MINUTES OF MEETING WITH REPRESENTATIVES OF STATE MENTAL HOSPITALS ON WHAT DO WE KNOW ABOUT ALCOHOLISM IN THE STATE MENTAL HOSPITALS OF MARYLAND

March 13, 1961

PERSONS PRESENT
Eastern Shore State Hospital - C. Van Eyk Grobler (Psychologist), Springfield - Dr. Julian Abrams (Psychologist), Spring Grove - Dr. Fernando Cabrera (Psychiatrist), Dr. John W. Shaffer (Psychologist), and Dr. A. Simopoulos (Psychiatrist), Crownsville - Dr. John A. Mcgee (Psychiatrist), Dr. Carl B. Schleifer (Psychiatrist) and Gwendolyn O. Kirkland (Psychologist).

Other persons present were Dr. Isadore Tuerk (Commissioner, Department of Mental Hygiene), Dr. Louis P. Gundry (Chairman, Commission on Alcoholism), Dr. Leo Bartemeier (Member of Commission on Alcoholism) and Miss Lillian M. Snyder (Research Associate).

SUMMARY OF FINDINGS

Miss Snyder presented a brief statement of the reason the Governor appointed the Maryland Commission on Alcoholism and how the Commission has proceeded to fulfill its charge.

Although the major concern of the Commission is the individual whose alcohol pathology is hidden or the uncommittable alcoholic (about 75% of persons for whom alcohol has become a problem), before this group can be studied and assisted attention must be given to the problem of the police court inebriate (about 3 to 7% of the alcoholic population) and the psychiatric patient with alcohol pathology (about 20% of the alcoholic population). Services and treatment of the two latter groups should be approached simultaneously in view of the fact that the police
bring about 80% of the alcoholics who are admitted to the State Mental Hospitals (also called police patients).

Which Alcoholics Come to the State Mental Hospitals?

The General Assembly of Maryland has designated the Department of Mental Hygiene to have "full and complete power and supervision of all matters relating to custody, care and treatment of the insane." In line with this charge every alcoholic admitted to the State Mental Hospitals must be certified by one or two physicians that he is insane and in need of hospital care. No alcoholic with a physician's statement has been turned away. Some patients at their own request without a physician's statement have been admitted.

Alcoholic patients admitted to State Mental Hospitals are given the following diagnoses:

**Acute Brain Syndrome Associated with Alcohol Intoxication (02.1)**
This typically refers to those persons suffering from delirium tremens and acute alcoholic hallucinations.

**Chronic Brain Syndrome Associated with Alcohol Intoxication (13.0)**
This refers to types of chronic delirium formerly called Korsakoff's psychosis and implies some degree of permanent brain damage resulting from use of alcohol.

**Sociopathic Personality Disturbance with Alcoholism (addiction) (52.3)**. Under this diagnosis are placed cases of well-established addiction to alcohol without recognizable underlying disorders.

Patients suffering from psychoses in which excessive drinking may be contributory are not classified as alcoholics in the State Mental Hospitals.
How do Individuals with Alcohol Pathology Come to the State Mental Hospitals?

<table>
<thead>
<tr>
<th>Type of Admission</th>
<th>Alcoholic Patients</th>
<th>Percent</th>
<th>All Patients</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary</td>
<td>171</td>
<td>17%</td>
<td>424</td>
<td>10%</td>
</tr>
<tr>
<td>Two Physicians</td>
<td>656</td>
<td>64%</td>
<td>2996</td>
<td>71%</td>
</tr>
<tr>
<td>Court</td>
<td>197</td>
<td>19%</td>
<td>821</td>
<td>19%</td>
</tr>
<tr>
<td><strong>TOTAL:</strong></td>
<td><strong>1024</strong></td>
<td><strong>100%</strong></td>
<td><strong>4241</strong></td>
<td><strong>100%</strong></td>
</tr>
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</table>

During the calendar year 1960, 125 inebriate court orders were issued from the Baltimore City and Baltimore County Courts. Of this number, 122 alcoholics were assisted by the Legal Aid Bureau, Inc. These patients were sent to the following hospitals:

- Crownsville - 4 (2 women)
- Springfield - 74 (6 women)
- Spring Grove - 44 (5 women)

What was the Admission Procedure?

