Plymouth Community Healthcare CIC

Home Alcohol Detoxification Policy Incorporating the Administration of Pabrinex® Intramuscular Procedure

Version No.1

Notice to staff using a paper copy of this guidance

The policies and procedures page of Intranet holds the most recent version of this guidance. Staff must ensure they are using the most recent guidance.

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	Sullivan et al British Journal of Addiction Volume 84, Issue 11, ages1353–1357 November 1989 The Validity of the Short Alcohol Dependence Data (SADD) Questionnaire: a short self-report questionnaire for the assessment of alcohol dependence (Davidson R & Raistrick D) British Journal of Addiction Volume 81, Issue 2, pages 217–222 February 1986
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0.1	New policy	September 2014	PCH Clinical Lead in Substance Misuse	New policy
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Home Alcohol Detoxification Policy incorporating the Administration of Pabrinex® Intramuscular Procedure

1 Introduction

A detox is but one event in a continuing process … a technical step between dependent drinking and sobriety.

1.1 This policy has been designed to provide a clear and overarching reference of the expected standards that any Alcohol Home Detox in Plymouth should meet. The policy, consistent with NICE Guidelines, supports the delivery of high standards of safe practice for the benefit of those clients selected for Home Detox, their family and friends, practitioners, service leads and commissioners alike.

1.2 The main providers of such interventions will be Plymouth Community Healthcare (hereinafter referred to as "PCH") staff working within Harbour along with General Practitioners (GPs) who possess the necessary competencies. Each provider will need to generate their own organisation specific procedures which will implement the expectations of this document.

2 Definitions

GP	General Practitioner
WHO	World Health Organisation
Harmful alcohol	Refer to Section 4 – Establish the Need
ICD–10; WHO, 1992	Refer to Section 4.2
SADQ	Severity of Alcohol Dependence Questionnaire
SADD	Short Alcohol Dependence Data questionnaire
Cold turkey	Common expression of the sudden and complete withdrawal of a dependent substance, especially of a drug showing goose bumps in the skin.

3 Background

3.1 Alcohol dependence affects 4% of people aged between 16 and 65 years in England (6% of men and 2% of women). Of these 1 million alcohol dependents only 6% receive treatment in any one year.

3.2 Medically assisted home detoxification for alcohol dependence is widely accepted as a safe and effective intervention for most clients but for a minority there are risks of complications which tend to increase with each detox. In isolation, a detox may do more harm than good so is best viewed as but a technical step between dependent drinking and sobriety. **The quality of the preparation and subsequent aftercare is crucial to success and so form key elements to the policy.** The perspective is deliberately holistic with attention always to physical, psychological and social needs alongside each other and incorporated into action plans.

4 Establish the Need

4.1 Two criteria are essential prerequisites to a home detox are:

- The confirmation of alcohol dependency
- The client's clear expressed desire to stop drinking

4.2 The definition of harmful alcohol use in this guideline is that of World Health Organisation's International Classification of Diseases, 10th Revision – 10 Classification of Mental and Behavioural Disorders (referred to as "ICD–10; WHO, 1992"): **A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (i.e. hepatitis) or mental (i.e. depressive episodes secondary to heavy alcohol intake). Harmful use commonly, but not invariably, has adverse social consequences; social consequences in themselves, are not sufficient to justify a diagnosis of harmful use.**

4.3 The WHO (ICD 10) definition of dependency requires the presence of **three** or more of the following together at some time during the previous year:

a) A strong desire or sense of compulsion to consume alcohol.
b) Difficulties in controlling drinking behaviour in terms of its onset, termination or levels of use.
c) A physiological withdrawal state when alcohol use has ceased or reduced.
d) Evidence of tolerance, such that increased doses of alcohol are required in order to achieve effects originally produced by lower doses.
e) Progressive neglect of alternative pleasures or interests because of alcohol use, increased amount of time necessary to obtain or take alcohol or to recover from its effects.
f) Persisting with alcohol use despite clear evidence of overtly harmful consequences.

4.4 Screening audit scores are typically > 20 and **SADQ** (Severity of Alcohol Dependence Questionnaire) or **SADD** (Short Alcohol Dependence Data) questionnaire help establish the dependence severity. The history/presentation is often obvious and clarified by asking "how long can you sleep without alcohol?"

SADQ Scores		SADD Scores		Sleep without alcohol
1-15	mild	1-9	low	8 hours
16-0	moderate	10-19	medium	5-6 hours
30-0	severe	20 or greater	high	2-3 hours
40-0	very severe			

4.5 Caution is needed to avoid biased answers when utilising SADQ (WHO in 1989). Pay attention to the client's capacity to reflect on past and current drinking patterns accurately. SADD is more user-friendly.

4.6 Practitioners require specific skills to undertake assessment. The most important element being to build a good rapport with the client by way of a non-judgmental, interested and positive attitude. Awareness of stigma and discrimination is essential along with knowledge of the consequences physically, psychologically and socially of chronic drinking.

4.7 The client's desire for change needs to be evaluated respectfully to grasp the opportunity when it is the right time for detox, while supporting further preparations or exploration of other options if these are more appropriate such as harm reduction and controlled drinking.

5 Assess the Risks

5.1 Whilst the majority of clients can be safely home detoxed from alcohol, there are exceptions and responsible practitioners need to show that they have checked each client's profile to minimise the risk of dangerous and potentially disabling or fatal consequences. It is no legal defence for a practitioner to be unaware of a risk because they failed to ask about it. These risks (along with SADQ or SADD scores) increase with time as the drinking career extends due to deteriorating physical, mental health and malnutrition, hence the adage "beware the elderly drinker!".

5.2 In comparison to opiates, remember that detox from alcohol carries very different risks. There are far fewer medical risks during the uncomfortable 7-10 days of "cold turkey" from a heroin or other opiate detox.

5.3 PCH's mental health service and Harbour Drug and Alcohol staff routinely undertake a generalised Substance Misuse Risk Assessment (Appendix 2) that captures past and current risks to self, others, neglect issues and Safeguarding Children or Adult concerns. Whilst these formats are less familiar to GPs, they are an essential part of the comprehensive assessment and, so, the same topics need to be covered for each client whoever is responsible for the detox. These forms do not cover the specific clinical risks of an alcohol detox which are discussed later.

5.4 It must be also recognised that risk assessment is a dynamic process requiring active review if circumstances change and, so possibly, necessitating the transfer of a client from a home to a hospital setting during detox.

5.5 Risks representing absolute contra-indications to home detox:

a) past complicated detox including delirium tremens, Wernicke's
b) significant malnutrition
c) unstable epilepsy, seizures or history of severe seizures involving use of A&E or hospital care whatever the cause including withdrawal fits
d) any signs of Wernicke-Korsakoff's Syndrome (i.e. confusion, hallucinations, etc.)
e) unstable polydrug use
f) challenging behaviours that prevent co-operation with a detox plan
g) concurrent, severe mental illness including suicidality and self-harm
h) concurrent, severe physical illness including fever/dehydration
i) risks or signs of liver decompensation: ascites, encephalopathy, bilirubin > 50

j) home environment unsupportive of abstinence (i.e. hostility / drinkers)
k) insufficient home support - a responsible adult present for first 72 hours
l) social services input for Safeguarding Children / Adult investigation
m) active domestic abuse
n) young person (below 18 years) without specialist service support

5.6 Risks representing relative cautions to home detox:

a) pregnancy - requires specialist input
b) Child Protection Plan – only as an organised element of this
c) epilepsy or alcohol withdrawal seizures
d) stable polydrug use (i.e. methadone script)
e) cirrhosis, hepatitis or hepatic dysfunction - fully evaluated with Hepatology advice
f) cognitive/memory impairment or Learning Disability
g) old age

6 Decide if Suitable for Home Detox

6.1 An **assessment of suitability** (see section 6.10) must be undertaken **before** any prescribing takes place.

If in doubt consult specialist PCH staff within Harbour on 01752 434280

6.2 **Summary** - a positive evaluation to the following elements is required:

a) SADQ / SADD score or clinical history of dependence
b) The client's desire to stop drinking and stay abstinent
c) The client's realistic understanding of the process
d) The client's commitment to the care plan
e) Record of general risk assessment and those specific to detox
f) Blood test results
g) Health status information from client's GP and other hospital departments (diagnoses, medications and planned treatments)
h) Agreement to receive thiamine supplementation
i) Adequate home supporter and environment

6.3 **Detox Specific Risk Overview:**

- No past detox complications (i.e. delirium tremens, Wernicke's, seizures)
- No problematic polydrug misuse
- No signs of Wernicke-Korsakoff Syndrome
- No severe mental illness
- Adequate cognitive and behavioural insight and capacity
- Adequate liver function and nutritional state
- No severe physical illness
- Adequate home support and supervision
- No Child Protection, Vulnerable Adult or domestic abuse issues
- Over 18 years

6.3.1 Baseline - Pulse, BP and Temperature

6.3.2 Blood Tests - the following tests - GGT in particular - may assist evaluating liver and renal functioning and the physical impact of alcohol dependence:

FBC	Full Blood Count
LFT	Liver Function Test (LFT) especially Albumin and Bilirubin as liver disease markers
GGT	Gamma Glutamine Transferase (note: this a separate request from LFT)
Clotting screen	Prothrombin (PT), etc, if any suspicion of liver disease
U&Es	Urea & Electrolytes for renal function

6.4 **Tests** are unfortunately not very sensitive with many heavy drinkers having normal results. GGT, for example, is the best marker for alcoholism but a poor guide to the severity of liver disease. Hepatology staff are happy to discuss the management of abnormal results.

