Detoxification in a community-based alcohol recovery unit and psychiatric department of a general hospital

A comparative study

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The experience of detoxification and satisfaction of patients with their treatment in a community-based alcohol recovery unit established by a voluntary organisation and in a psychiatric unit in a general hospital were assessed with the help of a structured questionnaire. Patients admitted to the two units were satisfactorily matched on most, although not all, variables. The types of withdrawal symptoms and lengths of stay were similar. No patient was transferred to hospital from the community facility. Patient satisfaction was greater in the detoxification unit where the cost of treatment was about a third of that in the psychiatric unit.

During the last 20 years treatment facilities for people with alcohol-related problems in Southampton have become more and more community-orientated with increasing involvement of the voluntary services and a corresponding decreased input from traditional psychiatry. Although many patients are still referred to psychiatrists, most out-patients now receive help from the Southampton and District Alcohol Advice Centre and a day centre run by the Society of St Dismas – a voluntary organisation established during the early 1960s and named after St Dismas, the thief crucified with Christ. Detoxification is carried out in the Department of Psychiatry (DOP) at the Royal South Hants Hospital, but also in the Mayflower Unit of the Salvation Army Mountbatten Centre and in the most recent addition to our community services, the St Dismas Alcohol Recovery Unit (ARU), which was opened in June 1989.

The ARU was the first purpose-built unit to be established in Britain outside the hospital service. It has rehabilitation, as well as detoxification, facilities. Subject to availability, it accepts referrals to its five detoxification beds from all sources but not self-referrals. An attempt is made to divert drunken offenders from the courts into the unit. Follow-up treatment is provided in ten beds in the after-care section but there is often a waiting list for admission to these. The ARU is staffed by a team of 17 trained care workers, at least two of whom are always on duty in the detoxification centre, while medical cover is provided by a local general practitioner (Hayden, 1991).

In this paper we compared the detoxification process and patient satisfaction in the ARU with those in the DOP. The audit was part of RM's fourth year medical students' study carried out under the supervision of JGE.

The study and findings

Procedure

A structured interview schedule was designed to elicit demographic data; details concerning the drinking history, alcohol-related problems, previous treatment and experience of detoxification; and degree of patient satisfaction; and was then piloted. An attempt was made to administer the questionnaire to a random one in two sample of people admitted to the ARU and all those admitted to the DOP during the 11 weeks in which the fieldwork for the study was carried out. During this time there were 63 patients admitted to the ARU and of these 29 (including one re-admission) were interviewed while three left before they could be seen by RM. During the same period the DOP had 19 patients admitted of whom 17 (including one re-admission) were interviewed and two were missed. Significantly more referrals to the DOP were from doctors (χ^2=25.155, df=1, P<0.0000001).

Patients

The male:female ratio of those admitted to the ARU (7:1) was similar to that of the patients

https://doi.org/10.1192/pb.18.4.218 Published online by Cambridge University Press

Table 1. Patient satisfaction

Degree of satisfaction/ dissatisfaction	Medical care		Attention from staff		Support from other patients		Unit as environment		Unit as a whole	
	ARU	DOP	ARU	DOP	ARU	DOP	ARU	DOP	ARU	DOP
Very satisfied	21	13	26	12	18	7	22	9	26	8
Fairly Satisfied	7	2	1	2	10	6	6	5	2	7
Fairly Dissatisfied	0	1	1	2	0	2	0	2	0	0
Very Dissatisfied	0	0	0	0	0	1	0	0	0	1
Total	28	16	28	16	28	16	28	16	28	16

admitted to the DOP (8:1). Most patients were in the age range 30–49 years with (non-significantly) more aged 20–29 admitted to the ARU and more aged 50–69 admitted to the DOP. All but one admission to the ARU were native born. There were no statistically significant differences between the groups in marital status, number of patients with children, number in regular contact with their families, employment status or living arrangements prior to admission. Eight of the ARU group and one of the DOP group had been sleeping rough before admission.

Most patients in both groups said that they had been drinking since their early teens, some claiming that they had started between the ages of eight and 12 years. The vast majority in each group had previously been detoxified. There were no significant differences between the groups in the lengths of drinking histories; numbers of patients with marital, relationship or employment problems; or numbers who had previous alcohol or non-alcohol related medical and psychiatric problems. There were, however, significantly more patients in the ARU group who had had more than five drink related offences (χ^2=5.876, d.f.=1, P=0.02) and who had attended casualty departments for alcohol related accidents (χ^2=5.162, d.f.=1, P=0.02).

Detoxification and after-care

Significantly more patients were examined physically during the first 24 hours of admission to the DOP than to the ARU (χ^2=7.541, d.f.=1, P=0.006). All of the DOP patients were examined at some time, while 18 of those admitted to the ARU were not examined. More ARU patients than those admitted to the DOP were prescribed anxiolytic-sedative drugs (Fisher's exact test, P=0.005). More temazepam was prescribed at night in the ARU and more chlordiazepoxide was prescribed by day in the DOP. Carbamazepine also was used significantly more often in the ARU than in the DOP (χ^2=11.761, d.f.=1, P=0.0006), while the use of vitamins and other medication was similar in both groups.

