This report contains the collective views of an international group of experts and does not necessarily represent the decisions or the stated policy of the World Health Organization.

WORLD HEALTH ORGANIZATION

TECHNICAL REPORT SERIES

No. 48

EXPERT COMMITTEE ON MENTAL HEALTH

ALCOHOLISM SUBCOMMITTEE

Second Report

WORLD HEALTH ORGANIZATION

PALAIS DES NATIONS

GENEVA

AUGUST 1952

First impression, August 1953
Second impression, April 1953
Third impression, January 1954

EXPERT COMMITTEE ON MENTAL HEALTH

ALCOHOLISM SUBCOMMITTEE

Second Session

Copenhagen, 15-20 October 1951

Members :

Dr. S. Betlheim, University Neuro-Psychiatric Clinic, Zagreb, Yugoslavia

Dr. L. E. Dérobert, Professeur agrégé à la Faculté de Médecine de l'Université de Paris, France

Dr. R. Fleming, Director, Alcoholic Clinic, Peter Bent Brigham Hospital, Boston, Mass., USA (*Vice-Chairman*)

Dr. G. A. R. Lundquist, Associate Professor of Psychiatry ; Chief Physician, Långbro Hospital, Stockholm, Sweden

Dr. I. Matte Blanco, Professor of Psychiatry, School of Medicine, University of Chile, Santiago, Chile (*Rapporteur*)

Dr. M. Müller, Professeur de Psychiatrie ; Médecin-Directeur de l'Hôpital psychiatrique de Münsingen, Berne, Switzerland

Dr. M. Schmidt, Chief Psychiatrist, Institute of Forensic Psychiatry, Department of Police, Copenhagen, Denmark (*Chairman*)

Secretariat :

Dr. G. R. Hargreaves, Chief, Mental Health Section, WHO (*Secretary*)

Professor E. M. Jellinek, WHO Consultant on Alcoholism ; Dean, Institute of Alcohol Studies, Texas Christian University, Fort Worth, Tex., USA

The report on the second session of this subcommittee was originally issued in mimeographed form as document WHO/Ment/28, 2 November 1951.

PRINTED IN SWITZERLAND

EXPERT COMMITTEE ON MENTAL HEALTH

ALCOHOLISM SUBCOMMITTEE

Second Report[1]

1. Introduction

The Alcoholism Subcommittee of the Expert Committee on Mental Health held its second session in Copenhagen from 15 to 20 October 1951. Dr. G. R. Hargreaves, Chief of the Mental Health Section, conveyed the greetings of the Director-General of the World Health Organization. The subcommittee unanimously elected Dr. M. Schmidt as Chairman, Dr. R. Fleming as Vice-Chairman, and Professor I. Matte Blanco as Rapporteur.

The agenda of the second session concentrated more on practical and specific aspects of the problem of alcoholism in contrast to the more general and theoretical considerations of the first session.[2] The subcommittee regards as one of the most urgent matters recommendations on the organization of rehabilitation facilities for alcoholics. Without prejudice to the preventive aspects of a programme, the subcommittee feels that progress in the various phases of the problem of alcoholism is most feasible only after the large number of alcoholics throughout the world has been considerably diminished through a large-scale rehabilitation effort.

---

[1] The Executive Board, at its ninth session, adopted the following resolution:

The Executive Board,

Having considered the report of the Alcoholism Subcommittee of the Expert Committee on Mental Health on its second session;

1. THANKS the members of the subcommittee for their work;

2. AUTHORIZES publication of the report;

3. NOTES the recommendation in section 5 that a survey of alcoholism should be undertaken in one of the proposed health demonstration areas, and

4. REQUESTS the Director-General to study the possibility of undertaking such a survey in co-operation with the government concerned.

(Resolution EB9.R48, *Off. Rec. World Hlth Org.* **40**, 16)

[2] See *World Hlth Org. techn. Rep. Ser.* 1951, **42**.

The subcommittee also wishes to point out that the treatment of alcoholism contains an element of prevention, particularly through the favourable publicity which inevitably develops around such efforts. When the public understands the disease nature of alcoholism, a much greater acceptance of preventive measures may be expected.

2. Treatment Facilities

The deliberations of the subcommittee suggest that public care of alcoholics must proceed on four levels. These treatment levels are determined by the phase to which the alcoholic process has progressed and the degree of psychiatric involvements.

Broadly, the following levels may be distinguished:

(*a*) Early alcoholism, and alcoholism without gross neurotic origins.

(*b*) Alcoholism at the middle stages of the process, and alcoholism with primary neurotic characteristics.

(*c*) Alcoholism in the chronic stage, and alcoholism with psychotic involvements.

(*d*) Alcoholism with apparently irreversible deterioration.

