Treatment of Habitual Drunken Offenders

The report of the Home Office working party on habitual drunken offenders\(^1\) is a major review of a much neglected social problem. Though chary of proposing a solution, the working party has come up with a set of proposals which, if carried out, would do much to make society’s response to the man or woman drunk in the street more humane and more rational. For the continuance of the present revolving door system, which pushes the drunk repeatedly and aimlessly through court and prison, the report could find no one in favour—policemen, magistrates, prison officers, and social workers all shared the unanimous view that the present system is a degrading, expensive, and ineffectual absurdity.

The report does not envisage any one new type of treatment as holding the magic answer, but insists rather that the task is to design a system of integrated care by statutory and voluntary agencies. But within this system an important place would be given to new emergency treatment units, which would be called detoxification centres. A man who was publicly drunk would still be charged and picked up by the police, but he would be taken to such a centre rather than to the police cell, and the charge would usually later be dropped. At this centre an inebriate could initially be held for 72 hours, but on the signature of two doctors a further seven-day order could be made. The centre’s job would be not only the immediate one of detoxification and physical care, but would also include full assessment of social needs and the planning of aftercare, in which specialized alcoholism hostels would play a major part.

That society should today be taking the problem of the habitual drunkenness offender seriously results from the coincidence of several very different factors. Firstly, there has been the need to relieve overcrowding in prisons and the strain on the courts. In 1968 there were 2,719 receptions of men and 206 receptions of women into prison for drunkenness offences,\(^5\) while at any one time between 100 and 200 prison places were occupied by such cases. On an average day the police and the courts deal with more than 200 public drunkenness offences. Another stimulus for change has been the growing body of research which has followed on from the pioneering work of M. M. Glatt and J. S. Whiteley\(^6\) and of D. Parr,\(^7\) which has shown that the typical drunkenness offender—far from conforming to the popular stereotype of the happy roisterer—is most usually someone heavily addicted to alcohol\(^8\) and deserving of the label “alcoholic.” Research has also shown the extreme degree to which these people are socially isolated; they are usually without jobs, homes, or close human contacts. An experimental skid row hostel in London\(^9\) has proved that rehabilitation is a real alternative to repeated gaol sentences, while successful experiments with detoxification centres in Eastern Europe and the U.S.A. must also have been a spur to change. In America the contention that the drunk is ill rather than deserving of punishment was fought all the way up to the Supreme Court, and then the case was lost only because no real alternative to imprisonment seemed to hand. Avoiding the American dilemma, the Criminal Justice Act of 1967 invited new thinking on drunkenness by an enabling clause (Section 91) which would substitute alternatives to imprisonment for drunk and disorderly when (and only when) the Home Secretary of the day was satisfied that alternative facilities really existed. An important international conference held in London in 1968 brought many matters into focus,\(^7\) and the personal commitment of a reforming Under Secretary of State—Lord Stonham—set the working party on its task.

Given the report, how are any of its ideas to be realized? The last major review of the country’s drunkenness problem was undertaken in 1834, and that Select Committee recommended among other measures the abolition of the Navy’s rum ration: the recommendation was followed in 1970. We should heed that cautionary tale. The present working party’s report is in fact weak when it comes to the practicalities of action, and seems rather piously to hope that vastly complex organisational problems need be matched by no very special or imaginative efforts. Nevertheless, “co-ordination” must become more than a hopeful slogan. The Department of Health is presumably going to share some partnership with the Home Office, despite the working party’s restricted terms of reference, which supposedly limited its attention to “treatment within the penal system,” and a host of voluntary organizations with strong traditions of individuality are also going to have to be brought into the scheme. Moreover, even then much more than the right committee structure will be needed: people with conviction and energy and mobile teams willing to travel. The demand is for expansion of specialized hostel places from 92 at the end of 1969 to an eventual 5,000, and of detoxification beds from zero to something over 500. The way ahead will not be easy.

Antibacterial Agents in Renal Failure

A patient with poor renal function faces two risks when he has to be treated with a drug which is mainly excreted by the kidney. Firstly, there is the danger of toxicity resulting from a high blood concentration secondary to the impaired excretion; and, secondly, there is the equally important risk of his being denied necessary treatment because of the fear of this consequence. Certainly, it is wise to avoid all but essential drugs in these patients, but none need be denied them provided that the dose is appropriately modified.

The principles of drug dosage in renal failure have been discussed by C. M. Kunin and M. Finland.\(^1\) If a drug is stable in plasma and eliminated from the body entirely by
the kidney its plasma half-life will vary inversely with the glomerular filtration rate, while the half-life of a drug which is removed from the blood entirely by non-renal mechanisms will be independent of renal function. Other variables, such as urine flow rate and urine pH, influence the excretion of many drugs, but usually their contribution is less important than that of the glomerular filtration rate.

Most drugs depend on both renal and extrarenal routes of elimination, and the relation between half-life and glomerular filtration rate may be established by empirical means. From such studies a schedule which relates drug dosage to the renal function of the individual patient can be drawn up. If the drug is dialysable this schedule will have to be modified for patients who are being treated with dialysis. In treating infection of the urinary tract attention must be paid to the effect of renal impairment on the concentration of the drug in urine as well as in the plasma. The glomerular filtration rate can be estimated from creatinine clearance or from a clinical assessment of the patient’s renal function and his blood urea concentration. When dosage has to be reduced it is usually more convenient to reduce the frequency rather than the size of doses.

For most of the antibacterial agents we now have enough data to indicate how the normal dose should be modified. Thus these agents may be classified into four main groups. The first group includes those drugs which are potentially seriously toxic and which are excreted largely by the kidney. These include: the aminoglycosides, streptomycin, 3 gentamicin, 4 and kanamycin; 5 colistin; 6 vancomycin; 7 and paraaminosalicylic acid. 8 These drugs require a major reduction in dosage, while their blood concentration should be monitored for additional safety if these are to be used in prolonged courses.

The second group comprises drugs excreted by the kidneys but which are not highly toxic, so that though some adjustment of dosage is desirable this does not have to be major, nor do blood concentrations have to be checked. Examples are: the penicillins, benzylpenicillin, 9 ampicillin, 10 cloxacillin, 8 and carbenicillin; 11 the cephalosporins, cephaloridine, 12 cephalaxin, 13 cephalothin, 15 and cephalothin; 15 lincomycin; 17 1sioniazid; 8 and trimethoprim. 16

Thirdly, sodium fusidate is one of the few antibiotics whose excretion is almost entirely extrarenal, and hence no dose modification is needed. Other drugs which, though excreted by the kidneys, may also be given in normal dosage in renal failure are sulphadimidine, 18 sulphonamethoxazole, 18 and nalidixic acid. 20 The clearance of the two sulphonamides does not appear to fall with impairment of renal function (short of oliguric renal failure), while nalidixic acid is rapidly metabolized and, though its metabolites may accumulate, they have not been shown to be toxic.

Finally, there are a few antibacterial agents which should virtually never be used in the presence of renal failure. Foremost among these is tetracycline. In spite of the recognition for several years of its tendency to precipitate severe or even fatal uraemia 21 this complication is still being seen. 22 Chloramphenicol in its active form does not accumulate in the plasma in renal failure, but its metabolites do, 23 and since it may be these which cause narrow aurasia chloramphenicol should be used only on the very rare occasion when there is no safer alternative. The efficacy of nitrofurantoin in the treatment of urinary infections depends on its concentration in the urine. It is of no value in the presence of renal impairment, when only a negligible amount is excreted. 84