Planning the Treatment of Alcoholism

Any planning which is adequately to meet the problems set by alcoholism must face a number of realities. Otherwise, as M. Evans has put it,[1] there is a danger that we shall find ourselves catering largely for the "eccentric" case, while the families most in need are nobody's business.

Perhaps the first reality to be admitted should be the problem's approximate dimensions. Just over 20 years ago the World Health Organization applied the Jellinek estimation formula to England and Wales and suggested that the overall prevalence of alcoholism (with and without complications) might be about 11 per 1,000 adults.[2] The formula is based on cirrhosis death rate corrected by certain constants. Using health visitors and probation officers as intelligence agents, G. Prys Williams and M. M. Glatt[3] arrived at a figure very similar to the W.H.O. estimate, and in a critical review of the Jellinek method R. E. Popham has concluded that formula estimates have in most countries been in good agreement with data from field research.[4]

But most British epidemiological researches [5-9] give prevalence rates for alcoholism lower than those which the W.H.O. predict. The most credible explanation for the discrepancy is probably that alcoholics are difficult people to count because the disorder is often hidden and denied. This discrepancy points indeed to a second important reality: the larger part of the country's alcoholic population is today out of touch with treatment. We have little idea how to bring these people into contact with help or motivate them to seek that help. The average alcoholic who receives hospital treatment tends to be in his mid 40s[10] and has probably by then shown signs of abnormal drinking for at least 10 years.

Another reality of importance to the planning of services is that alcoholism is often a relapsing condition. Treatment cannot realistically be conceived as a one-shot affair. Some of the most important community work may be concerned with alleviating the worst consequences for the family. The homeless alcoholic is likely to present a particularly demanding problem, and a recent Home Office report[11] suggests that there may be a hard core of about 2,000 such men circulating round the courts in the guise of chronic drunkenness offenders.

Several other facts should also be on the planner's memo pad. He may be lobbied by advocates of this or that approach to the treatment of alcoholism, but factually there is a remarkable dearth of evidence to support anyone's claims. Treatment research has almost without exception been in terms of uncontrolled trials conducted on more or less highly selected groups. It should then further be noted that the very word "alcoholism" itself begs a question, for, as Jellinek pointed out,[12] we are undoubtedly dealing with a range of disorders rather than with a disease entity. The syndromes remain poorly defined.

There are also some important realities which must be given place on the other side of the planner's equation: not only is the alcoholism problem large and complex, but the available resources which might be deployed to meet it are constrained. There are fewer than six psychiatrists in all N.H.S. grades per 100,000 of the population, and if alcoholism is to make additional demands on psychiatric manpower it is going to bid against many competitors. And it is difficult to believe that as general practice is at present organized the family doctor is going to have much more time to help the drinker.

How is the National Health Service grappling with these realities? In 1962 the Ministry of Health issued a memorandum[13] which favoured the notion of specialization. It advised that each regional hospital board should establish special inpatient centres of 8-16 beds, which would operate on a group-therapy basis. There was no mention of outpatient care. However, a later circular[14] noted the possible value of the clinic approach and placed a new emphasis on community care, though suggesting that treatment would frequently entail an initial admission. There are now about 22 special inpatient units in the United Kingdom. Doubtless these centres have in general a lively concern for the community around them, though staffing puts limits on the degree of their involvement in the community.

The latest thoughts on the planning of services come in a document which has been prepared on the admirable initiative of the King Edward's Hospital Fund for London.[15] The authors point out the need for community involvement, though strangely they make no mention of primary outpatient care. They indeed suggest that "as soon as alcoholism is detected the patient should be persuaded to see a specialist and advised to enter hospital." They see this supposedly essential admission in terms of a 12-week stint of group therapy. Drug addicts would be treated in the same centre, and these units would be located in district general hospitals. Though the document is in many ways interesting, its concern with the minutiae of inpatient planning (the square footage for instance of the cleaners' room) suggests a certain imbalance when put against the quantity of thought which has gone into consideration of the community side of things. The realities have been somewhat passed by.

The critic might indeed suggest that none of our present thinking on alcoholism treatment services pays enough heed to these worrisome realities. To dub alcoholism a "disease" may have had eminently desirable and humane consequences, and no one would wish to put back the clock. But is the medical profession at present issuing a rather bogus prospectus? Have we anything like the required manpower to treat the real potential case load? Which syndromes are of medical concern and which are not? Would we not be swamped if all the cases at present hidden came forward? Who is the "specialist" to whom the most recent document refers? The cult of expertise has as a side effect the undermining of the ordinary man's self-confidence.

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