Outpatient clinics

The first level, namely, the treatment of early alcoholism and of alcoholism without serious psychiatric involvement, requires an outpatient clinic attached to a general hospital rather than to a mental institution. Alcoholics in the early phases of the disease, as well as alcoholics without grave neurotic encumbrances, are unwilling to go as outpatients to mental institutions in countries where this involves a certain stigma of mental abnormality.

Because of the lack of this simple type of outpatient clinic, many psychiatrists who see alcoholics have not gained experience with the incipient alcoholic or uncomplicated alcoholic, and many ideas of the past concerning the treatment of alcoholism are based entirely on experience with late and complicated alcoholism.

The intensity and nature of psychotherapy required depend upon the stage of the alcoholic process at which the patient has arrived as well as upon the degree of neurotic or psychotic involvements.

As the outpatient clinic of the general hospital should deal with the early and uncomplicated cases only — which constitute the majority of the alcoholic population — the psychotherapeutic requirements at such a clinic may be at a minimum. As a matter of fact, largely so-called

" supportive " psychotherapy is required, sufficient to set up and reinforce the motivation of the alcoholic for stopping drinking. This involves the restitution of self-respect and self-confidence, a diminishing of the guilt feeling which arises out of the drinking behaviour, and a briefing of the alcoholic on the mode of life which will make it possible for him to carry on without alcoholic anaesthesia. It also requires a full understanding on the part of the patient that no form of drinking is possible for him without relapsing into gross alcoholism.

This type of supportive psychotherapy does not require a psychiatric specialist, although the guidance of the personnel should preferably be in the hands of a psychiatrist.

In the absence of a psychiatrist, this type of outpatient clinic may be headed by a physician with a strong interest in alcoholics and a general understanding of psychiatric principles. As a minimum requirement this physician should be assisted by one full-time social worker and a secretary; the assistance of a trained nurse is also desirable. Should finances allow, a second social worker is useful, particularly for the purpose of " follow-up " care of discharged patients. If the outpatient clinic is to serve at the same time as a diagnostic clinic, the presence of a psychiatrist on the staff must be regarded as indispensable.

In every instance physical examination must be arranged for at the medical outpatient clinic and the patient should be given prescriptions for whatever medication seems appropriate. In the cases of more serious medical involvements, which at this level are rather infrequent, referral to inpatient departments is, of course, required.

Whether the services of the physician are required on two half-days or four to five half-days a week will depend upon other facilities in the community. If an Alcoholics Anonymous group [3] is located in the community or near by, referral to that group will be feasible after four or five consultations and in that case two half-days' attendance per week on the part of the physician will be sufficient. If, on the other hand, as in most countries, Alcoholics Anonymous groups are not available, the average number of consultations per patient will amount to about 12, which would require five half-days per week on the part of the physician. An outpatient clinic of the type described can treat about 100 new alcoholic patients per year and can carry about 150 patients under more or less active treatment at any one time.

In view of the large proportion of alcoholics who can be treated at this level, it would seem that the general necessity for hospital beds and special inpatient facilities for the treatment of chronic alcoholism has been much

[3] See *World Hlth Org. techn. Rep. Ser.* 1951, **42**, 15.

over-emphasized. It is true, of course, that in an occasional case of acute alcoholism, or of an alcoholic psychosis, hospitalization is a matter of urgent necessity, but such cases are the exception rather than the rule. It is unwise (as well as unnecessary) to organize the treatment of a large number of alcoholics around an *inpatient* set-up, although it is desirable to have such facilities available for the occasional cases where they are needed. The conventional outpatient department of the general hospital is ideal for treating most cases of uncomplicated alcoholism. From the patient's standpoint the emphasis is on the medical aspects of the problem, which is as it should be. From the doctor's standpoint it is easy to focus upon the ambulatory patient all the great resources in diagnosis and specialized treatment which a modern hospital affords. These include: laboratory techniques; x-ray; special clinics such as gynaecology, allergy, dermatology, endocrinology; a record system; and the appointment office. All the elaborate machinery for handling sick people is already set up and functioning, and absorbs an alcoholic clinic with little or no modification of existing facilities. Within such a framework it is possible to deal easily and effectively with most problems which come up in the course of treating an individual alcoholic.

It would seem to be educationally desirable for the medical personnel of the hospital, especially the interns and medical students, to have contact in an organized way with the clinical material of alcoholism. Alcoholic patients present many interesting and legitimate problems for medical investigation and research. One subsidiary function of an alcoholic clinic in a general hospital is to provide a framework for making alcoholic patients easily and routinely available for research and teaching purposes.

The time, effort, and cost entering into the treatment of alcoholics must be judged more at the level of early and uncomplicated alcoholism, as these form the largest proportion of the alcoholic population.

