COMMUNITY MANAGEMENT

of

"DETERMINED" DRINKERS

by

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Chapter 1: SUMMARY

1. The 1970's were times of considerable change in our understanding and beliefs about the nature of 'problem drinking'. The 'Disease Concept of Alcoholism' had been shown to have limited value and no validity. The hazards of inappropriate use of the 'Alcoholism' label had been highlighted.

There was no clear successor to the disease concept, although the hybrid model of 'The Alcohol Dependence Syndrome' seemed to be the nearest there was to a consensual view. But it adhered to the older notion of Inexorability, re-expressed as 'Restitution after Abstinence', in spite of growing evidence of Reversibility.

There was a need for the development of new models of alcohol problems. The Author has developed a method of examining Models of Alcohol Problems and has been able to derive the profile of the Alcohol Dependence Syndrome using this method.

2. Views about Treatment have also changed. Hospital-based treatment for 'problem drinkers' had been shown to be of little value: minimal interventions appeared as effective. The use of: Involvement of Spouse, Therapeutic Community Milieu, Antabuse (for an Abstinence Goal) and Vigorous Follow-up differentiated more successful from less successful agencies.

Assessment procedures were believed to be of great importance although the 'problem drinker' tended to be seen as an object of study and not as a participant in the process, whose views might also be of importance and value. The logic of matching the individual needs of the

'problem drinker' with what service is offered was advocated but had not been implemented systematically. Multidisciplinary Community-based Services were being suggested, but none had been established for long enough for an evaluation of efficacy to be undertaken.

3. Abstinence was no longer regarded as the major criterion of successful treatment outcome. Experimental controlled drinking programmes appeared to be promising.

4. No treatment system had been shown to make any impact on the prevalence of alcohol problems in a community. It was believed that gross per capita consumption of alcohol in that community was the major modifiable influence on that prevalence. By the late 1970's, no other attempt had been made to operate the major alcohol treatment resource of a whole community along the lines of the changes noted in 1 - 3 (above).

5. "The Leicestershire Community Alcohol Services" were instituted in 1978. For a population of just under one million, they provided a non-abstinence oriented, multidisciplinary community-based response. They attempted to maintain the "customers" in their own living and working environment and to reinforce their beliefs in their own essential normality and continuing responsibility for personal conduct.

6. Referral rates into the Leicestershire Services have risen greatly since their inception. "Customers" using the services had typical demographic and alcohol use characteristics of users of alcohol services in Britain generally. Mean consumption per drinking day was the alcohol equivalent for men of a bottle of spirits, for women a bottle of fortified wine (Sherry, Martini). At the time of presentation to the services, they were

judged to show a high degree of insight into their drinking and other problems. At follow-up, most saw themselves as 'ex-problem drinkers', whether they continued to drink or not.

7. Using the same method as he used to derive the profile of the Alcohol Dependence Syndrome, the Author attempts to explore a new model of alcohol problems, "Determined Drinking" based predominantly on the self reports of the "customers" of the Leicestershire Community Alcohol Services. It incorporates an acceptance of Reversibility.

8. A short-term uncontrolled follow up of a sample of users of the Leicestershire Services was carried out. There was a high rate of attrition from the study, particularly of less stably housed men. But this study appeared to indicate that six months after cessation of contact, consumption of alcohol had either ceased (24.4%) or reduced to approximately half reported intake at initial assessment. Patterns of consmption had changed from all-day solitary facultative drinking to drinking in the company of family and friends in the evening.

9. Using data collected from Hospital Records, Death Certificates and Police Records, a wide range of indirect indicators of alcohol problems were compared in a natural experimental design. Three counties in the East Midlands of England, with similar demography and drinking patterns, but different styles of Alcohol Services: Derbyshire (effectively generic only), Nottinghamshire (In-patient Alcohol Treatment Unit and 'outreach') and Leicestershire (Community Alcohol Services) were compared over time. Using a mathematical modelling method of data analysis that incorporated change over time as a factor, significant differences in the time series between the

three counties were found. Some baseline differences were present. But with the development of the alternative styles of alcohol services, further significant changes over time occurred. In general, compared with one or both of its neighbours, concomitant with a burgeoning usage of its Community Alcohol Services, there has been a flattening off or an actual reduction in alcohol related morbidity and criminality in Leicestershire.

One possible explanation of these findings is the difference in the style of provision of Alcohol Services in the three counties. Other possible explanations, such as differences in demography, alcohol use, general medical services' or policing practices would appear unable to account for the wide spectrum of differences reported.

Thus the policies and practices of the "Leicestershire Community Alcohol Services" appear to offer a timely and promising model of service provision for alcohol problems in a whole community. They now merit further examination and evaluation locally as do similar services established elsewhere, particularly in areas with very different drinking practices and prevalences of alcohol problems.

Chapter 2 PURPOSE OF THE STUDY

The Leicestershire Community Alcohol Services have been developed to provide a community-based service for people with problems of alcohol use from the county. They are multidisciplinary, non-abstinence oriented, designed to be non-stigmatising and to meet the specific needs of the individuals who use them, which is assessed initially by asking the consumers what they believe would be helpful.

The purpose of this study is to describe:

1. The background and theoretical basis of those services.
2. The county of Leicestershire and its alcohol services.
3. The use made of the services by the community.
4. The characteristics of persons who use the services.
5. The efficacy of this style of service for such persons.
6. The possible impact of these services on alcohol-related morbidity and mortality in the community.

Chapter 3 INTRODUCTION

a) PREAMBLE: MAN-IN-RELATION-TO-ALCOHOL

"Let us start by sparing a thought for the !Kung, a tribe of the Namibian Desert of South West Africa. For, within the last decade or so, the !Kung have done something that tribes have been doing for tens of thousands of years. They have settled; they have ceased nomadic hunter-gathering, and they have started brewing. The !Kung women have started producing what is a form of honey beer and they have started selling it to their menfolk for five cents a cup. (Leakey, R.E. 1981) The !Kung have done it. They have opened up the Pandora's Box of man-in-relation-to-alcohol. They have done it. There is no way back.

Sooner or later, members of the !Kung will drink or behave when intoxicated in ways which are disapproved of by other !Kung people. Sooner or later, the cry will go up, "something must be done". And among those 'somethings' that will be done are punishment of those disapproved of; attempting to close the Pandora's Box or Prohibition as it is called; controlling patterns of consumption by legal and fiscal means. Those 'somethings' will not be a success, for they never have been a lasting success for others who have tried them. The history of man-in-relation-to-alcohol is full of stories of the failure of those 'somethings'.

Then, if the !Kung are still in existence, the Tribe will decide that the disapproved-of drinkers cannot help themselves; that they are incapable of behaving more appropriately. So, explanations of their failure will be

sought. Perhaps they will try evil spirits. Perhaps they will claim that drink contains an ingredient which renders powerless some of its consumers- "the daemon drink"; or perhaps they will claim that demonic possession of these people explains their conduct. And the combatting of demons needs powerful magic.

But if by this time the !Kung are more sophisticated or secular, then other kinds of explanations will be sought: explanations involving fundamental differences in bodily function between 'wicked' drinkers and 'good' drinkers; and a non-moral definition of helpless will be used. These people will be called sick. Thus will the !Kung give birth to the "Disease Concept".

I need to make quite clear at this point that I am not talking about diseases caused by certain patterns of alcohol use; I am not talking of Cirrhosis of the Liver, or Pancreatitis, or Korsakov's Amnestic State. I am talking of that global all-encompassing concept of the disease of inappropriate alcohol use - habitual drunkenness, dypsomania, alcoholism, alcohol dependence: that which is meant to explain why some people break rules of drinking conduct.

Unless we export it to them long beforehand, then sooner or later the !Kung will create for themselves the "Disease Concept" of Alcoholism. They will arrive at the point we arrived at halfway through this century. It is from that point onwards that I wish to pursue the story of man-in-relation-to-alcohol, with particular reference to systems of care for people who present with problems of alcohol use."

(Cameron, D. 1982)

b) THE "DISEASE CONCEPT" OF ALCOHOLISM

In the 1950's in Britain, the "Disease Concept of Alcoholism" was more than the leading theory in the alcohol problems field. By most it was regarded simply as the truth. That truth had been foist upon us for the previous twenty years with a kind of evangelical zeal generated mostly in the United States. Deliberate attempts had been made in the corridors of political power to sell an entity as a "disease" and to forage out and diagnose sufferers in places other than in Skid-Row, to forage for 'respectable' sufferers. Also, the so-called signs and symptoms of the "disease" were described and validated by self-reports of the sufferers. (Jellinek, E.M. 1960) This in turn led to the production by an international body of a definition of the "disease":

Alcoholics are those excessive drinkers whose dependence on alcohol has attained such a degree that it shows a noticeable mental disturbance or an interference with their bodily and mental health, their personal relations and their smooth economic functioning, or who show the prodromal signs of such development. They therefore need Treatment."

World Health Organisation, (1952)

Looking back from the early 1990's, it now seems quite extraordinary that such a definition should first have been written and second gone uncontested for such a long time. Jellinek's caution in stating that his formulation of "Alcoholism" as a "Disease" was simply a working hypothesis which would serve until a better one was produced was soon forgotten. The "Disease" was quite

simply a reality, and contesting it had the quality not of scientific questioning but of heresy. Indeed to the Johns Hopkins University Inventory of Signs and Symptoms: the "ARE YOU AN ALCOHOLIC?" or colloquially "Who, Me?" questionnaire had been added the sentence: "The questioning of the validity of this questionnaire may in itself be a sign of the disease".

Even at a commonsense level, it was obvious that the W.H.O. (1952) definition was flawed. It contained value judgements such as "excessive", "noticeable", "smooth" and used the term "dependence" without attempting to clarify what was meant by it. Objective criteria were totally absent and yet if people were designated as having the "disease", they were deemed to be in need of treatment. It is perhaps in those final four words of the definition that its real purpose becomes clear. If someone suffers from a disease such as Carcinoma of Lung, then the definition of the pathology would involve malignant proliferation of cells within the lung. It would not contain a treatment rider. The need for treatment would be, in the definitional context, irrelevant. Not so with "Alcoholism". The W.H.O. (1952) definition was not about science, it was about politics. "Alcoholism" as a concept was said to have heuristic value, to enable non-stigmatising care and treatment to be provided for drinkers with problems. If the "Disease Concept" was contested then the protagonists would also be contesting people's right to care: there would be a return to the bad old days of the "Moral Model" by which was actually meant punishment of problem drinkers.

Another force of increasing power which was serving to inhibit questioning of the "Disease Concept" was the self-help organisation Alcoholics Anonymous. This was

formed in the United States in the aftermath of the failure of Prohibition and had had much to do with re-establishing alcohol problems on that nation's agenda, by the creation of a new deviant minority which effectively allowed the majority of Americans to get on with their drinking habits unfettered by the forces of Temperance.

But, eventually, contested it was. Despite the risks of being labelled "Alcoholic" themselves and of suffering the wrath of "The Alcoholism Movement", which by the 1960's had a stranglehold on treatment and research ideologies, some still small voices were heard. At first, these voices did not contest the existence of the disease, rather they questioned the Absolutism of some of the symptoms of the "Disease". Therefore it is appropriate at this point to discuss these in more detail.

Because it was covertly recognised by practitioners that the W.H.O.(1952) definition was so broad based as to be virtually meaningless operationally, and because people who presented to treatment agencies tended to report or be encouraged to report similar stories, some of the so-called symptoms of "Alcoholism" had become somewhat more "recognised" and regarded as cornerstones of the disease concept. In a major critique of the disease concept, these cornerstones were described by E. Mansell Pattison (Pattison, E.M. 1976). He was at pains to point out that not everybody would agree with his analysis but, apart from his use of the word "allergy" (which he placed in quotes), it would be difficult to argue with his elegant summary. If the "Disease Concept" was to be shown to be inadequate, then these propositions had to be shown to be lacking in substance:

PROPOSITION 1: THE ALCOHOLIC IS ESSENTIALLY DIFFERENT FROM THE NON-ALCOHOLIC.

Corollary a) There are inborn genetic differences or developmental genetic differences.

Corollary b) These genetic differences lead to fundamental changes in the biochemical, endocrine or physiologic systems of the alcoholic.

PROPOSITION 2: BECAUSE OF AN ORGANIC DIFFERENCE, THE ALCOHOLIC EXPERIENCES A DIFFERENT REACTION TO ALCOHOL THAN DOES THE NON-ALCOHOLIC.

Corollary a) The alcoholic develops an "allergy" to alcohol.

Corollary b) The allergic reaction creates untoward responses to alcohol, including a craving fo alcohol, an inability to stop drinking and a loss of control over the use of alcohol.

PROPOSITION 3: THE ALCOHOLIC HAS NO CONTROL OVER THESE INEXORABLE PROCESSES WHICH IS A DISEASE PROCESS.

Corollary a) The disease process will proceed in inexorable progression to ultimate deterioration and death.

Corollary b) The disease process is irreversible.

Corollary c) The disease process can be arrested but not cured.

PROPOSITION 4: THE ALCOHOLIC IS NOT PERSONALLY RESPONSIBLE FOR HIS ALCOHOLISM SINCE THE DISEASE PROCESS IS AN IMPERSONAL ILLNESS WITH WHICH HE IS AFFLICTED.

Corollary a) The Alcoholic is relieved of social stigma for moral failure.

Corollary b) The Alcoholic is relieved of personal guilt for his Alcoholism.

Corollary c) The Alcoholic is not blamed and punished for his Alcoholism.

Corollary d) Society has a responsibility to rehabilitate sick members of society, including sick Alcoholics.

c) DEMOLITION OF THE "DISEASE CONCEPT"

Pride of place for initiating the invalidation of the "Disease Concept" is normally given to the late David Davies for his paper "Normal Drinking in Recovered Alcohol Addicts" (Davies, D.L. 1962). In some ways, it is difficult now to see why; although few in the 'Alcohol Field' would deny that that paper was a watershed. All Davies did was to report anecdotally that seven out of ninety-three patients treated for "Alcoholism" at the Maudsley Hospital had, at up to seven years, reported resuming problem free drinking careers, and these reports were corroborated by Spouses or others who could be trusted by the investigators. Davies was not the first to come up with this finding, nor indeed was his study the biggest to show this. But what Davies did was to highlight this phenomenon and not regard it as of no validity. Other investigators 'wrote off' such people as being on a rather less steep slippery slope than those who continued to drink but overtly problematically. Simply, Davies was willing to stand behind his seven patients and say that these people might disprove that cornerstone of the "Disease Concept" later expressed by Mansell Pattison as Proposition 3 (see above).

In fact, Davies's very modest conclusions might have been an overstatement. A recent very long term follow-up study on those seven has been undertaken by Griffith Edwards (Edwards, G. 1985), who managed to trace them or their corroborates twenty-five years after the original inpatient treatment. All is not well. While two of them continue to do well, one is dead, one is a chronic Mental Hospital Patient with Wernicke-Korsakov's Amnestic State and two, at the time of the original study, were

ingesting large quantities of Benzodiazepines and continue to do so.

But David Davies's paper, however bad, however anecdotal, had laid open to scientific scrutiny the proposition of Inexorability, and on its coat tails the rest of Pattison's "Propositions". Since 1962, it has been possible in the field of alcohol studies to ask previously unaskable questions; to engage in laboratory experiments with so-called "Alcoholics" which previously the 'Alcoholism Movement' regarded as unethical. Scientists, particularly Behavioural Psychologists, could now give alcohol to "Alcoholics" and examine other cornerstones of the "Disease Concept". Social scientists could ask different questions of the General Population. Psychiatrists were now able to believe what some of their patients had been telling them for years. David Davies had opened the floodgates.

Over the next decade, a mass of studies were undertaken which looked at the other cornerstones of the "Disease Concept". They have been widely reviewed. (Mello, N.K. & Mendelson, J.H. 1971; Pattison, E.M., Sobell, M.B. & Sobell, L.C. 1977). A particularly succinct review of the "phenomenon" of Loss of Control (Pattison's Proposition 2b) by Nancy Mello came to these eight straightforward conclusions:

1. No alcoholic subjects allowed to freely programme their ethanol intake showed loss of control or drank to oblivion.

2. No alcoholic subjects drank all alcohol available, even when freely offered.

3. Alcoholics allowed to drink for 30-60 days continuously often started and stopped during this experimental period.

4. Amount of Alcohol consumed by alcoholics was shown to be a function of the amount of work or effort required to obtain Alcohol.
5. With sufficient money or other social rewards, alcoholics will abstain even though alcohol is freely available.
6. Alcoholics demonstrate the ability to taper their drinking to avoid severe consequences of abrupt withdrawal.
7. Alcoholics display social drinking and periods of abstinence during the course of a drinking career.
8. Priming doses of Alcohol do not lead to increased reported craving. (Mello, N.K. 1972)

Davies's study on treatment outcome was replicated, or rather people started looking anew at old results, and these also were comprehensively reviewed. (Pattison, E.M. 1966; Emrick, C.D. 1974; Emrick, C.D. 1975) The conclusion was much the same: that around 10% of people treated for "Alcoholism", told to abstain and threatened with 'ultimate deterioration and death' if they did not do so, flew in the face of that advice and appeared to resume problem free drinking careers. The folk-wisdom belief in inexorability was not being validated. That should not have been a surprise, its scientific, as opposed to its lay 'validity' was derived from nothing more robust than a summary of a postal questionnaire undertaken by E.M. Jellinek (Jellinek, E.M. 1946) on adherees to Alcoholics Anonymous; it was uncontrolled and it was without corroboration.

General population surveys by social scientists (Cahalan, D., Cisin, I.H. & Crossley, H.M. 1969, Cahalan, D. & Room, R. 1974) were producing a different kind of evidence which was also refuting the belief in

inexorability. They were showing that ordinary people, people who had never been construed by themselves or others as being "Alcoholics" , were reporting that they had experienced on occasion what had become recognised as 'symptoms' of "Alcoholism", such things as Alcohol Amnesias -'Palimpsests', Alcohol related absenteeism and (reversible) problems with physical health. As a result of these studies, Pattison's Proposition 1 was beginning to look highly questionable. Perhaps there was no clear dividing line, perhaps "Alcoholics" were simply people who had been detected having drinking problems. Thus, practitioners started talking of "The Hidden Alcoholic in General Practice" (Wilkins, R.H. 1974) and elsewhere.

There was even more uncomfortable information being reported in the literature. Not only were people in the general population reporting having serious problems historically out of which they had now grown, not only were some 'patients' defying the received wisdom of the treaters and their advice and resuming what appeared to be problem free drinking careers, but they seemed to be doing so in very large numbers. Drew (Drew, L.R.H. 1968) undertook an epidemiological study in Victoria, Australia which showed that around one third of people who had actually presented for treatment of 'Alcoholism' would mature out of it in later life.

To these findings had to be added a negative one. Despite many years of research, the 'Alcoholism Movement' had failed to find any substantial evidence to support Pattison's Proposition 1, Corollary a), that there are inborn genetic differences or developmental genetic differences between 'Alcoholics' and 'Normal Social Drinkers'. The most that was claimable was that there might be a genetic basis to a 'vulnerability' or

'predisposition' to 'Alcoholism' (Goodwin, D.W. & Guze, S.B. 1975). But there was now increasing data that drinking patterns were learned , that learning starting in early childhood in the home. (Ullman, A.D. 1962; Jahoda, G. & Cramond, J. 1972; McKechnie, R.J., Cameron, D., Cameron, I.A. & Drewery, J. 1977)

By the mid 1970's it had become clear that the cornerstones of the 'classical' "Disease Concept' had been very substantially eroded: no convincing evidence had been produced to show that *An Alcoholic Was Born And Not Made* : *One Drink One Drunk* was not neccesarily so and it was not true to say *Once An Alcoholic Always An Alcoholic.*

A number of workers in the field also commented that the Disease Concept Of Alcoholism contained within it the potential for *self-fulfilling prophesy.* If, for whatever reason, a person was 'labelled' as an alcoholic, that in itself would increase the probability of abnormal drinking styles, particularly with regard to such behaviours as 'inability to abstain' and such feeling states as 'craving'. This led to the alcohol field taking an interest in 'Labelling Theory'.

Roman and Trice had expressed the conundrum in this way some years earlier (Roman, P.M. & Trice, H.M. 1968, reprinted in Pattison, E.M. et. al. 1977)

The basic contention... is that the medico-disease concept of alcoholism and deviant drinking has led to the assignment of the labeling function to medical authorities which in turn has led to the placement of alcoholics and deviant drinkers in "sick roles". The expectations surrounding these sick roles serve to

further develop, legitimise, and in some cases even perpetuate the abnormal use of alcohol...The sick role assignment may legitimise deviant drinking patterns since these patterns have been labeled results of pathology rather than as inappropriate behaviour...[also] the labeling process may lead to secondary deviance through a change in an individual's self-concept as well as a change in the image or social definition of him by the significant others in his social life space.

In his characteristically unconventional and clear way, Mulford (Mulford, H.A. 1977) proposed an interesting model of the 'community labelling process'. All he said was that in his community (Iowa), there were four common experiences which if demonstrated, would increase the probability of a person would becoming labelled 'alcoholic' or 'problem drinker'. These were:

1. *Trouble Due to Drinking.* This could mean work or family complaints, police intervention or bodily or financial damage.

2. *Personal Effects Drinking.* This was drinking for psychological effect, i.e. it makes me less shy, more confident, more satisfied with myself.

3. *Preoccupied Drinking.* This means being preoccupied with the behaviour and with access to the substance. "I worry about not being able to get a drink when I need one.. I sneak drinks.. I stay intoxicated for several days at a time".

4. *Uncontrolled Drinking.* This means "without realising it, I end up drinking more than I planned to".

It is possible that someone could be labelled 'alcoholic' on the basis of just one of these experiences. But clearly the probability increases if an individual demonstrates two, and even more if he/she demonstrates three. Demonstration of all four makes the likelihood of being labelled very high indeed. Mulford said that the experiences could present in any order. So he was proposing a cumulative, non-sequential process of being labelled. This was very different from the usual view which had it that 'alcoholics' went in sequence through a series of predictable and defineable stages, Pre-alcoholic, Prodromal, Crucial and Chronic; each stage with its own set of phenomena.

At that time, none of these authors denied the existence of 'alcoholism' as an entity. Rather they were outlining the possible social consequences of being considered to suffer from it. They were not attempting to "throw the (heuristic) baby out with the bathwater". In 1977, however, the "Alcoholism" baby was declared dead. (Nathan, P.E. 1977)

The impact upon the 'alcohol field' of this has been both patchy and marked, following in most ways the analysis of Paradigm Shift reported by Kuhn. (Kuhn, T.S. 1970) Many self- and other-attributed "Alcoholics" simply contested the new findings, saying tautologously that people who could resume 'social drinking' were not real "Alcoholics" in the first place or they personified, saying it might be true for others but it was not true for them. Similarly, some claimed that sooner or later, these people would end up in a mess again: and they knew because they too had tried 'social drinking' many times and had found it to be impossible.

An interesting shift away from Kuhn's original anaylsis has been brought about in this field by a number of highly authoritative workers in the field, notably Griffith Edwards and his co-workers from many countries. They have attempted to define a new phenomenon, the Alcohol Dependence Syndrome, which is not "Alcoholism", nor is it a complete resynthesis, nor indeed is it a more precise refinement of the core disease concept. It is worthy of discussion.

d) THE ALCOHOL DEPENDENCE SYNDROME

Undoubtedly, there existed in the seventies a conceptual vacuum. 'Alcoholism' had been shown to be a seriously flawed model but those researchers who had been reponsible for highlighting its inadequacies had not provided the field with a new conceptual framework.

The first real attempt to reconceptualise both 'normal' drinkers and those with overt problems of alcohol use was made by Griffith Edwards and some of his international collaborators, notably the late Milton Gross. They published a series of overlapping descriptions (Edwards, G. & Gross, M.M. 1976, Edwards, G. 1977 and W.H.O. Expert Committee 1977) of a number of phenomena which they said clustered sufficiently closely and frequently to merit being proposed as a syndrome. Of course, by definition, not all syndromal components had to be present to diagnose a sufferer, and Edwards et al. have never stated whether, as in Schizophrenia, there are pathognomonic 'First Rank' phenomena.

The 'Essential Elements of the Syndrome' are described below. All sections in *italics* are taken from "Alcohol Dependence: provisional description of a clinical syndrome" by Griffith Edwards and Milton M. Gross (1976).

Narrowing of the Drinking Repertoire

by which the authors mean that drinking behaviour begins to become fixed and predictable: *The dependent person begins to drink the same whether it is work day, weekend or holiday: the nature of the company or his own mood makes less and less difference.*

Salience of Drink Seeking Behaviour

Alcohol acquisition and consumption is now one of the sufferer's major preoccupations, leading to a person becoming progressively less interested in other activities and the disapprobation of others.

Increased Tolerance to Alcohol

Clinically, tolerance is shown by the dependent person being able to sustain an alcohol intake and go about his business at blood alcohol levels that would incapacitate the non-tolerant drinker.

Repeated Withdrawal Symptoms

At first, symptoms are intermittent and mild and cause little incapacity, and one may be experienced without others. As dependence increases so do the frequency and the severity of the symptoms...

The spectrum of the symptoms is wide and includes tremor, nausea, sweating, hyperacusis, tinnitus, itching, muscle cramps, mood disturbance, sleep disturbance, perceptual distortion, hallucination, grand-mal seizures, and the fully developed picture of delirium tremens.

But the four key symptoms of Withdrawal are stated to be Tremor, Nausea, Sweating and Mood Disturbance.

Relief or Avoidance of Withdrawal Symptoms by Further Drinking

"Hair of the Dog that Bit You" drinking need not occur first thing in the morning: it can occur from in the middle of the night to anytime the next day but the sufferer *may well be aware that if he has to go three or four hours without a drink during the day the next drink is valued especially for its relief effect.*

Subjective Awareness of Compulsion to Drink

Edwards and Gross attempt to abandon those Cornerstones of the Disease Concept of Alcoholism, Loss of Control and Craving, by likening those experiences to that of any psychological compulsion: *The desire for a further drink is seen as irrational, the desire is resisted, but the further drink is taken.*

Reinstatement after Abstinence

Following resumption of drinking after cessation for a time, *Relapse into the previous stage of the dependence syndrome then follows an extremely variable time course.* For someone who is mildly dependent, this may take months but for someone who is severely dependent, it may take a mere three days.

Having described these essential elements the Authors then state that *"Each part of this syndrome relates in some way to each other part"* but make no attempt to clarify whether they mean that all the syndromal axes are separate and positively correlated or sequential with overlap or even, as Mulford speculated, nonsequential and cumulative. Nor do they elucidate the relationship of dependent drinkers to the others. Instead they opt for a plea for further research based upon an acceptance of the essential correctness of their views. *"We are suggesting, then, that a clinical syndrome of alcohol dependence can now be recognised fairly confidently. It is fully in accord with the development of medicine that a syndrome should occasionally be recognised considerably before its scientific basis can be determined. Very speculatively, we may suppose that here the abnormality involves both a biological process and aberrant learning."*

e) RESPONSES TO THE PROPOSAL OF AN ALCOHOL DEPENDENCE SYNDROME

"The notion of alcohol dependence syndrome is arguably the most important and influential development in the field since Jellinek's work (Jellinek, E.M. 1952, 1960). It is appropriate here to consider the alcohol dependence syndrome in some detail for three main reasons. First, it has been around long enough to stimulate informed debate and not a little controversy (Chick, J. 1980, Heather, N. and Robertson, I. 1983, Shaw, S.J. 1982). Second, as a result of the W.H.O. deliberations the term *alcoholism* has been dropped from the International Classification of Diseases and replaced by *alcohol dependence syndrome*. Third it has given rise to the description of a more broadly based drug dependence syndrome....."

(Raistrick, D. & Davidson, R. 1985)

"Through the 1960's and 1970's, the concept of alcoholism as a disease was under attack from psychologists, sociologists, epidemiologists, and psychiatrists. So many of the cornerstones were chipped away by a mass of experiments and observations of the general population that the whole edifice eventually collapsed. Practitioners responded to that collapse in many and varied ways. Some pretended that nothing had happened and continued to use tried and tested but predominantly poorly evaluated treatment. Some started rummaging in the rubble, trying to re-erect the old building, some started examining the individual bricks all over again and have begun to build a new structure very different in shape from the old. Some, however, have clung to a remnant of the old edifice; Griffith Edwards has clung to alcohol dependence and in this work attempts to convince readers of the supremacy of that remnant. Unfortunately, yet another response of practitioners to

the collapse of the alcoholism edifice is to stand knee-high in rubble throwing broken bricks at each other.....

Where do we go from here? Back to the building blocks, I am afraid."

(Cameron, D. 1983a)

The statements above, both from practising clinicians, give a flavour of how workers in the alcohol field responded to the concept of the Alcohol Dependence Syndrome following publication by Edwards and Gross of a provisional description of a clinical syndrome.

On the one hand, there was widespread acceptance and support: Alcohol Dependence filled a 'gap in the market'. Patients did not need to be called Alcoholics anymore. They could now be called Alcohol Dependent, or given that there was room for a continuum of severity, Severely Alcohol Dependent. The Alcohol Dependence Syndrome, in the perception of many, became the new Alcoholism. And it became so very rapidly. As had happened to Jellinek before them, Edwards's and Gross's many caveats were widely disregarded. Their comments about the tentative nature of the description and pleas for further research became well submerged. Rather than examining the elements of the Syndrome to elucidate the relevance and correlations of one component to another, much research time was expended on measuring the amount of dependence present in individuals as if it were beyond doubt that there was a discrete quantifiable core phenomenon present. (Stockwell, T.R., Hodgson, R.J., Edwards, G., Taylor, C. & Rankin, H.J. 1979; Stockwell, T.R., Murphy, D. & Hodgson, R.J. 1983.)

On the other hand a smaller number of workers have questioned the validity of the Alcohol Dependence Syndrome, philosophically, theoretically and empirically.

Anthony Thorley, another clinician, questioned whether 'the syndrome' had any clinical usefulness:

"Perhaps there is a basic point to make here. Patients who come eventually to believe that their drinking problem centres on their own inability to control their consumption or behaviour, and have that cognitive set, will probably drink and lose control more often than those who view their behaviour and drinking from a less fatalistic or determinist stance. The use of concepts of dependence and implicit ideas of impairment of control may or may not have a validity in terms of explaining a cluster of life problems...and therefore it may be entirely valid...to take dependence right out of the clinical situation." (Thorley, A. 1985)

Stan Shaw (Shaw, S. 1979), a sociologist, criticised the syndrome on two grounds. First, that only part of the Syndrome, the psychobiological alterations due to alcohol could be confirmed by scientific study; and secondly that its use in research and treatment would be at best superfluous but more probably misleading and confusing.

Nick Heather and Ian Robertson (Heather, N. & Robertson, I. 1983) argued that it is not logical to describe both a model demonstrating a continuum of severity of alcohol dependence within the general and clinic-presenting populations and at the same time to describe a specific syndrome deemed to be a very abnormal state indeed. They claimed that what was happening was that a disease concept was "simultaneously being rejected and objectified".

These arguments are very basic. They question whether it is possible to have both a continuum model and a syndromal one, and if it is possible, is it either testable or useful?

Perhaps it is useful to consider a medical metaphor. Hypertension is on a continuum. Some people are not at all, some are mildly and some are severely hypertensive. Also, some severe hypertensives develop "malignant hypertension", a vicious circle whereby the hypertension creates renal and other damage which further increases the blood pressure. That is an example of a co-existing continuum and a syndrome. The risk of hypertension related illnesses, strokes and the like is positively correlated with the degree of hypertension and is very high indeed in (untreated) malignant hypertension. Alcohol Dependence and the Alcohol Dependence Syndrome would appear to be analagous to Hypertension and "Malignant Hypertension".