6.5 **Blood Borne Virus testing**, especially Hepatitis C if history of injecting drug use:

6.5.1 If a client has had contact with the Hepatology Department - possibly for Hepatitis C, then the latest diagnoses/results, past treatment and future treatment plans should be acquired **before** commencing the detox to avoid triggering liver decompensation in a home environment.

Communication with other health practitioners, especially GPs, is a vital prerequisite before commencing any home detox treatment.

6.5.2 Thiamine deficiency - have a high index of suspicion!

6.5.3 Thiamine or Vitamin B_1 is a water soluble vitamin found in cereals, marmite and pork with a recommended daily intake of 1.4mg with a daily energy consumption of 2000 kcal. It is needed in many cellular processes - release of energy from carbohydrate and in the synthesis of the neurotransmitters acetylcholine and GABA (gamma- aminobutyric acid). It is absorbed in the upper small intestines and used mostly by the brain. A regular daily thiamine intake of < 0.2 mg/1000 kcal per day results in clinical deficiency and the disease known as beriberi that affects the cardiovascular and nervous systems. Little thiamine is stored so deficiency can occur rapidly in days.

6.5.4 Years of inadequate nutrition with money spent on alcohol rather than food, as well as gastrointestinal damage from the drinking, renders these clients liable to thiamine (and other vitamin) deficiency. The process of alcohol detox can trigger a severe acute thiamine deficiency reaction that can result in death or severe disability through the Wernicke-Korakoff Syndrome. Inpatient intravenous (IV) thiamine is the treatment of choice in such an emergency.

6.6 **Wernicke's encephalopathy** - originally described in 1881

6.6.1 The acute or sub-acute phase has the classic triad of confusion, ataxia (clumsiness) and ophthalmoplegia (weakness of eye muscles causing double vision and squint) but only occurs in 10% of cases. Easy to miss but initially reversible with a 20% mortality rate and 85% progression to Korsakoff's psychosis.

6.7 **Korsakoff's Psychosis / Syndrome / Dementia** - described in 1887

6.7.1 This is the chronic phase of permanent brain damage with severe short term memory loss, confabulation, meagre conversation, low insight, apathy and often requiring permanent institutional care.

Thiamine treatment is a vital preventative of the Wernicke-Korsakoff Syndrome (WKS) prior to and during home detox.

6.8 **Thiamine Treatment**

6.8.1 Intramuscular (IM) High Potency Pabrinex® – the default option

6.8.2 The British National Formulary (BNF) and NICE now emphasise that parenteral (not oral) thiamine is essential in patients at significant risk of Wernicke's encephalopathy. Pabrinex probably lasts two / three months. Injections also contain nicotinamide, pyridoxine and riboflavin.

6.8.3 Dose: Pabrinex® one pair of 3.5ml amps (250mg) once daily for three days. Maybe extended to five days in severe malnutrition. See PCH's "Administration of Pabrinex® Intramuscular Procedure" (Appendix 3).

6.8.4 There is a low risk of anaphylaxis (similar to a flu jab) so service specific protocols for anaphylaxis risk assessment and treatment need to be followed. Tablets and injection are similar costs so the benefits of preventing WKS tip the balance in favour of intramuscular Pabrinex® with any client at risk of thiamine deficiency. Getting the injections prior to the detox also checks client commitment and motivation.

6.9 **Oral**

6.9.1 Thiamine 200mg x 4 daily is recommended up to and during the detox and then reduced to 50mg 4 x daily after the detox for at least one month or until a health normal diet is resumed. Bear in mind that thiamine is poorly absorbed and the likely poor compliance with a multiple daily dosing regime. Thiamine is not stored in the body hence the need for regular intake.

6.9.2 **Note**: Vitamin B Compound Strong 2 x 30mg tablet three times daily are recommended to rectify other deficiencies. Each tablet contains 20mg nicotinamide, 2mg pyridoxine, 2mg riboflavine and 4.85mg thiamine.

6.10 **Assessing Suitability of Home Environment and Supporter**

Availability of Supporter	Attitude of Supporter	General Atmosphere
0 Always available 1 Often available 2 Sometimes available 3 Never available	0 Very supportive 1 Supportive 2 Slightly supportive 3 Not supportive	0 Very organised 1 Organised 2 Slightly organised 3 Disorganised
Commitment of Supporter	**Level of Noise**	**Presence of other Drinkers**
0 Very committed 1 Committed 2 Slightly committed 3 Not committed	0 Tranquil 1 Reasonably quiet 2 Noisy 3 Very noisy	0 Never present 1 Sometimes present 2 Often present 3 Always present
Space to be Alone	**Presence of young children / pets**	**Total Score:**
0 Able room 1 Some room 2 Little room 3 None	0 No children or pets 1 Sometimes present 2 Always present 3 Presence disruptive	

The higher the score (to a maximum of 24) the worse the home environment to support a Home Detox

Scores above 10 require careful consideration of how the home environment can be improved

Encourage family members and carers to be involved and discuss their concerns with them

Family and Carers are a key element to successful detox and should receive Fact Sheet for Client & Carer on Home Detox that are explained in detail

7 Establish a Care Plan

7.1 In order to secure higher chances of successful detox and subsequent abstinence it is essential to make a client specific Care Plan. Much of the Care Plan involves psychosocial activity but there are also prescribing issues and the need to pursue a client's healthcare agenda. The latter often neglected area becomes more appropriate once sobriety is achieved. Care Plans are dynamic not rigid and aim to both promote and record progress.

7.2 Harbour workers may use Halo to record plans whilst others will use their own record systems. It is essential that the client helps prepare their Care Plan, agrees to it and **holds a own copy of their Care Plan**. All involved professionals should receive a copy as well, especially the prescriber and GP.

7.3 Other documents detail National Treatment Agency for Substance Misuse (NTA) expectations on Care Planning however a Care Plan is, in essence, a tool to help monitor progress towards agreed goals that is an integral part of the treatment process for clients and practitioners alike.

7.3.1 A simple chart can be constructed with four columns:

- What is the identified need?
- How will it be met?
- Who will take action?
- When will this be achieved by or how will progress be monitored?

7.4 Typical considerations in plans are:

7.4.1 **Psychosocial**

- Use of mutual self-help groups - Alcoholics Anonymous (AA) or SMART Recovery
- Continued contact and support from alcohol workers and other involved professionals like a GP, Practice Nurse, Psychiatrist, CPN, Long-Term Condition Matron or Social Worker
- Specific interventions for anxiety, bereavement, anger, depression
- Family or couple interventions - Time4Change and Al-Anon
- Day services - Hamoaze House or Ocean Quay
- SURF (Service User Representative Forum)
- On-line self-help (**www.llttf.com** for cognitive behavioural therapy (CBT) and Helplines (i.e. SMART Recovery or National Association for Children of Alcoholics (NACOA)).
- Education, employment and training
- Housing support
- Benefit support
- Resolution of legal issues
- Also refer to Useful Contacts (Appendix 13)

7.4.2 **Prescribing**

- Thiamine supplements as above
- Acamprosate
- Naltrexone - recommended by NICE in 2011
- Disulfiram (Antabuse)

7.4.3 These adjuvant prescribing options below should be made available to all clients preparing for home detox. There is evidence for their effectiveness but they should not be prescribed in isolation without other psychosocial interventions to improve outcomes. They are all classified as “Specialist Prescribing” in the Local Area Formulary, therefore, GPs will have had attended training to attain the appropriate competency which is covered by the RCGP Alcohol Certificate Course.

7.4.4 For certain clients they can provide valuable assistance in their struggle to achieve abstinence helping to break well established patterns of behaviour. The action of sticking to a regime of medication can cement commitment into treatment and the periodic monitoring builds in important engagement. Appropriate pickup arrangements need to be agreed starting possibly with weekly and with a total treatment of about 6-12 months.

