Alcohol and Alcoholism

The habitual drunken offender: everybody's fool, nobody's friend

RICHARD SMITH

Whenever I am approached by a dishevelled alcoholic in the street whatever I do I feel awful. Just ignoring him seems an inhuman response, but quickly giving him 50p and walking on seems little better: surely he needs much more than money, which he will probably spend on drink anyway. But have I got the time, energy, or inclination to take him home, give him a bath and a meal, and talk to him? No, I have not, and nor it seems has our whole society. Sporadic attempts are made to deal with what are now called habitual drunken offenders, but most end in failure. The habitual drunken offender has few friends: George Orwell included him in his famous book¹; the BBC has recently produced a film and a book about him²; but the present Government has little time or money for him. One of his primary problems is administrative: he falls between the two giant stools of the Home Office and the Department of Health and Social Security. Is he "mad" or "bad"? The Government cannot decide and seems content to let him fall into the chasm between the two departments. The story of attempts to deal with the habitual drunken offender over the last 15 years is a sad but revealing one.

Prison is no place for him

The idea that putting habitual drunken offenders repeatedly into prison is an expensive waste of time is not by any means new. For over a century in Britain people have been making this observation: the Habitual Drunkards Act of 1879 suggested that there should be "retreats" for the "reception, control, care, and curative treatment of habitual drunkards."³ No such retreats ever existed, but the Inebriates Act of 1898 called for the establishment of State or Inebriate Reformatories. Fifteen were established, but they were not much used because the magistrates thought them expensive and by 1921 they had all closed.³

Other countries, however, have tried alternatives to prison for dealing with habitual drunken offenders. Since 1956 Poland has had "sobering-up stations" where a drunk can be taken by a policeman, examined by a doctor, bathed, and put to bed. He leaves the next morning and only if he is readmitted is further action taken, but the Polish problem seems to be more one of sporadic drunkenness than of habitual offending. Czechoslovakia has similar facilities and so does Russia. Sweden, too, has a detoxification system, the last stage of which is a voluntary labour camp.³

As is so often the case, however, it is North America that has led where Britain might follow. In 1958 Pittman and Gordon published an influential book, *The Revolving Door*,⁴ that argued persuasively with good data that prisons were inappropriate and treatment centres should be started. Earlier, in 1956, the American Medical Association had decided that alcoholism was a disease, and then two courts in the late 1960s allowed alcoholism as a defence for a charge of drunkenness. Over the next few years the Government called for and agreed to finance committees to set up detoxification programmes. Several States—in fact, 26 by 1976—"decriminalised" drunkenness, which meant that it was no longer an offence. Sometimes, unfortunately, this decriminalisation preceded the setting up of detoxification schemes, which led to chaos.⁵

Many detoxification schemes have now been set up in the United States and Canada and some have been evaluated—mostly in an unrigorous way. The St Louis centre was one of the first to open and an evaluation was reported in 1970 at an international conference on alcohol and addiction in Cardiff. Half of 160 patients had improved appreciably four months after discharge: 47% in drinking pattern; 49% in health; and 18% in employment. The arrest rate also dropped, from 46% in the three months before admission to 13% in the three months afterwards. A study at the same centre compared two different treatment programmes⁶: 78 controls were detoxified and given 7-10 days' inpatient care, while 177 probands were detoxified and given three to six weeks' inpatient care and aftercare. The results showed benefit for both groups from detoxification but little further benefit from aftercare.

Los Angeles, Washington, Boston, and New York have all now established detoxification programmes and reported on their results. One important report was on the Ontario detoxification scheme⁷: 522 patients admitted for the first time were followed up for six months; the rearrest rate was 53% with a mean of 4.3 arrests per man. The conclusions drawn by the author were pessimistic: this expensive system had not had much influence on arrests for drunkenness, nor had it resulted in good long-term results for abstinence and recovery. He thought that there was a danger of replacing one revolving door with another.

Numbers of habitual drunken offenders

Britain like all Western communities has habitual drunken offenders, but there are problems in describing them and determining how many there are. For one thing homelessness and habitual drunkenness are not the same thing: not all homeless people are habitual drunken offenders, and not all habitual drunken offenders are homeless. Yet they are part of a similar problem, and a solution that concentrates exclusively on the drunkenness or the homelessness may be doomed to failure.

Then, ways of viewing these people have changed: just as all people with alcohol problems were at one time thought of as morally weak so habitual drunken offenders were—and often still are—thought of as pathetic or disgusting people who could never escape from their circumstances. But now those who study the problem see them much more as victims of housing and other social policies and believe that given the right chances they may “blossom.” Though, as Tony Wilkinson’s programme and book showed,² some people opt for the homeless, drunken life and are not likely to be interested in attempts to rehabilitate them.

How many habitual drunken offenders are there? The 1971 working party on habitual drunken offenders⁸ defined habitual as more than three convictions in a year and calculated that about 16% of drunken offenders were convicted two or three times. In 1967 there were 71 167 convictions for drunkenness among men in England and Wales, which meant about 5000 habitual offenders. The prison authorities, however, thought that there were only about 200, and the police that there were even fewer. But the Scottish Home and Health Department study group of 1978 thought that there were about 2000-3000 in Scotland alone.² Since 1967 convictions for drunkenness have continued to rise: in 1977 there were 108 871 for men and women in England and Wales.⁹ There are probably many more habitual offenders—perhaps nearer to 10 000 than 5000.

British initiatives

In 1971 a Home Office working party produced a report on the habitual drunken offender.⁸ Age-old worries about the cost and ineffectiveness of the penal system, concern about increasing convictions for drunkenness, and the optimism and initiatives then prevailing in the United States all helped to inspire the report. It was a rare moment of optimism in thinking on the habitual drunken offender. The working party recommended a response on several levels: it wanted there to be experiments with hostels, half-way houses, information centres, social clubs, councils on alcoholism, and some detoxification centres.

