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Journal Interview, 4

In this occasional series we record the views and personal experiences of people who have specially contributed to the evolution of ideas in the Journal's field of interest.

Conversation with Max Glatt

Max Glatt has been a contributor to British and international thinking on alcohol and drug problems over a span of 30 years. In particular the Alcoholism Unit which he established at Warlingham Park Hospital exerted a crucially important influence on National Health Service commitment to the care of previously very neglected patients.

B.J.A. You first became known in the alcoholism field through your work at Warlingham. What can you tell us about the foundation of the Warlingham Park Alcoholism Unit – the prototype Alcoholism Unit in the U.K.

M.G. It came into being not by a plan, but just by muddling along. I had come to Warlingham in 1951 after having got the D.P.M. I became interested in group therapy, and the groups in which I took part dealt mainly with various neurotic conditions but also with a few alcoholics. I didn't know anything about alcoholism, but the alcoholics struck me as interesting people with wide experience, and they were good talkers. But somehow they didn't fit in with what was happening. I remember in particular one chap who was a stock-broker. He had been a very successful man. But he had now been put into Warlingham by his family-firm on the condition that he would do something about his drinking but that if he didn't come out cured after 6 months he would be sacked. So this highly intelligent man went along to the various doctors in the hospital and asked each one of us what we did about alcoholism, and none of us knew what to answer – 'there is nothing we can do'.When he was talking to me, I remembered a dentist who also had been at Warlingham a number of times and again he cut a lonely figure – a very nice, very intelligent man, who just walked around all day long with his books, hardly talking to anybody. He came back again and again. I also remembered a man who was, I think, admitted 11 times, usually in D.Ts. They all enjoyed Warlingham, which under T. P. Rees was a liberal, pulsating, active community – but they relapsed again and again.

Finally, it occurred to me that we had nothing much to lose if we took some of the drinkers we had at Warlingham and put them into their own group. It was about June 1952 that I found three other patients to join that stock-broker. We sat around talking about various things for an hour or so, and at the end of that session I asked them whether they wanted to meet again. They all said well, they didn't really think what was offered by me was other than a waste of time, but compared to the even more boring occupational therapy (better and bigger

elephants), there was no harm in wasting another hour. And so we had a second meeting and it was clear that something was happening. I didn't know what was happening, and I had no clue about alcoholism. Yet within a fairly short period we got in touch with A.A., and those four people became the nucleus of the first A.A. group in the Croydon area.

B.J.A. Could you tell us a bit about what sort of place Warlingham was at that time, and something about its superintendent, Dr T. P. Rees?

M.G. Dr T. P. Rees was one of the first superintendents to open all the doors of a psychiatric hospital, and he certainly was a personality. He allowed and encouraged any one of the junior doctors to do their own thing. His style of management was completely decentralized with lots of experiments going on. For example, Dr Dennis Martin started the Pinel House Neurosis Unit, and quite a few others who later did pioneering work elsewhere, were very active at W.P.H. at the time, such as R. A. Sanderson, Dennis Scott, Ken Weeks, Stuart Whiteley, Arthur Sanker, and others. It was a very stimulating place where we were all allowed to do within limits what we wanted – as long as we did something. There was not much systematic training but through regular staff meetings and discussions we all felt we were learning a great deal. It was a free and easy therapeutic community and patients also were given a lot of freedom, a lot of responsibility, and encouraged to take initiatives.

B.J.A. Had you before 1952 in any sense charted the direction of your career?

