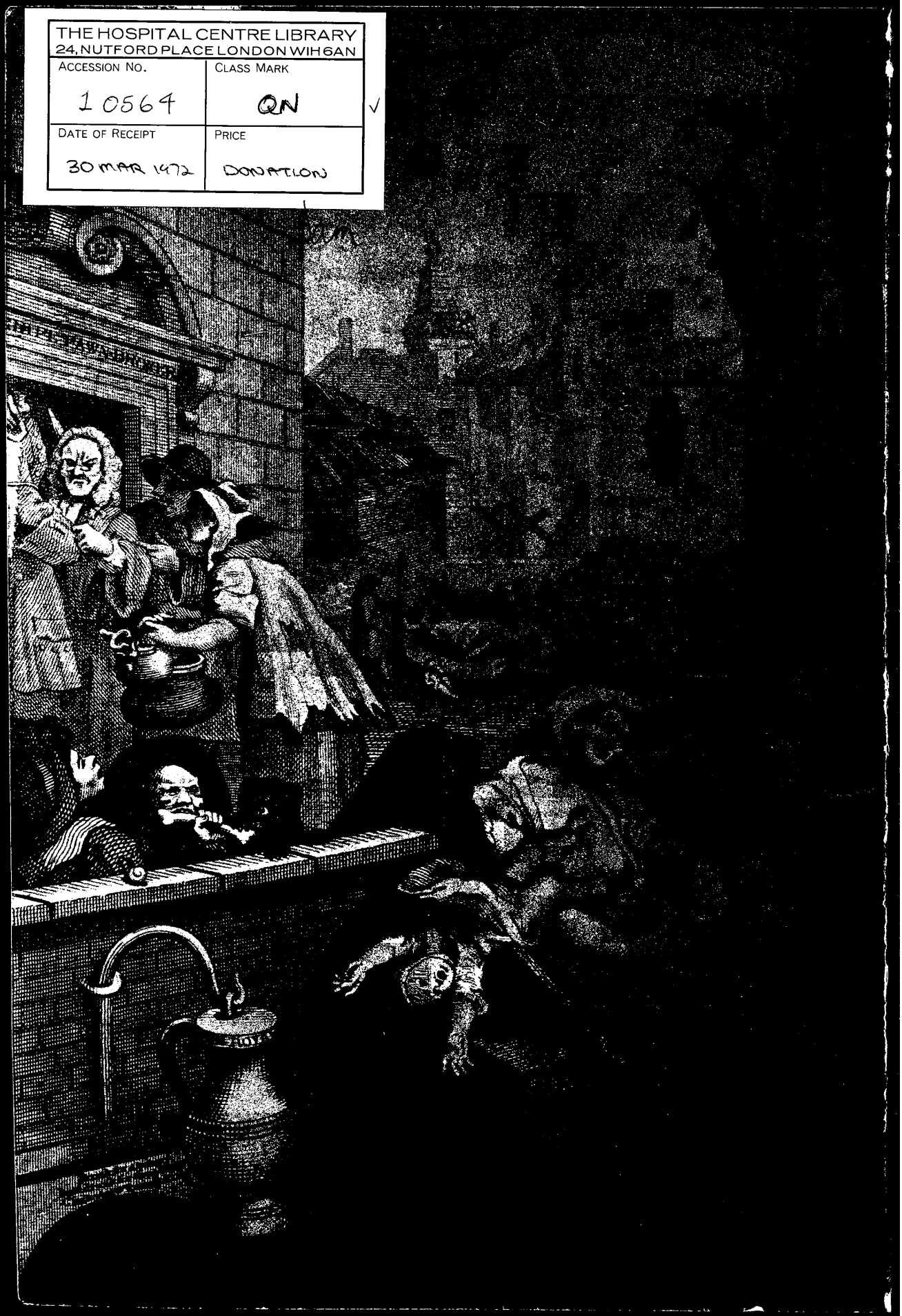
ALCOHOL AND DRUG DEPENDENCE-
TREATMENT AND REHABILITATION



ALCOHOL AND DRUG DEPENDENCE-TREATMENT AND REHABILITATION

KING EDWARD'S HOSPITAL FUND FOR LONDON

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ALCOHOL AND DRUG DEPENDENCE – TREATMENT AND REHABILITATION

A report correlating therapeutic principles with planning and design of facilities for the treatment of alcohol and drug dependence

by
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Foreword by M M Glatt MD MRCP FRCPsych DPM

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FOREWORD

The Secretary of State for Social Services has announced his intention to make £2 million available for improving facilities for the treatment of alcoholics. It is appropriate that this report has been written by a team of workers from Pinel House, the alcoholic unit at Warlingham Park Hospital. Pinel House, the first unit of its kind in this country, was opened almost 20 years ago and its work has continued, without interruption, to the present day.

Another reason for welcoming the report is the fact that, since most publicity in the field of addiction is directed towards 'drug' dependence, people may fail to realise, not only that alcohol is itself a potentially dangerous drug, but also that alcoholism is the most prevalent form of drug dependence in the country.

A World Health Organization Expert Committee, convened in 1967 to deal with 'Services for the Prevention and Treatment of Dependence on Alcohol and Other Drugs', recommended to member nations that alcoholism and other drug dependence should, in spite of certain important differences, be dealt with as basically one problem. This so-called 'combined approach' — a better term might, perhaps, be 'coordinated' — has since been adopted in many other places; and a few units in this country, in fact, deal with both alcoholism and drug dependence. The concept of combined treatment is discussed in the present report and the authors suggest that a joint alcohol and drug dependence treatment unit (ADD), set in the context of the district general hospital and supporting community services, could well be the ideal, both psychologically and economically.

Because there are many possible causes of alcoholism it is clear that no single method of treatment can be the best for each and every alcoholic. What seems necessary is that after detoxification and assessment of the factors applying to the individual patient, a comprehensive therapeutic approach is taken. Group therapy, conducted within a therapeutic community, is regarded by many observers as the most promising form of treatment and it is on this principle that the proposed ADD units are, or will be, functioning, under the direction of an interdisciplinary therapeutic team.

The three authors of this report can look back on considerable experience, gained mainly in connection with their own work in, and in association with, the alcoholic unit at Warlingham Park Hospital. They have also studied other facilities in this country and abroad, and describe some of these in the report. One is the unit at the Royal Edinburgh Hospital — the first custom-built alcoholic unit in Scotland — where the functional relationships were found to be similar to those at the Warlingham unit, modified by the fact that the Scottish unit is set in a teaching hospital. This might, to some extent, explain its better staff/patient ratio. (Many English alcoholic units are labouring under a limited staff/patient ratio, which is to be regretted, in spite of the positive aspect of the need for the patients themselves to contribute to the running and organisation of the unit, a point referred to in the report.) The authors also describe briefly some American treatment centres in the District of Columbia and in North Carolina, including a detoxification centre in Washington DC and, in greater detail, the rehabilitation centre at Butner, North Carolina where, as at Warlingham Park, group psychotherapy is the main treatment used.

Inpatient therapy represents no more than the first step in a long-term rehabilitation programme, and the authors lay stress on the need to provide a comprehensive service, the importance of after-care, and the necessity to include the family in the programme. Treatment results show a better prognosis for alcoholics than is generally assumed. Even so, alcoholism is a progressive illness with high morbidity and mortality rates. Thus, prevention remains an overriding task and the ADD unit must have adequate programmes and facilities for training and research.

May I, in conclusion, be allowed to remark how pleased I am, personally, about the publication of this report from Warlingham Park Hospital. The hospital, under the leadership of the unforgettable Dr T P Rees, pioneered many aspects of the modern approach to mental illness, including the 'open door' policy, the 'permissive' atmosphere, the emphasis on a therapeutic community approach and on group therapy, the role of the nurse as a 'social therapist', the staff's therapeutic role outside the hospital and, among physical methods of treatment, modified electro-convulsive therapy.

What is particularly relevant to the present report is Dr Rees's constant reminder, since the early 1950s, that the inpatient department of a psychiatric hospital is only one of the many links in a comprehensive service and that other departments, situated in the community, would play an increasingly important role, so that one day the psychiatric hospital would be regarded as merely an annexe to the main facilities in the community itself.

In spite of all progress, alcoholism is still a relatively neglected problem. This report, with its review of certain aspects of the work carried out at Warlingham Park; its attempt to correlate therapeutic principles with the planning and designing of new facilities; and in particular its recommendations of what should be done in the future, will undoubtedly prove influential in the planning of services for the alcoholic. King Edward's Hospital Fund for London, which has shown its interest in the problem of alcoholism in many ways over the years, deserves thanks for publishing the report and for making possible the research it describes.

MMG
London
1972

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W Paul James Dip Arch FRIBA is a consultant architect specialising in the planning and design of hospital and health service buildings. He was himself a patient in an alcoholic treatment unit and owes a long period of recovery to the help he received from the treatment course as a hospital inpatient and to the follow-up services provided by the day hospital and Alcoholics Anonymous.

Clifford E Salter MA MB BChir (Cantab) MRCPsych DPM is consultant psychiatrist and clinical tutor at Warlingham Park Hospital, Surrey, in charge of Pinel House, the regional treatment unit for addiction to alcohol and allied drugs of dependence, South West Metropolitan Regional Hospital Board. He is consultant on alcoholism to the Croydon psychiatric services, a member of the executive committee of the Medical Council on Alcoholism, and chairman of the medical committee, National Council on Alcoholism.

H George Thomas MBE RMN has been nurse in charge of the alcoholic unit at Warlingham Park Hospital, now Pinel House, virtually since the unit was established in 1952. He was awarded the MBE in recognition of his work there.

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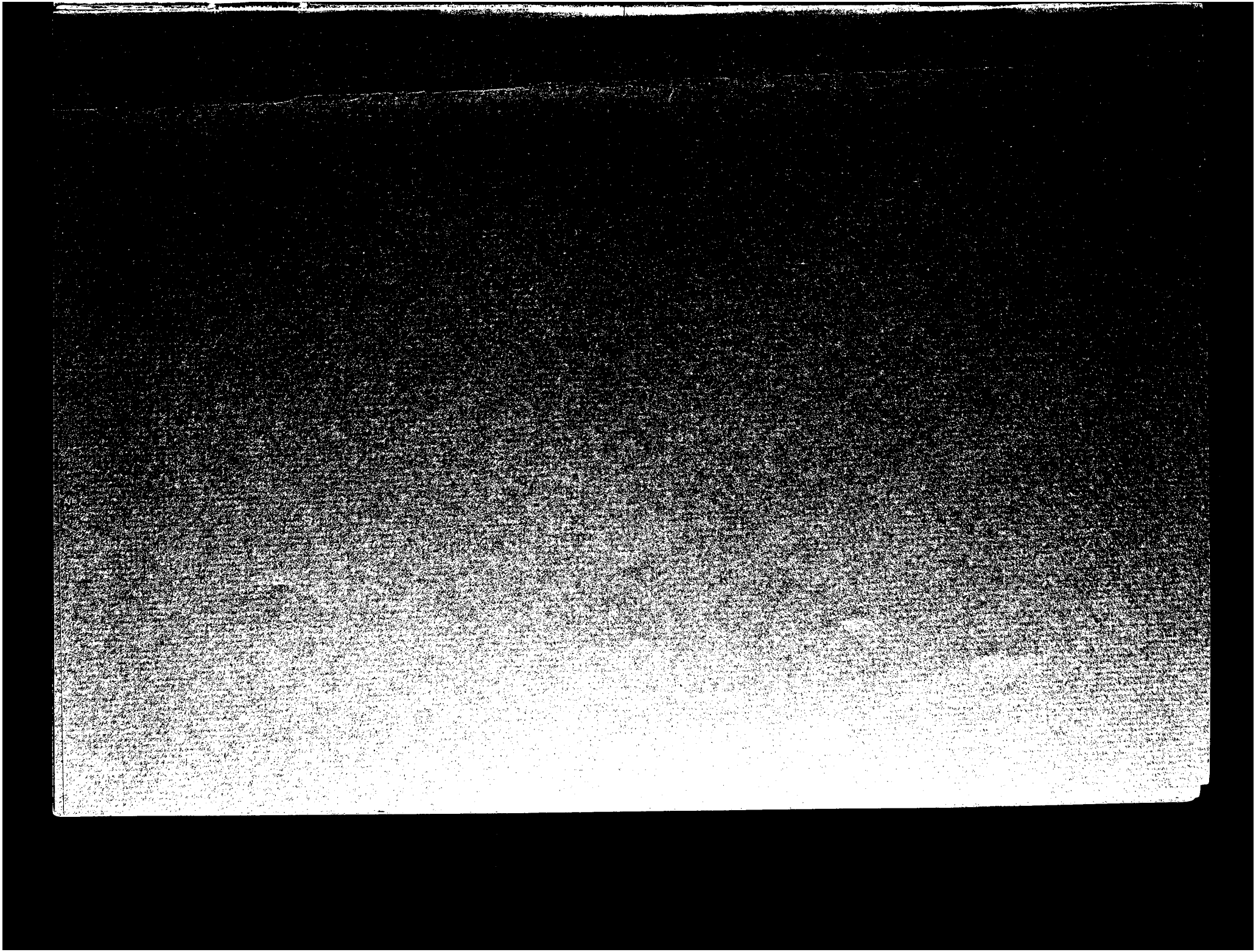


1 PREAMBLE

1 ALCOHOL AND DRUG DEPENDENCE IS AN ILLNESS AND IS AMENABLE TO TREATMENT Before useful comparison of therapies and therapeutic milieux can be made it is essential to clarify the basic concepts and definitions which will be used in this report. The emphasis throughout will be on alcoholism, in so far as most work has been done, and most facilities exist, for this form of drug dependence; but much of what applies theoretically and practically to this illness can be extrapolated to include all dependencies. Where it is possible to indicate that such is the case, the authors have made this clear in the text.

For the purpose of this study, the authors used a brief version of the World Health Organization's 1952 definition of alcoholism (Appendix A) as their term of reference:

> 'Alcoholism is a chronic disorder manifested by repeated drinking in excess of social uses of the community and to such an extent that it constantly interferes with health and social and economic functioning'.

Narrower and more restrictive definitions do not seem to prove useful clinically, and this definition helps to avoid useless discussion about so-called borderline cases of heavy drinking supposedly *en route* to alcoholism, and those equally supposedly (over-hopefully) thought to be not yet dependent. The definition implies:

a that the disorder is an illness
b that it is beyond the control of the individual

After all, no one would choose to drink in this way unless he were forced to, or 'not in his right mind'. In other words, either physical or psychological dependence, or both, make it clear that we are dealing with an illness and not sin, vice or lack of character.

The authors take the view that there is a broad spectrum of personality disorder ranging from the very minor to major disruptions of integrity accompanying all cases of drug dependence — that such personality disorders should be viewed as a kind of sickness, since there is precious little, if any, choice for the sufferer to change his deviant behaviour unaided; and that such disorders are, in fact, amenable to psychiatric, medical, social and spiritual therapies.

Much of what follows has been published in various papers (Glatt[3-15, 33, 34], Rathod[32], Kessel and Walton[26]), but clearly it will be useful to summarise these findings as a background to the present research.

2 THE SIZE OF THE PROBLEM The psychological consequences of acute intoxication are, of course, a part of most people's experience. The connection between a large number of clinical states and the excessive consumption of alcohol has, in addition, long been part of every clinician's awareness. Such things as vitamin deficiences, chronic gastritis, portal cirrhosis and polyneuritis are familiar states. In addition, the more obvious psychological consequences are part of common clinical experience, namely, such things as morbid jealousy, delirium tremens, alcoholic hallucinosis, Korsakov's psychosis and Wernicke's encephalopathy. These are, nevertheless, merely the complications of a much larger problem — alcohol addiction — which has only attracted professional attention in more recent years. In fact, the alcohol addict is commonly not recognised as such for many years. After all, alcohol is a readily available, socially sanctioned means of reducing tension. As a result, the family endures tremendous emotional and material suffering before the diagnosis is eventually made. It was estimated by WHO, using the Jellinek formula[25] based on deaths due to cirrhosis,

that in England and Wales in 1951 there were 1100 alcoholic addicts per 100 000 adult population. This works out to approximately 350 000 alcoholics. More recent studies, including one field study by Moss and Beresford Davies, all tend to support this as a realistic figure.[27]

On the other hand, Dr Parr's survey among general practitioners in 1956, in which he asked GPs for numbers of alcoholics on their lists, led to a total figure of approximately 35 000.[29] It has become clear that the difference in these figures can be attributed to two main factors: firstly, the alcoholic tends to seek help from agencies other than his GP; and, secondly, it is still true to say that most practitioners are only aware of chronic alcoholics with secondary complications because they are not always familiar with the early symptoms.

Why does not the alcoholic seek help earlier when he is (secretly) aware of the disaster it produces? Firstly, he shares society's attitude to himself, that is, a moralistic one. Admitting to being an alcoholic is for him an admission of sin, vice, or lack of character, rather than a compulsion or a disease. Fear of the truth increases his conflict and leads to increased drinking. The drinking leads to behavioural abnormalities which, in turn, lead to increasing anxiety, guilt, depression and isolation, until the cause and effect of continuous drinking become the same. The final link in a vicious circle is completed. His thinking and behaviour are ruled by forces that distort normal, intelligent processes, and he is unable to make any decisions about taking action concerning himself. Secondly, his drinking pattern may be in the form of periodic bouts with intervals of relatively 'social' drinking leading to the false belief that he can still control his alcoholic intake. Thirdly, many doctors have, until now, approached the alcoholic as an undesirable outcast with only nuisance value. It is hardly surprising that, if he seeks help, it is often from other agencies.

Examination of recent trends suggests that more young alcoholics are seeking help for their alcoholism. Also, the proportion of female alcoholics appears to be on the increase. These changes probably only reflect changing social attitudes: alcoholism is becoming more widely accepted as a disease as a result of educational and propaganda programmes in the papers, radio, television and public lectures. It has become less shameful to admit to having a drinking problem: it is also more widely known that help is available from a number of quarters. Early diagnosis is clearly desirable to prevent both medical and socio-economic considerations from becoming difficult or impossible to treat.

3 **DIAGNOSIS AND BEHAVIOUR PATTERNS** How then is diagnosis established? In the first place, information must be collected, not only from the patient, but from the family, friends, and other involved agencies. Getting a reliable history requires patience and an understanding, enquiring approach with an intimate knowledge of the types of problem which are likely to be encountered, both by the patient and the family. Ideally, the family doctor should be the person in the best position to do this, though, for the reasons already given, he is often the last person to be consulted. Even when he is consulted, the alcoholic seldom presents with drinking as the problem, and may even deny it when asked directly. He may present with anxiety, depression, insomnia and various physical complaints, the commonest of which is some form of indigestion. From a psychological point of view, he may come with marital problems, express paranoid ideas, be suffering from hallucinosis, or complain bitterly of chronic tension, feeling 'different from other people', 'being afraid of going mad'. The first encounter with the GP may even be a suicide attempt.

Instead of the patient coming, the family may consult the GP for their bad nerves, or consult various voluntary agencies. Sometimes they are direct and frank about the problem, but very often even the relatives take a long time to come out with it. Mental welfare officers and psychiatric social workers are often the first point of contact with the family seeking an escape route from their terrible predicament.

Direct enquiry into the drinking pattern is particularly useful in differentiating between compulsive and heavy social drinking. Firstly, of course, the frequency and consumption progressively increase. This may be an insidious process, though sometimes it is very rapid and the compulsive nature of the drinking is evident from the beginning.

Drinking occurs when it is unnecessary by social standards. Instead of enjoying and savouring his drinks, the alcoholic tends to gulp them. He begins to take several before going to social events. He starts asking himself, 'Where is the next drink coming from?' He will plan his day so as to be near public houses when they are open, or arrange for other sources of supply. He will choose occupations which lend themselves to drinking. Without drink for any length of time he becomes miserable, irritable, restless and feels unbearably tense. In time, he may develop the 'shakes' on waking in the morning and be unable to face the day, or work efficiently, without several drinks. By the time his drinking has reached this stage, he will justify and rationalise it. He says such things as 'It's for my sinuses', 'It's my indigestion', 'It's good for my circulation', 'My doctor told me I was anaemic' or other similar excuses. If he has not already done so, he will change to stronger beverages, and in time begins to be hazy after drinking bouts, and eventually he will experience the characteristic, so-called 'alcoholic blackouts'. In these, there is complete amnesia for the period of drinking which may be for as little as one evening, or as long as several weeks. In the latter case, the patient may go on an extensive fugue. The episode may at times assume medico-legal importance because the alcoholic frequently appears 'normal', seldom 'drunk', in the amnesic period.

He will start building up stores in various places and taking drink home on every available opportunity. He will go to greater and greater lengths to hide his stock of supplies. Instead of boasting about his ability to hold vast quantities of drink as he used to do, he will minimise to a ridiculous degree the amount he drinks. The 'dry' periods of the periodic drinker get shorter and shorter. Remorse follows each bout and he gives promises he cannot keep. His tolerance for alcohol diminishes and he neglects his food and appearance. Concern for the welfare of the family fades, and may disappear altogether, and eventually the spouse may live in constant fear of not knowing what next to expect. The children may appear frightened, or show signs of anxiety or behaviour disorder which, if left untreated, may lead to personality and dependence problems arising in the next generation, and so on. Wives frequently describe the personalities of their alcoholic husbands as 'like Jekyll and Hyde'. Aggressive outbursts are by no means constant features of alcoholism, but can be very prominent in some cases. Verbal aggression is more common than frank brutalisation. The patient's amiable social front is frequently in sharp contrast to his behaviour at home with the family. Eventually, he may get into debt and start pawning or selling his home. Petty crimes may start, leading to greater offences, but always with one aim in view: maintaining the source of supply. The majority of car-driving alcoholics often drive when seriously drunk. Indeed, this one aspect of behaviour may be an early diagnostic pointer to addiction. The craving outweighs all the possible physical and legal consequences, of which he is well aware.

Clearly, not all those features described occur in chronological order; nor do they all occur in any one patient, but a combination of two or three of these factors is really all that is needed to establish the diagnosis. (See Appendix B.)

4 MANAGEMENT OF ALCOHOLICS Firstly, it is important to remember that advice and threats never make a patient stop drinking. Emphasising the terrible complications (including death) which arise from the illness increases the fear he already has and usually leads to renewed drinking. The alcoholic immediately lines his adviser up with the rest of the world in failing to grasp the fundamental difficulty, namely, that hitherto alcohol has been the solution to his problems.

In the second place, it is important never to take the alcoholic at face value. The addiction leads to a state of mind in which the making of excuses, justification and convenient rationalisation come as natural as breathing. The alcoholic always respects the man who sees through the excuses and helps him to face up to himself, providing the approach is frank, friendly and understanding. Helping someone not to deceive himself is not the same thing as disbelieving. Much of what appears to be conscious dissembling is, in fact, unconscious, and the patient is genuinely unaware of the manipulative purpose of his words and deeds with their object of secondary gratification through drink.

Thirdly, it is always important to be alive to the fact that although sedatives and tranquillisers are sometimes helpful in times of stress and crisis, all drugs should be used

sparingly, but preferably never. There is always the risk of producing drug dependence instead of, or in addition to, the alcoholism. Indeed, the personality difficulties of drug addicts and alcoholics can be very similar.

Lastly, and perhaps most important of all, it is imperative to remember that, once alcoholism has been diagnosed, the patient can never drink again, even in small amounts, without great danger of relapse. In fact, it is true to say that relapse is only one drink away.

5 TREATMENT AND REHABILITATION So much for the basic attitudes. What about more positive action? As soon as alcoholism is detected the patient should be persuaded to see a specialist and advised to enter hospital. In any case, he must be put in touch with his local AA group.* It is important, too, to remember from the start that alcoholism is a family disease, and the wife or husband of the alcoholic is going to need support and help, not only in understanding the spouse and the illness itself, but in coming to terms with their own personality difficulties. The relatives' attitudes to alcoholism nearly always need examination and an attempt usually has to be made to change them to more helpful attitudes. One of the most valuable ways of doing this is to encourage relatives to join the family groups known as Alanon, the parallel organisation of AA for the help of the relatives of alcoholics.

Another thing to realise is that the patient's treatment enters a new phase when he leaves hospital. He has only been put on the road to recovery at this stage. When he leaves the hospital he is no longer sheltered and can no longer fly back to alcohol without grave risk. He has, therefore, to practise dealing with problems realistically in a world which is not always going to be tolerant and understanding. It is vital, therefore, for the patient to continue with regular AA contact.

