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A Structured Programme for Out-patient Alcohol Detoxification

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An out-patient alcohol detoxification service based in a psychiatric emergency clinic is described. Of 173 patients referred during the first year, 76 (44%) were accepted for the programme; 60 (79%) of these successfully completed detoxification with no medical complications. Compared with previous years, during the year of operation of the service there was a 50% fall in the number of in-patient admissions for detoxification to the local hospital. We conclude that a structured out-patient detoxification programme is safe and effective, and may obviate the need for many patients to be admitted, freeing psychiatric beds for other uses.

The medical management of patients who are dependent on alcohol and who present with a request to be 'dried out' is often haphazard. In some cases they will be admitted to hospital, either to a general psychiatric or, sometimes, a general medical ward. They may be referred to a specialist alcohol unit where such a unit is prepared to assess patients on a 'demand' basis, or they may be referred to their general practitioner (GP). The economic and social consequences of admission to hospital are enormous, but surprisingly few studies of out-patient detoxification have been performed in the UK.

Out-patient detoxification is widespread in Scandinavia (Alsen, 1975; Bjorkqvist *et al*, 1976) and has been described in detail in the USA (Feldman *et al*, 1975; Stinnett, 1982), with results suggesting it is both safe and, in the short term, effective. Webb & Unwin (1988) studied 50 patients treated at the unit originally described by Stinnett (1982) and attempted to identify predictive factors for successful out-patient treatment. At the Maudsley Hospital Emergency Clinic in London, 10.2% of attendances over six months had alcohol or drug problems (Lim, 1983). Out-patient detoxification is offered to attenders at this clinic, and outcome in a group of 26 patients seen consecutively over a month has been described (Drummond & Chalmers, 1986). GPs probably supervise detoxification of alcoholic patients quite frequently: a postal questionnaire sent to all GPs in the Exeter health district estimated that approximately half of all patients seen in the practices with alcohol dependence were managed at home (Stockwell *et al*, 1986).

We identified the need for a service offering out-patient detoxification with medical supervision and structured counselling for patients with alcohol dependence; we intended to provide an alternative means of treatment for those patients who might otherwise have been admitted to hospital, but did not see the service as addressing longer-term management issues. The purpose of this paper is to describe the programme, the results of the first year of operation, and to speculate on the effects this might have on in-patient services.

Method

The service was provided from the Psychiatric Emergency Clinic of St George's Hospital, London. The clinic is open Monday to Friday, 9 a.m. to 5 p.m., and accepts referrals, from any source, of patients from the appropriate catchment area of Wandsworth and Merton health districts; self-referrals, although not encouraged, are seen. The clinic is staffed by two trained nurses, who see all referrals and where necessary seek the opinion of a psychiatric registrar on site. Back-up medical cover is provided by a senior registrar and consultant psychiatrist.

Patients referred for out-patient alcohol detoxification are first interviewed by the nurse who takes a full history, including a detailed drinking history, and assesses their suitability for the programme. Criteria for acceptance are that the patients are aged 18–70, from the appropriate catchment area, fulfilling the requirements for a diagnosis of alcohol-dependence syndrome and with an expressed inability to detoxify themselves without assistance. Those abusing substances other than alcohol are excluded, and patients must be physically capable of attending the emergency clinic on a daily basis. If delirium tremens is present or thought to be imminent, the patient is referred for in-patient treatment. Each patient completes the Severity of Alcohol Dependence Questionnaire (SADQ; Stockwell *et al*, 1979; 1983). Physical and mental state examinations are performed by the duty registrar, and blood taken for full blood count, analysis of urea and electrolytes, blood sugar level, and liver function tests.

If accepted, a patient is given a starting date which is usually the next working day, although no patient starts on a Friday; those patients who have already stopped drinking may start on the day of assessment. A typewritten hand-out explaining the details of the programme is given to the patient and a relative where appropriate. A condition of treatment is that patients submit to a daily breath alcohol measurement, and if there is any evidence of alcohol consumption during the programme, then treatment is

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immediately terminated; this point is emphasised in the hand-out and reinforced verbally.

For the purposes of detoxification the patient is assigned to either a severely dependent or a moderately dependent group, depending on drinking history and SADQ score. The SADQ is a 20-item self-completion questionnaire in which the previous month's drinking is considered and items rated on a four-point frequency scale (0–3) ranging from 'almost never' (0) to 'nearly always' (3) (total possible score range 0–60). A score of 30 or less indicates mild to moderate dependence, while a score of 31 or more indicates severe dependence.