M.G. I arrived at that point in my career really because of an utter muddle. I got out of Germany in 1937 just after getting the M.D. with a dissertation on a psychiatric theme (G.P.I.). In Germany at that time in order to get a doctorate you had to be given a topic by a University Professor. I had been thrown out from Berlin University in 1934 because of the tide of anti-semitism: one didn't know from one month to another what was going to happen, and every few months there was a new discriminatory law. But somehow I was allowed to finish medical studies at Leipzig University and I then tried to find somebody who would give me a topic for a thesis but at that time (1937) no German professor dared to help – till I finally arrived at the psychiatric clinic at the Berlin Charité Hospital. Here Professor Bonhoeffer (whose son, Dietrich, the famous theologian and an active anti-Nazi was murdered by the Nazis in 1945), gave me as a theme 'The Treatment of Syphilis and the Causation of G.P.I.' When I came to England in 1939 I had hoped that there was a Unit here treating G.P.I. with malaria. In England, a year after the outbreak of the war, because I had a German passport, I was interned and sent to Australia, coming back to the U.K. in 1942. I was then given a job in the Emergency Medical Service: at that time the general hospitals were evacuated to mental hospitals in the suburbs and I was working at Cane Hill, a large mental hospital in Surrey. I was a resident M.O. in charge of four general wards with mainly medical and surgical patients.

B.J.A. And who introduced you to British psychiatry?

M.G. Well, after three or four weeks I felt I didn't have enough work to do, and I asked whether I could do any surgical and medical work on the psychiatric side of the hospital. The Superintendent must have thought me an idiot who hadn't learnt the first rule that one never volunteers. My interests were really in general medicine, especially neurology and cardiology, but I hadn't got any English degrees and had no useful connections. Psychiatry? By 1947/8 when I was naturalized, I had been in psychiatric hospitals for several years, so I thought I would try the D.P.M. first but perhaps later try to get back into medicine. Having then got the D.P.M., I thought well, perhaps I should find out a bit more about psychiatry from a progressive mental hospital and that's why in 1951 I went to Warlingham. From group therapy, I think, I got into alcoholism.

B.J.A. What strikes me on checking through the dates is that in 1952 you tried to get this group of four alcoholics together and three years later in 1955 you were publishing papers which are highly thought out, and which present the whole vision of what an alcoholism unit could be. It looks as though within a mere three years of starting you have had some surge of ideas and have got a vision that you can present to the world.

M.G. Oh, I don't know – I am very impressed with what *you* are saying but it wasn't like that at all. I got into alcoholism not knowing a thing about it, and I can say with good conscience that may have been a great advantage because I had no fixed ideas and no axe to grind. Afterwards, having met these few alcoholics and on listening to them finding that the few notions I may have had about alcoholism were utterly wrong, I felt quite guilty. Here were intelligent, pleasant people obviously suffering acutely and here I was without having a clue what to do next. So I continued listening to them and whatever they said to me made sense. I also began to read about the problem but there was nothing much written about alcoholism treatment in this country. The way you now describe it suggests I had this wonderful idea but I had no ideas whatsoever, I was just sitting there listening to a group of patients. But it very soon turned out to be a field in which hardly anyone in this country had taken any interest. Patients' own experiences surely have to be taken into consideration. There is said at the present moment to be an alleged controversy between the 'craftsmen' and the 'scientists', and even though it is quite clear that the so-called craftsmen should learn from research and not just go off with their own 'wild' ideas, so it seems to me to that so-called scientists also should listen to what the patient says. Anyhow at the time (1952) I just took notice of what went on in our discussions – it wasn't really my ideas but rather I was a blank sheet and I just recorded what came out of the discussions. At any rate, as soon as Rees allowed this Unit to be set up we had requests for admission from all over the country.

B.J.A. So how long was it before you opened Pinel House and were fully in operation?

M.G. We started our first discussion in some dilapidated huts which later were to become Pinel House but when we began to have more patients, we were moved

into one of the more modern villas. For some administrative reason, a few months later Dr Rees took us out of the Villa again and put us into the middle of the old hospital which the alcoholics didn't like. After quite a bit of grumbling from me, Rees said 'Listen, if you shut up and agree that we give you 12 patients in that ward and you and the alcoholics accept the demotion from the Villa, you can choose whoever you consider the two best male nurses in the whole hospital.' That's how we got two excellent helpers, Mr George Thomas (who 20 years later was given the M.B.E. for his work on the Unit), and Mr Gray who unfortunately died a few years later from a coronary. We had a number of wonderful nurses throughout the years, and there we were with 12 male beds as part of a ward in the middle of the old building, though the few female alcoholics from the female side of the hospital attended the meetings as did social workers, psychologists, clergymen, etc. Pinel House only became the location of the alcoholic group much later, long after I had left.

