Middle Articles

CONTEMPORARY THEMES

Clients of Alcoholism Information Centres

GRIFFITH EDWARDS,* M.A., D.M., D.P.M. ; MARION KELLOG FISHER,* B.A.
ANN HAWKER* ; CELIA HENSMAN,* M.A.

IN CO-OPERATION WITH THE NATIONAL COUNCIL ON ALCOHOLISM AND THE GLASGOW, GLOUCESTER, AND LIVERPOOL
ALCOHOLISM INFORMATION CENTRES

Brit. med. J., 1967, 4, 346-349

In Britain alcoholism is a condition which causes embarrassment and perplexity. The alcoholic is often ashamed to seek help, and if he does want help he may be uncertain where to find it. The National Council on Alcoholism, a voluntary organization inaugurated in 1963, has sought to meet this problem by fostering the setting up of alcoholism information centres and has encouraged and assisted local community councils on alcoholism, in various parts of Britain, to open centres which break away from the rescue mission and "Skid Row" aura which so often clings to alcoholism. The centres have been set up in better and central areas of towns; furnishing and décor are of good quality and tend to suggest a modern office suite rather than a clinic. The policy has been to employ staff with wide practical experience of helping the alcoholic rather than to look for counsellors with professional training.

An important part of the job of a centre is that of making contact with the local community and by means of visits, talks, pamphlets, articles in local newspapers, etc., ensuring that the existence of the centres' services is widely known. The hours of opening vary from centre to centre. The aim is to provide help which is friendly, confidential, and immediate, and the door is open to the alcoholic, his spouse, the employer, or any other concerned person or agency. The work of the centres is seen as that of sorting out immediate problems, and directing toward help, rather than providing treatment or long-term counselling.

In 1966 the staff of the Alcohol Impact Project were approached by Colonel Peter Perfect, the executive officer of the National Council on Alcoholism, with the suggestion that the research team should carry out a survey of the work of the three longest-established centres.

Method.—A precoded structured questionnaire was evolved which could be used at an initial interview without interfering with the helping relationship. Staff of the Glasgow, Gloucester, and Liverpool centres then administered this questionnaire each to a consecutive series of 100 clients. The collection period differed slightly between the three centres, but averaged about four months. Data from the 300 completed schedules were analysed on the University of London's I.B.M. 7090 computer.

Of the 300 clients 264 were men and 36 were women. Data on the men are presented in detail, and results on the women are given more briefly.

* From the Alcohol Impact Project Addiction Research Unit, Institute of Psychiatry, Maudsley Hospital, London S.E.5.

Male Clients

Twenty-three per cent. of the male clients had been referred to the centre by a doctor, 20% were self-referred, 14% had been brought or sent along by the spouse or other member of the family, 9% had been referred by a probation officer, 5% had been brought along by a friend other than family member, and the remaining 29% had been referred from a wide variety of agencies, which include Alcoholics Anonymous, Family Welfare and Marriage Guidance, personnel officers, clergymen, etc.

The mean age was 43.1 years (S.D. 9.4). Forty-nine per cent. had been born in England, 39% in Scotland, 9% in Northern or Southern Ireland, and 2% in Wales; 1% gave other places of birth. Forty-eight per cent. of clients were married, 16% single, 24% separated, 9% divorced, and 3% widowed. Social class determined according to the Registrar-General's Classification (General Register Office, 1966) (Table I), shows that there has been a slight tendency toward downward drift.

TABLE I.—Male Clients: Socio-economic Class by Occupation

Class	"Best"	"Now"
I (professional)	6	6
II	22	18
III	48	41
IV	18	23
V (unskilled)	6	12

Eighty-six per cent. described a pattern of continuous drinking and 14% a pattern of bout drinking. Ninety per cent. of male clients had experienced "morning shakes," and 76% of these had been in the habit of taking a morning drink to relieve shakes. All but 5% had experienced amnesias for the previous evenings, and 37% had at some time attempted suicide.

Thirty-two per cent. had not been on a drunkenness charge, 51% had been convicted and fined only, 17% had been convicted and gaoled. Twenty-eight per cent. had been convicted of driving when drunk. Twenty-five per cent. had been in prison for offences which were not technically "drunkenness" offences but which the clients believed to be a direct consequence of their drinking.

Only 22% of clients believed their general practitioner to be unaware of the drinking problem. One per cent. had not seen a general practitioner during the previous year—56% had seen their doctor during the preceding month, 10% during the preceding one to two months, and 14% in the preceding two to

three months. Forty-four per cent. had personally sought help from their doctor, while 30% believed that the wife had consulted the doctor for assistance. However, 74% said that during the previous year they had attempted to "fool" a doctor, and had given false reasons for requiring a medical certificate.