But there are major differences. Unlike Hypertension, Alcohol Dependence does not cause bodily damage. As this Author understands it, it does nothing other than increase the probability of an individual consuming alcohol. It is the alcohol that causes the bodily damage. And if there is not a high positive correlation between Alcohol Dependence and the quantities of alcohol consumed by individuals, then Dependence might become an independent and perhaps irrelevant variable. Much work in this area remains to be done, for the relationship between Consumption, Dependence and Problems is not simple or straightforward (See Thorley, A. 1982).

Another possibility is that Dependence might be no more than a by-product of a particular pattern of alcohol

consumption by particular individuals, a 'cart' rather than a 'horse'. To quote Jonothan Chick :

"The link is clear, namely, if you have dependence symptoms, you are likely to run into some other problems that may be ascribed to your drinking. What is less clear... is whether the relation depends on consumption, that is, whether if you are simply drinking enough to be dependent on alcohol then you will run into other problems." (Chick, J. 1985)

Also, unlike "Malignant Hypertension", the Alcohol Dependence Syndrome is not neccessarily that malignant. It need not lead to spiralling self damage outwith the control of the individual. Indeed it might be of no more than nuisance value and temporally self-limiting. (See pages 12 - 14 and 61 -65)

But more worrying for the Alcohol Dependence Syndrome protagonists than that is another finding by Jonothan Chick (Chick, J. 1980) using a structured interview on 109 men attending an Alcoholism Treatment Unit of a failure to demonstrate a single underlying dimension. Rather, he found that Subjective Need, Withdrawal and Aspects of Salience clustered. Narrowing of Repertoire and Impaired Control formed totally separate dimensions.

In another critique of the Alcohol Dependence Syndrome, the Author of this thesis attempted to highlight its theoretical and philosophical inadequacies (which are mentioned above) but his main focus of interest was to seek an explanation of why it emerged as an idea when it did. That explanation (Cameron, D. 1985) is quoted below.

" A DIMENSIONAL EXPLORATION OF MODELS OF ABNORMAL DRINKERS

....at different times different ways have been used to understand and deal with persons designated as deviant drinkers. They have been punished, preached at, medicalised and so forth. Teasing out from each other the various ways of looking at problem drinkers is no easy task since now, as ever, we do not operate a pure model but in a mixture of perspectives. At times we are preoccupied with the sickness aspects of a person's problems, at other times interested in a person's psychopathological processes, and at yet others determined to modify his or her drinking habits.

Thus, the exercise undertaken by Siegler, Osmond and their colleagues, firstly on madness (Siegler, M. & Osmond, H. 1966), thence extending into other areas including 'Alcoholism' (Siegler, M., Osmond, H. & Newell, S. 1968) will be used as the starting point for this section. These authors published a series of papers in which they attempted to unravel the various discrete philosophical models underpinning our beliefs about mental disturbance. Using much the same basic framework as they do, but abbreviated and somewhat changed, I have elicited what I believe to be six discrete models of problem drinkers. While I am indebted to these authors for the concepts and the framework, I have not adhered strictly to their view, since for reasons beyond the scope of this paper I am particularly unhappy with their 'Models of Alcoholism' paper. The framework and 'my' six models are shown as Table 3.1.

TABLE 3.1

Six Models of Abnormal Drinkers

Nature of Disorder	Disease	Psychological disturbance	Bad habit	Wickedness (weakness, indulgence)	Spiritual problem	Normal (scapegoat)
Cause	Unknown ? genetic	Scars of childhood	Faulty learning	Unknown but the person's fault	1. Demonic possession 2. Alienation from spirit	Nothing wrong, so no cause
Behaviour to be changed	Excess consumer Disease process	Excess consumer Underlying conflicts	Excess consumer	Excess consumer	Excess consumer	None
Method of changing	1. Medical care 2. Self help (AA)	Psychotherapy	Behaviour therapy (relearning)	Punishment	Spiritual counselling and love	No change required
Personnel	1. Doctors etc. 2. AA Recovering Alcoholics	Trained psychotherapists or analysts	Psychologists	Courts, police, prison	Priests, gurus	Delabellers, drinker's companions, publicans, etc.
Success, drinking non-problem-atic since:	1. Cured 2. Abstinent 'Arrested' since no cure	Psychologically 'mature'	Good habits	Reformed	'State of Grace'	People leave him/her alone
Cause of failure	1. Denial, lack of co-operation 2. Denial, not at rock bottom	Lack of insight	Unco-operative	Incorrigible	'Infertile ground'	Society won't leave him/her alone for its reasons
Duties of client	1. Come for sick-ness to be treated 2. Co-operate with AA	Co-operate with therapist	Co-operate with psychologist	None	To seek spiritual realisation	None
Duties of society	1. To provide medical care 2. To accept AA and encourage it	To provide psychotherapy	To provide facilities for relearning	None	To make available spiritual guidance and resources	Not to scapegoat

Having elicited these six discrete models, I wish to examine them upon four dimensions:

(1) An abnormality of drinking dimension.
(2) A personal abnormality dimension.
(3) A personal culpability dimension.
(4) An expertise dimension. (Do our 'clients' or we 'helpers' know best about the nature of problem drinking?)

Each dimension has been expressed as a five point scale with at either end the the absolute position, in the middle the balanced, equivocal position, and at the ¼ and ¾ points the 'more' and 'less' positions. When the models are individually fitted onto these dimensions, the result is the highly complex Figure 3.1.

If one starts at the left hand side, the sickness model is absolutist on all four dimensions - the client's drinking is totally deviant; the client himself is diseased and thus totally abnormal; he is a hapless victim of his disease process so not responsible; and we the (medical) experts know about his status whereas he, the sufferer, does not. At the right-hand side the conspiracy (normal) model is similarly absolutist - believing that both the client and his drinking are absolutely normal; that he is totally responsible for his drinking behaviour; and that he knows he is normal, a view at variance with those who would wish to modify his conduct for their own (sinister) reasons.

All the other models occupy in varying degrees less absolutist positions. For instance, according to the wicked model, the client's drinking is equivocal, neither normal nor abnormal, in fact irrelevant to the more

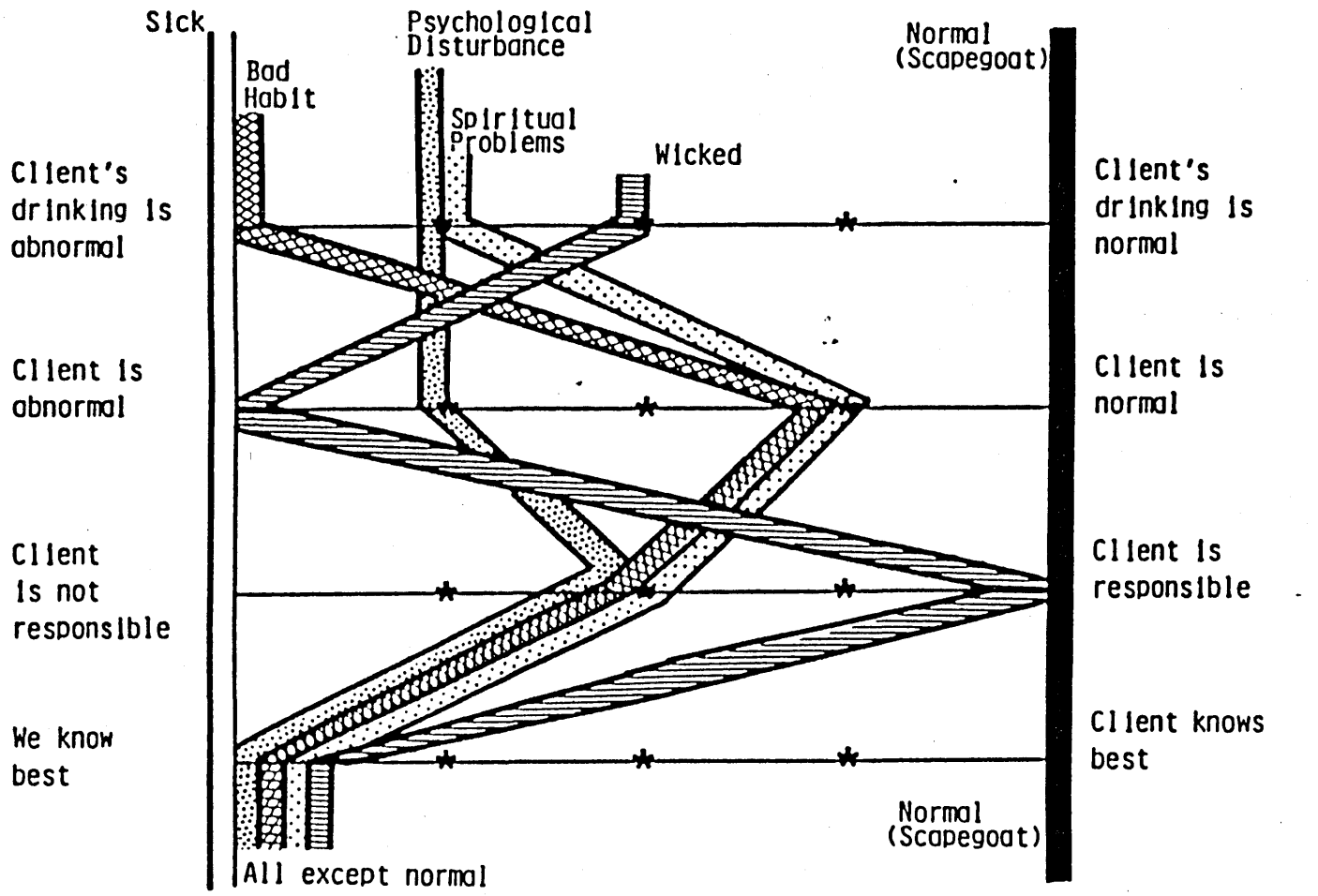


FIGURE 3.1: Diagram of Models of Abnormal Drinkers

important dimensions of his being abnormal (a criminal) but totally responsible for his conduct. Further, we (of law abiding status) know how to deal with criminals and have the right to do it (punish them). Each of the other models is similar in its profile as can be seen in Figure 3.1.

Having elicited these profiles, it is possible on the basis of only two assumptions to derive a consensual view. These are firstly, that all models are of equal validity - that demonic possession is no less acceptable as an explanation than is an (as yet undiscovered) biochemical or metabolic abnormality - and secondly, that simple summation of the models upon these dimensions is valid.

If one makes these two assumptions, adds up the total scores on each dimension and divides each by six, one ends up with the profile shown in Figure 3.2.

Figure 3.2. suggests that the consensual view is that the client's drinking is more towards abnormal than normal, that he himself is marginally more abnormal than normal, but that nonetheless he is more responsible than not responsible for his behaviour. Further, we 'experts' know more about his 'problem drinking' than he does.

This view has been derived totally empirically from simple averaging of the six pure models and is, of course, the profile of alcohol dependence, which carries with it beliefs about the client's drinking being not exclusively but somewhat abnormal, about the clients having predispositions to become dependent, and about the substance (alcohol) being addictive in its own right.

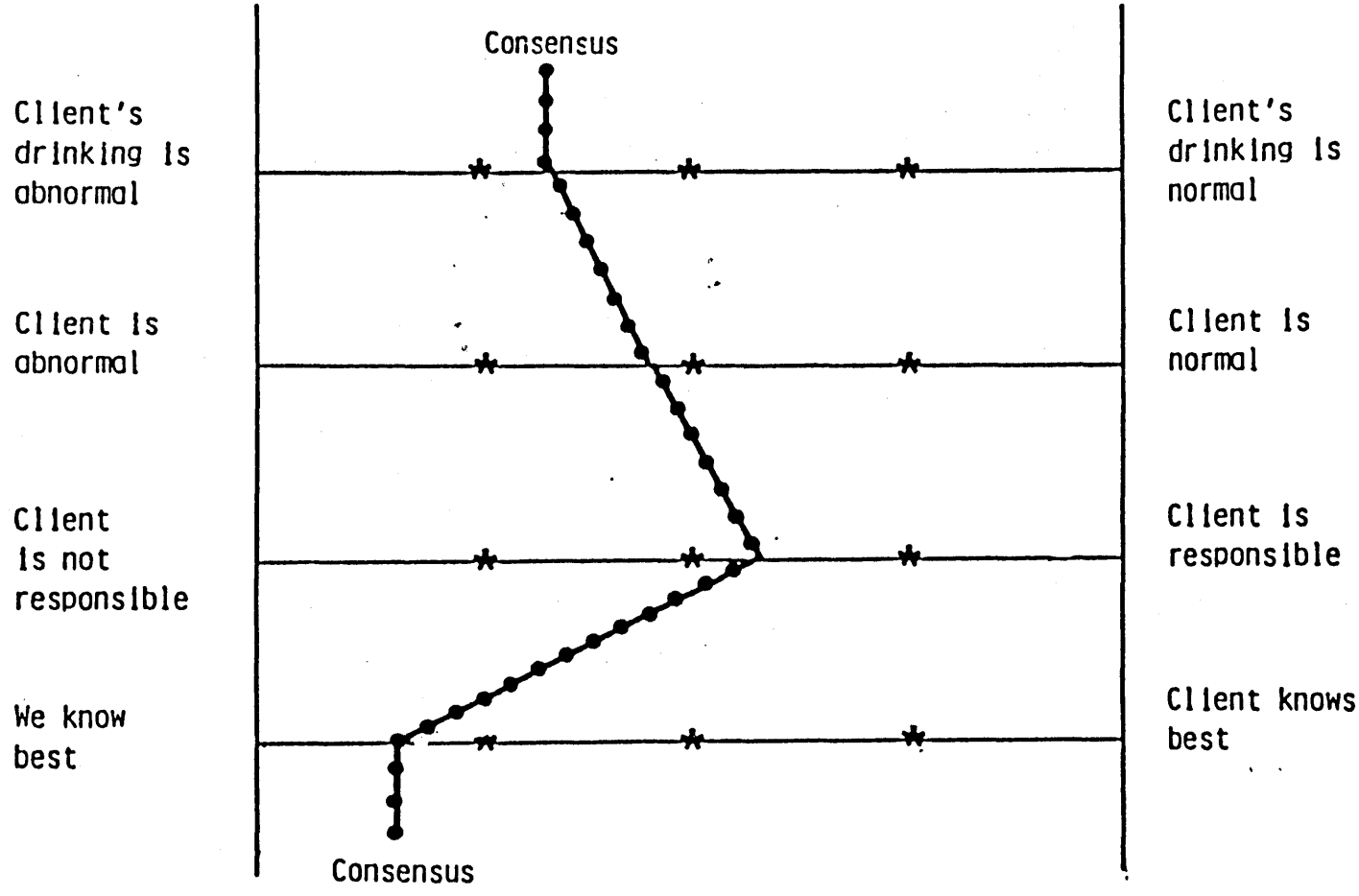


FIGURE 3.2: Diagram of Model of Alcohol Dependence

I do no think it is too farfetched to argue that the protagonists of the alcohol dependence syndrome have distilled out intuitively from our current beliefs what to them must appear 'a nugget of gold', a real phenomenon, but what in fact is no more than a single frame of a long-running motion picture.

If one returns to the 'pure' models, it is interesting to note that the newest, the normal (scapegoat) model is that of the conspiracy theorists (e.g. Szasz, T.S. 1974) which really came into being only in the 1960's. The addition of this new model onto the existing five has had the effect of pulling the consensual view of the problem drinker away from the left-hand side of the four dimensions towards a more central position, i.e. away from 'alcoholism' the disease towards the 'alcohol dependence syndrome', a psychobiological reality.

It will remain a reality for just as long as it converges with the generally held philosophical beliefs about the nature of normal and abnormal drinkers and drinking. If and when that day passes, it will become yet another of yesterday's simpleminded conceptualisations. But at the present time it is new, increasingly determining the [definitions of deviant/non-deviant] and increasingly being seen as the proper subject of research. Woebetide those of us who in the latter half of this century march to a different drum."

(Cameron, D. 1985)

These , at times vehement, debates about the presence or absence of or relevance to clinical practice of 'The Alcohol Dependence Syndrome' were not happening in isolation. There was a general shift away from categorical 'syndromal' accounts of relevant phenomena towards dimensional views, and these had even pervaded what used to be called the "Abstinence Syndrome". Changes in our understanding of the nature of Withdrawal Phenomena are outlined in the next section.

f) WITHDRAWAL AND TOLERANCE

Even if there were conceptual and operational uncertainties about the Alcohol Dependence Syndrome, that did not mean that all the components said to be part of it were similarly open to criticism. One of the core components of the Alcohol Dependence Syndrome, as described, was alcohol withdrawal; and there is a mass of evidence to support its existence.

The seminal study by Isbell and colleagues (Isbell, H., Fraser, J.F. Wikler, A., Belleville, R.E. & Eisemann, A. 1955) put the matter beyond any reasonable doubt. It is probably a good thing that the definitive study was done then because their methods would almost certainly be regarded now as inethical; it could not be repeated. What they did was to give to 'normal' volunteers the alcohol equivalent of three - quarters of a bottle of spirits per day for up to six weeks, and then abruptly discontinued it. The majority of their subjects who had stood the course demonstrated symptoms from the entire spectrum of recognised withdrawal phenomena which will be described in detail below. What was also interesting, however, was what happened to those subjects who dropped out of the study long before the six weeks. They also showed substantial disturbance, with sweating, shaking, insomnia and anorexia after not necessarily more than one day's drinking. Criticisms have been made of this study. The so-called normal volunteers did happen to include some ex-heroin 'addicts'! but nonetheless it remains a study which suggests very forcibly that if anybody consumes a sufficient quantity of alcohol over a sufficient length of time, physical addiction to that substance occurs.

The classical description of withdrawal phenomena from alcohol defined the following states:

1. *Tremulousness and Irritability, ("The Shakes")* which can occur after just a few days' drinking and after a few hours of withdrawal.
2. *Tremors and Hallucinations* (initially auditory, later visual and tactile), which reach peak intensity 24 hours after cessation of drinking.
3. *Generalised Convulsive Seizures ("Rum Fits")*, usually of the Grand Mal type which tend to occur on the second day but may occur up to six weeks after stopping drinking.
4. *Delirium Tremens* with clouding of the Sensorium, Tremors, Agitation, Nausea, Vomiting, Diarrhoea, Sweating and Disturbances of Perception. This tends to occur on the third or fourth day after cessation of drinking.

(Victor, M. & Adams, R.D. 1953)

However, during the 1970's the phenomena were re-described. This major undertaking was the work of the late Milton Gross who collaborated for a substantial part of it with Griffith Edwards. (Gross, M.M. (Ed) 1975) The starting points were twofold. First, there was a recognition that more than half the cases of alcohol withdrawal did not 'fit' the classical account. They were atypical. Secondly, there were degrees of severity of withdrawal. So Gross started by producing a rating scale which listed and quantified Withdrawal Phenomena. This was the Total Severity Assessment (T.S.A.) Scale. It was administered to hundreds of people and a smaller scale, the Selected Severity Assessment (S.S.A.) was derived from it. That is shown as Table 3.2.

TABLE 3.2

SELECTED SEVERITY ASSESSMENT

1. EATING DISTURBANCE	
Ate and enjoyed last meal	0
Ate Nothing	7
2. TREMOR	
None	0
Marked at rest	7
3. PAROXYSMAL SWEATS	
None	0
Constant and Heavy	7
4. CLOUDING OF SENSORIUM	
None	0
Disorientated in Time, Place and Person	7
5. HALLUCINATIONS	
None	0
Auditory only	1
Visual only	2
Auditory and Visual (non-fused)	3
Auditory and Visual (fused)	4
6. QUALITY OF CONTACT	
(Awareness of people around)	
Total	0
None	7
7. AGITATION	
None	0
Paces back and forth during interview	7
8. SLEEP DISTURBANCE	
Slept all night	0
No sleep at all	7
9. TEMPERATURE	
99.5°F or below	1
(1 point for every 0.5°F up to 103°F or above)	9
10. PULSE RATE	
70 - 79 beats per minute	1
(1 point for every 10 beats per min. up to 150+ beats per minute)	9
11. CONVULSIONS	
Noted but not scored.	

RANGE 2 - 68

(Gross, M.M. 1975)

The advantage of this was that it allowed for people having a low score, showing mild withdrawal, or a high score, showing severe withdrawal. Also, as the phenomena were separately defined, a cluster analysis could be undertaken to see which, if any of these phenomena occurred together. It was a way of deriving empirically a new nosology.

The analysis of the T.S.A. led to a description of three clusters, called by Gross 'factors':

Factor I (Hallucinogenic Factor)
Nausea, Vomiting, Itchiness, Muscle Pain, Tinnitus, Visual Disturbance, Sleep Disturbance, Agitation, Auditory and Visual Hallucinations, Tactile Hallucinations.

Factor II (Affective Factor)
Tremor, Sweats, Anxiety, Depression.

Factor III (Impaired Level of Consciousness Factor)
Clouding of Consciousness, Impaired Contact, Disturbance of Gait, Nystagmus.

These factors are very interesting and like any new nosologies beg questions of aetiology. The similarity between the effects of sleep deprivation and Factor I and Autonomic Arousal and Factor II are very clear and do lend support to some current theories of the causes of withdrawal phenomena. It is much more difficult to find a clear parallel of Factor III elsewhere.

Gross's work also imposes another question. Given that withdrawal phenomena are not all-or-nothing but are

on a continuum of severity, and given that they can occur after only one days' drinking, what, then, is a Hangover?

It would appear to be comprised of four separate components:

1) The direct toxic effects of alcohol on the Gastro-Intestinal Tract, leading to Inflammation and giving rise to Nausea, Anorexia, Diarrhoea and Vomiting.

2) Dehydration.

3) Positional Alcohol Nystagmus, that bizarre but well documented phenomenon (Aschan, G., Bergstedt, M., Goldberg, L. & Laurell, L. 1956) which gives rise to the spinning "whirling pit" sensation well known to drinkers.

4) Minor Withdrawal Phenomena.

The view that a component of Hangover is, indeed, withdrawal is not new. Swedish workers proposed that many years ago. (Goldberg, L. 1966) It is also not radical. It is simply another piece of evidence that in the area of alcohol problems, notions of continuum rather than of discrete and categorical entities pervade.

Thus it is probable that withdrawal phenomena are widespread in the drinking community and therefore that many regular drinkers experience and know how to deal with their own withdrawal phenomena without professional intervention. No doubt many have acquired the skill, described as Conclusion No. 6 by Nancy Mello (Page 20), that *'Alcoholics' demonstrate the ability to taper their drinking to avoid the severe consequences of abrupt withdrawal.* Perhaps, then, it is not appropriate to give to many drinkers the degree of medical intervention in

the withdrawal process that was customary in In-patient Treatment or 'Detoxification' Units. Perhaps we were medicalising and managing over-zealously ordinary, everyday experiences.

Exactly the same argument applies to Tolerance. It is well established that naïve drinkers are more susceptible to the same dose weight for weight of Alcohol than are regular drinkers. Thus regular drinkers have, by inducing the appropriate liver enzymes and regularly exposing their nervous system cell membranes to alcohol, developed a degree of Tolerance. (Goodwin, D.W., Powell, B. & Stern, J. 1971) The more regular and heavier drinkers have developed it to a greater extent than irregular light drinkers. If a heavy drinker reduces his consumption and becomes a light drinker, his tolerance goes down and vice-versa. Tolerance is yet another example of the Continuum of Drinking Experiences and not of a Categorical Difference.

g) CHANGES IN TREATMENT

i) Making Contact with the People with the Problems

The changes in the therapeutic goals for people who presented with alcohol problems were part of a general process of change in attitude towards drinkers which are demonstrated above. If the view was shifting away from 'the Left-hand side' of Figure 3.1., then a number of consequences follow that. If these people did not suffer from a clearly definable disease that required, if not medical care then at least medical supervision, then other parts of the 'Medical Package' would appear redundant also, particularly In-patient Care in Specialist Alcoholism Treatment Units. As late as 1973, the Standing Medical Advisory Committee of the English Department of Health and Social Security and the Welsh Office, in a report simply entitled "Alcoholism", states:

"There are at present 18 special alcoholism units with a total of 391 beds and a further 6 units are planned."

Within five years, the Advisory Committee on Alcoholism with Professor Neil Kessel in the Chair, established by those selfsame governmental departments (1977), reported:

"we do not recommend that other large treatment units of a regional character should be set up. We expect more people to come forward for treatment but a smaller proportion of them will require admission."

As is so often the case, changes in attitude are often more easily seen on retrospect. At the time, the debates were at a much more mundane level. Without

appearing to question the underlying validity of the Disease Concept, questions were being asked about the efficacy of treatment in the Alcoholism Treatment Units, about their costs and about their impact on the prevalence of alcohol problems in the Community.

To that must be added the voice of the Voluntary Sector, which, for many years, had provided low-cost alternatives for people with alcohol problems, often for those seen as undesirable: the habitual drunken offender, the person of no fixed abode, the 'unmotivated Alcoholic'. That voice was saying that for a fraction of the costs, the Voluntary Sector could provide meaningful Community Care, in Night Shelters, Hostels and Day Centres, and that recognition and linkage of these resources should take place by and with the statutory services. (F.A.R.E. Working Party 1978)

In the heyday of Alcohol Treatment Units, the model of treatment of people with alcohol problems used to be conceptually a relatively straightforward matter. However they presented, these patients were told that they were 'Alcoholics', that they suffered from an inexorable disease that could be arrested, not cured and that the only hope of any worthwhile future for them depended upon an acceptance of that 'fact' and its rider that total abstinence for life was mandatory. Then, they were separated from Alcohol, usually by a hospital-based Detoxication (Drying-out) Regime, and the goal of Abstinence was reinforced, perhaps by Group Therapy, by Aversive Conditioning techniques and/or by close liaison with the local Alcoholics Anonymous group(s). There were, of course, problems. Some patients refused to accept 'their' diagnosis and thus demonstrated 'Denial'. Some appeared to do well while in treatment, but relapsed soon

after discharge. Despite the treatment, the majority of drinkers kept on drinking.

The responses to that perceived failure were many and varied. New, more sophisticated treatments were tried. Relaxation therapy, Rational-Emotive Therapy, Yoga, Transcendental Meditation, Acupuncture and 'Black Boxes' all had their advocates. New Wonder Drugs came and went. Alcohol Education became a mandatory part of some programmes, compulsory attendance at Alcoholics Anonymous of others. But the majority of drinkers kept on drinking.

Not only were the units not doing very well therapeutically, they also were not seeing very many people. The survey data suggesting that there were hundreds of thousands of "hidden Alcoholics out there" was believed. So the staff of the Units went looking for them. They started "public relations" work with the more community-based workers: General Practitioners, Social Workers, Health Visitors. They tried to get others to find clients for them, by education of Primary Care workers. The messages were twofold. First, "How to Spot One" and secondly that the expertise on how to treat them existed in the specialist Units. These forays in the community were not notably successful which was fortunate. Because if they had been, the Units would have been overwhelmed. As it was, the majority of drinkers kept on drinking!

Major change was necessary. It came. It came as a result of the work of Terry Spratley, Alan Cartwright and Stan Shaw, a psychiatrist, a psychologist/psychotherapist and a sociologist. They were working on a project in Camberwell, South London which was designed to answer these questions:

What was the size and nature of alcohol abuse in that district?
What was the current response to alcohol abuse and what were its problems?
How might the problems be overcome and a better comprehensive response developed?

Their results were reported in a monograph "Designing a Comprehensive Community Response to Problems of Alcohol Abuse" (Cartwright, A.J.K.,Shaw, S.J. & Spratley, T.A. 1975) and later in a book "Responding to Drinking Problems" (Shaw, S.J., Cartwright, A., Spratley, T.A. & Harwin, J. 1978). These people write with such clarity and precision that it is possible to glean from just a number of sentences from them both good factual information and an image of the beliefs from which they were operating. These quotations come from their 1976 Liverpool Conference Presentation (Spratley, T.A., Cartwright, A. & Shaw, S. 1977)

It is believed there is no small discrete group of people in the community who are 'alcoholics'. Rather that there is in the community a large pool of problems from drinking affecting all areas of physical, social and psychological health in all degrees of severity.
People [with alcohol problems] *are quite prepared, when asked properly, to admit to these problems but they do not regard themselves as 'problem drinkers' or 'alcoholics'.*
During the study year 0.16% of the district's adult population was treated for alcoholism by a psychiatric service of any kind.....only a minority [of those] *attended the psychiatric alcoholism facilities.*
...it would... appear quite clear that their [Alcoholics Anonymous and the psychiatric alcoholism services's]

impact upon the total pool of problems in the community was very small.

There is a failure by community agents to recognise and diagnose the problem.

Patients are only diagnosed, if at all, at a very late stage when treatment can be extremely difficult.

Although general practitioners state that alcoholism is a disease they did not see it as clearly within their role...

There is no statutory obligation for social workers to treat alcoholics and consequently they sometimes avoid doing so.

..they [Community Agents] *lack the skills necessary to elicit an appropriate drinking history, to come to a correct understanding of the situation, and to establish a treatment contract with the patient.*

The first possible solution is to massively increase the specialised psychiatric alcoholism facilities. This is not feasible in the present economic circumstances. Neither is it likely to be the best solution. Many alcohol abusers would refuse to attend and there is a doubt whether the psychiatric services are the best form of treatment for most of them.

The alternative approach to improving the situation would be to concentrate on improving the quality of care given by general practitioners, nurses and social workers already working in the community...[They] *will not be able to perform these tasks without a great deal of help. They will need much more education, training in skills and much more support before they will be able to effectively recognise and treat drinkers themselves.*

It has been suggested that in the district being researched, a multidisciplinary medico-social team be formed, called a COMMUNITY ALCOHOL TEAM....

The operating model of the Community Alcohol Team would not be that 'alcoholism is a disease' but that excessive

drinking leads to problems, and both the drinking and the problems need to be understood and responded to by the helpers, using the resources of the individual and his family.

The Spratley, Cartwright and Shaw model was quite radical. It suggested that rather than encouraging the drinkers to seek the assistance of 'the experts', the expertise should go out to the drinkers, and it should do so via pre-existing general community agents. It was, so to speak, a 'beacon' model. There would be in every district a 'beacon', radiating out knowledge, skills and confidence which would eventually enable those 'doing the work' to do it competently and comfortably. The Community Alcohol Team was to be that ' beacon'. But it was not that radical. It still believed that expertise rested with psychiatric or related specialists. It still referred to the drinkers as 'patients'. It still accepted the notion of progression, and that the problem was excessive drinking (undefined). Also, at a time when in many areas of human service, the voice of the consumer was becoming important, it was rather deaf to that. Nonetheless it was a major liberating force.

As time has gone by, other problems have emerged. First, as Stephen Morley has pointed out (Morley, S. 1982), it takes a long time for community agents to gain sufficient supervised experience to feel competent in the unaccustomed role, and many of these people do not stay in one place for more than two or three years. While the 'beacon' may be blazing away, many of the workers will haved moved too far away to be influenced by it. Secondly, many community agents are simply not interested: they probably could do the job perfectly well but it is not regarded as a priority, either by them personally or more likelily by the management of the

Agency that employs them. (Clement, S. 1986). They do not want advice and assistance: they want someone else to take these people away. So, where experimental Community Alcohol Teams have been set up on this model, the workers have found themselves having to engage in 'client-contact', partly to stop themselves from becoming deskilled, partly because that is initially what the community agents were asking for, partly to increase the perceived credibility of the team and finally, because the demand for education and support tended not to be very great: it was something to do.

In the late-seventies, none of these things were known. Community Alcohol Teams were considered to be the way ahead. Although not mentioned by name, it was clear that the Advisory Committee on Alcoholism (the Kessel Committee - see above- 1977) was thinking in these terms when it recommended in Paragraph 4.19: *First and foremost the function of those working at the secondary level of care should be to support and advise those working at the primary level. They should be readily accessible and be prepared to provide advice to those who need it regardless of their professional disciplines. The approach here, as at the primary level, should be multidisciplinary.*

ii. What Sort of Treatment Should be on Offer?

