Clinical Topics

An alcoholism service

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It is becoming clear that the most serious medical problems presenting in the immediate future are the treatment of the chronic alcoholic and of the sick and handicapped aged.

Since the mid-1950s there have been established by the DHSS some 25 alcoholism units in England and Wales. It would be true to say that the treatment in all of these units is based on the concept of the therapeutic community.¹ There will be differences in these units. Differences in ethos, in attitudes to the concurrent exhibition of psychoactive drugs, and also in the application of physical treatments—for example, aversion therapy, deconditioning, controlled drinking learning, disulfiram or citrated calcium carbimide, etc.

It soon became apparent that alcoholism units could provide only limited treatment of a condition which if not merely chronic and relapsing was life-long. Treatment had to be made available to sufferers after the relatively brief period of inpatient treatment. Thus activity inevitably extended outward from the alcoholism units and from outside the units inwards.

More often than not patients are referred to these units without the referring agents' knowing much about the nature of the treatment. What follows is a description of a continuously changing and developing alcoholism service, which it is hoped will give colleagues an understanding of a treatment programme for the chronic alcoholic and his family. I add his family (and could legitimately extend this extension—for instance, to his colleagues at work) because it is not only the ostensible sufferer who needs treatment and support but also the people immediately around him.

The alcoholism unit

Our alcoholism unit is a self-contained part of a modern psychiatric department based in the district general hospital. The psychiatric unit has 90 beds, a day hospital, and an outpatient department. The alcoholism unit has 16 beds—three wards of four beds, one single-bedded room, and one suite consisting of a single-bedded room and a twin-bedded room, which can be used as a family suite. All the rooms are well-appointed. There is a spacious day area and a dining area, separated by a folding divider, which turn into a single large area when necessary. In addition there are offices for the nursing staff, social worker, secretary, and doctors.

STAFF

The unit is staffed by one charge nurse and one other nurse per daytime shift (no night nurse), one part-time social worker, one part-

time secretary, and two doctors (a consultant and a senior registrar), who have heavy general psychiatric commitments as well. The catchment area served is the county of Surrey and parts of London, with a population of 1 021 000.

PATIENTS

Referrals for treatment come from surgeons, physicians, general practitioners, and from psychiatrists. The patients are assessed at the outpatient department (sometimes with the help of the inpatient group) or in the patient's home by one of the unit doctors. This assessment has the following aims: firstly, to determine the patient's ability to conform in a liberal atmosphere to minimal demands of social behaviour; secondly, to determine his personal stability, for the unit's programme is intense and can be too demanding for some patients, who may break down under the stress of the programme; thirdly, to uncover and understand any psychiatric condition basic to the presenting alcoholism; and fourthly, to give the patient some understanding of the nature of the illness and of the treatment programme.

He is told that if he agrees to become an inpatient then he must make several commitments, including an agreement to stop drinking while an inpatient, to take only those drugs prescribed by us, to agree to be an inpatient for at least six weeks, and to accept the unit's treatment programme. He is asked to stop drinking because the treatment demands the active participation of the patient, and an immediately demonstrable contribution to treatment is useful and probably prognostic. We would in any case find it difficult and probably impossible to administer this unit placed in a district general hospital if we allowed drinking that might become uncontrolled. If he does not want to stop drinking then we think he is not yet ready for our treatment, but we would be prepared to assess him again later.

The same reservation would apply to patients who insist that they cannot cope without tranquillisers and hypnotics because they would feel too tense or would be unable to sleep. We tell them that if this is so and they are not prepared to try without these aids then they should have a different treatment, which we will discuss with the referring doctor. We do recognise that there will be patients who cannot cope without tranquillisers, hypnotics, and alcohol, and for these we accept a need for compromise and alternative treatment; but in the approach we practise alcohol, tranquillisers, and hypnotics are proscribed because they would interfere with the treatment programme.

The six-week period for inpatient treatment laid down has no scientific basis—it is an arbitrary period thought to be sufficiently long to give the patient an opportunity to make a worthwhile commitment to treatment and not too long to frighten off a prospective inpatient.

If the patient is still drinking when he agrees to become an inpatient he is told that he must be "dried out" before he is admitted because there are no night staff—if patients developed withdrawal fits or delirium tremens at night sooner or later there would be a fatality. Thus the referring doctor is advised to arrange detoxification at the catchment area district general hospital or psychiatric hospital. We admit our local patients to our own general psychiatric beds for this purpose (and for research into the biochemical and endocrine disturbance of acute ethanol intoxication).

We emphasise to referring doctors our opinion that the treatment of alcohol intoxication is primarily medical and should ideally take place in the medical ward of the general hospital, just like the treatment of overdose or chronic intoxication with barbiturates, salicylates, opiates, or other psychotropic drugs. Alcohol intoxication is a rewarding condition to treat—almost invariably the patient makes a remarkable

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recovery, which is more than can be said for many other medical conditions treated in hospital. Referring doctors often do not care to make this arrangement because of difficulties posed by their hospital colleagues. We promise, however, to take over the management of the patient once he is dried out. We insist that the drying out should be done locally because we believe that doctors and hospitals must recognise the existence of this vast problem, which they are inclined to will away, and must make suitable provision for it.

Inpatient programme

The inpatient programme is concentrated. On every weekday there is a meeting from 0900 to 1000 and from 1330 to about 1415. On three days a week there are also meetings from 1100 to about 1215. The meetings are attended by all the inpatients, some partners, and some ex-patients as well as staff members.