Employment

At the time of interview only 50% were in full-time employment; 4% were in part-time employment, 13% off sick with a job to which to return, 32% unemployed, and 1% retired. That the working population under study consisted of others besides transients and casuals is suggested by the finding that 23% of clients had been with their present employer for less than six months, 15% for 6 to 12 months, 13% for one to two years, and 49% for more than two years. Further evidence on this point is the finding that only 5% of men gave less than one year as their longest period with one employer ever, while 65% gave more than five years as the longest period spent in one job.

The mean time off work for those sick or not employed at the time of interview was 6.5 months: the distribution was in fact skewed, with 75% of the non-working having been out of work for six months or less, and 25% having been out of work for periods ranging from six months to five years. When replies from the total sample of 264 men to a question on days lost from work due to drinking during the previous year were analysed it was found that only 2% stated that they had lost no time from work, and the average number of days lost during the year was 86 (S.D. 82). Only 10% thought that they had received any promotion at work during the previous five years, only 24% believed that drinking had not interfered with promotion, and 47% were in a lower-paid job than their immediately previous employment. Eleven per cent. were certain that during the previous year their drinking had contributed causally to an accident at work, while 32% thought that their drinking might in some way have been implicated in such an event. Seventy-five per cent. had at some time lost a job because of drinking and 12% had been sacked more than five times because of drinking. Thirty-eight per cent. had been dismissed because of the drinking during the immediately preceding year.

Many also gave a history of frequent lateness at work and Monday morning absenteeism due to drinking (Table II).

TABLE II.—Male Clients: Frequency of Unpunctuality and Monday Morning Absenteeism During Previous Year

Frequency	Late at Work %	Absent on Monday morning %
Never	9	7
Rarely—once or twice per year	20	27
Quite often—once or twice per month	44	40
Frequently—more than twice per month	22	21
Not applicable—unemployed, retired, etc.	5	5

Sixty-two per cent. stated that they had on occasion brought a bottle into work with them, and 12% were doing this every working day. Eighty-eight per cent. were at times having a drink before coming into work, and all but 9% said they could occasionally contrive to keep drinking throughout the working day.

Sixty-nine per cent. of male clients had during the previous year received some warning from their employers, and 59% had indeed been warned about their drinking more than once during that year. Fifty-two per cent. of men said they believed that the company had no consistent policy as regards drunkenness, a further 22% were unsure on this point, and only 26% felt they really knew where they stood. Fourteen per cent. said that the company simply ignored drinking. Fifty-eight per cent. of the clients stated that other employees in the firm had definitely lost a job because of drinking, while 53% had heard of fellow employees being warned. Where there was a com-

pany doctor—in 31% of instances there was no one holding this position—49% of clients said it would be impossible to consult him because of the drinking problem, 36% were unsure whether it would be wise, 11% felt it possible but had not done so, while 13% had indeed sought advice and help from this source.

During the preceding year 74% of clients had sought help from a general practitioner, 55% from a hospital, 44% from Alcoholics Anonymous, 26% from a probation officer, 25% from a minister of religion, and 21% from a marriage guidance counsellor.

Women Clients

The mean age of the women was 44.9 (S.D. 10.5)—not significantly older than for men. The distribution for place of birth and marital status closely resembled male distributions. The general impression is of less severe involvement in pathological drinking: 41% reported continuous drinking, 76% had experienced morning shakes (45% of these had been in the habit of taking a morning drink), and 12% had not experienced amnesias. The incidence of attempted suicide was similar—33%. Only 18% had been charged with a drunkenness offence, and half of these had been to gaol. None had been charged with drunken driving. Six per cent. had been in gaol for some other offence connected with drinking. Rather closer contact was being maintained with the general practitioner—76% had seen their doctor during the previous month. The number in employment was too small to allow any meaningful analysis of the impact of drinking on work. Women seem to seek help from much the same agencies as men.

Discussion

Did this study get at the truth? Proper caution is necessary before accepting any information given by alcoholics that has not been validated, but, if anything, the results probably err toward underestimating rather than overestimating the damage which drinking has done to these people's lives—a man is more likely to conceal the fact that he has been in prison than to invent a story that he has served a gaol sentence. With questions such as whether the general practitioner or employer knows of the client's drinking, or whether the firm has a consistent policy, what is being reported is simply what the client believes to be the case. Moreover, the interviewers were not trained research workers, though they had very considerable experience in talking to alcoholics and forming good and easy relationships, and the structured design of the questionnaire obviated many difficulties.

Who Comes to the Information Centres?