On a number of occasions in this Thesis, the Author and other workers whom he has quoted have alluded to the low efficacy of Treatment, particularly in inpatient settings. It is now appropriate to justify those less than complimentary remarks. For if the suggestion was that the expertise within such units would be the basis of our advice to our primary care colleagues who were being encouraged to look after their own 'problem drinkers', then we had to be sure that we knew what advice to give and what styles of intervention to support. In those in-patient settings, we knew what we were doing and at an anecdotal level we knew that we were meeting with some successes and some failures. But we did not know what it was that we were doing that was useful or otherwise: we did not know which components of our treatment programmes were beneficial. Illuminating work in this area was undertaken by Ray Costello (Costello, R.M. 1975a; Costello, R. M. 1975b). As this work was a major influence on the methods that the Author did and did not use in the system of intervention that is the central concern of this Thesis, it will be quoted in some detail.

Costello's study was derivative, that is it was a study of studies. He searched the world-wide literature seeking one year outcome reports. He found 58 such studies, the majority from the U.S.A., dated between 1951 and 1973. There were only three Outcomes: Success, meaning totally abstinent or (rarely) no problem drinking; Problem Drinking or Dead. There was also Attrition, being lost to follow up. Some of the studies, notably those with shifting baselines, or "floating n"s as Costello called them were, if possible, recalculated to take account of attrition. He then did a cluster

analysis of these 58 studies and discovered five Outcome Groups (Table 3.3). He then asked that question that is remarkably seldom asked in Health Care: Why are some programmes so much more succesful than others?

TABLE 3.3:

GROUP PERCENTAGE MEANS FOR EACH OUTCOME INDEX:

ONE YEAR FOLLOW-UP STUDIES

Group	N	Dead	Problem Drinking	Success	Lost
Best	15	1	44	45	10
Good	11	1	27	35	37
Intermd.	12	2	47	30	21
Poor	13	0	79	18	3
Poorest	7	0	60	12	28

(Costello, R.M. 1975)

The first answer concerned exclusion. Those units or agencies that had shown good results also showed greater use of exclusion. In fact there was a perfect correlation between the two. 80% of the Best, 45% of the Good, 25% of the Intermediate, 17% of the Poor and 14% of the Poorest Programmes reported Use of Exclusion Criteria.

Criteria used for exclusion included the following: psychosis, organic brain syndrome, inability to pay fees, physical disabilities, sociopathy, contraindications for or unwillingness to take Antabuse, vagrants, unmarried,

no contact with relatives in the past year, geographical (state or county) residence, other "obvious" psychiatric problems, outstanding police problems.

So, the first lesson from Costello is this: If you wish to report good results, do not accept 'bad bet' clients! But then Costello looked at the actual components within the treatment programmes, and these are shown. (Table 3.4.) These figures are the percentage of programmes using these components. They are not percentage of Successes. So 80% of the Best Programmes, those reporting achieving 45% Success, were in-patient facilities, and so on.

TABLE 3.4:

OVERVIEW OF TREATMENT COMPONENTS REPORTED

BY STUDIES IN EACH OUTCOME GROUP - IN PERCENT

Component	Best	Good	Intermediate	Poor	Poorest
In-patient	80	55	100	83	67
Milieu	33	50	17	0	0
Group Therapy	73	73	91	46	57
Collaterals	60	45	17	8	0
Antabuse	40	27	33	8	0
Behaviour Mod.	27	18	25	0	14
Follow-through	67	64	50	0	0
Alc. Anonymous	26	64	58	8	29

Costello, R.M. (1975)

In-patient care was the norm in all units, so did not differentiate the programmes. Milieu means 'therapeutic milieu' or 'therapeutic community concept'. Poor and Poorest Programmes did not use that approach whereas a sizeable minority of the better outcome programmes did. Use of Collaterals (Spouse, Relative or Employer) was positively linearly related to the succesful outcome units, as was aggressive Follow-Up and the use of Antabuse (with one reversal). No linear trend was detected for reported use of Group Therapy, Behaviour Modification, by which Costello meant classical aversive conditioning techniques, or for close affiliation with Alcoholics Anonymous.

Costello also found that the more that was on offer, the more successful was a programme likely to be, and as a final and not surprising finding, he found that people who had a job and a spouse to return to did better than those with only one or neither of those supports.

These findings are worth summarising. First, Costello found that the major determinant of Outcome was Use of Exclusion. Secondly, he found that the following Components discriminated the Good to Poorest Programmes linearly, or almost so: Therapeutic Community Milieu, Involvement of Collaterals, Use of Antabuse and Vigorous follow-up. The following components showed no such linearity: In-patient Care (because most studies used it), Group Therapy, Behavioural Aversion and close liaison with Alcoholic Anonymous. Thirdly, he found that the client's domestic and employment situation seriously influenced the Outcome.

It is, perhaps, worth noting that at that time, and even now predominantly, it is those components of not

proven efficacy which are usually, in this Country, the United States and Canada and Australasia anyway, provided by way of 'Treatment' for 'problem drinkers'. Those that Costello found did discriminate may or may not happen as an incidental adjunct to that 'Treatment'. This theme will be returned to in the Description of the Leicestershire Alcohol Services (Chapter 4).

However, it needs to be stated that Costello did not use or attempt to use Control Groups. Simply, he compared one Treatment Programme with another. In fact, he states baldly that in this field, there is no such thing as a control group, for refusal of treatment <u>is</u> a form of intervention.

Two years later, Griffith Edwards and his colleagues (Edwards, G., Orford, J., Egert, S., Guthrie, S., Hawker, A., Hensman, C., Mitchison, M., Oppenheimer, E. & Taylor, C. 1977) did attempt, if not a controlled trial, then a comparison between comprehensive in-patient treatment and a minimal regime of advice and follow-up via the corroborate. This "Advice versus Treatment" study compared two randomly allocated groups of fifty male married 'alcoholics'. One Group was offered all that the Maudsley Hospital had to offer; the other was given a long assessment and then simple advice that they were indeed alcoholics and that for them the advice had to be to abstain absolutely from drinking alcohol. They were also told that only they could do that, but that their wives would be contacted every month for the next year to see what progress was being made.

The result was that there was no difference in outcome of the two groups at one year. This result needs to be interpreted cautiously, however. The advice group received two of the components of successful outcome

elucidated by Costello, namely vigorous follow-up and involvement of Collaterals, and, of course, they had spouses so might be expected to do reasonably well anyway. So, it was a comparison of two programmes, one which contained only components of established efficacy and the other which contained both them and a number of components with no such proven value, delivered to people who carried a reasonable prognosis. If the null hypothesis had been disproved it would have been a real surprise.

The probable lack of efficacy of conventional inpatient treatment had also been highlighted in some major American reviews (Pattison, E.M. 1966.; Emrick, C.D. 1974.; Emrick, C.D. 1975.) The messages were becoming clear. High cost intensive treatment programmes did not seem to produce better results than minimal interventions. The best that could be claimed was that probably some treatment was better than none, and that which took place in a facilitative atmosphere, capitalising on family involvement and vigorous follow-up was probably best.

A further theme pervading the treatment literature of the mid-seventies has already been mentioned in passing. Broad based treatment approaches had been shown to be more effective than narrow ones. Blunderbuss theory seemed to be the explanation. If there was a large number of treatment options available to the drinker then it was commonsense that he or she would be more likely to find an approach of some assistance than if there was only one modality available. Clearly, therefore it would be helpful to drinkers and therapists alike if the randomness of the Blunderbuss could be replaced by very precise provision by the agencies of that intervention approach most likely to benefit an individual drinker.

Surely it would be wise to MATCH the NEEDS of the client with the services provided? The surprising thing was that this was not done routinely by the treatment agencies, which tended to run essentially similar 'package deals' for all comers. Fred. Glaser, an American Psychiatrist, has been at the forefront of promoting this matching approach. He is proud of the simplicity of the concept and states the four underlying ideas thus:

(a) that persons having difficulties in relation to alcohol and drugs are more different than they are alike;
(b) that, as a result of these differences, different clients may require different kinds of treatment;
(c) that current service delivery arrangements do not systematically take such differences into account; and therefore,
(d) that a treatment system which consistently takes client differences into account in differential treatment assignment should be implemented.

Glazer's response to his 'simple' ideas has been to design a CORE-SHELL Model, a diagram of which is Figure 3.3. He describes it thus:

Basically, it consists of two major elements, a 'core' which subserves the function of primary care, assessment and research, surrounded by a shell of treatment programmes; hence it is commonly referred to as the Core-Shell Treatment system.

Access to the system is through the core and its functions, which are viewed as being required by all clients, as opposed to the more specialised shell services, which are likely to be utilised by some clients but not by all. A major feature of its design is the provision of a highly specialised and meticulous process

of assessment of each client, which can lead in turn to the elaboration of an individualised treatment programme uniquely suited to his needs and able to draw with equal facility upon all available treatment resources. As noted above and elsewhere, the approach of matching patients to teatments would appear to be most promising....

Because the system embodies a strong research component as an integral part of its clinical operation, it is capable of reviewing the results which it generates and, based on these results, readjusting the pattern of assignment of clients to treatment interventions in order to produce an incresingly better match. By this means, the system should generate more and more positive results as it gains experience.

(Glazer, F.B. 1978)

Despite the overwhelming logic of Glazer's case, he has had great practical difficulty in initiating and maintaining his Core-Shell in his current workplace, the Clinical Institute of the Addiction Research Foundation in Toronto. This appears to have been because of 'preciousness' and a lack of cooperation from some of the agencies in the shell, and because of the prolonged and meticulous nature of the assessment: many clients depart before its completion. As with the Community Alcohol Team Model, the service consumer is construed as a rather passive recipient of expert Assessment and Care. Demonstration by the Core-Shell Model of the efficacy of the Matching Hypothesis has yet to be reported.

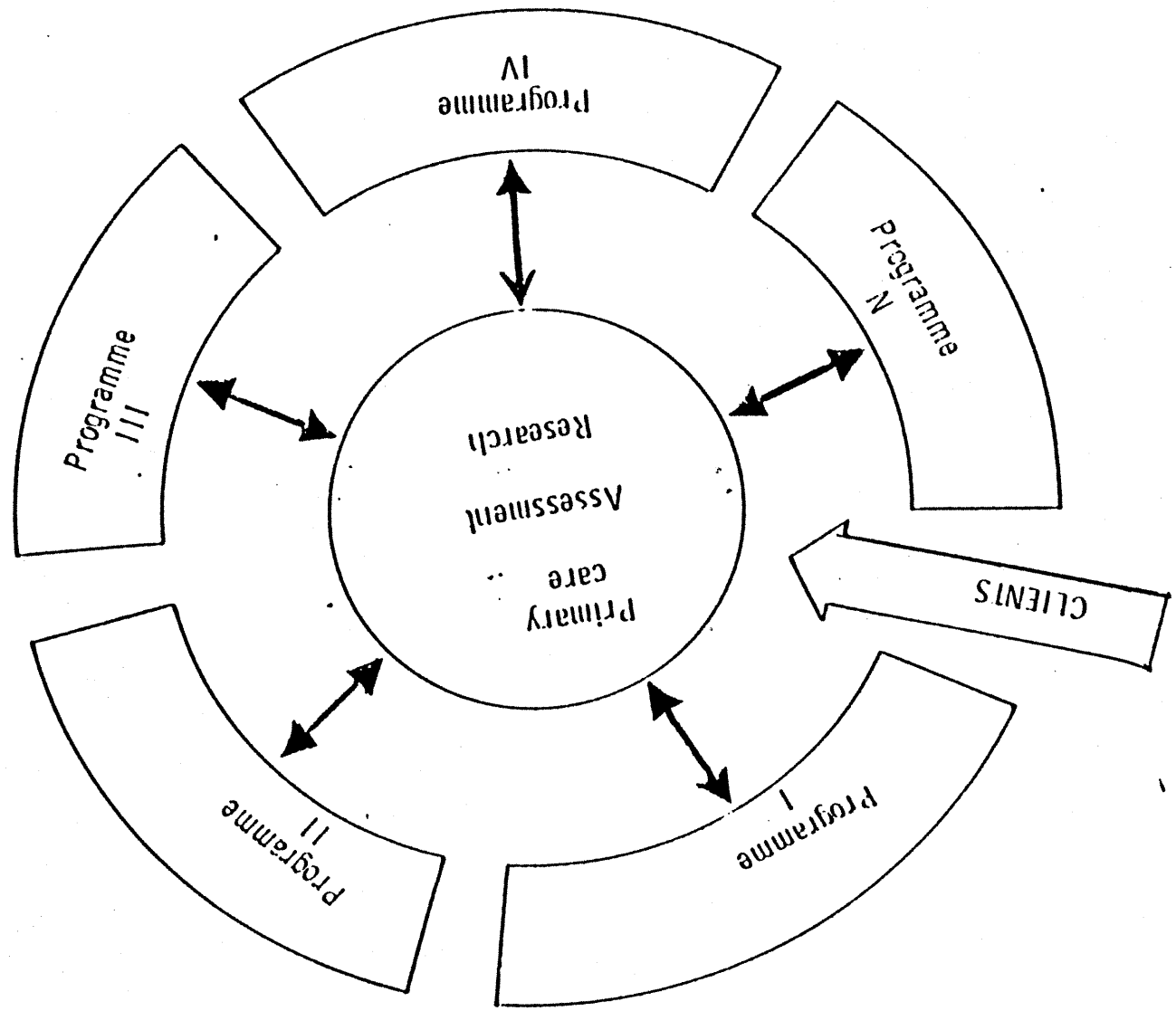


FIGURE 3.3: Glazer's Core Shell Treatment Model

iii) To Drink or Not to Drink?

The final major area of debate in the alcohol problems treatment field in the 1970's concerned the goals of intervention, and this probably was the most contentious area of all. Again, it was the liberating effect of the D.L.Davies paper (Davies, D.L. 1962), along with the sociological studies of drinking patterns in the community at large that started off this debate. If there was in the general population a large number of people who had 'bootstrapped' themselves out of severe problems of alcohol use into harm free consumption again, and if the same thing appeared to happen to a small minority of ex-inpatients, then surely it was possible to find out who could do that and how. That 'how' could perhaps be turned into treatment techniques which would allow resumed drinking as a therapeutic goal.

The problem was that this very suggestion chiselled at three of the cornerstones of the Disease Concept of Alcoholism. Were it possible to retrain people to consume alcohol in a harmless way, then Pattison's Proposition 1 (Essential Differences); 2 (Different Reaction) and 3 (Inexorability) would all become questionable. That would only leave Proposition 4 (Disease Process), which is only justified by the validity of the other three. [See Pages 16 and 17] So even to advocate resumed drinking as a therapeutic option was to question the essence of what the 'Alcoholism Movement' had been trying to achieve for forty years.

It was discovered on retrospect (Pattison, E.M. et al 1977) that the first studies which had advocated resumed drinking as a therapeutic goal, rather than harmless drinking being observed as a transient by-product of abstinence oriented treatment, had taken place

in the mid-1960's, first in Japan (Musaka, H., Ichihara, T. & Eto, A. 1964; Musaka, H. & Arikawa, K. 1968). A single psychoanalytic case study was then turned up in South Africa (Lazarus, A.A. 1965). But these papers had not been widely read and thus had made no impact upon the 'first world'.

That task was left to an Australian Psychologist, Sid Lovibond. As is frequently the way of these things, what Lovibond did was deceptively simple and naïve. In the late 1960's and early 1970's, there was some interest in measurement of intoxication (Pryor, W.J. 1966; Bois, C. & Vogel-Sprott, M. 1974). It had been found possible to teach normal volunteers to know their own blood alcohol concentration by getting them to discern their bodily and mood state and then feed back to them their blood alcohol level as measured on a new instrument, a Breathalyser. After a relatively small number of training sessions, some subjects could get quite good at this. So all that Sid Lovibond did was to train some of his 'alcoholic' sujects to do this, and then gave them electric shocks if their blood alcohol concentration exceeded 70 mgms. per 100 ml. Prior to any follow-up being undertaken, he presented a paper on this in 1970 at an International Conference on Alcohol and Drug Problems in Australia, and it caught the imagination of 'the field'. (Lovibond, S.H. & Caddy, G. 1970). It was eventually written-up with an 18 month follow-up attatched. (Caddy, G. & Lovibond, S.H. 1976) when it appeared that 10 of the 28 subjects were engaging in drinking which involved 'rarely exceeding a Blood Alcohol Concentration of 70 mgms. per 100 mls'.

Other workers in other places also started experimenting on their 'alcoholic' subjects, attempting to restitute for them what became known as *Controlled*

Drinking. A variety of techniques were being used, but in the early days these involved some sort of aversive conditioning in a laboratory or mock bar setting.

In 1975, the Author of this thesis and his colleague Mary Spence undertook the first British study to be published in this area. It was different because it took place in the community and involved no aversive conditioning. It was similar in that it was small-scale, uncontrolled and had short follow-up! Again it was a deceptively simple clinical experiment (Cameron, D. & Spence, M.T. 1976a, Cameron, D. 1977). All that was established was a therapeutic group in a community setting in the evening which as well as engaging in the usual psychotherapeutic exploration also provided instruction and practice on moderating and monitoring of alcohol consumption.

So, the 'treatment' package consisted of regular group therapy sessions, daily at the beginning of the project thence twice weekly. These sessions also included didactic instruction on drinking behaviour (using the behavioural observations of Sobell, M.B., Schaefer, H.H. & Mills, K.C. 1972), personal intake goal setting, engineering change of peer group (in accordance with the social analysis of Bacon, S.D. 1971), social reinforcement (as advocated by Hunt, G.M. & Azrin, N.H. 1973) using the group, the spouse and a group-member drinking companion and group drinking sessions. Group members kept a record of their consumption, which, when possible, was corroborated by the spouse.

All six subjects were men, either married or cohabiting, aged between 22 and 49 (Mean 37.5) years. Two were unemployed. All reported serious problems with alcohol use for between 9 months and 20 years (Mean 4.66

years). Initially, the Authors had attempted to recruit subjects from the general population by advertising. They had believed that one of the reasons why 'problem drinkers' appeared loathe to present for 'treatment' to agencies was because of the traditional abstinence goal. However, that recruitment technique was unsuccessful. (Cameron, D. & Spence, M.T. 1976b) So the authors, with consent, recruited from General Practitioner referrals to psychiatric services.

The reported consumption levels of the subjects for the first four months of the experiment are shown in Figure 3.4. It was the group expectation that subjects remained abstinent in their own environment for one week prior to engaging in any attempt at moderated further drinking.

The modest conclusion drawn by the Authors was that the study was of no greater validity than clinical observation and anecdote. Further, it was accepted that there were no controls and that self-report data on consumption (albeit corroborated by spouses) was of highly dubious validity but that in real life community settings, it was difficult to obtain more robust data. What was claimed was that <u>self reported</u> consumption by most of these subjects fell substantially while they were in contact with the group. Nothing more.

What this study and subsequently a number of others like it did was to enable practitioners in Britain who had been accepting non-abstinent goals in individual patients to do so more publically. An aggregation of such people took place where this study was undertaken (Dumfries) in 1976. That aggregation eventually became 'The New Directions in the Study of Alcohol Group', which

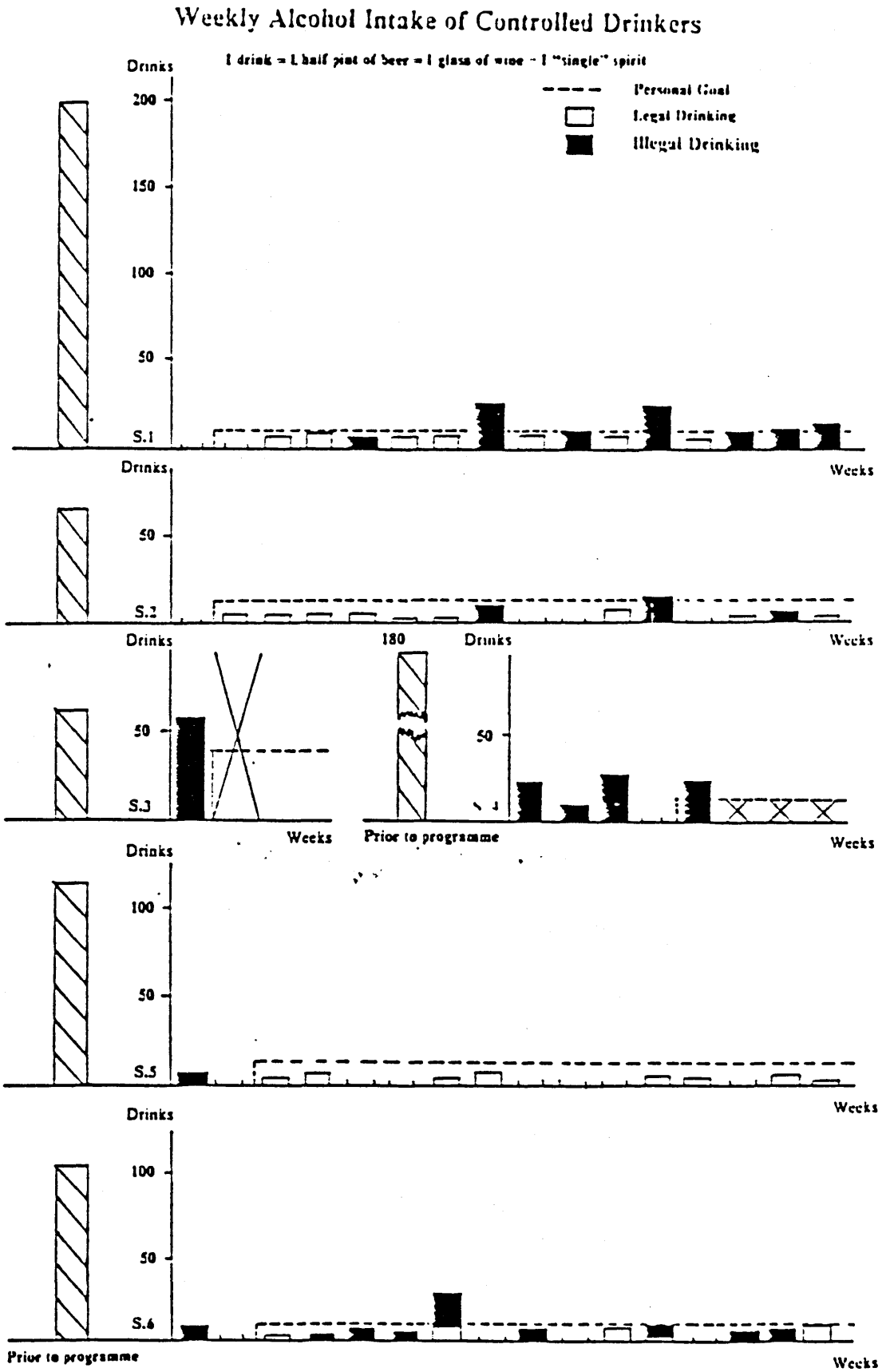


FIGURE 3.4: Reported Consumption of Subjects in the Pilot Study

has acted as a coherent counterbalance to the British "Alcoholism Movement".

However, abroad, particularly in the United States of America, many people had started working with clients on Controlled Drinking Programmes at around this time. These have been well reviewed (Pattison et al. 1977; Robertson, I. & Heather, N. 1981). Methods have varied greatly, from superbly designed individualised behavioural programmes (Sobell, M.B. & Sobell, L.C. 1973; Sobell, M.B. & Sobell, L.C. 1976) to simple practical advice backed up with written material (Miller, W. & Taylor, C. 1980). The evidence that 'Controlled Drinking' was a predictable outcome following, though not necessarily the result of, various interventions had become overwhelming. Alcohol Problems were beginning to be seen as being more like other appetitive disorders than as some discrete and mysterious disease.

In fact, both in the United States and in Britain, there has even been a proliferation of Do-it-Yourself Manuals on controlling drinking akin to those available for dieting. (Miller, W & Munoz, R. 1982; Grant, M. 1984; Chick, J. & Chick, J. 1984 and Robertson, I. & Heather, N. 1986)

But in the United States, the "Alcoholism Movement" struck back. Following the publication of a reappraisal of the original Sobell Study's (1976) findings by Pendery and colleagues (Pendery, M., Maltzman, V. & West, L. 1982) the Sobells became the subjects of legal action accused of causing the death of some of their subjects because of inappropriate management.

All that was to come. In the mid-1970's, resumed drinking was being seen as a therapeutic option and experiments were being undertaken in many places on how best to help 'problem drinkers' achieve that goal. These experiments, however, were being undertaken on supervised, often self-selected small samples of the 'problem drinking' population.

What was not being explored was what would happen if these new beliefs and techniques were to be operated by the main specialist alcohol treatment agencies serving a whole geographic area. That is the subject of this Thesis.

h) THE QUESTION OF CONSUMPTION

It is self-evident from the data presented so far in this Introduction that the field of study of alcohol problems in the 1970's was filled with conflict and uncertainty. While it appeared that there were more individuals than ever before getting into difficulties with their alcohol use, people who attempted to help them no longer had a clear set of principles to govern their interventions. The Disease Concept had shown limited returns. Alcohol Dependence was an all encompassing, but vague hybrid model which had not yet proposed operational guidelines. It was hardly surprising, therefore that as has happened many times before in our history, the focus was moved away from individuals with problems back on to the substance again (See Pages 12 and 13). The 'Daemon Drink' was the problem: if only people did not drink it, they would not get into bother and they would not require help.

As one might expect in the latter half of the twentieth century, that message came in very sophisticated form. It was not the simple prohibitionist 'Drink is an invention of the Devil and should be avoided' but a message from meticulous social scientists and epidemiologists. (Bruun, K., Edwards, G., Luncio, M., Mdelei, K., Pan, L., Popham, R.E., Schmidt, W., Skog, O-J., Sulkunen, P. & Osterberg, E. 1975; de Lint, J. 1977) In essence their argument was that they agreed with a French epidemiologist, Ledermann, that the consumption of alcohol in a community was lognormally distributed and that therefore the number of heavy consumers could be predicted if the Gross Consumption of the Community was known. There was a very high correlation between the number of heavy consumers and the number of alcohol problems, so if the number of heavy consumers could be

reduced then the number of alcohol problems would fall. The way to reduce the number of heavy consumers was to reduce the gross consumption of the whole population. These workers, among others, compared rates of such indirect indicators of alcohol problems as hepatic cirrhosis, admissions to mental hospitals for 'alcoholism' and drunkenness arrests between various countries, finding high correlations between these and gross consumption.

Their findings were contested on statistical grounds (Miller, G.H. & Agnew, M. 1974; Duffy, J. 1980), and on theoretical grounds (Tuck, M. 1981) and a number of papers highlighting exceptions have appeared. McKechnie (McKechnie, R.J. 1977) showed that Scottish - English differences in Morbidity and Mortality existed despite essentially similar gross consumption. Mulford, always parochial and provocative, found that in Iowa, his state, there had been a gradual increase in alcohol sales during the 1960's and 1970's with no similar increase in Cirrhosis deaths or six survey indicators of problem drinking. (Mulford, H.A. & Fitzgerald, J.L. 1983). An even more intriguing finding came from Sweden. Norstrom (Norstrom, T. 1988) showed that following a change in control policy in that country, from Spirit rationing to control by price, there was a dramatic rise in death rate from cirrhosis, which could not be explained by the gradual smooth rise in per capita consumption. He suggested that the shape of the lognormal distribution had been skewed by the change in control policy. These papers suggest that these consumption curves are much more 'plastic' than the original protagonists supposed.

But the 'reductionists' also received substantial support from influential bodies. (Royal College of

Psychiatrists 1979, 1986; World Health Organisation 1980).

If this mass of studies show anything, it is a variable but, if present, positive correlation between consumption and problems, which does not prove causality. The results from retrospective natural experiments have produced results which both show (Kendall, R.E., De Romanie,M. & Ritson, E.B. 1983) and fail to show (Mulford, H.A, & Fitzgerald, J.L. 1983, Smart, R.G. 1987) that positive correlation.

Nonetheless, in the late 1970's this was seen as an approach which may lead to a reduction in the number of people suffering from alcohol problems and it did not involve that technique of highly questionable value, 'Treatment'.

More recently, however, a paper has appeared which suggests that the widespread availability of treatment for drinking problems in Ontario may be reducing the number of cases of Cirrhosis presenting to Hospital in that Province. (Mann, R.E., Smart, R.G., Anglin, L. & Rush, B.R. 1988) A major finding of this thesis provides what might be corroborative evidence from the United Kingdom for that view.

i) SYNOPSIS OF THE INTRODUCTION

1. The 1970's were times of considerable change in our understanding and beliefs about the nature of 'problem drinking'.

2. The 'Disease Concept of Alcoholism' had been shown to have limited value and no validity. The hazards of inappropriate use of the 'Alcoholism' label had been highlighted.

3. There was no clear successor to that concept, although the hybrid model of 'The Alcohol Dependence Syndrome' seemed to be the nearest there was to a consensual view. But it adhered to the older notion of Inexorability, re-expressed as 'Restitution after Abstinence', in spite of growing evidence of Reversibility.

4. In an attempt to understand the conflicting views about the nature of 'problem drinkers', the Author devised a method of examining current beliefs.

5. Views about treatment have also changed.

6. Hospital-based treatment for 'problem drinkers' had been shown to be of limited value: minimal interventions appeared as effective.

7. The use of: Involvement of Spouse, Therapeutic Community Milieu, Antabuse (for an Abstinence Goal) and Vigorous Follow-up differentiated more successful from less successful agencies.

8. Assessment procedures were believed to be of great importance although the 'problem drinker' tended to be seen as an object of study and not as a participant in the process whose views might also be of importance and value.

9. The logic of matching the needs of the 'problem drinker' with what service is offered was advocated but had not been implemented systematically.

10. Multidisciplinary Community-based Services were being suggested, but none had been established for long enough for evaluation of efficacy to be undertaken.

11. Abstinence was no longer regarded as the major criterion of succesful treatment outcome.

12. Experimental controlled drinking programmes appeared to be promising.

13. No treatment system had been shown to make any impact on the prevalence of alcohol problems in a community. It was believed that gross per capita consumption of alcohol was the major modifiable influence on that prevalence.

Chapter 4: LEICESTERSHIRE AND ITS COMMUNITY ALCOHOL SERVICES.

a) DEMOGRAPHIC CONSIDERATIONS

Leicestershire is in the East Midlands of England, a region that also includes the counties of Derbyshire, Lincolnshire, Nottinghamshire and Northamptonshire. (Figure 4.1.)

As can be seen in Figure 4.2. Leicestershire itself is a roughly diamond-shaped county. It is approximately 50 miles from East to West and 35 miles from North to South and covers an area of 986 square miles. It is an area of gentle rolling countryside three quarters of which has been under predominantly arable cultivation since Domesday (1082). The City of Leicester, the county town is centrally placed and 'market towns' such as Melton Mowbray, Market Harborough and Hinckley are located in a ring around the county approximately 15 miles from the City. The county has a good system of roads, including the M1 Motorway and a spur from it to the M6. Leicester is on both the London-Sheffield and the Birmingham-Norwich main Railway Lines. The East Midlands regional Airport is at Castle Donnington in the North of the County.

The population of Leicestershire is gradually increasing, from 845,000 in 1975 to 884,860 in 1985. Half the population lives in the City conurbation, which includes Oadby and Wigston which are effectively suburbs. The city itself has a population of 282,300. The other half live in the market towns which have populations of 20,000 - 50,000 or in the numerous small villages in the county.