The contents of these meetings vary from internal domestic matters to discussion of tensions arising in the group and trying to relate these tensions to behaviour at home and at work.

The Monday 1100 meeting is an open meeting in that ex-inpatients and outpatients can attend. At the other two 1100 meetings a patient may present his life story, in which case the spouse, close friend, or parent may also attend. The life story is then discussed by the rest of the group, and again an attempt is made to relate his behaviour as an inpatient to his behaviour as described in his life story.

Every weekday afternoon after the 1330 meeting the patients travel two miles to West Park Hospital, which is a 1200-bedded psychiatric hospital, where there is a high proportion of long- and medium-stay patients.

At the 1330 meeting the alcoholism unit patients have already been divided into groups to attend particular long-stay wards. In these wards they may entertain or in other ways occupy the long-term patients. For example, they may organise a game of bingo or a tea-party, or on a bright, sunny day they may take out in a wheelchair patients who are otherwise bedridden, or they may just talk to a lonely patient. At about 1600 the patients return to the alcoholism unit. This service to long- and medium-stay patients is much appreciated by patients and nursing staff; it also has a public relations value in that the alcoholic patient feels and is seen to be in a useful and caring role.

On Mondays at 1600 there is a partners' support group—that is, the spouse or cohabitee of the patient attends this meeting—individual or general problems of the partners are discussed in the presence of a doctor and social worker.

On Tuesday evenings the inpatients are taken by coach to St Thomas's Hospital, where from 1815 to 2000 they act as hosts to their spouses and partners and to ex-patients, and also tell outpatients who are referred for this purpose about their own experience of alcoholism, as well as the inpatient treatment programme.

On Wednesday evening there is a meeting at the unit at 1930. This meeting is addressed by an invited speaker, sometimes an ex-patient, sometimes someone from Alcoholics Anonymous, or other relevant agencies—for instance, the probation service, the social services, or a religious organisation. To this meeting are invited the spouse or cohabitee of the inpatient, ex-patients and their partners, and outpatients and their partners.

On the last Friday of each month there is an evening party from 1930 to 2200, and again partners of inpatients are invited as well as ex-patients and their partners. This party is largely financed and entirely catered for by the patients and on average 80 people attend.

On Saturday mornings at 1000 there is a meeting of those inpatients who are not on weekend leave, and to this meeting are invited ex-patients and outpatients with their respective partners. On Sunday afternoons there is a similar meeting at 1500.

Aftercare

At all times ex-patients are encouraged to maintain contact with the unit. We emphasise that we want to hear from our ex-patients as early as possible when they are in relapse. But we want to have as much contact as is reasonable when they are not in relapse. We therefore provide a well-used 24-hour service, both by personal contact and by telephone. Although we do not have night staff, ex-patients who are in trouble at night can telephone the unit; then a member of the staff can make contact with our own "flying service," composed of ex-patients with cars. These ex-patients will then visit the patient and try to organise help—for example, by contacting the GP or the local hospital casualty department.

We do not have a rigid attitude to relapse into drinking. The relapse of an inpatient into drinking is used as material for group discussion. A relapse of an ex-patient calls for renewed consideration of treatment, whether inpatient or outpatient.

The unit also provides a 48-hour accommodation service, if accommodation is available, for ex-patients who at a particular time are apprehensive about their grip on their sobriety, or for those who think that a short refresher course would help.

Evaluation of treatment

Statistics of admissions from 1968 to 1976 and the results of treatment are given in tables I and II. The results of treatment are based on joint appraisal by the staff of 100 consecutive first-admission patients first admitted in 1975 and assessed one year after treatment as inpatients. The term "improvement" represents an improvement in quality of life and is not necessarily related to abstinence.

TABLE I—Admissions and readmissions and mean age of patients, 1968-76

	No (%) of admissions	No of readmissions (% of admissions)	Mean age (range)
Men	585 (70.1)	167 (28.5)	43 (22-67)
Women	249 (29.9)	81 (32.5)	42 (21-66)
Total	834 (100.0)	248 (29.7)	42.7 (21-67)

TABLE II—One-year follow-up of 100 consecutive first admissions (1975)

	No of patients	Improvement
Men	66	38 (57.6%)
Women	34	15 (44.1%)
Total	100	53 (53%)

Comment

We see the treatment we practise also as training in communication. The average person has great difficulty in discussing differences within the family: all too often discussion of differences rapidly deteriorate into angry exchange and worse. Our patients learn to express their feelings. They learn to understand the difference between malicious and constructive comment—that is, they learn that they cannot say just what they like. They learn to respect the feelings of others and at the same time to tolerate the discomfort arising from the constructive criticism of others.

It may well be asked what we are treating. The answer is that we are treating patients or people with personality disorders, anxiety states, and depression who also have a drink problem. In other words, we are treating vulnerable people with drink problems. Thus our treatment is directed to this vulnerability as well as to problem drinking.

Acknowledgment is sincerely made to patients and staff who have participated in the development of the unit. Every participant has made a contribution.

Reference

- 1 Jones, Maxwell, *et al*, *Social Psychiatry*. London, Tavistock Publications, 1952.

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ONE HUNDRED YEARS AGO On Saturday last, an inquest was held by the Manchester city coroner on the body of Eliza Jane Holloway, aged 26, who died two days previously in the Manchester Royal Infirmary, and a verdict of "Death from hydrophobia from the bite of a cat" was returned. (*British Medical Journal*, 1878.)