He will encounter some problems for the first time ever when he comes home: for example, the wife may find it difficult to shed responsibility to which she has become accustomed. In addition, she cannot suddenly change pity and/or disgust to affection. The patient may often expect otherwise. He has a need to be accepted whole-heartedly as though very little has happened. It is not surprising, however, that the spouse remains for some time suspicious of the newly-attained sobriety and fears that, as in the past, promises will inevitably be broken. Most patients resent this lack of trust bitterly. Sometimes, the personality disturbance in the spouse is sufficiently great to warrant group treatment in his or her own right, away and above that which can be offered by Alanon. Some treatment units run such groups for the relatives of alcoholics.

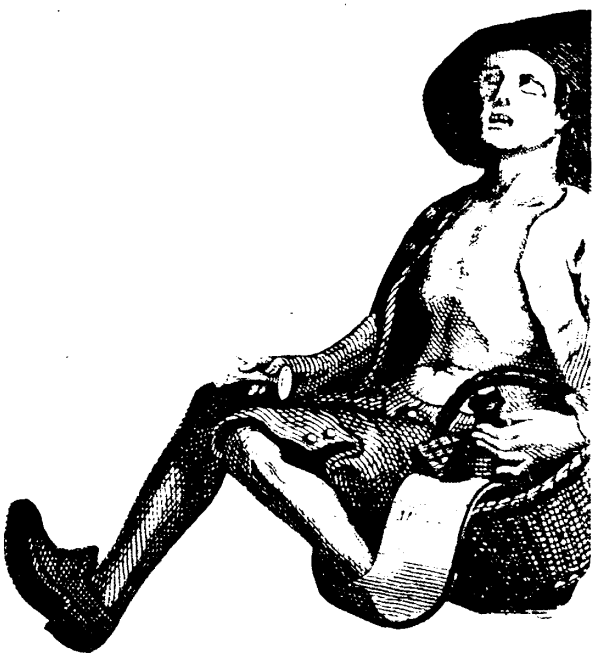
6 ALCOHOLISM IS A FAMILY ILLNESS Wives of alcoholics quite often have unusual personalities. Many of them have had alcoholic fathers or other key figures with the same problem. Most of them are aware when they marry that the husband has a drinking problem. They initially seem to enjoy trying to manage, mother, and control him. Their need to dominate seems matched by the patient's need to depend. The patient's alcoholism has often masked, and been the solution to, psychosexual difficulties and conflicts and those of aggression. These problems will have to be met when the alcoholic is 'dry'. In fact, some spouses say that they prefer a 'wet' alcoholic to a 'dry' one.

All this underlines the importance of after-care. Friendly counsel and guidance are needed both by the patient and his family. The first year is the most crucial. Most relapses occur then. Follow-up seems to have indicated that if the patient remains dry for two years there is greater likelihood of his still being dry by the end of a five-year period.[32,36]

Clearly, the handling of an alcoholic and his family may be, and often is, very trying and demanding of resources. Nevertheless, it can be fascinating and very rewarding. The family doctor plays an important part in the treatment of an alcoholic but, however great his concern, the attention he can give to each individual is necessarily limited and

* The address of Alcoholics Anonymous Central Service Office will be found in the list in Appendix D.

must fall far short of the patient's need. This underlines once again the tremendous importance of the help and support alcoholics receive from psychiatric social workers, district psychiatric nurses and voluntary agencies, and, perhaps more important than any of these, from the fellowship of AA.



2 DEVELOPMENT OF TREATMENT FACILITIES IN THE NATIONAL HEALTH SERVICE

7 **HISTORICAL OUTLINE** The viewpoint of the voluntary agencies concerning alcoholism has always been in advance of that of the medical profession. Surprisingly, perhaps, William Booth, founder of The Salvation Army, was among the first to recognise the condition as an illness. Even though for many years alcoholism has been officially recognised internationally as an illness, individual doctors have either been slow to accept this, or have not been sufficiently aware of the facts of the addiction to ensure their giving correct advice and adequate treatment. Indeed, most of the stimulus for research has come from the voluntary bodies (Appendix D), including AA, apart from a small, select and very dedicated band of doctors from many different disciplines – though principally from within the psychiatric field. The impoverished alcoholic, in particular, was without help until recent years. It has always been possible to secure so-called 'cures' privately (or to escape public acknowledgement), and much wealth has been spent in various 'drying out' procedures at private clinics. Some of these clinics have used, in addition, various physical methods of treatment including Apomorphine, Emetine, Antabuse, or the more complicated desensitisation techniques of the behaviour therapies, not with outstanding success. Hypnotherapy is used in some clinics with benefit for a very few patients. Individual psychotherapy (including psychoanalytic procedures) has contributed very little towards aiding recovery of the alcoholic.

8 **WARLINGHAM PARK HOSPITAL** The first treatment centre for alcoholics in the National Health Service was started at Warlingham Park in 1952 through the drive and initiative of Dr Max M Glatt, and the present structure of the unit evolved over the years from that experimental project. Whereas every kind of physical as well as psychological treatment was used in those early days, it gradually became apparent that the successes in treatment were principally due to group processes. A follow-up study over a two-year period by Rathod, Gregory, Blows and Thomas shows an approximate 45 per cent recovery rate.[32] This compares very well with the more usual figures one gets with other methods of treating alcoholics. Of the remainder, approximately half get worse and half stay unchanged. The traditional pessimism about alcoholics seems, therefore, not to be justified. After all, these figures compare very well, not only with other alcoholic treatments, but with the treatment of other psychiatric disorders. As a result, the present unit uses group psychotherapy as the therapeutic instrument, and very little else. In order to make the service comprehensive, physical treatments are available when necessary in the general psychiatric part of the hospital.[36]

In Section 5, page 49 of this report, the authors deal at length with the group method used here and suggest the positive indicators emerging from the concept of the 'inward' therapeutic community from a staffing and design viewpoint.

9 **ALCOHOL DEPENDENCE TREATMENT UNITS** Since 1962, it has been the policy of the former Ministry of Health (now the Department of Health and Social Security) to encourage each hospital regional board to provide at least one special unit for the treatment of alcoholism.[20] At the end of 1969 in England and Wales there were 13* official units (Appendix C), many of them modelled to some extent on the unit at Warlingham Park, although each in its way developing different cultures. While the authors admire the early initiative shown by the Ministry in encouraging the setting up of treatment units on a national scale, they are, nevertheless, concerned to note the number of areas still without adequate treatment facilities.[36] Significantly, and to its credit, the South West Metropolitan Regional Hospital Board, which administers Warlingham Park

* By 1971 there were 22 treatment units in the UK.

Hospital, has set up two official units which, together with two unofficial units, make a total of four units serving a population of 3.2 million! Treatment facilities exist in certain postgraduate, university and teaching hospitals – notably in Edinburgh.

Otherwise, such facilities as there are for inpatient treatment are private. The debt owed by society to the voluntary agencies, such as AA, The National Council on Alcoholism, The Medical Council on Alcoholism Limited, the Carter Foundation, The Calix Society and many others*, is incalculable and without them the inadequacies of the NHS services would be even more glaring. Inadequate facilities and lack of response to earlier advice resulted in another Ministry circular (May 1968) addressed to regional hospital boards, reaffirming the need for more units for treatment and for after-care hostels for recovered alcoholics returning to the community.[21]

10 DRUG DEPENDENCE TREATMENT UNITS At the time of the study there appeared to be two main bodies of authoritative opinion on problems of addiction: specialists in the field of alcoholism; and specialists in what has become known as addiction to 'hard drugs' – heroin and cocaine. There is some overlap in these two fields in that many psychiatrists dealing with 'hard drug' addiction were formerly interested in alcoholics, and specialists in alcoholism have some knowledge of, or interest in, 'hard drug' addicts. Indeed, most authorities agree that the two problems are not distinct, certainly not dissimilar, and, indeed, have much that is basically in common. Whereas the treatment of the physically dependent aspects of these disorders may differ, the psychiatric aspects are so alike that it is becoming more widespread to consider the two problems as simply special facets of a single problem – drug dependence – a view supported by the later publication of WHO (Appendix A). Whilst the newly created so-called 'drug addiction treatment centres' attached to teaching hospitals are meeting some of the needs engendered by the increasing numbers of hard drug addicts, it is already apparent that the main function of these centres to date has been to identify, restrict and maintain the addict, rather than effect any kind of recovery. It is the view of the authors and other authorities that recovery from any addiction, whether it be to alcohol or to other drugs, can only be achieved by total withdrawal, and that this can often only be realised during inpatient treatment. Further, it is generally accepted that treatment has little chance of success without primary motivation; that is, the patient's conviction that he wishes to stop using the drug of choice.

Some experience has been obtained of attempting to treat young, hard drug addicts in groups as inpatients; for example, at St Bernard's Hospital, Southall, Middlesex; at the Salter Unit, Cane Hill Hospital, Coulsdon, Surrey, now closed; and at The Bethlem Royal and Maudsley Hospitals. On the other hand, it is agreed by some authorities that the young, well-motivated addict can sometimes be helped to recover in the setting of an alcoholic unit, where the population is normally of middle to late middle age and where the generally more mature patients give a relatively stable matrix for the more grossly disturbed young drug addicts.

11 THE HOSPITAL PLAN The majority of treatment centres are at present located in area psychiatric hospitals which are geographically isolated from the community they serve. This fact has been recognised in the forming of official building policy which envisages acute psychiatric treatment facilities being provided as part of the new district general hospitals. This facilitates inpatient treatment in circumstances which preserve contact with the community and help to provide continuity of care in a follow-up service based on the day hospital concept, the local authority services and the general practitioner. Official policy goes on to predict the progressive 'run down' and eventual closure of the old area psychiatric hospitals as the new psychiatric units are built, and as the day hospitals and rehabilitation services of the local authorities are developed.[19]

The future of the existing special units is obscure. Vague reference to units being provided in annexes to certain of the larger psychiatric units have appeared in unpublished policy documents. The authors have had the opportunity of discussing these problems with official bodies responsible for planning, but such policies as exist are still under review.

* See Appendix D.

In Section 5 of this report the authors develop the concept of the combined alcohol and drug dependence unit (ADD unit) which would be added to the psychiatric unit in certain district general hospitals, supported by, and closely linked to a pattern of after-care services in the community, and suggest how a rationalised service can be provided within the National Health Service.

3 STUDIES OF TWO EXISTING TREATMENT FACILITIES IN THE UNITED KINGDOM

Centres now providing facilities for the treatment of alcoholics and, in certain cases where the problem exists, for the treatment of a limited number of hard drug addicts, are listed in Appendix C. The policies, programmes and staffing structures of these centres are broadly similar and are based to a varying extent on those developed at the pioneer centre started at Warlingham Park Hospital in 1952. The authors decided, therefore, that the facilities now existing at Warlingham required detailed investigation.

In Scotland, a new treatment centre had opened at the Royal Edinburgh Hospital under the direction of Dr Henry Walton, a leading authority on alcoholism.[26] Although this unit had been in operation for less than two years when the authors visited (compared with over 18 years in the case of the Warlingham unit), its unique teaching hospital setting, generous staffing, intensive treatment programme and 'custom-built' environment merited special study and provided useful comparison with the regional service centres 'south of the border'.

12 PINEL HOUSE – REGIONAL TREATMENT UNIT FOR ADDICTION TO ALCOHOL AND ALLIED DRUGS OF DEPENDENCE

CATCHMENT AREA

Patients are accepted from a catchment area covering officially those areas of Greater London served by the South West Metropolitan Regional Hospital Board (except Lambeth, Tooting and Mitcham which form part of the catchment area of the alcoholic unit at West Park Hospital which, in addition, serves Surrey) together with the whole of the London Borough of Croydon. The area represents about a million people or, approximately, 7000 alcoholics. In addition, patients are referred to Pinel House by the Royal Air Force (from Wroughton Hospital, principally, although occasionally there are direct referrals from other RAF hospitals). Selected patients may be accepted by special arrangement from other areas if facilities are unobtainable there.

RELATIONSHIP TO HEALTH SERVICES IN THE AREA

Illustration 1 on page 23, shows the then existing relationship of the treatment unit to the 'district general hospital' (Mayday, Purley, Croydon General, Waddon and Queen's hospitals), the area psychiatric hospital (Warlingham Park Hospital), the Croydon local authority mental health services (Rees House) and the general practitioner and other referral agencies.

When Warlingham Park Hospital ceases to be the centre of the psychiatric inpatient service and the acute and sub-acute beds are replaced by a new psychiatric unit at the newly-sited, custom-built district general hospital (Mayday Hospital) – in line with current official planning policy – a new alcohol dependency treatment unit will need to be provided as part of the psychiatric unit. It can be seen that a new unit at the (new) 'Mayday' would strengthen the links with the day hospital and community services. (See also Section 5.)

EDUCATION AND RESEARCH

The educational function has tended to increase in a formal way. Until 1964, it showed itself in private research projects (for example, follow-up study[32]), inservice training of registrars rotating every six months, self-training by experience of senior staff, visits from professional and voluntary organisations all over the world.

Since then there has been a gradual blossoming of educational function due to the influence of the present consultant. There are now, in addition:

inservice training of staff nurses (rotating every six months)

observation of groups by student nurses (two weeks in rotation)

inservice training in group methods for qualified psychologists (part-time)

inservice training in group methods for social workers (several weeks)

inservice training in group methods for probationer clinical psychologists (several weeks)

observation by Richmond Fellowship trainees, St Luke's and St Mary's House trainees, voluntary organisations, visitors from other hospitals (from one day to several weeks)

visits by medical students from the Royal Hospital of Saint Bartholomew, London, (three visits minimum in two weeks)

visits by theology trainees in pastoral counselling and human relationships (several weeks)

visits by occupational therapy students (one day)

formal lectures to nurses and occupational therapists

public lecturing to various community organisations

distribution to all visitors of information on treatment methods and the metapsychology of the unit*

Research has been held back by increased demands on the service, and by lack of staff. Such research as there is at the present time is privately undertaken and sponsored, and not part of an integrated policy. There is such a policy, but there is just not the time – nor the resources – to put it into effect.

REFERRAL

Referral is commonly by general practitioner to a special outpatient clinic sited in the local authority building, Rees House, which also forms the hospital's centre for community psychiatry. Some patients are seen in the psychiatric outpatient clinic at Mayday Hospital when waiting lists for the special clinic get too full. On the whole, patients are seen separately in the special clinic for a number of reasons:

many are unreliable and do not turn up – thus wasting valuable general psychiatric outpatient time

some arrive sufficiently under the influence of alcohol to make history-taking prolonged and laborious

some are so ill as to be unable to give a proper history, or to be in need of urgent admission to hospital

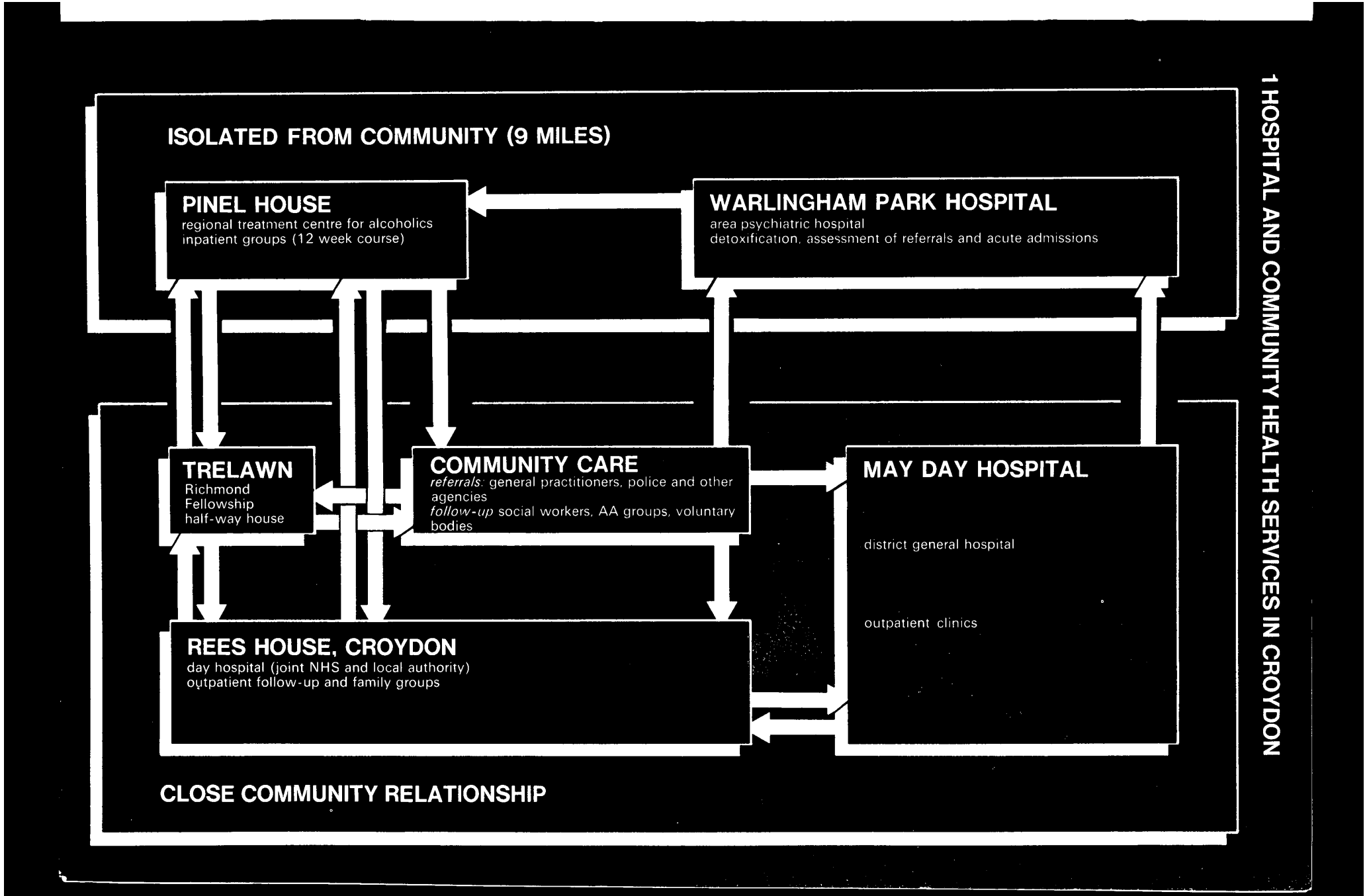
some arrive with a relative or friend as requested, others do not

All these factors make it impossible to predict the form of any particular clinic and may interfere seriously with any appointments system in a general hospital outpatient department.

Some patients come as direct referrals from voluntary agencies or even by self-referral. A first consultation with the GP is encouraged; but the unit sees many patients who do not have a GP or who have long since been removed from his list due to their past nuisance value or lack of cooperation. Every effort is made to gain the confidence of the patient so that he will allow contact with a GP at a later date. (This can assist the educational function of the unit in informing those practitioners who have little experience of alcoholism as an illness which has treatment and recovery prospects.)

Some patients are referred by way of a domiciliary consultation; others by internal referral within the psychiatric hospital teams or the group complex of general hospitals. Referrals from the RAF Hospital, Wroughton, are usually dealt with via the outpatient

* A brochure presenting these ideas in a way readily understood by intending patients is reprinted as Appendix E.


ISOLATED FROM COMMUNITY (9 MILES)
PINEL HOUSE
regional treatment centre for alcoholics
inpatient groups (12 week course)
WARLINGHAM PARK HOSPITAL
area psychiatric hospital
detoxification, assessment of referrals and acute admissions
TRELAWN
Richmond
Fellowship
half-way house
COMMUNITY CARE
referrals: general practitioners, police and other agencies
follow-up social workers, AA groups, voluntary bodies
MAY DAY HOSPITAL
district general hospital
outpatient clinics
REES HOUSE, CROYDON
day hospital (joint NHS and local authority)
outpatient follow-up and family groups
CLOSE COMMUNITY RELATIONSHIP
1 HOSPITAL AND COMMUNITY HEALTH SERVICES IN CROYDON

clinic but can be admitted for assessment in Warlingham Park Hospital. Transfers from other hospitals in the region are sometimes effected in this way, rather than by outpatient referral, when the problem is urgent.

Some flexibility of catchment area is allowed and cooperation exists from other units which are not too far away if the unit is full and has a temporary bed crisis. Some patients are taken from outside the South West Metropolitan Regional Hospital Board's designated catchment area for special reasons; for example, the patients are themselves doctors, clergy or other well-known professional people living in areas near their local unit; or patients in need of an intensive group psychoanalytic procedure which they cannot get in any other way. All these exceptions to the rule are, of course, a matter for personal arrangement with the consultant-in-charge and are allowed for in the regional board's policy note on catchment areas for the alcoholic units in their region.

DETOXIFICATION

Most patients seen in the outpatient clinics are still drinking – some are dry and are no problem in relation to admission which is then automatically direct to the special unit, provided they fulfil the necessary criteria.

Drinking alcoholics may still be admitted direct to Pinel House, but when the patient is obviously very ill physically or is known to have drunk over 1½ bottles of spirit daily (especially without food), he will first be admitted to the main hospital for detoxification and, if necessary, further assessment later as to motivation for group therapy.

On the whole, detoxification seems to proceed more smoothly in the alcoholic unit with group support, than in the main hospital. On the other hand, where there is a risk of DTs and/or withdrawal fits, nursing services have to be provided twenty-four hours a day. As there is only one visit in the night by the night superintendent to Pinel House, such people must perforce be dried out in an admission ward. Transfer to the alcoholic unit is as swift as circumstances allow.

ASSESSMENT

Assessment consists of a very full, detailed history based on the scheme used routinely at the Maudsley Hospital, Denmark Hill, London, with an additional section dealing specifically with the progress of the actual drinking pattern. Part of the interview is given over to a semi-therapeutic type approach to get a subjective estimate of motivation and suitability of group method. (This is followed up later by objective measurement with psychological tests.) A near relative or friend is also interviewed to increase the reliability of the information and, wherever possible, to get over the concept that alcoholism is a *family* illness needing their help, and, that in some cases, the close relative or friend needs to be involved in a treatment plan of his own.

The manifold purposes of assessment can be listed as follows:

to confirm the diagnosis

to be sure that the alcoholism is not (as far as can be detected) a symptom of another psychiatric disorder

to ensure that the patient accepts the diagnosis and recognises the implication that he must give up drink for the rest of his life, and can never drink socially again

to see whether he recognises that he is extremely unlikely ever to be able to give up drinking unaided

to assess the best method likely to help him achieve his resolve to gain sobriety (including, possibly, inpatient group therapy)

to advise on the best method of treatment and/or management of the condition (both the patient and nearest relative or friend are involved in this discussion)

to advise, in any case, involvement with AA, Alanon or Alateen*, as appropriate, and to

* **A voluntary self-help service for teenagers in 'alcoholic families', similar to AA and Alanon. (Originating in the US, this movement has not yet become widespread in this country.)**

give an open invitation to seek help again if the patient refuses help at the moment; and if, for the time being, inpatient treatment is not advised, to make the same recommendations and to offer outpatient follow-up appointments, or an open invitation to re-apply later.

TREATMENT

Treatment is in the main by group psychotherapy for patients admitted to Pinel House (groups 1 and 2). Inpatient treatment usually lasts a minimum of 12 weeks, although this period can be extended in certain cases. On completion of inpatient treatment, the recommended period for attendance at weekly outpatient sessions is from one to two years (groups 3 and 4). Relatives are helped with outpatient psychotherapy (group 5). In the main hospital there is a mixed bag of those refractory patients who just come in and out of hospital for detoxification and are lacking motivation; patients awaiting assessment; and patients of good motivation 'drying out' after a relapse (group 6). Patients who start in this group often go on to further help in Pinel House. Antabuse, Apomorphine, Emetine, behavioural deconditioning procedures, hypnotherapy, have seldom been found of much long-term value in helping any of the alcoholics seen in the unit. Indeed, reliance on them as crutches hinders involvement in group processes and seems mainly to lead to worse results than insight therapy alone. LSD abreaction has a limited use and seems to help those younger, more disturbed, personalities with large areas of total amnesia in childhood and infancy, or those with marked obsessional traits, provided always that they are at the same time in a group experience and feed back to the group their self-discovery as revealed in the individual relationship with the psychiatrist. In practice, this process is very difficult and has led to many difficult group rivalries and subgroupings, although individuals have, in fact, apparently been relieved of conflict to such a degree that their personalities have blossomed out of all recognition. At present, attempts are being made to plan such treatment, if it continues at all, as a staff group activity, thus removing, it is to be hoped, most of the harmful effects of gratification of the need for attention from a particular individual.