B.J.A. Where did the idea of each patient telling his life story come from, and how did your treatment evolve?

M.G. At the same time as the Alcoholic Unit started, we also did the life story in the Neurosis Unit which Denis Martin ran. Our treatment methods seemed to develop very easily and logically – group sessions, the formation of the A.A. group in the Hospital, the ex-patients reunions which started in 1954 at St Martin-in-the-Fields, and the magazine written by the Warlingham ex-patients and the present patients.

B.J.A. Were you yourself at that time very much engaged in the therapeutic work?

M.G. Yes, very much so. I had an intense clinical involvement and my interests has always been mainly clinical, although I have also always liked teaching and clinical research. At that time in Warlingham the alcoholics were only a relatively small part of my duties. Nevertheless, I wasn't married, I lived in the Hospital and I don't think I took many weekends off. I still remember most of the names of the old Warlingham Park alcoholic patients at that time, and I am still friendly with quite a few of them. From the beginning the chaplain had a group, the social worker had a group, the nurses had a group and all these allegedly new great ideas about interdisciplinary team work were obvious already at that time to anyone taking the trouble to listen to what patients had to say. I had an O.P. group in 1952, and saw alcoholics as out-patients from the beginning.

B.J.A. How much was A.A. shaping your ideas in this early stage?

M.G. We worked closely with the A.A. although I always tried to make it clear to patients that the uncovering, dynamic hospital group therapy meetings were not A.A. – a lot of overlap but also certain differences – yet complementing each other. Obviously, we learnt a great deal from this warm-hearted, outstanding fellowship. In turn, I think ex-patients of the Units have greatly influenced the

work of A.A. in this country; for example, in addition to the ordinary A.A. group meetings, many A.A. groups now function mainly as discussion meetings rather than a main speaker telling his story at very great length.

B.J.A. Accepting your modest insistence that you learnt from your patients, nonetheless by 1955 you clearly had learnt, and your writings gave by then an extraordinarily coherent view of the possibilities of NHS treatment for alcoholism centred on specialised units. You were offering a new model of alcoholism treatment although it may have borrowed from the nuerosis unit, and from A.A. Was there any sense of joy, of discovery, of something in which you could believe?

M.G. Of course. I had met these alcoholics, realized I didn't know anything, but soon found that the 'great men' in British psychiatry did not have a clue either about alcoholics. I realized how much these people were suffering, and had seen too how much their families were suffering, and then there didn't seem to be anybody to help. Not only did no one have an answer, but hardly anyone seemed to care (apart from A.A. and the members of the Society for the Study of Addiction). And I got the feeling that one ought to do something. I did not feel we were doing very much, but at least one was able to say that there was one place in the country which was *trying* to do something.

B.J.A. Did you feel yourself consciously drawn into campaigning to make this not only a local model but something which could influence national thinking? I note that by 1961 the B.M.A. and Magistrates' Association produced a report which was very much inspired by your experience.

M.G. Because of the interest shown by patients, their families, A.A., probation officers, Churches, magistrates, etc. one began to feel that there was an obvious need for this type of experimental work and that it ought to spread further afield. We had lots of visitors to the alcoholic groups coming from abroad and they too were getting very interested. As for the B.M.A./Magistrates' Committee I did not instigate the setting up of their special sub-committee, and incidentally it was rather characteristically called the Alcoholics and Vagrants Committee. I was invited to one of their last meetings and gave evidence – the far from flattering outcome was a pessimistic feeling among the Committee members that nothing more could be done. But one of the Committee Members, Dr Boardman, a paediatrician from Bristol, said he didn't agree with the pessimistic view. It was really his persuasive intervention which then led to a suggestion that I should write a paper and make some suggestions, and that paper was then accepted as the basis of the B.M.A. and Magistrates' Committee's report (1961). We also discussed at that time what should be done with alcoholic vagrants, and with alcoholics who were obviously killing themselves. Rather than just standing by and waiting till alcoholics kill themselves we ought to give them a chance at least to sober up, and if when cold-bloodedly sober they still decide to drink themselves to death, then perhaps one can't do more. However the Committee felt that sufficient provision was already made for compulsory admission of those drinkers who required it.