Nothing happened, however, until 1973, when responsibility

for the habitual drunken offender was transferred from the Home Office to the DHSS. The DHSS issued a circular calling for the development of the recommendations of the habitual drunken offender working party and saying that it would provide finance. The voluntary sector took up the job, and the idea was that after a few years the public sector would take over. Although he may not have realised it, this was a golden age for the habitual drunken offender: hostels, shop fronts offering help, day centres, and sheltered housing were all being set up piecemeal round the country.

A detoxification centre was not set up in England until 1976, when one was established in Leeds—as part of a community project. In Edinburgh, however, a detoxification project had by this time been and gone.³ It was an experimental project set up to determine the feasibility of detoxification centres in Britain and to try to gather evidence on whether such projects were effective. From February 1973 until March 1974 it functioned at the regional poisoning treatment centre, which was in the Edinburgh Royal Infirmary, the main hospital. Then it was moved until its demise in February 1975 to the Andrew Duncan Clinic, an acute psychiatric hospital. Interestingly, the trial was controlled: there were 52 patients who were given a yellow card, which meant that whenever they were picked up by the police they were taken to the detoxification centre. The 49 controls were dealt with in the usual way.

The results showed that a detoxification centre was certainly feasible, although there were many minor problems and the psychiatric hospital seemed to be a better place than the general hospital. Compared with the controls at the end the probands had better accommodation and drinking habits, but only the former reached statistical significance. Some attempt was also made to cost the exercise: the cost per proband during the experimental year was about 20% more than that during the year before enrolment.

Nipped in the bud

In 1977 progress was being made with facilities for dealing with the habitual drunken offender: another detoxification centre was set up in Manchester and various other detoxification projects were starting up around the country; also hostels, day centres, housing associations, and the like were establishing themselves. Then in 1979 came the “cuts” and everything began to look vulnerable.

The DHSS announced that the policy of gradually implementing the recommendations of the habitual drunken offender working party and local authorities taking over what the voluntary sector established would be discontinued: the voluntary agencies were to hand over to local authorities immediately. Vigorous protest from those most concerned led to an extension of the policy until 1981, but now it has been discontinued. So far nothing has been lost but there can be no more growth.

But, while the DHSS has turned away from the problem, the Home Office has again become concerned because the prisons are now fuller than ever. The Home Office has no power to set up detoxification centres—because they are a health matter—but it has developed plans for “wet shelters.” Those who have been concerned with detoxification centres think that “wet shelters” will be nothing more than cheap police cells: they have little medical cover, and the patients are thrown out after 24 hours. The primary aim of these shelters seems to be not to help the habitual drunken offender but rather to keep him out of the way.

So one decade has seen the rise and fall of grand schemes for dealing with the habitual drunken offender. At the moment things are presumably better than they were 10 years ago in so far as some detoxification projects and many community facilities now exist. But how long will they survive and how can they deal with what are likely to be expanding problems as

rising unemployment and rising alcohol consumption take their toll? Is it inevitable that as times get harder then habitual drunken offenders are ignored? Is our society quite incapable of dealing with these chronic problems?

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This is the seventh in a series of articles on alcohol.

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Lesson of the Week

Lithium treatment and preoperative fluid deprivation

M SCHOU

The standard instructions given to patients on lithium treatment include a warning to drink plenty of fluids when there is a risk that a negative fluid balance will occur. As the following case report shows, it is not enough that patients and their psychiatrists know this rule: nurses and doctors in general hospitals should also know that depriving such patients of fluids may have serious consequences.

Case report

A woman aged 35 years was given lithium treatment for manic-depressive illness. While on the treatment she developed polyuria and polydipsia, passing 8 to 10 litres of fluid a day, but she put up with her thirst and frequent micturition because the treatment completely removed the frequent episodes of mania and depression. She was admitted to a surgical ward for uterine curettage and was told to take no food or fluids during the night before the operation. This led to malaise, tremor, and dysarthria. Serum lithium and sodium concentrations were not measured, but from experience she recognised the signs and symptoms of dehydration and impending lithium intoxication.

Later, at a second admission for curettage, she protested against being deprived of fluids before the operation, but the nurses thought that her energetic insistence on having something to drink was the whim of a psychiatric patient. Only when a

Patients who take lithium may develop polyuria and polydipsia if they are deprived of fluids before an operation

psychiatrist, who knew about lithium-induced polyuria, was called was she given an intravenous infusion before the operation. She thus had no signs of dehydration or lithium intoxication.

Comment

As many as two people in a thousand are being treated with lithium for recurrent manic-depressive illness. In many patients the treatment lowers the renal concentrating ability, and polyuria and polydipsia develop. These side effects may be troublesome for the patient, but they do not reduce the excretion of lithium and are not dangerous. Owing to a reduced reabsorption of water in the kidneys, however, fluid loss in these patients is greater, and they are likely to become dehydrated if the fluid intake is restricted or additional fluids lost. Dehydration may cause reduced clearance of lithium and reduced excretion of lithium. Patients on lithium treatment should therefore drink plenty of fluids when there is a risk that a negative fluid balance will occur. If they do not, or are prevented from doing so, they may become dehydrated and develop signs of lithium intoxication. If patients with lithium-induced polyuria must abstain from drinking before an operation because of the narcosis they should be given intravenous fluids the night before the operation.

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Psychopharmacology Research Unit, Aarhus University Psychiatric Hospital, 8240 Risskov, Denmark

M SCHOU, MD, professor and research director