REHABILITATION

Rehabilitation goes hand-in-glove with treatment as the term is used here to include not only occupational placement, but also social and spiritual reawakening. It includes marital guidance, involvement in a totally new type of community commitment, resumption of religious activities where these have been abandoned, and so on. For those without friends, families or homes, residence at a halfway house run jointly by the hospital and the Richmond Fellowship and largely subsidised by the local authorities — Croydon in particular — is offered, subject to approval by the warden and residents. Out of 15 places, ten are subsidised for former Croydon residents and up to two extra places may be provided for recovered drug addicts in special circumstances.

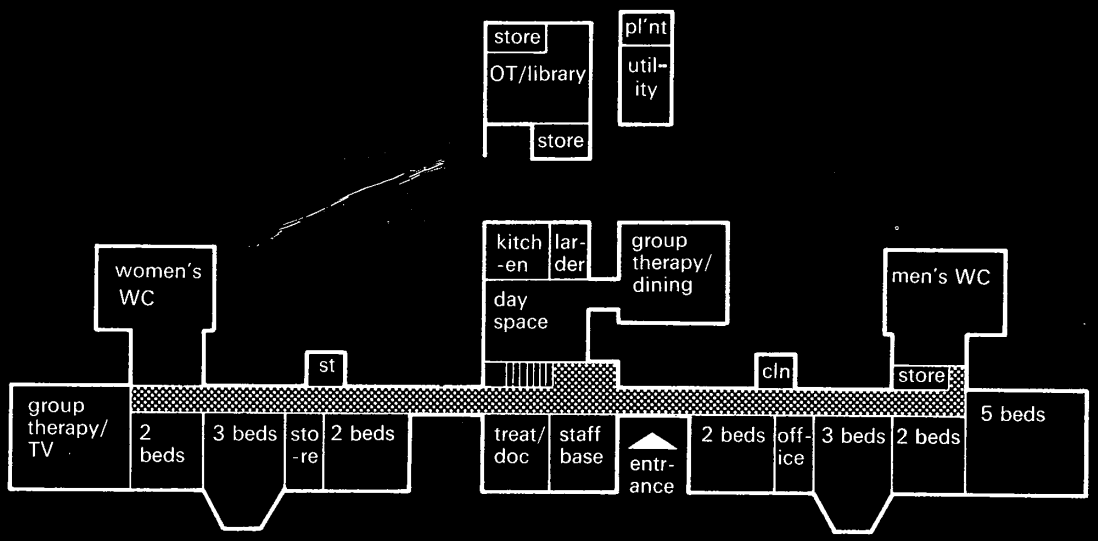
All patients on discharge are advised to attend weekly follow-up groups (groups 3 and 4) for from one to two years, and at least one AA meeting weekly.

STAFFING STRUCTURE

The staff team consists of consultant psychiatrist (six sessions), registrar (three sessions), senior psychologist, senior psychiatric social worker, hospital chaplain (psychotherapist), charge nurse and staff nurse. The post of registrar is a rotating training post and falls vacant every six months. The senior psychiatric social worker and charge nurse are full-time posts. The senior psychologist and hospital chaplain give four sessions each, by tradition, but not by official establishment. The staff nurse is a recently created inservice training post, rotating every six months, leading to the award of a postgraduate hospital certificate on satisfactory completion.

It has been found that the full treatment programme can only be carried out when all staff are working, leaving virtually no time for special research. At holiday time, and when staff are sick, considerable inroads are made on the 'free time' of the remaining

2 PINEL HOUSE (FLOOR PLAN)



staff. Geographic separation of nine miles between outpatient and inpatient services adds to the difficulties and time is wasted, travelling from one to the other.

The highly-skilled nature of the group programme prevents ready substitution by locums or 'covering' by staff trained in general psychiatry. Transfer of the unit to the district hospital would obviate some of these difficulties and, in addition, would have the advantage that when a patient is seen for the first time as an outpatient or inpatient he or she can be shown over the unit, thus helping to dispel misgivings as to the nature of the place.

Experience of running the unit with a comparatively small staff has highlighted the importance of the positive part the patients themselves can play in their own treatment, particularly in group life. One group therapy session a week is conducted by the patients without staff attendance. Control of admission to ensure that at least 50 per cent of the group at any one time have completed half the basic treatment programme (three months) helps to build up a constructive element in the group which makes the group process work with minimum staff supervision or guidance. This fact, combined with the method of selecting and appointing leaders, enables the group to be completely self-sufficient as regards domestic work in the unit (all cleaning, bed-making, transport arrangements and serving of meals is done by the patients themselves). Even more significant from the staffing aspect is the fact that Pinel House is not staffed at night. A single visit from the night superintendent (on duty at the main hospital building), who receives a routine report from the group leader and who is on call if required in an emergency, is all that is needed in the way of staff cover at night.

FUNCTION AND DESIGN

Experience at Pinel House suggests that the major hazard in undermining a successful group experience is the danger of subgrouping; this latter, in its turn, inevitably leads to a conspiracy of silence (either conscious or unconscious) and effectively removes those involved from the treatment process, unless interpretation can reveal the underlying 'transference' needs and allow the patient to 'work through' them in the proper setting, thus preventing continued 'acting-out' or 'acting-in'.[35] Figures show a 100 per cent relapse rate for one or both of the parties in a two-person subgroup, and much personal unhappiness for the other, if not relapse.

The unit is housed in an existing two-storey pavilion, originally designed as the isolation unit of the old mental institution. The accommodation consists of a number of small rooms and spaces arranged in a linear form mainly on one side of a single corridor, as shown in Illustration 2 on page 27. It has become obvious that the fragmented layout of the converted building, if it does not exactly encourage subgroups, does nothing to make it easier to prevent their formation. Clearly, a structure which can reflect the inward-looking process of group psychotherapy and actively discourage, or even prevent, escape from group life with the opportunity for working through of new insights in the new 'family' settings, is highly to be desired. Such a structure cannot, of course, force group involvement, but it can avoid absolute ignorance by staff and patients alike of significant developing subgroupings and give the opportunity for their being discussed openly, rather than being allowed to be disruptive and destructive through sheer lack of knowledge of their existence. (See Section 5.)

The unit provides inpatient accommodation for from 17 to 19 men and from three to five women in dormitories containing from two to five beds. Dining and recreation space is adequate and is multi-purpose in that the group therapy sessions also take place in this area. The total floor area is approximately 5050 sq ft (470 m^2) giving a gross area per patient of 265 sq ft (25 m^2). Main meals are supplied to the unit from the central kitchen at the main hospital. In addition, a small pantry allows facilities for patients to prepare their own snacks and beverages at any hour of the day or night. (See Appendix F.)

The unit provides a reasonably pleasant environment; however, lofty ceiling heights, 'hospital type' fittings, furniture and finishes all contribute to the preservation of the institutional character of the original building. The ceiling heights and unnecessarily

elongated plan with its high ratio of external wall-to-floor area must result in high running and maintenance costs when compared with a purpose-designed unit of similar floor area.

13 ROYAL EDINBURGH AND ASSOCIATED HOSPITALS UNIT FOR THE TREATMENT OF ALCOHOLISM

RELATIONSHIP TO HEALTH SERVICES IN THE AREA

Though the details of the interconnections with the remainder of the hospital service vary somewhat here compared with the situation in Croydon, the basic relationships are similar, albeit modified by the teaching hospital nature of the unit setting. Most mental hospitals have, by tradition, attempted treatment of alcoholics, much as an obligation.

The Royal Edinburgh Hospital has been specially associated with the treatment of alcoholics for over a hundred years. The institution, originally known as the 'Mad House', became the 'Lunatic Asylum' and finally the 'Hospital'. It has always been a pioneer hospital in many ways – for instance, voluntary admissions were taken 30 years before the law made this a generally applicable procedure. The hospital was the first, too, to give nurses formal lectures on mental illness.

On the site known as Jordanburn, alcoholics were treated and the new unit is now to be found here. (A hundred years ago 30 per cent of the men and 18 per cent of the women admitted were alcoholics!) The Nuffield Provincial Hospitals Trust financed this, the first custom-built alcoholic unit in Scotland, and Dr Henry Walton was the first consultant. The unit was conceived as part of the acute admission unit (Andrew Duncan Clinic) and there is some interchange of staff, especially at student nurse level.

EDUCATION AND RESEARCH

The unit provides inservice training for a registrar (full-time), two medical students (part-time), two staff nurses, one enrolled nurse, one post-registration student nurse (in rotation), and one staff nurse and one SEN on night duty. At the time of the study there was one student nurse undertaking the advanced course in psychiatric treatment methods and group dynamics. Eventually it is hoped that this experimental course, run jointly with Dingleton Hospital, Melrose, will be officially recognised. At the time the authors visited, secondment had to be on staff nurses' salary, although it was felt that such an appointment should be aimed at 'Salmon' No 7 grade[22], and this had led to difficulties in recruitment.

The consultant director, the registrar and a full-time research assistant are able to fulfil the research function of the unit, especially as the staffing arrangements at other levels and ancillary grades are very adequate (see Staffing Structure, page 32).

REFERRAL

Referral to the unit is primarily from the general practitioner to an outpatient assessment clinic where a decision is made as to whether to help the patient as an outpatient or an inpatient. Other referrals are principally via the admission unit (Andrew Duncan Clinic) when an emergency situation has arisen.

DETOXIFICATION AND ASSESSMENT

Detoxification can take place in the admission unit or the alcoholic unit itself, according to availability of rooms. Assessment is felt to continue throughout the six weeks period of inpatient treatment and not to be an isolated event which takes place in the outpatient clinic.

TREATMENT

The inpatient unit comprises 18 beds for both men and women, of which six are usually reserved for 'drying out' purposes only. The other 12 beds are for patients who are considered to have a 'neurotic illness' which is amenable to group psychotherapy of a very intensive and almost continuous kind. The large numbers of staff may influence the forms of the group process considerably, as patients and staff are near enough equal in numbers. The length of the inpatient stay in the unit is approximately six weeks.

The morning treatment programme is:

Monday	9	– 9 45 am	staff meeting to discuss patients (doctors, day nurses, night nurses and psychiatric social worker)
	9 45	– 11 am	group psychotherapy (consultant)
	11 am	– 1 pm	ward round during which selected patients are seen by the staff group
Tuesday	9	– 9 30 am	professorial unit staff meeting
	9 30	– 10 am	reporting session
	10	– 11 15 am	group psychotherapy (registrar)
Wednesday and Thursday	9	– 9 30 am	reporting session
	9 30	– 11 am	group psychotherapy (registrar)
	11 am	– 12 30 pm	selected patients seen by the staff group (one nurse stays with the patients, continuing the group discussion)
Friday	same as Wednesday and Thursday except that the consultant is present 11 am – 1 pm		

Afternoon and evening programmes are:

Monday to Friday	occupational therapy between 2 and 4 pm
Monday to Friday	group psychotherapy between 4 and 5 pm conducted by one of the nurses (seven nights a week another session is held by the night nurse at about 9 30 pm)
Saturday and Sunday	7 – 8 30 pm group discussion conducted by a nurse, attended by all inpatients and outpatients waiting for a closed outpatient group, or any outpatient who wishes to attend
Tuesday	2 – 5 pm art group (patients paint something important to them, usually relevant to their alcoholism: 3 30 pm tea break, then a discussion on the paintings from 4 – 5 pm)
Wednesday	3 45 – 5 pm spouses group (conducted by PSW or, in her absence, by a nurse)
Thursday	4 – 5 30 pm spouses group (wives who attend this group have elected to involve themselves more personally in their husbands' treatment and the group is conducted by the PSW)

Visiting hours are from 6 – 8 pm Monday to Friday, and 2 – 5 pm Saturday and Sunday. Nurses talk to patients and their relatives during visiting time in an attempt to help them to look at and modify difficulties in their relationships.

All wives or husbands of patients are interviewed individually either by the PSW or one of the nursing staff.

REHABILITATION

All patients on discharge go into a closed outpatient group of approximately 12 patients, conducted by a psychiatrist. These groups meet for 1½ hours one evening a week. The outpatient group is continued for at least one year. After each session the group has tea with the inpatients, when free discussion is encouraged.

During the hospital stay there is at least one joint interview between the patient, his wife and two members of the staff.

STAFFING STRUCTURE

This is more than adequate (ratio 1 : 1) and although perhaps appropriate in a teaching hospital setting, the authors believe it to be unnecessary at the regional unit level. Not only is it uneconomical, but there is a strong feeling that such numbers may be a distinct disadvantage when the emphasis is on encouraging the patient to assume responsibility for his own health and behaviour. The full complement of staff working in the unit is:

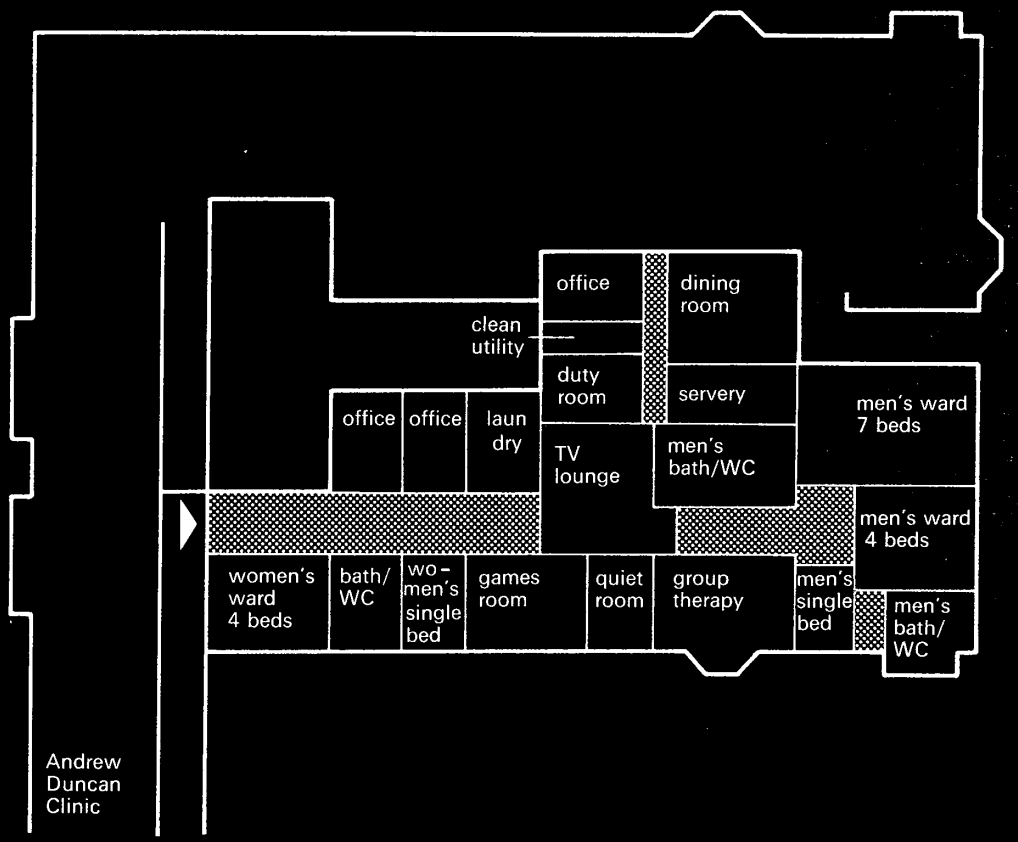
consultant and director of unit
registrar
medical students (two part-time)
research assistant
assistant chief male nurse
ward sister
charge nurse
staff nurse
enrolled nurse
student — advanced course in psychiatric treatment methods and group dynamics
staff nurse — night duty
enrolled nurse — night duty
social worker
secretary
occupational therapist
deputy matron
assistant matron

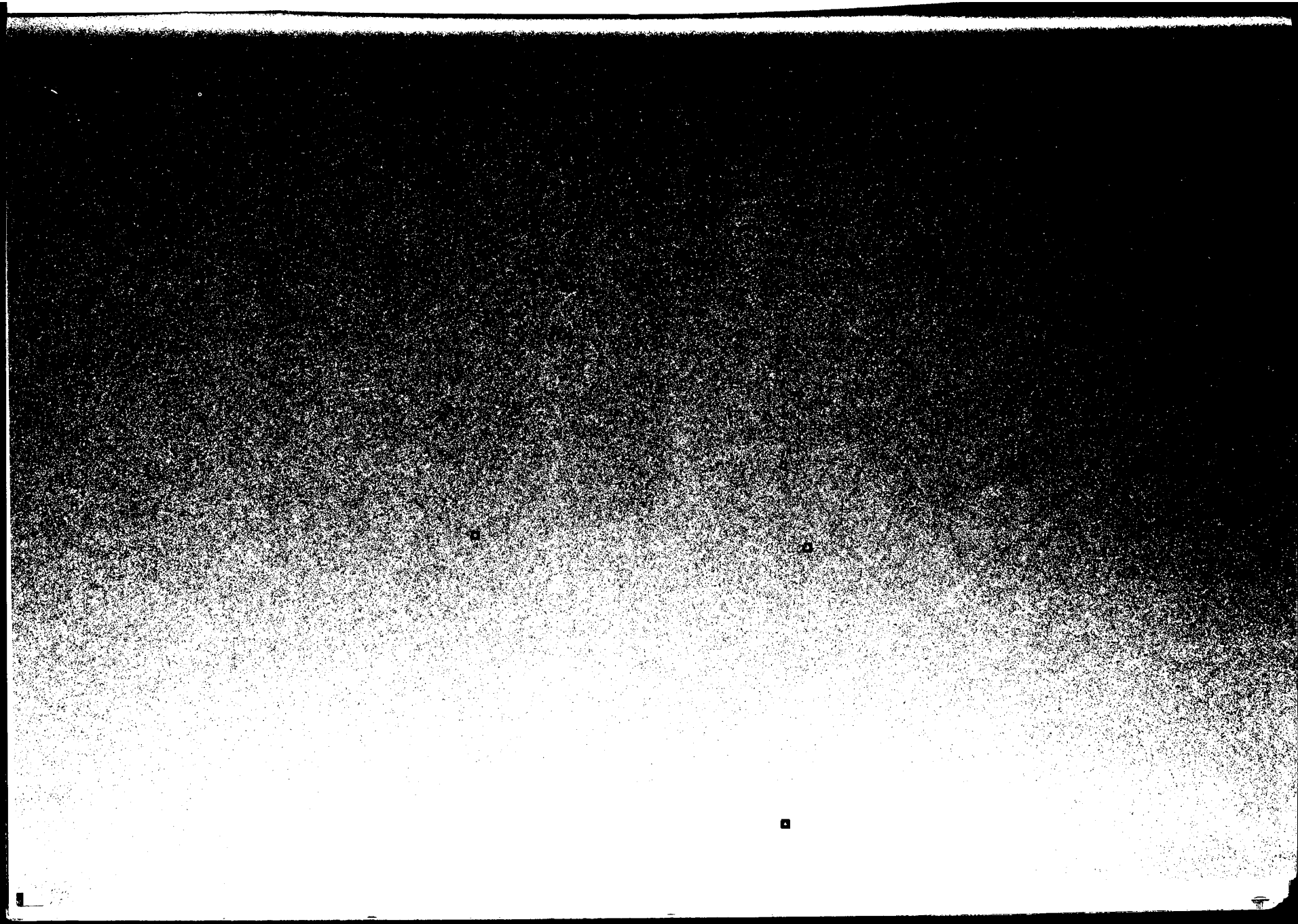
FUNCTION AND DESIGN

The unit is situated in part of the former Jordanburn Hospital and is directly linked to the Andrew Duncan Clinic. A major conversion and extension of the existing structure was carried out in order to provide purpose built accommodation for a total of 18 inpatients (13 men and five women) in single and multi-bed rooms. As Illustration 3 (opposite) shows, the design is compact and a well-placed central lounge provides a focal point controlling access to most of the other rooms in the unit. The arrangement reflects the inward-looking function of group psychotherapy, helps to prevent escape from group life and assists in avoiding the problem of subgrouping. It is a pity, in the authors' view, that this idea could not have been taken a step further by providing the dining and lounge area as one free space, thus ensuring maximum flexibility of use. (See also Section 5.) The high standard of interior design and furnishings helps to offset the fact that the living area is entirely dependent on roof lights for natural light and ventilation. The authors were much impressed with the humane and domestic character of the environment provided in this unit.

The compactness of the plan and the small amount of space wasted on corridors are reflected in the economical floor area — approximately 558 m^2 giving an area per patient of 33 m^2. (See Appendix G.)

3 ROYAL EDINBURGH AND ASSOCIATED HOSPITALS UNIT FOR THE TREATMENT OF ALCOHOLISM (FLOOR PLAN)





PITMAN PRINTER

4 TREATMENT FACILITIES IN THE UNITED STATES OF AMERICA

Before proceeding to conclusions and recommendations regarding the planning of medical services for alcoholics in this country, the authors were anxious to obtain information from abroad and particularly from those countries where the incidence of alcoholism is known to be high. It was felt that a visit to America — birthplace of AA, with an estimated five to eight million alcoholics, and absenteeism in industry due to alcoholism costing the nation $433 million annually[31] — would provide useful comparative data on the provision and effectiveness of treatment services.

Accordingly, two of the authors made an eight-day visit to Washington, DC. Clearly, within the time and resources available, it was not possible to carry out a comprehensive survey of services in America, and the authors confined themselves to the following limited objectives:

to investigate the Federal Government's plans for mental health services, with special reference to alcohol and drug dependence

to view at first hand custom-built treatment centres for alcoholics recently completed in the vicinity of Washington.

14 MENTAL HEALTH SERVICES IN THE USA With no national health service as we know it here, the US Department of Health, Education and Welfare is primarily a Federal Government agency which provides supplementary funds for State health development programmes under the Hill Burton arrangements.*

Health service development policies are generally initiated by the State governments, and their scope and effectiveness can vary considerably from State to State. Programmes are subject to considerable political influences. The Federal agency (Department of Health) vets all proposals from State governments or agencies seeking Federal funds and at the same time provides comprehensive guidance material and research data which seek to influence the way in which the joint finance (State and Federal funds) is used.

In 1963, President Kennedy, in an Act of Congress, drew attention to the inadequacies of the majority of the State institutions for the treatment of mental illness and the lack of community care and follow-up facilities. He recommended a radical reorganisation of mental health services into a new coordinated pattern of care based on the concept of the community mental health centre (CMHC).

15 THE COMMUNITY MENTAL HEALTH CENTERS PROGRAM The task of implementing the CMHC Program and of providing Federal funds for its development is undertaken by the Department of Health assisted by the National Institute of Mental Health, a Federal Government research agency. The NIMH carried out a massive research project aimed at establishing the validity of the CMHC concept, enlisting workers of many disciplines from a number of universities. The results of this work were written up and published in two beautifully produced volumes (production budget alone amounted to $50 000).[38]

Briefly, the CMHC Program envisages the coordination of all mental health services — in particular, outpatient, day-patient, rehabilitation and after-care — from community mental health centres each serving catchment areas of 60 000 to 200 000 population. A number of comprehensive mental health teams — consisting of doctors, nurses,

* The Act of Congress dealing with the planning of hospital and health service buildings.

psychologists, social workers – would look after the total mental health needs of defined sections of the population (up to 60 000) and would be responsible for the care, both in hospital and in the community, of all patients within the teams' allocated sections. In this way, large numbers of patients at present languishing in overcrowded State mental institutions, located in isolated areas, would be treated in the CMHC day hospitals and looked after at home or in community hostels. Similarly, even larger numbers of people adrift in the community and in need of psychiatric treatment, who would in present circumstances inevitably end up permanently in a State mental institution, could seek help earlier in their illness by referral to the CMHC. Among these people are large numbers of alcoholics. Indeed, a San Francisco case study, carried out as part of the NIMH research programme, revealed that readmission rates for alcoholics to State mental hospitals in the San Francisco area amounted to 45 per cent of the total for all other types of mental illness! This staggering total reflects the complete absence of positive programmes for treatment and rehabilitation in existing State institutions.

16 ALCOHOL DEPENDENCE TREATMENT IN RELATION TO THE CMHC CONCEPT The CMHC concept has much to commend it and the authors were particularly impressed with the fact that provision of facilities for the treatment of alcohol and drug dependence, far from being ignored, is a major feature of the programme. (NIMH had formed a National Center for Prevention and Control of Alcoholism advised by a 'visiting scientist' from the UK, Dr Richard Phillipson, an expert on alcohol and drug dependence.[30]) The programme envisages a special team of workers based on a CMHC serving a population of 200 000, engaged whole-time on the care of alcoholics and their families. A number of beds in the inpatient sections of the proposed centres are to be reserved exclusively for alcoholics and the specialised nature of their treatment (group psychotherapy) is recognised, as is the need for adequate follow-up services.