B.J.A. The Ministry of Health's memorandum on 'The hospital treatment of alcoholism', published in 1962, substantially accepted the B.M.A. recommendations. Did you or others actively campaign for the ear of the Ministry of Health?

M.G. I certainly didn't campaign at all, although I knew Brigadier Phillipson who at that time had a position at the Ministry. Perhaps through the influence of Phillipson to a certain extent, the Ministry accepted what the B.M.A. memorandum had suggested.

B.J.A. Did you give evidence to the Ministry?

M.G. Not at all, no, although I couldn't see what was holding them up, why nothing was done for alcoholics when we had plenty of alcoholics in the country in need of help. One often got visitors from abroad who came to Warlingham after they had already been to the Ministry and they had always asked the officials 'What do you do in England about alcoholics?', and they always got two answers. Firstly, we have not got any alcoholics and secondly, all our mental hospitals are adequately equipped to deal with them. I'm afraid my contributions were limited to writing letters to the medical press on this issue, and giving lots of talks.

B.J.A. In retrospect, do you feel that the people who then took up the ball and ran with it to the point where we now have 30 alcoholism units in the U.K., achieved what you had in mind?

M.G. On the whole, yes. We have all learnt, but one only learns gradually about alcoholism and its ramifications. The idea was never that every alcoholic should be treated in the same way; but quite a number of advanced alcoholics required hospitalization (and aftercare), and the haphazard admission of alcoholics into various hospitals over the whole country, with nurses and doctors who took not the slightest interest in them, was a waste of time. I was always sure that the majority of alcoholics could be treated as out-patients. I don't really think that the in-patient Unit was ever seen as a universal formula for treating all alcoholics, but if so that was certainly a misunderstanding. And from the beginning we were aware of the great influence of social problems on the causation and development of alcoholism. Again, as to the length of in-patient treatment, I believe we started off with one month and later it became a bit longer. Personally, I don't think I ever said we should always say three months – anyhow in the earlier years there were few A.A. groups and few G.Ps or other organizations to help in the necessary follow-up treatment, so that in those years such patients really did require relatively longer in-patient therapy than nowadays where there is much more community backing.

B.J.A. Do you have any impression that the special units, which had very purposely taken alcoholics away from scattered general psychiatry wards, as a side effect may actually have persuaded the professions that alcoholism is not a job for the generalist?

M.G. I think there is something in your question, but we did try to point out from the beginning that alcoholism was the business of all doctors and every profession, but as you know many doctors and other professionals are only too keen to avoid involvement with alcoholic patients. The question may come down to the functions of the unit – I don't agree with them being called just Alcoholism *Treatment* Units – it was clear from the word go that these units were also excellent education and training facilities and a good base for research. Moreover as T. P. Rees said many years ago, not about alcoholism but about psychiatry in general, that the time surely would come when the hospital would only be one part of a community network, and in the same way we saw the in-patient unit only as one part of the total network with O.P. clinics, domicilaries, collaboration with other specialists and G.Ps, etc.

B.J.A. When you first became interested in alcohol problems early in the 1950s, who else was on the scene in this country?