There were no significant differences in the types of withdrawal symptoms experienced or in the length of stay. None of the ARU patients had to be transferred to a general medical or psychiatric unit. All of the patients in both units had planned after-care discussed with them by a member of staff and most left with plans to receive help from one or other of the services for alcoholism. Thirteen of the ARU admissions planned to return to the unit for rehabilitation and were invited to report daily until a bed became available. However, only seven of these entered the programme; others had returned to drinking, did not report or decided they did not want after-care. The DOP staff followed up eight of its admissions themselves by out-patient appointments or visits by community psychiatric nurses, while two were referred to the Nelson Unit, a rehabilitation unit in St James Hospital, Portsmouth. Residential and day care services were taken up by more of the ARU patients while more of the DOP group were referred for follow-up to the Southampton and District Alcohol Advice Centre.

Patient satisfaction

Twenty-eight patients admitted to the ARU and 16 admitted to the DOP were asked how satisfied they were with the medical care they received, the attention they received from staff, the support they had from other patients, the ward or unit as an environment for drying out and the detoxification service as a whole. The fixed-response categories ranged from 'very satisfied' to 'very dissatisfied' and the results are shown in Table 1. It can be seen that the ARU group were more satisfied with the attention from staff, support from other patients and environment, although not to a statistically significant degree. This group was, however, significantly more often satisfied with the detoxification service as a

https://doi.org/10.1192/pb.18.4.218 Published online by Cambridge University Press

whole, 26 being very satisfied, compared with eight of the DOP group (χ^2=10.841, d.f.=2, P=0.004).

If dissatisfied, patients were asked to give the reason. They were also asked if there were any changes they would like to see made to the facilities. Significantly more of the DOP group than the ARU group responded to this question (χ^2=5.753, d.f.=1, P<0.02) but the difference was almost entirely made up of dissatisfaction at having to share a ward with mentally ill patients and the restrictions on areas in which smoking was allowed in the DOP.

Comment

Ideally, larger numbers of patients should have been randomly allocated over a longer period to treatment either in the ARU or DOP and assessed blind in a major research project. Unfortunately the managers were not agreeable to this more objective research-orientated approach to the evaluation of the service. Such an assessment was considered by them to be impracticable and, even if thought otherwise, the necessary funding would not have been available. An attempt was therefore made to incorporate the evaluation into a fourth year student project as a pilot study. Although the numbers of patients studied were not large and the two populations were not matched on all variables, clinically, as well as statistically, significant results were obtained.

The most important of these were the safe and successful withdrawal in the ARU with no necessity to transfer a single patient to a psychiatric or medical unit and the patients' satisfaction with their treatment in the ARU. The successful withdrawal occurred in spite of the fact that there was no resident medical officer in the unit and not all patients were physically examined. The ARU had at least two care staff on duty during the day and night to cover five beds, while the DOP had a minimum of four trained nursing staff per day and three at night to cover 22 beds, mostly occupied by severely ill psychiatric patients. Having to give priority to these could possibly have explained some of the difference in patient satisfaction but overall patients were more satisfied with detoxification in the ARU. Small numbers of patients would have liked more attention, counselling, education and activity but the ability to offer these was limited by the resources available.

Detoxification units run by voluntary organisations and based in the community are to be recommended so long as there is adequate medical cover (for medico-legal as well as clinical reasons) and the ability to transfer to a psychiatric or medical facility if necessary. Up to the time our study was carried out there had been 1629 admissions to the ARU. Only four of these have been transferred to the DOP and only 17 have been transferred to a general hospital.

The cost of treatment in the ARU at the time of our evaluation was about £266 per week, while the cost in the DOP was in the region of £850 a week – about three times the cost in the ARU. Our results are therefore consistent with those of Hague & Hibbert (1990) in Oxford who found that subjects could be detoxified as effectively in a hostel for the homeless as in a hospital and that the hostel was generally preferred and less expensive to run.

Prospective randomised comparative trials are crucial in the assessment of new medical treatments, yet there is a reluctance to accept that such trials are equally important in the evaluation of new treatment facilities. This is partly due to lack of resources but due also to an apparent lack of awareness of the importance of established research methodology, preconceived ideas about the effectiveness of the facility and eagerness to 'get on with the job'. This is unfortunate, especially at a time when so much importance is being attached to audit and when there is a great need to improve its efficacy. Audit could take a big step forward if it adopted some of those well-tested techniques that are now an integral part of sound research methodology.

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https://doi.org/10.1192/pb.18.4.218 Published online by Cambridge University Press