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PRACTICE OBSERVED

Practice Research

Detoxification from alcohol at home managed by general practitioners

TIM STOCKWELL, ELIZABETH BOLT, JANE HOOPER

Abstract

General practitioners have an important role in identifying and responding to problem drinkers, but no study has attempted to document their use of detoxification at home. A questionnaire was mailed to all general practitioners in Exeter Health District (n=168) that was concerned with how they managed patients who presented with problems related to alcohol. The 145 (86%) responses showed that collectively they were identifying many more cases of problem drinking than any other local treatment agency. Of the estimated 230 patients a year for whom detoxification was arranged, half were managed at home, 40% in a local psychiatric hospital, and 9% in a local general hospital. Of those who were managed at home, 38% were unsupervised, a close relative held the medication for 45%, and 17% were supervised by a nurse. Fifty six per cent (81) of doctors favoured chlormethiazole (Heminevrin) treatment, and many (17%) were prepared to prescribe this for longer than 10 days. Three quarters of the respondents thought that there was a need for specialist community services, such as community alcohol teams, to support general practitioners by supervising detoxification at home.

Introduction

The extent and seriousness of alcohol abuse in the United Kingdom have been well documented. Alcohol abuse is widely accepted as a major contributor to road traffic accidents, absenteeism at work, crime, and medical and social problems.[1-5] Economists estimate that the cost to the UK is roughly £1500m a year.[6] Because the problem is so big no single specialist agency or network of agencies can be expected to provide a comprehensive response. For example, alcohol abuse is implicated in about a fifth of admissions to general hospitals.[7-9] In a recent survey of patients who were registered with a general practice in London 11% of men and 5% of women were drinking at levels that were likely to endanger their health.[10] It is estimated that only 10% of people with serious drinking problems contact alcohol treatment agencies.[11] Others successfully cut down or stop drinking with no medical or specialist help.[12] It is widely recognised that general practitioners have an important part to play in identifying and helping problem drinkers.[11,13] Of the non-specialist agents, general practitioners are particularly well placed to respond to drinking problems because they are consulted by roughly 70% of their patients each year and by 90% every three years.[14]

Although a recent review has highlighted problems that are associated with special alcohol detoxification units, the important role of primary care workers has been neglected in the published research on detoxification for severely dependent drinkers (J Orford and T Wawman. Alcohol detoxification services, in preparation). Treating such patients as outpatients is relatively safe, effective, more accessible, carries less stigma, and can better link patients to aftercare.[15]

Given the success of outpatient programmes, it seems a short step to recommend detoxification at home under the responsibility of the general practitioner. General practitioners, however, need support from other community services to carry out the close supervision provided by such programmes. It is important to monitor patients' progress daily, preferably including a breathalyser check. The risks of unsupervised detoxification include accidents resulting from oversedation, severe withdrawal symptoms, overdose, and substitute (or joint) dependence. There are other risks if a decision to treat a patient for alcohol withdrawal is made too hastily. For example, a mildly dependent drinker may be introduced unnecessarily to hazardous drugs for the first time when the withdrawal symptoms may simply be mild discomfort.[16]

Exeter Community Alcohol Team, Exeter EX2 4HY

TIM STOCKWELL, MA, PHD, senior clinical psychologist and honorary research fellow, Exeter University

ELIZABETH BOLT, BA, research psychologist

JANE HOOPER, RMN, community psychiatric nurse

Correspondence to: Dr T R Stockwell.

The aim of our study was to obtain as accurate a picture as possible of current detoxification procedures used by general practitioners and to assess the need for additional support and supervision for detoxification at home.

Method

In July 1985 a questionnaire was sent through the local family practitioner committee to every general practitioner who practised in Exeter Health District. Prepaid envelopes were provided for its return, and questionnaires were coded to preserve anonymity. A second questionnaire was distributed similarly to non-respondents one month later.

The questionnaire comprised sections dealing with (*i*) general practitioners' estimates of the numbers of problem drinkers seen in the past year; (*ii*) knowledge and use of local services for alcohol abuse; (*iii*) assessment of their local community alcohol team; (*iv*) attitudes towards problem drinkers; (*v*) estimates of the yearly demand for detoxification among their patients; and (*vi*) procedures for managing detoxification.

Extensive use was made of multiple choice frequency scales—for example, "almost never," "sometimes," "often," "nearly always," "none," "1 or 2," "3 or 4," "5 or 6," and so on. Such frequency scales have been used in alcohol research and can be both reliable and valid for global estimates of, for instance, average alcohol intake.[10,17]

All 168 general practitioner's who were registered with the family practitioner committee and practised in Exeter Health District were included in the sample. The district covers roughly 4000 square miles and serves a population of 291 000. There are three psychiatric hospitals and two general hospitals but no alcohol treatment unit for inpatients.

