Recovery: A need to protect what is already existent alcohol community detoxification

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Introduction

Recovery has become central to policy in the UK and its message has been to try and get people out of treatment as possible. This has been welcomed but there are some people who take time to recover and will only exit the system after a series of detoxifications. Infact the learning from the detoxifications before the very successful one are critical as they can enable a patient to finally achieve abstinence.

Alcohol treatment is such as area and this needs to be recognized and recovery needs to be seen as a series if attempts that enables a patient to learn how to be better at developing abstinence.

Coupled with the recovery agenda all drug and alcohol funding has been cuts as a result from being moved from the NHS to the public health budget held by local authorities. This has challenged commissioners to argue the case for budget savings as local authority funding is all squeezed. Also with recovery figures linked to funding this has led to tighter budgets and often re-designed and streamlined service provision.

In this streamlined drug and alcohol service often shared care has been severely reduced and sidelined with the loss of very effective care. This paper argues that services such as nurse-led alcohol detoxifications can be lost and this as be a very effective recovery pathway for patients and therefore needs to be protected. Areas such as this are important to protect especially in the ‘Recovery’ led approach to drug and alcohol provision.

Community detoxification is usually asked for by patients who present to alcohol as the first line of treatment services. This is seen as an effective treatment pathway for many patients that present and can be enabling for them to experience some ‘dry’ time from alcohol. There is some evidence to suggest that this can be as effective as in-patient detoxification off alcohol and cheaper to complete.

There needs to be good insight into the triggers and patterns that influence a dependent drinking pattern. Time spent on examining this to improve a patients’ insight can be the best way to prepare for a successfully community detoxification. This is an important tool for recovery and is part of the journey. Also, nationally, the planned episode of care with preparation followed by a community detoxification and then aftercare is advocated by NICE guidance.

However, despite preparation time for patients now being widely accepted, there are a cohort of patients that may need more than one detoxification within a twelve period, sometimes as many as four to five. This paper focuses on this cohort and looks at the rationale for providing this pathway and the overall outcome. It therefore asks: How many alcohol community detoxifications is enough? This paper tries to answer this by examining the data collected from a primary care service based in Islington, London. It tries to argue that is an effective and safe pathway for patients. It can also be psychologically enabling for patients to have some ‘dry’ time away from alcohol.

Therefore, this paper is looking at the planned detoxifications that were completed in the community for over two years in 2016 & 2017. All of the detoxes were completed in primary care by the specialist primary care alcohol team based in Islington London. It examines the cohort that within the data collected needed more than one detoxification within a twelve month period.

Primary care alcohol and drug service: Islington (PCADS)

This service was established in 2007 as an alcohol and drug service for patients who are registered at Islington G.P.’s. PCADS works with the support of a specialist psychiatric service as well. This means it works with the service with a Consultant Psychiatrist, who provides clinical guidance. This service provided a framework for the development of PCADS detoxification protocol that was produced to inform the team a safe and effective way to complete community detoxifications. The service provides in-reach to all GP surgeries in Islington currently at 34 practices. It does this by providing nurses’ that can also provide non-medical prescribing and therefore assess, manage and prescribe for the patients holistically. Therefore, in essence, the patient presenting for alcohol treatment need only see one clinician for every aspect of care (alcohol) and this provides a quick accessible service for patients.

Community detoxification is a large part of the activity of PCADS and is defined as: A prescribed clinical detoxification process which can be given in the community with a level of patient monitoring which is less than in the in-patient setting. It is given to patients who are assessed as ‘not confusing’ No hallucinations/DT’s

Criteria for community detoxification:

• Not severely dependent: Alcohol consumption under 200 units a week
• Age 18-65 (service remit)
• Not confused. No hallucinations/DT’s
• No recent uncontrolled seizures
• No acute physical illness including reduced respiratory function, cardiac failure or severe liver damage.
• Not pregnant or breast feeding
• Not physically compromised
• Not dependent on benzodiazepines or chaotically misusing illicit drugs
• Have no presenting Wernicke-Korsakoff’s syndrome
• Have not suffered from unstable or severe psychiatric illness including a risk of suicide, frequent self harm or impaired cognitive function
• No history of uncomplicated medication assisted withdrawal or are likely to disengage with services for monitoring during withdrawal
• Have a supportive home environment
• The results of the last two years results are now analysed with a focus on the patients that needed more than one community detoxification in the tie period of the last twelve months

