Middle Articles

CONTEMPORARY THEMES

The Rathcoole Experiment: First Year at a Hostel for Vagrant Alcoholics

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At the present time the vagrant alcoholic in this country is subject to repeated arrest and short-term imprisonment for drunkenness and allied offences. It is not difficult to find men who have had more than 100 short prison sentences. Unfortunately, there seem to be few facilities for attempting more constructive rehabilitation.

Rathcoole House was established in an attempt to show that there can be a more humane yet effective way of dealing with the Skid Row problem. There were two sources of financial help. Firstly, a grant provided by the Carnegie Trust, and, secondly, the grant paid by the Home Office for people living in aftercare hostels. The hostel is situated in the densely populated South London suburb of Clapham. In January 1966, when Rathcoole was first rented from the Greater London Council for the purpose of setting up a hostel, it was a derelict eight-roomed Victorian private house scheduled for demolition. Four months later the house had been decorated and fully furnished, mainly by the efforts of various voluntary organizations. The warden then took up residence and no difficulty was experienced in finding the full complement of vagrant alcoholics. The house thus began to function fully during the summer of 1966 under the general guidance of a management committee which included social workers, probation officers, and psychiatrists.

Hostel Policy and Aims

Rathcoole was envisaged as a therapeutic community in which group discussions would assume central importance. In addition, an attempt was to be made to build up long-standing relations with men who, over considerable periods of time, had previously led lives devoid of normal social contacts. Inherent in this policy was the resolve to readmit men in spite of their repeated relapse, provided that they did not otherwise abuse the hostel's facilities.

The warden provided a great deal of individual support for the residents. He also carried out the initial selection of men, though some were referred to the psychiatrist for further opinion when overt mental illness was suspected; as a rule such individuals were excluded from the house. The psychiatrist made a routine psychiatric assessment of all men soon after admission, and he also met the residents as a group each week by joining in an evening meal at the house. In this way psychiatric care took the form of simple supportive measures in a group setting. The general practitioner took responsibility for the men's physical health. Each new arrival visited the doctor's surgery to undergo a full physical examination and a range of special investigations, including routine E.C.G.s.

All residents were expected to obey two rules. They were told that immediate expulsion would follow if drink was brought into the house, and that no man would be allowed

inside while under the influence of alcohol. Readmission after relapse was always delayed until the man had become fully sober. Antabuse (disulfiram) was given only when it was requested. The general aim was to get all men into regular work, and they were allowed ample time in which to find an acceptable job.

Case Material

A total of 34 men were admitted to Rathcoole during its first year. Practically all were so deteriorated and isolated from normal social contacts that they constituted hopeless therapeutic problems when judged by usual prognostic criteria. Their average age was 45 (range 28-58) years, and most of them had been leading a Skid Row existence for several years. All had come from families in the lower socioeconomic groups, usually in distant parts of the country. They had left home at an early age and had failed to settle into a stable life pattern, taking jobs in quick succession as they moved from city to city. Half the men had a record of 50 or more convictions from drunkenness, and a substantial proportion (70%) had received repeated spells of hospital treatment with no lasting beneficial effects. The level of physical fitness was surprisingly good; results of routine E.C.G.s and liver-function tests were invariably normal. Adequate psychiatric evaluation was possible in 25 cases (73%); the main findings are summarized in Table I. Some sort of personality disorder was found in all cases and abnormality of early home environment was very common. The absence of other types of gross mental subnormality is clearly related to the policy of excluding overt mental illness from this particular hostel.

TABLE I.—*Psychiatric Assessment and Home Background (25 Men)*

Psychiatric Diagnosis	No. of Cases	Home Background			
		Normal	Anomalous	Disturbed	Anomalous and Disturbed
Personality disorder:					
a, p, w	10	0	2	6	2
p, w	10	3	1	4	2
p	5	3	0	2	0

a = Recurrent antisocial behaviour. p = Lifelong difficulties in establishing interpersonal relationships. w = Never achieved stable work record.

Response to Treatment at Rathcoole

It is possible to divide the men into three distinct groups on the basis of length of stay at the hostel. The first consists of 11 men who stayed for one month or less. Apart from one

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individual who later returned for a second stay at Rathcoole, these men used the hostel as a resting-place between drinking bouts. They disappeared either with their first wage packet or after a few days of food and rest. The second group of eight men stayed for periods lasting between one and three months. They settled into work within a few days, but were unable to sustain their efforts for very long. They too resisted attempts to help them, and seemed to regard the hostel merely as a better-class boarding-house. The third group of 12 men remained at Rathcoole for longer than three months, and represent the best results so far achieved. Four of these men were still in residence at the end of the 12-month period under study. Details of this group are given in Table II, which compares their achievements at Rathcoole with their record over the previous 12 months. (Three men were excluded from the present report as they had arrived immediately before the end of the period under analysis.)