Results

From the first mailing 104 (62%) completed questionnaires were returned and a further 41 from the second mailing, an overall response rate of 86%. Two were returned uncompleted. The response rate for individual items among returned questionnaires varied from 88% to 100%. Responses to items of concern in this report were as follows:

(1) *In the past 12 months approximately how many patients have sought your help specifically for a drinking problem?* Taking the midpoint of each response category and multiplying by the response frequencies in table I provides an estimate of 495 patients a year. Extrapolating from this 82% sample to the total sample yields an overall estimate of 608 patients a year.

TABLE I—*General practitioners' estimates of the numbers of patients per year who seek their help for a drinking problem*

No of patients	No (%) of general practitioners
0	13 (9)
1 or 2	35 (25)
3 to 5	68 (50)
6 to 9	16 (12)
10 or more	5 (4)
Total	137 (100)

(2) *In the past 12 months in approximately how many patients have you diagnosed alcohol abuse or dependency underlying their presenting complaint?* With similar assumptions the data in table II yield an overall estimate of 1575 patients a year.

TABLE II—*General practitioners' estimates of the number of patients per year in whom they diagnosed a drinking problem underlying the presenting complaint*

No of patients	No (%) of general practitioners
0	5 (3·5)
1 to 10	85 (60)
11 to 20	43 (30)
21 to 30	5 (3·5)
31 or more	4 (3)
Total	142 (100)

(3) *In the past 12 months approximately how many times have you arranged for a patient to undergo withdrawal from alcohol?* With similar assumptions these data yield an overall estimate of 230 patients a year who required detoxification.

TABLE III—*General practitioners' estimates of the numbers for whom they arranged detoxification in the past year*

No of patients	No (%) of general practitioners
0	52 (37)
1 or 2	62 (44)
3 or 4	22 (16)
5 or 6	3 (2)
7 or more	1 (1)
Total	140 (100)

(4) *When you arrange for a patient to undergo alcohol withdrawal where does this take place?* About a half (51%) of all detoxifications arranged by the respondents took place in their patient's home, 40% in a psychiatric hospital, and 9% in a general hospital.

(5) *When you manage a patient's withdrawal (out of hospital) who usually administers the medication—that is, who actually looked after the pills?* Most (62%) were supervised by a third person—usually a close friend or relative (45%), sometimes a nurse (17%). An appreciable proportion (38%), however, "supervised" themselves.

(6) *If you ever prescribe medication to assist with a patient's alcohol withdrawal which of the following commonly used drugs do you prefer?* Of the 135 respondents to this question, 101 (75%) preferred chlormethiazole (Heminevrin), 19 (14%) chlordiazepoxide (Librium), and five (4%) diazepam (Valium). A few other drugs were suggested by respondents, including Antabuse and chlorpromazine.

(7) *If you sometimes prescribe medication for alcohol withdrawal for patients to administer themselves what is the longest period you are happy to prescribe for?* Eighty per cent of respondents would allow their patients to administer their own Heminevrin for at least one day. Patterns of use for both Heminevrin and Librium were virtually identical with most restricting the prescription to within 10 days, but an appreciable number (16%) exceeded this limit.

(8) *It is usually possible for general practitioners to take medical responsibility for detoxification at home if the patient can be given adequate support.* Of the 145 respondents to this question, 8% strongly agreed, 58% agreed, 26% were unsure, 7% disagreed, and only 1% strongly disagreed.

(9) *Considering the wide range of problem drinkers presenting in your practice, in what proportion do you feel community alcohol team supervision of home detoxification would be of use to you?* Roughly a quarter selected each of the options: "less than 5%," "5 to 20%," "20 to 50%," and "over 50%."

(10) *In your experience what factors would contraindicate detoxification in the patient's home?* Responses to this open ended question were subjected to a content analysis. Table IV lists the eight categories.

TABLE IV—*Contraindications for home detoxification (n=127)*

Category	No (%)
Unsupportive family or friends	63 (50
Patient unreliable or unmotivated	41 (32)
Social isolation	38 (30)
Severe mental or physical illness	31 (24)
History of repeated failures	20 (16)
Severe alcohol dependence	17 (13)
Inadequate housing	13 (10)
Young children at home	11 (9)

Note: Most respondents provided more than one suggested contraindication.

A preference for home detoxification was positively correlated with a belief that medical responsibility could be taken for this ($r=0·44$, $p<0·001$) and negatively correlated with a preference for hospital detoxification ($r=-0·51$, $p<0·001$). Furthermore, allowing patients to hold their own medication was positively correlated with prescribing medication for longer periods of time ($r=0·39$, $p<0·005$) and negatively correlated with frequently using close relatives or friends to supervise detoxification ($r-0·27$, $p<0·01$).

