

Outpatient Detoxification of the Alcoholic

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Recent and proposed decreases in federal funding in support of publicly funded detoxification facilities and increased costs of inpatient detoxification will predictably lead to family physicians being faced with the problem of alcohol detoxification for many of their patients. Outpatient detoxification is possible in the majority of cases, provided that good initial screening is accomplished and strong supportive resources exist.

The ambulatory route is frequently not considered when examining mechanisms for the withdrawal of individuals from alcohol. The literature and experience indicate that, except in a small number of cases which can be adequately screened during the admission process, outpatient withdrawal can be an effective mechanism. Outpatient withdrawal must be considered not only by family physicians operating in the absence of alcohol support programs but also by alcohol treatment programs as a cost-effective alternative to many of the more expensive means of detoxifying alcoholic patients.

In the face of increasing budgetary reductions at all levels for the treatment of the alcoholic, outpatient detoxification must soon be considered as a

cost-effective and safe method of treatment. The literature has documented successful treatment of the alcoholic on an outpatient basis if adequate support mechanisms and treatment regimens are employed. Successful inpatient detoxification of the alcoholic has been accomplished without use of psychoactive medication.

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Three methods of detoxification have emerged, including inpatient drug-assisted withdrawal, inpatient social setting detoxification without the use of drugs, and outpatient drug-assisted withdrawal. The most popular method of withdrawal has been the inpatient route. Federal funding decisions presently being made will change that pic-

0094-3509/82/050863-05\$01.25
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ture drastically within the coming year. Physicians will be faced with many more alcoholics being brought to them by helping agencies because detoxification facilities will be forced either to close or decrease services in response to decreasing funding.

Successful treatment of the alcoholic on an outpatient basis is well documented in the literature. In examining the data gathered from 564 patients, Feldman et al¹ showed that only 47 percent of the patients presenting for detoxification actually required detoxification, and only 19 percent of those who required detoxification required inpatient care. Inpatient care was felt to be indicated when the patient demonstrated severe hallucinations, psychomotor agitation, convulsions, disorientation, or marked elevation in blood pressure. Patients with severe clinical withdrawal symptoms were retained for hospitalization. These authors report a successful outpatient detoxification with a blood alcohol level (percent milligrams of alcohol per milliliter of blood) of 530 mg/100 mL. Perhaps one of the more significant aspects of this study is that 82 percent of the patients who began outpatient detoxification returned regularly to complete that phase of treatment. In addition, 50 percent of the sample continued in further treatment.

In a similar study by Tennant,² 57 of 60 consecutive patients who entered an ambulatory withdrawal program successfully completed withdrawal. Tennant reported no seizures, although six persons experienced mild hallucinations, delusions, tremor, nausea, or agitation that required injectable diazepam in addition to hydroxyzine. Fifty-five of these 60 patients entered a long-term treatment program following withdrawal. It is important to point out that one of the criteria was the patient must be accompanied by a spouse or other person when he or she began the detoxification process.

A study by Whitfield et al³ on the detoxification of alcoholic patients without psychoactive drugs indirectly supports outpatient detoxification. Of 1,124 consecutive alcoholic patients who entered the program, 90 (8 percent) were sent to a hospital emergency department for further examination. Of those 90, 28 were admitted to the hospital and 62 were returned to the originating unit for further treatment. Although this study concentrates primarily upon the detoxification of alcoholic patients without psychoactive drugs, it also reports

that only 28 out of 1,124 patients were admitted to a hospital for intensive treatment with drug therapy. The remaining patients were cared for in a treatment unit without drugs. Supportive measures were available, and reality orientation was a strong component of the program. Of the total number of patients admitted, only one patient had a full-blown episode of delirium tremens. Even though this study was completed in inpatient units, it does indicate the expected severity of withdrawal occurs only in a small proportion of the total patients admitted.

These studies indicate that outpatient detoxification is a valid response to an alcoholic who wishes to withdraw from alcohol. The expected severity of withdrawal symptoms is simply not found in the majority of cases presenting for withdrawal.

Screening Criteria

Not all alcoholics who present for detoxification are in need of it. The decision to hospitalize the alcoholic for withdrawal should be based on screening criteria developed to fit each physician's comfort level in dealing with the alcoholic client and the many needs of the alcoholic himself. Not all such decisions are medically based. Often the absence of a proper home environment or another facility where withdrawal can be accomplished safely necessitates inpatient detoxification. In dealing with a transient population for whom housing is not available, inpatient detoxification is often undertaken.