M.G. Apart from the people in A.A. whom I really felt understood more about the whole thing than anyone else, there were the members of the Society for the Study of Addiction (the S.S.A.). The strong man was John Yerbury Dent, a charismatic personality. He believed in apomorphine, not as an aversion treatment but because of his theory that it had some effect on the hindbrain. He dominated the meetings of the S.S.A. The people who ran the S.S.A. were at that time mainly private doctors, some were G.Ps, and some psychiatrists, but it was mainly a physically oriented approach. There was once a debate between Dr Carver and Dr Dent. Carver's view was that neurosis led to alcoholism, whereas Dent's view was that alcoholism led to 'neurosis-like behaviour'. Dent really said alcoholism was a disease like diabetes, and one doesn't treat a disease by talking. Dent was a very persuasive personality, a great friend of alcoholics. I think most of us agreed with Dr Hobson at that time, when he said that Dent without apomorphine would be a much better therapist than apomorphine without Dent – but Dent was upset when being told about this.

B.J.A. How often did the S.S.A. meet?

M.G. The meetings were quite regular, every three months, and the attendance was roughly about fifty people (including many interested non-professionals), and always too a bit of a social gathering with coffee and biscuits. There were often very good lectures, which were then usually written up in the Journal together with a discussion, and the discussions were sometimes more interesting than the lectures. But the meetings were certainly dominated by Dent and by the apomorphine approach.

B.J.A. What about the European connection at that time? Were you travelling a lot?

M.G. Having come to England in '39 and then having been sent as an 'enemy alien' to Australia (three months on the water either way and sea-sick most of the

time) and having learnt after the war what had happened on the Continent, I didn't want to travel any more. I didn't leave this country again until I got engaged in 1960 – my wife is a Hungarian who then lived in Vienna. I thought I had finished with the Continent or probably that the Continent had finished with me. But then I met Dr Hans Rotter in Vienna who told me of the conferences of the International Council on Alcoholism and soon afterwards I went to the Stockholm International Conference in 1960, and there I greatly enjoyed meeting the European experts – with well-known 'references' coming to life. I found these conferences very stimulating but I must say that what really seemed to count with me had previously come out of Jellinek's researches and from the *Quarterly Journal of Studies on Alcohol.* The American work seemed more relevant to the British situation than the Continental ideas; and the mid-European countries seemed then stuck with their mainly organic-oriented therapeutic notions. T. P. Rees was a member of various W.H.O. committees and he passed along a number of excellent World Health Organization reports, which obviously reflected Jellinek's thinking. Having said that, from the early 1960s onwards, I gained a lot from frequently mixing with people from other countries and they obviously faced the same difficulties in their countries which we had over here.

B.J.A. Did you know Jellinek?

M.G. I didn't know him very well but I always admired him, as I still do although I no longer agree 100 per cent with what he said. I first met him when he visited Warlingham about 1954 (as incidentally did Marty Mann). Jellinek came into our treatment group and he got on very well with the patients; he came back one or two years later and I think that was written up by the patients in their magazine. I seem to remember that Jellinek said something to the effect that he was quite impressed with the therapeutic community and with the psychotherapeutic group, but he felt perhaps that we were not doing enough about the organic approach though we used antabuse and non-addictive drugs. I met him once or twice later and he invited me to contribute to his projected encyclopaedia on alcoholism (which I did, enlisting the help of Cecil Heath for the British statistics), but Jellinek died before the Encylopaedia was finished. I was very impressed by him. He had a very broad vision, he seemed to know everything about alcoholism that was going on in all countries in the world. He was a very stimulating character and (perhaps similar to Freud) he was always putting forth lots of hypotheses. But what he said in 1960 he would not necessarily have been saying in 1983.

B.J.A. Were you yourself involved in any of the W.H.O. Expert Committees?

M.G. Yes, in 1965 and 1966, the Committees which put forward the idea of a 'combined approach' to alcohol and drug problems. The idea was not necessarily to treat alcoholics and drug takers in the same group, but to recognize that basically alcohol is a drug like other drugs. Some of the Americans felt that so much heartache and headache had gone into persuading society to regard alcoholics as people in need of help, and that the image might become contaminated by brack-

eting alcoholics along with 'dope fiends'. David Pittman was against the idea, so I asked him (about 1967) to write an article for the *British Journal of Addiction*, which he called 'The Rush to Combine'.

B.J.A. In 1962, D. L. Davies published his paper on normal drinking among former alcohol addicts. What did you make of that paper, and what do you make of it now?