If the information centres are attracting anything like the "average" alcoholic, then our findings are a powerful corrective to the view that the ordinary alcoholic is a drifting down-and-out. The centre clients are quite different from those of London's Skid Row (Edwards *et al.*, 1966) (Table III). The social background of the person who comes to the alcoholism information centre closely approximates to that of the ordinary socially integrated citizen.

The demographic characteristics of men in this study may be compared with those of Alcoholics Anonymous members

TABLE III

	Information Centre	Skid Row
Semi-skilled or unskilled males	35%	88%
In one job for more than 5 years	65%	6%
Married or had been married at some time	84%	36%
Still married	48%	0%

(Edwards *et al.*, 1967) and patients attending a National Health Service hospital (Edwards and Guthrie, 1967).

This study also answers the question whether people who come to information centres are suffering from alcoholism of the same type and degree as those who go to doctors. By any definition the majority of clients of information centres are indeed "real" alcoholics. Ninety per cent. of the men studied here had suffered from morning shakes—a symptom which may be regarded as pathognomonic of severe alcohol dependence. The figure for Alcoholics Anonymous was 84%, for hospital patients 100%, and for Skid Row 92%.

Why do people go to an information centre? Why are they asking for help at all? The answer to this part of the question seems to be simple—these are people who are undergoing a great deal of suffering. We did not attempt to analyse the impact of their drinking on their physical or mental health, but that 37% of men and 33% of women have attempted suicide is some indication of the degree of social damage which is being undergone. Breakdown of marriage, entanglement with the law, and failure at work are some of the elements of chaos—the personal suffering of the alcoholic is not something to be forgotten in the statistics (Lowry, 1967). It would be too optimistic to suppose that the relative under-representation of subjects in the older age groups among clients of information centres is just explained by older people having generally got the treatment they required or having reverted to normal drinking (Davies, 1962; Kendell, 1965); it seems likely that this finding is in part a hint of the diminished life expectancy of the alcoholic.

The question why it is to the information centre that these alcoholics turned perhaps has its answer in the fact that the alcoholic who in this country today wants help can have a very frustrating time finding it. His confusion often seems equalled by the bafflement of those to whom he turns.

The frequency with which the alcoholic seeks to mislead his doctor when asking for a certificate illustrates another aspect of the confusion. Perhaps one reason why the information centres are attracting business is that this reflects the consequences of a system of medical training and qualifying examinations which put little stress on the understanding of personal problems and social distress.

Impact on Industry

The statement has recently been made that alcoholism is costing the country's industry millions of pounds a year (National Council on Alcoholism, 1965). Only very rough estimates of the number of alcoholics in Britain are available, but in 1948 the World Health Organization (1951) made a guess that there were about 350,000 alcoholics, 75,000 of them being "chronic alcoholics," in England and Wales. If the W.H.O. figure is even anywhere near correct, multiplying up the losses to industry caused by the 264 men attending the three information centres studied by a factor to give the total national impact of alcoholism on industry would suggest a quite astonishing figure. The cost to various welfare services would also be enormous. The findings that 50% of male clients were out of work at the time of interview, that 38% had been sacked because of their drinking in the previous year, that the average days missed from work during the preceding year was 86 days, that only 1.5% had not lost time from work during that year, the data on lateness and Monday morning absenteeism set out in Table II, all this suggests an industrial disease deserving the most urgent attention. Quite apart from actual time lost from work, there is the question of inefficiency while still at work: some measure of this aspect of the problem is suggested by the 76% who believed that their promotion has been blocked and by the 11% who say that they have caused accidents by their drinking, and inefficiency is hardly to be wondered at when 88% of clients were occasionally drinking

before work, 62% sometimes bringing in a bottle, and 90% sometimes drinking throughout the day. Quite terrifying risks are being taken.

As for sacking as a solution, the alcoholic will usually simply go and find another job, and take his unsolved problem with him. The State will for a period pay out some more sickness or unemployment money, and then another firm takes on the problem where it was left off. The 12% who have been sacked more than five times present extreme examples of this process of circulation.

Future of Information Centres

Besides their specific value in giving help to alcoholics, these information centres probably have a wider importance. They provide an interesting example of what must surely be the new trend in mental health, of the effort to reach out into the community rather than to sit back in the hospitals. In America the approach to drug addiction seems to be taking very much this direction.