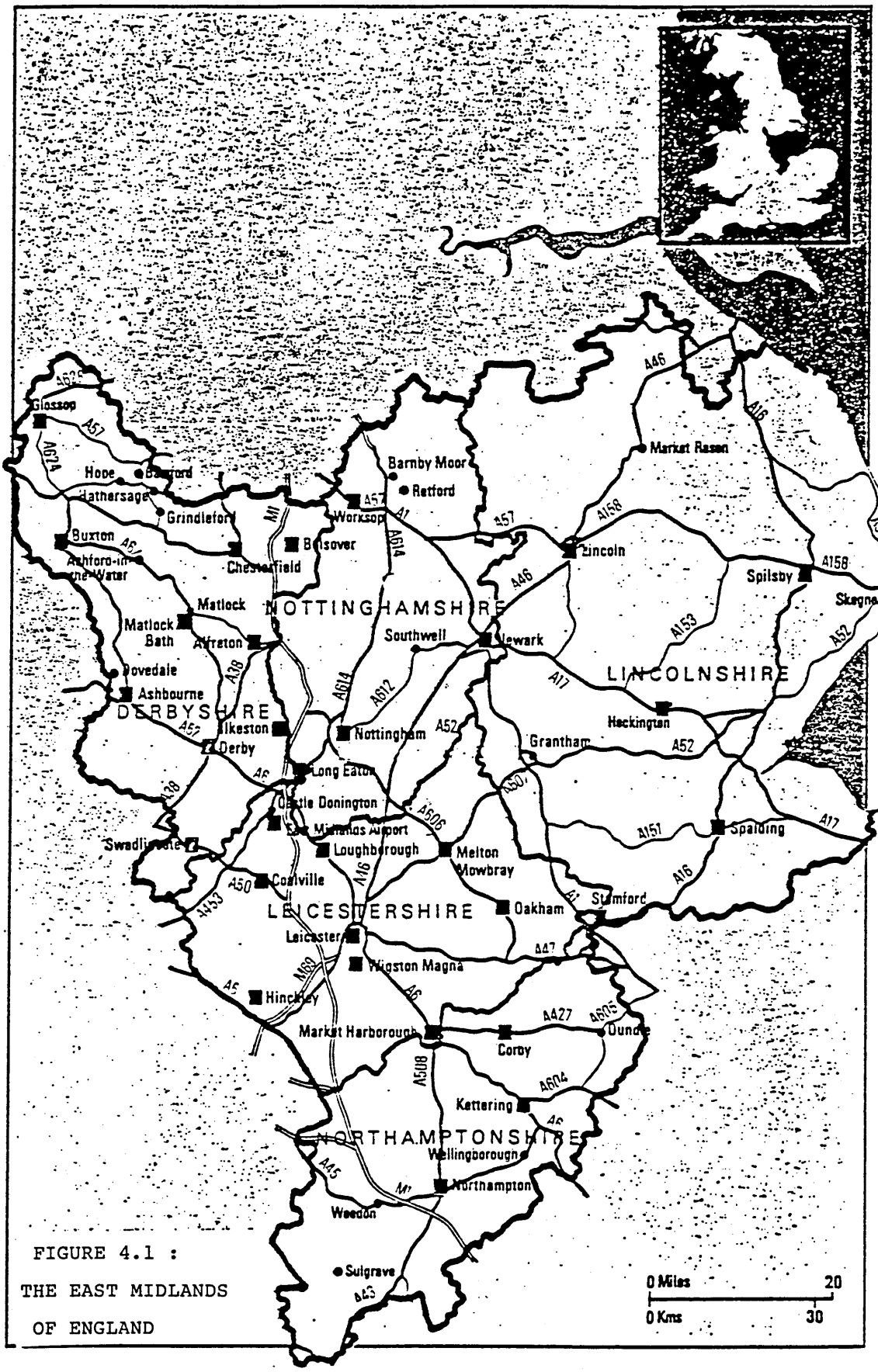


FIGURE 4.1 :

THE EAST MIDLANDS

OF ENGLAND

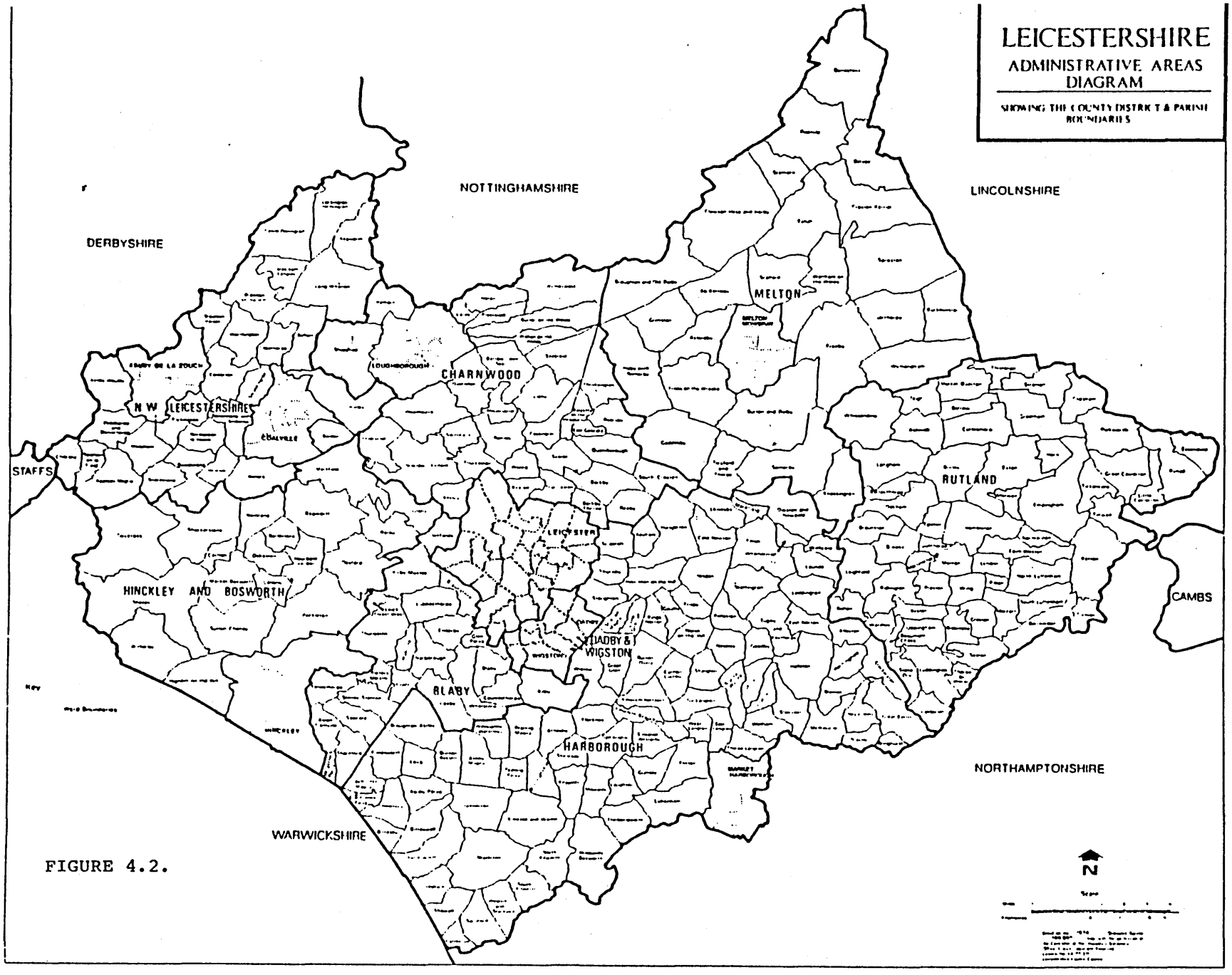

LEICESTERSHIRE
ADMINISTRATIVE AREAS
DIAGRAM
SHOWING THE COUNTY DISTRICT & PARISH BOUNDARIES
NOTTINGHAMSHIRE
LINCOLNSHIRE
DERBYSHIRE
MELTON
CHARNWOOD
N W LEICESTERSHIRE
STAFFS
RUTLAND
HINCKLEY AND BOSWORTH
CAMBS
OADBY & WIGSTON
BLABY
HARBOROUGH
NORTHAMPTONSHIRE
WARWICKSHIRE
N

FIGURE 4.2.

The city of Leicester is markedly multi-racial, with proportions as follows:

White	214,355	(74.9%)
Asian	63,186	(22.1%)
West Indian	5,084	(1.8%)
Chinese	552	(0.2%)
Mixed	1,387	(0.5%)
Other	1,444	(0.5%)
Not Stated	12	(0.0%)

The religious preferences are similarly diverse:

Christian	188,923	(66.1%)
Hindu	39,743	(13.9%)
Sikh	10,808	(3.8%)
Muslim	12,434	(4.3%)
Jewish	471	(0.2%)
None	30,692	(10.7%)
Other	2,071	(0.7%)
Not Known	878	(0.3%)

All data are from the Leicester City Council's 1985 Survey

The largest ethnic minority group is of Indian sub-continental extraction. The group has increased in size gradually since the 1960's. Originally, these people came to Leicester either directly from India (particularly Gujerat) and Pakistan or via East Africa. There was a more abrupt increase in 1972-3 after many people of Indian extraction were ejected from Uganda (by Idi Amin). This population has thus been stably resident in Leicester since before this study period commenced. It is somewhat more youthful (82% < 45 years of age) than the 'white' population (62% < 45 years of age).

Leicestershire has a buoyant mixed economy. Apart from the farming, it is predominantly an area of light industry: shoes, hosiery, knitwear, electronics and machine tools. There are Coalmines in the North-west of the county, mostly running down but there is promise of a new pit. Large numbers of Scots and 'Geordies' moved to Leicestershire to work in the mines. The county has an unemployment rate below the national average (12.5% compared with 13.5%), and a large relatively lowly paid female workforce. Double Incomes are common so despite relatively low wages, it is a county with high rates of home ownership and 'two car families'.

With regard to organisation of health care, Leicestershire, along with Health Districts in the Counties of Derbyshire, Lincolnshire, Nottinghamshire and South Yorkshire is in Trent Regional Health Authority. (Northamptonshire is in the adjacent Oxford Regional Health Authority.) Leicestershire's health care is provided by approximately 400 General Practitioners, a few cottage hospitals and in three general teaching hospitals, one with a psychiatric department. There are also two large Mental Hospitals both of which are scheduled for closure. There are 4.01 General Beds and 0.88 Psychiatric beds (Excluding Mental Handicap) per 1,000 of the population. There is at the University of Leicester a medical school which was established in the early 1970's and led to a substantial increase in medical care in what used to be an area of very low provision. The private sector operates on a small scale. There are no psychiatric beds for private patients in the County.

b) DRINKING IN THE EAST MIDLANDS

In 1978, the Office of Population Censuses and Surveys undertook an enquiry on behalf of the Department of Health into Drinking in England and Wales. (Wilson, P. 1980) In one part of this wide ranging survey of drinking practices and problems, eleven areas were compared. These were North West, Inner London, North, Wales, South West, Outer london, West Midlands, South East (excluding Greater London), East Midlands, Yorkshire/Humberside and East Anglia.

The East Midlands was consistently ranked lowly in terms of Alcohol Consumption and Problems. It was tenth lowest for level of male consumption, with a mean of 14.5 standard units per week, compared with the national norm of 20.3 Units (Range 26.3 - 12.0). It was lowest for female consumption with a mean of 3.8 Units compared with the national norm of 7.2 Units (Range 3.8 - 9.4). Only 5% of the East Midlands men reported drinking more than 35 Units per week compared with the national norm of 14% and none of the women sampled reported drinking over 20 Units compared with 3% of the total national female sample. Interestingly, none of the East Midlands men reported abstinence, compared with 6% nationally, and they drank more frequently in bars with their wives present (47%) than in any other region.

In terms of problems in the year 1978, now with Inner and Greater London combined to produce ten regions, the East Midlands was second lowest in terms of Deaths from Liver Cirrhosis (3.9 per 100,000, national range (3.4 - 5.9) and lowest on admissions to Mental Hospitals with a primary diagnosis of Alcoholism or Alcoholic Psychosis (24 per 100,000, national range 24 - 50) and on Drunkenness Convictions (93 per 100,000, national range 93 - 672).

c) DESCRIPTION OF THE COMMUNITY ALCOHOL SERVICES

The Leicestershire Community Alcohol Services are a multi-agency multidisciplinary community-based response to problems of alcohol use in the county. They consist of the following components:

ALCOHOL ADVICE CENTRE
This provides:-
1. A common entry point into the services for all referrals.
2. A telephone counselling service.
3. A city centre advice/assessment and counselling premises.
4. The focus of the Services' educational output.

The advice centre has three full-time employees, a Director who is primarily concerned with professional and public education, an Administrator/counsellor who is responsible for the everyday running of the centre and a Secretary. Also, there is on a daily rota basis a member of the Community Alcohol Team at the Centre to undertake advice/assessment work. Contact and advice session records are maintained at the centre.

COMMUNITY ALCOHOL TEAM
This provides:-
1. Assessment, management and follow-up services in the community for problem drinkers and their families who present directly to or are referred to the Services via the Alcohol Advice Centre.
2. Support and Education for primary care workers who wish to deal with 'their own' problem drinkers.
Public and Professional Education.
3. In-service training for medical, social work and psychology students, junior doctors and nurse learners,

4. A small (12 place) day unit.

The Community Alcohol Team has a membership of approximately 12 Clinical Staff and 2 Secretaries. The clinical staff are Community Psychiatric Nurses (6½), Psychologists (1½) Social Worker (1) Occupational Therapist (1) Craft Instructor (1) Psychiatrists (1½). The ½ Nurse and ½ Psychologist are senior staff who both manage members of their disciplines and carry limited caseloads in both the Alcohol and the Drugs Services, which are separate. There are also a variable number of Students attatched to the team, usually at least two. Multidisciplinary case records are maintained at the base of the Community Alcohol Team.

HASTINGS HOSTEL

This is a core and cluster unit with 16 bed-sitting rooms in the main hostel and two three-bedded group homes affiliated. Sharing as it does the same ethos as other parts of the services, it is not a 'dry' house. Residents make their own decisions about their drinking. While some elect to be abstinent, most wish to drink moderately and non-problematically. The maximum length of stay in the Hostel is 2 years. The main building is staffed 24 hours per day.

It provides:-

1. A residential setting with support and counselling for homeless problem drinkers.
2. Emergency accommodation and support for problem drinkers who require time-out from their home environment.
3. Second stage housing.
4. Ready access to and continuing support in Council and Housing Association Accommodation.

The Hostel has a Warden, supported by 4½ residential care staff and a secretary/administrator.

Unlike the Spratley, Cartwright and Shaw model of a Community Alcohol Team, the Leicestershire Services see as their prime function clinical service delivery. The Community Alcohol Team is a mobile 'treatment resource'. Of course there is, and has always been, a heavy and willingly-undertaken teaching commitment. But that has always been seen in terms of informing other professional workers what the Services are, how they construe drinkers, what they are trying to do and what support they can give for what purposes to primary care workers.

A consistent set of messages have been fed out from the services from their inception:

1. There is nothing special about 'problem drinkers'. They are simply people with problems who drink.
2. There is nothing special about what we do in these services. The skills posessed by primary care workers are the same as the skills that we use. This is a specialist service, not an 'expert' service.
3. Therefore there is no reason why you, primary care worker, should not try to do what we try to do.

A flow chart of the 'Customer' Services is shown as Figure 4.3.

All referrals are directed to the Alcohol Advice Centre, which is the common entry point into the services. A rapid appointment for Assessment Interview is made, normally within 48 hours, except at weekends. Assessment is carried out at the Advice Centre if the 'customer' can get there. If that is impractical, Assessment will be undertaken at the 'customer's' home or at some other site, i.e. General Hospital if that is where the customer is at the time. Assessments at the Advice Centre are undertaken by members of the Community Alcohol Team on a daily rota basis. People coming in off

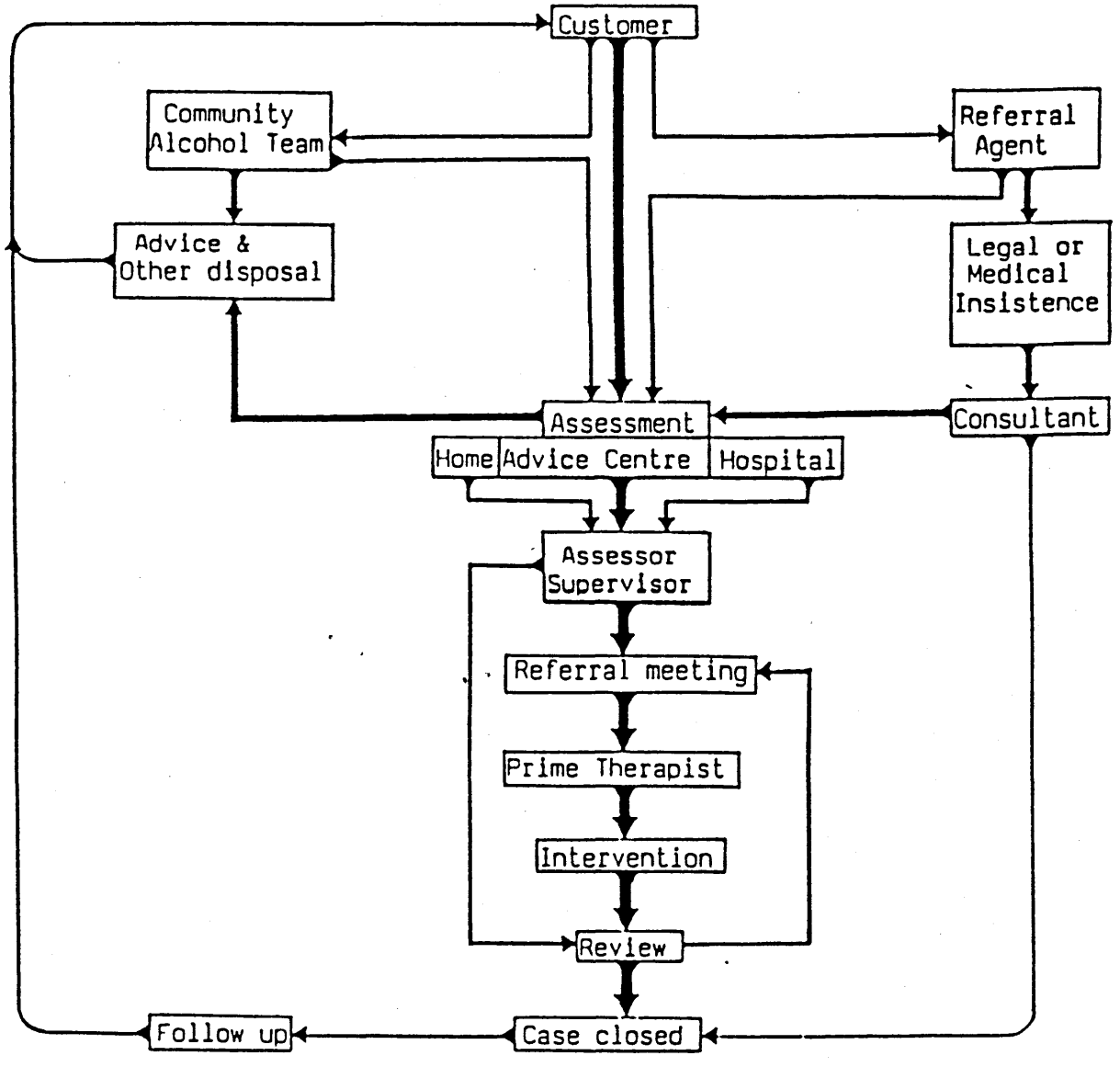


FIGURE 4.3:

Flow Chart of Community Alcohol Services

the Street will be seen instantly if there is Assessment space; if not an appointment will be given.

Assessment consists of a semi-structured interview using a questionnaire that has been developed over the past decade. (Appendix 1) Apart from basic demographic data, the 'customer' is asked about previous interventions and current treatment; previous and past drinking patterns, including a drinking diary for the past week; intoxication and withdrawal phenomena; job, marital and legal history; self-concepts and appraisals of responsibility using analogue scales. **At the heart of the Assessment is the question on 'customer's' perceived needs.** Data from a sample of these interviews is presented in Results.

Some 'customers' are simply seeking advice, either for themselves or for a third-party. If that is all that is required, that is all that is provided. No attempt is made to 'suck' the presenter further into the Intervention process than they wish to go.

If referral agents insist on Medical Assessment then it can be provided but there is a waiting time deliberately kept at about six weeks. The referrer is given the option of multi-disciplinary team involvement, say, the next day or an assessment by the Author or junior medical colleague in six weeks. Very few referral agents insist on Medical Assessment.

If a more comprehensive intervention is sought then the Assessor presents the Assessment at the next day's Community Alcohol Team Alloction and Review meeting. There another member of the team picks up the case. She or he is then designated Prime Therapist and is

reponsible for seeing that 'customer' right through that episode of contact.

Allocation to the Prime Therapist is undertaken informally at the team meetings. Although the purpose is to match the needs of the 'customer' with the skills of the team member, this is often overridden by caseload or geographical considerations.

The Prime Therapist then visits the 'customer' normally at their home and the Intervention starts. If some procedure appears urgent to the Assessor, it may be instituted by them. This applies particularly to home detoxication (see below). The kinds of interventions requested are many, and have been labelled 'packages' or 'foci'. A list of these is included as Table 4.1.

This list represents a 'self-service cafeteria' of provision but as will be seen in the Results, the number of 'packages' regularly chosen is small. It is the eqivalent of a Glazer 'Shell' (See pages 58-60). The Prime Therapist and the 'customer' negotiate on what is required throughout the entire intervention. If some 'package' does not appear to be having any benefit, it will be abandoned in favour of another. Thus the service operates by sampling therapeutic options recurrently rather than deciding what is required at Initial Assessment and administering it regardless.

TABLE 4.1 :

'TREATMENT' PACKAGES

Detoxication:
- Home-based
- Hospital Based

Abstinence Training
Controlled Drinking Training
Education in Alcohol
Time Out:
- Day Unit
- Hostel
- Hospital

General Support and advice
Marital Counselling
Sexual Counselling
Family Therapy
Individual Therapy
Women's Group Therapy
Occupational Therapy
Assertion Training
Relaxation Training
Desensitisation/flooding
Social Skills Training
Leisure Counselling
Job Counselling
Help with Accommodation
Welfare Rights Counselling
Psychiatric Assessment
Psychological Assessment
Medication, including
- Antabuse

Follow-up
Open Contact
Referral to other agencies, inc. Alcoholics Anoymous

NOTES ON 'PACKAGES'

DETOXICATION.

Detoxication ('Detox.')is carried out in the home or if there is no social support, in a general psychiatric admission ward. In either setting the routine is the same. The customer is provided with Chlormethiazole 'Heminevrin' Capsules (192 mgm. base) and a schedule showing when to take them, and is told to cease drinking alcohol completely. If the drinker has been consuming a great deal over a long period, a 10-day Detox. would be advocated. This starts at 3 Capsules three times per day and reduces by one capsule daily, leaving the nighttime doses longest. A total of 46 Capsules are required for this. If the length of drinking and quantities consumed are not great, then a 5-day Detox., which uses only the second half of the 10-day Schedule is provided. 16 Chlormethiazole Capsules are provided for that. If the regime is undertaken in the home, the General Practitioner is requested to prescribe the medication, is informed that a team member will visit daily if required and that that team member will inform him/her if any difficulties arise and would welcome supporting visits. Vitamin Supplements are given only if there is a history of dietary neglect. Because the customer is actually asking to 'come off the drink', there are very few problems with people continuing to consume alcohol while on the detoxication regime and a surprisingly low intensity of withdrawal phenomena are noted. Approximately one in five customers referred to the service receive formal detoxication of this sort. Many others receive advice on cutting down or tapering off their drinking completely, effectively using Alcohol as its own detoxication agent.

ABSTINENCE TRAINING.

This mostly concerns supporting and validating the customer's decision to be totally abstinent. It involves advice on alternative beverages; (This era of low and zero-alcohol beers and wines and the widespread marketing of mineral waters has been very helpful); practical advice on how to deal with social occasions where there is alcohol present: how to say "No!"; involving the spouse in actively supporting the abstinence goal and offering alternative activities; and reassuring the customer that they <u>will feel</u> better for not drinking. Such strategies are made more palatable if there is evidence of alcohol-related bodily damage. Of course, abstinence training does impinge upon other 'packages' such as leisure counselling.

CONTROLLED DRINKING TRAINING.

This, in many ways, involves the same strategies as are outlined in 'A Pilot Controlled-drinking Out-patient Group' (Cameron, D. and Spence, M.T. 1976a), but offered for individuals. There is more emphasis on self-monitoring with Drinking Diaries and validation of self-control than the Author believed possible in those early days. Gradual re-shaping of behaviour rather than a week's abstinence followed by imposition of a completely new pattern of drinking is the norm.

EDUCATION IN ALCOHOL
This used to be provided regularly in the day unit and involved the usual information about Units of Alcohol, risks of bodily damage and the like. It has been superceded by simple provision of the Health Education Council's (now Authority's) booklet 'That's the Limit', which is part of an information pack sent out on request from the Alcohol Advice Centre.

TIME OUT.
This is self-evident. Unfortunately, it is not easy to convince staff in general psychiatric admission wards that the reason that somebody is there is to be left alone!

TALKING THERAPIES.
The major modality of intervention in the services is talking with people in their own homes. It would be possible to call this all sorts of sophisticated and complex names, but it would not be justified. General Support and advice has varied between bereavement counselling to advice on what to do about greenfly on the garden roses! A number of workers in the Services take a special interest in working with couples and families and the team's Social Worker has a particular role in surveillance of the welfare of Children. Group Therapy comes and goes in the Services contingent upon demand. At times there has been single-sex group therapy, mixed- sex group therapy, couples' group and a relatives support group. At the time of writing, the only one functioning is a women's support group.

ACCOMMODATION.
Apart from Hastings Hostel, the services do not provide accommodation. If somebody homeless presents, he/she will be helped by liaison with other agencies, including the local night shelter, and particularly for men the local resettlement unit with which the services have always had a close working relationship. There is in our catchment area a shortage of accommodation for homeless women, so priority for entry to the Hostel is given to them. Hospital admission because of a primary need of homelessness is used only as a 'last resort'.

SPECIFIC DISCIPLINARY SKILLS.
People who ask for specific interventions, i.e. Relaxation training, Psychiatric Assessment and Treatment, can receive these by the prime therapist co-working with the relevant member of the multidisciplinary team, or by 'customer transfer' or by incorporating that specific 'package' into the overall intervention plan with the prime therapist maintaining overall case-management responsibility.

ANTABUSE.
This drug, Disulphiram, which acts by blocking the breakdown of alcohol at the penultimate stage, thus liberating Acetaldehyde into the bloodstream of takers who also consume alcohol, is used sparingly in the Services. It is used by negotiation with the customer and never imposed upon him/her; and when it is perceived by

relevant people to be a potentially useful adjunct to whatever else is on offer. It is not a treatment in itself.

REFERRAL TO OTHER AGENCIES.
This is undertaken as appropriate. Apart from the accommodation agencies (above), the services have found the Money Advice Centre, Welfare Rights Centre and the Area Psychotherapy Service particularly valuable. While the service refers some of its customers to Alcoholics Anonymous, that organisation does not seem to reciprocate. Tolerance of a resumed drinking therapeutic goal is not acceptable to them. The services would see A.A. as being 'one of the plates on the cafeteria' of services whereas A.A. would appear to wish to 'take over the dining room'.

FOLLOW-UP.
This represents an important area of the work of the services. While the majority of the customers are actively 'processed' by the services within three months, there is a small number of people who require long-term support, although not active intervention. Most team members have a number of these customers whom they have known for a long time and whom they tend to 'drop in on when they are in the area'. That is called a coffee-stop visit, and demonstrates no more than a sustained interest in that individual. Even a note left saying that a team member has visited is often responded to by a telephone call or letter. This activity on the part of team members does not lead to representation in crisis. In fact the Author believes that it has exactly the converse effect, minimising the need to create another crisis and thus acquire more care. Team members who have been with the services for many years may have a large number of these 'coffee stops' as part of their workload and they represent one of the more rewarding parts of the job.

OPEN CONTACT.
This is normally offered after the more active part of the intervention is over. In essence it is "I won't call you, you call me if you want to." Thus there is an ever present network of perceived support present for customers of the services and numbers of them and their spouses make irregular calls for advice or assistance sometimes even years after the initial presentation. This does not comprise an onerous part of the workload.

Prime Therapists can and frequently do recruit other members of the team as co-therapists, or for one-off joint visits where additional advice or a new perspective on a problem would be valued. There is no formal heirarchical system of supervision, except for students.

Six weeks after the start of the Intervention, the initial assessor contacts the 'customer' to appraise more

independently whether the intervention is what the 'customer' requires and in what way the service could be improved. That reassessment is discussed at a Community Alcohol Team meeting. 'Customers' are then reviewed at six weekly intervals in team meetings until the intervention is over.

It is inevitable in a service which has had dozens of people working in it and has seen thousands of customers that, occasionally, there will be a mismatch of team member to customer, despite the fact that one of the functions of the daily team meetings is to avoid just that. This normally is discussed at a review and a 'customer transfer' is arranged, with the knowledge and consent of the customer, who is normally equally pleased to 'see the back of' his first therapist. This happens exceptionally infrequently.

Re-referrals within six months of case closure are returned to the Prime Therapist. After that time, the 'customer' has to re-enter the system via the Advice Centre.

d) THE DEVELOPMENT AND ETHOS OF THE LEICESTERSHIRE COMMUNITY ALCOHOL SERVICES

i) Development

The Leicestershire Community Alcohol Services did not appear overnight in the form described in the previous Section. That mode of service delivery evolved gradually over a period of years; indeed it is still evolving. This section is therefore a description of that process of evolution. Inevitably it is a personal account.

Quite simply, the Author decided to see what would happen if those new beliefs and ideas of the mid-1970's, sometimes ill-formulated and untested, and certainly not the 'current treatment model' at that time, were operationalised into a major system of care for people with alcohol problems from a whole community.

Prior to the development of the Community Alcohol Services, there was no psychiatrist designated to work specifically with drinkers, but two had taken some interest and had developed close liaison with the small local Alcoholics Anonymous group, which met weekly in one of the two large mental hospitals in the county. Apart from that, there was no specialist service of any sort within the county. The Trent Regional Alcoholism and Drug Dependency Unit in Mapperley Hospital in Nottingham, some 30 miles from Leicester was willing to admit Leicestershire residents but tended to do so for people from the North of Leicestershire only. With the appointment of a Leicestershire Consultant with special interest (the Author), this policy ceased. Thus, in 1976-7, the area was, as nearly as one could get in Britain, without a specialist alcohol service.

People with alcohol problems were dealt with either in the community by General Practitioners, Social Workers, Probation Officers or Community-based Nurses; or they received no professional help at all. Some were referred for General Medical Care, mostly for bodily damage. Some were referred to 'catchment area' General Psychiatrists, from whom the usual treatment offered was in-patient detoxication followed by referral to and liaison with Alcoholics Anonymous. Out-patient follow-up was also offered, often at clinics near the patient's home.

Over the next three years, a new secondary tier of specialist services was developed incrementally, but the order in which the agencies arrived was determined by staff and premises availability, not by rational planning.

Andrew Pettigrew (Pettigrew, A.M. 1975) has charted the development of specialist units in industry and found common routes and stages. These are illustrated diagramatically as Figure 4.4.

The Conception Phase tends to be the result of major changes within the umbrella organisation, to be poorly formulated and whimsical, the wish of a powerful sponsor. The Pioneering Phase is characterised by the new team showing great enthusiasm, involvement and commitment to the task and indifference, even disdain, of the views of outsiders. After about eighteen months, the Unit enters a period of Self-Doubt, which starts when the first efforts or products of the enterprise become public. This is a period of turbulence and factionalisation. Depending upon how the Unit deals with self-doubt, there are a number of options for progression out of that phase, as seen in the diagram.