7.4.5 For full details please consult the latest version of the Substance Misuse – Drug & Alcohol Employment Policy available on the Intranet. GPs with the Royal College of General Practitioners (RCGP) Alcohol Certificate will offer these options. Here is a brief summary:

7.5. **Naltrexone**

7.5.1 A new use to an old product (though not yet fully licensed) recommended by NICE as having better evidence than Acamprosate. National Treatment Agency (NTA) (now part of Public Health England) suggest best with lapsing drinkers and locally benefits from reduced heavy drinking has been noted in binge drinkers. Blocks endorphin release so reduces the pleasure associated with drinking.

7.5.2 Dose: start **at 25mg Day 1 then increase to 50mg daily at end of detox**. Initiate as a trial - if relapse into heavy drinking within 4-6 weeks then stop. Duration: 6-12 months or longer if beneficial and at client's request. Advantage: blocks opiate receptors for heroin users in remission. Disadvantage: blocks analgesic effects of codeine, morphine and other opiates. Cannot be used with methadone or buprenorphine substitute prescribing. Baseline LFTs, GGT and U&Es before prescribing and at 3-6 month intervals.

7.6 **Acamprosate**

7.6.1 Recommended for clients to reduce 'craving' – not an effective measurement in research studies. Licensed for use immediately after detox or with harmful drinking/mild dependency.

7.6.2 Dose: **333mg x two Acamprosate tablets three times daily or half this dose if weight <60kg at end of detox**. Initiate as a trial - if relapse into heavy drinking within 4-6 weeks then stop. Duration: 6-12 months or longer if beneficial and at client's request. Up to 10% complain of diarrhoea. Contra-indicated in pregnancy and breast feeding. Baseline LFTs, GGT and U&Es before prescribing and at 3-6 month intervals.

7.7 **Disulfiram (Antabuse)**

7.7.1 Blocks metabolism of alcohol leading to accumulation of acetaldehyde that results in some or all of the Disulfiram Alcohol Reaction (DAR) in varying intensity:

- facial flushing
- respiratory difficulties
- palpitations or chest pains
- blurred vision
- severe throbbing vomiting
- headaches
- collapse from hypotension
- confusion

7.7.2 Less likely to be prescribed than two medications above but for certain clients can be very effective aversion style treatment. Baseline LFTs, GGT and U&Es before prescribing and at 3-6 month intervals. Great care has to be made to avoid contact with alcohol by mouth or skin so that clients need to check mouth washes, hair dyes, antiperspirants, desserts etc.

7.7.3 Dose: **1 x 200mg DAR tablet daily** ideally supervised by a responsible adult with whom the client has a healthy relationship or maybe by private arrangement at a pharmacy. Commence 24 hours after last consumption of alcohol. Clients tend to stop collecting if they relapse. Advise not to drink ideally for seven days after cessation of use. Some clients get no response at 200mg daily and can be increased to a 400mg or 600mg daily dose but greater monitoring and specialist input required.

7.7.4 Beware interactions with other medications:

- enhances the effect of warfarin
- inhibits metabolism of benzos, phenytoin and theophyllins
- increased DAR with amitriptyline

7.7.5 Contra-indicated with coronary heart disease, cardiac failure, stroke, hypertension, pregnancy and breast feeding. Beware rare hepatotoxicity - client feels unwell, maybe with fever or jaundice when a devise is to stop medication immediately and seek medical assistance.

8 Agree a Detox Regime

8.1 Considerations

a) Prescribe either **chlordiazepoxide** (Librium) or **diazepam**. Past client experience, any allergic reactions and prescriber and/or client choice should determine which.

b) Their sedative effect on the central nervous system is the rationale for use to counteract withdrawals and brain excitability caused by the sudden removal of alcohol.

c) Detox should **last up to six days** and be of a fixed-dose regime**.** Longer treatments under exceptional circumstances only. Front-loaded regime for use in hospital/rehabilitation settings.

d) **15mg chlordiazepoxide is equivalent to 5mg diazepam.**

e) Clomethiazole (**Heminevrin**) is **not** to be used outside of hospital settings.

f) Carbamazepine, oxazepam and lorazepam may be used by specialist clinicians. Shorter half-lives of the two benzodiazepines can benefit liver impaired clients.

g) **Cessation of alcohol** intake should be arranged for the Sunday evening or Monday morning depending upon onset of withdrawals. First detox dose to be taken **4-8 hours later** when healthcare staff are available.

h) Use SADQ or SADD scores to assist deciding on initial dose.

	Moderate Dependence	Severe Dependence
SADQ Score	15 – 30	30 – 40
SADD Score	10 – 19	20+
Initial dose **Chlordiazepoxide**	**30mg four times daily**	30-40mg four times daily
Initial dose **Diazepam**	**10mg four times daily**	**10-12mg four times daily**
Notes:	• Very high doses are rarely required for women and never in the elderly. • Beware **dose** accumulation **with** liver or renal impairment when lower doses maybe required; if renal GFR (glomerular filtration rate) is <10 then reduced dose by half	

8.2 **The Details:**

8.2.1 Agree **start date** and contact arrangements throughout the detox. Each client should see a suitably qualified practitioner **every day for the first three days** then alternate days until the detox is completed. Where available perform alcohol breath testing at each contact.

8.2.2 **CIWA-Ar** (Clinical Institute Withdrawal Assessment for Alcohol revised) will be used at each contact to assess the degree of withdrawal severity (see Appendix 4) and determine any dose adjustments. **Note: high anxiety can affect scores.**

8.2.3 The **location** of the clinical contact depends upon the detox provider and so will be either be at home, a GP surgery, Harbour premises or a day service.

8.2.4 Check client and carer are aware of times service is available and when messages will be acted upon. Set contingency for unexpected staff absence.

8.2.5 Issuing (quantity and pickup) and safe management of medication will be the responsibility of the prescriber. Usually this will be by the responsible adult carer but occasionally collection from a pharmacy or delivery by a healthcare worker is needed. Recognition of the risks of misuse, client relapse, overdose and medication diversion needs to be considered. NICE recommend no more than two days of medication be issued at a time but certain clinical contexts demand larger quantities.

8.2.6 **Note: a blue FP10MDA can be used for daily dispensing of Diazepam but not Chlordiazepoxide.**

8.2.7 The client's **responsible adult carer** must be independently briefed on their role, what to look out for and how to react. Agreement to this should be confirmed in writing and written information supplied especially access to out-of-hours' services. **The carer will agree to spend the first 72 hours of the detox constantly within the client's earshot, and manage and record all medication taken**. This support can be provided by more than one carer.

8.2.8 It is crucial that this carer is capable of contacting the detox provider(s) as needed in a confidential manner without being compromised by personal loyalty to the client. Confidentiality will be breached if in the best interest of the client.

8.2.9 Supportive medication needs to be available as well as the chlordiazepoxide or diazepam such as paracetamol, metoclopramide (nausea/vomiting) and loperamide (diarrhoea/abdo cramps) with advice on usage.

8.2.10 Check that **all alcohol has been removed** from the home and that a plan is in place to minimise contact with other drinkers and obvious trigger situations.

8.2.11 The **home environment** needs to be calm and prepared with easy access for the client to rest, distract with DVDs or jigsaws and have access to fluids and food.

8.2.12 Check an aftercare action plan has been completed and client has a copy.

8.2.13 Run through the Pre-Detox Checklist with the client and carer (Appendix 7).

8.2.14 Sign Consent Form (Appendix 10).

8.2.15 Issue prescriptions and Detox Medication Chart (Appendix 6)**.**

8.2.16 Inform all relevant professionals, including pharmacy, of detox start date.

9 The Detox Process

9.1 Beginning Stage

9.1.1 The **Checklist** has been completed and completed paperwork present in both client's home and provider agency records with copies to relevant colleagues particularly Primary Care.

9.1.2 Anxiety is natural for the client and the carer so time spent understanding and attending to any concerns, reassuring about the process and maintaining a positive outlook is important.

9.1.3 **The carer will spend the first 72 hours of the detox constantly within the client's earshot, and manage and record all medication taken.**

9.1.4 Plans to occupy the time previously spent drinking need to be in place including mental distractions (DVDs, jigsaws etc.) as well as gentle activities such as walking or housework and later attendance at self-help mutual aid groups.

9.1.5 Detox medication is in place with safe storage. Detox Record Chart for recording every dose and time taken to be kept at all times in the home for reference by the detox provider(s) or out of hours or emergency medical staff.

9.2 Middle Stage

9.2.1 The core activity here is to ensure that adequate sedation is achieved to reduce the risk of complications. The CIWA-Ar was developed in the 70's at the London Maudsley Hospital for use with in-patients and remains, alongside vital signs of Pulse, BP and temperature, the most useful clinical tool to manage an alcohol detox.

