Middle Articles

CONTEMPORARY THEMES

Community Care for Alcoholics and Their Families

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Continued care for alcoholics and their families in the community is complementary to in-patient, day-hospital, out-patient, and domiciliary services.¹ Members of the staff of the special unit and the public health department must work as a team in close liaison with the disablement resettlement officer, officers of the National Assistance Board, and other full-time or part-time social workers. It seems timely² and useful to describe our experience of an experiment in inter-professional cooperation which aims to provide community care for alcoholics and their families.

The Alcoholics

The figures in our report refer to the first hundred alcoholics who were residents of Cardiff and were admitted to Whitchurch Hospital and later to Adfer, the special unit, during 1961-4. There were 87 men and 13 women, with an average age of 42½ years. Thirty-nine were married, 33 single, 12 separated, 10 divorced, and 6 widowed. The distribution in social classification according to occupation was 1, 13, 30, 13, and 31 for class I to V respectively; the remaining 12 were unclassified. The intractable and relapsing nature of the disorder is illustrated by the follow-up figures at October 1965, when only 11 had remained abstinent after first admission. Of the remaining 89 39 had started drinking within a week, and another 25 within the next three weeks. Offers to help the families were invariably accepted, and continual follow-up was much appreciated in most instances.

Services Provided

In view of their special skill and the nature of their routine commitments, the social workers and health visitors of the mental health section of the public health department became the key personnel in the community-care team. Social casework with alcoholics and their families usually begins before admission and continues in the unit and after they leave. These social workers are honorary members of the staff of the hospital unit, and we cannot speak too highly of their work.

Of the first hundred patients admitted 49 remained members of a family group of one kind or another. This figure, combined with 149 offspring, of whom more than a half were under 16, amply justifies our emphasis on help to family members and others involved in this destructive illness. Financial stresses were common: 41 of the patients had received National Assistance in recent years, and 20 were receiving assistance on

the date of admission. Officers of the National Assistance Board often made extra visits to the patients in hospital or in the evening clinics, and visited most families at home.

Part of the benefit of community care is early readmission after relapse. Sixty-four had been readmitted up to 1 January 1966, making a total of 268 readmissions. It reflects credit on the team that it is unusual for the offer of readmission to be resented or rejected. The great majority of those who relapsed early and of those who moved out of the area, who remained unemployed, and who were generally unresponsive to treatment were single, separated, or divorced. Thanks largely to the efforts of the disablement resettlement officer, about half the number remained in employment. In between relapses many families lived near-normal lives for the first time in years, and members of the primary groups involved knew that a relapse was likely to be short-lived because of the help readily available. The following figures give some indication of the work done in the field: personal interview 100%; group-counselling was carried out in 50 cases; visits were made to all those who had homes and to 75% of those who were resident in lodgings and hostels; referrals were made to other social services in 75%; most important of all, casework for prolonged periods was undertaken with 29 families, and at the time of writing this was continuing for 20. Information has come from a variety of sources about 17 drifters, but of subjects available in the first 100 it is remarkable that only three have been hostile and uncooperative throughout.

It is difficult to convey in these figures the overall beneficial effects of the community-care work. In a special exercise in February 1965 we calculated the total months of follow-up of the 100 patients after discharge from first admission, and the total months that they had been known with certainty to be entirely abstinent, including readmissions. The first of these figures came to 2,416 months and the second to 716 (30%). Even this cautious estimate gives some indication of the benefit conferred on alcoholics and others involved, particularly children. The effects of an alcoholic parent on the lives of his or her children cause us great concern, and call for extensive investigation. Not least among the reasons for establishing continual supportive care in the community is that in some measure it will restore prospects of normal emotional development for the children involved.

Future Trends

The case load of the community-care team is certain to increase as further cases are discovered. We are not unduly concerned about this, because, first, the social casework load can be shared with many other full-time and part-time social

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workers³; secondly, we anticipate a greater proportion of early cases with better prognosis, a trend which is already noticeable. The problems of alcoholism are unlikely to disappear, but no doubt the situation would change rapidly if a treatment of the addiction was discovered which would be curative in that it would restore a normal pattern of drinking.