TABLE II.—*Long-stay Men (at Rathcoole 3 Months or Longer)*

Year Before Admission (Average)			Behaviour After Admission (Average)		
Prison	..	5 months	Stay at hostel	..	6 months
Skid Row	..	4 "	In work	..	4.5 "
Hospital	..	1 month	No. of jobs	..	3 "
Other hostels	..	1 "	Longest period sober	..	2.7 "
Work/digs	..	1 "	No. of relapses	..	4.5 "

The various groups of men tended to interreact in the hostel ; for example, the "long-stay" triers tended to resent the "short-stay" men, many of whom had no other aim than to misuse the hostel facilities. However, on the whole the men got on surprisingly well together, and no aggressive outbursts occurred, though some individuals tended to be verbally abusive when they returned drunk. Most of them had strong anti-authoritarian views. They strongly resented help which had any hint of condescension, and they were suspicious of helpers in any form, whether they were doctors or the hostel warden. In view of these attitudes it is perhaps not surprising that it was difficult to help these men. Almost without exception they showed a profound apathy which severely impaired their ability to follow a constructive rehabilitative programme. They were afraid to take the most elementary steps in establishing contacts with normal society ; some measure of their difficulty can be gained from the fact that several men found it a strange experience merely to walk down the street in respectable clothes, and many were prevented from eating in restaurants by extreme self-consciousness. Only two men had sufficient self-confidence and initiative to attend on one occasion a Saturday afternoon football match.

On the whole men were too eager to find work, and tended to rush into inappropriate jobs. They clearly equated recovery with being in regular employment and were generally very unsettled in the hostel when they were out of work. Many of the men voiced the fear that the psychiatrist might send them into mental hospital unless they were in regular employment. This preoccupation with work has persisted at the hostel in spite of constant reassurances by the hostel staff. Such enthusiasm for work is in direct contrast to the general tendency for the men to isolate themselves from outside contacts during their leisure hours, using the hostel as an island on which they marooned themselves.

Considerable attention was paid by the hostel staff to the problem of recurrent relapses, in which there seemed to be no consistent pattern. Sometimes it seemed that a man's tensions and dissatisfactions gradually built up over the weeks until a trivial upset set off a relapse into drinking. However, it is also clear that these men consistently have great difficulty in dealing effectively with the frustrations of everyday life, and they usually resort to alcohol when faced with minor difficulties such as a critical employer or unsympathetic workmates. Attempts to deal with the problem were made all the more difficult by the fact that when men disappeared they usually did so suddenly

and without warning, making it impossible for the hostel staff to anticipate a pattern of recurrent drinking. Disulfiram played little part in the hostel programme. Few men had faith in it as a deterrent, many had drunk alcohol while taking the drug previously, and its compulsory administration at Rathcoole was thought to be neither practicable nor desirable.

Discussion

The results during the first year at Rathcoole show that men who have been leading a Skid Row existence can often maintain quite long periods of sobriety up to several months in duration in a hostel setting with no more than supportive treatment. Admittedly, some stayed at the hostel for no more than a few days, but many men were able to make much more determined efforts, about a third staying for three months or longer. These results are all the more remarkable in view of the fact that the men were usually in regular outside employment during residence at the hostel.

It is clear, however, that we cannot yet hope to speak in terms of cure of the Skid Row alcoholic ; relapse in the present setting seems to be inevitable sooner or later. The hostel routine has gradually had to gear itself to accept this, and whenever possible it has taken back men who have recurrently relapsed after admission. Frequently it has been possible to keep a man in the same job in spite of several short drinking spells. Rathcoole has in this way attempted to build up long-standing relations with men who had previously been estranged from normal social contacts for long periods.

In trying to adopt more active therapeutic measures many difficulties were encountered. Men retreated from help when they most needed it, and without adopting a more directive approach it was impossible to initiate a regular group discussion. They were unwilling to make majority decisions on hostel policy, and tended to present a façade of behaviour in a group, saying only what they thought would be acceptable to the other men. They feared repercussions in Skid Row, with which there was always constant interchange of information. They therefore did not wish to appear to be identified with the hostel in case they might prejudice their Skid Row reception at the next relapse, such was their lack of confidence in ultimate success. During the first year, therefore, it was left to the hostel staff to decide on the standards of behaviour to be expected of the residents. While having to accept recurrent relapses, it was necessary to guard against misuse of the house by men who relapsed too often. A good work record while at the hostel was thought to be a useful indication of a man's achievements, and could often be maintained by well-motivated individuals in spite of recurrent short relapses.