Data collection

Data on the community detoxification was taken from the last two years of PCADS activity that spanned from the time frame of April 2015 to April 2017. In this time period there were 98 community detoxes completed for the service and some of the patients in this data had more than one community detoxification. This cohort when examined is a small part of the overall figure that may indicate that maybe the preparation work of the majority of patients is good and they achieve ‘dry’ time in order not to re-visit the service again for another community detoxification. Or they relapse and indeed drop out of treatment. From the 98, this ratio that drop out is also very small, however, this will be the focus of another paper, for as mentioned the patients that have more than one detox will now be examined. First here are some summary charts that indicate some the data analysed from the two years activity of the PCADS in Islington (Figure 1).

Two years chart of detoxification activity

Figure 1 It shows how the service operates and there are two main ways patients are detoxed in PCADS.

The above chart illustrates how the service operates and there are two main ways patients are detoxed in PCADS. One is ambulatory that is a hospital-based detoxification of alcohol conducted through the outpatient department. This is for patients that are admitted into hospital and are discharged earlier if they can be seen every day in an outpatient department. This is a process that works for patients reluctant to stay in hospital and can be very cost effective. In Islington a bed night saved by this service can save up to 200 pounds a night. The community detoxes are conducted out of general practices in Islington. As described before, the patients need to meet the criteria. This usually excludes very dependent drinkers who are physical very unwell. The detoxifications are usually planned and there is some preparation time as well. In this time, the patient is asked to outline their alcohol pattern and focus on the triggers for alcohol. This will hopefully try to increased understanding and insight into their alcohol pattern. Then the detoxification will be planned when there has been a reduction in their alcohol consumption from the original figure given at the assessment stage.

Therefore, the detoxifications being planned, can give the team valuable time to work with a patient to be ready for a detoxification and focus on the period after this to establish some dry time (Figure 2).

Gender profile of alcohol detoxes

Figure 2 It shows the gender mix of the patients that present for a community detoxification in primary care Islington.

This figure looks at the gender mix of the patients that present for a community detoxification in primary care Islington. This has always been at the same level for many years. It is roughly a two-thirds male to a third females’ split. This would indicate what is a national picture in that males are better represented in services than females. Particularly in drug and alcohol services where the gender split nationally is a 4:1 ratio in favour of males (www.nta.nhs) (Figure 3).

Age profile of community detoxes completed by PCADS

Figure 3 It shows the age profiles all the detoxes.

This is also similar to previous statistics. However PCADS is seeing an aging population that is indicated in the above chart for the number of community detoxifications over a two year period. The number of detoxes for the patients over the age of 45 at 67% of the
all the detoxes completed. This is a significant figure. It does indicate that the older the patients the more likely they have been exposed to alcohol treatment in the past and therefore would enable them to make better use of services when needed to achieve their aims for treatment. However this will also be the subject of another paper as mentioned the scope of this paper is to focus on the patients that have had more than one detoxification and the significance of this chart is that this cohort of patients, in the majority are also over 45 and have been exposed to treatment before.

More than one community detoxification

This section will examine the cohort that has had more than one detoxification over the time period of a year from April 2016-2017. This cohort when examined is a small number of patients at twelve exactly. The numbers of detoxification that have been completed by this cohort are now shown below (Figure 4).

Patients that needs more than one detoxification (Community)

As one can see the majority of patients need only two to three community detoxes however there is a few patients that have needed more than this. The question this paper will ask is there any ‘dry’ time achieved in between each detoxification and how does this relate to the next detox. Does it inform the patients to be better able to use the services when needed to achieve their aims for treatment. Or does it take for some patients more than a few detoxifications of alcohol to achieve some ‘real’ abstinence off alcohol therefore giving a rationale of giving patients more than a few detoxification of alcohol to achieve some

Figure 4 The majority of patients need only two to three community detoxes.

