Adult Guidance Center, San Francisco

By McCLAIN JOHNSTON, M.D.

WITH THE RECOGNITION of chronic alcoholism as a public health problem, more interest is being shown in public education on the subject, more legislation to establish and operate clinics and hospitals for alcoholics is being passed, and medical, sociological, and psychological research in this field is increasing.

Ten months after publication of a report on the extent of alcoholism in San Francisco, the city board of supervisors made a lump sum appropriation of $50,000 for the fiscal year 1949–50 to establish an inpatient facility for treating men charged with and convicted of drunkenness. The pilot clinic opened July 15, 1949, in the hospital ward of the men's division of the San Francisco county jail. A psychiatrist, a psychiatric social worker, and a clerk-stenographer comprised the staff. During the 20½ months the pilot clinic was in operation, medical and psychiatric treatment was given to approximately 200 patients. The pilot clinic was under the direction of the City and County of San Francisco Department of Public Health.

There were definite disadvantages in attempting to treat alcoholics in a jail setting. It was felt that the problem of alcoholism could be handled better if the treatment and punitive programs were completely separate. Funds for both inpatient and outpatient facilities were not available. However, an additional $35,000 was added to the original budget of $50,000 to establish and maintain a voluntary outpatient clinic which would be apart from the jail. On April 2, 1951, the Adult Guidance Center opened and the pilot clinic in the jail closed.

Dr. Johnston, a psychiatrist, is the full-time director of the Adult Guidance Center, a bureau of the City and County of San Francisco Department of Public Health.

Organization

The Adult Guidance Center is open 12 hours a day, 6 days a week, to accommodate patients whose work schedules might conflict with clinic attendance. A psychiatrist-director, 4 psychiatrists, 3 psychiatric social workers, 2 nurses, and 3 stenographers make up the staff. The 4 psychiatrists and 1 of the nurses are on a half-time basis. All services are free. The clinic is a bureau of the City and County of San Francisco Department of Public Health. The budget for the fiscal year 1952–53 is $75,000.

The psychiatrists on the staff interview and evaluate new cases coming for treatment, make progress notes on the active cases who receive medical treatment only, and see cases in psychotherapy. The duties of the social workers fall into three major areas: intake-interviewing on new cases, liaison with other agencies about individual cases, and the carrying of cases in psychotherapy. The nurses administer medication, and make progress notes on cases receiving medical treatment only, when the psychiatrist on duty is interviewing a patient.

Two staff meetings are held weekly: one is for case presentation; and the other is an administrative meeting where general policy, procedural changes, and clinic problems are discussed. Each social worker has a weekly supervisory conference with the director to discuss problem cases or to review psychotherapeutic interviews.

Admission

Each new patient must live in the city and county of San Francisco. He must be "dry" for 24 hours prior to admission. He must feel that he has a drinking problem. Under this criterion, we require only that the patient come to the clinic voluntarily with the realization that his drinking is causing some problem in his day-to-day living. Not all patients are chronic alcoholics in the usual sense of the expression. Many state they are not alcoholics at all. The criterion of a 24-hour "dry" period was set because the clinic is not equipped to handle the acute emergencies which severe intoxication presents. Rare cases of this type are taken to an emergency hospital. One bed is maintained in the clinic for the occasional patient with convulsions.

Patients are referred to the center from Alcoholics Anonymous and from all psychiatric clinics in the city. Referrals are also made by private physicians, the courts, municipal social agencies, the State bureau of vocational rehabilitation, the city-county hospital, and the county medical society.

Our patients represent a fair cross section of the city's population according to social and economic levels. The majority are skilled and semiskilled laborers and white-collar workers. Women have consistently represented 25 percent of the admissions since the opening day of the clinic.

Procedures and Services

On arrival, each new patient gives his name and address to the receptionist. The patient is next introduced to the psychiatric social worker. In his own way he describes his problem during an unhurried interview with the social worker—lasting from 45 minutes to an hour. Specific information for statistical evaluation is elicited at the end of the intake interview if the patient has not spontaneously provided the answers during his conversation with the social worker. Before the interview closes, the medical and psychiatric facilities available at the center are discussed with the patient. The social worker attempts to ascertain what type of treatment will be most helpful.

If a new patient manifests no interest whatsoever in group or individual psychotherapy, and if he has had no prior contact with Alcoholics Anonymous, then the functions of Alcoholics Anonymous are explained and a referral may be made to that organization.

The social worker writes a short summary of the intake interview just after seeing the patient. This summary is given immediately to the psychiatrist on duty, who reads it, and then interviews the patient. The drinking problem and the patient's general emotional status are evaluated, and again the various forms of treatment are discussed. On the first day of their contact with the clinic, most new patients are started on medical treatment which consists of adrenocortical hormones and vitamin preparations. Group and individual psychotherapy are discussed, but the first appointment with the therapist—either a psychiatrist or a social worker—is usually deferred for 2 or 3 days in most cases.