Medical indications for inpatient admission include elevated blood pressure, recent or present evidence of seizure activity or psychomotor activity, hallucinations, disorientation, convulsions, and severe tachycardia or hypertension. Indications of impending delirium tremens should be considered as a strong determinant in proceeding with inpatient withdrawal. Length of drinking history and other data gathered in relation to past history about seizures and withdrawal symptoms are probably better indicators of the severity of withdrawal than is blood alcohol concentration. If a recent blood alcohol concentration (BAC) level

is available, perhaps from the arresting officer or other source, it can be a useful diagnostic tool. A BAC over 300 mg/100 mL is considered medically dangerous, and the patient will require monitoring for the development of withdrawal symptoms. Placing the patient in a comfortable position in a room that has low illumination and providing reassurance while monitoring symptoms will provide an atmosphere in which severe symptoms should not develop. Perhaps the most important assessment to be made is whether withdrawal symptoms have begun. If they have, medical management may begin. If they have not, the person's drinking history, if available, should provide some clue to the severity of the oncoming withdrawal. Some persons may require little or no medical intervention.

Treatment Considerations

Perhaps most important when determining whether to initiate outpatient detoxification is the support system that exists for the patient, including not only family but also helping agencies such as Alcoholics Anonymous or other public or private treatment facilities. While reports in the literature show marked variation in the use of medication, almost all researchers report that a soothing and comfortable environment will lessen the severity of withdrawal.

Inpatient treatment backup, whether at a hospital or a treatment facility designed exclusively for the alcoholic client, is necessary when inpatient hospitalization is indicated. In cases of severe withdrawal symptoms, inpatient facilities should be immediately available to the physician.

It is important to obtain a history of the drinking pattern and an indication of the quantity of alcohol consumed prior to presenting for detoxification. The history will usually reveal past episodes of delirium tremens, seizures, or other activity in relationship to withdrawal. The amount of alcohol consumed and the length of the current drinking spree usually indicate the severity of the impending withdrawal symptoms.

In dealing with the transient patient, it is useful for the physician to be acquainted with the availa-

bility of temporary housing that could provide a supportive atmosphere for the alcoholic in withdrawal. Often, contact with members of Alcoholics Anonymous will provide information about such facilities.

Another consideration in determining whether outpatient detoxification is feasible is past evidence of mental illness or chronic organic brain syndrome, both complicating factors that can often increase the severity of the withdrawal and necessitate close observation and monitoring. Often family members are reluctant to assist the patient when these complications exist, and the need for inpatient treatment is usually indicated, particularly when the drinking spree has been a heavy one.

Since medications in outpatient detoxification are administered on a daily basis, it is important to know if the client can report daily to the physician's office to receive medication and have his withdrawal symptoms monitored. If the benzodiazepine drugs are to be used, daily contact with the client is necessary because of the potentially addicting quality of these drugs. Some patients are unable to take oral medication, in which case the medication may be injected. However, those unable to take oral medication may present some problems for the outpatient detoxification process.

Finally, the attitude of the patient and his family or support system is an extremely important variable when considering outpatient detoxification. It is important for the spouse or person responsible to be supportive during the withdrawal period and provide nurturing to the alcoholic. If an attitude of hostility exists between the alcoholic and his or her family or other responsible persons, then referral to Alcoholics Anonymous or the assistance of one of their members may be very useful in accomplishing a successful withdrawal on an outpatient basis.

Treatment Regimen

When a patient presents for alcohol withdrawal, the nature of the medical situation must be assessed. A decision must be made as to whether

inpatient withdrawal is indicated, observation is indicated, or outpatient detoxification may begin. The most important treatment consideration at this point is to withdraw the individual from alcohol. Attempting to reason with the patient or attempting other intervention techniques at this stage is practically useless. If an outpatient withdrawal regimen is undertaken, a verbal contract should be entered into, with either the patient (if he is capable) or the person responsible for bringing in the patient, about the necessity of taking medication and coming daily to the office for additional medication and monitoring. The physician should be thinking about long-range treatment resources for the individual once he is detoxified. The outpatient detoxification process takes from two to five days, depending upon the severity of the withdrawal. Resources should be mobilized at the end of this time to continue treatment.

Views diverge among practitioners and in the literature on the issue of medical management of withdrawal. Many different drugs have been used in the withdrawal process. Some physicians attempt to withdraw the individual with ethanol, and others advocate the use of no drugs other than thiamine and a multiple vitamin preparation. If medical management is used, it is important to remember that the medications should be prescribed according to the symptoms that are seen. Psychomotor sedation, anxiety, nutritional deficiencies, and other symptoms are treated with medications appropriate to those symptoms. The strength of the dosage is generally dependent upon the severity of observed symptoms. Among the medications that have been prescribed for withdrawal are hydroxyzine (Vistaril, Atarax), the benzodiazepine drugs (Librium, Valium), clorazepate (Azene, Tranxene), oxazepam (Serax), the anticonvulsants (Dilantin, phenobarbital), haloperidol (Haldol), multiple vitamins, and thiamine.