It can be argued that the community-care programme should, ideally, be provided by the family doctor, whose modern role is outlined in the Annis Gillie report.⁴ During the years surveyed we were far removed from the fully integrated health and welfare services envisaged in the Porritt Report.⁵ The organization of social work in general practice is only now receiving adequate attention.⁶ The general medical services that are based on self-referral by a cooperative patient are at a disadvantage when trying to deal with alcoholics. Furthermore, there are unlikely to be large numbers of alcoholics in any one practice. Of the 100 patients reviewed five had no general practitioner and the remaining 95 were distributed between 67 family doctors. At the present time we have to accept the necessity for the team to operate from the public health department. The approval of the family doctors, and extremely good liaison with them, is therefore of paramount importance. That we pay more than lip-service to this dictum is supported by the fact that the family doctor was involved in the transaction in 70% of admissions. Nevertheless, it is probable that, in the future, community care of alcoholics and their families will be based on group practices or health centres; but this will have to wait for extensive administrative action leading to integration of the health services and to organization of skilled socio-medical teams based on health centres. We hope that these alternatives may be examined in Cardiff in the next few years.

One of the questions that we have asked ourselves continually is whether the organization we have described could be dupli-

cated in other communities. The means are available in cities where special units for alcoholics are established, but probably not elsewhere. However, modified plans could be run from any large public health department, but it would be wise to seek the aid of the regional special unit even if it is a considerable distance from the department. The success of a venture of this kind depends very much on the enthusiasm and personalities of the key members.

Summary

The community-care services provided for 100 Cardiff alcoholics, including 49 family groups, are described briefly. Patients and their relatives, including children, appreciated the continual support which was so necessary and so freely given. Future trends of this service are discussed, and the suggestion is made that the effect of alcoholism on the children in a family is worthy of study.

We are thankful to many colleagues for their encouragement and assistance: in particular, the social workers and health visitors of the mental health section who work under the enthusiastic leadership of Mr. L. Clutterbuck.

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MEDICAL HISTORY

Cheadle Royal Celebrates its Bicentenary

[FROM A SPECIAL CORRESPONDENT]

*This month Cheadle Royal Hospital celebrates its bicentenary, and Manchester is holding a civic reception on 24 June to commemorate the occasion. As Brockbank has said: "Manchester can justly claim credit for being the first place in England, or indeed anywhere, to have founded a hospital specially for the humane treatment of lunatics, as they were generally called at the time. In the words of those who took this important step in the history of medicine in 1766, their object was 'to provide for these miserable objects being carefully attended and tenderly treated.'"*¹ An account of the progress of this provision over 200 years is printed below.

When the Manchester Lunatic Hospital, the forerunner of Cheadle Royal, was founded in 1766 as an offshoot of the Manchester Royal Infirmary the care of the mentally ill was at its lowest ebb in Great Britain, as in most other countries. In a contemporary pamphlet explaining their plans for admitting "*Poor Lunatics as In-patients*," the Trustees of Manchester Infirmary pointed out that there were only three public foundations for them in the kingdom—"to wit, the Hospital of Bedlam, and that of St. Luke's, both in our great Metropolis, together with one at Newcastle upon Tyne."

When the Manchester Royal Infirmary was established in 1752 it expressly barred "Persons disordered in their Senses." They were, however, treated as outpatients, and, as there was a constant demand for admission, the Infirmary Board at its meeting in 1763 struck out of its rules the reference to "Persons disordered in their Senses," agreed that "all Lunatics may be consistently admitted as In-patients," and opened a subscription for the building of a ward to receive them. It was to consist of two wings to be added to the Infirmary building, at that

time in Piccadilly, Manchester, at a cost of £1,500. It is an interesting reflection that we have only recently returned to the idea that psychiatric wards should be attached to general hospitals.

By the spring of 1766 the new hospital was completed, furnished, and equipped, and from its origin to the present day the psychiatric patients have benefited from the connexion with the Royal Infirmary. The Infirmary itself assured its in-patients that they might expect "the greatest civility and attention from the Apothecary, the Matron, the Nurses, and every other person employed by the Charity," whose intention it was that they should have "every comfort that their situation could reasonably require."

The rules of the Lunatic Hospital, as it was called, laid down that its patients were to be treated "with all tenderness and indulgence compatible with the steady and effectual government of them," and an early rule enjoined that "no Stripes or Beatings, no Coercions whatever more than what is necessary to restrain the Furious from hurting themselves or others shall