Twenty eight general practitioners, who had also returned the questionnaire, had referred a client to the community alcohol team in the previous year. In all but one case the responses indicated that they referred to the team at least once a year.

Discussion

The strength of this study includes a high response rate compared with other studies in which a postal questionnaire was sent to general practitioners[18] and a degree of both internal consistency and external validity. Thus the results appear to be representative of the views and practices of general practitioners in Exeter Health District.

The limitations of the study were accepted at the outset—namely, that precise quantitative data would not be attainable. The data must be regarded as reflecting subjective and global impressions and estimates of the respondents and are therefore subject to a variety of biases. It was hoped that by ensuring the anonymity of responses such bias would be kept to a minimum.

Despite the subjective responses to the questionnaire several important conclusions may be drawn from the results. Firstly, collectively the general practitioners appear to be identifying roughly 2000 problem drinkers a year among their patients compared with the 305 new cases seen by the local specialist alcohol treatment agency, Exeter Community Alcohol Team. Secondly, detoxification took place in the patient's home for most of the estimated 230 patients a year for whom general practitioners arranged detoxification.

If Exeter is not an atypical health district these results suggest the intriguing possibility that most treatment for alcohol withdrawal in the UK is carried out by general practitioners in the community rather than in a hospital. Thus details of their management procedures may be of general interest. Most commonly a close relative or friend of the patient held the medication, usually chlormethiazole, and the withdrawal regimen lasted between four and ten days. There were, however, an appreciable number of general practitioners (38%) who permitted patients to supervise their own medication and a further proportion (17%) who were willing to prescribe either chlordiazepoxide or chlormethiazole for longer than the recommended limit of ten days.[19]

General practitioners expressed a great deal of uncertainty as to whether they could accept medical responsibility for detoxification at home, although 64% thought that they could if the patient had adequate support. Social and psychological factors were cited most often as contraindications—for example, lack of social support and poor "motivation"—rather than clinical factors such as severity of alcohol dependence or psychiatric state. Some respondents thought that detoxification at home was always appropriate, others that it was never so.

Given the extent to which general practitioners are treating alcohol withdrawal in the community under conditions of minimal supervision, it is encouraging that three quarters favoured supervision of home detoxification by community alcohol team nurses. Detoxification at home may be more cost effective; a study is underway in Exeter both to test this hypothesis and to determine if it is also a safe, practical, and clinically effective procedure for drinkers who are severely dependent.

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100 YEARS AGO

At the fourth meeting of the Statistical Society, a paper was read on "Suicides in England and Wales in Relation to Age, Sex, Season, and Occupation," by Dr. Ogle. The following is an abstract of the paper in question. The deaths registered in the twenty-six years 1858-83 in England and Wales as due to suicide were 42,630, and in the proportion of 72 annually per million persons living. The suicide-rate increases rapidly with age until after middle life, but in the more advanced age-periods again diminishes. The maximum rate is in the 55-65 years period, when it reaches 251 per million persons living. At all age-periods, with one exception, the male rate is far higher than the female, and the difference between increases with age. The one exceptional period is the 15-20 years period, when the female rate is slightly the higher. At this same period, the female death-rate and lunacy-rate are also exceptionally above the male rates. Taking all ages together, out of equal numbers living and in the same age-distribution, the male suicides are to the female suicides as 267 to 100. The occupations in which the suicide-rates are lowest are those which imply rough manual labour, carried on mostly out of doors, and by men who are comparatively uneducated, such as miners, quarrymen, shipwrights, fishermen, gardeners, labourers of all kinds, bricklayers, and masons. The occupations with the highest suicide-rates are those which are sedentary, and carried on by highly educated men, as the learned professions, and also such as notoriously lead to intemperance, as those of innkeepers, publicans, soldiers, butchers, butlers, commercial travellers, etc. Between the two extremes come farmers, shopkeepers, and town artisans. Tables are given of the rates in a number of selected occupations; and some of these—for example, those of soldiers and farmers—are subjected to special examination. As regards farmers, it is shown that their suicides were nearly doubled in the two years 1879-80, when agricultural distress was most acute; and that, simultaneously with the rise in their suicide-rate, there was a corresponding rise in their reigistered bankruptcies. It is shown that the amount of suicides of men in different occupations, varies to a considerable extent with the lunacy-rates, and with the general death-rates, the same causes that conduce to insanity and to general unhealthiness also conducing to self-destruction. It is also shown that the amount of suicide varies very definitely with the seasons, forming a regular annual curve, of which the minimum is in December, and the maximum in June. The commonest method of suicide is hanging; then follow in order, drowning, cut or stab, poison, gunshot. Women, however, select drowning before hanging, and poison before cut or stab. Women also differ from men in selection of poisons, men choosing painless and sure preparations, while women take any poison that is at hand, indifferently. The choice of method is also affected by age, the young showing a comparative preference for drowning, poison, and gunshot; and by occupation, men using preferentially the instruments of their crafts; and by season, drowning being avoided in the cold months. (*British Medical Journal* 1886;i:359.)