M.G. Well, I have to be careful not to talk from hindsight. I always thought that it was *theoretically* possible but not *practically* likely to return to normal drinking, and that's still my position. By that time – after my marriage – I started also to practise in Harley Street where I met middle-class alcoholics who were usually convinced that they could drink in moderation. Previously if alcoholics had come to me and said they wanted to drink in moderation, I probably would have said I can't help you, though I wish you good luck. But from 1962 on I had begun to make a kind of gentleman's agreement with that type of patient. I said to them, well, whatever I believe or don't believe, there are very reliable research workers who say that it is possible for you to achieve that goal. Try your own way if you want, but if you don't succeed give another method a chance. Some of these patients could indeed hold to social drinking for a little while; and I had also told them, look, if you want to do it that way then try to sip your drinks and don't gulp, try to stick to beer rather than spirits, drink with your spouse and above all don't drink when depressed.

One certainly did see people who could control their drinking for a short period, and I began to see it in terms of a variable threshold-range – if people by hook or by crook could keep to the right side of that threshold-range, they might get away with drinking. The debate raises the difficulty of trying to keep a fair position between two extremes – between, on the one hand, those people who say it is quite impossible, and certain sociologists and psychologists who now claim that 'normal drinking' could almost become the rule. My present position is that I believe that in theory every alcoholic could drink normally if the going remained good in three areas – in the area of the individual's personality, in the area of work and the environment, and in the area of the 'agent' (the drinking rules the individual is employing). For instance, as far as the individual is concerned, this might mean drinking only when cheerful and contented and not taking drink as a medication for one's nerves. In relation to the environment, it could mean drinking in the company of the spouse or of moderate drinkers only; and the drinking rules might be sipping wine or beer rather than gulping spirits. If the going remained good in all those areas, that person might go on drinking in a controlled way for ever, but unfortunately the wife does sometimes nag, unfortunately one does sometimes have to listen to boring lectures, unfortunately England doesn't win all the cricket and soccer matches, and unfortunately it does sometimes rain in this country, and one's boss does not always recognize what a wonderful person one is. And given that reality-situation, while in theory I don't see any reason why it should not be *possible* to return to 'normal' drinking, because of the unlikelihood in reality of the perpetual fortunate constellation in the three areas, I believe that what in theory is possible, in practice is not all that

likely. I have been looking around for these elusive controlled alcoholics now for twenty years at least, I keep in touch with many ex-patients, and I would have thought sooner or later I should have met one of these cases, but I haven't seen one. Critics then say, perhaps rightly, that this is the result of a self-fulfilling prophecy: and although (initially) I do not tell such patients at the first interview that I don't believe in alcoholics' 'normal' drinking, they may perhaps still know or suspect my scepticism. Critics might also say the results of a systematic behavioural approach aimed at normal drinking would be different from the results gained from my approach (although such a view would not be confirmed by Pendery *et al.*'s recent follow-up of the Sobells' patients). I think one has to keep an open mind about it.

B.J.A. Did you and Davies know each other at the time his paper came out? Did you and he ever discuss things together, or was it two separate worlds divided by the Thames?

M.G. Yes we did know each other, he was at my wedding, and that was two years before he published that paper. As to the Thames, I think you are right. Since I left Warlingham in 1958, visiting the Maudsley and crossing the Thames has always been a bit of a – South Pole expedition. I don't think Davies and I ever discussed the issue privately, but we debated it for example on a platform in Ireland where the hefty, stocky chairman was sitting between the two of us because he seemed afraid that we would come to blows. This discussion was written up at length in an Irish newspaper. But in practice, I don't think in actual clinical practice we were all that much far away from each other as it seemed when the debate was reported. Initially of course Davies did not say 'Come all you alcoholics I offer you an eternal paradise where you can all drink in a controlled way till the end of your days.' He only said it seemed possible but not to be recommended. It was only later that he gradually moved his position a bit or a lot further – possibly prodded along in the main by psychological and sociological fellow travellers.