17 TREATMENT CENTRES FOR ALCOHOLISM IN THE DISTRICT OF COLUMBIA The authors were able to take a brief look at the implementation of the CMHC Program in the District of Columbia (population 811 000). Four community health catchment areas have been established with populations varying from 136 000 to 261 000. Each area has a community mental health centre which provides facilities for consultation, emergency treatment (detoxification and withdrawal) and outpatient psychiatric treatment. No extended inpatient treatment (group therapy) of the type offered at Warlingham or Edinburgh is provided at these centres. Extended inpatient facilities are available at a vast (5000 beds) State mental institution at Occoquan, Virginia, (30 miles from the centre of Washington) where over 600 beds are reserved for alcoholics.

The DC Department of Health was the first city health department in the USA to operate a specialised alcoholism treatment facility and it claims to have the largest alcoholism treatment system in America. However, there is evidence that the service is severely strained by having to devote a large part of its resources to dealing with 'drunkenness' due to a change in the law. In 1966, following a case brought by a chronic drunk called DeWitt Easter against the District of Columbia, the US Court of Appeals ruled that alcoholics were sick people and that 'chronic alcoholism is a legal defence against the charge of public intoxication'. Following this ruling, the Washington courts began certifying all drunken offenders as alcoholics (excluding traffic offenders, 50 per cent of all arrests in Washington are for 'public intoxication'), with the result that the area CMHCs and the Occoquan centre were swamped with thousands of people (5000 in four months) 'judged' by the courts to be alcoholics. As has been stated, little can be done medically at the present time for the advanced alcoholic who lacks motivation for recovery, other than purely physical treatments aimed at assisting detoxification and withdrawal. Such advanced cases are often the product of neglect in the past. Referral to AA or other agencies can sometimes produce better results than custodial care in a mental institution.* Over 50 per cent of those admitted to Occoquan were readmissions and a large proportion of these had been sent back to the centre

* Some success with the 'Skid Row' alcoholics problem has been achieved with the Incentive Therapy Program, a form of industrial therapy used at Occoquan.

several times. Fortunately, personal motivation often increased, even in patients needing frequent readmission – with eventual recovery – especially those who involved themselves in the AA programme.

Despite the efforts of a dedicated and experienced staff, it was clear that the task of dealing with the detoxification of a large number of referrals from the courts made it difficult to provide positive treatment programmes for those well-motivated alcoholics who could benefit from group psychotherapy in the setting of a therapeutic community. The environment at Occoquan – massive in scale (the alcoholic unit alone is similar in size to a British general hospital!) and remote from the community – is far removed from that visualised in the planning and architectural programme of the National Institute of Mental Health.[38]

In an effort to relieve the pressure on resources caused by the police referrals, the health authorities are building a number of detoxification centres in Washington. The team visited one of these new centres recently opened at 619 N Street, NW Washington. The 'Detox Center' is the health department's version of the old police 'drunk tank' and consists of a small unit of 50 beds located in 'an area easily available to both patients and police'.

Patients are brought here by the police (50 per cent) or arrive accompanied by a friend, a family member or a member of AA. Each patient is screened by a nurse experienced in working with alcoholics, who checks for physical injuries or problems beyond the scope of the unit. The patient is then given a bath and admitted to a ten-bed acute care area. Medication is given, if necessary, and the patient is kept under observation for up to 12 hours before transfer to a 40-bed self-care area. A physician is always on call and visits the centre daily. The patient stays at the centre for three to five days during which time his illness is explained to him. He is encouraged to go for extended treatment at Occoquan and he is counselled by neighbourhood clergy, social workers and AA.

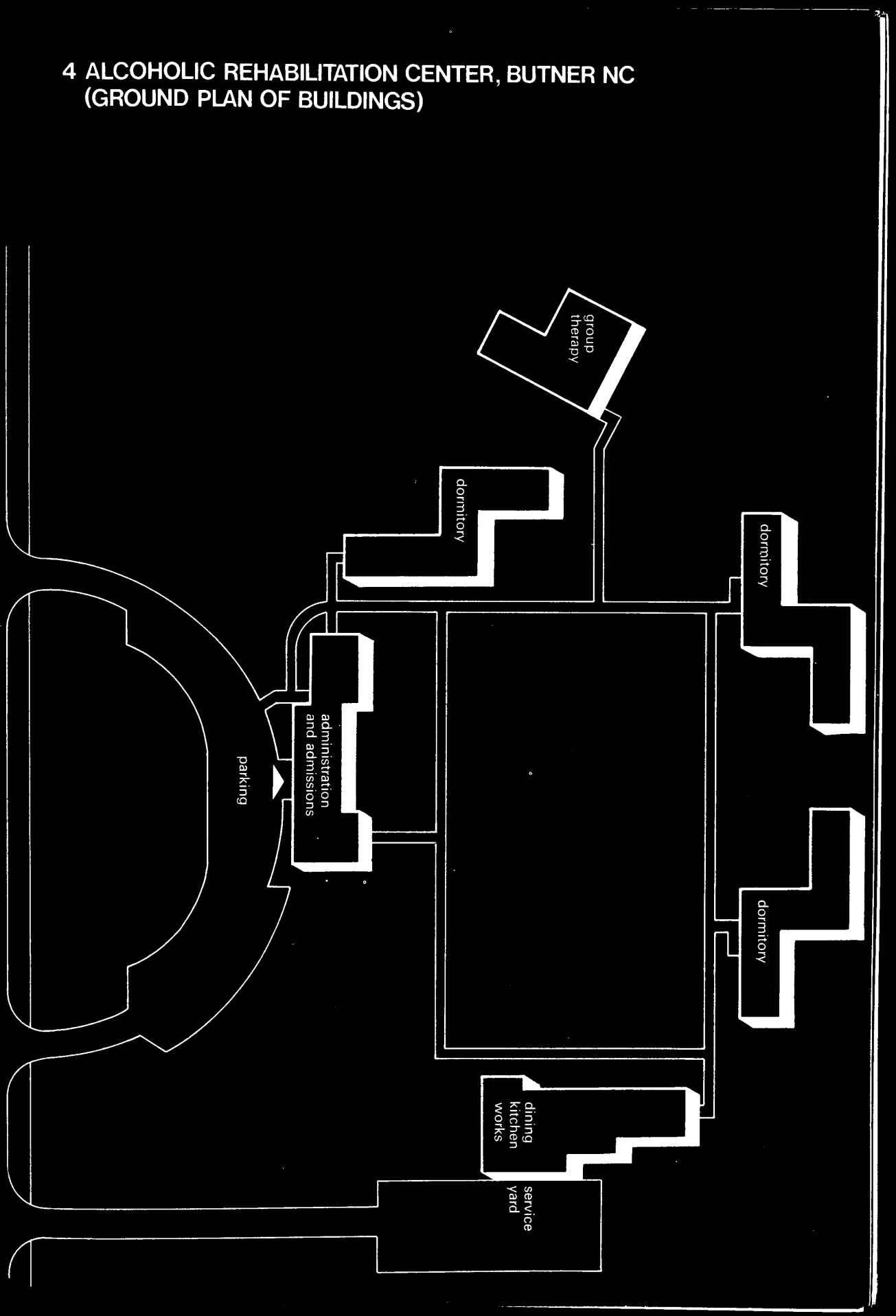
In most cases, he is free to leave the centre after three days (72 hours) and, unfortunately, this can mean the end of the advice and counselling (within 72 hours of a massive drinking session alcoholics are not in a fit state mentally to benefit much from counselling) as the after-care and follow-up services in DC are, admittedly, 'one of the missing links' in the public health service. Nevertheless, the authors were much impressed by the informal and humane environment of the Detox Center and its close contact with the life of the community (situated in downtown Washington opposite a church and next to a brothel). The fact that the staff, of both sexes, under a woman chief nurse of great ability, experience and dedication, have been able to deal with all admissions (600 a month) without once having to call the police, is significant comment on the idea that an alcoholic is a sick person and not a criminal.

18 **ALCOHOLIC REHABILITATION CENTER, BUTNER, NORTH CAROLINA** Instead of concentrating all inpatient treatment facilities in one vast centre, as at Occoquan, the health authorities in North Carolina are carrying out a programme under which a number of smaller self-contained units will be provided throughout the State.

The authors visited the first of these new units at Butner, North Carolina, near Raleigh. In fact, only the buildings (and some of the staff) were new because the unit had been in operation in an old building for 18 years previously.

Group psychotherapy is the main treatment used but groups are 'closed' and last only one month. The fact that each week new admissions constitute a complete new group gives little opportunity for the building up of group 'tradition', and it is difficult to understand how constructive thought and feeling can develop in one or two formal therapy sessions per day over such a short period (with no follow-up groups), particularly as the patients do not necessarily live as a group in the same villa. Experience at Pinel House and Edinburgh suggests that the optimal size of a therapeutic community for alcoholics is around 18 patients. At Butner, there are 90 patients living in three separate villas, each accommodating 30 patients and divided into four groups for group therapy, which tends to become a more formal affair conducted in special accommodation in a

4 ALCOHOLIC REHABILITATION CENTER, BUTNER NC (GROUND PLAN OF BUILDINGS)



separate building some distance from where the patients live.

The treatment programme is:

8 am	breakfast
9 – 10 am	group meeting of all patients in assembly room (films, lectures etc)
10 – 10 30 am	break
10 30 – 11 30 am	group therapy with 'group leader'*
12 noon	lunch
1 15 – 4 15 pm	recreation** – workshop, sports, 'culture' (that is, music, theatre, arts, meal out)
5 pm	supper
6 pm onwards	recreation – 'tailored activities' for individuals

* Equivalent to 'group conductor' in the nomenclature of Foulkes and Anthony.[1]
** Recreational activities must be voluntary according to Federal law. The Center receives a $40 000 Federal grant (for every State dollar there are three Federal dollars).

The formality of the group therapy sessions is further emphasised by the high staff/patient ratio (1:4 compared with 1:8 at Pinel House) and the fact that 'group leaders' are chosen from the staff and not the patients. The full staff establishment is as follows:

psychiatrists	3 (including director with 90 per cent administrative function)
general physician	1
psychologist	1
psychiatric social worker	1
vocational rehabilitation (postgraduate)	4
recreational director (postgraduate occupational therapist)	1
* counsellor	1
business manager	1
** graduate nurses	6 (shift system)
nursing aides	5

* Minister with experience in the alcohol unit in Virginia; not religious counselling.
** All have a general training of four years which includes three months psychiatric experience.

The centre consists of a dispersed group of single storey buildings in a very attractive woodland setting with ample room for future extension within the large site, as Illustration 4 on page 39 shows.

The separate blocks provide a completely self-sufficient hospital complex consisting of dormitory accommodation arranged in three identical units each for 30 patients, a treatment block accommodating 12 rooms of varying sizes for group and individual psychotherapy, a reception and administration block containing admission and assessment facilities for patients as well as office accommodation for the large staff and, finally, a central dining-room, kitchen and stores block. A further block is planned to house the occupational therapy facilities which are at present located in an old building some distance from the centre.

At the time of the authors' visit, the unit had been in operation in the new building for about three weeks and it was difficult to assess how effectively the design was meeting the treatment function. The formalisation and separation of treatment from living space

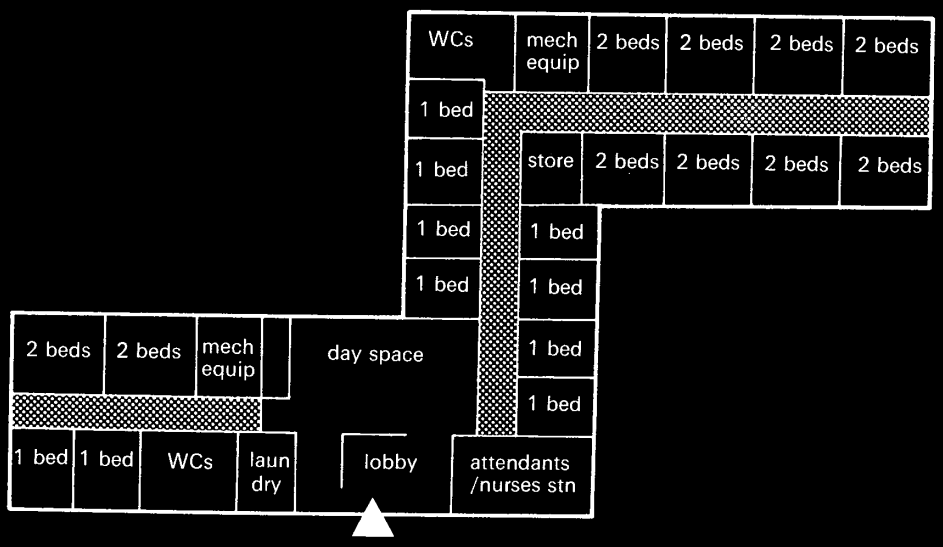
tends to lead to an unnecessarily extravagant duplication of space which is reflected in the fact that the total floor area per patient is in excess of 450 sq ft, 50 per cent more than the area per patient provided in Pinel House, even though this unit, unlike Butner, is providing facilities for outpatients as well as inpatients.

The three dormitory blocks each provide accommodation for 30 patients in ten single-bedded and ten double-bedded rooms; all rooms are equipped with lavatory basin and built-in wardrobes. The central multi-purpose daily-living area is well sited in relation to the bedrooms and staff base and opens on to a paved terrace. See Illustration 5.

The authors consider that these dormitory blocks could provide, each with minimal conversion, ideal units for 20 patients working and living in self-contained 'inward' therapeutic communities on the Pinel House or Edinburgh pattern. The central block of group therapy rooms could then be used for occupational therapy, obviating the need to build any additional facilities.

The environment at Butner is humane and well suited to an inpatient treatment programme. Small, self-contained treatment units could fit in well with a community mental health centre, provided they were properly coordinated with the rest of the mental health services and particularly with after-care and follow-up in the community. Unfortunately, at Butner there is no direct follow-up service of any kind. A recent follow-up survey was severely restricted by the unit's inability to locate ex-patients in the community; only 50 per cent of the sample could be contacted.

5 ALCOHOLIC REHABILITATION CENTER, BUTNER NC (FLOOR PLAN OF DORMITORY)



5 DISCUSSION AND RECOMMENDATIONS

19 INTERRELATIONSHIP OF HEALTH SERVICES IN THE AREA

COORDINATION OF HEALTH SERVICES

In 1968, the then Minister of Health, in his memorandum to Hospital Boards and Local Authorities (HM(68)37), reaffirmed the need for more special units for the treatment of alcohol dependency; and, because it is a chronic relapsing illness, the need for rehabilitation and follow-up services for patients and their families.[21] Attention was also drawn to the need for all branches of the health service to coordinate their efforts and aim to provide a comprehensive service which would include prevention, assessment, treatment and after care. More recently, the Department of Health has given similar advice to public health authorities, in areas where the problem exists, with regard to the setting up of coordinated services for the treatment of drug dependence.

While the authors are in general agreement with the broad policy set out in this memorandum, concern is felt at the lack of specific guidance on how the need for services is to be assessed, or how the need is to be met in terms of facilities; or, indeed, how much money is to be made available for financing the services. Under the present tripartite structure of the health service, these problems are left for the various planning authorities to solve within the total resources made available to each of them, which, in turn, makes the aim of coordination and rationalisation difficult, if not impossible, to achieve. Increasing recognition of this fact must eventually lead to a complete reorganisation of the health services. However, the implementation of radical reform will take time and the authors have, therefore, considered their recommendations in terms of the present organisation in the knowledge that implementation could be made very much easier if, or when, a new integrated structure, such as that proposed in the Consultative Document, is put into effect.[17]

ASSESSMENT OF NEED

The original Ministry of Health memorandum (HM(62)43) recommended that at least one special unit should be provided in each region.[20] The most experienced of the regional boards in this field — the South West Metropolitan — already has two units serving a catchment area of approximately 3.2 million population, both of which now have waiting lists for admission, and the board is considering whether or not more treatment places will be required to meet the future needs of the region. There is a need for studies aimed at assessing precisely how many alcoholics there are in the country and how they are distributed throughout the population. Not enough studies of this kind are on record.[28]

The authors believe that as the population grows more aware of the fact that alcohol dependence is an illness which is amenable to treatment, people who at present suffer in the shadows for social and moralistic reasons, will come forward for treatment in increasing numbers. It would seem, on the limited experience to date, that a reasonable basis for planning would be one special inpatient unit (15-18 beds) per one million population, with corresponding outpatient and follow-up facilities.

THE COMBINED ALCOHOL AND DRUG DEPENDENCE TREATMENT UNIT

The need for treatment facilities for hard drug addiction has been much publicised in recent years. In fact, the incidence of this problem, compared with that of alcoholism, is small and mainly localised in the large conurbations. Much thought has been given to the

idea that, as the psychiatric aspects of alcoholism and hard drug addiction are so alike and the treatment of these aspects is usually the same in both cases (group therapy), the two problems can be conceptualised as special facets of a single, though complex, illness. The conclusion is reached that, if the need can be met by the provision of not more than two places per unit for drug dependence, the ideal setting, both from a psychological and economic point of view, could well be the combined alcohol and drug dependence (ADD) treatment unit.

RELATIONSHIP OF THE ADD UNIT TO HOSPITAL AND LOCAL AUTHORITY SERVICES

Illustration 6 (opposite) shows diagrammatically the suggested relationship of the ADD unit to the psychiatric department of the district general hospital and to the local authority and other services in the area. It can be seen that these suggested relationships are similar to those existing in the Croydon psychiatric service shown in Illustration 1 on page 23, with the important exception that the ADD unit is considered as an annexe to the district general hospital and not to the isolated psychiatric hospital.

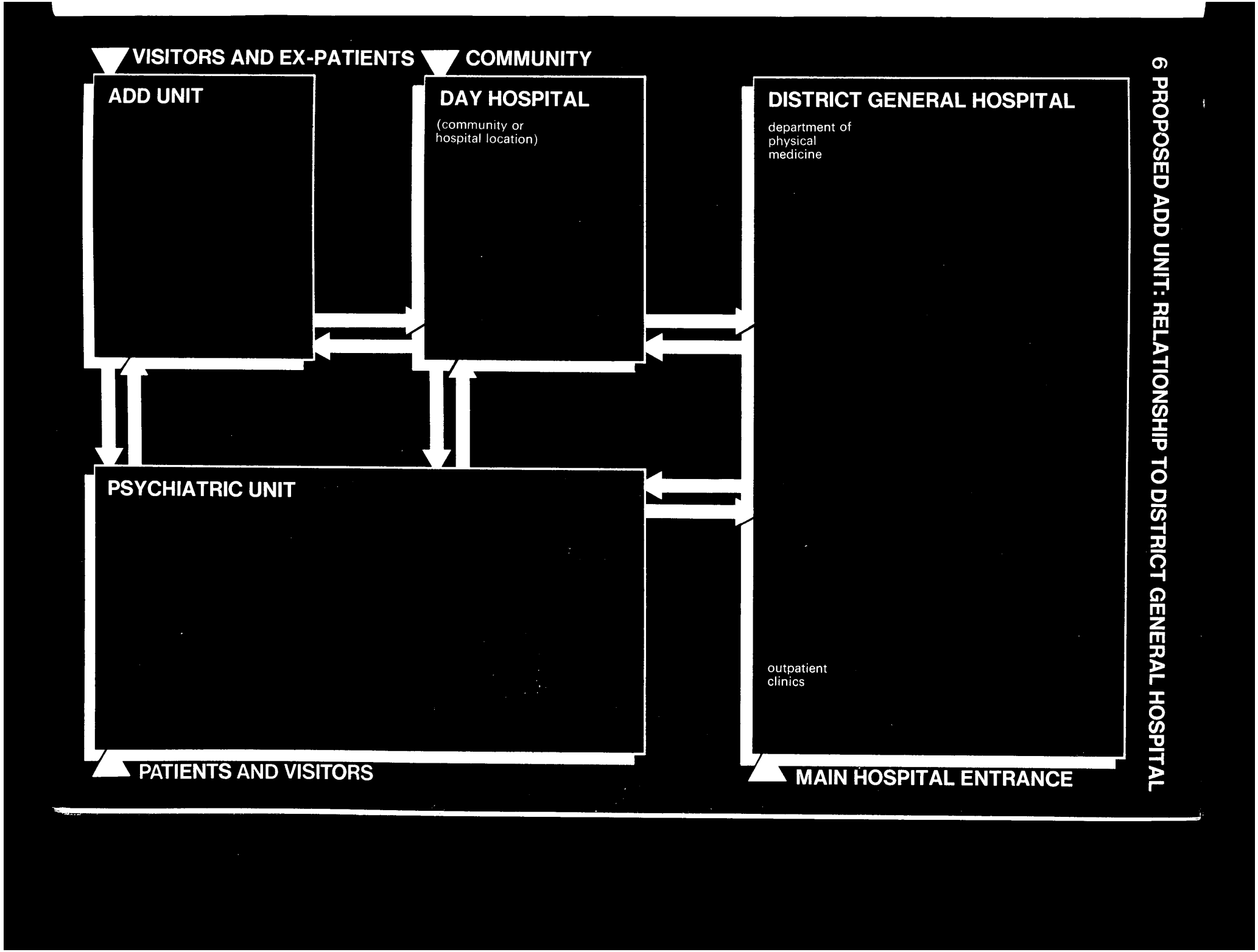
In suggesting that the ADD unit is set in the context of the district general hospital, the authors are assuming that the recent policies forming the basis of the Department of Health's experimental 'best-buy' hospital project will form the future pattern of patient care in the health service.[24] These policies envisage a coordinated health service based on a network of district general hospitals of limited scope and size (serving areas of 180 000 population with 540 acute beds, including 60 for psychiatry) supported by health centres which provide the link between the general practitioners and the hospital.

The more recent Bonham Carter report[16] recommends an altogether different scale — large medical centres serving catchment areas in excess of 300 000 population, each containing more than 1000 beds with psychiatric units of up to 150 beds. This could result, as far as the mental health setting is concerned, in the substitution of one remote institutional environment for another, without careful, highly skilled planning, and unless catchment areas are reasonably confined. Such large centres would suit dense conurbations such as Croydon, but be less suited to other areas.

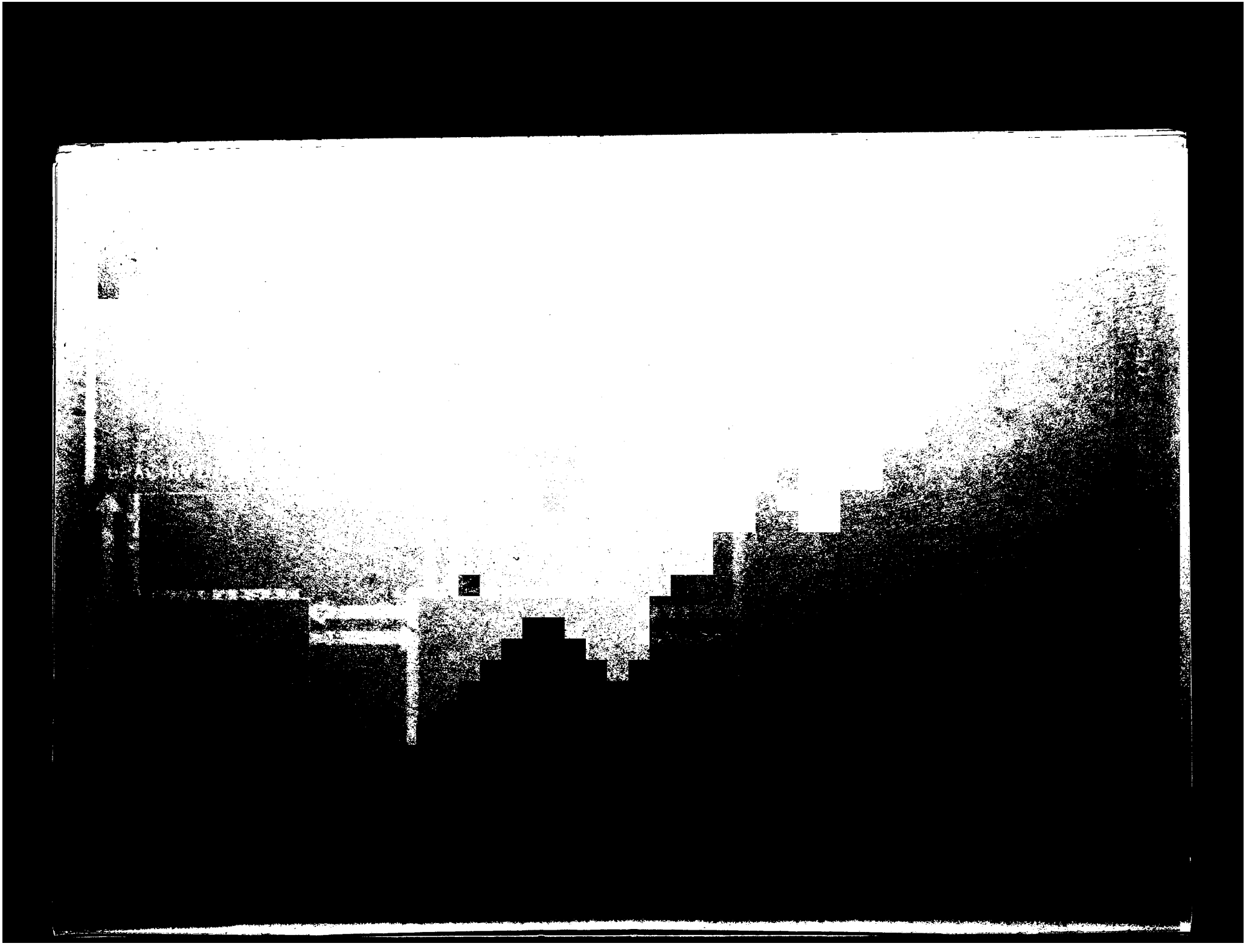
Assuming that the district general hospital is correctly sited in relation to the community it serves, and that all services — general practitioner referrals, hospital admission, detoxification and assessment procedures, treatment programmes, day hospital and half-way house facilities, social work, domestic agencies and voluntary bodies — are effectively coordinated, there is, in the authors' view, a real chance of achieving a rationalised, economical and successful treatment service based on the ADD unit. These coordinated functional relationships are shown in Illustration 7 on page 51.

