Managing presenting alcohol users – an Introduction to SPECTRUM (CRI)

By Dr Gideon Felton MRCPsych

Consultant Psychiatrist and Clinical Lead

PLAN OF PRESENTATION

- Assessment of alcohol dependence
- Psychiatric manifestations
- Medical and psychiatric management of alcohol addiction
- The patient journey
- SCENARIOS

PROBLEMS FACED

- Intoxication
- Medical and Psychiatric complications
- Withdrawal
- Addiction

INITIALLY

- Pt takes alcohol and gets positive reinforcement in terms of pleasure
- This results in increasing the number of receptor sites being made by brain
- This results in needing more alcohol to satisfy the increasing number of receptor sites
- More CNS/Autonomic suppression

CONSEQUENCES-SIGNS OF DEPENDENCE

- Increasing tolerance as more alcohol needed
- Rebound autonomic hyperactivity when not drinking leading to sweats and shakes
- Increased cravings to stave off withdrawals
- Earlier onset of cravings
- Psychological-PRIMACY – Pt's life dominated by ensuring adequate alcohol supply.

LEADING TO

WITHDRAWALS-symptoms associated when alcohol discontinued-

happens within 24-72 hours

Pt has autonomic hyperactivity eg increased BP and HR – risk of seizures

Can lead to Delirium Tremens (10-15% mortality)

- INTOXICATION describes altered behaviour secondary to drug

- ADDICTION is pt's behaviour in acquiring drug to stave off withdrawals ie negative reinforcement (no joy in drink just drink to avoid adverse symptoms of withdrawal)

PSYCHOLOGICAL COMPLICATIONS

- DT's – disoriented to time
- Wernickes-confused with eye movement disorder (Rx vit B1)
- Formication-Pt describes feeling ants
- Psychosis-Pt has persecutory delusions – morbid jealousy- responds to antipsychotics-can happen 3/52 after stopping

- ALL NEED A&E attendance

MEDICAL COMPLICATIONS

- Liver failure
- GI bleed
- Pancreatitis
- Cardiomyopathy
- Neoplasms

HOW TO MANAGE ALCOHOL DEPENDENCE

- When Pt presents to GP it is necessary to
- Establish patients eagerness to address problem
- Establish evidence of dependence focussing on primacy and withdrawal symptoms (not CAGE)
- NEVER prescribe librium or diazepam as you are creating a 2nd addiction without treating the 1st one!!

TREATMENT PLAN FOR ALCOHOL DEPENDENCE

- Pt drinking daily with withdrawal shakes and autonomic overdrive on discontinuation
- MUST DECIDE URGENCY!!!!

- CAN SEND TO A&E For Medical detox if Hx of DT's
- OTHERWISE GP/self refer to CRI – seen by key worker < 2/52

MEDICAL DETOX POST A&E

- If pt has a history of DT's then A&E needs to be involved for consideration of medical detox
- However this takes place on a medical ward and has very high failure rate due to inadequate preparation, uncomfortable detox environment and aftercare
- Often pts self discharge themselves to the pub!

NON-EMERGENCY PATHWAY via CRI

- Pt or GP can refer to CRI
- Keyworker assesses pt within a week requesting blood tests
- Dr to see Pt within 2 weeks
- Decision made on whether it is home detox or in-patient detox
- Home detox preferable as contiguous with home environment and can happen within 2/52

INPATIENT DETOX

- If patient has poor home support or medically complex then in-patient detox preferred
- I/P detox needs 4-6/52 to organise
- Once detox scheduled then pre-detox and post detox work can be organised

JOURNEY –Predetox-detox-post detox

- Once detox plan (home vs I/P) decided upon by Dr
- KW sets pre-detox care plan with patient
- Pt reduces drinking by 10% per week with kw support to make detox more seamless
- Pt attends early to minimise intoxication
- Motivational Interviewing sessions which explore pt's motivation to change

KEYWORKING SESSIONS

‘What do you see is the problem’

‘What do you see is the solution’

- Explores Pt’s barriers to change

‘ What do you think needs to be done to remove these barriers ?’

Answers framed in pt’s own words to drive motivation

MEDICATIONS USED IN DETOX

- Chlordiazepoxide/Diazepam (GABA agonists)
- 25mg clordiazepoxide = 10 mg diazepam
- (oxazepam if liver deficit)
- Used to counter the autonomic overdrive when alcohol stopped suddenly
- Addictive and tolerance inducing
- Vitamin preparations

DETOX

- Daily reducing dose of Chlordiazepoxide eg day 1-25mg qds day 2- 25, 20, 25, 20 etc
- Day 3 20 qds etc
- Pabrinex
- ? Acamprosate

POST DETOX

- Relapse prevention
- Exploring triggers to relapse and establishing coping mechanisms when triggers appear
- Finding alternatives to drinking
- Keyworking
- AA
- Group work

POST DETOX MEDICATIONS

- Acamprosate – GABA agonist
- Treats cravings and anxiolytic for 1 year

- Pregabalin – as above but not label

- Disulfiram(Antabuse) – use only if very motivated

SCENARIO 1

- Pt brought in by relative and disoriented in time. BP and P elevated – not smelling of alcohol

SOLUTION

- Treat as acute confusional state – A&E attendance – do not treat yourself as you will not monitor him.
- A&E will refer to medics to admit for medical detox , usually starting librium at 100mg in 4 divided doses and reducing at a rate of 10mg per day(oxazepam if liver failure)

SCENARIO 2

- The same patient gets admitted for his DT's on a medical ward. He self discharges after 1 day feeling confused and comes to your office. He states he does not want to go back to the hospital and asks you for medication as he is shaking.

SOLUTION 2

- Again, do NOT prescribe anything. He must re-attend A&E for consideration He is still in danger from DT's and the ambulance may need to be called.
- No role for mental health team as diagnosis is alcohol withdrawal still

SCENARIO 3

- This same patient tolerates 3 days of hospital treatment and self discharges. He comes to the clinic stating that the librium is working and can he have some more?

SOLUTION 3

- Treat as incomplete detox but at least he is out of danger from DT's.
- Again don't prescribe librium as you are contributing to a new addiction
- Refer to CRI who will re-assess his motivation for a planned detox

SCENARIO 4

- 45M presents to surgery stating that they stopped drinking 2 days ago and wants something to stop him shaking-he states he has fits

SOLUTION

- Do NOT give him Librium or diazepam script. Librium to be given only under trusted supervision and decision taken by specialist

- If he is intoxicated, he is unlikely to be in DT's
- He can engage with CRI in normal way

SCENARIO 5

- The patient engages with CRI and is seen by the Dr who deems him fit for a home detox. After brief pre-detox work, he commences his detox and after 3 days, he relapses and is intoxicated

SOLUTION

- Explore reasons for relapse
- Home situation may not be as stable and I/P detox may be preferred choice

SCENARIO 6

- 32 yo male brought in by relative disoriented and c/o double vision. Not oriented.

- Discuss diagnosis and management

SOLUTION 6

- Wernickes encephelopathy likely
- Needs Vitamin B1 (Pabrinex)

SCENARIO 7

- 43 yo male confused and convinced that someone is spreading malicious gossip about him. He appears very frightened and threatening to hurt the next person who annoys him. Not smelling of alcohol.

SOLUTION 7

- Derogatory and persecutory beliefs – Think psychosis – needs psychiatric admission as risk to others. May need mental health act to enforce treatment and police help.

- Will respond to anti-psychotics