There can be no doubt that information centres are reaching the alcoholic, but whether, having reached him, they are able to take appropriate action is another question. It would seem likely that workers in these centres, widely knowledgeable as they are about the networks of local referral systems and local availability of treatment resources, are providing an extremely useful service; but, in the end, the limit to what they can achieve is set by limits of availability of treatment and rehabilitation. Recently, after the most useful stimulus provided by a Ministry of Health (1962) memorandum, regional hospital boards have set up a number of special units for the treatment of the alcoholic: it is to be hoped that energetic community-orientated treatment services, coping with the needs of every type of alcoholic rather than with the few who can benefit from intensive inpatient psychotherapy, will now be developed on the basis of existing units, and on the basis too of the very considerable skill and experience gained by the staff who have been running these regional units.

When such community treatment services are developed alcoholism information centres would clearly continue to play a very important part within them. Surely sooner or later the information centres must be given official and permanent financial backing rather than that their survival should depend largely on their ability to raise money from charity. The staff of these centres will also of course go on playing a valuable part as educators. Rational planning, education of the public, and better education of many specialist groups are all urgently needed if chaos is not to be perpetuated.

Summary

By the use of a structured questionnaire information was obtained on 100 clients attending each of three alcoholism information centres—Glasgow, Gloucester, and Liverpool.

People making use of these information centres are very largely citizens with a normal background of social integration—the lack of similarity with the Skid Row stereotype is stressed. Clients come to these centres because they are confused regarding where else to turn.

Besides their importance because of the service they are giving to alcoholics, these information centres are of wider significance in the example they provide of a "reaching-out" type of community approach to mental health.

Appendix: Location of Information Centres

Cardiff and District Council on Alcoholism and Drug Dependence, Dyfrig House, Fitzhamon Embankment, Cardiff (Tel.

32127). East Midlands Council on Alcoholism, The Dan'l Lambert, Albion Hill, Leicester. Glasgow Council on Alcoholism, 141 Bath Street, Glasgow C.2 (Tel. City 3111). Gloucester Council on Alcoholism, 11 Barton Street, Gloucester (Tel. 22682). London Alcoholism Information Centre, 25a Wincott Street, London S.E.11 (Tel. Rel 0456). Merseyside Council on Alcoholism, 14 "B" The Temple, Dale Street, Liverpool 2 (Tel. Central 0300 and 1372). Staffordshire Council on Alcoholism, 48 Greengate Street, Stafford. Centres are also currently being established in Edinburgh and Herefordshire.

We wish to thank Dr. D. L. Davies, Senior Director of the Alcohol Impact Project, for his continued encouragement. Our thanks are specially due to Colonel Peter Perfect and Miss E. M. Keys, of the National Council on Alcoholism, to the members of the Medical Committee of the N.C.A. (chairman at that time Dr. H. D. Chalke), who gave much help at the planning stage, and to the staff and directors of the three co-operating information centres—Mr. John

Gray (Glasgow), Mr. Michael Taylor (Gloucester), and Mrs. W. H. Kenyon (Liverpool). Mrs. Barbara Kinsley, Mr. Michael Clark, and Mrs. Hedi Firth kindly helped with statistical analysis. We thank Mrs. Julia Polglaze and Miss Ethane Cross for all their secretarial work. The study was supported by a grant from the Bethlem Maudsley Research Fund.

REFERENCES

- Davies, D. L. (1962). *Quart. J. Stud. Alcohol*, 23, 94.
 Edwards, G., and Guthrie, S. (1967). *Lancet*, 1, 555.
 — Hawker, A., Williamson, V., and Hensman, C. (1966). *Ibid.*, 1, 249.
 — Hensman, C., Hawker, A., and Williamson, V. (1967). *Soc. Psychiat.*, 1, 195.
 General Register Office (1966). *Classification of Occupations*. London.
 Kendell, R. E. (1965). *Quart. J. Stud. Alcohol*, 26, 247.
 Lowry, M. (1967). *Under the Volcano*. London.
 Ministry of Health (1962). H.M. (62) 43. London.
 National Council on Alcoholism (1965). *What You Should Know About Alcoholism*. London.
 World Health Organization (1951). *Wld Hlth Org. techn. Rep. Ser.*, 42, 20.

CONFERENCES AND MEETINGS

Uses of Niridazole

[FROM A SPECIAL CORRESPONDENT]

A conference on the pharmacological and chemotherapeutic properties of niridazole and other antischistosomal compounds was held by the New York Academy of Sciences from 10 to 13 October.