The number of ADD units required in a region will depend on the size of the catchment area. It is suggested that units are added to certain of the larger psychiatric departments of district general hospitals.

20 EDUCATION AND RESEARCH It is recommended that, in view of the small numbers of units at present operative and since much of the accumulated wisdom over the years has never been written down, all old and new units should have built into their staffing structure adequate training programmes, both inservice and otherwise, for doctors, nurses, psychologists, psychiatric social workers, student nurses, welfare workers, probation officers, and those voluntary services and various religious organisations with approved training schemes of their own. It is vital, too, that each centre should have as a *sine qua non* of its pattern of functioning an inbuilt research function which is part of the culture and tradition of the unit; so much so that it is recognised as an integral part of the treatment programme, thus causing minimal disturbance to the individual or the group as a whole. Perhaps, with so few reliable large-scale statistics, much fact-gathering, especially epidemiological, could be standardised in all units, whilst at the same time allowing for independent thought and work of an observational or experimental nature. Much still remains to be learnt about the causes and treatment of alcohol and drug dependence.



6 PROPOSED ADD UNIT: RELATIONSHIP TO DISTRICT GENERAL HOSPITAL



Special facilities for experiment and research and for processing data should be provided in relation to a few ADD units, which could be part of the clinical psychiatric departments of university teaching hospitals. Computer time should, nevertheless, be readily available to research workers wherever they are working.

21 REFERRAL, ASSESSMENT AND DETOXIFICATION Normally, referral will be by the general practitioner to the outpatient clinic in the district general hospital. The close association of the ADD unit to the hospital will greatly reduce the waste of staff time which exists at present due to the isolation of the special units. The physical treatments needed for the acute alcoholic or drug addiction problem (drying out and withdrawal) would be dealt with in the psychiatric admission beds of the hospital. Only after assessment as to motivation and suitability for group treatment would the patient be transferred to the ADD unit.

22 TREATMENT It has been found that groups of less than 12 and more than 18 patients do not work effectively and that mixed groups (men and women) are generally more active therapeutically than those comprising one sex only. Taking into account the sex ratios and the relative numbers of alcoholics and drug addicts (by comparison of *estimated* incidence and prevalence figures of each group), the best arrangement of bedrooms, in the view of the authors, would be four rooms with four beds each and two single-bedded rooms. Experience has shown that rooms with two or three beds each are more likely to encourage complicated sub-grouping problems. Single rooms may not be ideal therapeutically but are needed for flexibility of use; for example, adjusting sex ratios at any particular time, 'sleeping out' a patient who has lapsed, putting up former patients who are 'at risk' or relatives who have travelled a long way. The unit's accommodation should reflect the ratio of alcoholics, ten men to six women, to two drug addicts.* Two rooms will be needed for simultaneous inpatient and outpatient group therapy. Each room should be large enough for approximately 26 people; that is, 18 patients and up to eight staff, students and visitors (see Illustration 8 on page 55).

Efficient programming of functions should ensure that daily living space requirements can overlap with the space provided for group therapy.

It is important to design the unit so that the special requirement of the 'inward-looking' therapeutic community is met — namely, that spaces should be contiguous and largely uninterrupted, so that the possibilities of escaping from the 'family' or group, and the consequent dangers of subgrouping, are reduced to a minimum (see Illustration 9 on page 59).

Simple nursing facilities will be needed in the form of a staff base or office from which the daily living space is easily, but unobtrusively, observable.

Occasional special treatment needs (LSD, individual psychotherapy, abreaction, hypnotherapy, relaxation therapy, behaviour therapy) can be met by the dual use of one of the single bedrooms. A small quiet room will be needed for patients to interview relatives and to write their 'life stories' undisturbed. A room for the use of patients engaged in occupational pursuits, such as the preparation of a unit journal, and to house the unit's library would be, on the experience of Pinel House, a useful additional requirement. Patients will require a small utility room for washing and ironing clothes.**

The unit will depend on the centralised services of the district general hospital for all supplies of linen and so on, and patients' main meals will be provided on a routine delivery basis. However, the family living process is assisted if patients are able to cook their own snacks and prepare beverages at any time, and a small domestic kitchen should be provided for this purpose. In this connection, for the reasons given above,

* An approximate estimate of the need to be met for the community at large, based on the demand found in the catchment area of Pinel House.

** A suggested schedule of accommodation for the proposed ADD unit is shown in Appendix H.

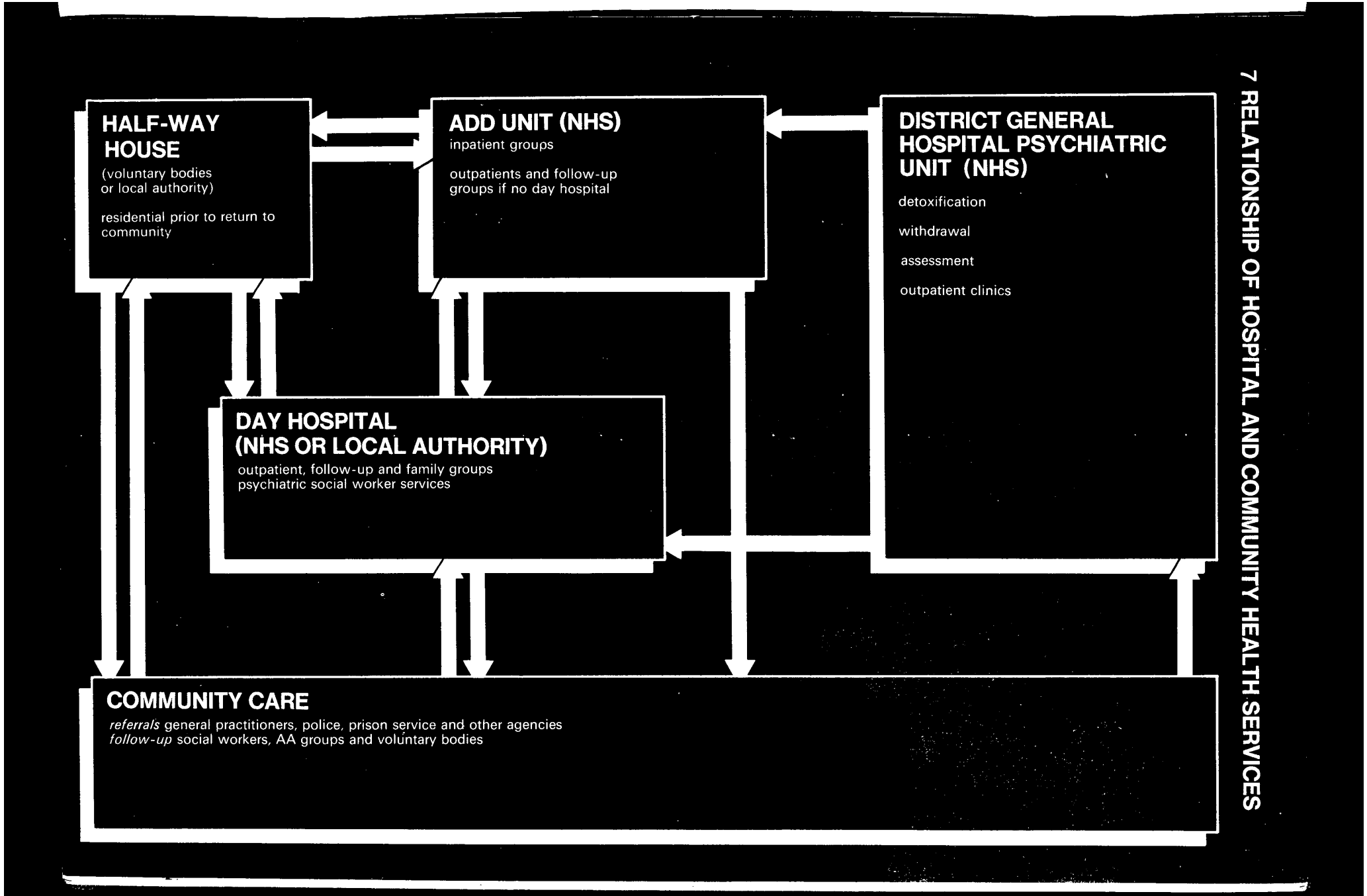
treatment policy favours, in general, the restriction of patients to the group at all times of the day and night. The normal inpatient course of treatment for alcohol dependence will be 12 weeks but the treatment period for drug dependence may be considerably longer – if necessary, up to 12 months in some cases. The inpatient throughput of the unit can be increased if halfway house facilities are provided by the local authority or by the voluntary agencies. Selected patients who have completed 8-10 weeks of the inpatient course could then sleep out at the halfway house and join the group during the day.

Outpatient follow-up groups for patients who have completed the inpatient course would normally take place in the evenings. Programming of sessions should ensure that at least one family group per week for the relatives of patients undergoing treatment can be held at the unit during the day.

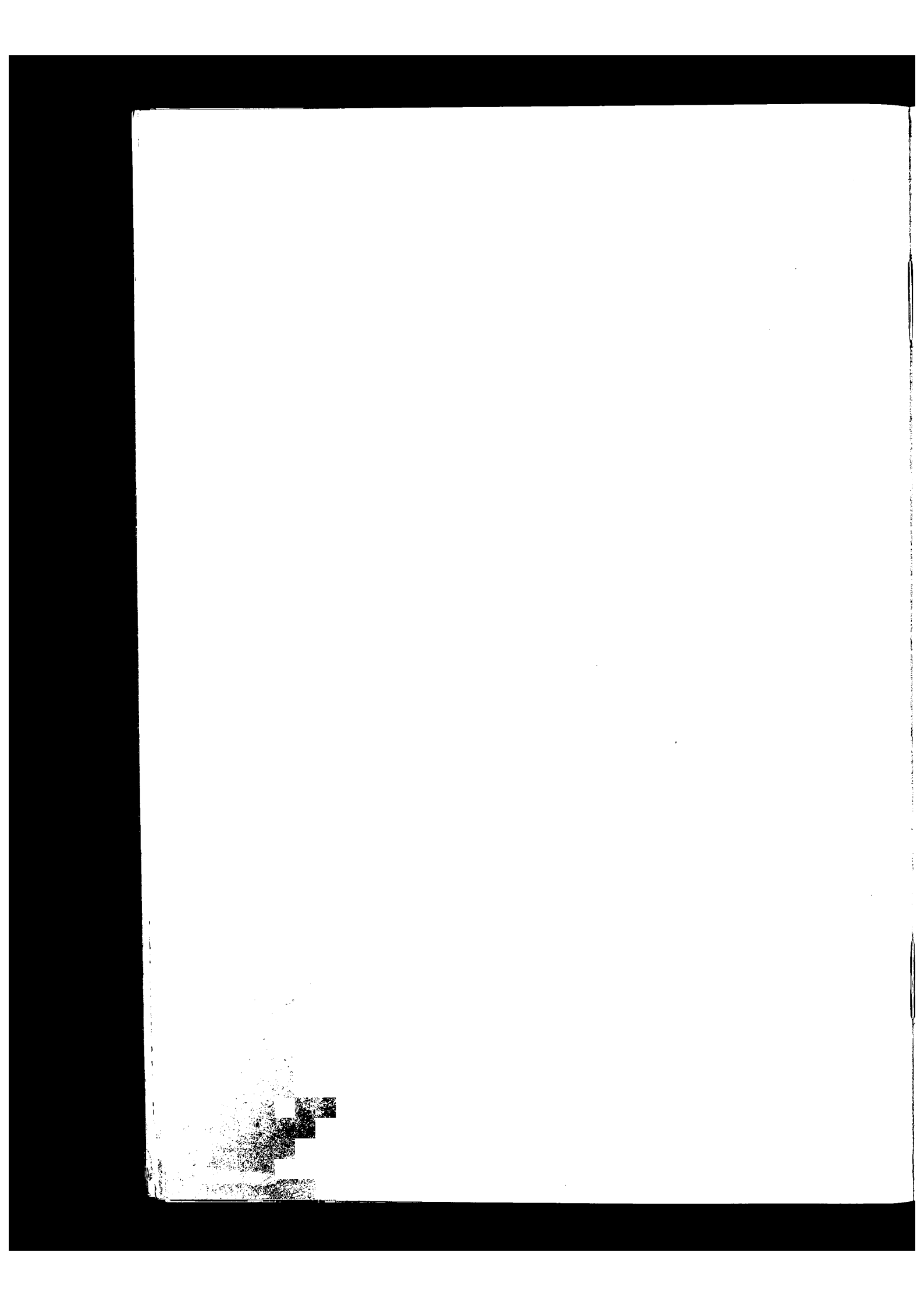
23 SUGGESTED TREATMENT PROGRAMME

8 am	breakfast	
8 30 am	occupational therapy (domestic)	
9 30 am	GROUP 1 (new admissions and readmissions in first three weeks)	GROUP 2 (all other patients)
	didactic and educational (films, lectures, discussions, talks, tapes)	meeting to discuss weekends at home, impact of visitors, letters, phone calls, and so on (if necessary, relatives and/or friends may be invited for special purposes)
10 30 am	coffee	
10 45 am	'open-ended' psychotherapeutic group (presentation of 'life story' by individual patient will take place about once a week)	
12 noon	opportunity for 'post-group' informal discussions	
12 30 pm	lunch	
1 30 pm	occupational therapy (domestic)	
2 pm	structured group activities of occupational nature including training and lectures on rehabilitation	
	visits by disablement resettlement officer (DRO) as required art therapy once a week (possibly psychodrama or drama therapy)	
4 pm	tea	
4 30 to 5 30 pm	unstaffed discussion groups or nurse-conducted group psychotherapy, as needed	
7 30 to 9 30 pm	outpatient groups in either the unit or day hospital (including group for relatives and combined groups for families)	
	visits to AA three times a week and one AA meeting on Sunday in unit	

The programme will be elastic and flexible enough to permit alteration in the day's routine if necessary, and to allow certain other desirable features to be included; for example, 'life story' meetings for patients who have been in the group process for six weeks or more, 'life sketch' meetings (unstaffed) for new entrants, visits to halfway houses and joining in outpatient group meetings. At selected times relatives' groups will meet (with staff supervision). In addition, AA, Alanon and Alateen will have access. Recovered patients in the community, needing temporary support, may be admitted as



7 RELATIONSHIP OF HOSPITAL AND COMMUNITY HEALTH SERVICES



guests. Marital groups (mixed groups of patients and spouses) will also take place with skilled psychiatric guidance. Facilities will exist for promptly ascertaining (chemically) if a patient has been drinking, and, if possible, and/or necessary, for spontaneous group discussion of the incident at the time.

The new referrals, from both outpatient and inpatient sources, will be seen on the premises and, after assessment, will have opportunity to see over the unit, meeting the recovering alcoholics and staying for the day. This promotes motivation to accept treatment if offered. The staff will meet daily, but will have longer meetings on 'life story' day and at the end of the week. This last meeting will not only be to discuss patients but to enable staff to discuss their own difficulties and counter-transference problems.

A halfway house (similar to that provided by the Richmond Fellowship in the Croydon psychiatric service) should be provided in the community, having close links with the ADD unit. The house should accommodate up to 15 people who would either be attending evening outpatient follow-up groups after work, or joining the inpatient groups each day for the last few weeks of their inpatient course.

24 STAFFING STRUCTURE

MEDICAL AND PARAMEDICAL STAFF

In order to estimate the staffing needs of an inpatient unit of 16 to 18 beds, preliminary studies were made of two units of similar size at present functioning within the National Health Service – the one running on minimal resources and being a converted out-building of a mental hospital (Warlingham Park); the other having more than ample staffing due to its university and teaching hospital connections, and, in addition, having been custom-built (Royal Edinburgh Hospital).

Combining group treatment of dry alcoholics with that of drug addicts would have the advantage of the additional part-time services of another consultant psychiatrist with special knowledge of addicts and group psychotherapy. Sickness and annual leave would no longer be a problem. Normal clinical time spent in actual treatment in the unit would be halved for each consultant, thus freeing time for research. Research programmes should, wherever possible, be built into the treatment programme as a routine. Such routine statistical measures should be standardised and used automatically at every treatment centre, apart from any separate research plans made by individual psychiatrists or other team members.

Staff posts below the level of consultant should have an accent on training, in view of the shortage of staff with knowledge of this specialty throughout the country. Two part-time registrars, each attached to the appropriate consultant, would, between them, provide eight sessions including one evening session each. Their remaining duties would be in the sphere of general psychiatry, as in the case of the consultants. Continuity of care, an important feature in the treatment of personality disorders, has to be balanced against the need for rotating training posts. This can be partly obviated by rotating registrars out of phase, that is, at three-monthly intervals. In addition, a senior registrar with duties both in the unit and general psychiatric sphere would add longer spells of continuity and make a valuable teaching member of the team who could take part in research programmes. The full-time psychiatric social worker should remain fully involved in unit 'business' as at Pinel House, but supplementary services from the mental welfare officer, probation officer, disablement resettlement officer and other social workers (for example, child care officers) should be readily available. The services of a full-time psychologist with psychotherapeutic training would further enhance the treatment and research possibilities. Even better, two half-time psychologists, with involvement in community care or general clinical psychiatry for the rest of the time, would provide for cover during leave and sickness. Thus far we have dealt with the medical and social aspects of the illness, as catered for by staff, but not with the spiritual aspect. Traditionally, in a number of alcoholic units the hospital chaplain has come to play an important part in the treatment centres. Perhaps clergy of other denominations could be encouraged to become involved in the programme, but it is

stressed that all such help should be informed and trained in group methods and be properly supervised.

NURSING STAFF

Much more participation of the nurse in treatment should be planned for in future. At Pinel House, the present charge nurse has had some 20 years' involvement in the treatment of alcoholics and is very experienced in the special form of group therapy used there.

What the alcoholic patient needs is a nurse who will show a clear and informed understanding of the disease concept of alcoholism. In this way, the nurse will take benevolent control of the situation from the start, will see the patient's need to 'act out' as an attempt to confirm his own bad feeling about himself, and will work towards helping the patient see the deeper reasons behind his own actions.

The alcoholic enters the unit emotionally immature, and may hope to find in the nurse a parent figure who can be controlled in innumerable devious ways, thus avoiding insight into his illness. The alcoholic will go to great lengths to test out the nurse, hoping to discover the nurse's own anxieties and problems, attempting to create anger and rejection and striving to get contradictory attitudes from different members of the staff. On the one hand, he attempts to bring the nurse to the level of insecurity and badness which he himself feels and, on the other hand, he exalts the nurse as a hero.

It is in view of this that the number of nurses needs to be kept to a minimum and that great care should be taken in the selection of third-year student nurses for this specialised training. It must be stressed that not everyone is able to be in close contact with the regressions and pressures of the group without becoming personally involved. The charge nurse must observe carefully the students' reactions. A comment from a past staff nurse in the Pinel House unit is relevant here. 'The things I found difficulty with when I first started working with alcoholics were the feeling of inadequacy when anyone had a slip, and my taking this as a failing in myself. I think that for nurses coming into this type of work it is important, as is the case here, that there should be a good staff group in which they can discuss their feelings. It can be disturbing and confusing if one has had no previous group experience.'

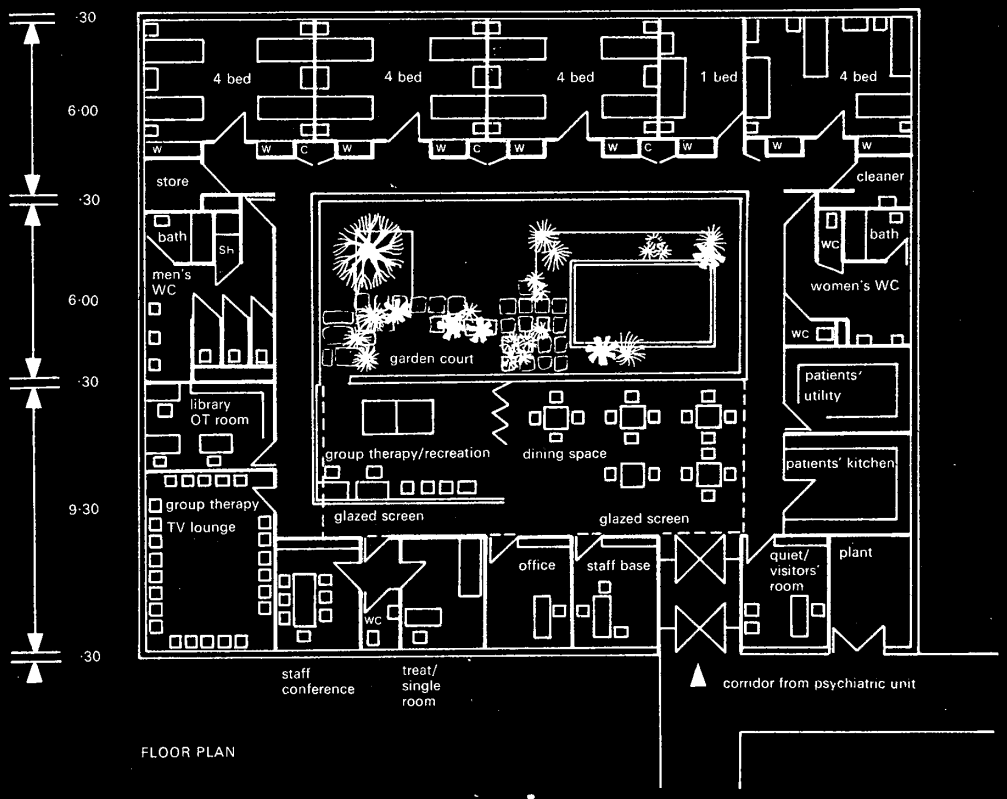
The first contact between nurse and patient is of vital importance. The new patient is a person first, an alcoholic second: the way in which each is received must depend on the type of person he or she is. In general, it is important to reassure the patient about the method of treatment offered by the unit for the disease of alcoholism; to remove all alcohol and drugs; to ascertain whether the daily intake of alcohol or drugs has been such as to cause severe withdrawal symptoms when the drinking stops.

It is very important to have staff discussion at least once a week, during which group conductors discuss their groups, including outpatient groups, and also the progress of individual patients. Ex-patients are encouraged to maintain contact by telephone, letter or visit, as well as by attending the outpatient groups if they are able. Ex-patients of Pinel House are, in fact, constantly in touch and the nursing staff share with the hospital chaplain the task of dealing with them. Often, the ex-patient just wants to talk, but it is very important that he have a sympathetic though firm listener. The nurse must learn to be a vehicle for the patient's feelings. Sometimes, direct advice is sought and if it is not feasible to suggest outpatient group support, the advice must follow along lines indicated when the patient was in treatment.