Patients are told that if they are interested in either group or individual psychotherapy they should mention their interest to the psychiatrist on duty on their return in the next few days for injections. At that time, an appointment will be made with a psychiatrist or a social worker if individual psychotherapy is requested; if group psychotherapy is desired, the patient's name is listed for one of the group meetings. When an appointment for individual psychotherapy is made with a social worker, the patient is almost always referred to the person who conducted the original intake interview.

The psychiatrist briefly checks the general physical status of the patient, and he may give him a physical examination if it seems indicated. Whenever physical disease is found or is suspected, or if a medical checkup appears necessary, the patient is referred to his family physician or to one of the city or university outpatient clinics.

The Adult Guidance Center believes that a temporary deferment in appointments is often helpful in attempting to elicit motivation for psychotherapy. Our past experience has been that many new patients, particularly patients who are weak and physically rundown from a recent "drunk" or those patients who exhibit the

usual symptoms of hangover, will request medical treatment, individual psychotherapy, and group psychotherapy. Then, in a day or two when they are closer to par, their motivation for psychotherapy would greatly decrease, and they would state that probably the hormones and vitamins would be sufficient.

On January 1, 1952, when the clinic staffing was completed, the policy that all patients be offered either individual or group psychotherapy became effective. In some cases, a patient may receive both individual and group psychotherapy. Prior to that date, only selected cases were offered psychotherapy. Although the budget appropriation provided for full staffing earlier, the acquisition of adequately trained psychiatric social workers and psychiatrists was not completed until then.

Individual psychotherapy is dynamically, that is psychoanalytically, oriented. The patient is given an opportunity to attempt to work through his emotional problems with the help of the psychiatrist or psychiatric social worker. Since all patients at the clinic have a drinking problem, with the possible exception of some of the relatives, the psychotherapy is naturally concerned with this symptom, although no specific attempt is made to limit therapy to this one aspect of psychopathology.

The clinic does extend psychiatric help to the significant member or members of the patient's family when this seems indicated.

Each one of the psychiatric social workers has had considerable experience in psychotherapy. Seldom is there a differentiation between psychiatrist and social worker as to the handling of a particular case. Individual psychotherapy is conducted by the psychiatric social worker under the supervision of the clinic director.

Group psychotherapy is also conducted along dynamic lines with the group leader, a psychiatrist, occasionally giving interpretations, focusing on a particularly significant point in the session, and at times acting as an arbiter. Generally, the group sets the pace. The leader supplies factual information when it will be helpful. The groups are small ranging from 3 to 9 persons and are separated as to sex. Each group meets once a week. The duration of individual interviews is approximately 50 minutes. Group sessions last approximately 75 minutes.

Followup

Prior to a major policy change in August 1951, patients were given medication by injection and the frequency of patient appointments was gradually decreased. When a patient had returned physically to par and did not exhibit too much nervousness or tension, he was told that the clinic thought he was doing well and that he had probably achieved the maximum benefit from the injections. He was then asked to return in about a month for a followup interview.

On the basis of experience, this method of followup was not effective. Returns for interviews were few. With the rather sudden discontinuance of clinic contact, many patients resumed drinking. Lacking was the supporting effect of frequent interviews over a long period of time.

Patients are now seen more frequently in the early days of their treatment program, and the decreasing frequency of contact is more gradual. The philosophy of continued contact is discussed with each new patient early in his treatment, and he is told that even though he will eventually be seen only once a month, the clinic would like him to come indefinitely. Definite appointment dates are set. No patient is automatically discharged by the clinic. Patients in individual or group psychotherapy naturally attend more frequently.

In a reasonable period of time the psychiatric social worker attempts to follow by telephone any patient receiving medical treatment only who has missed an appointment. A reasonable period is determined on the basis of frequency of appointments. The tenor of the telephone contact is that the clinic has noticed the patient has missed his appointment—what can be done to help him? This procedure seldom provokes the guilt and hostility generally felt in a situation of being checked on.

It depends on the individual patient in psychotherapy whether a letter followup is used after he has missed one or more appointments. In any case the door is left open and the patient is in no way pressed to return. It is the opinion

of the staff that more active and forceful methods of followup are not directly proportional to a greater number of patients maintaining sobriety or even to longer periods of sobriety in individual cases.

Field followup has never been possible because of the small size of the social service staff. But aside from staff limitations, close followup in the home might not be desirable for the alcoholic patient. Actually, too close surveillance may operate against beneficial results.