The alcoholic, his family or others (including police officers) very seldom used the State Hospital Pre-admission Service. Voluntary admission was usually used the first time at the suggestion of staff members at Johns Hopkins or University or medical departments of industry. Few persons seemed to be aware of the existence of voluntary admission. After the alcoholic has used this type of admission once, he usually prefers to use it again in subsequent admissions if this becomes necessary. Some State Hospitals permit only two voluntary admissions a year. This is to discourage the alcoholic from using the State Mental Hospital as a free drying-out facility.

When the patient presents himself in the Admitting Office, the social worker sees him and his family first to see that his papers are in order and to be sure he is where he thinks he is. The social worker
prepares him for the next twenty-four hours. The admitting physician then examines the patient. Alcoholic patients coming to the Admitting Office with the family request or community request are usually accompanied by a relative or a police officer. The group is first seen by the social worker who looks over the papers and attempts to prepare the patient and family members for the hospital experience. The police officer who accompanies the patient is seldom the one who has made the arrest or who has talked with the family.

The Inebriate Court Order is prepared by a staff member (usually a law student) of the Legal Aid Bureau between 9 and 10 A.M. The patient waits at the Legal Aid Office while a clerk takes the papers to Judge Allen's office (Circuit Court No. 2) before 10 A.M. Judge Allen signs the petition sometime between 10 and 12 before his Court convenes. It is not necessary for the patient to appear at Court. As soon as the patient is given the Court Order, he may take the streetcar to Spring Grove or may go in a taxicab. Occasionally, he goes in a police car. Sometimes he holds the Order until his money runs out or until a week or so before it expires. The Court Orders are usually written for 60 days.

Through What Process is the Patient Given the Label of an Alcoholic?

As soon as possible after the patient is admitted, the examining physician, usually a third-year resident or less, sees the patient. His diagnostic impression is based on the patient's history, information from the referral source (often a private physician or a physician from a general hospital), the physician's certificates, the observed behavior of the patient during the examination and the relatives' story. The
examining physician may not make a final diagnosis until after the acute stage has passed.

Labeling is not done by a medical specialist for the treatment of alcoholics nor is there an admission staff conference in which a joint, multi-professional study and diagnosis is made.

What Therapies and Treatments are Provided?

Attention is first given to saving the alcoholic's life. There were thirty-seven deaths of alcoholics in State Mental Hospitals during the year ending June 30, 1960 (4% of all deaths). Five alcoholics died in police lockups before they ever reached the hospital.

The next step in treatment is to provide relief of pain and discomfort during the acute stage. Attention is also given to other ills associated with drinking. This may include malnutrition and liver dysfunction among other ills.

Following recovery from the acute stage, patients who remain in the hospital are provided a variety of therapies by many professions depending upon the needs of the individual. At Spring Grove State Hospital in the Alcoholic Rehabilitation Unit, these therapies are specifically directed toward the alcoholic individual.

What Are the Goals in Treatment?

Staff members state that their goals in assisting the alcoholic patient are as follows:

(1) to achieve sobriety (for life)
(2) to assist in vocational rehabilitation
(3) to get along with others including family members and the boss
(4) to develop self-appreciation, self-confidence and usefulness

Some staff members concentrate on one of the goals and others believe they are all important.
How Effective is the Treatment?

Staff members can see improvement in their alcoholic patients from the time of admission to the time of discharge. Comments about the nature of the improvement is summarized in the Medical Record. Staff members, however, do not know what happens to their alcoholic patients after discharge. Nothing is known about whether the improvement has been maintained at the end of one month, six months, one year or three years.

There is no follow-up built into the service program either by letter, by appointment or by home visit.

There are no agreed upon criteria for evaluating results.

What Researches are being Done to Find Out More About Alcoholism?

Two researches have been published. These studies have been made on the efficacy of drug therapy during the acute stage at Springfield State Hospital and Spring Grove. The results of several other studies at Spring Grove are about to be published. Multivariat factors are currently being studied among alcoholic patients at Spring Grove. About 150 patients have completed these studies.

The most urgent need is to know more about the phenomenon of alcoholism. Is it a disease? Psychiatry says "no", that it is a symptom and yet psychiatry identifies three disease labels. Is it a syndrome with medical, social and moral components? Members of Alcoholics Anonymous say that it is. Is it a symptom that can be used at will by indigent individuals who need a "ticket of admission" to an institution such as a jail, mental hospital or corrective institution.

There is a need to classify the diverse types of alcoholics and to
compare the types of alcoholics with the types of therapies rendered and results obtained. There is an excellent opportunity at the present time to make classification studies before more selection is made of patients admitted to the Spring Grove Rehabilitation Unit. There is already some natural selection such as the economic factor.

