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▶ Audit of alcohol detoxification at Leeds Addiction Unit.

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In a specialist hospital unit in Leeds, virtually all the alcohol dependent outpatients completed detoxification and all but a few went on to try to sustain their drinking reductions using the aversive medication disulfiram, indicative of what can be achieved in these settings.

Summary This brief report documents two annual audits of the outpatient alcohol detoxification and allied aftercare services of the Leeds Addiction Unit in northern England, based partly on a three-month follow-up of patients. The unit's psychiatrists, psychologists and community psychiatric nurses are all trained in motivational dialogue and have regular, observed supervision. They are a specialist and experienced team with the skills to take on severely dependent and complex cases. Timely follow-up by the assigned key worker at home or unit and the medically supervised administration of disulfiram – which produces unpleasant reactions in response to even low levels of drinking – monitored every four to eight weeks by doctors, were key elements of the treatment. Typically social and behavioural network therapy is also used to help maintain abstinence.

Decisions to offer outpatient detoxification are taken on the basis of health complications, severity of dependence, previous history of medical detoxification, safety considerations (like arrangements to visit day units for physical and mental health monitoring), availability of social support, and access to emergency services.

The featured study documents audits intended to check the effectiveness and safety of this service from the pre-detoxification period through to three months after detoxification. All 50 community detoxifications in March 2009 were included in a first audit, all 59 from March 2010 in a re-audit. Notes routinely made during the process were inspected, and respectively 48 and 53 of the patients re-contacted and assessed

three months after completion of detoxification. Two thirds were men and they averaged just over 35 years of age. Most were already known to the service.

Main findings

The first audit revealed that the pre-detoxification assessment was often incomplete or incompletely documented in respect of providing a detoxification preparation worksheet (noted in 58% of cases), giving blood screen results (73%) and discussing with the patient their readiness to alter their drinking in terms of their stages of change (38%). All three rates had improved a year later to to 70%, 100% and 62% respectively.

In the two years 96% and 98% of detoxifications were successfully completed without any adverse events. Three months after being detoxified, in the first audit 11 patients (23%) had dropped out of treatment compared to eight (15%) in the re-audit. The majority, 73% and 83% respectively, were still in contact with their therapists. After detoxification, disulfiram continued to be prescribed to 66% of patients in the initial audit and 89% in the re-audit, when acamprosate was also prescribed after detoxification to 52% of patients. Roughly half the followed up patients in initial audit were on regular disulfiram, whereas in re-audit this was the case for almost everybody.

In the first audit 15 (31%) patients had remained completely abstinent during the three-month follow-up and another five (10%) were drinking within safe limits, improving a year later to 16 patients (36%) and 10 (22%). In the two years, 46% and 42% had relapsed.

The authors' conclusions

Virtually all detoxifications were successfully and safely completed. Social and behavioural network relapse prevention therapy seemed to contribute significantly to maintenance of abstinence or safe drinking after detoxification, and disulfiram taken under medical supervision played a pivotal role. During the next three months, 53% of patients in the initial audit and 58% in the re-audit maintained in treatment were either completely abstinent or (though the therapeutic stress was on abstinence) managed to confine their drinking to normal limits.

Findings from the first audit suggested that follow-up contacts after detoxification and continuing disulfiram prescribing were delivering good results, leading the unit to incorporate follow-up appointments in to treatment planning before detoxification and to offer these more often. Clients maintained their relationships with their dedicated key workers before, during and after detoxification, and received regular advice on initiating or continuing with disulfiram. These changes led to clear improvements in the second audit in terms of better abstinence rates and reduced drop-out.

FINDINGS For an outpatient procedure, completion rates in the audits were remarkably high, a testament perhaps to the quality and the intensity of therapy and monitoring, including the readiness to prescribe disulfiram and to try to make sure patients took it. Though approaching half the patients relapsed in the following months, many must have remained in contact with their therapists (for example, 42% relapsed in year two but only 17% of all patients lost contact), suggesting that, as intended, the motivational style of the therapy was seen as non-judgemental support, even when things had not turned out as therapist and patient would have wanted.

Disulfiram is sometimes seen as a niche alternative only for highly motivated patients with associates close enough to effectively supervise its consumption. The featured study shows that with sufficient medical support, it can successfully be prescribed to almost all patients who qualify for outpatient detoxification. It has support from a UK randomised trial, which found the drug effective at least in the first months of treatment when its daily consumption was supervised mainly at home by the patient's female partner, and both knew the consequences of drinking while taking it. Over the six months they were followed up, disulfiram patients reduced their drinking days and amounts drunk by significantly more than patients prescribed a vitamin, though by the final four weeks the extra reduction had evened out, and by the end they had lasted without drinking no longer.

In contrast, hampered by high drop-out and failure to take the medication, the major UK randomised trial of acamprosate versus a placebo found that the drug did not improve abstinence rates or prevent relapse. Even among those who took the tablets at least for the first two weeks, there was no added benefit. Nevertheless, evidence from Europe supports the effectiveness of acamprosate for relapse amelioration/prevention following alcohol detoxification. It seems likely that poor retention among the more unstable and irregular drinkers seen at the UK clinics in the study decreased the drug's impact, as they would also have done disulfiram.

The two medications used by the featured unit are recommended in national guidance for Scotland and England and Wales. The guidance envisages a more routine and/or first-line post-detoxification role for acamprosate than for disulfiram, the latter coming with the caution that total abstinence is required to avoid unpleasant and potentially dangerous reactions, and that the positive evidence derives from situations where consumption has been supervised.

Statistics for England in 2011 show that doctors in general have also forefronted acamprosate, prescribed 107,389 times compared to 60,375 for disulfiram, figures dominated by GP prescribing. However, in hospitals such as those audited in the featured study, disulfiram is prescribed slightly more often. In these settings patients are likely to be so severely dependent that at least initial abstinence is the preferred objective and there is the expertise to handle the risks of prescribing disulfiram.

Thanks for their comments on this entry in draft to Duncan Raistrick of the Leeds Addiction Unit in England. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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