The majority are overwhelming over 40 years plus with 8 being over 45 years of age. This does show similar findings to the first chart that the patients that do detox that tend to be older are more experienced in alcohol treatment and therefore are more able to understand what services can be provided. Also they are able to use them to meet their aims as well. This will hopefully be illustrated in the case studies that will now be presented.

Since the cohort is small there is an opportunity for it to be studied in more details and the case study analysis would indicate the best approach to this. This is now explained and its applicability.

Case studies

Case studies used here are looking at the individual cases that do engage with community services in Islington, as these patients can show the service of what works so that this process can be more uniform. Case studies in this sense can be informative and enlightening. They can be very useful for medical research and provide clinical staff with very good information from an in-depth study that can improve care. This is the purpose of this paper to see if the valuable things that help people engage, and can this be worked into a uniform process. Since the number are small there is an opportunity to use the case study approach to look in-depth to the profile of the patients and see if there are any major factors or commonality that can be informative to clinical staff. It could improve and inform the community detoxification process for PCADS and also a wider audience of clinical staff that conduct community detoxification for alcohol dependent patients.

Case study A: Five detoxes in one year (Age 34)

Presentation: He was becoming a young father but was not living with his girlfriend but wanted to get himself alcohol free as he felt that he did not want to drink at the levels he has so far. This is at 20 units a day and he has never had any days off alcohol for the last six years. He drinks beers and small bottles of spirit/whiskey a day. This is around 20 units a day. Therefore 140-150 units a week. He has no physical or mental health problems; He was relatively young and has been involved in sports for years. Since he struggled to find work he has been drinking. He feels depressed with his situation and alcohol helps block things out. Also he gets very stressed and easily angry and alcohol can calm him down. He has had no counseling or psychological help in how to better solve his problems in a more constructive way.

It was felt that a community detox was possible. He was drinking under 200 units a week and has no history of fits. He did not have any alcohol free days however the idea was he needed to reduce the amount of alcohol he had. When he was seen in the afternoon he always breathysed at 0.20 or above (a little). I wanted him to show greater control and breathysed at zero. His Liver function was good and there were no abnormalities in his blood test. It was his first detoxification therefore he needed support and had the engage with aftercare services after the detox. It was thought he could engage with local day programme and still see the nurse specialist after the detoxification.

Treatment: He started a detoxification regime however; he was always late for his appointments. He did not miss doses and was able to communicate with text messages and e-mails. There was a high level of communication during the detoxification. He successfully completed the detoxification regime in seven days. However, he failed to engage with the day programme and then stopped engaging with sessions with me. He still texted me to say he was ‘dry’. The text messages stopped after six weeks. He had relapsed back into drinking. He presented to me again in primary care and asked for another detox.

Figure 5 Shows the age profile of the patients that need more than one detoxification.
What next? He was aware that this was the first time he has stayed ‘dry’ and that this was very new to him. He did under estimate the idea of returning to controlled drinking and thought that after six weeks, he could. Only to discover that he could not as the first drink he has led to him relapsing back into his original pattern. It was not a bad idea of having another detoxification as he had experienced some ‘dry’ time he did not have for a long time. However the main point was what he had learnt from this episode of treatment.

He learnt that staying ‘dry’ was harder and he said he would engage with aftercare more and he would see me for sure. After a two month period from the first detoxification where he has controlled his alcohol more and we reflected a great deal.

He had a second detoxification and this was shorter than the first one as he was drinking less at 90 units a week. He found the detoxification easy and he was on time for his appointments to see me. Post detoxification he still failed to engage with the day programme but did continue to see me for the period he was ‘dry’. He did maintain a high level of contact with text messages and e-mails and did stay dry for longer this time. It was three months. He again relapsed to drinking after failing to learn enough about his pattern and triggers for dependent drinking after drinking after getting stressed.

