ALCOHOL TREATMENT SERVICES

THE PSYCHO - SOCIAL REHABILITATION OF ALCOHOL DEPENDANTS

REHABILITATION UNIT FOR ALCOHOLICS - MOUNT CARMEL HOSPITAL

Mr P. Sciberras, M.Sc. - Clinical Psychologist

(i) BRIEF HISTORY

Up to December 1985, the treatment of alcoholics at Mount Carmel Hospital consisted only of a period of in-patient care for detoxification usually done at the admitting wards. No rehabilitation service existed.

A group of Mount Carmel Hospital professionals, consisting of a psychiatrist, psychologist, a psychiatric social worker and two nurses formed a team (Alcohol Dependence Team) which started to hold two group psychotherapy sessions for alcoholics on a weekly basis. These sessions started to be held at the psychologists' office at the hospital in December 1985.

A care group of alcoholic patients actively participated in the preparation of the new Rehabilitation Unit, which was officially opened in September 1986.

(ii) R.U. BED CAPACITY

The Unit has a full capacity of nine (9) beds. These are only for male patients. Females cannot be in-patients in the Unit. Although they can follow a day programme and participate in all Unit activities, they always return to their wards.

(iii) ALCOHOL DEPENDENCE TEAM - R.U. STAFF COMPOSITION

One clinical psychologist, two psychiatric social workers, two nurses. A Senior House Officer is also responsible for the medical needs of the R.U.

The members of the multi-disciplinary Team contribute their individual expertise in their respective fields in a co-ordinated effort to help the patient or client and his family to restructure their lives so that through sustained total abstinence from alcohol they can identify and correct certain negative personality attitudes and traits which contributed to the pathological process of dependence (or can lead to dependence in the case of the alcohol abuser), develop better and more effective coping skills, enhance personality growth, thus achieving and maintaining an overall healthier lifestyle.

The nursing staff are the only members of the Team who work on a full-time basis at the R.U. The nursing duties form only a part of the nursing staff's functions in the Unit. They are also therapists. The other members' regular contribution is through group, individual, family, marital therapy sessions and social work, according to the R.U. treatment programmes and arising needs.

In charge of the Rehabilitation Programme is the psychologist. As much as possible, decisions are made by the Team on a consensus basis. At all times there is contact and co-ordination with the hospital consultants and other professionals of the multi-disciplinary team of the referring agency.

(iv) R.U. GROUP THERAPY SCHEDULE

Two group therapy sessions for alcoholics are held during the week which are open to everyone. Individual, marital, family therapy sessions and home visits are held as the need arises and as often as necessary.

(v) R.U. TREATMENT PROGRAMME

1) Admission of alcoholic patient to Mount Carmel Hospital (admitting ward, not R.U.)

2) Initial contact with patient by R.U. staff to assess the patient and encourage attendance to group therapy sessions.

3) day programme: the patient is still in the admitting ward. During the day, the patient spends his time at the R.U. returning to his ward usually in the evening. He participates in any activity in the Unit, has his lunch there, integrates with the Unit's in-patients and shares in the chores and duties of the Unit.

4) Transfer to R.U. It is the perogative of the Unit's Alcohol Dependence Team to decide on a patient's suitability for transfer for long-term rehabilitation at the R.U. At all times, the staff is in contact with the referring consultant and his firm to exchange views and discuss plans.

Criteria for transfer to R.U.:

a) patient has to show adequate insight into his problem and motivation to abstain totally from alcohol

b) patient has to be free from drugs, excluding Disulfiram (Antabuse), Vitamins and basic maintenance of psycho tropic drugs (i.e. doses that can be easily taken at home without medical staff's constant supervision)

c) patients with symptoms of psychoses, major depression and medical conditions necessitating constant staff supervision are not eligible for transfer

The Unit is an open-door, rehabilitative facility with no night nurse.

5) programme duration: Each individual case is treated according to its particular merits. In most cases, no fixed time is set for the termination of the programme. Before a final decision is taken to transfer a patient, a programme with time-schedules for the immediate future (usually from two to three weeks) would have already been discussed between the staff and the patient. As much as possible, the patient is encouraged to contribute to the plan as long as their proposals are not counter-productive to the programme. Should the patient's goals coincide with that of the Unit, the patient is transferred already with a set time-table.

The following plan is usually implemented:

Stage 1: following transfer to the Unit, the patient spends a further period of time at the hospital. Since the Unit has an open-door policy, he has access to all the hospital grounds but is not allowed to leave the hospital gate. He still needs to be in an alcohol-free environment. No leave is granted.

Stage 2: should the patient be employed, he will resume working, returning to the Unit after working hours and sleeping there. Whenever it is possible, the patient is still attending the morning group sessions. According to his progress, restricted periods of leave will be granted, usually during the day-time, on week-ends.

Stage 3: At this stage, the patient is allowed to start sleeping at home on specific days. The period of time spent in the Unit is gradually decreased.

Stage 4: The patient is sleeping only one night at the Unit. Still attending group sessions.

Stage 5: Patient is not sleeping in the Unit and cantact is only through regular attendance to therapy sessions. Unless the patient requests formal discharge, or the Team sees that it is therapeutically beneficial, he is still kept on as a formal patient on the Unit books.

In certain cases, the fact that the patient knows that he still has a formal link with the Unit gives him a sense of security and a point of reference. It also facilitates 'prophylactic hospitalisation', i.e. preventive hospitalisation. This is a voluntay hospitalisation whenever the patient is either craving for alcohol or is experiencing a moment of crisis not necessarily related to alcohol.

The patient's insight, motivation and compliance -- the overall consideration to be taken into account in the commencment and duration of the in-patient' rehabilitation programme should be his insight into the problem and his motivation to abstain totally from alcohol. These two necessary prerequisites will determine compliance of patient with the programme and hence its duration.

Whilst the programme might have a set-back due to the alcoholic's relapse during his in-patient treatment, his willingness to continue with the programme will decide its continuation and duration.

Since September 1986 to December 1993, 106 individuals have undergone a rehabilitation programme of varying length at the R.U.

The R.U. staff notes with satisfaction that alcohol dependence and alcohol abuse are being given more attention by the Department of Health and the policy makers. Misconceptions and lack of adequate information and emphasis on this very serious problem both by the general public, professionals and public health officials have led to it being underestimated in spite of the medical, psychological, social, economic and occupational dysfunctioning which are its natural consequences.