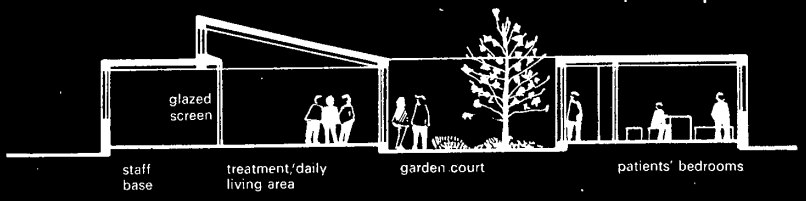
Staff nurse training posts of a rotating nature (similar to the principle of inservice training of registrars) should be continued and increased to provide possible candidates for future units, and generally to educate nurses in proper attitudes in the management of alcoholics. Both general and psychiatric nurses could benefit from such training.

Finally, nurses training for State Registration should have the opportunity of experiencing treatment of alcoholics. At present, such experience is only afforded for two weeks, but should be extended to a minimum of six weeks up to a maximum of 12 weeks. A training scheme should be available in long-established centres for workers of all types.

8 PROPOSED ADD UNIT, (FLOOR PLAN AND SECTION)



FLOOR PLAN



SECTION

The suggested nursing staff structure is one full-time charge nurse and one staff and two student nurses rotating every six months.

It is proposed that no night supervision be provided, other than a visit from the night superintendent based in the psychiatric department of the district general hospital.

25 FUNCTION AND DESIGN The function and design of the proposed purpose-built ADD unit is considered in the context of the current planning policy, aimed at providing acute psychiatric units as departments of the district general hospital. The psychiatric unit will usually provide accommodation for from 90-120 inpatient beds and associated day hospital services, for a wide range of mentally ill patients. Patients will normally be admitted to the ADD unit following detoxification and assessment in the psychiatric department.

Illustration 6 on page 47 shows the relationship of the ADD unit to the psychiatric department of the district general hospital. An enclosed link corridor will provide access for patients and staff from the entrance and reception area of the psychiatric department. All essential supplies and services to the ADD unit will use this route. Visitors to patients will normally enter the unit via the psychiatric department's reception point, provided the policy will allow unrestricted visiting hours. An essential part of 'follow-up' policy of the ADD unit is to allow ex-patients access to the staff or the group at any time of the day.

A suggested layout for the ADD unit is shown in Illustration 8 on page 55. The design seeks to correlate the principles of the 'inward-looking' therapeutic community with the various functional requirements of inpatient hospital care (treatment, daily living, eating, sleeping). Patients' bedrooms, toilet accommodation, kitchen and utility room, together with staff rooms, are 'banded' around a central treatment and daily living area, providing both indoor and outdoor space, the latter in the form of an open garden court. Two group therapy rooms are provided, each accommodating up to 25 people, with easy chairs arranged around a square. One of these rooms is fully enclosed and will 'double up' as a TV room and lounge; the other is formed by glazed screens out of part of the dining and recreation space. A sliding, folding screen will enable this space to be enlarged to meet the needs of larger groups of people – for example, AA meetings or combined inpatient and outpatient groups.

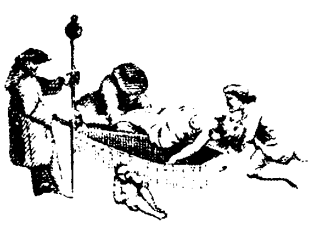
The external walls surrounding the garden court can be fully glazed so that the entrances to all the rooms and spaces are observable from the central daily-living area. This concept of a free and unobstructed living space is aimed at encouraging patients to live in the group as a family and at avoiding, as far as is physically possible, the opportunities for patients to isolate themselves individually or in subgroups.

The staff base is next to the entrance, with easy observation of the unit. To ensure privacy, the staff conference room and treatment/single room are arranged en suite, with a toilet cut off from the rest of the unit by an entrance lobby.

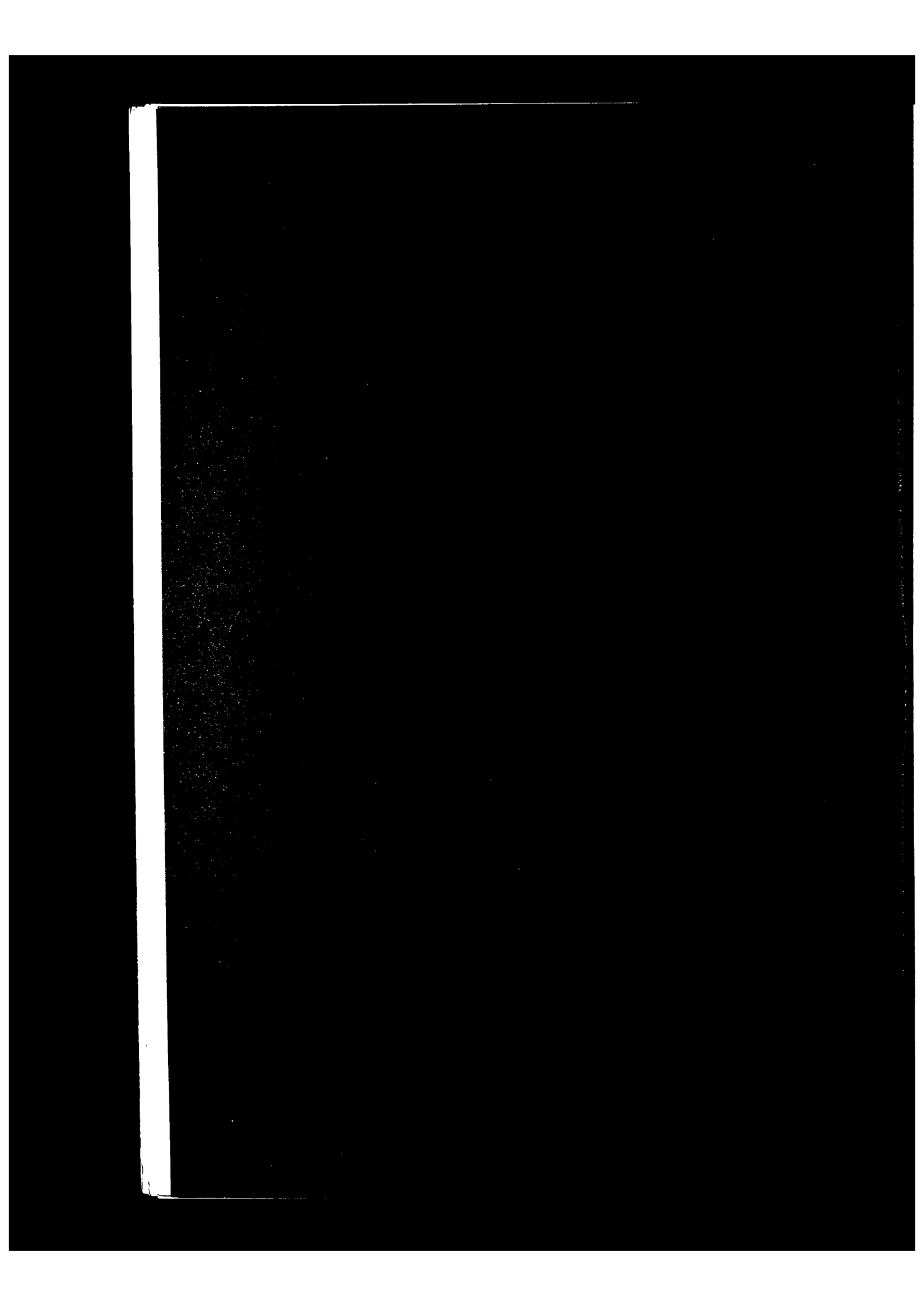
The total floor area of the proposed unit is 483 m^2 inclusive of circulation, giving an area per patient of 26.8 m^2. The building can be either of conventional construction or, because it is designed on a basic 300 mm module with preferred structural grid, it can be built from the range of standard prefabricated structural assemblies now offered under the Department of Health's Inter-hospital Board programme. The total cost of building and engineering services and fixed equipment would be in the region of £45 000 (including an allowance for external works) based on current prices for labour and materials.

Equipment not included in the estimate would be needed for the following activities:

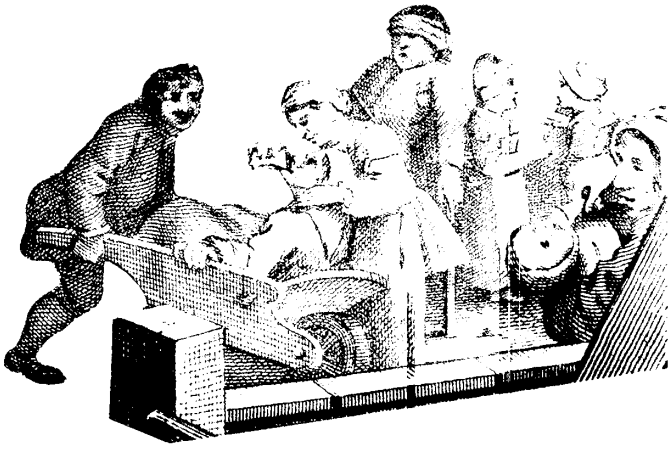
treatment and research	500 watt transparency projector with circular cassettes
	large portable, collapsible, beaded projector screen
	cine projector 16mm
	large tape recorder and tapes
	library of suitable educational tapes, films and slides
research teaching	TV camera, videotape, microphone and lighting
records	office equipment to include typewriters, small separate switchboard (by-passing the district general hospital) with direct private line to the consultant (eventually, in remoter future, a computer terminal)
recreation	radio, record player and records
	colour TV
	sports facilities
	patients' telephone



9 PROPOSED ADD UNIT: FUNCTIONAL RELATIONSHIPS



APPENDICES



APPENDIX A

DEFINITIONS OF ALCOHOLISM AND DRUG DEPENDENCE

1 ALCOHOLISM*

a Any form of drinking which, in its extent, goes beyond the traditional and customary 'dietary' use, or the ordinary compliance with the social drinking customs of the whole community concerned, irrespective of the etiological factors leading to such behaviour and irrespective also of the extent to which such etiological factors are dependent upon heredity, constitution, or acquired physiopathological and metabolic influences.

World Health Organization.[41]

This was one of the first attempts at a universally acceptable definition. It was subsequently superseded by the following definition which is perhaps the most widely used now, although it still has major flaws.

b Alcoholics are those excessive drinkers whose dependence on alcohol has attained such a degree that they show a noticeable mental disturbance or an interference with their mental and bodily health, their interpersonal relations and their smooth social and economic functioning; or who show the prodromal signs of such developments. They therefore require treatment.

World Health Organization.[42]

2 DRUG DEPENDENCE

Drug dependence is defined as a state arising from repeated administration of a drug on a periodic or continuous basis. Its characteristics will vary with the agent involved, but it is a general term selected for its applicability to all types of drug abuse and carries no connotation in regard to degree of risk to public health or need for a particular type of control.

World Health Organization.[39]

3 FROM THE *MANUAL ON ALCOHOLISM* OF THE AMERICAN MEDICAL ASSOCIATION, 1968

IS ALCOHOLISM REALLY AN ILLNESS?

There is still debate over this question, but the preponderance of evidence points to the conclusion that alcoholism is an illness. The American Medical Association and the World Health Organization, as well as many other professional groups, have come to regard it as a specific disease entity. Some have even made official pronouncements that designate it as such, in order to stimulate interest and focus effort. Recent court decisions recognising it *legally* as a 'disease' have lent additional support to this position and in so doing have shifted the brunt of responsibility for the care of an impressive number of alcoholics away from law enforcement agencies and more appropriately onto the medical profession, and health and rehabilitation groups.

* These definitions represent views of an international group of experts and do not necessarily represent decisions of WHO, nor are they universally accepted by all authorities though the trend is in their direction. A careful critique is given by Seely.[37]

Some authorities continue to consider alcoholism as essentially a *manifestation* of underlying psychopathology. Certainly it can be seen at times as primarily a *complication* to other conditions, both physical and mental. It has also been described as basically a symptom, which increases and eventually attains such magnitude as to become an illness.

For practical purposes, however, and in view of evidence presently available, it seems most logically classified as a highly *complex illness,* and it will be regarded and referred to as such in this manual.

DEFINITION

Literally hundreds of definitions of alcoholism have been offered. While many are accurate enough to be genuinely helpful, each, of course, reflects the viewpoint of its author, and none has become distinguished by universal acceptance.

Because of the complexity of the illness, and because of divergent orientations among its investigators, it seems unlikely that any one of them will ever be endorsed completely by everyone interested in the subject. Nevertheless, enough agreement exists to support the accuracy of the following broad definition:

'Alcoholism is an illness characterised by preoccupation with alcohol and loss of control over its consumption such as to lead usually to intoxication if drinking is begun; by chronicity; by progression; and by tendency toward relapse. It is typically associated with physical disability and impaired emotional, occupational, and/or social adjustments as a direct consequence of persistent and excessive use of alcohol.'

In short, alcoholism is regarded as a type of drug dependence of pathological extent and pattern, which ordinarily interferes seriously with the patient's total health and his adaptation to his environment.

As the illness progresses, the alcoholic's preoccupation with alcohol leads him to organise and orient his life around drinking. He very often takes great pains to obtain, ensure and perhaps conceal his supply. Consumption of very substantial amounts of alcohol, however, and frequent intoxication *per se* are not *necessarily equated* with alcoholism, even though these signs usually are prominent in the course of the illness. *It can* happen that alcoholics actually consume less liquor over a given length of time than do some social drinkers, but this fact in itself does not alter the basic condition nor make it less serious. *The key factor is in control.*

Physical disabilities and impaired life adjustment certainly may precede or contribute to the development of the illness, rather than result from it. Some alcoholics, also, at least seem to escape these difficulties. The concept that alcoholics *always* show progressive deterioration as a direct result of drinking really is not valid, and it therefore is not a *requirement* of the definition of alcoholism.*

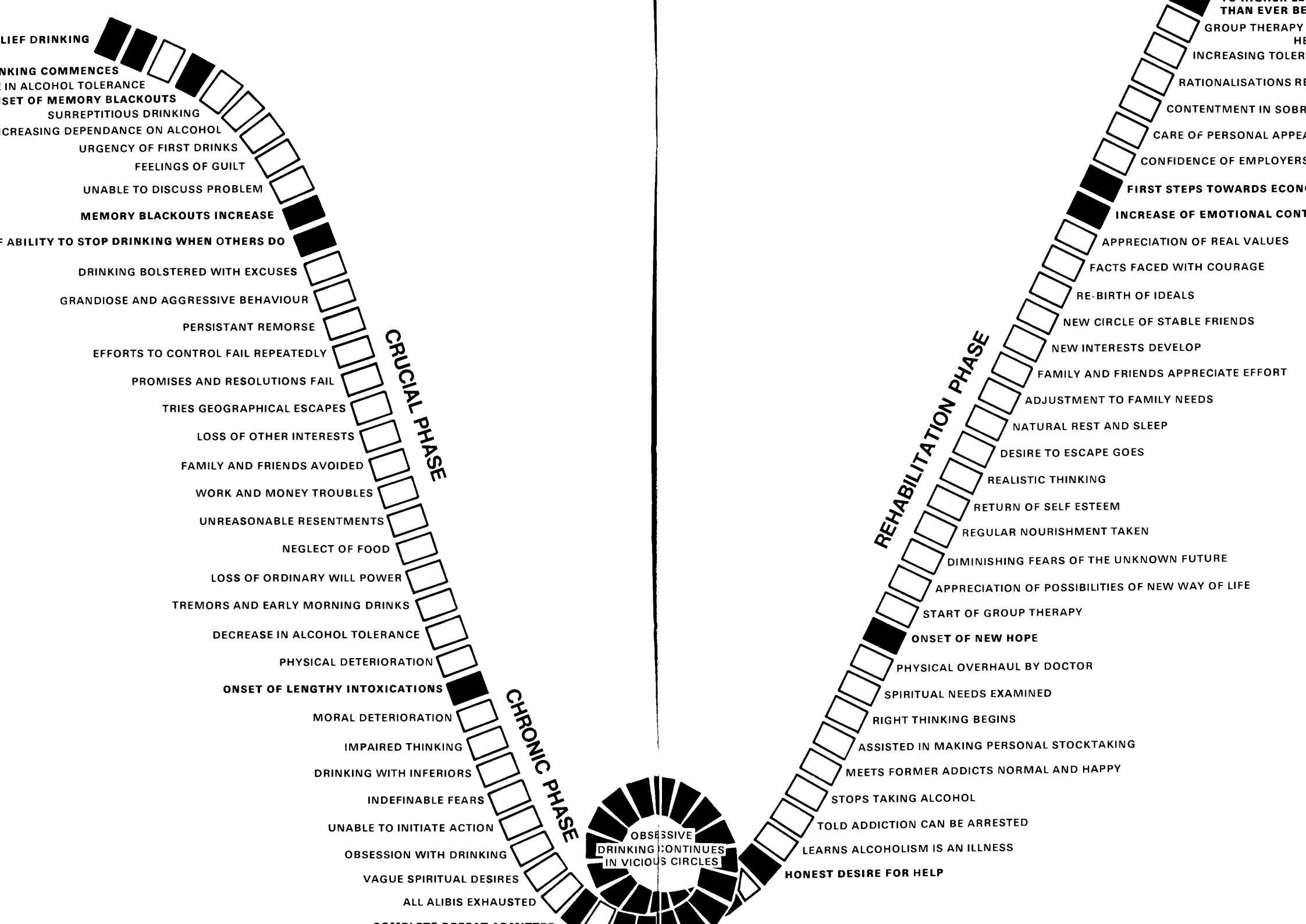
Popular standards such as drinking by one's self, drinking early in the morning, or drinking only one kind or brand of liquor cannot be used as absolute criteria in defining the disorder (or in diagnosing it). It is not uncommon for the alcohol-dependent person to use the absence of these features from his drinking pattern as 'proof' in his denial of his problem to himself and to others. Their presence may well represent danger signs among non-alcoholics, or they may be of no particular significance. When they are evaluated in the context of the total clinical picture, in association with additional signs and symptoms, they fall into proper perspective.

* This is, in the opinion of one of us (CES), a circular argument. The level of function before taking alcohol cannot be anything but a guess, and no account is taken here of functional aspects of the disease. In any case, the concept is more usually expressed that alcoholism is a progressive disease, not that deterioration is progressive.

Similarly, living on Skid Row*, exhibiting irresponsible or erratic behaviour, and other such factors so often thought of as being pathognomonic of alcoholism and fundamental to it are neither limited to the disorder nor necessarily parts of it. In fact, alcoholics among the financially successful may well be one of the most sizable, and certainly one of the most seriously neglected, groups in this country.

* Approximately three per cent of alcoholics, according to most authorities. (CES)

APPENDIX B


LIEF DRINKING
NKING COMMENCES
IN ALCOHOL TOLERANCE
SET OF MEMORY BLACKOUTS
SURREPTITIOUS DRINKING
CREASING DEPENDANCE ON ALCOHOL
URGENCY OF FIRST DRINKS
FEELINGS OF GUILT
UNABLE TO DISCUSS PROBLEM
MEMORY BLACKOUTS INCREASE
F ABILITY TO STOP DRINKING WHEN OTHERS DO
DRINKING BOLSTERED WITH EXCUSES
GRANDIOSE AND AGGRESSIVE BEHAVIOUR
PERSISTANT REMORSE
EFFORTS TO CONTROL FAIL REPEATEDLY
PROMISES AND RESOLUTIONS FAIL
TRIES GEOGRAPHICAL ESCAPES
LOSS OF OTHER INTERESTS
FAMILY AND FRIENDS AVOIDED
WORK AND MONEY TROUBLES
UNREASONABLE RESENTMENTS
NEGLECT OF FOOD
LOSS OF ORDINARY WILL POWER
TREMORS AND EARLY MORNING DRINKS
DECREASE IN ALCOHOL TOLERANCE
PHYSICAL DETERIORATION
ONSET OF LENGTHY INTOXICATIONS
MORAL DETERIORATION
IMPAIRED THINKING
DRINKING WITH INFERIORS
INDEFINABLE FEARS
UNABLE TO INITIATE ACTION
OBSESSION WITH DRINKING
VAGUE SPIRITUAL DESIRES
ALL ALIBIS EXHAUSTED
CRUCIAL PHASE
CHRONIC PHASE
OBSESSIVE DRINKING CONTINUES IN VICIOUS CIRCLES
HONEST DESIRE FOR HELP
LEARNS ALCOHOLISM IS AN ILLNESS
TOLD ADDICTION CAN BE ARRESTED
STOPS TAKING ALCOHOL
MEETS FORMER ADDICTS NORMAL AND HAPPY
ASSISTED IN MAKING PERSONAL STOCKTAKING
RIGHT THINKING BEGINS
SPIRITUAL NEEDS EXAMINED
PHYSICAL OVERHAUL BY DOCTOR
ONSET OF NEW HOPE
START OF GROUP THERAPY
APPRECIATION OF POSSIBILITIES OF NEW WAY OF LIFE
DIMINISHING FEARS OF THE UNKNOWN FUTURE
REGULAR NOURISHMENT TAKEN
RETURN OF SELF ESTEEM
REALISTIC THINKING
DESIRE TO ESCAPE GOES
NATURAL REST AND SLEEP
ADJUSTMENT TO FAMILY NEEDS
FAMILY AND FRIENDS APPRECIATE EFFORT
NEW INTERESTS DEVELOP
NEW CIRCLE OF STABLE FRIENDS
RE-BIRTH OF IDEALS
FACTS FACED WITH COURAGE
APPRECIATION OF REAL VALUES
INCREASE OF EMOTIONAL CONT
FIRST STEPS TOWARDS ECON
CONFIDENCE OF EMPLOYERS
CARE OF PERSONAL APPEA
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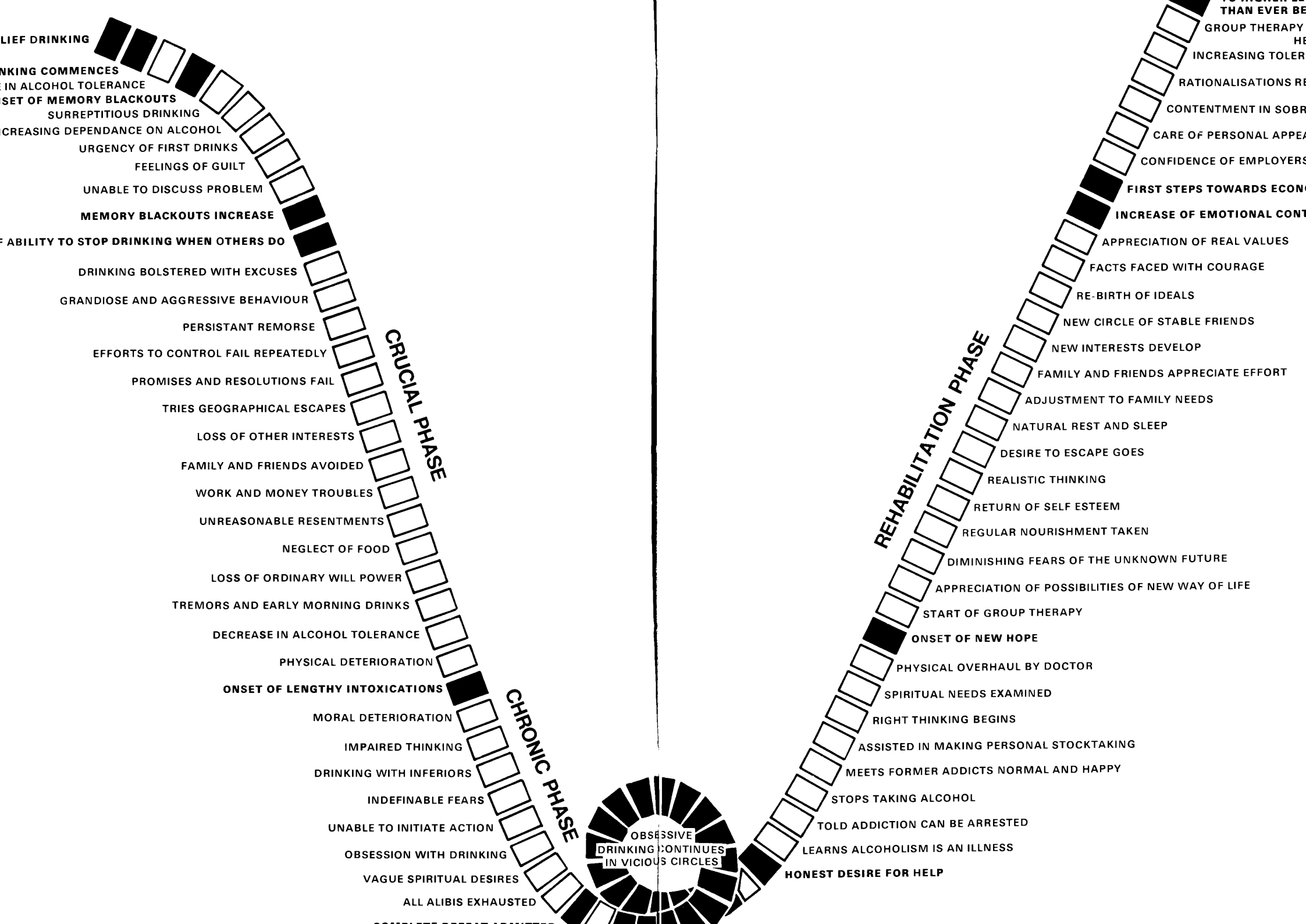
REHABILITATION PHASE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CONTENTMENT IN SOBR
RATIONALISATIONS RE
INCREASING TOLER
GROUP THERAPY
HE
THAN EVER BE
REHABILITATION PHASE

APPENDIX C

NATIONAL HEALTH SERVICE TREATMENT CENTRES

1 For alcohol dependence*

ENGLAND AND WALES

Regional Hospital Board	
Birmingham	All Saints' Hospital Lodge Road Birmingham 18
	St George's Hospital Stafford
Leeds	Scalebor Park Moor Lane Burley-in-Wharfedale Ilkley Yorks
Liverpool	Moston Hospital Upton-by-Chester CH2 4AA
Manchester	Lancaster Moor Hospital Lancaster
	Springfield Hospital Crumpsall Manchester M8 6RD
North West Metropolitan	St Bernard's Hospital Southall Middlesex
Oxford	Littlemore Hospital Littlemore Near Oxford
Sheffield	Mapperley Hospital Porchester Road Nottingham NG3 6AA
South East Metropolitan	Bexley Hospital Dartford Heath Bexley Kent
South Western	Exe Vale Hospital Exeter Devon
South West Metropolitan	Graylingwell Hospital Chichester Sussex
	Tooting Bec Hospital Tooting Bec Road London SW17
	Warlingham Park Hospital (Pinel House) Warlingham Surrey CR3 9YR

* Information supplied by The Medical Council on Alcoholism Limited. These centres have not necessarily been set up by the regional boards. They are often the product of local enthusiasm without special financial backing centrally although still, of course, within the NHS.