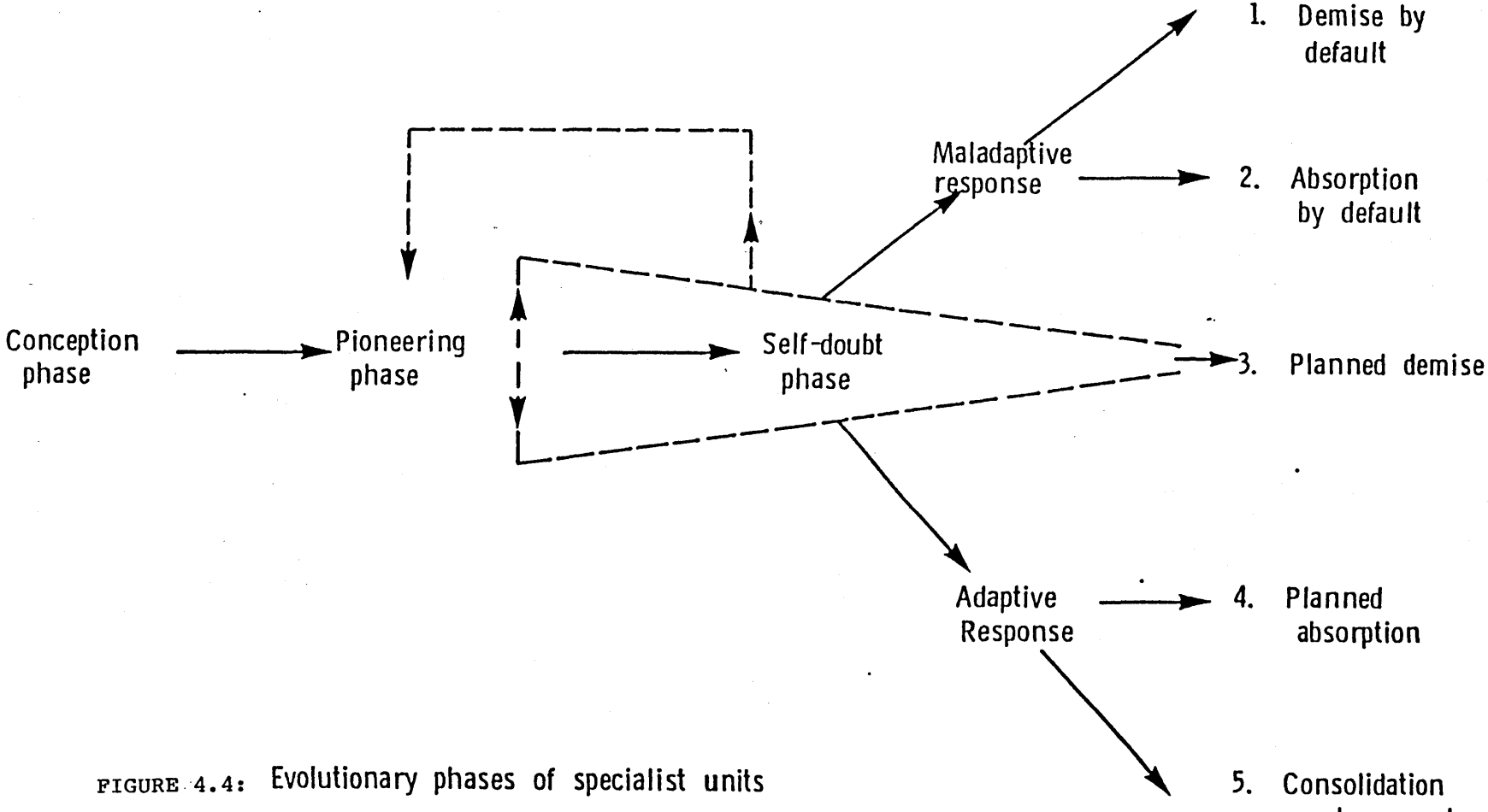


FIGURE 4.4: Evolutionary phases of specialist units

Pettigrew, Andrew M (1975)

Apart from one 'looping back' from Self-doubt to Pioneering in 1981, the Leicestershire Community Alcohol Services seem to have followed the path from Conception onto an adaptive response pathway. The Services cannot remain as they are. Consolidation and Renewal is not static. Planned Absorbtion is always possible, particularly with the development in Leicestershire of generic Community Mental Health Teams.

With the development of the Medical School and a concomitant enhancement of Health Service resources, a gap in Service Provision for 'Alcoholism' was noted. The University Department and the Division of Psychiatry, who collaborate closely (The newly appointed Professor of Psychiatry was Chair of the Division at that time), recommended that a new post of Consultant Psychiatrist with special interest in 'Alcoholism' be created. The Author was appointed , taking up post in September 1976. It was made clear that the shape and style of the Alcohol Services were 'his business', and thus the original sponsors handed the sponsorship role over to the Author early in the Conception phase. It is unusual for The Sponsor also to be a key member of a Specialist Unit. That convergence gave to the Author a marked degree of autonomy (and a lack of accountability) which is rare in the Public or the Private Sector. It enabled him to lay down, de novo, a template for service delivery without hindrance. His views determined the early modus operandi of the service, which, during the pioneering phase, became established as service norms.

The *Pioneering* Phase started with the aggregation of the Multidisciplinary Community Alcohol Team in April 1978. During the first week of its existence, the Author conveyed to other team members (2 Community Psychiatric Nurses, 1 Social Worker and Student and 1 Craft

Instructor) current views about the nature of people with alcohol problems and the nature of the responses that may be appropriate (Much in accord with the Synopsis on Page 70-71). As a result of this week's activity, the following was produced:

The Aims of this Unit are:-

To Provide For Our Customers:
1. A within 24 hour consultative service to existing agencies.
2. Vigorous follow-up with groups, family casework, social support, occupational therapy, help for the kids
3. A 'really' community-based service which is visibly efficient.

To Provide for the Public at large:
1. General Education on alcohol use and abuse.
2. Accurate information and documentation on our work

To Provide for Ourselves:
1. An open egalitarian team where individual assets rather than accepted roles govern our job.
2. A situation in which it is fun to work
3. Ongoing self-education and development of knowledge and skills.
4. Research opportunities.

Having determined its own aims, the Community Alcohol Team set about its *pioneering* task exactly as described by Pettigrew. The Author was highly protective and reinforcing of the Team's efforts, and the team did not need to account for itself to anybody. Line managers were kept at a distance.

As Pettigrew would predict, The Community Alcohol Team entered the *self-doubt* phase about eighteen months after its inception. Two members of the Team left midst marital breakdowns, there were questions asked of the "Are we doing any good?" kind. New members of the team who had been gradually assimilated, however, maintained the esprit de corps and external scapegoats were readily found for the Team's difficulties. External threats were vigorously fended off by the Author who maintained his active sponsorship role, and outcome data such as the Team could obtain were mustered to its defence.

As noted above, the first response to the self-doubt phase was a looping back into a new pioneering phase by aggregating the Community Alcohol Team, Hastings Hostel and The Alcohol Advice Centre into one functioning unit - The Leicestershire Community Alcohol Services, which comprise, in order of appearance:

1. DRURY HOUSE DAY UNIT. (May 1977) During its early months the Day Unit ran an after-care support group. Drinkers who had been in-patients at the nearby mental hospital (Carlton Hayes) started attending the Unit three times a week to attend an open-closed psychotherapeutic group run by the Author and a hospital-based social worker. People were encouraged to continue in contact with it after they had returned home. With the appointment of a craft instructor in September 1977, the Unit opened its doors for 5 days per week and provided diversional and recreational activities.

2. HASTINGS HOSTEL. (December 1977) This was initially funded under Circular 21/73: Community Services for Alcoholics, with deficit funding assured by Leicestershire Social Services. Each resident has his/her own room and front door key. It is situated in the city.

It still contains the only beds designated specifically for 'problem drinkers' in the county. At the time of its opening, it had two full-time staff, who were non-resident.

3. COMMUNITY ALCOHOL TEAM. (April 1978) This was originally staffed by the Author, one Social Worker and two Community Psychiatric Nurses (C.P.N.'s). In September 1978, a Clinical Psychologist and a further C.P.N. were added. The Health Service staff were appointable from the revenue consequences which at that time were allocated to support new consultant appointments (R.R.C.A.'s). As well as staffing the Drury House (where the team is based) Day Unit, the team was mobile, visiting 'Customers' (for that was what the users of the Services were called) in their own homes. With the arrival of the Community Alcohol Team, a policy of avoiding psychiatric hospital admission if at all possible was instituted and the services now accepted all referrals of Drinkers direct as opposed to the previous policy of being a secondary resource only. This policy reaped rapid dividends. There was a marked fall in the number of 'problem drinkers' in the admission wards at the local mental hospital at any one time which meant that it was possible to liberate more nurses from the Hospital into the Community Alcohol Team.

4. ALCOHOL ADVICE CENTRE. (July 1979) This was established as the Shop-front for the Services with grant-aid from the now defunct National Council on Alcoholism matched by joint financing. It has always been located in the city centre although it has had to move twice because it has outgrown its premises. When it opened it had an ex-probation officer Director and a part-time Secretary and the Services could now accept self-referrals. It was always expected of the Advice

Centre that it would be available for advice, not only on problems but also on general alcohol issues, such as "Where can I get a pint of...?" but in fact from the outset it has been used by the people of the county as a source of help with and for people with problems. Advice sessions and some on-going counselling work was done on site by the Director but if a more 'therapeutic' approach was required then referral-on took place, almost exclusively to the Community Alcohol Team.

From their inceptions, these agencies have worked very closely together. The Author, who was instrumental in their development, worked in the Day Unit and Community Alcohol Team and was also on the management committees of the Hostel and the Advice Centre. 'Customers' were shared freely and the staff of the various agencies were in and out of each other's premises everyday. The Drury House Day Unit acted as a 'training base' for staff of all the agencies and a period of regular attendance at the open-closed group, which became known as 'The Core Group', was perceived as a necessary component of that training. The Core Group thus became the ethos carrier for the whole service. (As the service became more community-based, the 'core group' became less popular with the 'customers' and eventually the daily groups ceased. The day unit now functions as a small unstructured 'middle-aged youth club'.)

The Services have not returned to that early, destructive self-doubt. This is because they have established more meaningful links with the 'outside world'. Hastings Hostel is particularly well integrated into the non-statutory housing sector. Links between the newly developed Drugs Services are very close, and the Author retains regular contact with general psychiatric services and colleagues.

ii) Ethos

By a process of influencing staff selection, regular in-service training and heavy involvement in all components of the Services, the Author established within them an ethos and style of working which converged with what he believed to be an appropriate model. Two years after the inception of the Integrated Services, he attempted to describe the ethos as part of a presentation on the work of the Services, called "A Radical Model for Alcohol Services - The Leicester Experiment" which took place at the 1981 Liverpool International Conference on Alcohol Related Problems. An extract of that presentation is quoted below:

"I need to start by making eleven statements of what, for us in Leicestershire, are effectively articles of faith upon which our services are established:

(1) THERE IS NO SUCH THING AS ALCOHOLISM...
(2) ALCOHOL DEPENDENCE IS UNIMPORTANT...
(3) PEOPLE'S DRINKING MAKES SENSE...
(4) PRESENTERS ARE DIFFERENT INASMUCH AS THAT THEY PRESENT...
(5) PEOPLE PRESENT AT TIMES OF CRISIS...
(6) REJECTION REFERRAL IS THE USUAL REASON FOR SPECIALIST INVOLVEMENT...
(7) MOST CONVENTIONAL TREATMENT MODALITIES ARE USELESS...
(8) SIMPLE HUMAN CARING SKILLS ARE HELPFUL...
(9) SOME THERAPISTS ARE BETTER THAN OTHERS...
(10) THERE IS NO GENERALLY ACCEPTED BODY OF KNOWLEDGE ABOUT ALCOHOL PROBLEMS...
(11) GOALS OF INTERVENTION MUST BE NEGOTIATED, APPROPRIATE, ATTAINABLE AND MEANINGFUL..."

(Cameron, D., Coope, G. & Hopley, F.M. 1981)

There is, as one would expect, much similarity between these 'Articles of Faith' and the Author's current synopsis of the the state of knowledge in the alcohol field in the late 1970's (Pages 70 - 71). But there are also important differences which make it worthwhile to compare and contrast the two.

First, there was, even then, an unwillingness on the part of the Author to accept that the concept of Alcohol Dependence was operationally useful. That theme has been pursued at length in the Introduction.

Second, there was the clear view expressed that drinking, even for 'problem drinkers' was functional and rational. This view was at variance with the Consensus view, which the protagonists of the Alcohol Dependence Syndrome express succinctly (Pages 26-28). There are obvious consequences arising from the Author's view. If 'problem drinkers' are engaging in rational, goal directed behaviour then they are to be seen and treated as being responsible for their actions and in no sense victims of some disorder over which they have no or have lost control. That is at the other end of the Responsibility Dimension of Figure 3.1. It converges with the Moral Model and with the view of The Conspiracy theorists.

Third, there is in the fourth tenet, a statement about labelling. The suggestion is clearly made that 'problem Drinkers' are not different from many other drinkers in the community. They have become different by the process of 'getting caught'! That again is the view of the Conspiracy Theorists, and it does have implications for the way in which responses to presenters are coloured. Rather than attempting to convince unwilling listeners that they are 'Alcoholics' or

'Problem Drinkers', the response can be much more overtly to 'start where the client is'.

To see whether the Community Alcohol Team seemed to be achieving its objective of being a destigmatising response, a very small pilot study on labelling was undertaken on the first 41 customers ever seen by team members. The question asked 3 months after case closure was:

""Are you now or have you ever been an Alcoholic or a Problem Drinker?"

Approximately 60% of the sample never bought the label [Alcoholism] in the first place. About 33% thought they might have "the disease" when they met us, but at follow-up, they had given up that view of themselves. That is they had therefore been de-labelled. Only 7.3% still believed themselves to be suffering from 'Alcoholism'. The [perceived] views of the corroborates, normally spouses, show the same general trend but not as markedly so. The 'problem drinker' status is rather different. Here, 63% of the sample thought they had been problem drinkers but were not anymore, a belief moreorless concurring with that of their corroborates. A much smaller percentage [20%] thought they never were problem drinkers and 17% thought they still were, again a view moreorless shared by their spouses." So, as an agency, we seem to be very succesful at removing the "Alcoholic" label or validating that they [customers] never had it in the first place. However, we seem to validate rather an ex-problem drinker's status, the inference being that even though they have had problems with alcohol, that situation does not obtain any longer."

(Cameron, D. 1983b)

Fourth, there was an acceptance that the knowledge base in Alcohol Studies at that time was unclear. Previously held self-evident truths had been called into serious question. Further, consumer rights and choice were receiving greater recognition in this as in other fields of Medicine.

The set of beliefs, although somewhat more radical than the hybrid Dependence Model (Figure 3.2), is not simply conspiracy theory. It differs inasmuch as it is not blind to the fact that some people do drink in socially inappropriate or bodily damaging ways not all the time, but certainly on occasions. It also does not accept that the knowledge within the field is part of a plot to stigmatise innocent citizens simply to maintain social norms. This model can therefore also be schematised on the dimensions of Figure 3.1. That is shown as Figure 4.5. It is also a Hybrid Model. That theme is followed further in the Discussion.

Finally, in the 'Articles of Faith' there were some comments about psychotherapeutic efficacy generally and about the need for rapid responding which were not relevant to the Synopsis of the Introduction, but are relevant to service delivery.

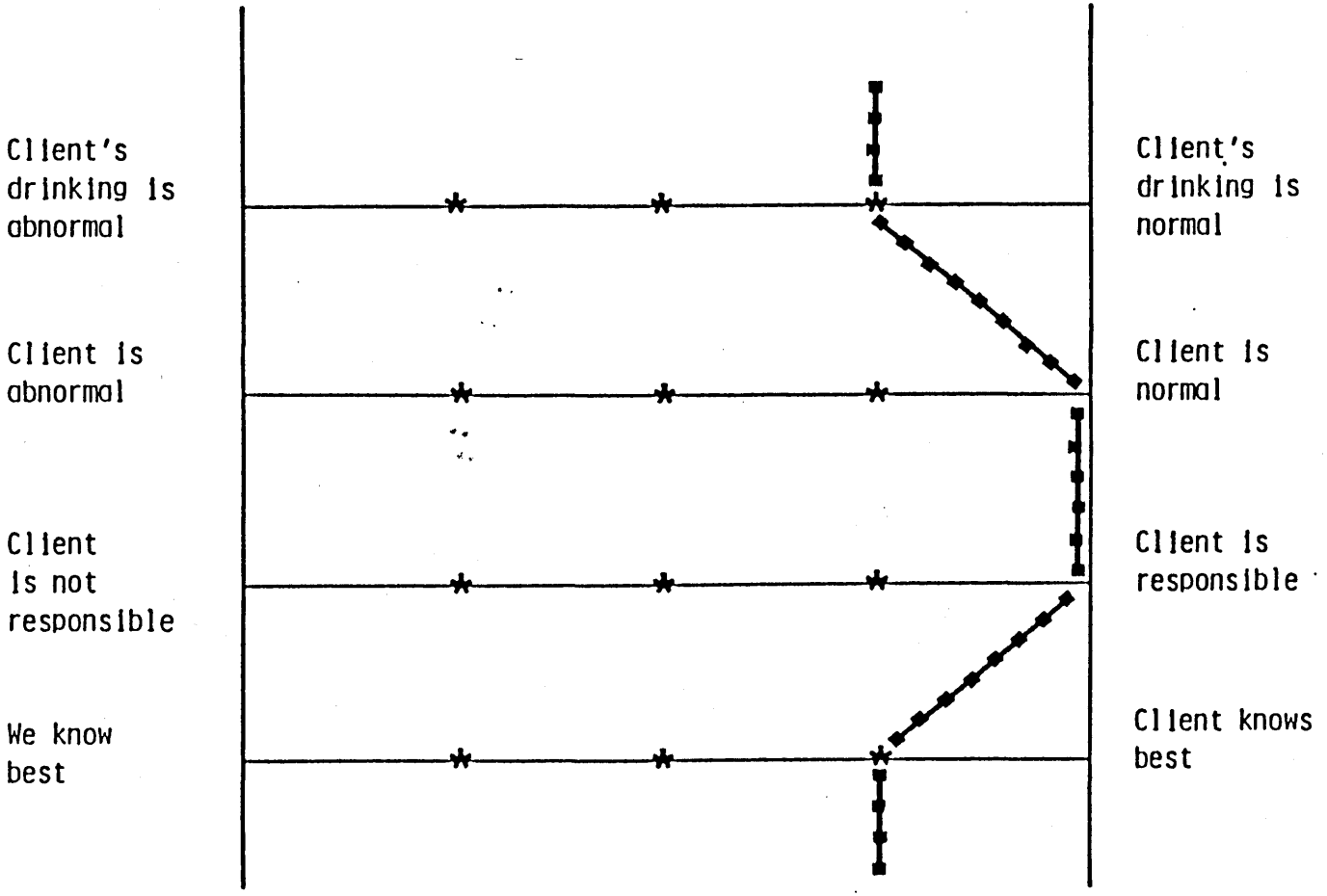


FIGURE 4.5: Diagram of the Nameless Model

e) SYNOPSIS OF LEICESTERSHIRE AND ITS COMMUNITY ALCOHOL SERVICES

1) Leicestershire is a diamond shaped county of approximately 1000 square miles. Nearly 900,000 people live there, with half of them in the conurbation in and around the centrally sited county town, the City of Leicester. The city has an ethnic minority population, mostly of Indian sub-continental extraction of nearly 30%.

2) Leicestershire is in the East Midlands of England, an area of gently rolling countryside intensively farmed and with predominantly light industry, especially clothing manufacture and electronics. It has below average unemployment but relatively low wages.

3) Compared with other regions in England and Wales, The East Midlands is an area of (relatively) low alcohol consumption and related problems.

4) Health care in this teaching district is provided in the usual British manner, by approximately 400 general Practitioners, three general hospitals, one with a psychiatric department, and two psychiatric hospitals.

5) In 1977, Services for people with alcohol problems were delivered by generic workers with some support from Alcoholics Anonymous, and very occasional use of admission to the Regional Alcohol and Drug Dependency Unit in Nottingham, some 35 miles from Leicester.

6) Thus, as nearly as one could find in Britain, Leicestershire was at that time without a specialist Alcohol Problems Service.

7) From 1977 on, a community-based service for people with drinking problems was developed incrementally.

8) Since 1979, The Leicestershire Community Alcohol Services have consisted of a non-statutory Alcohol Advice Centre, which is the common entry-point to the services; a multidisciplinary community alcohol team, which provides a broad range of home based interventions; a small day unit and a voluntary hostel with follow-on accommodation.

9) These agencies collaborate closely to provide a service which is eclectic, non-abstinence oriented and which attempts to be destigmatising and client demand led.

10) At the heart of the structured Initial Assessment is an evaluation 'Client's Perceived Needs and Problem Areas'.

11) Intervention is an unfolding process of continuing renegotiation, starting from 'where the Customer is'.

12) The services see their role as minimising harm caused by episodes of problem drinking when they occur and increasing the length of time between such episodes, hopefully so that such episodes do not recur.

13) As well as direct client intervention, the Services also provide education for primary care workers and the public at large, promulgating views consistent with the general ethos of the Services.

14) The Leicestershire Community Alcohol Team is now the biggest full-time and longest-surviving such team in Britain.

Chapter 5: METHODS

The last chapter consisted of a description of the area in which the Leicestershire Community Alcohol Services operate and a description of both the services themselves and their therapeutic ethos. In reality, The citizens of Leicestershire were the subjects of this study and the Community Alcohol Services the method under study. But as previously stated, these services were not established as a rigorous experiment. They were designed as a response to Leicestershire's Problem Drinkers. Therefore the methods of study described are not those of a comprehensive evaluation. They describe the techniques used to create a number of reportable findings from a service which has, since its inception, attempted no more than to monitor its everyday functioning.

What is presented here is a description of the methods used to produce the results presented in the next chapter.

a) REFERRAL RATES

These data were collected from four Alcohol Advice Centres in three neighbouring counties. The Leicestershire data was collated from the annual reports of the directors presented at the Advice Centre's Annual General Meetings. In two neighbouring counties these data were forwarded to the Author by the Directors of the equivalent agencies. For Nottinghamshire, this was the Nottingham-based Alcohol Problems Advisory Service; and in Derbyshire, there are two agencies, Derbyshire Alcohol Problems Advisory Service in Derby and the North Derbyshire Council on Alcoholism in Chesterfield. For the purpose of comparison, the two Derbyshire agencies were aggregated and all rates were converted to number of contacts (i.e. People using the services whether

referrals or re-referrals) per 10,000 of the population. They therefore reflect the demand on these recognised street agencies. They do not, however, reflect the number of drinkers seen in other community agencies: the Probation Service, Social Services, General Practitioners or Psychiatric Outpatients' Departments.

b) DESCRIPTION OF CUSTOMERS USING THE LEICESTERSHIRE COMMUNITY ALCOHOL TEAM, THERAPEUTIC INTERVENTION AND FOLLOW-UP.

This is the part of the study which was most collaborative. These data were acquired predominantly from the Initial and Follow-up Assessment Forms (Appendices 1 and 2). The early design was the Author's but the forms have been developed over the years predominantly by the Services' Research Psychologist, Marilyn Christie. All members of the Community Alcohol Team collect initial interview and follow-up data. During the period 1981-1982, a more comprehensive evaluation of the services was undertaken by Marilyn Christie, the Author and Michael Hopley. The study was designed by Marilyn Christie. The report was compiled by all three Authors. Most of the results in this section have been extracted from this unpublished Manuscript. Extracts from it have been presented elsewhere. (Christie, M.M., 1983, Cameron, D. 1986)

The Subjects consisted of all customers referred into the Leicestershire Community Alcohol Team over a five month period. (September 1981 - January 1982), that is once the treatment system described earlier had become fully established and operational. People who attended the Advice Centre and did not request further involvement (Advice Sessions) were excluded. Only those people who had a full initial assessment and allocation to a Prime

Therapist were deemed to have become customers. The total sample size was 162 customers. A group of 30 of those were selected out as subset for collection of treatment data, on the basis of a random one-per-five referral allocation.

As previously stated, the structured interview collected information on drinking habits, drink-related and life-related problems, and self-appraisal data using 10-point rating scales and open questions which are quoted in full if used in Results. The follow-up interview schedules were of similar design, repeat a number of the questions and asked about the value (if any) of the intervention.

Assessors and Prime Therapists were also interviewed about what they thought was the appropriate intervention and what they thought they were trying to do. Information was also gathered from the Therapists case-notes.

The statistical analysis was undertaken on the *Statistical Package for the Social Sciences* (S.P.S.S.) using a basic within subject repeated measure design illustrated below.

In this way the individual differences on a multitude of factors were isolated as main effects as measured over time, allowing the statistical freedom for correlation. In addition, subjects were grouped into between-subject variables, such as sex, abode, referral agent or perceived needs for treatment.

TABLE 5.1.

EXPERIMENTAL DESIGN OF FOLLOW UP STUDY

		B1	B2	B3
A1	S1	x_{111}		
	S2			
	S3			
	S4			
	Sn			x_{n1b}
A2	S5			
	S6			
	S7			
	S8			
	Sn			x_{nab}
An				

B = Time A = Alcohol Effects

S = Subject/Customer x = Cell Frequency

c) MEASURES OF THE IMPACT OF ALCOHOL SERVICES ON THE COMMUNITY.

These data were collected by the Author with the assistance of numerous others, particularly Dr. Michael Metcalfe.

i) Morbidity

The Hospital Deaths and Discharges Data on Indirect Indices was based on the Hospital Activity Analysis (H.A.A.) and Mental Health Enquiry (M.H.E.) returns

extracted from the Trent Regional Health Authority computerised data base with the assistance of Dr. David Pinder. The data are analysed by place of residence, not by place of treatment and where available cover the 11 year period 1975 - 1985. The Diagnoses are classified according to International Classification of Diseases (I.C.D.) It was revised during the study period. I.C.D. 8. covered the period 1975 - 1978, I.C.D. 9 from 1979 on. It is noteworthy that the classification showed a notable change in the diagnosis of Alcohol Related Disorders between the two. Alcoholic Psychosis (291) was constant but Alcoholism (303) was replaced by the Alcohol Dependence Syndrome (The new 303) and Non-dependent Alcohol Abuse (305.0). These changes occurred simultaneously in all three counties and therefore do not effect the comparisons reported.

ii) Mortality

These data are collated from death certificates submitted to the Registrars of Births, Deaths and Marriages of the three counties. These 'Death Tapes' are also stored on the Trent Regional Health Authority computerised data base. Data were also collated on Deaths from 'Alcoholism', Alcohol Dependence Syndrome, Non-Dependent Alcohol Abuse (I.C.D.8 and 9 Codes 291, 303, 3050 - see above) but the numbers were so small, between 0 - 6 persons per county per annum, that statistical comparison would be valueless. The results of these data are not presented.

iii) Criminality

The Criminal Statistics were obtained from the Records Departments of the Police Forces of the three counties with the permission of the Chief Constables.

iv) Barrelage

The beer production data was obtained from the managing director of a local brewery who prefers that neither he nor his company be named.

v) Statistical Analysis

The data for these three county comparisons consist of a series of rates for each of the counties over a number of years, typically 1975 - 1985 inclusive. The usual method of analysing time-series data such as this is by fitting ARIMA models which allow for the possible autocorrelation of the observations between successive time - points. However ARIMA models require much longer time series than the ten years in this data set for accurate model fitting.

Thus the statistical method employed was to assume that the rates followed a Poisson distribution with mean μ and that

$$\log (\mu) = \Sigma \beta x$$

where x is the vector of explanatory variables and β are regression coefficients. This model is the standard analysis for count data of this type (McCullagh, P. & Nelder, J.A. 1983). The *Generalised Linear Interactive Modelling* (GLIM) Package was used for the analysis.

The explanatory variables fitted were COUNTY and YEAR. COUNTY was fitted as a factor on three levels. YEAR could have been fitted as a linear term and higher order polynomial terms formed and fitted. Instead YEAR was fitted as a factor as this overcame the problem of possible autocorrelation between successive time points and allowed for less systematic patterns over time. The main effects of COUNTY and YEAR were entered into the model. If subsequent inclusion of the interaction between

COUNTY and YEAR was significant this suggested that the patterns over time for the three counties were not consistent.

Also undertaken (In the INSERT at Page 142) was a Relative Risks Comparison of the three counties using the MINITAB programme.

The analysis on all these data was undertaken by Dr. Carol Jagger, Lecturer in Medical Statistics in the Department of Community Health at the University of Leicester.

Additional information on the statistical techniques used can be found in:

Healy, M.J.R. (1988) *GLIM, An Introduction.* Oxford. Oxford University Press.

McCullagh, P. & Nelder, J.A. (1983) *Generalised Linear Models.* London. Chapman and Hall.

d) DEMOGRAPHY OF LEICESTERSHIRE, NOTTINGHAMSHIRE AND DERBYSHIRE.

For two sections in results, referral rates and impact on the community, comparisons are made between what happened in Leicestershire and in two of its neighbouring counties, Nottinghamshire and Derbyshire. It is therefore appropriate to compare the demography and health and alcohol services of all three.

The counties of Derbyshire (D), Leicestershire (L) and Nottinghamshire (N) are adjacent and each has an area of about one thousand square miles (D:1016; L:986; N:836.), a population of a little under a million (D:910,700; L:884,860; N:995,340.), a county town of about a quarter of a million (D:217,000; L:282,300;

N:271,000.) with a large ethnic minority population. All three have large rural hinterlands and multiple Market Towns of 20,000 or so. Between the 1971 and 1981 Censuses, the populations of the three counties showed similar changes in sex and age distribution. (M:F Ratios, D 1971: 0.9722, 1981: 0.9661. L 1971: 0.9746, 1981: 0.9687. N 1971: 0.9712, 1981: 0.9632. Age Distribution Changes were 0 - 15: D - 2.8%, L - 2.7%, N - 3.6%. 16 - 34: D + 2.7%, L + 2.6%, N + 2.7%. 35 - Pensionable Age: D - 1.4%, L - 0.9%, N - 1.0%, Of Pensionable Age: D + 1.5%, L + 1.0%, N + 1.9%.

All three counties are in the East Midlands, an area which appears more prosperous than it is. It has below average unemployment (12.5% compared with the national average of 13.5%) but the lowest average rates of pay in Britain. There is a good deal of agricultural work, but mostly the area is light industrial: shoes, hosiery, knitwear and other light manufacturing. All three counties also have Coalmines, often running down. They even have similarly good County Cricket Teams and the cities have similarly erratic Soccer Teams!

Hospital Medical and Psychiatric care is provided in the three counties in the usual mixture of settings, Teaching Hospitals (L & N), District General Hospitals, Psychiatric Units in General Hospitals and Large Psychiatric Hospitals. (D,L & N) The number of beds per 10,000 are as follows: General Hospital (excluding Psychiatric): D 33.84 L 40.09 N 45.37 and all Psychiatric (excluding Mental Handicap) D 14.14 L 8.79 N 10.70. (All figures for 1985).

Services for people with Alcohol Related Problems are not immutable and there were changes in the services towards the latter part of the study period, for

instance the Development of D's Alcohol Advisory Services and very recently, D's N.H.S. Alcoholic Day Unit in Kingsway Hospital and N's Community Alcohol Team. With the advent of these developments, the purity of the natural experiment reduced (1986). During the majority of this study period, the services were as follows:

D had very little by way of specialist Alcohol Provision. It had two small relatively recently established Alcohol Advisory Services, in Chesterfield and Derby. (Total Specialist Staffing, all Non-statutory: 5.5.) Otherwise services for problem drinkers were aggregated into generic psychiatric or other provision.