Reflections on Practice

Does writing in the "BMJ" bring about change?

J BAHRAMI

Though doctors write in medical journals for many different reasons, the original reason for writing, now perhaps considered outdated, was a genuine desire to challenge the establishment, question traditional habits and customs, and seek change where it is needed. Having had the urge to write for the *BMJ* from time to time on causes which I thought were crying out for a champion, I decided to look at the articles that I have published over the past few years and try to evaluate their effects. In other words, did the effort achieve anything in the end?

The articles

Access to physiotherapy services—The article on physiotherapy services was written after months of futile discussions in Bradford among various sections of the profession, which were aimed at gaining direct access for the patients of general practitioners. The editors of the *BMJ* thought that the subject was so important that they asked the opinions of other general practitioners, which were published with mine.[1] I became even more unpopular than usual for a short time and received angry letters from interested parties. Soon, however, an experimental scheme allowing general practitioners' patients direct access to physiotherapy services was started. The patients were vetted first by a committee of a general practitioner representative, a consultant representative, and the district medical officer. But the experiment proved to be so valuable that there will soon be two community physiotherapists in post to receive direct referrals from general practitioners in Bradford.

Uncertainties in Bradford—Because of the overwhelming number of applicants for a place on the Bradford Vocational Training Scheme and the ineffectiveness of the traditional methods of selection I decided to revise the procedure. I devised an objective method that was based on clearly defining the type of trainees required, a structured evaluation, rating scales, and personality profiles.[2] The editors decided to turn the topic into a series of articles by course organisers throughout the United Kingdom. Since then the methods of selection on many schemes have been revised, and procedures for selecting applicants objectively have been introduced. Needless to say, this is bound to be fairer to the applicants and less stressful to the members of the appointment committee.

Time for change?—After almost three years of examining for the DRCOG examination I felt that for the sake of general practice obstetrics, trainees, and the interests of specialist colleagues a serious debate was needed on the aims, structure, and methods of assessing the examination. This article caused me more problems than others.[3] Not surprisingly, I found myself isolated and the subject of some harsh and rash criticism. But, thanks to the foresight of some of my examiner colleagues and the chairman of the examination committee of the Royal College of Obstetricians and Gynaecologists, for the first time the examination was the subject of some serious and heart searching analysis. In 1985 a special workshop was held for DRCOG examiners to look at the issues. There are already signs of a change in attitude, particularly with regard to the clinical and oral parts of the examination. Whether or not the written part will also be altered remains to be seen.

Is there a need for a national association of course organisers?—After years of unrewarding and unrecognised work as a singlehanded, isolated course organiser for a large vocational training scheme, and saddened by the loss of close friends and colleagues, who after many years as course organisers had suffered major health problems, I suggested that a national association should be formed.[4] At the time there seemed to be a general feeling of gloom and despondency among the dwindling numbers of course organisers. Within a few weeks of the article being published, however, I was inundated with letters of support for the idea. In only three years the Association of Course Organisers has been firmly established, a source not only of information on postgraduate training for general practice but also of the experience and skills of course organisers.

JCPTGP: from the other side of the fence—Increasingly disappointed with the efforts of the Joint Committee for Postgraduate Training in General Practice to define and monitor the standards of training, my feelings of hopelessness grew as I experienced the difficulties of a regional general practice subcommittee trying to enforce the laudable but impracticable pronouncements of the committee. Concluding that ideologically and structurally the committee could not perform its function—that is, to improve the standard of training—I wrote an article about which I received many letters and messages of support.[5] It was puzzling that so many of my colleagues who had wanted to say the same things for a long time had never got round to saying them. A new working party has been set up by the committee to tackle some of the issues that were raised in the article.

Conclusion

Although I feel gratified to see so much change in such a short time, a cynic might take the view that cause and effect has not been established, or that the sequence of events might have been coincidental and unrelated. But I console myself with one crumb of comfort: coincidence may occur once, or even twice, but five times?

Field House Teaching Centre, Bradford Royal Infirmary, Bradford, West Yorkshire BD9 6RJ

J BAHRAMI, MRCOG, FRCGP, general practitioner

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100 YEARS AGO

So much inconvenience has been experienced at Poplar during the last few days, from what is described as the fearful condition of the bodies awaiting inquest, consequent upon the excessive heat of the weather, that the coroner, Mr. Collier, took the very judicious course at five inquests of sparing the jury the duty of viewing the bodies, and expressed the hope, in which we heartily concur, that the time is not far distant when the custom of viewing the bodies except in special cases, will be done away with. (*British Medical Journal* 1886;ii:466.)