NATIONAL HEALTH SERVICE TREATMENT CENTRES

1 For alcohol dependence*

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	St George's Hospital Stafford
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Manchester	Lancaster Moor Hospital Lancaster
	Springfield Hospital Crumpsall Manchester M8 6RD
North West Metropolitan	St Bernard's Hospital Southall Middlesex
Oxford	Littlemore Hospital Littlemore Near Oxford
Sheffield	Mapperley Hospital Porchester Road Nottingham NG3 6AA
South East Metropolitan	Bexley Hospital Dartford Heath Bexley Kent
South Western	Exe Vale Hospital Exeter Devon
South West Metropolitan	Graylingwell Hospital Chichester Sussex
	Tooting Bec Hospital Tooting Bec Road London SW17
	Warlingham Park Hospital (Pinel House) Warlingham Surrey CR3 9YR
	Epsom Surrey
Welsh	Whitchurch Hospital (Adfer) Whitchurch Cardiff CF4 7XB
Wessex	Park Prewett Hospital Basingstoke Hants

SCOTLAND

Regional Hospital Board	
South-Eastern	Royal Edinburgh Hospital
Western	Ailsa Hospital Dalmellington Road Ayr
	Southern General Hospital 1345 Govan Road Glasgow SW1

NORTHERN IRELAND HOSPITALS AUTHORITY

Shaftesbury Square Hospital
116-120 Great Victoria Street
Belfast BT2 7BG

Downshire Hospital
Downpatrick
County Down

2 For drug dependence*

a Heroin dependence clinics (outpatients in London)

Psychiatric Unit Annexe
Charing Cross Hospital
1A Bedfordbury
London WC2

Special Psychiatric Unit
Hackney Hospital
London E9

Drug Dependence Clinic
Lambeth Hospital
(St Thomas' Hospital Board of Governors)
Brook Drive
Kennington Road
London SE11

Addiction Treatment and Research Unit
The Maudsley Hospital
101 Denmark Hill
London SE5

* Information supplied by The Medical Council on Alcoholism Limited. These centres have not necessarily been

Drug Addiction Clinic
Norwood and District Hospital
Hermitage Road
London SE19

Drug Treatment Centre
Queen Mary's Hospital
(Westminster Hospital Board of Governors)
Roehampton Lane
London SW15

Addiction Unit
St Clement's Hospital
(London Hospital Board of Governors)
2A Bow Road
London E3

Drug Dependence Treatment Unit
The Day Hospital
St George's Hospital
Tooting Grove
London SW17

Drug Addiction Unit
St Giles' Centre
(King's College Hospital Board of Governors)
Camberwell Church Street
London SE5

Simmons House (adolescents only)
St Luke's-Woodside Hospital
(Middlesex Hospital Board of Governors)
Woodside Avenue
London N10

St Mary's Hospital Drug Dependency Centre
Woodfield Road
London W9

Drug Addiction Centre
University College Hospital
Gower Street
London WC1

Drug Addiction Centre
Psychiatric Department
West Middlesex Hospital
Twickenham Road
Isleworth
Middlesex

Westminster Drug Treatment Centre
52A Vincent Square
London SW1

b **Provincial hospitals treating heroin addicts as outpatients or known to have special interest in drug dependence**

Town	Hospital
Belfast	Shaftesbury Square Hospital 116-120 Great Victoria Street Belfast BT2 7BG
Birmingham	All Saints' Hospital Lodge Road Birmingham 18

Bournemouth	St Ann's Hospital Haven Road Canford Cliffs Bournemouth Hampshire
Bradford	Lynfield Mount Daisy Hill Bradford 9
Brighton	Herbert Hone Clinic 15/17 Princes Street Brighton BN2 1SL Sussex
Cambridge	Addenbrooke's Hospital Trumpington Street Cambridge
Crawley	Roffey Park Rehabilitation Centre Horsham Sussex
Fareham	Knowle Hospital Fareham Hampshire
Glasgow	Department of Psychiatry Eastern District Hospital 253 Duke Street Glasgow E1
Liverpool	Liverpool Psychiatric Day Hospital 10 Croxteth Road Liverpool L8 3SG
Nottingham	Regional Addiction Unit Mapperley Hospital Porchester Road Nottingham NG3 6AA
Portsmouth	St James's Hospital Milton Portsmouth PO4 8LD
Prestwich	Prestwich Hospital Prestwich Nr Manchester
Wakefield	Stanley Royd Hospital Aberford Road Wakefield Yorkshire
Welwyn Garden City	Queen Elizabeth II Hospital Howlands Welwyn Garden City Hertfordshire
York	Drug Addiction Treatment Centre Clifton Hospital York YO3 6RD

c **Hospitals offering inpatient facilities for drug addicts**

BIRKENHEAD
St Catherine's Hospital, Church Road, Birkenhead, Cheshire L42 0LQ

BIRMINGHAM
All Saints' Hospital, Lodge Road, Birmingham 18

BRADFORD
Lynfield Mount, Daisy Hill, Bradford 9, Yorks

BRISTOL
Barrow Hospital, Barrow Gurney, Nr Bristol
Bristol Royal Infirmary
Glenside Hospital, Blackberry Hill, Stapleton, Bristol

CAMBRIDGE
Addenbrooke's Hospital, Trumpington Street, Cambridge
Fulbourn Hospital, Fulbourn, Cambridge

CARDIFF
Whitchurch Hospital, Whitchurch, Cardiff CF4 7XB

CARMARTHEN
St David's Hospital, Carmarthen

CHESTER
Devon Hospital, Liverpool Road
Moston Hospital, Liverpool Road, Upton-by-Chester CH2 4AA

DERBY
Kingsway Hospital, Kingsway, Derby
The Pastures Hospital, Mickleover, Derby

EDINBURGH
Royal Edinburgh Hospital

EXETER
Exe Vale Hospital, Exminster, Nr Exeter, Devon EX6 8AB

GLASGOW
Eastern District Hospital, 253 Duke Street, Glasgow E1
Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow W2
Leverndale Hospital, 510 Crookston Road, Glasgow SW3
Southern General Hospital, 1345 Govan Road, Glasgow SW1

GLOUCESTER
Coney Hill Hospital, Coney Hill, Gloucester

HULL
De La Pole Hospital, Willerby, Hull HU10 6ED

LIVERPOOL
Sefton General Hospital, Smithdown Road, Liverpool L15 2HE
Walton Hospital, 107 Rice Lane, Liverpool L9 1AE

LONDON
The Bethlem Royal Hospital, Monks Orchard Road, Eden Park, Beckenham, Kent
Cane Hill Hospital, Coulsdon, Surrey CR3 3YL
Hackney Hospital, Hackney, London E9
The Maudsley Hospital, Denmark Hill, London SE5
North Middlesex Hospital, Silver Street, London N18
St Bernard's Hospital, Southall, Middlesex
St Clement's Hospital, 2a Bow Road, London E3
St Luke's-Woodside Hospital, Woodside Avenue, Muswell Hill, London N10
Tooting Bec Hospital, Tooting Bec Road, London SW17
Warlingham Park Hospital, Surrey (selected cases only)
West Middlesex Hospital, Twickenham Road, Isleworth, Middlesex

LUTON
Luton and Dunstable Hospital, Lewsey Road, Luton, Beds

MANCHESTER
Prestwich Hospital, Prestwich, Nr Manchester

NEWCASTLE-UPON-TYNE
Newcastle General Hospital, Westgate Road, Newcastle-upon-Tyne NE4 6BE
The Royal Victoria Infirmary, Newcastle-upon-Tyne NE1 4LP

NORTHAMPTON
St Crispin Hospital, Duston, Northampton NN5 6UN

NORWICH
Hellesdon Hospital, Hellesdon, Norwich, Norfolk Nor 31A
St Andrew's Hospital, Thorpe, Norwich, Norfolk Nor 58A

NOTTINGHAM
Mapperley Hospital, Porchester Road, Nottingham NG3 6AA

OXFORD
Littlemore Hospital, Littlemore, Nr Oxford

PORTSMOUTH
St James' Hospital, Milton, Portsmouth PO4 8LD

SOUTHAMPTON
Knowle Hospital, Fareham, Hants

SOUTHEND-ON-SEA
Runwell Hospital, Nr Wickford, Essex

TEESSIDE
St Luke's Hospital, Grove Hill, Morton Road, Middlesbrough, Teesside
North Tees Hospital, Hardwick, Stockton-on-Tees, Co Durham

YORK
Clifton Hospital, York

APPENDIX D

VOLUNTARY ORGANISATIONS*
including some general projects with special interests

Alanon Family Groups UK and Eire
c/o St Giles' Centre
Camberwell Church Street
London SE5
01-703 0397
or:
UK and Eire Central Services
B/M Hope
London WC1

Alcoholics Anonymous
11 Redcliffe Gardens
London SW10
01-352 9779

Association for the Prevention of Addiction
15 King Street
London WC2
01-836 3781

Avenues Unlimited
Tower Hamlets Youth and Community Project
124-128 Bethnal Green Road
London E2
01-739 5004

Birmingham Addiction Prevention Centre
Granville House
2 Oxford Road
Birmingham B13 9EJ
021 449 1715

BIT
141 Westbourne Park Road
London W11
01-229 8219

The Blenheim Project
269a Portobello Road
London W11
01-727 3163

Board for Information and National Tests in Youth Aid
Community Service
67 York Place
Edinburgh 1
931-556 8671

* Information supplied by The Institute for the Study of Drug Dependence

British Temperance Society
Stanborough Park
Garston
Watford
Herts
447-2251/2/3

The Calix Society (Great Britain)
40 Lamington Road
Glasgow SW2
041 882 1941

Cambridge Association for the Prevention of Drug Addiction
45 Kingston Street
Cambridge

Carter Foundation
34 Seymour Street
London W1
01-262 6689

Change
101 Monmouth Drive
Sutton Coldfield
Warwickshire
021-354 2708

Church of England Council for Social Aid
Church Information Office
Church House
Dean's Yard
London SW1
01-222 9011

Church of England Youth Council
Church House
Dean's Yard
London SW1
01-222 9011

The Coke Hole Trust
Ashley Copse
Smannell
Nr Andover
Hampshire

Community Drug Project
Burnett Hall
Wren Road
London SE5
01-701 0294

Egham Rehabilitation Centre
Woodlea
Bagshot Road
Egham Surrey

Eleventh Hour Project
Dockland Heathway
Dagenham, Essex

Friendship Unlimited
31A Mansfield Road
Nottingham

The Gloucestershire Association for Family Life
2 College Street
Gloucester
GL1 2NE
0452 25817

The Golbourne Centre for Discharged Prisoners
92 Golbourne Road
London W10

The London Centre
13 Suffolk Street
London SW1

The Medical Council on Alcoholism Limited
8 Bourdon Street
Davies Street
London W1X 9HY
01-493 0081

National Association of Voluntary Hostels
33 Long Acre
London WC2
01-240 0665

National Association of Youth Clubs
Devonshire House
30 Devonshire Street
London W1
01-935 2941

National Bureau for Cooperation in Child Care
Adam House
1 Fitzroy Square
London W1
01-387 4263

The National Council on Alcoholism
Hope House
45 Great Peter Street
Westminster London SW1
01-222 1056/7

Neighbourhood Service
34 Tavistock Crescent
London W11
01-727 9883

New Life Foundation Trust
PO Box 20
Bromley BR1 1DW, Kent
01-460 0500

Northwick Park Rehabilitation Centre
Blockley
Nr Moreton-in-the-Marsh
Gloucestershire

Release
50a Princedale Road
London W11
01-229 7753

The Richmond Fellowship for Mental Welfare and Rehabilitation
8 Addison Road
London W14
01-603 6373/4/5

Rink Club
275 Oxford Street
London W1
01-629 5424

Royal Prisoners' Aid Society
56 Stamford Street
London SE1

The Samaritans
St Stephen's Church
Walbrook
London EC4
01-626 9000
(and locally – see local press)

St Anne's House
57 Dean Street
London W1
01-437 5006

St Giles' Centre
Camberwell Church Street
London SE5
01-703 5841

Salvation Army Headquarters
101 Queen Victoria Street
London EC4
01-236 5222

Scottish Association of Youth Clubs
13 Eglinton Crescent
Edinburgh 12

Simon Community Trust
Toynbee Hall
28 Commercial Road
London E1
01-247 9652

Social Services Unit
St Martin-in-the-Fields
5 St Martin's Place
Trafalgar Square
London WC1
01-930 4137

Social Responsibility Centre
Peterhouse
122 Forest Rise
Walthamstow
London E17
01-520 3100

The Student Advisory Centre
142 Piccadilly
London W1
01-723 4247

Trelawn
30 Russell Hill
Purley
Croydon
01-660 4586

Westminster Council of Social Service
1 St Mary's Terrace
London WC2
01-723 8511/8516

Women's Royal Voluntary Service
65 East Hill
Wandsworth
London SW18

The Youth Service Information Centre
The National College for the Training of Youth Leaders
Humberstone Drive
Leicester
LE5 0RG
0533 67855

APPENDIX E

Information for Patients and Intending Patients

PINEL HOUSE

REGIONAL TREATMENT UNIT
FOR ADDICTION TO ALCOHOL AND
ALLIED DRUGS OF DEPENDENCE

WARLINGHAM PARK HOSPITAL
WARLINGHAM SURREY

South West Metropolitan Regional
Hospital Board

Croydon and Warlingham Park Group
Hospital Management Committee

INTRODUCTION

This is a separate inpatient unit for the treatment of alcoholic addiction, situated in the grounds of Warlingham Park Hospital. There are facilities for treating (in a small community) from 17 to 19 male alcoholics, and from three to five female alcoholics. The total number in the group never exceeds 20 and averages about 16. Patients are accepted from a catchment area covering officially those areas of Greater London known as Inner and Outer London served by the South West Metropolitan Regional Hospital Board (except Lambeth, Tooting and Mitcham, which form part of the catchment area of West Park Hospital Alcoholic Unit, which in addition serves Surrey), together with the whole of the London Borough of Croydon. The area represents about one million people, or approximately 7000 alcoholics! In addition, selected patients are referred by the Royal Air Force - from Wroughton Hospital, principally, although occasionally there are direct referrals from other RAF hospitals. Selected patients may be accepted from other areas by special arrangement if the facilities provided here are otherwise unobtainable.

As alcoholism is a disease, this small community has representatives from many different walks of life with differing social, economic, educational and religious backgrounds. The group borrows from AA the practice of using first names for identification. The group is encouraged, as far as possible, to be responsible for itself in house management and discipline. A group or deputy group leader is chosen every month by the staff team and this may be a matter for group discussion - similarly with the selection of the editor of 'Whaakey-Whaakey', the Reunion Magazine.

ASSESSMENT

Before entering the unit, you will have been interviewed and had your case assessed by the medical officer in charge. (This will often involve meeting the staff team after inpatient 'detoxification' and routine psychological testing - especially if you have been referred for assessment by another consultant in the Croydon Psychiatric Service.) The purpose of this interview was manifold:

a to discover whether you were an alcoholic addict
b to discover whether you accepted that you were an alcoholic addict and realised the implications
c to discover whether you wanted to stop drinking forever, knowing that you can no longer ever drink 'just socially'
d to discover whether you realised you were unable to do this alone
e to assess the best way of helping you to achieve your resolve to gain sobriety

Group psychotherapy is the method of treatment used in Pinel House. It is not suitable for every case and the medical officer will, from his special experience in treating alcoholic addiction, endeavour to give you the best advice on treatments available at the present time, (elsewhere, should that be necessary) but within Warlingham Park Hospital if you come from the Greater London Borough of Croydon.

Before accepting admission to Pinel House, every applicant will be expected to agree to commit himself 100 per cent to the treatment regimen. If you feel you cannot agree to this, then please say so rather than come in. Anyone who subsequently finds himself unable to cooperate fully will be discharged; in effect,

he will have requested his own discharge. Past experience has led to the view that, for your own sake, in your very difficult task of attaining permanent sobriety, very firm rules are necessary. Good group morale is an important factor in treatment and no exceptions can be made.

THE REGIMEN

Treatment usually lasts a minimum of twelve weeks, although it may be varied by the medical officer in charge, and you will be expected to agree to a full treatment period in advance of admission.

1 There are group psychotherapy discussions, known as Group 2, daily except Sundays. A member of the staff team will be present. Everyone is expected to go to all these meetings. Confirmed physical illness and, towards the end of your stay, interviews for jobs, are exceptional reasons for non-attendance.

2 There are at least four AA meetings each week. Everyone will attend these meetings, subject to the same exceptions as for group discussions.

3 Everyone will take part in occupational therapy of some kind each day, and join fully in the communal life of the unit. This includes a group session of art therapy (and possibly other special treatment opportunities in the future).

NB 4 Experience has shown that the formation of subgroups and special relations, including those with the opposite sex, completely 'removes' the people concerned from the treatment process and is often destructive in its effects on the rest of the group. As a result, with very few exceptions, people who do this fail to remain sober when they leave the unit; indeed they often 'slip' while still in the unit. Strong and often complex feelings about other group members will, of course, arise - but they are properly discussed in the psychotherapy meetings and not indulged outside the group.

5 No drink or drugs are to be brought into the unit.

6 No drink or drugs are to be consumed on or off the premises.

7 Please have the courtesy not to encourage others to drink or take drugs with you. If you do not wish to continue treatment, say so and leave. There is no point in drinking and trying to conceal it - you are only kidding yourself and annoying others.

8 If, on the other hand, at any time you feel like drinking but, nevertheless, wish to continue with treatment, ask for help from the group leader, his deputy or any member of the group or staff. After all, your drink problem is your sole reason for being in Pinel House.

9 Everyone will be expected, about half-way through his treatment, to read to the other members his 'life story'. In this, as indeed in all discussions, you must be completely frank and honest, no matter how difficult or embarrassing you may find it. Covering up or leaving out important incidents and feelings only serves to harm you by lack of committal to therapy. The staff and group members cannot help you if you present a false picture to them. When you write your life story you should be looking at yourself honestly for the first time.

10 After the life story, subject to medical approval, you will be allowed occasional weekend leave, if this is appropriate.

11 After the first two weeks, a certain amount of parole is allowed just outside the hospital grounds. At first this will be 'au pair' and does not include long journeys and days out.

NB Except on Saturdays and Sundays, visits further afield than Farleigh Post Office are not allowed without exceptional reasons which must be discussed in the group in advance of permission being sought.

12 The hospital grounds are quite extensive and may be used throughout the week when this does not clash with any part of the official programme. You are encouraged to avoid relationships with patients in other parts of the hospital, as this would otherwise interfere with your commitment to the group work.

13 Alcoholism often has its roots, and certainly has effects, within your family. Sometimes your closest relative, spouse or friend has a personality difficulty in his or her own right. Even when this is not so, it is important to involve these people early on in the treatment situation, wherever possible. They are often very puzzled and hurt by the effects of your illness and need help in understanding it. The psychiatric social worker will see you shortly after admission and will meet and interview your relative. We try to get relatives interested and involved in Alanon - the organisation for relatives parallel with AA. Some of them will need more help in a relatives' group run by the psychiatric social worker before, and sometimes after, you leave the treatment group (Group 5).

14 After the third week, you will be invited to look over Trelawn, the Richmond Fellowship House run with the local authority's cooperation, and whose psychiatric adviser is the unit director. The aim of this half-way house is to give skilled assistance in social rehabilitation after discharge from the unit. The house is available to all treated patients with or without social contacts, but particularly the latter; or with marriages in the process of repair or dissolution and, exceptionally, for some new patients awaiting assessment and admission to Pinel House. At a later date, if you are recommended to continue treatment after discharge by living at Trelawn, you will be invited to an assessment interview by the house group on the recommendation of your consultant when this has been fully discussed in Group 2. You may be invited for a weekend visit, but certainly will have a discussion with the house group after supper on a Thursday regarding your possible residence there. Referral does not necessarily imply acceptance.

15 When you leave the unit, you are advised to attend your local AA group regularly. You should also come to the reunion meetings at St Martin's-in-the-Fields on the second Thursday of every month. There is an Alanon meeting the same evening in the same place. You will have been to the reunion meeting at least three times before you leave the unit and these attendances, too, are a compulsory part of the treatment. Rarely, some of you may need follow-up support by a medical officer or psychiatric social worker. Most patients will need to continue with group psychotherapy for a while on an outpatient basis. Such groups meet in Rees House once a week on Tuesdays at 7 30 pm and are known as Groups 3 and 4. During the final weeks before discharge, inpatients are expected to discuss in the group the relevance of this type of rehabilitation to their own case. In those cases where travel or distance from the discharge address presents no real obstacle, applications to attend these groups will be considered by the staff team and

appropriate referrals will be made to a suitable group (possibly after interview) at the Friday staff meeting.

NB 16 If you 'slip' within a year of leaving the unit you will not normally be reconsidered for admission. If, however, you feel the danger of such a 'slip' and ask for help, rather than take a drink, a full period of readmission may be offered if a vacancy exists. If not, it may be possible to suggest other help of an appropriate nature; for example, temporary residence in Trelawn, or admission to George Ward (men)/Anne Ward (women) (Group 6). Former residents of Trelawn may only reapply there six months after leaving if relapse has occurred. In most instances, medical help is almost certainly needed first.

17 At any time preference will be given to those who ask for help instead of 'slipping', but under some circumstances a second admission can be arranged if you do 'slip' after a year. Paradoxical though it may seem, the longer you have managed to stay dry, the more likely is readmission to be allowed. Once again, ask for help before you 'slip'. Readmissions already attending Group 3 or 4 will discontinue these groups, but may reapply after completion of the course.

18 Some patients may be told on rare occasions that the method of treatment used at Pinel House has proved not to be suitable in their case; it is not always possible at the assessment interview to predict suitability with certainty. Such patients will be informed of other help they may seek elsewhere, should they ask for it, if they live outside the Greater London Borough of Croydon. Residents of Croydon will be offered help in Group 6 - a part of Warlingham Park Hospital set aside for such other forms of treatment. (These beds are often used, in addition, for assessment purposes prior to transfer to Pinel House.)

19 Rarely, for special psychological reasons, it may be necessary to recommend additional treatment in order to overcome some special difficulty. This special treatment may take the form of:

LSD abreaction
You may already have heard of this; in any case, should it become necessary, it will be fully explained to you. In this particular instance, you will be allowed the choice of refusing treatment without incurring immediate discharge. You will, however, recognise that you may get less benefit from your stay in doing so. Insights and memory recall afforded by this treatment must be fed back into the group.

Behaviour therapy - a special psychological technique only helpful in clearly defined problem areas. Should such treatment be thought useful, once again you will be fully informed by the staff as to the reasons and possible value.