B.J.A. When did you start to get interested in drug problems?

M.G. One of the first things I learnt about drug problems was that many alcoholics feel that if you give them one tablet, four tablets would do them four times as well. From 1953 onwards we were seeing quite a few barbiturate and amphetamine addicts at Warlingham, mainly middle-aged female patients. We also had an occasional narcotic addict, mainly doctors, several years before the new wave of young addicts came along in the early 1960s. In 1967 Roger Tredgold and I opened an out-patient addiction centre at University College Hospital, and this was a year before the new N.H.S. Clinics opened – there was one earlier centre at Westminster Hospital. By when I was at St Bernard's (I had moved there in 1958), and because nobody knew where to send these young addicts and as St Bernard's had a large alcoholism unit with 60 to 70 beds and we were already taking some barbiturate and amphetamine users, we were sent these young addicts from about 1961 onwards. We put them together with the

alcoholics, and they did fit in, despite all the differences in personality, age, social and economic circumstances, pharmacological agents. But after a while we began to have separate group sessions for the young narcotic addicts on the one hand, and on the other hand for the alcoholics and some more middle-aged sedative and amphetamine users though keeping them in the same ward. That started in about 1962, and the aim was to get them off narcotics completely within about a week and then start group therapy. The U.C.H. O.P. centre was started five years later.

B.J.A. Did you give evidence to either of the Brain Committees?

M.G. No, but I had of course by that time written quite a bit about drug problems. I was present at the quite memorable discussion (about 1961) when Lord Brain talked at the Society for the Study of Addiction about his first Report. I'm sure it was not Lord Brain's fault, but it was a whitewash committee.

All, or rather the few, of use who were then treating narcotic addicts knew that not everything in the garden was lovely. The Committee said they hadn't found any evidence of any doctor prescribing in an unethical way. And everyone of us knew that this was not so. There were one or two world famous prescribers; Francis Camps was so indignant about the indiscriminate over-prescribing that he once seriously intended to test the matter in court, but he was told that if he was bringing addicts as witnesses, the court would throw their evidence out. It was well-known that there was overprescribing going on; but this first Brain Committee said nothing needed to be done. There was at that S.S.A. discussion a Mr Benjamin, a pharmacist working in the West End, who asked the Committee members 'how is it you only have found so few cocaine takers? I can give you many more from my own pharmacy'. Their answer was 'Why if you knew that, didn't you tell us before?' And there was at least one official in the Home Office who probably knew more about the drug situation than any of us but he felt he was not at liberty to talk.

Immediately after, as you know, they convened a second committee which changed most of what they had originally said. In between the publication of the First and the Second Brain Report, Peter Chapple, Tom Bewley and one or two others, formed an unofficial committee. Those of us who were involved in treating addicts went along to these meetings as did some of the over-prescribing doctors. It was called, I think, the London Committee for Addiction. Chapple was a moving force. Most of us were very adverse to prescribe what we thought were killer drugs. But in the end when we were asked to man the new addiction centres, the arguments were that if we didn't prescribe, the black-market would take over. The aim was to take the prescribing of narcotics out of the hands of private and general practitioners and put it into the hands of the N.H.S. doctors at specially licensed clinics. Whilst one hated doing what one was doing, one would participate, as it seemed the lesser evil. But it's quite wrong to say (as people do nowadays) that we thought at the time this was the *treatment* for drug addiction. It was just a kind of first aid and one hoped, partly naively, but partly to give one's own conscience a kind of alibi, that the new centres would not be just prescribing units, that they would have sufficient multi-disciplinary staff and sufficient time

to establish relationships with addicts and motivate at least some of them to give up drugs.

I remember that I felt guilty whatever I did at that time. When I prescribed the stuff I felt guilty prescribing killing drugs. And if I didn't prescribe to someone who came alone and said 'I really need it, I've got severe withdrawal symptoms and you only give me so little', well then again I felt bad. Nevertheless, compared with the sometimes scandalous over-prescribing that had been going on before 1968, I still feel that at that time the Clinics were justified and for a time did quite well. The criticism that was later always levelled that we were only dealing with a small segment of the addicts was again something of which we were fully aware; at St Bernard's we of course always also admitted and treated addicts to non-narcotics.