N had, in the County Town, a progressive In-patient Alcohol and Drug Dependency Unit which offered structured inpatient programmes with developing outpatient and community work. It also acted as a secondary service with detoxication being undertaken on general medical and psychiatric wards. There was, also in the City, an active Alcohol Advisory Service which was a major educational resource as well as a Counselling Service and there was also a 'Dry House'. N's services were long established, and prior to the development of Alcohol Services in the other counties, the in-patient unit was the major Health Service resource in the Region for Problem Drinkers and Drug Users. (Total specialist staffing, Statutory: 14.5; Non-statutory: 3.5.)

L's services have already been described at length (Pages 76 - 85). Compared with the other counties it had a very large integrated Community based service, operating predominantly in people's homes. (Total specialist staffing; Statutory: 14, Non-statutory: 9.)

Chapter 6: RESULTS

a) REFERRAL RATES

Referral Data into the Leicestershire Alcohol Advice Centre are presented as Tables 6.1 - 6.4. All numbers cover the period April 1st. to March 31st. of the following year except for 1979 - 1980 which only covers the first nine months of the Centre's activities.

TABLE 6.1

REFERRALS INTO THE LEICESTERSHIRE ALCOHOL ADVICE CENTRE

	TOTAL	Male	%	Female	%	M/F Ratio
Jul 1979- Mar 1980	125*	76	60.8%	49	39.2%	1.55
Apl 1980- Mar 1981	332*	259	78.0%	73	22.0%	3.55
Apl 1981- Mar 1982	730	522	71.5%	208	28.5%	2.51
Apl 1982- Mar 1983	687	443	64.5%	205	29.8%	2.16 (N/K 39)
Apl 1983- Mar 1984	631	410	65.0%	221	35.0%	1.86
Apl 1984- Mar 1985	615	416	67.6%	199	32.4%	2.09
Apl 1985- Mar 1986	738	522	70.7%	216	29.3%	2.42
Apl 1986- Mar 1987	827	549	66.4%	278	33.6%	1.97
Apl 1987- Mar 1988	760	507	66.7%	249	32.8%	2.04 (N/K 4)
Apl 1988- Mar 1989	822	554	67.4%	266	32.4%	2.08 (N/K 2)

N/K = Not known

Between 1976 and 1978, the Author provided an outpatient clinic for new referrals and follow-up groups for drinkers who had been admitted to the acute general psychiatry wards by colleagues. That was little more than the patients had received from the general psychiatrists.

The Community Alcohol Team came into existence in April 1978 and received referrals direct from General Practitioners and other primary care workers. Its arrival marked a real increase in service provision, even though it was relatively small in 1978 - 1979. (See Development of the Services, pages 86-92) The referral numbers into the total services are shown below:

	TOTAL	C.A.T.	A.A.C.	Transfers	Re-referrals
1978 -79	250	250			36
1979 -80	460	371	125	36	16
1980 -81	615	433	332	150	44
1981 -82	730	(504)	730	485	70

Transfers are cases assessed at the Alcohol Advice Centre (A.A.C.) and referred to the Community Alcohol Team (C.A.T.) for more intensive work.

Except for some "personal" re-referrals and referrals direct to the Author by primary care agents insisting on a medical opinion, since April 1981, all referrals were, if possible, diverted to the Alcohol Advice Centre which then became the common entry point for the whole community service. The referral numbers since that time represent the best estimate of service activity. There remains some "leakage" but that has not been quantifiable. To reflect the fact that the Alcohol Advice Centre was not the main point of entry into the

services until April 1981, the totals reported for the early years are marked with an asterisk.

TABLE 6.2:

REFERRALS IN AND OUT OF THE LEICESTERSHIRE ALCOHOL ADVICE CENTRE

	REFERRAL AGENT (%)					REFERRED TO C.A.T.	
	SELF	REL	MED	OTH	N/K	n	%
Jul 1979-Mar 1980	45 (36.0)	42 (33.6)	5 (4.0)	27 (21.6)	6 (4.8)	36	28.8
Apl 1980-Mar 1981	129 (38.9)	68 (20.5)	8 (2.4)	122 (36.7)	0 (0.0)	150	45.0
Apl 1981-Mar 1982	177 (24.2)	134 (18.4)	215 (29.4)	177 (24.2)	28 (3.8)	485	66.4
Apl 1982-Mar 1983	164 (23.9)	86 (12.5)	229 (33.3)	167 (24.3)	41 (6.0)	407	59.2
Apl 1983-Mar 1984	158 (25.0)	127 (20.1)	235 (37.2)	111 (17.6)	0 (0.0)	330	52.3
Apl 1984-Mar 1985	244 (39.7)	47 (7.6)	213 (34.6)	103 (16.7)	8 (1.3)	403	65.5
Apl 1985-Mar 1986	285 (38.5)	82 (11.1)	264 (35.8)	94 (12.8)	13 (1.8)	475	64.4
Apl 1986-Mar 1987	339 (40.3)	99 (11.4)	250 (30.0)	139 (17.8)	0 (0.0)	438	52.9
Apl 1987-Mar 1988	308 (40.5)	116 (15.3)	231 (30.4)	98 (13.0)	7 (0.7)	394	51.8
Apl 1988-Mar 1989	387 (47.1)	126 (15.3)	202 (24.6)	104 (12.7)	3 (0.4)	425	51.7

The seemingly very large increase in referrals in 1981 year particularly of (MED) Medical Referrals (from General Practitioners, Health Visitors, General Hospitals and Psychiatrists) is explained above . Self-referrals (SELF) have shown a gradual increase over the decade, but referrals from relatives and friends (REL) have been more constant. Referrals from other (OTH) sources include from Social and Probation Services, Voluntary Organisations, Hostels, Employers and the Job Centre.

TABLE 6.3:
AGE OF REFERRALS INTO THE LEICESTERSHIRE ALCOHOL ADVICE CENTRE

AGE	<20		20-29		30-39		40-49		50-59		>59		N/K	
	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
Jul 1979- Mar 1980	1	(0.8)	11	(8.8)	23	(18.4)	19	(15.2)	11	(8.8)	10	(8.0)	50	(40)
Apl 1980- Mar 1981	6	(1.8)	26	(7.8)	42	(12.7)	71	(21.4)	23	(6.9)	8	(2.4)	156	(47)
Apl 1981- Mar 1982	14	(1.9)	119	(16.3)	198	(27.1)	172	(23.6)	105	(14.4)	46	(6.3)	76	(10.4)
Apl 1982- Mar 1983	8	(1.2)	98	(14.3)	199	(29.0)	146	(21.3)	89	(12.5)	47	(6.5)	100	(14.5)
Apl 1983- Mar 1984	8	(1.3)	82	(13.0)	164	(26.0)	130	(20.6)	70	(11.1)	35	(5.5)	142	(22.5)
Apl 1984- Mar 1985	10	(1.6)	75	(12.2)	183	(29.7)	150	(24.4)	83	(13.5)	44	(7.2)	73	(11.9)
Apl 1985- Mar 1986	12	(1.6)	120	(16.3)	206	(27.9)	170	(23.0)	78	(10.6)	45	(6.1)	107	(14.5)
Apl 1986- Mar 1987	23	(2.8)	103	(12.4)	201	(24.3)	179	(21.7)	79	(9.5)	52	(6.3)	191	(23.1)
Apl 1987- Mar 1988	24	(3.1)	93	(12.2)	208	(27.4)	183	(24.1)	63	(8.3)	42	(5.5)	147	(19.3)
Apl 1988- Mar 1989	20	(2.4)	114	(13.9)	209	(25.4)	184	(22.4)	86	(10.5)	46	(5.6)	163	(19.8)

TABLE 6.4:
EMPLOYMENT STATUS OF REFERRALS INTO THE LEICESTERSHIRE ALCOHOL ADVICE CENTRE

n (%)	EMPLOYED	UNEMPLOYED	HOUSEWIFE	OTHER/N/K
Jul 1979- Mar 1980	39(31.2)	37(29.6)	20(16.0)	29(23.2)
Apl 1980- Mar 1981	123(37.0)	153(46.1)	41(12.3)	15(4.5)
Apl 1981- Mar 1982	226(31.0)	345(47.3)	30(4.1)	129(17.7)
Apl 1982- Mar 1983	181(26.4)	313(45.5)	31(4.5)	162(23.6)
Apl 1983- Mar 1984	189(30.0)	214(33.9)	14(2.2)	214(33.9)
Apl 1984- Mar 1985	170(27.7)	249(40.5)	36(5.9)	160(26.1)
Apl 1985- Mar 1986	181(24.6)	313(42.4)	41(5.5)	203(27.5)
Apl 1986- Mar 1987	209(25.2)	256(31.0)	23(2.8)	339(41.0)
Apl 1987- Mar 1988	242(31.8)	241(31.7)	10(1.3)	267(35.1)
Apl 1988- Mar 1989	310(37.7)	181(22.0)	28(3.4)	303(36.8)

These 'customers' were thus notably typical of presenters to alcohol services elsewhere in Britain. Compared with the 1965 Camberwell data (Edwards, G., Hawker, A., Hensman, C., Peto, J. & Williamson, V. 1973), still the most widely quoted source, these Leicestershire drinkers were somewhat younger with more women. In part this is explained by the Camberwell study containing a higher proportion of vagrants (32.2%) compared with 24.2% in this sample for dwellers in Hostels (including the Resettlement Unit), Institutions and being of no fixed abode, Leicestershire's equivalent of vagrants (see below). Over the study period, there was a consistent trend towards more women and younger presenters.

b) COMMUNITY ALCOHOL TEAM CLIENT CHARACTERISTICS

These data were extracted from the initial assessment questionnaire (Appendix 1), which was completed on 162 consecutive referrals into the Community Alcohol Team during a formal evaluation project undertaken between September 1981 and January 1982.

i) Demography of the Sample

There were 113 (69.8%) males and 49 (30.2%) females, making a male:female ratio of 2.3 : 1. The mean age of the total sample was 39.13 years (Standard Deviation 13.2) with a range of 79 years (16 - 95 years).

Place of birth of the subjects was as follows:

England	68.6%
Scotland	13.7%
Ireland	10.5%
Wales	0.7%
E.Europe	0.7%
Asian	5.9% (Indian or East African born)

Marital Status was as follows:

Single	31.5%
Married	29.6%
Separated	16.0%
Divorced	17.9%
Widow/er	4.9%

Crosstabulations show a very stable married sample, with 92% of those married having been so for more than five years. The divorcees were more variable in the recency of the divorce and of those separated, 77% had been so for five years or less.

In answer to the question "With Whom Living?" the following responses were given:

Alone	18.5%
Spouse	29.6%
Children only	4.3%
Parents	12.3%
Other relative	1.9%
Residents/Lodgers	25.9%
Cohabite(e)	7.4%

The large proportion of customers living with other residents or lodgers is a reflection of the close relationship between the Services and the local resettlement unit, which provides 100 beds for men 'of an unsettled way of life'.

The types of dwellings in which customers were living were as follows:

House	59.6%
Flat/Bedsit	10.5%
Lodgings	4.3%
Hostel	21.7%
Institution	0.6%
N.F.A.	1.9%
Prison	1.2%

Their employment status was:

Employed - Full time	24.2%
- Casual	1.8%
- Self	3.1%
(Total in employment...	29.1%)
Housewife	7.3%
Education/Training	0.6%
Retired	4.2%
Disability Pension	3.6%
Unemployed	54.9%

Thus the users of the Community Alcohol Services manifested a wide spectrum on measures of social stability, but there was a higher proportion of unemployed persons and dwellers in Hostels/Bedsits than in the general population. The latter is accounted for, as previously stated, by the presence of the resettlement

unit. The reason for the higher rate of unemployment (compared with the 12.5% county figure) will not be pursued. It is a common finding in any group of presenters to 'caring' service.

Comparisons between the Subset of 30 who were to have their 'treatment' examined in more detail and the main sample revealed no significant differences on main variables using Mann-Whitney U-tests and $\chi 2$ Tests. The Subset could thus be regarded as truly random.

An analysis was done of the entire sample by breaking it down into three groups, Leicestershire-resident Females, Leicestershire-resident Males and (all male) Resettlement Unit Visitors. This yielded predictable demographic results which will not be presented in detail here.

From these multiple comparisons, the men-only D.H.S.S. Resettlement Unit sample was consistently less socially stable than their Leicestershire resident male counterparts in terms of Marital Status, Housing, Employment and job stability. They tended to be single men from an unstable Hostel-type setting who were unemployed, both in the past and currently.

The differences between resident males and resident females were also significant; with the females tending to show a higher proportion of intact marriages, to live in houses as opposed to Lodgings, Flats etc., and to be either employed or housewives.

Sources of Referral were as follows:

Medical	36%	
- G.P.		-21%
- Hospital		-15%
Other Professionals	18%	
- Probation		- 7%
- Social Services		- 8%
- Day Centres		- 2%
- Court		- 1%
Resettlement Unit	17%	
Self Referrals	21%	
Non-professionals (Relatives etc.)	7%	

ii) Alcohol Use at Initial Assessment

Perception of Problems.

All customers were asked to rate the seriousness of their drinking on a 10-point scale (0 = Not at All, 10 = Extremely Serious) according to how much it interfered with their lives. 25.5% rated their problem as not terribly serious, i.e. a score of 5 or less with 10% claiming it not to be a problem at all. But the majority said that drinking was a serious problem, with 42% scoring it as maximally problematic.

Ideas of what was wrong with their drinking involved concepts such as 'too much' and 'can't stop', with 54.5% of the sample thinking that that was their problem. Only 9% said that it was interfering with their lives and only 6.9% reported that it demeaned them personally. 4.8% confessed that 'it costs too much' and 4% thought it was a problem because it enabled them not to deal with problems of living. 12.4% thought there was nothing whatsoever wrong with their drinking.

When asked for how long they considered their drinking to have been problematic, 16% considered it to have been

a problem for less than one year, 33% for between 1 - 5 years, 28% for 6 - 10 years, 19% for 10 - 20 years and 4% for more than 20 years.

So, not only did the customers believe they had a serious problem with alcohol, the vast majority considered that it had been a problem for at least a year (84% of the Sample).

Despite this, when asked why they had referred, only 35.8% came for help because of internally oriented reasons. The other 64.2% admitted to being under external pressure to attend, as is shown below:

INTERNAL:	
"Just Decided"	16.4%
Frightened, worried	10.1%
Health Problems	6.3%
Shame/Guilt	3.0%
TOTAL	35.8%
EXTERNAL:	
Medical Pressure	26.4%
Other Professional	15.7%
Family/Spouse Pressure	12.6%
Legal Trouble	5.7%
Pressure from Friends	2.5%
Employment Problems	1.3%
TOTAL	64.2%

68% of the sample had tried to stop drinking for more than one day since they recognised that they had a problem and the majority suceeded for 1 - 6 months. But only 14% managed 7 - 12 months, 6% for 1 -2 years, 3% for 2 - 3 years and only 1% for more than 3 years.

The reasons given for attempting abstinence were as follows:

Dry Environment (Prison, Hospital etc)	38%
Health Reasons	11%
Lack of Problems	10%
"I decided to"	30%
Social Pressure	7.4%

Social pressure was from friends; family pressures had no reported influence at all for any of the subjects.

Drinking Habits.

Reported early drinking patterns revealed that these drinking careers started between the ages of 14 - 18 years, with three-quarters of them having an initial beverage choice of Beer, with 13% starting on Wine and 14% on Spirits. There were sex differences reported, with 51% of the women being initiated on Wine or Spirits as opposed to 86.6% of the men starting on Beer.

Quantities Consumed at the time of initial assessment were converted into 'Units of Alcohol' where 1 Unit = ½ Pint of Beer or Cider = 1 Glass of Wine = 1 small Glass of sherry or other fortified wine = 1 single measure of Spirits. These all contain approximately 10 mls. or 8 gms. of Absolute Alcohol.

The mean for the whole sample was 26.9 Units per drinking day, (Standard Deviation 15.5, Median 25.17, Range 4 - 74 Units) which is the equivalent of a bottle of Spirits. There were highly significant differences between the Resettlement Unit Sample and the Leicestershire-resident Males ($z = -3.69$, $p < 0.0002$), with the Resettlement Unit males drinking a minimum of a bottle of Spirits or equivalent per drinking day while

only 53.5% of the Leicestershire-resident males consumed at that level or above. Leicestershire-resident females also differed from their male equivalents ($z = 3.157$, $p \leq 0.0016$). Only 18.4% of the females drank the equivalent of a bottle of Spirits per day, the majority drank between 10 - 20 Units per drinking day.

Frequency of Drinking was as follows:

Daily	47.5%
Most Days	15.0%
2-3 times weekly	9.4%
1 Day per week	2.0%
Weekends only	2.0%
2-3 times monthly	0.6%
Binges	23.8%

Again there were differences between the resettlement unit visitors and the rest of the sample ($\chi 2 = 23.33$, $p \leq 0.0003$). This was because 63% of the resettlement unit residents described themselves as binge drinkers, with only 22% drinking daily whereas binge drinking accounted for only 6.5% of the Leicestershire-resident males, with 57% drinking daily. There were no male/female differences in the Leicestershire-residents. Daily drinkers covered the whole range of consumption levels whereas weekend-only drinkers tended to be heavy consumers at that time.

There were significant differences in beverage choice between the females and Leicestershire-resident males, ($z=-3.27$, $p \leq 0.0011$), with females preferring Sherry and Spirits and males preferring Spirits and Beer. No women reported getting into difficulties with Beer consumption whereas 31.4% of the males did.

Reported time of starting to drink showed that 68% of the sample had started drinking, on drinking days, by

midday, with 42% engaging in early morning drinking. There were no male/female differences, but again the Resettlement unit sample were significantly different from the Leicestershire-resident males ($z = -2.599$, $p \leq 0.0093$) with 74% reporting this time of starting to drink as opposed to 38.8% for the rest of the males. As one would anticipate, the resettlement unit men also reported significantly longer drinking sessions.

Men preferred drinking in Public Houses, with three-quarters of them drinking there, whereas women preferred drinking at home with 79.2% of them drinking there. That is again significant ($\chi 2 = 42.43$, $p \leq 0.0000$) . Only the resettlement unit men drank with any frequency (15.4 %) in the open air. (park benches etc)

Solitary drinking was the norm for both sexes, but with significant differences between them. 92% of Women and 64% of Men drank alone ($\chi 2 = 13.08$ $p \leq 0.0045$). These data and the last on site of drinking confirm the stereotype of the solitary home-based female drinker. Their male equivalent is also drinking alone but in a public drinking place.

Reports of physical withdrawal phenomena, complications and associated phenomena were surprisingly infrequent. with a mean on the three checklists with maximum scores of 9, 9 and 10 being only 2.5, 2.0 and 1.9 respectively. These data were not prompted, but volunteered. There is little doubt that higher scores would have been obtained if these people had been 'fed' symptoms, but that was deliberately not done.

Insight into Drinking.

Customers were asked what alcohol tended to do for them, what triggered off a drinking session and how responsible they felt about it. There were no differences between Leicestershire-resident men, women or the resettlement unit visitors in these responses.

52% reported deriving some sort of positive effect from drinking, with 31.2% claiming an improvement in mood and/or social skills; 13.6% reporting an anxiolytic effect.

48% reported negative effects, comprising 13.6% reporting Depression, 4.5% Sleepiness and 15.6% verbal and/or physical aggression.

Only one person in the entire sample could not specify exactly what he got out of drinking in terms of effects on mood or behaviour, thus demonstrating that the whole sample showed a high degree of insight. The same was true about their description of the 'triggers' or 'cues' which initiated drinking sessions. Only 2.6% claimed to have "no reason", and 8% said it was simply habit. 74.4% attributed the start of a drinking session to internal factors, with 22% citing boredom and loneliness, 16% Depression and 7.7% Anxiety. 'To forget' was mentioned by 3.8%

The 25.6% who claimed their drinking was externally triggered cited family or work pressures in 15.4%, available cash for 4.5% and a specific time such as 'opening time' in 3.2%. Nobody mentioned positive reasons, parties or celebrations as cues relevant to resuming drinking.

Consistent with this high level of knowledge and understanding about their drinking was their feeling of responsibility for their problematic use of alcohol. Subjects were asked to rate their personal responsibility for drinking on a 10 - point scale (1 = None, 10 = totally) and the results of this are shown as Figure 6.1. 54.1% claimed to be fully responsible and 80.4% mostly so. Of those who did not feel totally responsible, only 20% could think of anything or anybody else whom they would claim were responsible. 28% saw it as the result of a generally unstisfactory life, 28.1% blamed domestic relationships and for the rest (21.8%) bad company, recent disappointment or work pressures.

iii) Problems of Living

Domestic Problems.

Those in some form of domestic relationship were assessed by using rating scales to measure total quality of the relationship (1 - terrible, 10 - excellent) extent of conflict (1 - none, 10 - extreme) and the percentage of that conflict not related to Drinking. There were no differences between men and women on these variables.

The average for the total quality of the relationship was 6.2 (S.D. 3.0, Median 7.1, Mode 8). However despite this satisfactory perception, the amount of conflict was also high, with a mean of 6.18 (Median 6.9, Mode 10) with 26% rating the conflict as maximal. This was attributed predominantly to their drinking habits with 51% stating that 'they never row about anything else'. Only 18% believed that their drinking was less than half the cause of the conflict.

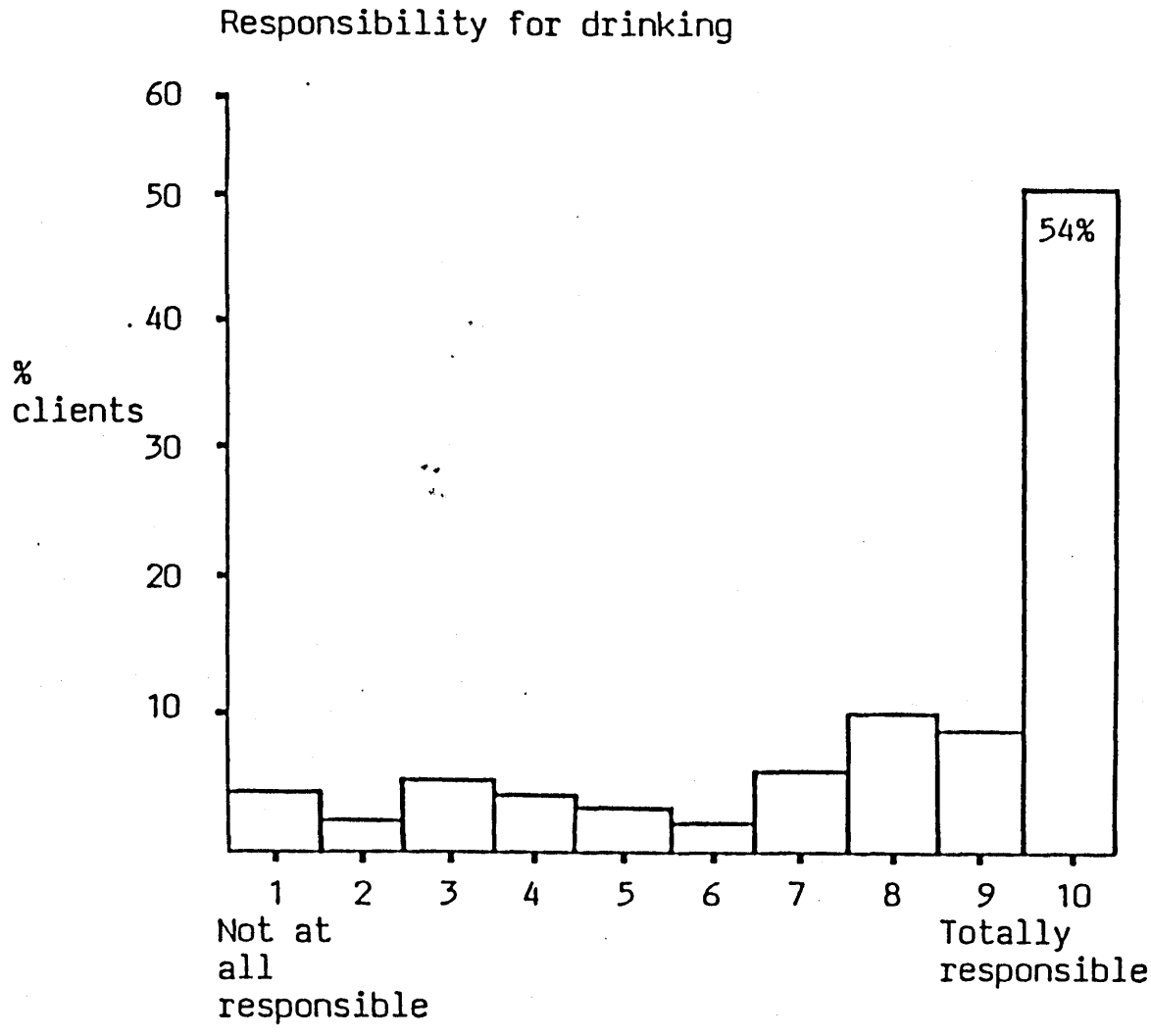

Responsibility for drinking
60
50
40
%
clients
30
20
10
54%
1
2
3
4
5
6
7
8
9
10
Not at
all
responsible
Totally
responsible

FIGURE 6.1.

Employment Problems.

For the minority of the sample who were employed at the time of initial assessment, a 10 - point rating scale on job satisfaction was used. There was a significant difference between men and women on this ($z = 2.593$ $p \leq 0.0095$). Men were very much more satisfied with their jobs, 91.4% rating it above 5, but women had lower satisfaction with only 50% so rating it. 87% of the total sample rated satisfaction with co-workers as very good or excellent on a similar 10 - point scale.

Involvement with Police.

As would be expected, the Resettlement Unit Sample had significantly more criminal history (81.5%) than did the Leicestershire-resident males (67.1%) than did the Females (27.7%). The differences were all significant.

Self Esteem.

The whole sample tended to be negative about itself showing ratings on a 10 - point scale at a mean of 4.26 with 24% of the sample rating themselves at 1, the lowest point. Leicestershire-resident male/female differences emerged as not quite significant, ($p<0.0625$) with women having lower scores than men, but there were significant differences in the reasons given for the low self-esteem rating. ($\chi 2$ 15.49, $p \leq 0.033$) Men (22%) claimed more frequently than women (8%) to be having a bad effect on others whereas women appraised themselves negatively because of general failure and underachievement.

13% of women compared with 3% of men claimed that their drinking problems further reduced their self - esteem.

iv) Perceived Needs

As has been stated previously, the Leicestershire Community Alcohol Services attempt to meet the needs of their customers. Therefore a vital part of the initial assessment is to ask the customer what they think it would be helpful for the services to provide for them: that is what are their perceived needs. These Data are presented as Table 6.5. below. But the most striking finding on asking such a question is that the users of the service had a very clear and often specific need which they believed that the services would 'be good for'. Further, they did not transact only in terms of needs related to their alcohol use, but were equally able to define their life-related problems:

As over half the sample claimed that they were drinking too much or that it was out of control, it is no surprise to find controlled drinking training, followed by abstinence training in great demand. Similarly, given the knowledge and understanding demonstrated by these people about their alcohol use and problems, their requests for insight into their drinking, "I want to know why I do it", and for straight factual information about alcohol were negligible. Also of note is the low level of request for help with physical problems related to alcohol use. This is consistent with their low level of complaint. These subjects were not overly concerned with the physical problems related to their alcohol use even if they were aware of them.

TABLE 6.5:

PERCEIVED NEEDS OF SERVICES USERS AT ASSESSMENT

PERCEIVED NEEDS	FREQUENCIES (%)		
	Males	Females	R. Unit
Drink-related			
None	7.0	4.1	0.0
Abstinence Training	10.5	14.3	14.8
Controlled Drinking	40.7	38.8	48.1
Insight into Drinking	2.3	2.0	3.7
Detoxication - Home	3.5	6.1	0.0
- Hospital	8.1	0.0	0.0
Medication (Chlormethiazole or Disulphiram)	2.3	2.0	0.0
Dry House	8.1	0.0	25.9
(Education in Alcohol	0.0	0.0	0.0)
Life-related			
None	4.7	2.0	0.0
General Support/Advice	25.6	12.2	11.1
Marital Couselling	15.1	32.7	0.0
Job/Financial Counselling	8.1	14.3	33.3
Leisure Counselling	5.8	10.2	3.7
Other Medical Help	5.8	2.0	0.0
Social Skills/ /Assertion Training	3.5	12.2	3.7
Problem Solving Skills	5.8	2.0	0.0
Accommodation	5.8	10.2	51.9
Other Psychiatric Help	2.3	0.0	0.0

There was also matching between the perceived problems of living and the help requested. General Support and Advice, however, reflects such comments as " I just want someone to talk things over with." The relatively high level of requests for marital counselling appears to reflect the high levels of reported conflict, not the perceived underlying soundness of the marriages. Low levels of requests for skills training probably reflects the customers' unawareness of the availability of these. It was no surprise that the homeless men of the resettlement unit's predictable response was that "if they had a job and a flat, they would be fine!"

Between the sexes, there was a 75% convergence on percentage identification of needs, with the drink related needs differences reflecting those interventions that involved leaving home: Dry House Accommodation ($z = 2.043$, $p \leq 0.041$) and Hospital Detoxication (also $z = 2.043$, $p \leq 0.041$). Life related needs differed in that more women than men sought Marital Counselling ($z = -2.38$, $p \leq 0.017$ and Social skills/Assertion Training ($z = -1.95$, $p \leq 0.05$).

c) TREATMENT

i) What the Therapists Saw

As can be seen in Table 6.6. below, the staff of the Community Alcohol Services show a high level of agreement with their customers on the percentage identification of individual treatment needs. There were four areas of significant discordance, and all of them were in the drink-related categories. They were on the need for:

Abstinence Training	($\chi 2$ = 17.053,	$p \leq 0.000$)
Controlled Drinking	($\chi 2$ = 4.645,	$p \leq 0.031$)
Home Detoxication	($\chi 2$ = 12.071,	$p \leq 0.001$)
Dry House Accommod.	($\chi 2$ = 8.45,	$p \leq 0.004$)

In the first two categories, generally, more customers than therapists saw the need for these with all cases of discrepancy on abstinence training and 71% of cases on controlled drinking training being in that direction. Thus, the therapists appeared not at all preoccupied with attempting to enforce cessation of drinking, and although they recommended controlled drinking for more of their customers, they were less likely to recommend it as an initial need. The latter two were in the opposite direction, with more staff than customers perceiving the need for these, which may be explained by the therapists greater knowledge of available resources.

Concordance at initial assessment on the number of people for whom each life-related need was seen as appropriate was 100%, that is the therapists shared the customers' perceptions of their life problems.

TABLE: 6.6.

PERCEIVED NEEDS FOR TREATMENT AT INITIAL ASSESSMENT vs. TREATMENT PROGRAMME

	NEEDS		TREATMENT FOCI
	Clients	Assessors	
	%Identified	%Identified	% Occurrence
Drink Related Needs			
Abstinence Training	12.3	0.6**	23
Controlled Drinking	41.4	33.3*	33
Insight into drinking	2.5	3.7	13
Detoxication - Home	3.7	12.3**	10
- Hospital	4.3	3.7	10
Medication	1.9	1.2	7
Dry House Accommodation	8.6	17.3**	10
Education in Alcohol	0.0	2.5	7
Life Related Needs			
General Support/Advice	19.1	21.0	10
Marital Counselling	17.9	21.0	47
Job/Finance Counselling	14.2	14.2	37
Leisure Counselling	6.8	12.3	33
Other Medical Help	3.7	2.5	7
Social Skills/ Assertion Training	6.2	7.4	33
Problem Solving Skills	3.2	2.5	7
Accommodation	14.8	9.8	20
Other Psychiat. Help	1.2	2.5	7

** $p < 0.01$ level of significance,

* $p < 0.05$ level of significance

Crosstabulations were performed on the quantities of needs reported. For the customers, but not shared by the therapists, there was a negative relationship between drink- vs. life- related needs ($\chi 2 = 18.2$, $p \leq 0.03$.) . Simply, the more drink-related needs a customer presented, the less life related needs were initially presented and vice versa.

ii) What the Customers actually got

A subset of 30 was selected for examination of treatment foci. It was not significantly different from the main sample (see above).