There is a need to study responsiveness. Under what conditions can we expect responsiveness? We must identify the response types. The general practicing physician is at a loss to know how to treat his alcoholic patients until he knows what therapies have been proven successful. What is the purpose of building large rehabilitation facilities for various alcoholics if we do not know who the alcoholic is and what his needs are and how responsive he will be to the rehabilitation provided?

How Many Alcoholics were Processed in the State Mental Hospitals?

The number of alcoholic patients admitted to the four State Mental Hospitals during the calendar year 1959 was as follows:

<table>
<thead>
<tr>
<th>Admission</th>
<th>Crownsville</th>
<th>Eastern Shore</th>
<th>Spring Grove</th>
<th>Spring-Field</th>
<th>Total</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>212</td>
<td>43</td>
<td>179</td>
<td>124</td>
<td>558</td>
<td>54%</td>
</tr>
<tr>
<td>Re-admis.</td>
<td>104</td>
<td>26</td>
<td>160</td>
<td>176</td>
<td>466</td>
<td>46%</td>
</tr>
<tr>
<td>Total</td>
<td>316</td>
<td>69</td>
<td>339</td>
<td>300</td>
<td>1024</td>
<td>100%</td>
</tr>
</tbody>
</table>

There was a slight increase in the alcoholic admissions during the year ending June 30, 1960.

Alcoholic Admissions:

<table>
<thead>
<tr>
<th>First Admission</th>
<th>609 (52% of all hospital admissions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Re-admissions</td>
<td>552 (48% of all hospital re-admissions)</td>
</tr>
<tr>
<td>Total</td>
<td>1162 (100% of all patients)</td>
</tr>
</tbody>
</table>
If we compare the alcoholic patients with patients admitted for treatment of schizophrenic reactions, we observe the following information:

<table>
<thead>
<tr>
<th>Schizophrenic Admissions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Admission</td>
</tr>
<tr>
<td>Re-admissions</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
</tr>
</tbody>
</table>

On any one day in the State Hospitals there are 414 alcoholic patients (a 15% increase in five years) and 4,309 schizophrenic patients (a 2% decrease during the last five years).

During the year ending June 30, 1960, a total of 1,121 alcoholic patients were discharged. Of this number 621 were discharged on completion of their first admission.

Study of the 621 alcoholic patients who were discharged at the end of their first hospital experience revealed the fact that these patients averaged 65 days hospitalization (50 days in Eastern Shore to 79 days in Spring Grove). At an overall per diem cost of $4.69 per day, the average cost of care per patient amounted to $304.85. About 42% of these patients were discharged at the end of a month's hospitalization (as compared with 33% for all alcoholic patients discharged (including re-admissions) and 11.6% for all hospital patients discharged (including re-admissions).

**Questions for Discussion**

What is the meaning of the information collected?

What are the gaps in the data?

Why did Crownsville have the lowest percent of returnees?
Why did Springfield have the highest percent of returnees?

Does Crownsville provide the most effective treatment, or is the treatment program so bad that patients refuse to return? Are patients going to Crownsville in a later stage of their illness so that they die before returning? Is the diagnosis changed on the return trip? Is there a post discharge treatment program which holds the treatment gains made in the hospital? Is there greater selection for admission in the pre-admission service? Do the returnees remain longer in the hospital?

Do we really know why patients come back?

Before the Chapter on the State Mental Hospitals in the Commission's final report is completed, what more do staff members wish to know?

**SUMMARY OF DISCUSSION**

The question was asked, "What proportion of alcoholics admitted to State Mental Hospitals are admitted in the acute stage?" Dr. Cabrera replied that from 60 to 70 out of the last 400 patients admitted to Spring Grove were admitted in the acute stage. Many intoxicated alcoholics sober up in jail before entering the State Mental Hospital.

Dr. Bartemeier wondered what proportion of patients enter the State Hospital by way of the police lockup. Although it is estimated that approximately 80% of alcoholic patients are "police patients" the exact number is unknown. Dr. Bartemeier hopes that the time is near at hand when all alcoholics and mental patients will be taken directly to a medical facility and by-pass the police station. Dr. Tuerk pointed out that he has recommended that a receiving hospital be established. This plan has worked well in other cities and should meet the need in Baltimore.

Dr. Cabrera stated that there were 6,000 arrests last year in Baltimore.
due to drinking. Most persons who die in jail have an elevation of alcohol in the blood stream at autopsy.