9.2.2 **CIWA-Ar is your early warning detection for detox complications. It only takes less than five minutes to complete.**

9.2.3 CIWA-Ar has ten sections covering key symptoms and signs:

1	Nausea and vomiting	"Do you feel sick in the stomach? Have you vomited?"
2	Tremor	Extend arms, spread fingers and observe
3	Anxiety	"Do you feel nervous?"
4	Agitation	Observe
5	Paroxysmal sweats	Observe
6	Orientation	"What day is it? Where are you? Who am I?"
7	Tactile disturbances	"Any itching, pins & needles, bugs crawling on skin?"
8	Auditory disturbances	"Any sounds you know aren't there that frighten you?"
9	Visual disturbances	"Is light bright or colours altered? Is it disturbing you?"
10	Headache	"Any band around head? How severe? Are you dizzy?"

9.2.3 Each item is scored from 0 to 7 except Orientation which scores 0 to 4. The lowest score is zero and highest 67. **CIWA-Ar** chart (Appendix 5).

9.2.4 Dose adjustments from the fixed dose regime relate to the CIWA-Ar score as follows:

Score ≤ 15	no change
Score > 15	consider increasing dose
Score > 20	high risk of delirium tremens

Do not wait until the client is unwell; aim to keep scores low

9.3 The progression of Alcohol Withdrawals

9.3.1 This graph summarises the frequency and timings of specific complications although it should be noted that seizures can occur over a wide time frame.

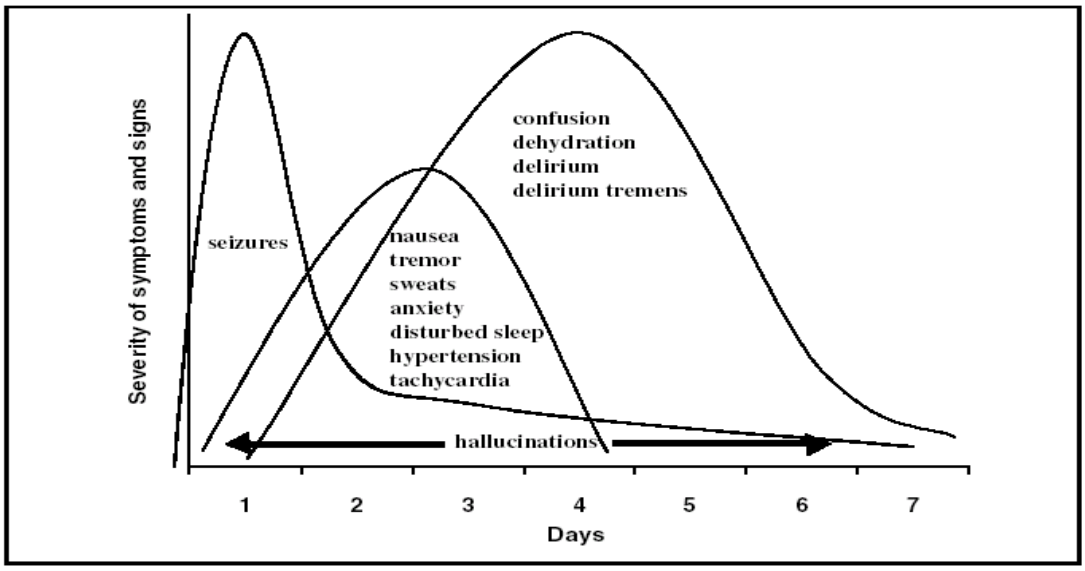

Figure 5.1: The progression of the alcohol withdrawal syndrome.

Source: Frank & Pead (1995). Reproduced with permission [129]

9.4 Reasons to Alter Baseline Regime During Detoxification

9.4.1 Over-medication – if client has CIWA-Ar scores consistently less than ten after Day 3 of detox review dosages with a view to a more rapid completion by advancing the regime by 24 hours. If client appears over-sedated then omit a dose of medication.

9.5 Under-medication

9.5.1 If the CIWA-Ar is > 15, then the next dose of chlordiazepoxide given should be 50% greater than the planned dose (up to a maximum of 60mg in a single dose).If the CIWA-Ar is > 29, then the next dose of chlordiazepoxide should be 100% greater than the planned dose (up to a maximum of 60mg in a single dose). If the CIWA-Ar is > 39, the GP or specialist doctor should be contacted to discuss the case, or if he is unavailable, the client should be taken to A&E for assessment.

9.5.2 If the CIWA-Ar remains >15 for both readings on a single day then do not reduce the dosage and the duration of the detox may need to be extended.

9.6 What to do if Client Resumes Drinking

9.6.1 If the breathalyser reads positive at any time during the detox, then obtain a drinking history from the client and their carer. Discuss situation with prescriber and worker(s) (+/- GP) before continuing. Due to the dangers of combining alcohol and CNS depressant drugs (chlordiazepoxide or diazepam), it may be necessary to stop the detoxification. The client's commitment to continue needs careful re-evaluation.

9.6.2 However stopping detoxification carries its own potential for harm. If it is agreed to stop the detox, then the client should always be advised to resume drinking at a level appropriate to the length of detox completed to avoid withdrawal consequences. For example return to 75% of their daily pre-detox intake if within the first few days but less if later into detox when advised to drink 2 units of alcohol only if withdrawal symptoms occur is appropriate.

9.6.3 If it is felt on a balance of risk and benefits that the detox should continue then resume medication based on observed symptoms of withdrawal, and not until the CIWA-Ar scale is greater than 15. This may be achieved by leaving the client and returning again later in the day.

9.7 Delirium tremens

9.7.1 The CIWA-Ar provides an early warning for the extreme manifestation of withdrawals namely the neuropsychiatric complication of DTs or delirium tremens by securing appropriate levels of sedation. Note that the presence of infection increases this risk.

9.7.2 Delirium tremens is a short-lived, toxic, confusional state occurring between 24 and 50 hours after the last drink with a peak between 72 and 96 hours (3-4 days). Usually there is a history of several years of dependence and heavy drinking. The disturbance often fluctuates being worse in the evening in low lighting.

Beware increases of BP from baseline of 20 systolic or 10 distolic as this indicates the autonomic over-activity that precedes the DTs

9.7.3 DT is considered as a syndrome with a continuum of severity and a variation in symptom clusters. The classical triad is:

1) clouding of consciousness and confusion
2) vivid hallucinations of any sensory modality
3) marked tremor

9.7.4 **Delusions, agitation, sleeplessness and autonomic arousal are frequently also present - heavy sweating, no appetite, rapid pulse, raised BP and raised temperature.**

9.7.5 Hallucinations and illusions are typically vivid, chaotic and bizarre with clients preoccupied by and interacting with them.

9.7.6 Generally treatment is best conducted within an in-patient setting with 24/7 nursing care, intravenous fluids to restore electrolyte imbalance, parenteral thiamine, close monitoring of higher dose sedation, full investigative facilities to rule out other diagnoses, and access to skilled medical care. Lorazepam with its faster onset and shorter half-life may be preferred and antipsychotics (haloperidol or olanzepine) can help manage hallucinations.

Transfer clients with suspected DTs or Wernicke-Korsakoff Syndrome directly to hospital (if at all possible)

9.7.7 **Once a client suffers from DT they are more likely to get DT next time.** The condition usually lasts 3-5 days with gradual resolution. Mortality is reported at 5% of admissions with cause of death typically cardiovascular collapse, hypothermia or infection. Differential diagnoses include liver failure, pneumonia and head injury.

9.8 **Alcohol Withdrawal Seizures**

9.8.1 Generally these occur within the first 24 hours of a detox starting though they can occur at any time. Unless these are complicated or have led to status epilepticus (a persistent run of seizures) then they are best treated with adequate doses of chlordiazepoxide or diazepam rather than adding antiepileptic medication. The supporter or carer can be taught to administer rectal diazepam if indicated. See Fact Sheet that advises carer to put client in recovery position and call an ambulance if expected seizure lasts more than five minutes (NHS Choices website).

9.9 **End Stage**

9.9.1 Now chlordiazepoxide or diazepam is gradually reduce and stopped avoiding any inadvertent benzodiazepine dependence by prolonging its supply. In addition the client now needs to attend to health issues previously ignored whilst drinking took over. These may be physical or psychological exploring any relevant tests, referrals or new treatments. Adjuvant prescribing (naltrexone, acamprosate or disulfiram) if required will need to be established about the 4th day of detox and a monitoring processes put into place. Clients will also need encouragement to address social issues ranging from housing to training and employment. Involvement with AA or SMART Recovery now become essential components of the Care Plan. The Satisfaction Survey should be administered.

9.9.2 Core data for the Evaluation Form (see Section 11) needs to be collected and recorded ready for submission at the three month review date.