McNemar tests of significant matching (Siegal, S. 1965) were utilised and did not yield high results. They showed only 55% Concordance between customer's initially perceived needs and the exact treatment package. But the concordance needed to be perfect. For instance, if abstinence was the customer's goal then only abstinence training would be a match for it. Detoxication, which may well be an appropriate first step, would be regarded as a mis-match. Nonetheless, using even that narrow focus, there were significant findings. There was a higher rate of Concordance between therapists' perception of customers' needs and what was actually provided (70%). There was, using the same statistic, a 79% treatment rate for drink-related perceived needs and 62% rate for life-related ones. The corresponding treatment figures for customers' perceived needs were 61% and 42% respectively.

However, when the full treatment programmes were examined, it was found that they comprised only 38% of the foci identified at initial assessment. Thus, almost two-thirds of the treatment was on specific foci that neither therapist nor customer identified at initial

assessment. Despite this, 66% of customers (at follow up) reported that they thought the treatment was totally appropriate! This reflects a process of gradual unfolding of needs and negotiation of treatment foci during the whole intervention. Spearman's Rank Correlation Coefficient confirmed this by demonstrating a positive correlation between the number of weeks in contact and the number of drink-related foci (R_S = +.712, $p \leq 0.01$) and the number of life-related foci (R_S = + .536, $p \leq 0.01$). The longer customers were in contact the more 'packages' they got.

iii) Treatment Efficacy

These data are the weakest in this part of the study because of a very high attrition rate. They comprise first 'Reassessment' data on a total of 77 (ex 162) customers at between 4 and 20 weeks after the initial assessment and on 61 (ex 162) at 'Follow-up', which took place three months after closure of contact, that is at approximately six months after initial assessment.

Those unavailable for second follow up could be accounted for thus:

Still in active contact or not yet closed for three months;	41	(25.3%)
Left Resettlement Unit	23	(14.19%)
Dead	4	(2.4%)
In prison	7	(4.3%)
Moved House and un-contactable	10	(6.2%)
Cancelled visits	4	(2.4%)
Not in when visited	9	(5.5%)
Totally lost	2	(1.2%)

Thus there is a bias away from the unstable resettlement unit residents who tend to wander the country anyway, away from cases who became involved in more protracted interventions and away from unstably-housed people. This was clearly a follow-up reserved for 'good bets'!

The results, however are striking even taking account of those major biases, and show myriad significant changes.

Drinking

Consumption levels showed highly significant changes over the total measurement ($\chi 2 = 52.69$, $p \leq 0.000$) which was achieved during treatment ($z = -6.56$, $p \leq 0.000$) and maintained during follow-up. (n.s., $p \leq 0.976$). The average number of Units per drinking day fell from the initial assessment mean of 26.9 Units to 10.72 at first drinking day and 11.05 at follow-up.

Frequency of drinking sessions also reduced, with a 23% reduction in daily drinking and a 20% increase in drinking 2 - 3 times per week and a 12% increase in those drinking 2 - 3 times per month. There was also a dramatic drop of binge drinkers from 23.8% at initial assessment to 5.3% at Reassessment and 8% at Follow-up. This can be accounted for by the high attrition rate of the Resettlement Unit Residents.

Time of day of starting to drink became later. Early morning drinking at follow-up was undertaken by 27% of the sample compared with by 43% at initial assessment. During treatment, i.e. at Reassessment, the percentage was very low (5.3%) but rose again after its cessation.

Almost half the sample at follow-up had shifted their drinking to an early evening start.

Related to the previous finding, there was a significant reduction in length of drinking sessions ($\chi 2 = 29.866$, $p \leq 0.000$) which occurred during treatment ($z = -5.164$, $p \leq 0.000$), with sessions for 58.3% then lasting 1 - 4 hours.

Drinking site showed no significant changes, but drinking company showed changes. There was a drop in solitary drinking from 73.5% at initial assessment to 57% at Reassessment to 44.7% at Follow-up. Concomitant with this, there was an increase of 16% in those drinking with friends (as opposed to 'pub mates') and an increase of 15% in drinking predominantly with spouse and/or family.

Along with these changes, there was a significant reduction in reported physical withdrawal phenomena ($\chi 2 = 20.074$, $p \leq 0,000$), physical complications ($\chi 2 = 30.787$, $p \leq 0.000$) and associated phenomena ($\chi 2 = 30.156$, $p \leq 0.000$) over the whole study period. There appeared to be a virtual cessation of physical problems concomitant with the reduction in reported consumption.

In the light of the dramatic changes reported, it was not surprising that at Reassessment, 81.8% of the sample reported that their drinking patterns had changed (whether for the better or the worse) and that that change appeared relatively stable, for at Follow - up the percentage remained 80.3%. Further 65% claimed maintenance of a new stable pattern for between 2 - 6 months. However, there was a remaining 20% who noted absolutely no changes in their drinking.

Attempted abstinence was also commonly reported, with 82% reporting at least two days of abstinence by Reassessment and 79.7% between then and Follow - up. Reasons given included as proof of self control. i.e. to prove to themselves or to others that they could do it. Unavailability and absence of finance accounted for only 15% of the subjects. Stable abstinence was reported by 40%, who were sober at Reassessment and had been so for the previous week. At Follow - up, that figure had dropped to 24.4%

Although there was a small increase in those reporting positive effects in mood, social performance and self concepts (12%) and a corresponding reported decrease in negative effects, i.e. depression, aggression, these were not significant. There was a shift in cues and triggers from internal to external, with the greatest increment between Reassessment and Follow - up. That is, it appears to be something that customers notice once left to their own devices. They report drinking not because of such phenomena as depression, loneliness and anixety but because of the presence of friends, as evidenced by an increase in external cueing from 1.9% to 24.9%. About the same percentage of people reported drinking in response to family or business pressures and to the availability of cash.

There were also dramatic changes in what people still perceived to be wrong with their drinking. Perceived excessive drinking fell from 34.5% at initial assessment to 20.8% at Reassessment to 11.9% at Follow - up, and perceived loss of control from 26.2% at initial assessment to 3.9% at Reassessment to 6.8% at Follow - up.

Even though it started at a very high level, Self - responsibility shifted to an even higher level. ($\chi 2$ = 10.99, $p \leq 0.000$), which occurred during treatment (z = - 3.89, $p \leq 0.000$) and remained present at follow - up. There was no change in the mean, simply a tighter clustering around the self - responsibility end of the rating scale. Those few who still attributed responsibility to external factors, 13% continued to attribute their drinking to their spouse or family situation, and 7.5% claimed that the change was the result of professional intervention.

Social Stability

There were no significant changes in these measures apart from those which can be attributed to the virtual absence of follow - up data from the men from the resettlement unit.

Problems of Living

There was no significant change in reported overall quality of domestic relationships, but they did start at a relatively high level. However, reported conflict did reduce significantly. ($\chi 2$ = 7.128, $p \leq 0.028$). It was marked at reassessment (z = - 4.75, $p \leq 0.000$), but increased again minimally by follow - up. ($p \geq 0.211$). At initial assessment, only 43.3% of the sample rated conflict at less than 5 on the 10 - point rating scale. At Reassessment and Follow - up those figures became 73.2% and 71.4% respectively.

Changes in Employment Status and in involvement with the law were insignificant.

There was a transient increase in self - esteem between initial assessment and Reassessment (z = -4.780,

$p \leq 0.000$), but it was not maintained until Follow - up. Examination of the scores showed that the skew towards the negative end of the rating scale at initial assessment was replaced by a skew towards the positive end at Reassessment and then a split into a bimodal distribution, with peaks at both ends of the scale at follow - up.

Customer's View of Treatment

60% of the sample said at Reassessment that they felt better than they did at initial assessment, but 14% reported no change and 26% said they felt worse. Reasons for changes in feelings were given as Help from Prime Therapist (22.2%), Drinking Changes (15.6%) and changes in life events (15.6%).

The customers were also asked to rate the helpfulness of the Prime Therapist on a 10 - point Scale and this yielded a positive score with a mean of 7.2 (Median 7.3, Mode 10). At least 70% of the Follow - up sample rated the Community Alcohol Services as very helpful or better. For 20% the Services were reported as useless, and for the remaining 10% the Services were reported as having done more harm than good.

d) IN THEIR OWN WORDS

The previous sections of this chapter consist of a categorical and numerical analysis of customers of the Community Alcohol Team and of their 'treatment'. By its very nature, such an analysis cannot convey the richness and diversity of the accounts given by clients of their alcohol use, their problems, their views of themselves and the changes (if any) that they experienced during their time in contact with their therapists.

As can be seen in Appendices 1 and 2, these people were asked a number of open questions and encouraged to answer them in their own words. This section simply records a representative sample of those statements, which were obtained by examining all the Assessment and Reassessment Forms of the 77 subjects who had completed both a first and a subsequent interview.

i) Initial Assessment

Behavioural/mood effects of alcohol (i.e. What do they get out of it)?

I can't get going without it. I can't help it. Initially it lifts my spirits. I feel good for a few moments and awful afterwards. It gets rid of anxiety and feelings of loneliness. I get nothing out of it: it's all in my mind. When I'm drinking, I'm permanently hazy. I feel more myself. It makes me more adventurous. It gives me Dutch Courage to associate with people. It gives me confidence. It helps me to be among the crowd. I mix better. It blots out loneliness. It gives me more energy . It makes me feel marvellous, great. It makes problems go away. I get peace, I escape from the kids. It helps me unwind. It helps me relax. It's an antidepressant. It brings happiness. It helps me sleep. I achieve oblivion.

What is wrong with their drinking, according to them?

It's killing me. I can't stop when I start. I can't control it. I can't stop. Too much. Excessive. Too much in one go. Too much, too often. It's a bit more than moderate. It's no problem when I'm in company, it's uncontrolled when I'm alone. If it's there, I have to drink it. I like it but my family don't like me doing it. I'm not drinking socially. I can't cope without it, I can't control it. It makes me violent. I climbed the Clock Tower [Leicester's City Centre Landmark] and got into trouble with the police. It's a habit. It costs too much. It's a silly thing to do. I can't stand it anymore. It's secretive. It's no problem, it's moderate!

How do they feel about themselves as a person?

I'm worse than a very heavy drinker. I've reached very low standards, I don't care about other people, I've lost a lot of friends through drinking. I'm pretty rotten. I let people down. I'm a loner. I'm an alcoholic. I'm not an alcoholic, but I must be like it. I'm a problem drinker. I'm a morbid drinker. I'm not a normal person. I'm a drunkard. I'm a drunken chef. I'm disgusted. I'm fed up with myself. Drink is the only problem. I realised I couldn't go on like this. Bloody idiot. I'm ashamed: I'm not a proper mother. Someone else inside me wants to drink; another person takes me over. I can't understand why I have to drink. I'm a nuisance. I'm horrible when I'm drunk. I'm a disgrace. I hate drinking; it's a weakness. I'm a good guy. I'm too kind. I'm lost.

These comments illustrate that at the time of Initial Presentation, these people had very mixed feelings about their drinking. Even though they were quite able to describe the benefits they got out of it, they felt that there was something wrong with their drinking. They were also strikingly self depreciatory even though many of them did not feel in control of their drinking behaviour. They felt both responsible for and trapped by their drinking at the same time. They did not describe themselves as sick or as victims.

Thus, if one attempts to fit their beliefs onto the dimensions used in Figures 3.1 and 3.2, they saw their drinking as abnormal, but rewarding. They saw themselves as abnormal but as noted earlier (Figure 6.1) they felt

responsible. By virtue of the fact that they had presented to the Services, they were asking for assistance from the 'experts',so it reasonable to assume that they felt at that point less competent to deal with their difficulties than those to whom they had presented.

ii) Reassessment

What does your present drinking do for you?

For energy, for me it's a sort of food. I escape from reality for a short while. Total escape to the point of being practically unconscious. Just for company. It slows my head down. I can be depressed, I can be lively. It can give me confidence but then I'm a bitch. Decreases boredom. I'm able to converse with others. It helps the stomach pains, it's medicinal, there's nothing wrong. I enjoy myself. Numbed out of boredom till next day.

What is wrong with your present drinking?

Nothing. Nothing, but I feel I'll go down again. It's still to excess at parties. I can't stop when I'm with friends. Too much when I'm alone. I still have the occasional silly craving. It's when I feel happy that I fancy a wee drink; I shouldn't feel like that. Spasmodic. It's just the same. It's making my health bad. I still drink after work to cope with stress. It makes me sick [this subject was pregnant]. Still too fast. I still need the liquid. I'm almost down to my target [4 crates of Guinness per week!]. Still getting it under control.

How do you presently feel about yourself as a person?

I'm trying harder. Normal Sociable Drinker. Social Drinker. Scarcely a social drinker [means drinking trivially]. Ordinary drinker. Concerned drinker. I'm no longer an alcoholic, I'm a foolish drinker. Weakwilled. Lonely. Hopeless. Not quite normal. Determined. More in control. I realised what a bloody fool I was. A bit better. I'm afraid to drink again. Well and in control. T.T. There's a little bit that I think I can't control. Now I'm a quiet drinker. Mild. I like myself a lot. Drinking no longer interferes with my life because it is my life. I'm beginning to wonder if I could drink on the odd occasion [currently abstinent]. I still might drink at moments of despair. My approach to drinking is wrong. Depressed when not drinking. I'm a rotten person in God's eyes. I don't feel guilty about my drinking, it's now a conscious decision on my part. Bored to tears. I'm cured, but not by you lot; it's just willpower. I just decided to overcome it. I want to stop smoking now!

These reassessment interviews took place between 4 and 20 weeks after initial asssessment and, of course, not all customers had improved. At this point, they no longer gave such glowing accounts of the benefits of drink. Many reported that their drinking behaviour was now normal, but that did not mean that they also were normal. They still felt both vulnerable to further problematic drinking and responsible for it. Some who thought they were doing well believed that they had done it themselves by willpower or by recognition of what 'a bloody fool I was'.

Using the same dimensions again (Figures 3.1, 3.2), it appeared that at reassessment, clients were beginning to see their drinking as normal, themselves as not quite normal, being still vulnerable. Also, they continued to feel totally responsible and were moving away from the 'experts, please help me!' position.

Thus, not surprisingly, these people did not have a fixed, static view of their drinking, of themselves nor of the significance of their therapists to any changes that were taking place. Their views changed during the processes of intervention. Why this might have taken place and what might be generating these shifts is pursued further in the Discussion.

e) IMPACT ON THE COMMUNITY

This part of the study consisted of a comparison of the impact upon three broadly similar counties of very different styles of service provision for problem drinkers: virtually Generic Services alone (Derbyshire) versus the Alcohol Treatment Unit Model (Nottinghamshire) versus an Integrated Community Alcohol Services Model (Leicestershire). For a demographic description of these three counties, see Methods (Pages 104 -106).

All results are presented graphically as rates per 10,000 population, by place of residence and cover the 11 year period 1975 - 1985, except for Deaths and Discharges from Mental Hospitals (Figure 6.3.). Mental Health Enquiry (M.H.E.) Data on these were not available before 1978; and for mortality from Cirrhosis and Chronic Liver Disease and from Carcinoma of Oesophagus, both of which cover a longer time-frame (1975 - 1988).

i) Referral Rates

Figure 6.2. shows the referral rates per 10,000 of the general population into the Alcohol Advisory Services of the three counties. There are highly significantly different time patterns between the three counties(χ^2 249.9 d.f. 10 $p < 0.0001$)

The 1975 - 1979 figures from the Nottingham Centre were not reliable: the Service started in 1975 and was thus receiving zero referrals at the beginning of that year. With the appointment of the current Director in 1979, accurate statistics were collated. The Derbyshire figures are a summation of contacts with the Alcohol Advice Centres at Chesterfield (founded 1981) and at Derby (founded 1983). The 1978 Leicestershire figure is

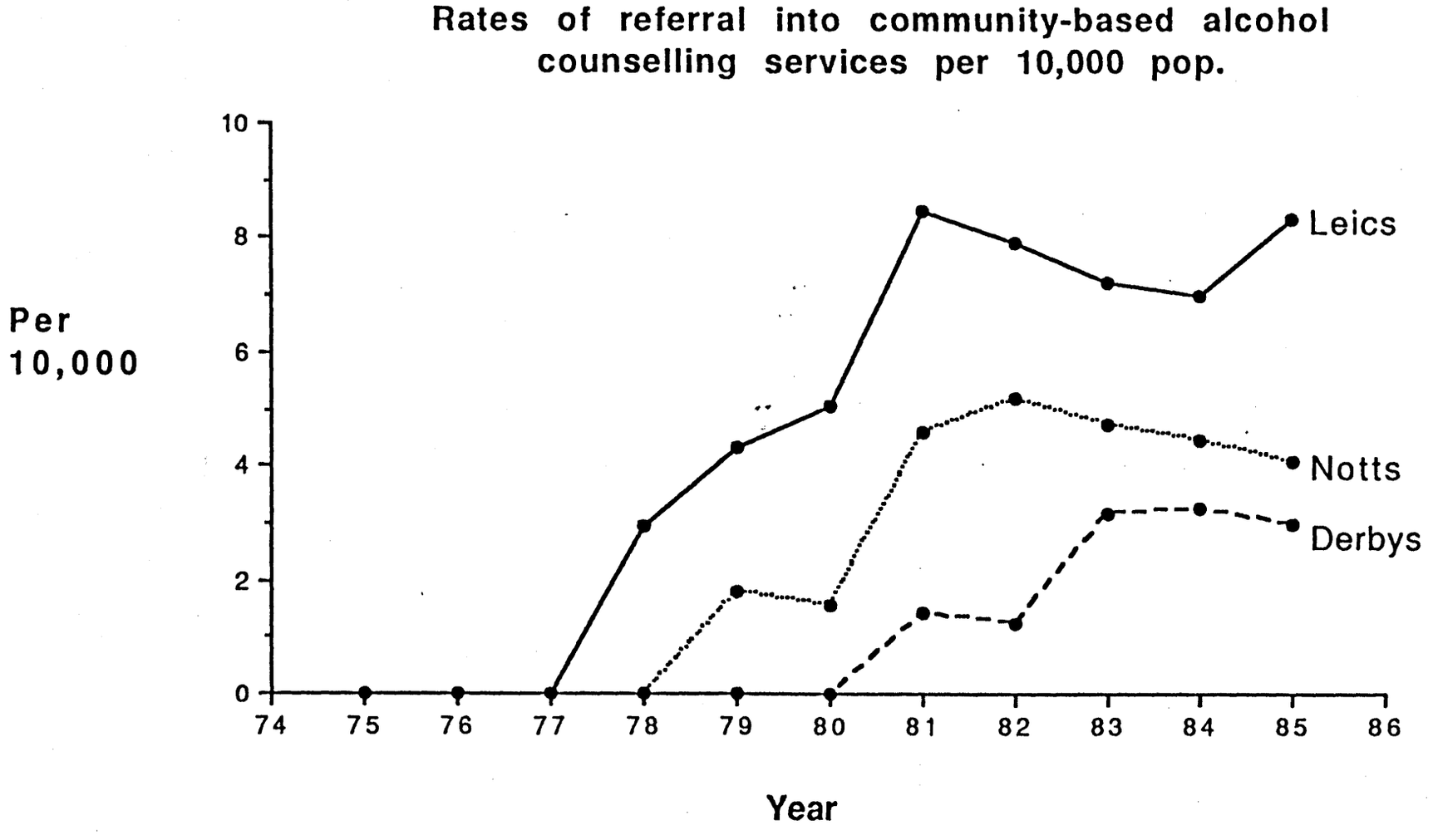

Rates of referral into community-based alcohol counselling services per 10,000 pop.
Per 10,000
10
8
6
4
2
0
74
75
76
77
78
79
80
81
82
83
84
85
86
Year
Leics
Notts
Derbys

FIGURE 6.2.

of referrals to the Community Alcohol Team alone. The contact rate into the Leicestershire Services, apart from a minor reversal in the early 1980's has risen inexorably whereas in the other two counties it has peaked and flattened off at a much lower level. In Leicestershire many more 'customers' make (or have made for them) contact with the Advice Centres than occurs in the two neighbouring Counties. The Leicestershire Centre was contacted in 1985 by 0.158% of the general population.

ii) Morbidity

Figures 6.3 and 6.4 show the rates of Discharge and Death from Mental Hospitals and General Hospitals for Alcoholic Psychosis, Alcohol Dependence and Non-Dependent Alcohol Abuse (I.C.D. Codes (8) 291, 303; (9) 291, 303, 3050). These show significantly different time patterns between the three Counties for both Mental Hospitals [χ^2 25.4 d.f.12 p 0.013] and for General Hospitals [χ^2 126.0 d.f. 20 p<0.0001], with Leics. always below Notts. and during 1979-82 above Derbys. Data for these prior to 1978 was not available. In General Hospitals the trends for Derbys. and Notts. become parallel and rising, with Leics. falling compared with both.

Figures 6.5 and 6.6 show the rates of Discharge and Death for Hepatic Cirrhosis and Chronic Liver Disease (I.C.D. (8) 571, 573; (9) 571, 572.2 to 572.8, 573, 573.3 to 573.9) and for an aggregate of Liver (as above) and other systemic disorders associated with heavy alcohol consumption (I.C.D. (8) 261, 262, 263, 281.2 (9) 265, 266, 281.2: (8 and 9) 577.0, 577.1. Again the time patterns are significantly different between the Counties. For Livers, χ^2 48.2 d.f. 18 p 0.001, For the aggregate, χ^2 76.3 d.f. 18 p <0.0001.

Rates of deaths and discharges from mental hospitals for alcoholic psychosis, alcohol dependence and non-dependent alcohol abuse

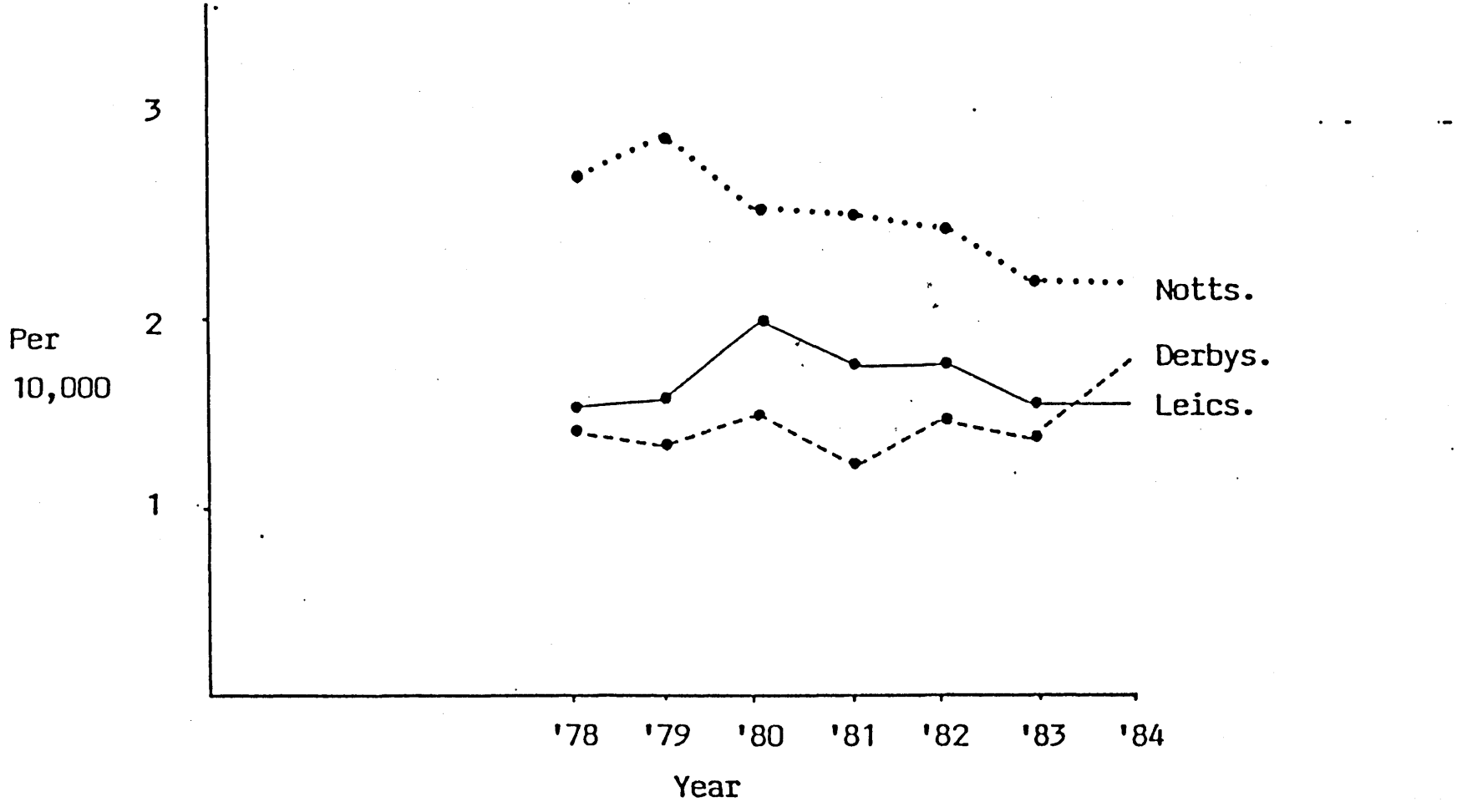


FIGURE 6.3.

Rates of death and discharge : Alcoholic psychosis/alcohol dependence
non-dependent alcohol abuse

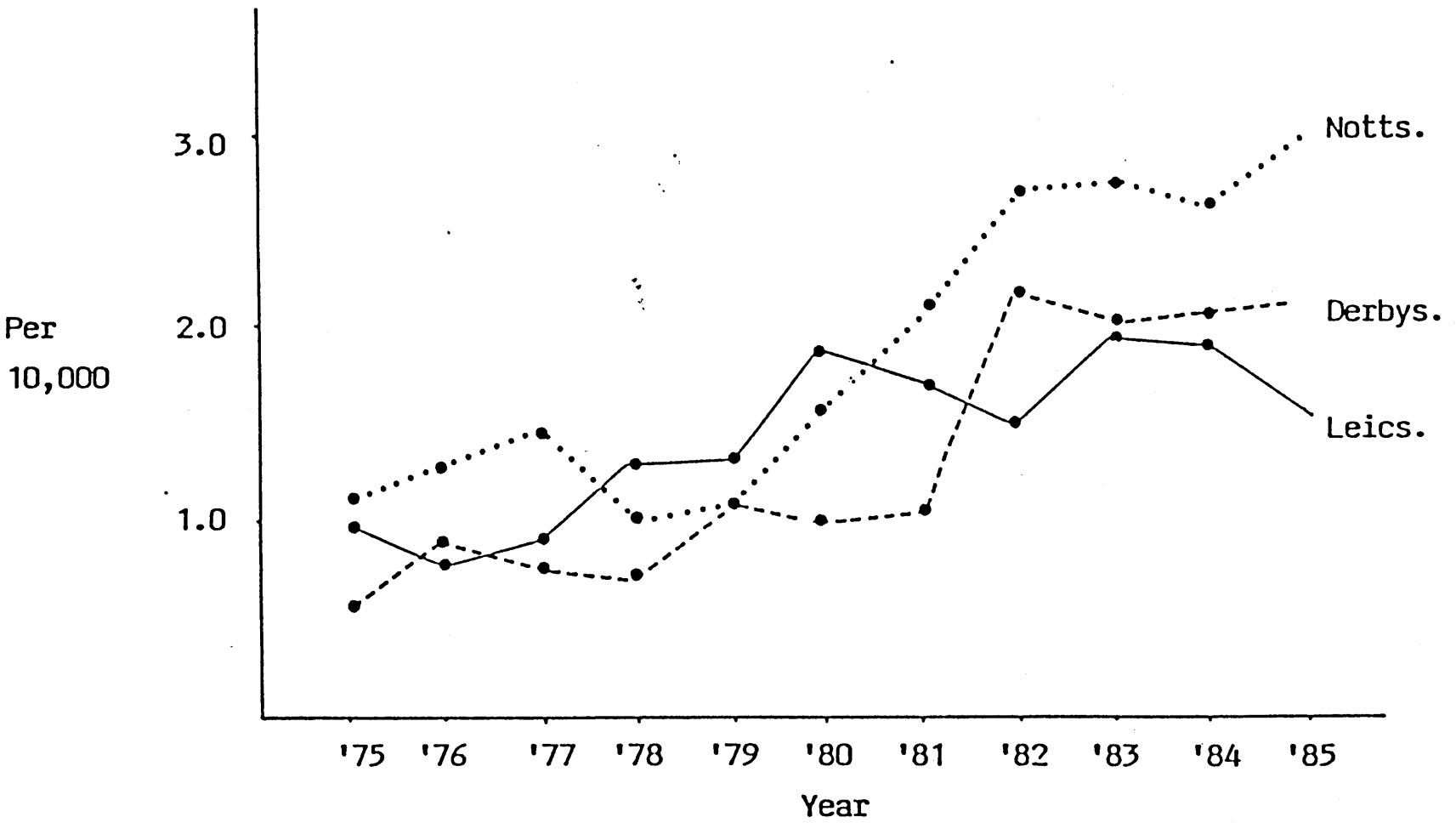


FIGURE 6.4.

Rates of discharge and death for
Cirrhosis and chronic liver disease

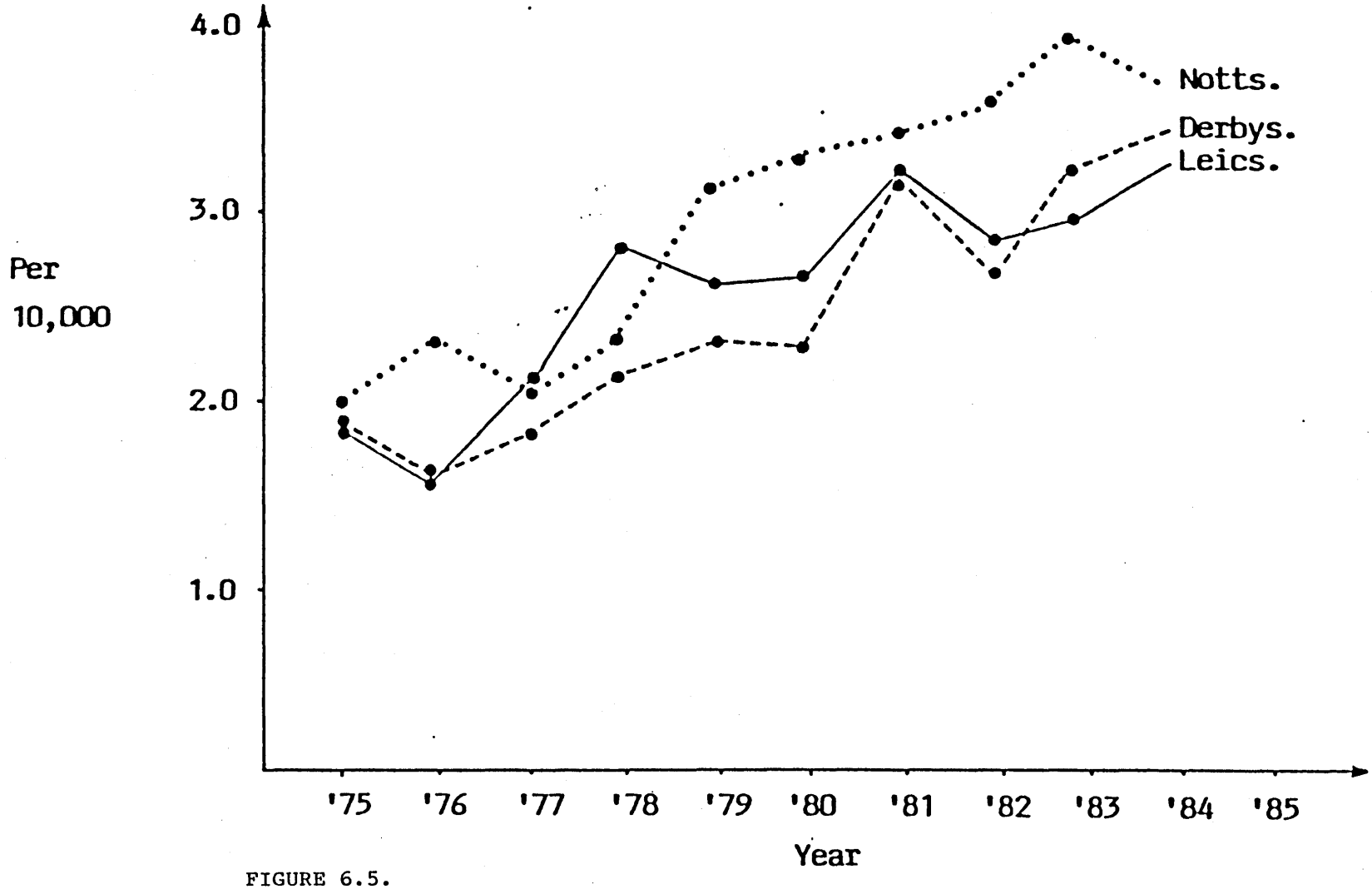


FIGURE 6.5.

