The Future of Alcoholism Programs

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In the closing paper at the 10th annual meeting of the conference of the North American Association of Alcoholism Programs, held in West Harwich, Mass., September 11, 1959, Dr. Brightman appraised current programs for treating alcoholics and suggested some future trends. Following is a summary of his statement.

A PROGRAM for alcoholism can be no stronger than the total public health, mental health, educational, and welfare programs of the community. No matter how many specialized clinics and hospital services we have, we shall still be dependent upon adequate medical and mental health clinical services in the community to accept, treat, and rehabilitate alcoholics if the total needs are to be met.

The best vocational programs of local alcoholism committees cannot serve the alcoholic as well as an adequately organized public vocational rehabilitation service which evaluates, trains, and places persons with all types of long-term illnesses and disabilities, including alcoholism.

Indeed I question whether we are justified in asking for well-organized alcoholism programs in the absence of adequate public health services. What about a community which is weak in maternal and child health and welfare services, has inadequate tuberculosis control, and lacks an approach to cancer control? Which program should have priority? Recognition of such deficiencies means that a group interested in alcoholism control has a double duty; it must first argue for the development of these more basic services.

Scientists, including Dr. E. M. Jellinek, are working on an improvement of the Jellinek formula for estimating the prevalence of alcoholics in the country, the State, and the community. We can look forward to the development of a more precise instrument to make comparisons, to observe trends, and to place alcoholism in perspective in relation to other public health concerns. However, our most elaborate alcoholism programs now provide for only a handful of the total number of alcoholics known to the courts, the family agencies, the welfare departments, and the waiting lists of the alcoholism clinics themselves.

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Planning for Types of Alcoholics

To a great extent, many of our programs were sold on the basis that the alcoholics were crowding our courts and jails and were disgracing our cities with skidrows. It was expected that development of public information centers and clinic services would reduce the court problem. Many clinics have developed, and most of these are taxed to capacity. I don't think many of us would claim that we have yet made a significant dent in the conditions upon which we based our premises. We have recognized that our clinics are serving a different population, the problem drinker whose alcoholism is interfering with his family, industrial, and community life, even though he may still be maintaining ties in these areas.

We must reconsider the alcoholics known to the courts and to the police. We must recognize that in these patients who are mostly homeless and have little or no social background upon which to build, nothing to which they may be rehabilitated, we have a sociological rather than a public health problem.

In New York State we have been interested

in the development of an institution, Camp La-Guardia, at Chester, N.Y., where men are referred from the Municipal Lodging House in New York City. Originally designed to give these men a few weeks stay in the country, the camp is now a 1,000-bed facility with two-thirds of its residents permanent. They have demonstrated that they need sheltered care more than they do alcohol; only about 20 percent violated camp rules and went to the village for alcoholic beverages, not satisfied with the beer purchasable on the premises. By having every man take care of his personal needs and all who are capable perform chores, the camp is run at the cost of $2 per person per day, or 10 cents less than the cost of operating the Municipal Lodging House.

Specialists may argue that nothing is being done to rehabilitate these unfortunate individuals and that it is not a "modern approach" simply to provide sheltered care. Obviously, a great number of professional services, including social work evaluations and vocational rehabilitation counseling, assuming professional personnel could be recruited, would send the costs of this operation beyond what the taxpayers and the legislators might be willing to meet. The question would arise as to what might be expected from such services. Certainly every attempt should be made to identify those campers who might have potentialities for achieving a better social and economic status in life. But our efforts might better be spent, from the financial and personnel viewpoints, in the rehabilitation of persons suffering with chronic alcoholism who have a more sound social structure upon which to build.

Public and voluntary agencies have made much headway in gaining support for alcoholism programs from certain segments of the population, but there are still many obstacles to reasonable acceptance of the program by the community as a whole.

Why is the public not inclined to support a dynamic program for victims of alcoholism? I think the answer is relatively simple. The public is appalled by the picture of the skidrow alcoholic which, for many persons, is synonymous with alcoholism. This is not the person seen in most of our clinics. Rather it is the problem drinker, with a family and a position in the industrial community, striving to preserve his ties to society. If the alcoholic himself cannot present a sympathetic picture, then his wife and children may do so, because they will become community responsibilities unless the alcoholic breadwinner is assisted. The cost and danger of alcoholism to the drinker's employer and fellow workers is also a powerful argument for treatment.