Professor BRIAN MAEGRAITH (Liverpool) opened the meeting by outlining the magnitude of the world problem of schistosomiasis, which is estimated to afflict 200 million people or roughly 1 in 10 of the world's population. Repeated courses of different schistosomicides are at present advocated for the cure of individuals in highly endemic zones, but Dr. A. H. MOUSA (Cairo) described trials aimed at mass chemoprophylaxis. In view of the possible theoretical development of resistance to any single drug and of toxicity due to them, he had employed combinations of subtherapeutic doses of antimonial and non-antimonial drugs in different schedules in infected mice. Despite variable results the combination was encouraging, particularly since there were different biochemical effects between antimonial and non-antimonial schistosomicides. Mice that had been infected with *Schistosoma mansoni* continued to excrete non-viable eggs for up to one year after treatment with niridazole (Ambilhar) even although there were no longer signs of active parasitism. Dr. C. R. LAMBERT (Basle) referred to them as black eggs or empty shells.

Niridazole is rapidly absorbed and accumulated in the vitellogenic gland of the female worm, and decrease in worm length and in the size of the worm ovary shows a clearcut dose-effect relationship. Dr. H. P. STRIEBEL (Basle) emphasized this sensitivity of the female and the relative refractoriness of male-worm testes to such treatment.

Orally administered radioactive niridazole is slowly absorbed from the gastrointestinal tract over several hours, and then rapidly broken down by a nitroreductase enzyme system in the liver. Dr. J. W. FAIGLE and Dr. H. KEBERLE (Basle) pointed out that this combination of slow absorption and rapid metabolism ensured a uniform concentration

of niridazole in the blood throughout the period of its absorption.

Professor A. W. WOODRUFF and his co-workers at the Hospital for Tropical Diseases (London) had compared the value of toxicity of sodium antimony tartrate, antimony dimercapto-succinate, sodium antimony gluconate, Anthiomaline (anthiolimine), lucanthone, and niridazole, bearing in mind the useful practical definition that a schistosomicide must be capable of eradicating heavy and light infections of all strains from persons of different racial, residential, and other characteristics when given in a regimen easy to apply under varying conditions. The main disadvantage of niridazole was the neuro-psychiatric disturbance which particularly complicated its use in hepatosplenic bilharziasis.

Hepatosplenic Disease

Professor A. M. COUTINHO and Dr. A. M. DOMINGUES had carefully studied 52 patients in Brazil receiving niridazole for the hepatosplenic form of the disease. In 20 treatment had had to be stopped because of side-effects, which included psychoses, often with suicidal tendencies, in 19 and convulsions in four patients. Serial electroencephalograms had shown changes in 15 of 18 patients studied. In the intestinal form of the disease only two of 30 patients had developed any of these complications. To some extent these side-effects could be minimized by the administration of barbiturates and tranquillizing agents. Dr. A. ABDALLAH (Cairo) described episodic excitement, euphoria, and hallucinations from the fourth day of treatment onwards; and also mental disorientation, generalized convulsions, and localized muscle tremors and spasms. Though the overall incidence of toxicity was less than 1%, it had been found to rise to about 28% in adults with *S. mansoni* infection and the hepatosplenic form of the disease. This was unlikely to be due to hepatocellular poisoning, for

serum-transaminase levels and bromsulphalein excretion were essentially unimpaired during treatment. Dr. A. RUAS, studying similar patients in Mozambique, had noted that liver biopsies showed no histological change after niridazole therapy compared with pretreatment sections.

The cerebral sequelae may be related to portal-systemic venous shunting, which is a feature of hepatosplenic schistosomiasis. This would allow niridazole to reach the brain without being metabolized by the liver. Dr. J. W. FAIGLE and Dr. H. KEBERLE (Basle) demonstrated high peripheral blood levels of the drug in patients with hepatosplenic schistosomiasis. Professor SHEILA SHERLOCK (London) believed that the mechanism was analogous to portal-systemic encephalopathy, in which products of bacterial action on protein bypassed the liver and induced hepatic coma. Impairment of liver function would facilitate the effect; hence the increased frequency in the malnourished and in older patients rather than children.

Despite its toxicity in hepatosplenic disease, it was agreed that niridazole was the drug of choice in *S. haematobium* infections. Dr. V. CLARKE (Rhodesia) had found that such infections were easily cured by niridazole in a dosage of 25 mg./kg. body weight for five to ten days—an experience which proved universal. Dr. G. RAFFIER (Ivory Coast) felt that the excellent therapeutic and prophylactic results obtained in vesical bilharziasis allowed her to predict its eradication by a mass campaign comprising niridazole for the bilharzial patients, together with a molluscicide for destruction of the intermediate host, the snail.

Dr. F. FONTANILLES (Basle) summed up the situation succinctly by balancing the risks of treatment (including the effect on the myocardium of some schistosomicides) with the tolerability and efficacy of niridazole in mass campaigns—particularly of children suffering from *S. haematobium* infections, in which it was of unequalled efficacy and suitable for outpatient therapy.