We chose diazepam as the detoxification agent. A plethora of drugs have been used over the years with various advantages and disadvantages (Butler & Messiha, 1986; Naranjo & Sellers, 1986) but benzodiazepines are probably the safest and most established; in particular, there have been reports of potential problems with chlormethiazole (McInnes, 1987) which is widely used in the UK. Table I displays the dosage schedules for the two groups. Patients were given 5 mg tablets and instructed in how to divide the doses appropriately. Most patients took the pills three or four times daily, but a few took them up to six times daily. Adjustments could be made on the second day depending on observed or reported oversedation or breakthrough withdrawal symptoms, but in practice this happened rarely.

Patients also received oral thiamine (100 mg daily). Medication was dispensed on a daily basis, no more than 24 hours' supply being given at a time. At weekends, where necessary, arrangements were made for the patient to collect medication from the local hospital casualty department or the nearest psychiatric hospital.

As well as medication, each patient received five sessions of counselling (30–45 minutes each) on consecutive working days with the same nurse who performed the initial assessment. The content of each session is partly structured and we identified specific issues to be addressed with every patient, a check-list being provided to ensure that each has been covered. The broad content of sessions is as follows.

(a) The first session is chiefly assessment, with an emphasis on ascertaining the patient's particular physical, mental, emotional, financial, work-related and relationship problems. The week's programme is explained in detail and the patient encouraged to ventilate fears about detoxification.

(b) In the second session the programme is recapitulated and further assessment made of immediate problems, particularly physical health. Any other worries are discussed. Health education is provided, focusing on evidence of what damage alcohol has done to the patient, combined with more general risks.

(c) The third session deals with issues arising from the previous sessions. There is specific discussion of identified problems in the various areas of patients' lives, with attempts at finding alternative coping strategies. Further health education is given.

(d) The fourth session is similar to the third session, with more emphasis on what longer-term changes need to be made now that the patient is beginning to feel better physically.

(e) In the fifth session, there is detailed discussion of long-term support including groups such as Alcoholics Anonymous, Accept and Turning Point (information leaflets and telephone numbers are given). Feedback is given to patients on how their problems appear to the counsellor, particularly emphasising the achievement of detoxification.

Throughout, the emphasis is on a supportive approach, with practical solutions to individual problems being sought. Direct confrontation is avoided except on the issue of drinking during the programme; the fact that a breathalyser is routinely used at every visit makes this paradoxically non-threatening. Responsibility for maintaining sobriety is placed firmly in the patients' hands, and they are expected to telephone at least one voluntary agency. Where appropriate, medical follow-up is arranged.

The final part of the study was designed to see if there was any indication of the effect this service might have on numbers of patients treated in hospital. All patients from the appropriate catchment area are admitted to one psychiatric hospital. Records are kept on file of all admissions, with a discharge diagnosis and brief indication of the problem and management. It is thus possible to identify all patients admitted with a diagnosis of alcohol-dependence syndrome where the purpose of admission was alcohol detoxification. Information on such admissions was recorded for the four years preceding the start of the out-patient service, and for the year of the out-patient service.

TABLE I

Medication regimes for patients severely and moderately dependent on alcohol

	Total daily dose diazepam: mg	
Day	*Severely dependent*	*Moderately dependent*
1	40	30
2	40*	30*
3	30	20
4	20	10
5	15	5
6	10	—
7	5	—

*The dose on day 2 may be varied according to observed and reported symptoms in the previous 24 hours.

TABLE II

Immediate management of all referred for assessment for out-patient detoxification

Management	n	%
Accepted for programme	76	(44)
Psychiatric admission	8	(5)
Medical admission	6	(3)
Referred to specialist alcohol unit	9	(5)
Referred to psychiatric out-patients	19	(11)
Referred back to GP	20	(12)
Referred to social worker	2	(1)
Referred to voluntary agency (e.g. AA, Accept)	22	(13)
Referred for housing assistance	11	(6)

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Results

Between 1 August 1987 and 31 July 1988, 173 patients were referred for assessment for out-patient detoxification. As one might predict, 135 (78%) were male and 105 (61%) were single or separated; 149 (86%) were aged between 26 and 55. A total of 97 of the 173 patients were not referred for out-patient detoxification (Table II). Sixty-nine were not physically dependent, while five were too drunk to be assessed and failed to return sober for assessments subsequently. A further six had medical complications of sufficient severity to warrant medical admission: these included two cases of severe jaundice, three of active delirium tremens with pyrexia and one of withdrawal fits. Eight patients were admitted to a psychiatric hospital: five categorically refused to consider attempting the out-patient programme, and three were thought unsuitable because of a combination of physical frailty, social isolation, and geographical distance from the clinic. Nine patients were under the active care of specialist alcohol units or hospitals outside our catchment area and were referred to their local services.