He repeated this pattern for the third and forth detoxification, however the fifth one was different. I did not detox him until he engaged with the day programme and this was important, and a deal breaker for the prescribing of another alcohol detoxification. If he did not engage with the day programme and get assessed and taken on, the detoxification would not happen. He did this and this was six months ago. He is still dry and this is the longest period he has had off alcohol. He still sees me but only once a month and has stopped texting me. He has engaged with the day programme and continues to go there and this has been important in him staying ‘dry’. His problem was over confidence in thinking two to three months was all he needed to show control over his alcohol consumption. This was a difficult lesson to learn but after the fifth detoxification he feels he has learnt this. Hence his longest period being alcohol free.

Case Study B: Four detoxes in one year

Presentation: John was a 54 year old man. He has previously been a heroin user and had stopped taking illicit drugs and switched to alcohol. When he had seen me in 2016 for the first time he had been drinking dependently for three years and this was at 6 to 7 cans of 9% lager a day. His LFTs were all abnormal and his GGT’s were at the level of over 900. He has no visible signs of liver damage but was aware that if he would not stop drinking this would change. He had no mental health history and as yet no physical complications linked to alcohol use. He had been in and out of hospital with alcohol withdrawal ‘fits’ and delirium tremors and to offer a community detoxification was seen as a way forward to reduce the number of hospital admissions and give John a chance of abstinence.

Treatment: The only previous treatment John had had was an admission into an in-patient detoxification centre that was locally based in Islington. He was referred to this service but had no real follow up care and relapsed back into dependent drinking after a few weeks. The detoxification was successful in that he did get to be abstinent. However this abstinence was short lived for only three weeks. He struggled on his own and wanted to still engage with services post detoxification. This he thought was a valuable lesson he had learnt. John was drinking 25 units a day. This was over the still under the 200 units a week. However, to show some motivation and commitment to the community detoxification I wanted him to reduce his drinking to 5 cans a day consistently and breathalyse under 0.20 in the afternoon.

What next? He did reduce his drinking and breathalyse under 0.20 for two weeks in a row. He was committed to the detoxification and wanted to stay ‘dry’. The first community detoxification was important as he was seen three times that week to monitor him through the process to avoid any alcohol withdrawal ‘fits’. He successfully detoxed and then had eight weeks off alcohol. He engages with his appointments post detox but after eight weeks started drinking again. He stopped attending appointments after this period. He was phoned and he came in again after three months. A second detoxification was planned but he had to engage with a day programme before this happened. The second detoxification enabled John to go three months off alcohol. However he failed to engage with the day programme and relapsed again.

The third detoxification followed after a hospital admission where he was taken in due to possible delirium tremors and acute confusion. He was sectioned under a section two. He detoxed in hospital and saw me on discharge and was able to stay dry for four months in total. The hospital admission scared him and seemed to the main motivator to enable to achieve his ‘dry’ time. However again he failed to engage with any structured aftercare and relapsed again.

The fourth detoxification was five months ago and he has now engaged in a day programme. The detoxification was started after he had fully been assessed for the day programme and he is still engaged with this to date. This is the longest time he has been dry and his liver function tests are much improved as a result. They have improved as with four detoxes in 18 months he has achieved significant time off alcohol that has enabled his liver some time to recover and heal. Hopefully this will carry on and he will go six months and more ‘dry’. He has learned not to be over confident about his alcohol. A common mistake and he is now aware that support post detoxification is very important to enable sustained ‘dry’ time.

Case Study C: Three detoxes in one year

Presentation: Fred (63 years old) has been a long term users of primary ace alcohol services for ten years. He has engaged well in the past. He has a very dependent pattern drinking 20 units day before he engaged with services. He has been able to stay ‘dry’ for long periods of four to five months. However he still craves alcohol at times and despite how long he maybe ‘dry’ the cravings never seem for him to diminish in their intensity. This is why he does relapse. He now relapsed into a binge pattern where he would drink 25 units a day for three weeks and then want to stop. He would present in acute withdrawals.

Treatment: He had no physical or mental health problems. His liver function test were good. This was because he had been able to stay ‘dry’ for long periods and therefore his liver was largely unaffected by alcohol for long periods of time. Each time he had a binge he needed a short and quick detoxification to get him to get abstinent again. This has always been a successful treatment path for Fred.