20 During your first three weeks stay, while you are 'drying out', you will have extra groups to attend - Group 1 meetings - where you will be given the opportunity to learn about alcoholism as such and to ventilate your early reactions to having to accept yourself as an alcoholic.

21 Apart from routine matters which would normally be discussed with nursing staff, all problems should be discussed in the group. Individual interviews with members of staff are discouraged. Where a patient has special difficulty in starting to talk about a particular problem or aspect of his life, if he finds that enlisting the aid of another group member, or the group- (or deputy group-) leader, is not easy, he may request an interview, on Friday afternoon, with the

staff team as a whole, on condition that all that is discussed will be fed back into the group as soon as possible, with staff help.

22 Former patients not living in Croydon who experience special difficulty in receiving help from their own area with 'drying out' after a relapse, may, at the discretion of the consultant, be taken into Group 6 for a limited period.

NB For the convenience of ex-members who have a special problem to discuss, there will always be at least one of the staff available in the hospital every day. In the first instance Mrs Butler (Dr Salter's secretary) should be contacted at UAO 2101, and she will ensure that your needs are attended to appropriately. Ordinarily, queries are properly dealt with by the duty medical officer at Warlingham Park Hospital. Both Mrs Butler and the duty medical officer can, at their discretion, in cases of very special difficulty, put you in touch with the charge nurse of Pinel House (9 am - 4 45 pm) who can advise whether a particular member of the staff team is available, or, indeed, whether such individual help is appropriate if you are currently attending outpatient Group 3 or 4. On Sundays, the hospital chaplain (UAO 2102) may be able to assist, at the request of the duty medical officer. The unit director can sometimes be contacted at home (Caterham 42587). When he is unavailable, the operator will intercept your call and re-route your enquiry to Warlingham Park Hospital. In these circumstances, ask to speak to the duty medical officer who will ensure that a message is passed on, or will recommend appropriate action.

STAFF

Director	(consultant psychotherapist and psychiatrist-in-charge)
Psychiatric registrar	(rotating post every six months)
Charge nurse	
Staff nurse (rotating post every six months)	
Senior psychologist	
Chaplain	
Senior psychiatric social worker	
Part-time charge nurse - special attachment	

All the above take part in meetings of Groups 1 and 2. (The psychologist undertakes special tests when these are felt to be essential for adequate assessment.)

Groups 3 and 4 are conducted by the chaplain and the senior psychologist respectively, and Group 5 by the senior psychiatric social worker. All are specially trained and skilled in group work. Other members of the team rotate on a monthly basis through the outpatient groups. Medical responsibility remains with the unit director.

Two ward orderlies work in the unit; both are highly valued friends of many alcoholics.

Various other agencies cooperate and/or visit as required; for example, probation officers, disablement resettlement officers, social workers, representatives of the Medical Council on Alcoholism, the National Council on Alcoholism, also accredited hospital visitors and volunteers, residential services officers, Richmond Fellowship workers, Samaritans and, last but certainly not least, AA and Alanon. Similarly, in keeping with our 20-year tradition, from time to time doctors, psychiatric social workers, psychologists and other prominent guests from home and abroad visit the unit, which was the first of its kind in the UK. These visits will always be by

arrangement with the group leader in advance. Group approval is assumed unless we are notified 48 hours beforehand, and normally is traditionally given as a privilege. Almost the only grounds for objection to study visits will be that the visitor is known personally to a patient who wishes to retain his or her anonymity.

Medical students and nurses attend from time to time as part of their training programme, as do social workers, psychologists and pastoral counsellors.

THE 'LIFE STORY'

Personality is the sum total of a person's attributes, his feelings and emotions, his intelligence and intellectual standards and his outlook and attitudes.

It is derived from two sources - heredity - or his parents and forebears; and from the environment - or the atmosphere in which he has been brought up. There have been many arguments amongst psychologists of the relative importance of 'nature' and 'nurture', but in the field of personality development it seems likely that the greatest contribution comes from 'nurture' or the environment, as opposed to physique and intelligence, where the greatest contribution is probably from heredity.

It is common for us to look for the cause of our troubles in our immediate environment and circumstances or heredity; but experience suggests that the roots of our emotional problems may stem from the way in which we have handled and reacted to experiences that life has presented to us in the past.

To assess why we are what we are, it becomes necessary to reflect in some detail over our past lives. Things that we may have accepted as normal in our development may be in fact very abnormal; but we came to accept them because in our limited life we have known no other way and repetition by over-learning has repressed or suppressed instinctual misgivings. It is important, therefore, to share our life experience with others, to compare notes and to ponder over the differences. There is no clear-cut 'right' or 'wrong' way in development, but it may be that, in telling others about our lives and feelings, especially when soberly considering our lives along these lines, deviations from the so-called normal become evident. The importance of deviant learning leading to maladaptive behaviour becomes more apparent.

In Pinel House it is the custom for one member of the group each week to present his 'life story' to the others. What is required is a frank autobiography which can be read to a group in fifty minutes. You will require some time to write it, and the best method is to write down notes as they are recalled to memory over the first few weeks of treatment. It is likely that the listening to the accounts of others will recall incidents in your own life, and furthermore, as the treatment progresses you will begin to see some meaning in the things the group points out and the sort of thing which is important in development. Your finished 'life story' then, will not be presented until you have been here some weeks and have gained some appreciation of the things that matter, but the earlier you begin to make notes the better, for even the changing emphasis in your notes will, of course, be significant.

What are you to write about then? Whilst it is important to give a chronological account of your life and put your age in from time to time, and your circumstances with regard to where you were living or what work you were doing, it is the relationships between yourself and other people which are most important: your

early memories of parents and family, school-fellows and teachers, friends of both sexes, marriage partners and your own children. Try to write what you felt at the time, the emotions and thoughts you experienced rather than just factual information. Make it a diary of your feelings, personal and secret though you have hitherto regarded them, as to where your life may have gone astray. In this connection it is important that you write about your sexual development and feelings at all stages, for herein lies a great deal of your emotional life which cannot be ignored. Remember that sexual relationships should be viewed in the widest sense, from infancy through puberty to adulthood. 'Sex' is not just the physical act, but here refers to your total feeling-life towards both men and women.

Do not regard the 'life story' as a confession sheet. The group and staff are here to help you - not to judge you. There may be things which you have difficulty in talking about - but be truthful and tell us about it - they are obviously important or the difficulty would not arise. Give us a broad outline, tell the group of your difficulty and they will be able to help you over it. If you are truthful - and do not hold things back entirely, pretending they never happened - then even hinting at their existence will release some of the feelings and enable you perhaps at a later date to discuss them in full. After all, it is because you have difficulty that you are writing your 'life story'.

NB Don't wait until you have read your 'life story' before participating.

Don't stop participating in the group when you have read your 'life story'.

The 'life story' is only part of what should be continued group involvement daily.

GROUP THERAPY

Treatment in a group is one of the modern approaches to psychiatric treatment and if properly utilised can bring the patient real help very quickly, but unless the object and mechanism of the group is properly understood and used by the patient it can be a waste of time.

1 The group of patients and staff which meet usually represents a fair cross-section of the types of personalities with which we are in day-to-day contact. Thus it is a reflection of ourselves in the outside community. We do not get on with everyone outside. Different people provoke different reactions in others, depending on age, sex, their attitude, mannerisms and behaviour, and our own reaction is dependent on previous experience with that type of person. Thus in the group we have a chance to examine our own reactions in what must always be remembered is an artificially constructed group of people, all willing to cooperate to help each other. The group becomes an experimental representation of the world outside.

2 What we say in the group depends on our life experience. Free expression of feelings and exchange of views is desired so that we can learn about these reactions between people: but exchanges need not become hurtful if everyone remembers the purpose of the group is to seek the reason why one reacts thus, and not just to react blindly - which is what one has done outside in the community. Interpretation should be seen as constructive, not destructive - at least at a conscious level!

3 Thus the main value to the patient is constantly to seek behind what he or his colleague says and does to lay bare the motive for his behaviour. In this respect a group discussion about commonplace happenings of the day is often more helpful than theoretical delving into someone's past history, although the latter will often show that present day behaviour is yet again a repetition of poorly learned responses early in life. For example, if 'A' becomes irritable over the washing up with 'B' and this is discussed in the group, 'A' may find out that it is not 'B' he dislikes, nor washing up, but that he is always made anxious if people work with him, chat to him, and make overtures of friendship. Perhaps he constantly falls out with people - outside - because he becomes anxious that he cannot give in a friendship what is expected and because in earlier friendships he has always felt let down. So now he somehow evades friendships, although he would like a satisfactory one, and this is why he tends to be irritable - and so on.

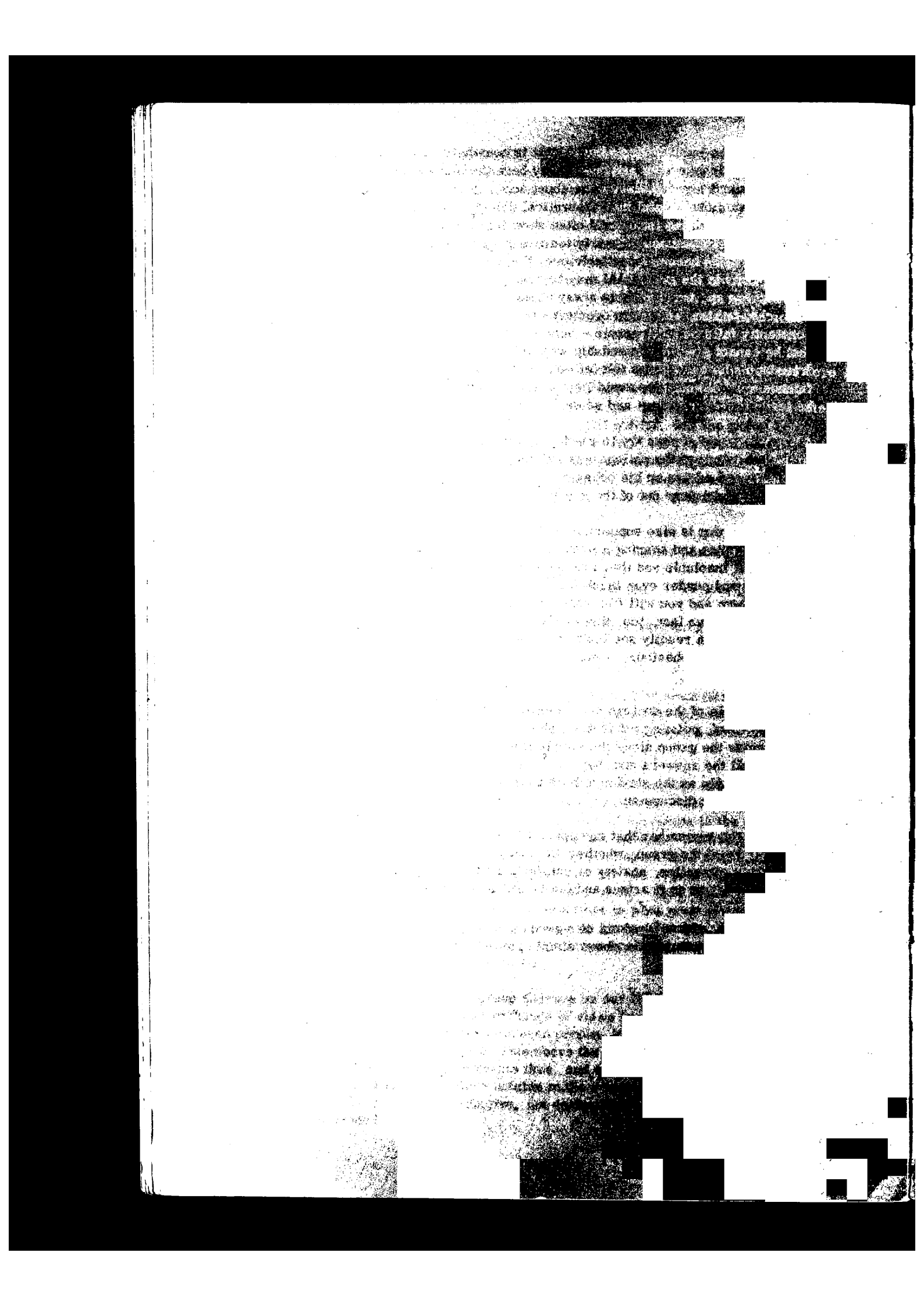
4 We should always try to relate what is happening in this group to the behaviour of the patient outside the group. If we can point out the faults and advise on his behaviour in the group, he may be able to modify his behaviour out of the group.

5 The group is also supportive and sympathetic. None of us can live in isolation and sharing a problem usually lessens it. Problems are seldom insoluble and they are seldom unique. If we keep them to ourselves and ponder over them they begin to feel insoluble and unique. Discuss them and you will find someone else had a similar experience. It is a well known fact, too, that one has blind spots to one's own faults, although one can readily see faults in another. In pointing out someone else's mistaken behaviour, it may be one realises that this could also apply to one's self.

6 The role of the doctors and other staff in the group is to keep a watching brief, pointing out factors which may otherwise go unnoticed, and to guide the group along the simple lines outlined above. The staff do not have all the answers and they have their problems too. The patient is just as likely as the staff members to find a solution to one of the problems under discussion.

7 Always remember that any special feeling for another member or members of the group, whether male or female or both, whether love, hate, fear, attraction, anxiety or comfort, MUST be discussed in the group meeting, as soon as it arises and not be indulged in outside the group.

8 Finally, you will get out of a group according to what you put in. You need only bear in mind the above simple guide-lines.



APPENDIX F

Pinel House — Schedule of Accommodation

	m^2	sq ft
1 room of 5 beds	32.5	350
2 rooms of 3 beds	43.7	470
4 rooms of 2 beds	59.5	640
Patients' lavatories — men's	30.6	329
Patients' lavatories — women's	34.1	367
Patients' kitchen (including larder)	13.9	150
Patients' utility room	9.3	100
Group therapy/TV lounge	32.5	350
Group therapy/dining-room	29.7	320
Day space	22.7	244
Library/occupational therapy room (including store)	24.9	268
Staff base	12.4	134
Office	7.1	76
Treatment room	12.4	134
Cleaner's cupboard	2.7	29
Storage	10	107
Plant	4.3	46
Circulation	86.8	936
total	469.1	5050

APPENDIX G

Royal Edinburgh and Associated Hospitals Unit for the Treatment of Alcoholism — Schedule of Accommodation

	m^2	sq ft
Men's ward (4 beds)	26.8	288
Single bedroom (man)	11.4	123
Women's ward (4 beds)	25.0	269
Single bedroom (woman)	11.7	126
Men's ward (7 beds)	31.0	334
Bathroom	3.6	39
Lavatory	2.2	24
Men's lavatory/bath	11.1	120
Men's lavatory	7.4	80
Women's lavatories	6.5	70
Women's lavatory	3.9	42
Laundry	7.8	84
Servery	14.2	153
Clean utility room	9.5	102
Group therapy room	31.3	337
Games room	26.0	280
Quiet room	12.5	135
TV lounge	31.8	342
Dining-room	31.4	338
Office	12.9	139
Office	12.7	137
Office	13.3	143
Duty room	14.3	154
Closet	2.9	31
Closet	6.1	65
Wall cupboards	4.4	47
Circulation	186.0	2003
total	557.7	6005

APPENDIX H

Proposed ADD Unit — Schedule of Accommodation

	m^2	sq ft
4 multi-bed rooms (each 24.6m^2) including wardrobe	104.6	1126
Single bedroom	12.2	131
Single bed/treatment room	11.0	118
Patients' lavatories and bathrooms (men)	24.7	266
(women)	21.1	227
Patients' kitchen	15.4	166
Patients' utility room	12.8	138
Group therapy/TV lounge	25.1	270
Group therapy/recreation room	27.9	300
Dining space	35.3	380
Library/occupational therapy room	13.2	142
Quiet room/visitors	11.4	123
Staff base	11.4	123
Office (social worker etc)	11.0	118
Staff conference room	11.0	118
Staff lavatory	2.6	28
Cleaner's room	3.4	37
Stores (including cupboards, etc)	5.7	62
Plant	10.6	114
Corridors	113.3	1220
total	483.7	5207

[redacted]

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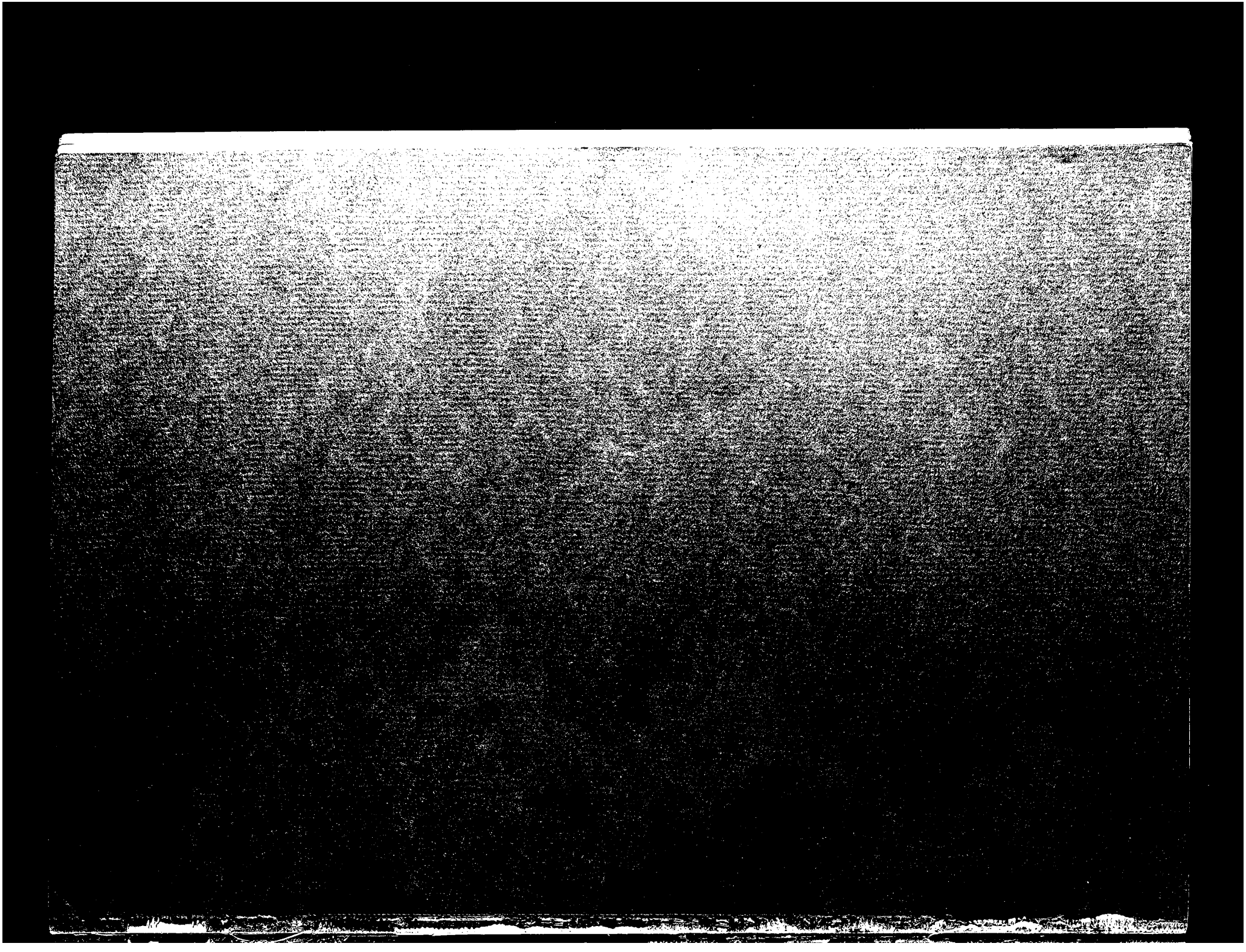

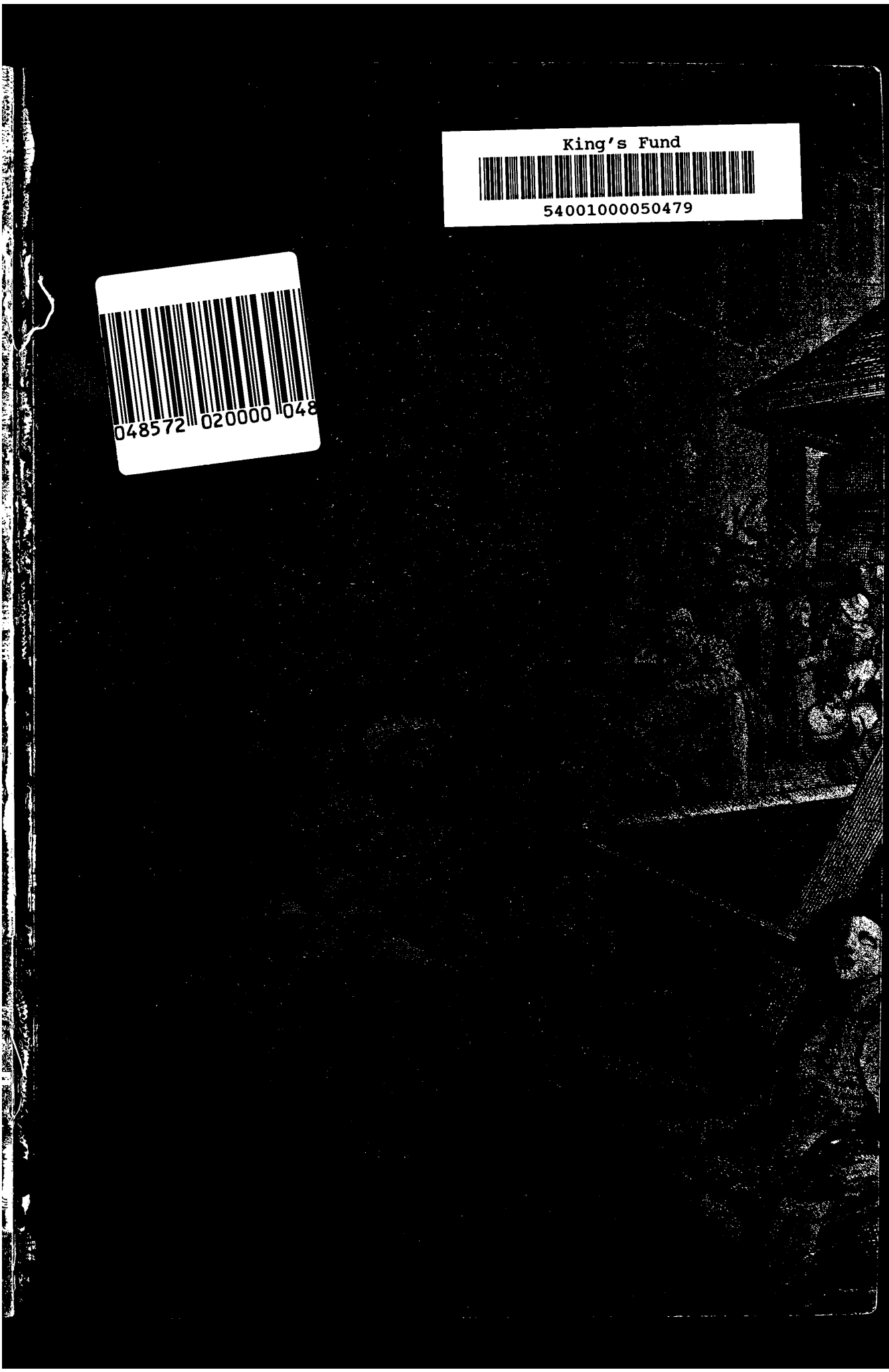

In this book a psychiatrist, a nurse, and an architect who is himself an alcoholic, combine their specialist knowledge and intensive experience of the regional treatment unit, Pinel House, of Warlingham Park Hospital in Surrey, to produce this report of their study sponsored by King Edward's Hospital Fund for London.

They describe principles underlining treatment and management of alcohol and drug dependence by group methods, including family therapy and the use of Alcoholics Anonymous and other voluntary bodies, and link these to design requirements. Units in Edinburgh, Washington DC and Butner, North Carolina, are compared. Treatment facilities in the national health service in the United Kingdom are critically examined.

Problems of addiction are similar regardless of the type of drug and the authors advocate a specially designed unit for the combined treatment of alcohol and drug dependence — the ADD unit, set within the district general hospital, with a coordinated inpatient and community health service.

They give detailed recommendations on

design and siting
equipment and furnishings
staffing requirements
daily treatment programme
built-in research and training facilities
functional relationships with the hospital and community health services.