10 Post-Detox Activity

10.1 Sobriety brings with it significant issues previously hidden by the drinking particularly emotional and psychological ones bringing unanticipated stresses. Good support and encouragement is key as well as access to CBT, therapy (individual and family), BCT, counselling, EMDR, psychology and psychiatry. Resources are often limited but specialists in the field can be consulted to find out what is currently available.

10.1.1 Typically clients have low self-acceptance and sobriety can give rise to the powerful emotions of guilt and shame. Preparing for these experiences and learning to handle emotional discomfort without self-medicating the pain away are crucial skills to develop. This takes time and new self-care habits need to fill the void through for example new friendships, constructive rewards, yoga, or mindfulness. Discuss that there will be lapses along the way that can generate vital learning about recovery. Reassure clients that they can access you again in the future and that you won't be angry or judgemental if they relapse. This all helps to build self-respect and the knowledge that control can be gained in time over the drinking.

10.2 **Being prepared for lapses/relapses is a necessary part of alcohol work.**

10.2.1 Be aware that some clients will need more input than is possible with community treatment particularly if the environment has many drinking triggers or the client is social isolated and has little recovery capital (supportive, friends or family, work, past successful treatment etc). In such situation a residential rehabilitation or therapeutic community approach may be indicated. Please seek specialist advice regarding such referrals.

11 Evaluation Process

11.1 Finally it is important to collect data regarding home alcohol detox in order to build capacity and quality of provision whilst contributing to fuller commissioning needs in the city. The following data is to be collected to evaluate each Home Alcohol Detox.

1	Client ID	
2	Date of Birth	
3	Gender	
4	Prescriber name and agency	
5	Alcohol Worker name and agency	
6	Average daily alcohol units prior to detox	
7	Does client have drug dependence?	Y / N - if Y please specify:
8	Detox Start Date	
9	Detox End Date	
10	Had client been home detoxed before?	Y / N - if Y how many previous? Home or other?
11	Was client abstinent at End Date?	Y / N
12	Highest individual dose of diazepam or chlordiazepoxide used	
13	Seizures or fits	Y / N
14	Delerium tremens	Y / N
15	A&E visit during detox	Y / N
16	Hospital visit during detox	Y / N
17	Other complications - please specify	
18	Pabrinex® prescribed?	Y / N
19	Oral Thiamine prescribed?	Y / N
20	Acamprosate prescribed?	Y / N
21	Naltrexone prescribed?	Y / N
22	Disulfiram prescribed?	Y / N
23	At three month review is client …	Abstinent? Y / N Lapse at 1 day every 4 weeks? Y / N Lapse at 1 day every 2 weeks? Y / N Lapse at 1 day every week? Y / N Relapse into daily drinking? Y / N

Please send completed forms to: **PSAS Clinical Lead, Harbour Drug & Alcohol Services, 1st Floor, Hyde Park House, Mutley, Plymouth, Devon PL4 6LF**.

A copy of reports generated will be circulated to all those submitting data.

12 Training – please see section 1.3 Appendix 3 of the attached Procedure

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: Director of Operations

Date: 5th February 2015

Alcohol Dependency Assessments

Severity of Alcohol Dependence Questionnaire (SADQ)

Client NHS Number:		Date of Birth:	
Client Name:		Date:	
Please recall a typical period of heavy drinking in the last six months:			
When was this?	Month:	Year:	

Please answer all the following questions about your drinking during that period of heavy drinking by **circling** your most appropriate response:

1	**The day after drinking alcohol I woke up feeling sweaty**			
	Almost never	Sometimes	Often	Nearly Always
2	**The day after drinking alcohol my hands shook first thing in the morning**			
	Almost never	Sometimes	Often	Nearly Always
3	**The day after drinking alcohol my whole body shook violently first thing in the morning if I didn't have a drink**			
	Almost never	Sometimes	Often	Nearly Always
4	**The day after drinking alcohol I woke up absolutely drenched in sweat**			
	Almost never	Sometimes	Often	Nearly Always
5	**The day after drinking I dread waking up in the mornings**			
	Almost never	Sometimes	Often	Nearly Always
6	**The day after drinking alcohol, I was frightened of meeting people first thing in the morning**			
	Almost never	Sometimes	Often	Nearly Always
7	**The day after drinking alcohol, I felt at the edge of despair when I awoke**			
	Almost never	Sometimes	Often	Nearly Always
8	**The day after drinking alcohol, I felt very frightened when I awoke**			
	Almost never	Sometimes	Often	Nearly Always
9	**The day after drinking alcohol, I liked to have an alcoholic drink in the morning**			
	Almost never	Sometimes	Often	Nearly Always
10	**The day after drinking alcohol, I always gulped my first few alcoholic drinks down as quickly as possible**			
	Almost never	Sometimes	Often	Nearly Always
11	**The day after drinking alcohol, I drank more alcohol to get rid of the shakes**			
	Almost never	Sometimes	Often	Nearly Always
12	**The day after drinking alcohol, I had a very strong craving for a drink when I awoke**			
	Almost never	Sometimes	Often	Nearly Always
13	**I drank more than a quarter bottle of spirits in a day or 1 bottle of wine or 7 beers.**			
	Almost never	Sometimes	Often	Nearly Always

Please answer all the following questions about your drinking during that period of heavy drinking by **circling** your most appropriate response/cont'd…:				
14	**I drank more than a half bottle of spirits per day or 2 bottles of wine or 15 beers.**			
Almost never	Sometimes	Often	Nearly Always	
15	**I drank more than 1 bottle of spirits per day or 4 bottles of wine or 30 beers**			
Almost never	Sometimes	Often	Nearly Always	
16	**I drank more than 2 bottles of spirits per day or 8 bottles of wine or 60 beers**			
Almost never	Sometimes	Often	Nearly Always	

Imagine the following situation:

1) You have been **completely off drink for a few weeks**.
2) You then drink **very heavily** for **two days**.

How would you feel in the morning after those two days of drinking?

17	**I would start to sweat**		
Almost never	Sometimes	Often	Nearly Always
18	**My hands would shake**		
Almost never	Sometimes	Often	Nearly Always
19	**My body would shake**		
Almost never	Sometimes	Often	Nearly Always
20	**I would be craving for a drink**		
Almost never	Sometimes	Often	Nearly Always

Scoring:							
Almost never:		Sometimes:		Often:		Nearly always:	
Score:							

Checked by (print name and title):

Notes on the Use of the SADQ

The Severity of Alcohol Dependence Questionnaire was developed by the Addiction Research Unit at the Maudsley Hospital. It is a measure of the severity of dependence
A score of 31 or higher indicates "severe alcohol dependence"
A score of 16 -30 indicates "moderate dependence"
A score of below 16 usually indicates only a mild physical dependency
A detoxification regime is usually indicated for someone who scores > 16

It is essential to take account of the amount of alcohol that the patient reports drinking prior to admission as well as the result of the SADQ
There is no correlation between the SADQ and such parameters as the MCV or GGT

Short Alcohol Dependence Data (SADD)

Instructions: Please read each question carefully but do not think too much about its exact meaning. Think about your **most recent** drinking habits and answer each question by placing a tick under the **most appropriate** heading.

SADD Score		0	1	2	3
If you have any difficulties **ask for help**		**Never**	**Sometimes**	**Often**	**Nearly Always**
Client's Name:					
Date:					
1	Do you find difficulty in getting the thought of drinking out of your mind?				
2	Is getting drunk more important than your next meal?				
3	Do you plan your day around when and where you can drink?				
4	Do you drink in the morning, afternoon and evening?				
5	Do you drink for the effect of alcohol without caring what the drink is?				
6	Do you drink as much as you want irrespective of what you are doing the next day?				
7	Given that many problems might be caused by alcohol do you still drink too much?				
8	Do you know that you won't be able to stop drinking once you start?				
9	Do you try to control your drinking by giving it up completely for days or weeks at a time?				
10	The morning after a heavy drinking session do you need your first drink to get yourself going?				
11	The morning after a heavy drinking session do you wake up with a definite shakiness of your hands?				
12	After a heavy drinking session do you wake up and retch or vomit?				
13	The morning after a heavy drinking session do you go out of your way to avoid people?				
14	After a heavy drinking session do you see frightening things that later you realize were imaginary?				
15	Do you go drinking and the next day finds you have forgotten what happened the night before?				