Facilities at the second level of treatment

In the following it is assumed throughout that the physical condition of the patient is taken care of and that adjuvant medical therapies (administration of hormone compounds, vitamins, disulfiram, conditioned reflex treatment, etc.) may be employed according to indications.

At the second level of public care intensive psychotherapy is required. If the alcoholic whose drinking behaviour originates in gross neurosis is to be helped successfully to live without alcohol, it will be necessary to give him insight into the conflicts which he is trying to solve through the use of alcohol, and to bring about an emotional readjustment which obviates the use of artificial means.

Such an elaborate attack on the response pattern of the patient is indicated also when gross neurotic origins are absent, but when the patient has progressed in his alcoholic career to a point at which his drinking behaviour has disrupted his inter-personal relations. At that juncture harassing social experiences and the accumulation of guilt lead the patient to a completely egocentric re-interpretation of his relation to his environment. It may be said that a superimposed or secondary neurotic response pattern develops which requires readjustment by psychiatric means.

Potentially the care of alcoholics at this level is feasible in any community which has a psychiatric or psycho-analytic outpatient department or a mental hygiene clinic. Actually, however, these facilities are rarely available to the alcoholic because of resistance of the clinic staff to admission of alcoholics. Such admissions are regarded as interference with the primary objects of such clinics. As a rule the staff do not wish to open the service to alcoholics because they fear a great influx of patients.

Because of this attitude it will be desirable to add to the staff a psychiatrist and a social worker who are specially interested in alcoholism, if such existing psychiatric or mental hygiene clinics should be suddenly opened to alcoholics.

Generally it may be more desirable to merge treatment of alcoholics at the first two levels into one clinic, rather than try to persuade psychiatric and mental health clinics to extend their services to alcoholics.

If such merging is performed, the outpatient clinic's staff will have to consist of one half-time psychiatrist, one full-time assistant psychiatrist, one half-time specialist of internal medicine, two full-time social workers, and one full-time secretary. If possible, the employment of a clinical psychologist for the administration and evaluation of tests should be considered. A clinic of this type will be able to deal with 350-400 alcoholics per year on a fairly intensive level.

Treatment at the third and fourth levels

At the third and fourth levels intra-mural treatment such as is available in public mental hospitals is necessary. In many countries mental hospitals admit alcoholics only when diagnosable psychosis is present. It is recommended that through amendment of the admission laws the facilities of such hospitals be extended to alcoholics without psychosis who fall into the categories described at levels three and four.

At the fourth level, by and large, only custodial care seems to be feasible, yet the degree of deterioration may be sometimes misjudged and measures must be taken to ensure periodic revision of the diagnosis. If such a course is indicated, the patient in custodial care may be referred to active therapy.

It is desirable that contact and co-operation be maintained between clinics and hospitals at the various treatment levels and that there should be every facility to make referrals from one institution to another.

Other measures for rehabilitation

Clinics devoted to the rehabilitation of alcoholics should seek mutual co-operation with social and welfare departments and societies, vocational guidance and placement agencies, speciality clinics, the courts, and police and prison authorities.

If formation of Alcoholics Anonymous groups should not be feasible, some type of group activity should be created for alcoholics and their relatives. It should be recognized that the families of alcoholics require counselling and aid and sometimes rehabilitation.

The subcommittee recommends that physicians be instrumental in establishing groups of Alcoholics Anonymous in their communities. This can be achieved only through encouraging their alcoholic patients to organize such groups and to assure the groups of their co-operation. The physician must realize, however, that Alcoholics Anonymous groups should and can be run only by recovered alcoholics; and he should not attempt, therefore, to give direction to the activities of the group. Once the group is established, physicians can keep the group alive and active by referring more and more alcoholics to it.

Selection and training of clinical personnel

The subcommittee has considered some desirable qualifications for the selection of clinical personnel working with alcoholics.

Some authorities have stated that the therapist treating alcoholics should be a total abstainer. This viewpoint seems to have been adopted in one or two countries. The subcommittee feels that the use or non-use of alcoholic beverages by the therapist is irrelevant as long as the therapist has no reputation for either excessive use of alcoholic beverages or for a censorious attitude towards any use. It is felt that such a censorious attitude excludes a sympathetic approach towards the alcoholic patient.

The employees of alcoholic clinics should have a good sense of public relations, as the goodwill of the public is essential for the continuance of such institutions, which in the beginning at least may be received with misgivings.

Size of the problem

The subcommittee has stressed the ambulatory treatment of alcoholics at the first two levels, i.e., for the great majority of the alcoholic popula-tion. In some medical circles it is felt that much more elaborate treatment