What next? Tis presentation was clinically unproblematic and Fred was a good candidate for a community detoxification as he always had some significant ‘dry’ time after the detoxes. However his cravings continue to be problematic which limits the extent of his
‘dry’ time. This has psychological roots and as yet Fred has yet to significantly engage with talking therapies to increase his insight into the problem. This will be the next approach we will talk about doing to increase Fred’s ‘dry’ time.

**Case study D: Two detoxes over one year**

**Presentation:** This was a 43 year old woman who had engaged with the primary care alcohol services with a dependent pattern around alcohol. It had been linked to a bereavement of her partner and this was a year ago. Her dependency on alcohol was not long. She had never been a problematic or dependent drinker before her bereavement. At first she wanted to reduce her drinking, however after a discussion she was interested in trying a community alcohol detoxification.

**Treatment:** She was asked to reduce her alcohol intake from 80 units a week to 60 units a week and to breathe as zero in the morning when she was seen to illustrate she had some control around her alcohol. She achieved this very quickly and was able to start a community alcohol detoxification. This was a course of chlordiazepoxide for over seven days.

**What next?** After her first community detoxification she was able to stay ‘dry’ and had engaged with bereavement counseling services. She found this very helpful in dealing with her loss. She was seen in primary care to help her stay abstinent with the prescribing of naltrexone to help her stay ‘dry’. She was very confident that she had left her alcohol dependency behind. However, when she stopped her bereavement counseling and stopped seeing me, she relapsed very quickly. She came back to the service after three months of relapsing. She asked for another community detoxification. At this point of her second detoxification she had reduced to under 50 units a week but was drinking every day. The palm was a short detoxification for five days and then prescribe naltrexone to help abstinence.

She has now stayed ‘dry’ for over a year to date and continues to engage with primary care services to touch base and re-orientate her to stay ‘dry’. She would say that without this she would start to be over confident again and this helps prolong her abstinence. This may not be sustainable for our service to continue but whilst it has a positive benefit on a patient outcome, there is a justification for it to be continued. Which at present it is.

**Discussion**

Therefore, some patients, despite some preparation time before the detoxification is started need more than one experience of a community detoxification. Some patients were the cohort that needed more multiple detoxes over a period of twelve months. It may be noted that this cohort is a small percentage of the overall figure of 98 detoxification completed in the two years.

In all the case studies presented in this paper it shows that each detoxification did make the patient more insightful for the next one. Indeed each relapse informed the clinical staff and the patients involved on what was needed to work on before another detoxification was considered. Whilst preparation time is important to provide a good outcome for patients who complete a detox off alcohol, some learn more about their pattern when they have been ‘dry’. Indeed it can be argued that some of the patients that needed more than one detoxification to increase their insight by failing to have more than three months ‘dry’ after their first detoxification. This is more applicable to Case studies A & B then C & D.

Case studies C & D seem to have very unproblematic presentation and over the period of twelve months were able to achieve significant ‘dry’. Whilst cases A & B seemed more complex in that one patient (B) had frequent hospitalization before going ‘dry’ for more than three months and Case A had very poor insight into his alcohol pattern and engagement.6–10

For case A each detoxification did increase his insight into how dependent his pattern was and he was able to prepare better for the next time. Also the same with Case B and the clinical staff involved in this also spent more preparation time to enable this to provide a better outcome. Infact most patients will need more than one detoxification off substances in order to achieve any abstinence time of over six months.14 This is applicable to the cases of A&B with a good outcome in the end. Therefore to limit community detoxification off alcohol should not be an aim but each case must be considered on a case by case basis. If a patient needs more than one detoxification, learning about their pattern and increasing their insight is essential for the patient and the clinician to consider before attempting another one. In Islington, from the case studies, this does seem to happen and will be encouraged as an approach to patients needing more than one detoxification.

In summary this paper illustrates that community detoxification for patients with very ingrained dependent patterns will need more than one detoxification. However, after each detox this cohort increased their insight into their alcohol pattern that enabled the patient for a better outcome. Importantly, this paper illustrates that the number of alcohol detoxifications should not be limited.

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**Conflicts of interest**

Author declares that there is none of the conflicts.

**References**


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