Total Score:	**Score Interpretation**	
	Low dependence	1-9
	Medium dependence	10-19
	High dependence	20 or greater

Raistrick, D., Dunbar, G., & Davidson, R., (1983). Development of a questionnaire to measure alcohol dependence, British Journal of the Addiction, 78, 89-95

Substance Misuse Risk Assessment – Tick box and Add Notes			
	Current ✓	**History** ✓	**Clinical Risk Management Plan** or **Notes**
Substance Risk			
New drug user			
Regular injector			
Injects alone			
Uses high risk sites (Neck, Groin)			
Poly drug use (includes Alcohol)			
Past overdose			
Sharing equipment			
Harm to Others			
Past history of violence to others (including sexual or domestic violence)			
Thoughts / threats of violence			
Violent fantasies			
Paranoid thoughts / delusions / hearing voices			
Impulsivity / poor anger			
Available weapon			
Arson			
Threats / acts of violence to workers			
Safeguarding Children			
Refer to Hidden Harm Protocol and PCH's Safeguarding Policy etc if specific risks are identified			
Currently pregnant			
New born baby (under one year)			
Responsible for children under 16 (state age of children in Notes)			
Sole carer (comment whether supported or support required)			
Use or intoxicated while responsible for child(ren)			

Expressed concern about risk to child(ren)			
Threats to harm a child			
Child acting as main carer			
Child involved with Social Services			
Child is subject to safeguarding plan			
Child access to substances/paraphernalia			
Personal Safety			
Self-Neglect			
Physical health neglect			
Neglects eating/poor nutrition/fluids			
Taking care of personal hygiene			
Other serious self-care problems			
Social Risk Factors			
Significant debt / poor management of finances			
Recent discharge from hospital / institution			
Employment/unemployment issues			
Homelessness / imminent loss of accommodation			
Drink / drug driving issues			
Risk or Threat from Others			
Physical / emotional / sexual domestic violence			
Vulnerable to exploitation by others			
Safeguarding vulnerable adult issues			
Self-Harm or Suicide			
Depressed mood (subjective)			
Hopelessness / helplessness			
Suicidal ideas			
Plans made			
Non-suicidal self-harm			
Use of violent methods			
Family history of suicide			

Administration of Pabrinex® Intramuscular Procedure

Applies to:	All PCH prescribers and nurses working with Harbour Drug & Alcohol Services
Approved by:	Medicines Governance Group
Date approved:	
Date for review:	Two years or sooner if any of the following apply: • Following a serious untoward incident, if learning points identify the need for a change to the procedure. • Following a significant change in legislation or best practice guidance.
Purpose:	To ensure all PCH prescribers and nurses are aware of the agreed PCH procedures for prescribing and administration of Pabrinex® IM.
Scope:	This SOP provides advice and guidance to prescribers on the correct procedures for prescribing and administration of Pabrinex® IM to clients undergoing a community alcohol detox in collaboration with Harbour Drug & Alcohol Services.
Relates to:	Home Alcohol Detoxification Policy
Responsibilities	The prescribing of Pabrinex® IM in the community is solely the responsibility of the prescriber (for definition see: Safe & Secure Handling of Medicines Policy v 6.1 section 4.1.4 – 4.1.6). The administration of Pabrinex® IM is the responsibility of the administering prescriber or nurse.

1 Background

1.1 Prevention of Wernicke-Korsakoff Syndrome by use of Pabrinex® IM is an important component of the alcohol detoxification and has been supported locally by the Clinical & Service Governance Forum for Substance Misuse (PPGFSM). Oral thiamine absorption is poor and compliance problematic with alcohol dependent clients.

1.2 Pabrinex®® IM is the trade name for a high dose vitamin preparation. Each pair of ampoules to be used in treatment is labelled Pabrinex® No 1 and Pabrinex® No 2. Each No. 1 5ml ampoule contains Thiamine Hydrochloride BP 250mg, Riboflavin (as Phosphate Sodium BP) 4mg, Pyridoxine Hydrochloride BP 50mg plus excipients. Each No. 2 2ml ampoule contains: Ascorbic acid BP 500mg and Nicotinamide BP 160mg plus excipients.

1.3 This protocol balances the very limited risk of anaphylactic reactions with Pabrinex® administered via the IM route by providing a robust protocol which covers:

- Training of staff administering Pabrinex® via the IM route
- Client clinical risk assessment with inclusion and exclusion criteria
- The provision and upkeep of suitable resuscitation equipment

2 Client Group

2.1 Pabrinex® IM may be administered to adult clients (18 years and over) including the elderly, whose suitability has been confirmed by the clinical risk assessment below.

3 Exclusions

- Clients under 18 years
- Known hypersensitivity to any of the active constituents or to the excipients. See Summary of Product Characteristics for full details www.medicines.org.uk
- Clients unsuitable as per risk assessment below

4 Special Precautions

4.1 Storage - store in a refrigerator at 2°C to 8°C. Keep the container in the outer carton. Do not freeze. For administration in the community the ampoules should be transported in a validated cool box and allowed to reach room temperature (up to half an hour) immediately before administration. Ampoules exposed to temperatures over 8°C for more than one hour should have their expiry reduced to 28 days (or original expiry if sooner).

4.2 In common with all parenteral products each ampoule should be visually inspected prior to administration and should not be used if particulates are present.

4.3 Pabrinex® is also available as an Intravenous High Potency Injection. Therefore before administration ensure that both the Summary of Product Characteristics and ampoule labels refer to the **intramuscular** injection.

5 Dose

5.1 The dose of Pabrinex® IM to be administered is: The contents of one pair of ampoules (7ml) twice daily for up to seven days.

5.2 The contents of one ampoule number 1 and one ampoule number 2 of Pabrinex® Intramuscular High Potency (total 7ml) are drawn up into a syringe to mix them just before use, then injected slowly high into the gluteal muscle, 5cm below the iliac crest. It is good practice to rotate sites (left and right) during the course of treatment.

6 Characteristics of Staff and Training

6.1 All PCH staff administering Pabrinex® IM in the community must be registered medical practitioners or registered nurses competent to:

a) administer the client risk assessment, interpret this and the risks associated with the administration of Pabrinex® via the IM route

b) be aware of the special precautions for use including cold storage

c) administer Pabrinex® ampoules and other parenteral drugs as needed with an anaphylactic reaction following the PCH Management of Severe Anaphylaxis policy.

d) administer Basic Life Support (BLS) and follow the PCH Resuscitation Policy. Annual resuscitation training will need to be attended by all involved staff at courses provided by PCH.

6.2 The responsible clinical manager will assess and record competency, and instruct staff members regarding training requirements.

7 Clinical Risk Assessment

7.1 **All** clients offered a community alcohol detoxification must be clinically assessed for their suitability for IM Pabrinex® with the questionnaire below.

7.2 The clinical risk assessment is based on information provided by the Scottish Intercollegiate Guidance Network (SIGN) and the National Institute for Health and Clinical excellence (NICE).

		Comments
1	Does the client have any clinical condition(s) under investigation or treatment that may impact on the use of Pabrinex®?	If “Yes” do **not** proceed and seek medical advice
2	Check Pulse, BP and temperature	If abnormal do **not** proceed and seek medical advice
3	Is there a history of anaphylaxis to any thiamine product which may preclude the client from receiving IM Pabrinex®?	If “Yes” do **not** proceed
4	Is the client High Risk (> 2) on Malnutrition Universal Screening Tool (MUST)*?	If High Risk on MUST then administer IM Pabrinex®
5	Does the client have other nutritionally related conditions (i.e. polyneuropathy, amblyopia, pellagra, anaemia)	If “Yes” then administer IM Pabrinex®
6	Does the client have any signs or symptoms of WKS (i.e. ophthalmoplegia, ataxia or acute confusion or unexplained neurological symptoms)?	If “Yes” do **not** proceed with IM Pabrinex® in the community setting and refer for full medical assessment and treatment in hospital.
7	Has this risk assessment for IM Pabrinex® been discussed with the prescriber and has their agreement?	If “Yes” to both then administer IM Pabrinex®

8 Resuscitation equipment

8.1 All staff administering Pabrinex® in the community or at PCH sites will carry drugs deemed appropriate by the staff role and the following PCH policies:

- Resuscitation
- Management of Severe Anaphylaxis
- Safe and Secure Handling of Medicines

8.2 Defibrillators will not be carried and assistance from paramedics will be called upon as appropriate.

Fixed Dose Regimes Chlordiazepoxide and Diazepam

The following are examples of various reducing regimes. These are based on the total dosage of chlordiazepoxide required during the first 24 hours. This total 24-hour dose should then be divided into four and taken at approximately 06:00, 12:00, 18:00 and 24:00. On Day 3 the dose is reduced by approximately 20% of the total daily dose. When dose frequency is reduced to 3 times a day then the dose should be taken at 08.00, 14.00 and 22.00 daily. Twice daily dosing should be taken at approximately 08.00 and 20.00 daily. Night time dose should be taken at usual bed time.

Low Dosage Regimes when SADQ <15 - check whether medication assisted detoxification is needed?