A further recurring difficulty at the hostel was the failure to predict when men would relapse. They usually did so without warning, and within a matter of hours they had rejoined their associates in Skid Row, often having squandered large sums of money in the process. This immediate return to Skid Row is consistent with the suggestion of Edwards *et al.* (1966) and of Myerson (1956) that vagrant alcoholism fulfils a specific need in these men.

Experience at Rathcoole so far suggests that only limited success will be achieved by a rehabilitation programme which consists merely of simple supportive measures. The Skid Row alcoholic needs a vigorous directive approach designed to foster an attitude of self-help rather than passive dependency. The hostel policy has been altered in the light of this experience. It is now proposed to involve all residents in policy decisions and responsibilities which they have so far carefully avoided, such as deciding which men should be readmitted or which should be excluded after relapse. Much more work has to be done before it is possible to decide which form of hostel routine is most conducive to the rehabilitation of Skid Row alcoholics,

and this is now the most important problem which the Rathcoole experiment has to face.

Summary

The first year at a Skid Row hostel is described and problems of hostel routine are discussed. The residents were found to be remarkably free from serious physical disorder in spite of prolonged alcohol abuse, including regular intake of methylated spirits. Some kind of personality disorder was found in all cases.

About one-third of the men stayed at the Rathcoole for three months or longer. It was often possible to keep men in work in spite of recurrent short relapses. This was achieved by readmitting men and attempting to build up long-standing relations with them.

It is hoped that the findings at Rathcoole will stimulate the formation of other hostels throughout the country in an attempt

to provide an alternative to the present-day system of repeated imprisonment of the Skid Row alcoholic.

We wish to thank the Carnegie Trust for providing financial assistance which made the Rathcoole experiment possible. We are also most grateful to Lady Reading, who played a major part in establishing the hostel, and who has continued to provide constant support and guidance. Dr. Griffith Edwards also played a leading part in planning the hostel, and has continued to provide valued advice. We also wish to thank Mr. Geoffrey Wicks, the deputy warden, the Rathcoole Committee, the W.R.V.S., International Voluntary Service, Community Service Volunteers, and all other individuals who have helped at Rathcoole. Thanks are also due to the Ministry of Labour, Brixton, and Ministry of Social Security, Kennington, for their help.

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MEDICAL EDUCATION

Central Committee on Postgraduate Medical Education

A statement recently issued by the Central Committee on Postgraduate Medical Education says that at its meeting on 12 January the Committee received a report from its Secretary, Dr. J. O. F. DAVIES, on the progress of inquiries undertaken on the Committee's behalf. A survey is being conducted of the number and nature of preregistration posts available in each region and the procedures governing both their recognition and the appointment of doctors into them. At the same time information is being assembled about present postgraduate activities in the regions, especially advisory and placement services. Further discussion of the shape and organization of postgraduate committee structures in the regions will take place at the Committee's next meeting on 2 February.

The Committee, which keeps the Chief Medical Officers of the Ministry of Health and the Scottish Home and Health Department informed of its agenda, decided to invite them to discuss the possibility of establishing

training posts comparable in training, tenure, and security to North American residencies in specialties such as anaesthetics, pathology, psychiatry, and radiology. The Committee wishes also to consider with them the possibility of the establishment by the appropriate authorities of additional professorial units in such specialties as anaesthetics, ophthalmology, orthopaedic surgery, otolaryngology, and radiology, and the creation of more National Health Service posts with an academic content and status.

The Committee, appreciating the need for vocational training following the preregistration year, and the difficulties involved in organizing it, agreed to set up a small committee to begin a study of the problems.

Training for General Practice

The Committee proposes to discuss with representatives both of the British Medical

Association and of the Royal College of General Practitioners recent reports produced by both bodies on vocational training for general practice and the role of the Central Committee in relation to the organization of this training.

The use of television in postgraduate medical education and the general support which might be given by the Committee in this field was considered briefly, and it was agreed to accept an offer from Dr. CHARLES FLETCHER to prepare a paper on this subject for discussion at a future meeting.

Finally, the Committee received a paper entitled "Postgraduate Instruction in Management of Patients with Cancer" produced by the Working Party on Cancer Education for the Medical Profession appointed by the Standing Medical Advisory Committee of the Central Health Services Council, and agreed to ask regional postgraduate committees to give effect to its recommendations so far as they might be in a position to do so.