Dr. Simopoulos expressed the fear that if facilities for treatment are improved that there will be more patients. Hospitals could not handle the 6,000 individuals arrested for drinking. It was pointed out that there would need to be a screening device so that the mentally ill patient would be classified and routed to the appropriate facility for care.

Dr. McGee criticized the current method of classifying the alcoholic in the State Mental Hospitals. He felt that many individuals were called alcoholics who really are not true alcoholics. He wondered if the main factor in the treatment of the alcoholic is not the psychogenic factor. He commented further that the AMA published a series of articles in 1956 advising the general practicing physician that alcoholism is a disease. This was an attempt to interest the private physician in the alcoholic. Dr. McGee feels that professional individuals treating the alcoholic should certainly be sympathetic and understanding toward the individual with a drinking problem rather than consider him as a degenerate or a criminal. At the same time, we should not oversimplify the problem and class all alcoholics in one overall category.

Mr. Grobler raised the point that if the alcoholic is treated in a mental hospital he should be treated like any other patient and should not be segregated. He implied that segregation lowers the status of the alcoholic and lessens the opportunity for all staff members to treat him and for other patients to associate with him.

Dr. Abrams commented that the re-admission of alcoholic patients is
automatic. He implied that alcoholics are expected to return and that they are never turned away.

Dr. Shaffer asked "Where do we go from here?" Do we build bigger and better mental hospitals or do we apply the knowledge we know and at the same time attempt to gain a greater knowledge about this problem? He felt there is greater need for classification of the individuals who become excessive drinkers; and we must find a more humane way to treat them. Through the research already begun at Spring Grove the staff believes that it is possible to analyze all of the different factors that go into the makeup of an alcoholic. We need to determine which type responds better to which types of treatment. The alcoholic is defined as one who gets into repeated trouble because of the ills associated with drinking. Many of the alcoholics are pure and simple character disorders. Dr. Tuerk wondered if physicians in private practice would see his group of patients as character disorders. He described the studies currently being done on personality types at the Winter General Hospital in Kansas. Dr. Shaffer commented about their study of conditioned reflex which may indicate which patients can use antabuse.

Dr. Bartemeier wondered how many patients currently being admitted as alcoholics are also addicted to other drugs. Dr. Cabrera estimated that about 5% of these patients use barbiturates or other drugs. It was agreed that the multiple addiction makes treatment much more difficult. Does the hope for the future lie in the use of tranquilizers as a substitute for all other drugs including alcohol?

Dr. Bartemeier commented that in his experience many alcoholics have told him that while they were in the hospital they had no desire to drink.
Miss Snyder commented that Professor Trice has often raised this point that one of the difficulties in dealing with this problem is that it is quiescent about 90% of the time. It is only during the acute stages that the individual gets into trouble. The quiescent stage may occur at any time, and the factors accounting for this are unknown.

Dr. Cabrera stated that in his opinion his staff is working to capacity. In comparing his program with the other State Mental Hospitals, the therapies used in other hospitals are not oriented toward the alcoholic. He felt that hospitals should use more community help and cooperation such as Alcoholics Anonymous and the psychiatric clinics. He elaborated on the difficulties he has in carrying out a follow-up program. He would like to see a follow-up program developed similar to the one in Minnesota. He also felt that the type of commitment should be changed. The alcoholic should be admitted as an alcoholic and the admission should be a voluntary agreement for a definite period of time similar to type of commitment now in use in Florida and Minnesota.

Dr. Tuerk stated that the difference in the various programs in the State Mental Hospitals depends on the interest of at least one person in every hospital who is dedicated to the treatment of the alcoholic. He believes that the establishment of the Central Registry will aid in the follow-up program. The joint program with the Health Department will aid in the exchange of information. There has been a lag in Baltimore City. However, at the present time, Doctors Schneidmuhl with the City Health Department, Fiedler at the University Hospital and Neustadt at City Hospitals are all in the process of working out programs to assist the alcoholic.
Dr. McGee stated that it is certainly necessary for a person who is dedicated to assist the alcoholic to spearhead the program at each State Mental Hospital. This person, however, should have the administrative responsibility for the program. There are three groups which should be assisted: the psychotic alcoholic, the alcoholic undergoing a psychotic episode during the acute stage and the schizophrenic patient with alcohol complications. The acutely medically ill alcoholic should be treated in a general hospital.