If clinically justified, start at Chlordiazepoxide 10-20mg four times daily, or Diazepam 4-6mg four times daily, and use latter stages of regimes below:

Intermediate Dosage SADQ 15-30:

Day	Chlordiazepoxide Dosage	Total Daily Dose
1	30mg 4 x daily	120mg
2	20mg 3 x daily and 30mg at night	90mg
3	10mg 3 x daily and 20mg at night	50mg
4	5mg 3 x daily and 10mg at night	25mg
5	5mg in morning and 10mg at night	15mg
6	5mg at night	5mg

Day	Diazepam Dosage	Total Daily Dose
1	10mg 4 x daily	40mg
2	8mg 3 x daily and 10mg at night	34mg
3	4mg 3 x daily and 8mg at night	20mg
4	2mg 3 x daily and 4mg at night	10mg
5	2mg in morning and 4mg at night	6mg
6	2mg at night	2mg

If SADQ 30-40 = severe dependence so higher dosing may be required
➔ Consider inpatient or residential detox

Plymouth Community HEALTHCARE	**Date:**												
	Time:												
CIWA-Ar Observation Sheet:	**Pulse:**												
Client Name:	**Temperature:**												
	Respiratory Rate:												
Client's NHS No:	**Blood Alcohol Content:**												
	Blood Pressure:												
Nausea/vomiting (0 - 7) 0 - none 1 - mild nausea; no vomiting 4 - intermittent nausea 7 - constant nausea, frequent dry heaves / vomiting													
Tremors (0 - 7) 0 - no tremor 1 - not visible but can be felt 4 - moderate with arms extended 7 - severe, even with arms not extended													
Anxiety (0 - 7) 0 - none, at ease 1 - mildly anxious 4 - moderately anxious or guarded 7 - equivalent to acute panic state													
Agitation (0 - 7) 0 - normal activity 1 - somewhat normal activity 4 - moderately fidgety / restless 7 - paces or constantly thrashes about													
Paroxysmal Sweats (0 - 7) 0 - no sweats 1 - barely perceptible sweating, palms moist 4 - beads of sweat obvious on forehead													

7 - drenching sweat												
Orientation (0 - 4) 0 – oriented 1 - uncertain about date 2 - disoriented to date by no more than 2 days 3 - disoriented to date by > 2 days 4 - disoriented to place and / or person												
Tactile Disturbances (0 - 7) 0 – none 1 - very mild itch, pins and needles, numbness 2 - mild itch, pins and needles, burning, numbness 3 - moderate itch, pins and needles, burning, numbness 4 - moderate hallucinations 5 - severe hallucinations 6 – extremely severe hallucinations 7 - continuous hallucinations												
Auditory Disturbances (0 - 7) 0 - not present 1 - very mild harshness / ability to startle 2 - mild harshness, ability to startle 3 - moderate harshness, ability to startle 4 - moderate hallucinations 5 - severe hallucinations 6 - extremely severe hallucinations 7 – continuous hallucinations												
Visual Disturbances (0 - 7) 0 - not present 1 - very mild sensitivity 2 - mild sensitivity 3 - moderate sensitivity 4 - moderate hallucinations 5 - severe hallucinations 6 - extremely severe hallucinations 7 - continuous hallucinations												
Headache (0 - 7) 0 - not present 1 - very mild 2 – mild												

3 – moderate 4 - moderately severe 5 – severe 6 - very severe 7 - extremely severe												
Total CIWA-Ar Score												

- **Nausea and Vomiting** - ask "Do you feel sick to your stomach? Have you vomited?" Observation
- **Tremor** - arms extended and fingers spread apart. Observation
- **Paroxysmal sweats** - Observation
- **Anxiety** - ask "Do you feel nervous?" Observation
- **Agitation** - Observation
- **Tactile Disturbances** - ask "Have you any itching, pins and needles sensations, burning sensations, numbness or do you feel bugs crawling on or under your skin?" Observation
- **Auditory Disturbances** – ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation
- **Visual Disturbances** - ask "Does the light appear to be too bright? Is its colour different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation
- **Headache, fullness in head** – ask "Does your head feel different? Does it feel as if there is a band around your head?" Do not rate for dizziness or light-headedness; otherwise, rate severity
- **Orientation and clouding of sensorium** - ask "What day is this? Where are you? Who am I?"

Detox Medication Chart

Client's Name:	
Client's NHS No:	**DOB:**
Harbour Worker:	**Prescriber:**

Day	Date	Time	CIWA Score	Pulse	BP	Chlordiazepoxide or Diazepam Dose given	Total dose given	Problems or Notes
1		06:00						
		12:00						
		17:00						
		22:00						
2		06:00						
		12:00						
		17:00						
		22:00						
3		06:00						
		12:00						
		17:00						
		22:00						
4		06:00						
		12:00						
		17:00						
		22:00						
5		06:00						
		12:00						
		17:00						
		22:00						
6		06:00						
		12:00						
		17:00						
		22:00						

Note: This template is a guide. Adjust times as needed.

Pre-Detox Checklist			
If you are ready to proceed with Home Detox then all items should be ticked as "Yes"			
	Please tick as appropriate:	**Yes**	**No**
1	GP background information received		
2	Physical examination and blood tests results received without need for further investigation		
3	GP or other prescriber in place		
4	Adequate family and social support at home with a responsible adult present for the first 72 hours		
5	Medication information sheet and Detox Fact Sheet supplied and understood by both client/supporter		
6	Consent form signed		
7	Client/supporter have contact details for Prescriber, Alcohol Worker and emergency services		
8	Detox Medication Chart in home		
9	Prescription issued and collected with safe storage		
10	Care Plan commenced with action plan for psychosocial interventions		
11	Adjuvant prescribing of acamprosate, naltrexone and disulfiram offered and prescribed as appropriate		
12	GP and any related agency informed of Start Date		

Consent for Alcohol Detoxification		
Client Name:		
Client's NHS Number:		
Prescriber:		
Harbour Worker:		
Carer:		
1	I have had the treatment explained to me, received and read the Detox Fact Sheet. I understand the process, the benefits and risks of this treatment and give my consent for this detoxification to take place.	
2	I understand that my carer(s) will be within earshot of me constantly for the first 72 hours of the detox to assist in taking medication and calling for help if needed.	
3	My prescription will start on:	
	at ……. mg Chlordiazepoxide / Diazepam (delete as needed) 4 x daily	
4	The assisted alcohol detoxification will involve varying doses subject to titration on the basis of withdrawal symptoms. Monitoring will be daily until the end of the detoxification by face-to-face contact or telephone.	
5	My General Practitioner will be informed of my detox.	
6	I understand that any use of illicit drugs or alcohol during the detoxification must be discussed with my Harbour worker and prescriber and this may result in stopping the detoxification and return to controlled drinking.	
7	I will take and collect my medication as directed.	
8	I will give specimens for testing when asked to do so. If alcohol is detected, the detoxification may be stopped with return to controlled drinking.	
9	I understand that any lost my medication will not usually be replaced.	
10	I understand that my medication is for **my use only**, never given to another person and kept in a safe place at all times away from children.	
11	I understand that failure to collect or take medication will lead to my prescription being stopped.	
12	I understand that any attempts to obtain medication by deception, including approaching other doctors or altering prescriptions, **will** result in my prescription being stopped.	
13	I understand that any verbal or physical aggression towards any member of staff, including pharmacy staff, will result in my prescription being stopped.	
Signed by Client:		Date:
Signed by Carer:		Date:
Signed by Harbour Worker:		Date:

Fact Sheet for Client and Carer on Home Detoxification

A home detox is an important step in the journey of recovery from dependence or addiction to alcohol. This fact sheet is designed to help you understand the process; please feel free to ask questions at any time as we are keen to give you plenty of support.

During alcohol detox or withdrawal, the nervous system becomes particularly sensitive or overexcited. The person may be sensitive to their surroundings for instance to light or noise. They may get tense and feel edgy or 'strung out'. Occasionally fits or seizures can occur. Physical symptoms can include shaking, sweating, vomiting or diarrhoea. Difficulty in sleeping is common, as are more vivid dreams.

Prescribed medication will assist in reducing and controlling all these symptoms however any lapse into drinking must be reported immediately to avoid unsafe interactions with medication. If this happens the detox may be abandoned and controlled drinking resumed.

Safety

- It is important to make the home environment as safe as possible. Avoid situations, which may cause accidents (i.e. pouring boiling water, sitting near open fires, unsupervised swimming or bathing and of course **driving** or **operating machinery**).

Avoid stress

- Allow plenty of rest and avoid unnecessary demands. Take time off from work.
- Try to avoid napping during the day as this may prevent sleep at night.
- Listen to music, take a walk or a bath to aid relaxation.
- Cancel any engagements that might add to your stress during the first week of the detox.
- Likewise, don't have any heavy arguments or discussions at this time. The focus is on a successful detox and these topics can be dealt with later.

Hygiene

- Excessive sweating is not unusual so bath or shower regularly.