B.J.A. At that time you were favouring the possibility of compulsory treatment for addicts?

M.G. Yes, though for certain addicts only under certain circumstances, and I still think compulsion has a role, provided that one has got a decent treatment centre. If one sees people who are undoubtedly doing a lot of harm to themselves and to others, then for all of us to stand by and say 'These people are free agents, this is a liberal country and one objects to compulsion in any shape or form', that is an easy cop-out. It comes back to what we were saying about compulsory treatment of alcoholism. An alcoholic or a drug taker with severe dependence is not a free agent, and it is quite wrong to say that motivation cannot be induced in at least some of these patients.

B.J.A. You've been a witness to everything that has gone on in this country in relation to drug and alcohol problems over a span of thirty years, and an active participant in nearly everything that has happened. Have we made any progress?

M.G. There is often criticism today that the medical profession by-and-large doesn't care about these problems and that so little is done, with the supposition that much of our organized response has gone wrong. But each of us is interested in our particular field, and there are hundreds of dedicated people who feel passionately the same as we do about other medical needs and other social needs. There are higher-ups who have to work out the balance between our respective demands. Taking such problems into consideration, I don't see that many other countries respond much better to alcohol and drug problems than does Britain. Of course, one cannot be satisfied and there's a lot of room for improvement, but it hasn't gone all that badly. I think doctors have begun to wake up, or as Dent once put it, to 'catch up'. I think alcoholics certainly now get a better hearing – perhaps one should now also try to understand the plight of the families of addicts who often suffer as much as the drinker or drug taker.

B.J.A. I have one last question. What were the roots of your compassion? You bothered to get interest in people who were discarded by the medical profession. You bothered to listen when many people wouldn't listen. You concerned

yourself with young drug addicts, you sat around in Wormwood Scrubs Prison. I am wondering whether you understand, as much as any of us can ever understand such things, the origin and motivations of your involvement?

M.G. Of course I don't recognize myself in all these things you say. But may I first briefly take up your Wormwood Scrubs remark? The addicts' therapeutic community in Wormwood Scrubs Prison – the 'Annexe' – has now been going on for a decade or so, and I think (as do its patients, ex-patients, staff and former staff) it is a great shame that hardly anything about it has ever come to the notice of anyone. Certainly in all the group meetings which I have attended over the years in and outside hospitals I have hardly ever come across such honest, searching and critical confrontations among patients, with – at the same time – an obvious underlying caring attitude for each other, as among these prisoner-patients with their double handicaps of often serious personality disorder and addiction. We all feel strongly that similar experiments – setting up therapeutic communities within certain prisons (followed up, if at all possible, by special half-way houses), should be tried elsewhere.

But as to your main question, I don't know whether I have got the real answer. Once I began to know alcoholics I developed a high respect for them as individuals. When I got married some years later we had about twenty recovered alcoholics at our wedding. It is quite difficult to come back from nowhere in the face of an ostracizing, non-understanding society. Very often they are good, even great personalities. The nearest I can come to answering your question, and I don't know how deep this goes, is that most of us pride ourselves that we care for the underdog. Coming from Germany as a refugee and having seen what happened in that country to a minority left in the lurch and forgotten by everybody – but whatever it was in 1952, it must have been in me before, and I think I always tended to side with losers. If I see a soccer game I always want the underdog to win. I think I felt guilty that I had completely misjudged the first alcoholics I met before 1952 when I had just said 'drink less', or some great statements such as that. I felt I had done them wrong and society, everyone else, was doing them wrong too. Here were people who suffered and deserved help and none of us were doing anything for them. Perhaps I felt it was somebody's, I don't know, responsibility to open his mouth, even, or perhaps because, it was with a German accent and a Jewish refugee mentality and background.