Dr. Schleifer emphasized the fact that there is a great deal of confusion in gathering information about alcoholic patients in making a clear-cut diagnosis. Usually there is very little information about the alcoholic when he is brought into the admitting office. If he is drunk, he is very likely to get the label of acute brain syndrome; and if he is sober but has been drunk he may get the label of chronic brain syndrome. If he has incipient DT's, he may be called acute. There is no logic or reason for the current labeling process. The figures factually don't mean anything because one patient in one hospital may have one label whereas in another it would be something else. Even different physicians may have a different opinion or on different days the patient may present different symptoms. Before there is any meaning to a diagnostic label, the process is going to have to be standardized. This will take a great deal more knowledge than we have at our disposal. Dr. Shaffer pointed out that this is exactly what his group is trying to do at Spring Grove. At the present time they are using about a hundred pre-admission variables and a hundred and fifty post-admission variables in a study of each person who agrees to participate. The studies include psychiatric inter-
views, personality tests, intelligence tests, medical studies and others. Although some of the studies may be redundant, it is hoped that in phase 2 of the research that a short cut can be found, so that there can be a standardized psychiatric work-up.

Miss Kirkland emphasized the fact that as a first step in any program to assist the alcoholic the professional staff in the mental hospitals must be educated. There is very little interest or understanding of the alcoholic patient. Nothing much is going to be accomplished until the attitude of professional staff members toward the alcoholic is changed.

Dr. Simopoulos put in a word of caution about devoting so much time and energy to treating the alcoholic patient to the neglect of other patients in the mental hospitals. The administrator of a mental hospital has a big job to do and the needs of many patients to consider. He usually tries to make investments of money and personnel in those projects which will bring the highest return. The alcoholic is often not as well motivated in dealing with his illness as other patients are. We do not know if any of our efforts are actually making more alcoholics sober. We should be making comparisons of treatment efforts toward a specific segregated group of alcoholics with results in other treatment approaches now being used in other hospitals in order to justify a specialized type of service.

Dr. Cabrera ended the discussion by stating that the problem of the alcoholic is a very serious one in the community. Every alcoholic who is rehabilitated becomes an individual who will be a taxpayer. Tax money expended in the rehabilitation of the alcoholic will be returned to the community in tax income.

Lillian M. Snyder
Research Associate
Maryland Commission on Alcoholism
<table>
<thead>
<tr>
<th>Age Group</th>
<th>Crownsville Negro</th>
<th>Eastern Shore White</th>
<th>Spring Grove White</th>
<th>Springfield White</th>
<th>Total Negro</th>
<th>Total White</th>
<th>Grand Total</th>
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<tbody>
<tr>
<td>Under 20</td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
<td>M</td>
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<td>M</td>
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<td>20-24</td>
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<td>10</td>
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<td>1</td>
<td>18</td>
<td>3</td>
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<td>5</td>
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<td>30-34</td>
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<tr>
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<td>154</td>
<td>46</td>
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<td>35</td>
<td>260</td>
<td>126</td>
<td>421</td>
<td>421</td>
<td>200</td>
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</tbody>
</table>
FIGURE I.
FIRST ADMISSION ALCOHOLIC PATIENTS
DISCHARGED FROM STATE MENTAL HOSPITALS
DURING YEAR ENDING
JUNE 30, 1960

NUMBER OF PATIENTS BY SEX AND RACE

Age Group

W Male
W Female
N Male
N Female
FIGURE 2.

FIRST ADMISSION EXCESSIVE DRINKERS DISCHARGED FROM PSYCHIATRIC OUTPATIENT CLINICS DURING YEAR ENDING JUNE 30, 1960

NUMBER OF PATIENTS BY SEX AND RACE

Age Group

W Male

W Female

N Male

N Female
FIGURE 3.
ALCOHOLIC PATIENTS ADMITTED TO STATE MENTAL HOSPITALS 1959

CROWNSVILLE  EASTERN SHORE  SPRING GROVE  SPRINGFIELD

NUMBER OF PATIENTS

First Admission
Re-admission
Figure 4.

ALCOHOLIC PATIENTS
DISCHARGED FROM STATE MENTAL HOSPITALS (4)
AND PSYCHIATRIC CLINICS (32)

<table>
<thead>
<tr>
<th></th>
<th>June 30, 1960</th>
<th>June 30, 1959</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOSPITALS</td>
<td>600</td>
<td>500</td>
</tr>
<tr>
<td>CLINICS</td>
<td>400</td>
<td>300</td>
</tr>
</tbody>
</table>

- First Admission
- Re-admission