Relationships With Other Agencies

To a great extent, alcoholism clinics have operated as isolated units, even when located in health departments, and the cause has suffered seriously from this provincialism.

We cannot possibly handle all the alcoholics through specialized services. While there is a valid basis for continuing to require specialized facilities, particularly in large centers of population, to serve as demonstration projects and to handle special problem cases, most alcoholic patients can be cared for by the general agencies: mental health clinics, family care agencies, general hospitals, vocational rehabilitation services, and many others. Acceptance of alcoholics by the general agencies will result in utilization of their staffs' professional personnel, reduction of the stigma of alcoholism, and better management of individuals and families with a complex of many problems.

To achieve such acceptance, we have two tasks to do. The first is to encourage the general agencies to feel that they can serve the alcoholic patient effectively. The reluctance of the physician, the social worker, or the vocational counselor to provide services for alcoholics is not too surprising. Their experiences have been frustrating and disappointing. But care of the aged was also rejected by many physicians and other professional personnel until demonstrations revealed the achievements possible. Such demonstrations would serve the alcoholics, as well.

Second, we must train the personnel of the general agencies in the management of alcoholism. New York State has been operating a scholarship and training program to send individuals to the Yale Summer School of Alcohol Studies and to other special courses. During the past 3 years, 57 persons have received

such training. Many are with general programs and we are hopeful that this training will increase their services to the alcoholic population.

Evaluation of Results

In evaluating the results of our work, it is essential not to make false claims. These can set us back many years or possibly eliminate our programs entirely. On the other hand, it is equally important to recognize where improvements have occurred. Certainly, we recognize that it is not necessary for alcoholic patients to develop into complete abstainers before they can begin to show improvement. Maintenance of family relationship which has been shaky during the period of frequent drinking, ability to keep a job that was previously threatened, ability to stay out of jail when frequent police pickups have formerly occurred; these are signs of real improvement, even though ideal behavior may not have been attained. Reductions in the frequency and intensity of alcoholic bouts permit the alcoholic to function to some degree and enjoy a more sympathetic environment, which is an important element of therapy.

The halfway house and other specialized services require careful study. It is not sufficient to say so many persons were placed in employment. The question is how long do they stay in employment. Data given out on the general vocational rehabilitation programs use as a criteria a placement of a person in a job for 30 days. But how many persons who can maintain themselves in jobs for 30 days, particularly after a great deal of supportive therapy by vocational counselors and other persons and possibly special consideration by their employers, are still able to hold a job after these special considerations are dropped? As more halfway houses develop, we must begin to develop procedures for following such persons to see how many are working at 3 months, 6 months, and 1 year. We may then determine whether such results are related to our own efforts.

The Future

The North American Association of Alcoholism Programs has grown from a handful of member agencies 9 years ago to our present 36 members. At the same time the number of commissions on alcoholism has declined from 18 to 14, and the number of State department of health alcoholism units has increased from 8 to 14. This is a healthy sign if, as I believe, alcoholism programs can be most effective when closely associated with other public health programs.

The association is fortunate to have had a joint committee with the National Council on Alcoholism. In every area of health, a proper balance of activities between public and voluntary agencies is essential to really effective action. There is not only ample room but definite need for both, and the more one progresses, the easier will be the task for the other.

We have three major goals for the years ahead; evaluation of what we have done, the development of better means of prevention, and the advancement of behavioral, biochemical, and administrative research. The association is sponsoring the development of an evaluation study through a new Coordinating Commission on Alcoholism, which has the potential of gaining confidence for our present activities, or if we are not operating in the proper direction, reshaping them.

Prevention, of course, is the ultimate goal. However, for the present there is no likelihood of prevention of alcoholism as a specific phenomenon. Prevention lies in the promotion of mental health and in assistance to emotionally immature or unstable persons. This course of action may serve to curb not only alcoholism but many other forms of destructive behavior.

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