Diet

- You may not feel like eating much during the first few days; eat small light meals regularly.
- Soups, bananas and breakfast cereals often go down well.
- Water is important and should be regularly available to keep up hydration.
- Fruit juice may irritate the stomach and cause nausea – milk may be better.
- Avoid too much tea or coffee both of which can cause insomnia.

Coping with Cravings

- Cravings for alcohol are to be expected and no matter how strong, they will fade and pass within 20 minutes. Find some way of distracting yourself while you are waiting for them to go. Keeping busy with things that you usually find enjoyable or doing something physically active often helps. Some find that being with another person and just talking helps to manage or distract from cravings. If you have access to videos, DVDs or a computer this can often help to distract you.
- Remember – craving will always reduce with time especially if you don't react to them.

Take a Day at a Time

- Just getting through the day without a drink is a success. Don't make decisions about the rest of your life at this stage. Sometimes people even take things an hour at a time. It is easier to feel that you are getting somewhere if you focus on an achievable goal that is within your reach. Thinking too far ahead may result in being overwhelmed. Make progress one step at a time.

Ask for Support

- A Detox is more likely to succeed if you are able to **ask for and get support** that you need. Don't be put off if the first person that you ask isn't able to help, try someone else. It's good to have a range of people to ask for help from. Here are some useful contacts/ help lines:

Samaritans	08457 909090
AA (Alcoholics Anonymous)	0845 769 7555
SMART Recovery	Every Wednesday 19:00-20:30, at Time4Change 46-48 Devonport Road, Stoke, Plymouth PL3 4DH Every Thurs 12:00-13:30, at Harbour Hyde Park House, Mutley, Plymouth PL6 4LF

Reward and value yourself

- If alcohol has been a way of rewarding yourself in the past, you will need to find other ways of doing this. Identify some alternative ways to value and acknowledge yourself so you develop a balanced lifestyle. Keeping a diary or a chart of your progress or talking to close family or friends, may be a start in this direction.

Medication - see separate Medication Information Sheet

- The main prescribed drug for you is a benzodiazepine tranquiliser.
- Please note that these drugs, if taken for too long, may be addictive.
- It is important to take the correct dose each day at the right time.
- Side effects and dose adjustment will be discussed each time you speak to or see a worker. Taking alcohol or misusing drugs whilst on detoxification medication can be very dangerous. Keep medication in a locked place away from children and **not** in the fridge.

Things to Things to Watch Out for:

- Severe withdrawal problems are unlikely.
- If they do occur it is important that you know what to do.
- **Severe vomiting** may prevent you being able to keep medication down. Your Detox worker will arrange for you to get some anti-nausea medication.
- **Withdrawal fits** or collapse into unconsciousness accompanied by shaking.
- Typically the person falls going firstly rigid then shaking and may bite their tongue and/or be incontinent of urine and occasionally faeces. Later they cannot recall what happened.
- If you witness someone having a fit:
    - Call for help
    - Try and note the time at the start and end of the fit
    - Don't restrain the person but clear a space around them to stop then hitting themselves
    - Put something soft beneath the head and loosen tight clothing
    - Remove anything from the mouth that may get inhaled or block the airway
    - **Phone 999 for the ambulance service if expected seizure lasts more than 5 minutes**
    - After the shaking stops roll them gently onto their side into the recovery position.
    - Support their head with a cushion. Check that they are not injured and are breathing normally
    - The person should return to consciousness after a few minutes but they may feel drowsy and be confused for some after this. Allow them time to come round and then explain what has happened
    - Inform your detox worker and/or GP what has happened

Medication Information: Chlordiazepoxide and Diazepam

Chlordiazepoxide also known as or **Librium**
Diazepam also known as **Valium**

What do chlordiazepoxide and diazepam do?

- Chlordiazepoxide and diazepam are benzodiazepines, a group of medicines that slow down the central nervous system so can help people with alcohol withdrawal. They are established as the safest drugs to take for alcohol withdrawal symptoms.
- Chlordiazepoxide and diazepam may also be prescribed for short-term relief of anxiety, nervousness and certain phobic situation but for only 2-4 weeks due to their risk of dependency.
- They are not licensed for long-term use when problems of poor memory and cognitive function can occur. We will be sure to prescribe in a manner to avoid long term use.

What should my prescriber or worker know before I take chlordiazepoxide or diazepam?

- Tell your prescriber if you suffer from any of the following:
  - depression
  - kidney disease
  - liver disease
  - lung disease or breathing difficulties
  - myasthenia gravis
  - Parkinson's disease
  - porphyria
  - shortness of breath
  - severe snoring
  - suicidal thoughts
  - an unusual or allergic reaction to any benzodiazepines, foods, dyes or preservatives.
  - pregnancy or trying to get pregnant
  - breast-feeding
  - all medications including over the counter/illicit medications or nutritional supplements.

Please note: Omeprazole and esomeprazole (anti-acid) may decrease the metabolism of diazepam.

How should I take this medicine?

- Take chlordiazepoxide or diazepam tablets or capsules by mouth only.
- Follow the directions on the prescription label or from your worker/prescriber.
- Swallow the tablets or capsules with a drink of water.
- If they upset your stomach, take it with food or milk.
- Only take your doses at the agreed time.
- Do not take your medicine more often than directed.

What if I miss a dose?

- If you miss a dose, take it as soon as you can. If it is almost time for your next dose, take only then omit the missed dose. Do not take double or extra doses. Inform your Harbour worker.

What side effects may I notice from taking chlordiazepoxide or diazepam?

- Minor and temporary side effects occur with all medication.
- Side effects that you should report to your prescriber or worker are:
  - rash or swelling in the mouth or breathing difficulties
  - confusion
  - depression
  - light-headedness or fainting spells
  - mood changes, excitability or aggressive behaviour
  - muscle cramps
  - restlessness, tremors
  - weakness or tiredness

What do I need to watch out for while I take chlordiazepoxide or diazepam?

- You may get drowsy or dizzy.
- Do not drive, use machinery, or do anything that needs mental alertness.
- To reduce the risk of dizzy and fainting spells, do not stand up quickly, especially if you are aged over 60 years.
- Even after you stop taking chlordiazepoxide or diazepam, it can still affect your body for seven days.

Where can I keep medicine?

- Always keep medicines out of the reach of children in a container that they cannot open
- Store at room temperature between 15 and 30 degrees C (59 and 86°F)
- Protect from light

Please note: This information is not intended to cover every possible uses, precautions, interactions or adverse effects for this drug.

If you have any questions about the drug(s) you are taking check with your Harbour Worker, GP or Pharmacist

Plymouth Home Alcohol Detox Satisfaction Survey			
In order to improve our service we would be grateful for your feedback			
Please indicate by circling whether you are a **client** or a **carer**			
Date of Detox:			
	Please tick	Yes	No
1	Did staff involve you as much as you wanted in decisions about your care?		
2	Did you feel you were treated with dignity and respect?		
3	Were you given enough time to discuss your treatment?		
4	Do you feel that staff listened to you?		
5	Did you understand about how your medication was used?		
6	Did staff explain and give you appropriate written information?		
7	Did you have enough support?		
8	Did you have confidence and trust in the doctor or nurse that you worked with?		
9	Do you have a copy of your Care Plan?		
10	Was your Care Plan useful to you?		
11	Were you offered Thiamine or Vitamin B?		
12	Were you offered Naltrexone or Acamprosate tablets to reduce relapse?		
Please rate how satisfied you are with the overall experience on a scale of 1- 5 where 1 represents ‘not at all’ and 5 represents ‘excellent’.			
Please write any comments you would like in this box or overleaf. Thank you			

Useful Contact Numbers		
Self Help		
Alcoholics Anonymous	Daily meetings	0845 7697555
NA especially for younger drinkers		0300 999 1212
DAA (Drug Addicts Anonymous)		07818 260 811
Gamblers Anonymous		www.gamblersanonymous.org.uk
Al-Anon for Family Members		0207403 0888
SMART Recovery UK	Every Wednesday 18:30 to 20:00 at Family Matters, 46-48 Devonport Road, Stoke, Plymouth PL3 4DH and Every Thursday 12:00 to 13:30 at Harbour, Hyde Park House, Mutley, Plymouth PL6 4LF	
Provider Agencies		
Broadreach (residential rehabilitation)		01752 790000
Hamoaze House (day service - requires referral)		01752 566100
Harbour (main reception at ET)		01752 434343
Harbour Criminal Justice Team		01752 434567
Harbour Young People's Service		01752 434295
Ocean Quay (day service) and ARC Project (Outreach)		01752 500003
Plymouth Options		01752 314520
Plymouth Community Health & Clinical Lead's Office (PSAS)		01752 435222
Shekinah (homeless, training, drop-in)		01752 220330
Time4Change (family services)		01752 606826