdrawal may help tailor the dose. Patients drinking more than 30 units/day are usually considered not suitable for detoxification in community settings.

A sample reducing regimen is included Appendix 2.

Benzodiazepine doses may need to be reduced for older people and people with liver impairment (Ref NICE CG115). Accumulation should be considered a significant risk in such patients. In these circumstances a shorter acting benzodiazepine is recommended (e.g. oxazepam or lorazepam). Specialist advice on prescribing should be sought.

5.3. Monitoring during medically supported withdrawal from alcohol

To assess progress and provide adequate support, it is recommended that the patient be reviewed daily by a healthcare professional (who is competent in undertaking alcohol detoxification) for the first 5 days. Daily instalment dispensing of medication is recommended where local circumstances allow.

Prior to commencing a detoxification programme:

- Check the patient's medical history, especially; hepatic function, history of seizures/hallucinations, current prescribed medication, illicit drug use, allergies and social support.

At each consultation the following parameters should be recorded or completed:

- Current alcohol intake, breathalyser, Short Alcohol Withdrawal Scale (SAWS) or similar symptom scoring scale (Appendix 3), signs of over-sedation, blood pressure (BP) and pulse.

While the above data can be helpful to clinicians for gauging any adjustment of dose required by a particular patient, this should not be seen as a substitute for the healthcare professional's clinical judgement.

Breath Alcohol Concentration (BAC) readings during medically assisted alcohol withdrawal table

Breath alcohol concentration	Treatment plan
Zero on commencement and on each subsequent appointment during medically assisted withdrawal.	Start/continue medically assisted withdrawal.
Between zero and 0.5 on commencement of medically assisted withdrawal with objective evidence of withdrawal symptoms.	Continue medically assisted withdrawal.
Above zero on any day after the first day of medically assisted withdrawal.	Stop medically assisted withdrawal.

6. Relapse Prevention

When undertaking detoxification consideration should be given to psychological interventions aimed at maintaining abstinence and preventing relapse. In addition to psychological interventions, pharmacological interventions including a prescription of acamprosate, naltrexone or disulfiram may be appropriate. It is recommended that acamprosate, naltrexone and disulfiram are initiated by, or on the advice of, a specialist alcohol service. Ongoing prescribing may be undertaken in primary care.

NICE CG-115 currently recommends disulfiram as second line for people who have a goal of abstinence but for whom acamprosate or oral naltrexone are not suitable, or who prefer disulfiram and understand the relative risks of taking the drug.

Information on indications, dosing and formulations can be found in the BNF British National Formulary (BNF) | Medicines Complete and Home - electronic medicines compendium (emc)

When clinically appropriate, other medications (e.g. baclofen), although not currently licenced for alcohol relapse prevention, can be considered for initiation by specialist alcohol teams. Please see guidance for requirements if continuation in primary care appropriate NHS Grampian Policy - Prescribing Following Private Consultation

Before starting treatment with any relapse prevention medication, a comprehensive medical assessment should be conducted (baseline urea and electrolytes and liver function tests including gamma glutamyl transferase via primary care). In particular consider any contraindications or cautions (see the Summary of Product Characteristics (SmPC)), and discuss these with clinical colleagues and the patient.

7. Consultation

Name	Title
Dr Claire Campbell	Consultant Clinical Psychologist, Aberdeenshire Integrated Drug and Alcohol Psychology Service (AIDAPS)
Roberto Cotroneo	Consultant Psychiatrist, Integrated Alcohol Service
Evelyn Finn	Gastroenterology Pharmacist, Aberdeen Royal Infirmary
Linda Law	Senior Practitioner/Care Manager , Community Substance misuse Service, HSCP Aberdeenshire
Sam Lawson	CPN, Team Lead Aberdeenshire Drug and Alcohol Service
Richard Legg	GP Specialist, Aberdeenshire Drug and Alcohol Service
Angela MacManus	Principle Pharmacist, Royal Cornhill Hospital
Andrew Mckechnie	Advanced Pharmacist Aberdeenshire SMS Service
Juan Khan	Substance Use Worker, Alcohol and Drugs Action, Aberdeen
Elaine Neil	Lead H&SCP Pharmacist Aberdeenshire
Esam Saki	Specialty Doctor, Integrated Alcohol Service
Mike Turner	Consultant Psychiatrist and Lead for Aberdeenshire Drug and Alcohol Service

8. References

1) Taylor, D., Barnes, T.R.E., Young, A.H., *The Maudsley prescribing guidelines in psychiatry (14th edition).* Chichester: Wiley & sons ltd; 2021

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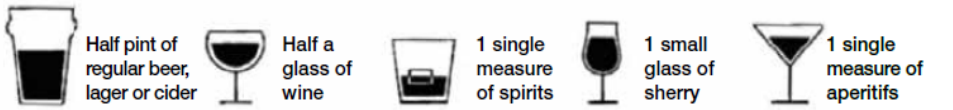
5) Baber, T.F., Higgins-Biddle, J.C., Saunders, J.B., Moriteiro, M.G., *The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care (2nd Ed).* Switzerland: World Health Organisation; 2001.

6) Alcohol Brief Intervention resources - Publications - Public Health Scotland

7) Lingford-Hughes, A.R., Welch, S, Peters, L, Nutt, D.J., 2012. *BAP updated guidelines: evidence based guidelines for the pharmacological management of substance abuse, harmful use, addiction and co-morbidity: recommendations from BAP*. London: Journal of Psychopharmacology BAPaddictionEBG_2012.pdf

Appendix 1: The Alcohol Use Disorders Identification Test (AUDIT) [6]

This is one unit of alcohol…



…and each of these is more than one unit

AUDIT	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	0 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence

SCORE

Appendix 2: Sample Chlordiazepoxide Reducing Regimen (Adapted from NICE2)

	CHLORDIAZEPOXIDE DOSING SCHEDULE				
Detox Day	Morning	Lunchtime	Evening	Bedtime	Daily total Tablets/caps
1	30mg	30mg	30mg	30mg	12 x 10mg
2	30mg	30mg	30mg	30mg	12 x 10mg
3	20mg	20mg	20mg	20mg	8 x 10mg
4	15mg	15mg	15mg	15mg	12 x 5mg
5	10mg	10mg	10mg	10mg	8 x 5mg
6	5mg	5mg	5mg	5mg	4 x 5mg
7	5mg			5mg	2 x 5mg

Note: This is a sample 7 day reduction and dosing should be adjusted to meet individual patient requirements. Specific points of note are as follows.

1. It may not be necessary to start all patients on a daily dose of 120mg. Starting dose will be determined by clinical assessment of level of dependence.

2. Symptoms of withdrawal generally peak in the first 48 hours of abstinence. For this reason day 2 has been repeated in this sample reducing regimen. The daily dose should be tailored according to individual patient response.

Appendix 3: Short Alcohol Withdrawal Scale [1]

SHORT ALCOHOL WITHDRAWAL SCALE (Consider symptoms experienced over the previous 24 hours period and tick the appropriate box)				
	NONE (0)	MILD (1)	MODERATE (2)	SEVERE (3)
Anxious				
Sleep Disturbance				
Problems with memory				
Nausea				
Restlessness				
Tremor (Shake)				
Feeling Confused				
Sweating				
Miserable				
Heart Pounding				
TOTAL				