Educational Activities

Ever since the inauguration of the clinic, staff members have given talks about the program before Alcoholics Anonymous, the Red Cross, regional groups of psychiatric social workers, and local and State public health meetings. The Adult Guidance Center has participated in panel discussions on psychiatric facilities in San Francisco during National Mental Health Week. Material concerning the clinic's functions has been sent to all social agencies, psychiatric clinics, and other referring organizations.

Research and Evaluation

To evaluate the overall results of treatment for a large group of chronic alcoholics is extremely difficult. Even sobriety, the most objective criterion, must be qualified whenever, it is discussed, since many patients who may have been sober only a few weeks or months during clinic contact have in the past been steady drinkers. With others, even though continued sobriety has not been attained, the conflict in their family relationships has decreased.

A less striking factor, but a meaningful index, is the increase in the number of days patients are spending at work because of less frequent "binges" and shorter recovery periods with clinic treatment.

A most important factor, of course, is the actual existence of a clinic to which sick patients can turn for help. This alone gives immeasurable hope and reassurance to patients and their families and friends.

Since August 1951, when the policy was initiated to have patients keep continued contact with the clinic, the staff has been able, at any time, to enumerate the active and inactive patients.

As of February 28, 1953, 2,435 patients had been accepted for treatment, and 31,591 visits had been made to the clinic.

From August 20, 1951, through February 28, 1953, 1,573 patients sought treatment; 25 percent of these were women. The 1,573 patients were divided into 4 groups:

Group	*Percent*
A—Active and "dry"	29
B—Known to have resumed drinking	12
C—Patients with whom clinic has lost contact	51
D—Discontinued clinic treatment for reasons other than drinking	8
Total	100

The clinic gives treatment to a large number of patients. At present, clinic visits average 65 a day. When the 3 criteria of clinic admission are met, treatment is begun almost immediately. No appointments need be made by telephone, and there is very little, if any, waiting for intake interviews. This immediate availability of treatment and the lenient eligibility criteria are undoubtedly important factors in the large percentage in group C. An additional factor is that this figure includes those with only 1 clinic contact. The clinic feels the 29 percent in group A is a reasonable return for the expenditure of funds and hours but naturally hopes to improve this figure. Although it is reasonable to assume that some of the patients in groups C and D are still "dry," adequate followup is not possible for several reasons: small size of the social worker staff, large number of patients, and frequent changes of address. Even though adequate personnel for followup were available, the frequent changes of address would make this activity extremely difficult.

Even the patients in group B, who are known to have had at least 1 slip, attained an average of 66 days sobriety prior to their resumption of drinking.

Since August 20, 1951, 21.1 percent of the patients have participated in either individual or group psychotherapy, or in both: 12.1 percent received at least 1 hour of individual psycho-

therapy in addition to the intake interview; 8.9 percent participated in group psychotherapy; and 0.1 percent participated concurrently in individual and group psychotherapy. The remaining 78.9 percent of the patients have received medical treatment only.

The average number of hours of psychotherapy to date is:

Group	*Average hours*
A	11½
B	6
C	6¾
D	6

Approximately 3 months after the clinic opened, plans were made for a controlled group study to evaluate the benefits achieved with adrenocortical hormone and vitamin therapy. Although laboratory facilities are not available for any extensive pharmacological determinations, the effect of the drugs on various physical and emotional symptoms and the duration of sobriety can and are being evaluated.

The comparative effectiveness of medical treatment with or without group or individual psychotherapy is in the process of assessment, although it is often difficult, if not impossible, to state specifically the factors leading to a patient's improvement. The clinic is interested in the comparative speed of recovery from acute alcoholic symptoms with the use of adrenocortical hormones and various vitamin preparations. The results of group and individual psychotherapy can be evaluated in terms of the individual development of healthier and more adequate personality defenses leading to more mature, realistic behavior. In most cases this realistic behavior leads to the state and maintenance of sobriety.

Gamma Globulin for Poliomyelitis Is Distributed

Initial supplies of gamma globulin for use against paralytic poliomyelitis were released by the Office of Defense Mobilization and shipped to State and Territorial health officers by the Public Health Service in mid-May.

Under policies established by the Office of Defense Mobilization, about 57 percent of the total national supply of immune serum globulin available for poliomyelitis inoculations is being distributed. An additional 33 percent is for use in mass prophylaxis where epidemics are most severe. The remainder, about 10 percent, will be assigned for research and emergency purposes. Concerning the allocation plan, the Office of Defense Mobilization notes "it is expected that further modification and supplementation will be necessary from time to time in the light of experience and existing circumstances."

The first release of the agent was not sufficient to provide State health departments with their complete basic allocations. Subsequent shipments are being made automatically, without further request from health officers, until distribution of the entire basic allocation has been accomplished.