Antianxiety agents are very useful in the short-term treatment of anxiety states, including those secondary to alcohol withdrawal. The benzodiazepines have a cross-tolerance to other central nervous system depressants, which accounts for their effectiveness in the treatment of alcohol withdrawal. These drugs are long acting with a half-life of 24 to 48 hours, whereas alcohol is short acting. The benzodiazepines, therefore, are used to substitute for and overlap the effects of alcohol. Long-half-life derivatives, such as chlordiazepoxide,

ide, diazepam, and clorazepate are preferred in alcohol detoxification in order to avoid fluctuation in blood levels. These drugs are not effective in the post-detoxification management of alcohol because tolerance develops very quickly.⁴ Withdrawal of benzodiazepines must be gradual to prevent the patient from undergoing a second withdrawal syndrome from the benzodiazepine itself. In addition, one must be cautious that the alcoholic does not become addicted to the benzodiazepine drugs, which have been proven to have a strong addictive potential.

Hydroxyzine, an antihistamine, is an effective antianxiety agent. In addition to causing sedation, this drug can also produce anticholinergic effects such as dry mouth and blurred vision.

Antipsychotic agents, of which haloperidol is the most potent, may also be used in the maintenance of alcoholic withdrawal. Palestine and Alatorre noted effective tranquilization without adverse sedative effects with haloperidol.⁵ The incidence of movement disorders with high dosages of haloperidol, however, is evident.

Various medications have been used in an effort to find the best drug available for outpatient detoxification. In addition to administering thiamine (100 mg per day) and multivitamins (1 per day) as supplements, clorazepate has been used in the medical treatment regimen. Clorazepate proved to be beneficial in that it did not produce the sedative effects often seen with the use of chlordiazepoxide. Patients did not appear sleepy or drowsy in group therapy, and there was no problem in stopping the drug after three days. The usual dosage for clorazepate was 13 mg every six hours. Hydroxyzine was tried for a short time but was discontinued because there was no substantial sedative effect. This drug was mainly used for nausea, and it did not result in much relief from anxiety. The dosages ranged from 50 to 100 mg every six hours. Oxazepam has a shorter half-life than clorazepate and chlordiazepoxide and does not produce active metabolites as do the longer half-life benzodiazepines. The outcome of oxazepam appeared to have been the equivalent of that with clorazepate. The usual dosage of oxazepam was 15 mg every six hours. Tranxene (another clorazepate) is currently being used in treatment regimen. The outcome of this drug is not yet determined. The dosage administered is 15 mg every six hours. When outpatient detoxification was first

begun, all patients were given phenytoin sodium (Dilantin), which is an anticonvulsant drug used in the treatment of grand mal seizures. Phenytoin sodium is presently being administered only to those alcoholics who demonstrate a history of seizures. The usual dosage of this drug is 100 mg four times daily. Experience indicates that if the patient is to remain in the home and be involved primarily in bed recovery, then the benzodiazepines, chlor-diazepoxide and diazepam, because of their strong sedative effects, are the drugs of preference. However, if the patients are to continue in their employment or are to attend a rehabilitation program during their withdrawal where their activity level is expected to be higher, then clorazepate is probably the drug of choice.

Disulfiram (Antabuse) is frequently used after the patient has been detoxified. It is important that the individual's system be cleared of alcohol before disulfiram is administered. A three-day period of withdrawal with no alcohol intake is usually sufficient to begin Antabuse.⁴ Disulfiram is administered 250 mg per day. It acts to block acetaldehyde metabolism, thereby causing adverse side reactions if alcohol is ingested. Disulfiram has a slow elimination process; therefore, reactions to alcohol usually occur up to five days, more rarely as long as two weeks after its cessation.⁴ When alcohol is ingested, adverse side effects, such as nausea, vomiting, facial flushing, and acetaldehyde poisoning, are noted. These side effects respond well to intravenous antihistamines (50 mg of Benadryl). Minor dose related side effects, such as rash and pruritis, may also be noted. Disulfiram can provide the necessary support for some individuals in deciding not to drink during this very crucial period. Prior to administration, the physician should thoroughly inform the patient of the consequences of alcohol ingestion and be sure that the patient understands these consequences. It is recommended that this be put in the form of a written contract between the physician and the patient and signed by the patient.

Once the individual is free of alcohol, then other resources can be called to bear on the problem. These resources include public and private treatment facilities, Alcoholics Anonymous, and a number of public agencies that operate programs for the alcoholic. The physician should make every attempt to refer the patient to one of these programs upon completion of the withdrawal process.

Conclusions

Outpatient detoxification occupies a valid position in the treatment regimen for an individual recovering from alcoholism. It is cost effective and involves the individual's family and concerned others in the treatment process from the very beginning. The occurrence of withdrawal in familiar surroundings leads to a lessening of anxiety and a less difficult detoxification process. In many cases, the individual will be able to maintain his employment while detoxification is taking place. Perhaps the most important element in outpatient detoxification is that it involves the individual's family. In so doing, it makes them partners in this first and most important step in recovery.

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