Of the 76 (44%) referred, 69 (91%) had an SADQ score of greater than 30, indicating severe dependence.

Our only measure of outcome was successful completion of detoxification; we made no attempt in this study to perform longer-term follow-up. Thus success was defined as attending all sessions, giving no history of alcohol consumption and having negative breathalyser results at all sessions after assessment. Sixty (79%) of those accepted for the programme successfully completed detoxification. There were no significant medical complications such as fits or delirium tremens in the successful group, and diazepam dosage was satisfactory in all but three patients, in whom minor adjustments were made on the second day. Of the 16 patients who failed to complete, eight continued to drink, while the other eight failed to attend. Although we did no more than inform the GPs of their failure, we know that none were admitted to the local general medical or psychiatric hospital at the time of their failed attendances.

Table III shows the numbers of patients with alcohol-dependence syndrome who were admitted to general adult psychiatric catchment area wards of the local mental hospital for each year from August 1983 to July 1988 for detoxification.

TABLE III
Number of patients admitted for in-patient detoxification

	n
August 1983–July 1984	104
August 1984–July 1985	106
August 1985–July 1986	105
August 1986–July 1987	117
August 1987–July 1988 (out-patient service operating)	52

Discussion

Our clinical experience suggests that out-patient detoxification is safe and effective for a group of alcoholic patients who might otherwise be admitted to hospital for want of out-patient resources. The financial implications of this are obvious.

Although only 44% of those presenting were in fact accepted for the programme, this figure is similar to that from other centres (Feldman *et al*, 1975). The reasons for rejection were more often social or bureaucratic than medical. Our basic data do not suggest that the group of patients accepted was particularly different from other reported groups. The vast majority were severely dependent on alcohol as judged by the SADQ, a widely accepted instrument of assessment.

The structure of the counselling sessions was concrete and practical; nursing staff who took the sessions found it helpful to have a check-list of areas to be covered. While we did not attempt to measure this, it was our impression, supported by spontaneous comments from experienced patients, that out-patients probably received more attention than in-patient alcoholics would have received on busy wards where overstretched nurses were more likely to be devoting their time to disturbed psychotic patients.

The diazepam detoxification regime was effective. While the choice of detoxification agent is the subject of debate (Naranjo & Sellers, 1986), we experienced no serious problems of breakthrough withdrawal or oversedation with diazepam. Even with the relatively rigid format of two fixed-dose regimes, only two patients required a 10 mg increase in dose on the second day, and one patient a 10 mg decrease. We cannot of course be certain that those patients failing to complete the programme suffered no medical complications, but suspect this to be unlikely, since they most probably would have been in contact with their GPs or local hospital if they were physically ill.

That 79% of patients accepted for the programme were able to complete it successfully indicates that it is achieving its desired effect. This figure is similar to the results of Feldman *et al* (1975), but better than results of Stinnett (1982) and of Drummond & Chalmers (1986): the latter may well have been dealing with a more socially vulnerable group of patients. Obviously detoxification is only the first step in the process of recovery from alcoholism. It is still unclear, however, whether elaborate long-term treatment is more effective than a single initial intervention in some alcoholic patients (Edwards *et al*, 1977). There are no particular reasons why out-patient detoxification should have any greater or lesser effect on long-term outcome than in-patient

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treatment. The only way to resolve this would be by a study using random allocation to in-patient and out-patient groups, with long-term follow-up of both.

Perhaps the most striking finding of our study is the dramatic fall (50%) in the number of patients admitted to the local hospital for detoxification during the first year of the out-patient service, compared with previous years (Table III). This indicates a potential saving of at least 74 in-patient weeks (assuming an average stay of ten days). Of course, there are several alternative explanations for our findings. There may have been a 'novelty value' attached to our service, other alcohol services may have been set up in the district without our knowledge, or this may have represented a chance swing. However, our service was not promoted beyond a letter informing colleagues of its existence, with no suggestion that it should be used in preference to other treatments. No new acute treatment facilities were notified to the district alcohol services co-ordinator. The fall in admissions was dramatic, without any suggestion of a declining trend over the preceding years. We therefore suggest that these figures lend strong support to the idea that the out-patient service is treating patients who would otherwise have been admitted to hospital.

Given the low cost of out-patient treatment compared with admission, the simplicity of administration of the programme by, in the main, nursing rather than medical staff, and its apparent safety, we would encourage others to consider setting up such services, allowing further research into longer-term efficacy. While our service is based in a psychiatric emergency clinic, there seems to be no reason why similar services should not operate out of general accident and emergency departments or general practice surgeries involving the practice nurse.

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