Rates of discharge and death for physical illnesses known to be associated with alcohol misuse (liver, pancreas, malnutrition)

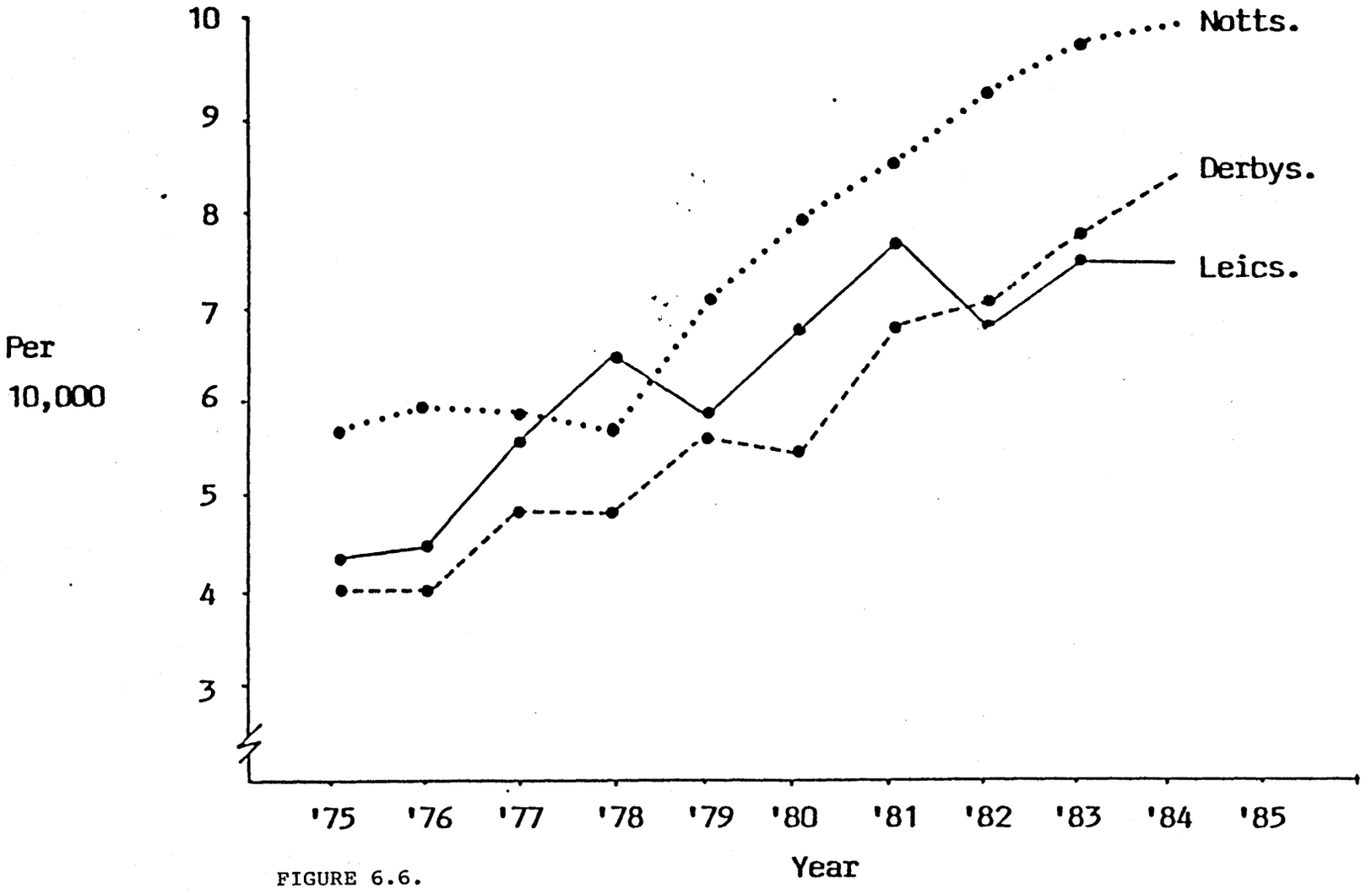


FIGURE 6.6.

iii) Mortality

Figures 6.7 and 6.8 show mortality rates from Cirrhosis and Chronic Liver Disease (I.C.D. Codes 571, 573) and for Carcinoma of Oesophagus (I.C.D. Code 150) between 1975 and 1988. These also show time patterns with significant differences between the Counties. For Livers, χ^2 39.6 d.f. 26 p 0.043, For Carcinoma of Oesophagus, χ^2 43.3 d.f. 26 p 0.018. It is notable that the separation out of the mortality trends in the three counties of Cirrhosis and Chronic Liver Disease only starts to occur from 1984 onwards.

iv) Criminality

Figures 6.9 and 6.10 show rates of arrest for Simple Drunkenness and Drunk and Disorderly (Home Office Codes 140 and 141) and for Drunken Driving and Failing to be Tested (Home Office Code 922). These results also show significant differences between the Counties [χ^2 410.23 d.f.18 p <0.0001 for H.O. Codes 140, 141 and χ^2 788.9 d.f.17 p <0.0001 for H.O. Code 922] , with Notts. appearing higher than its neighbours on drunkenness arrests at the start. For drinking and driving, Leics. is consistently below Derbys. but starts above Notts. and ends up below. [Leics, in fact, follows the National trend but that is distorted by changes in Metropolitan Policing -the Cautioning Scheme - which has led to a marked decrease in non-motoring offences between 1983 and 1985].

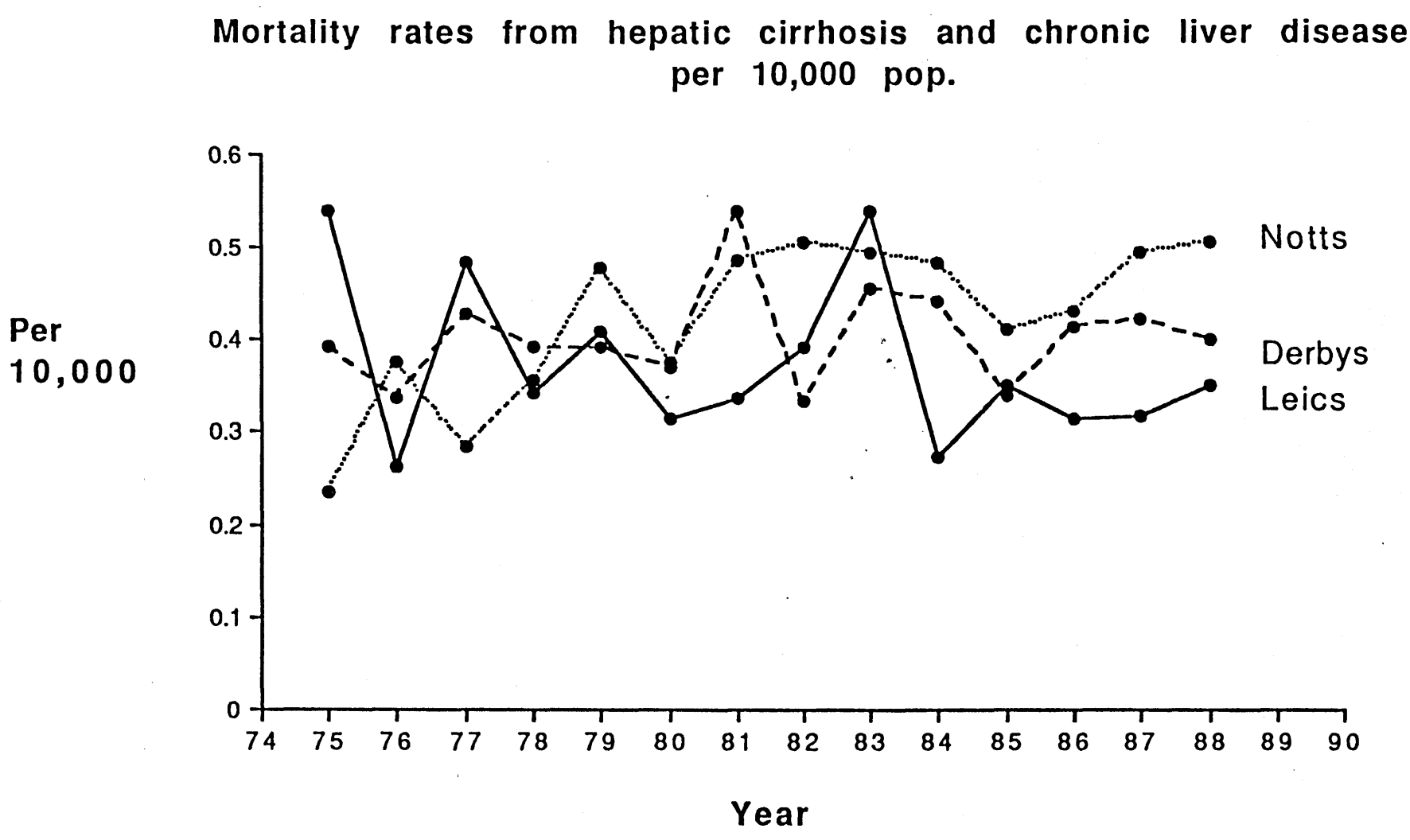

Mortality rates from hepatic cirrhosis and chronic liver disease per 10,000 pop.
Per 10,000
0.6
0.5
0.4
0.3
0.2
0.1
0
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
Year
Notts
Derbys
Leics

FIGURE 6.7.

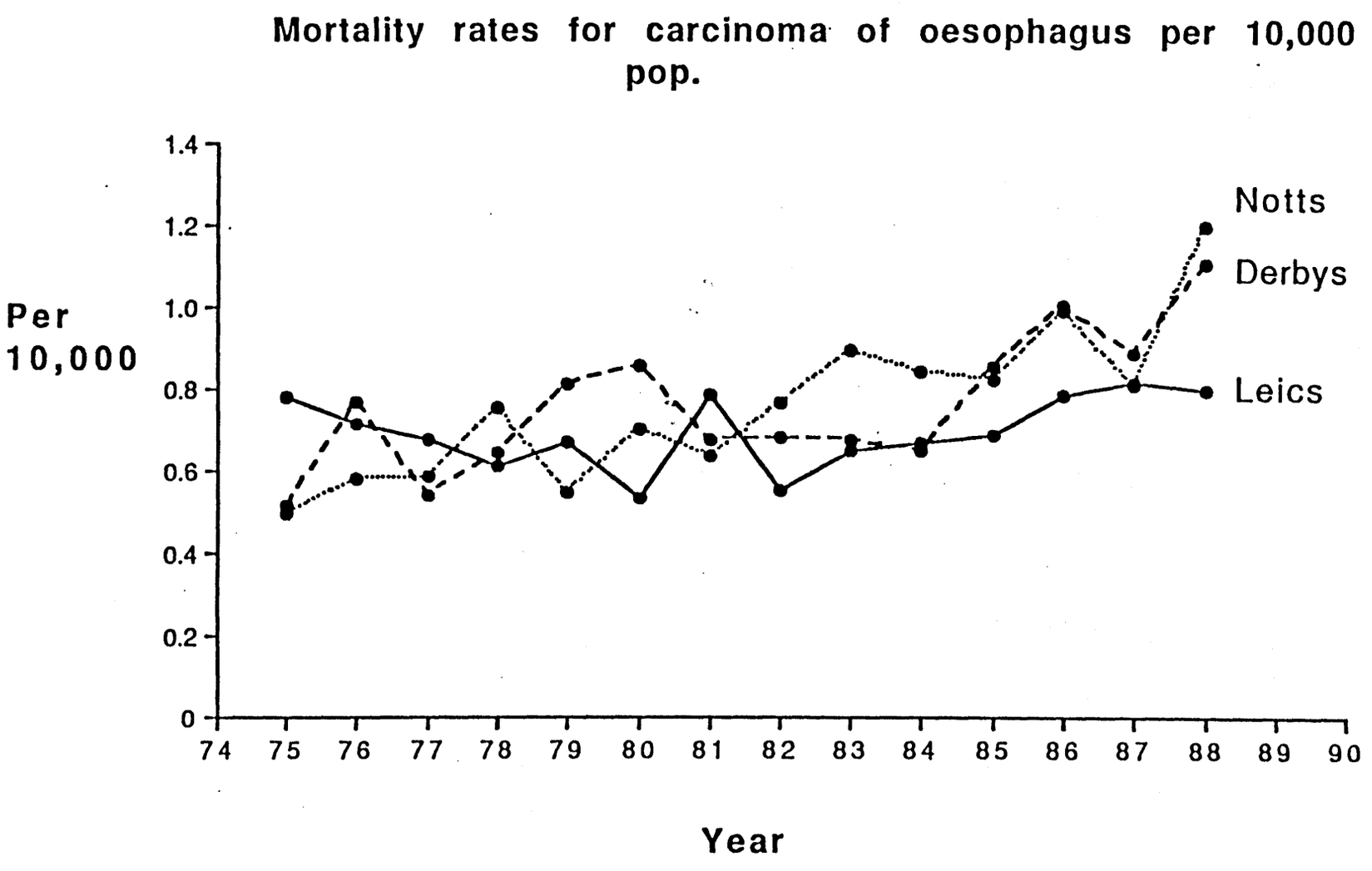

Mortality rates for carcinoma of oesophagus per 10,000 pop.
Per 10,000
1.4
1.2
1.0
0.8
0.6
0.4
0.2
0
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
Year
Notts
Derbys
Leics

FIGURE 6.8.

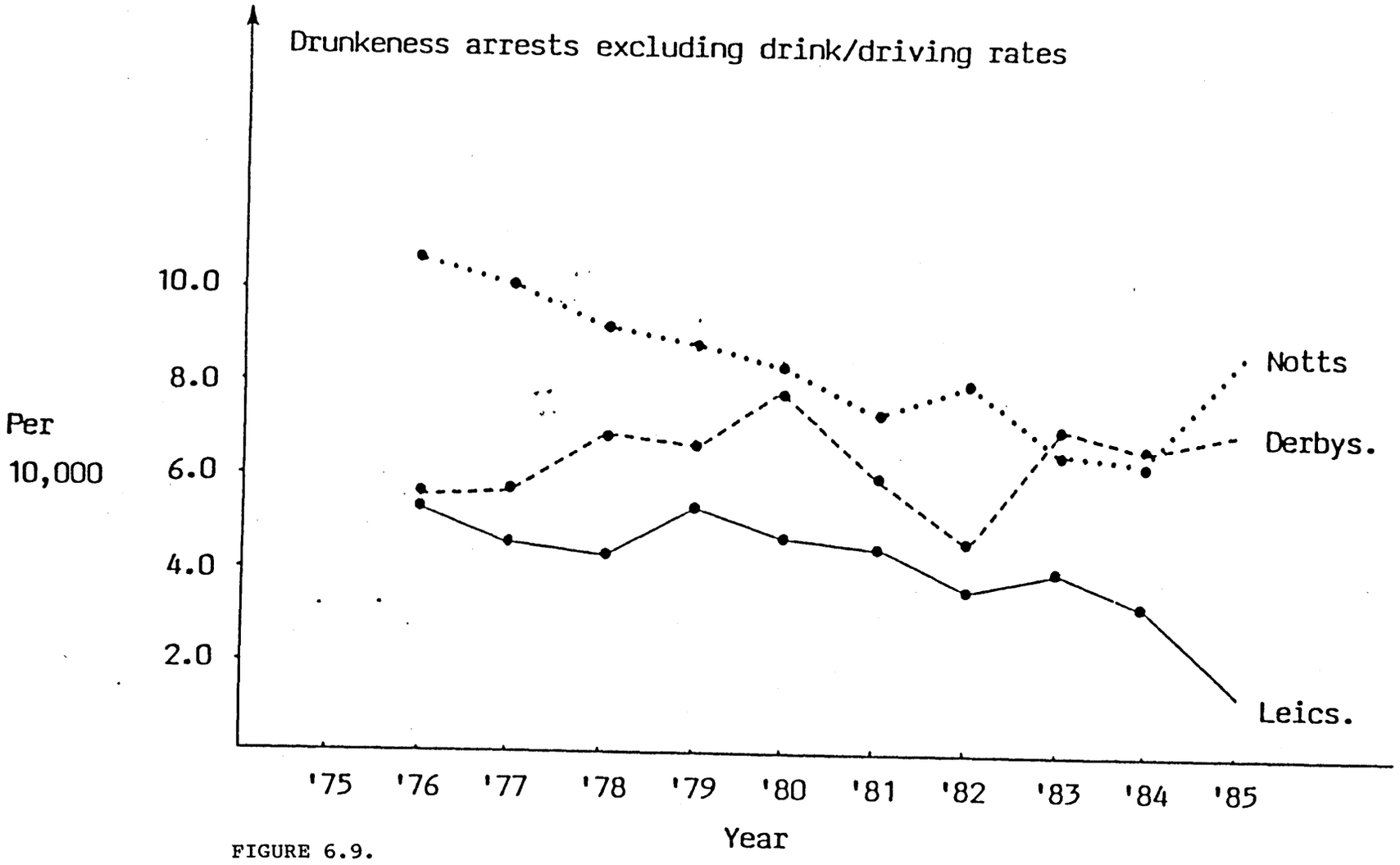

Drunkeness arrests excluding drink/driving rates
Per
10,000
10.0
8.0
6.0
4.0
2.0
Notts
Derbys.
Leics.
'75
'76
'77
'78
'79
'80
'81
'82
'83
'84
'85
Year

FIGURE 6.9.

Rates of drink/driving or failing to produce a specimen

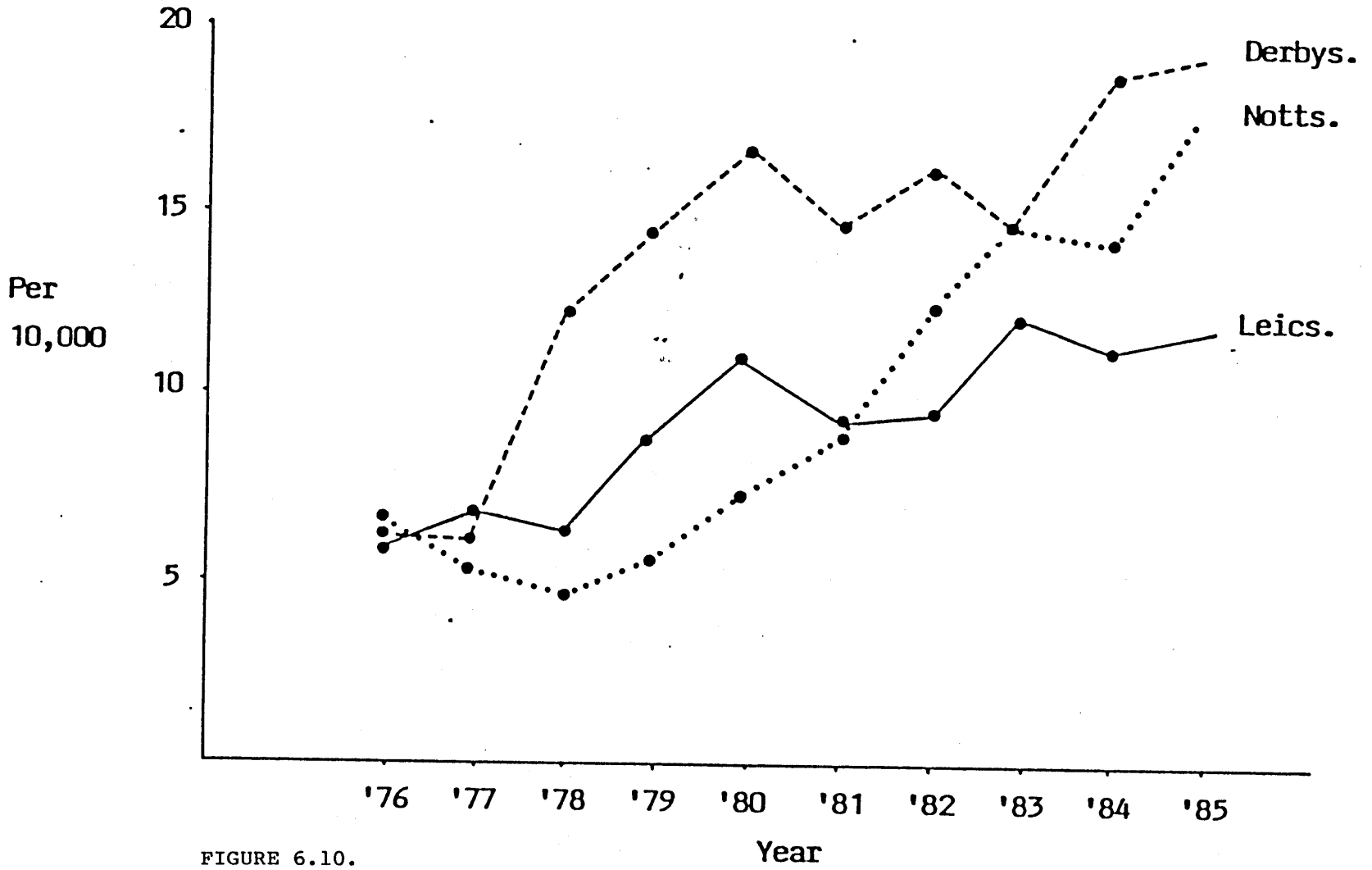


FIGURE 6.10.

INSERT:

Further Analysis and Description of the Three Counties Data

As well as the Time-series Analysis using GLIM described in the body of the Thesis, year-by-year relative risk comparisons were undertaken using the MINITAB programme. These involve crude multiple testing of each measure in each year, comparing each county with the other two. They do not test trends, they simply show year-by-year, the risk of being arrested for drunkenness or drunken driving, or of dying or being discharged from hospital with a condition in the diagnostic groups previously detailed (Pages 140 - 141 in the Thesis) comparing each of the study counties with each of the others. *Table S1.* shows a summary of all these relative risks.

These risks are illustrated in *Figure S1.* which shows, by way of example, the MINITAB Plots for Relative Risks of Deaths and Discharges from Mental Hospitals for Alcohol Related Disorders (Figure 6.3. in the Thesis). The Y-axis shows the relative risk. 1.0 Means the risks in the two counties are the same. A figure above 1.0 means that the risk in the first county is higher than in the second. A ratio below 1.0 means the converse. The bars show the 95% Confidence Intervals. The Risks in Nottinghamshire (Notts) clearly fall towards those of Derbyshire (Derbys) during the study period but at all times remain significantly higher. When Notts. is compared with Leicestershire (Leics): the Relative Risk appears fixed from 1980 onwards, with Notts. significantly higher. When Derbys. is compared with Leics., the curve is U-shaped, although there are only

Table S1: RELATIVE RISKS: THREE COUNTIES COMPARISONS

NOTTINGHAMSHIRE vs DERBYSHIRE

	1975	76	77	78	79	80	81	82	83	84	85
Alc. Related Mental Hosp.				+	+	+	+	+	+	+	
Alc. Related Gen'l. Hosp.	+	+	+	0	0	+	+	0	+	+	+
Cirrhosis	0	+	0	0	+	+	0	+	0		
Alc. Related Diseases-Gen'l	+	+	+	0	+	+	+	+	+	+	
Drunk (Non-drive)		+	+	+	+	0	+	+	0	0	+
Drink Drive		0	0	-	-	-	-	-	0	-	-

NOTTINGHAMSHIRE vs LEICESTERSHIRE

	1975	76	77	78	79	80	81	82	83	84	85
Alc. Related Mental Hosp.				+	+	+	+	+	+	+	
Alc. Related Gen'l. Hosp.	0	+	+	-	0	0	0	+	+	+	+
Cirrhosis	0	+	0	0	+	+	0	+	+	0	
Alc. Related Diseases-Gen'l	+	+	0	-	+	+	0	+	+	+	
Drunk (Non-drive)		+	+	+	+	+	+	+	+	+	+
Drink Drive		-	-	-	-	0	+	+	+	+	+

DERBYSHIRE vs LEICESTERSHIRE

	1975	76	77	78	79	80	81	82	83	84	85
Alc. Related Mental Hosp.				0	0	-	-	0	0	0	
Alc. Related Gen'l. Hosp.	-	0	0	-	0	-	-	+	0	0	+
Cirrhosis	0	0	0	-	0	0	0	0	0	0	
Alc. Related Diseases-Gen'l	0	0	0	-	0	-	0	0	0	0	
Drunk (Non-drive)		0	+	+	+	+	+	+	+	+	+
Drink Drive		-	+	+	+	+	+	0	+	+	

0: No significant difference between counties in that year.
+: First county greater than second (N>D, N>L, D>L) p <0.05.
-: Second county greater than first (N<D, N<L, D<L) p <0.05.
: Missing data.

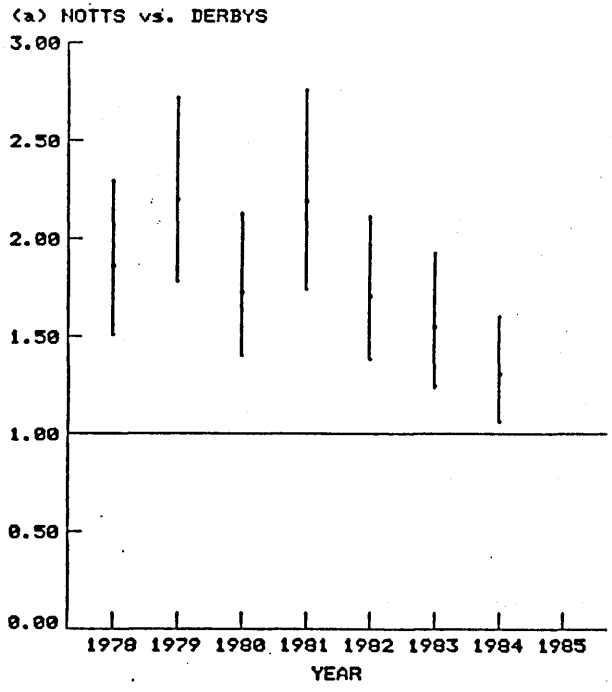
two years when these crude comparisons reach significance. In 1980 and 1981, an individual was more likely to die in or be discharged from a mental hospital bed with an alcohol-related disorder in Leics. than in Derbys.

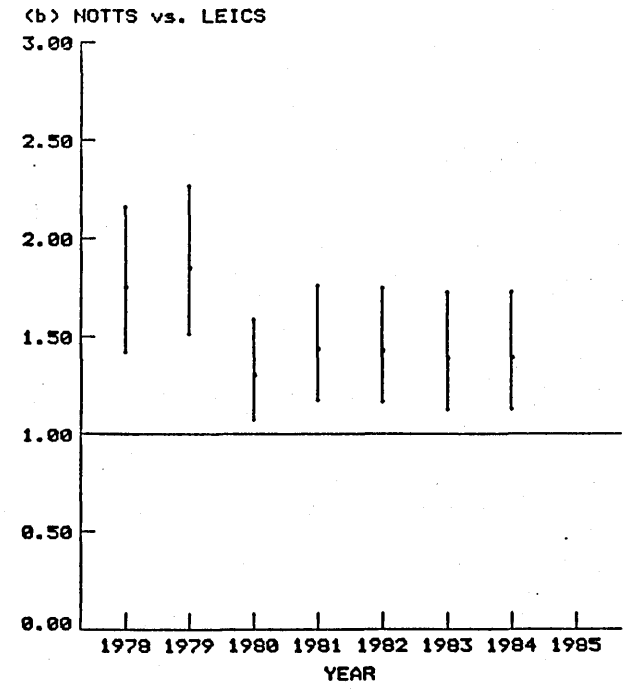
A more extreme example is shown in the penultimate comparison, that of Rates of Drunkenness Arrests other than Drink/Driving (*Figure S2*). The Relative Risks in Notts. appear to be approaching those in Derbys. as the study period progresses. However, comparisons of Leics. with both other counties appear to show very little change (apart from in 1985) and the risks in Leics. are consistently a little lower than Notts. in all years. Apart from in 1976 when there was no difference, the risks in Leics. are also consistently a little below Derbys. Visual examination of Figure 6.9. in the Thesis and the highly significant differences over time ($p<0.0001$) reflect these findings more accurately.

These relative risk comparisons are useful inasmuch as that they demonstrate <u>when</u> the points of absolute difference occur. However, since multiple significance tests are being performed there is a greatly increased Type I error rate i.e. spurious significant differences in risks being found. The analysis of patterns over time used in the Thesis avoids multiple significance tests.

Having ascertained using the linear modelling technique that there are significant or very significant differences between the counties in the time patterns of the morbidity, mortality and criminality indicators demonstrated, visual inspection (of Figures 6.2.- 6.10. in the Thesis, between pp 139 - 142) is required, attending particularly to the trends (long-term movement).

Fig. S1 RELATIVE RISKS of Alcohol Rel'td Death/Discharge from Mental Hospital





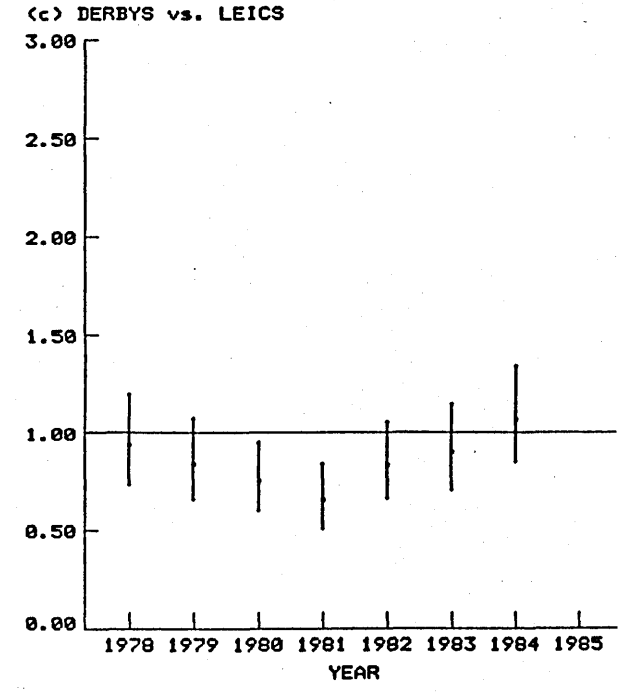
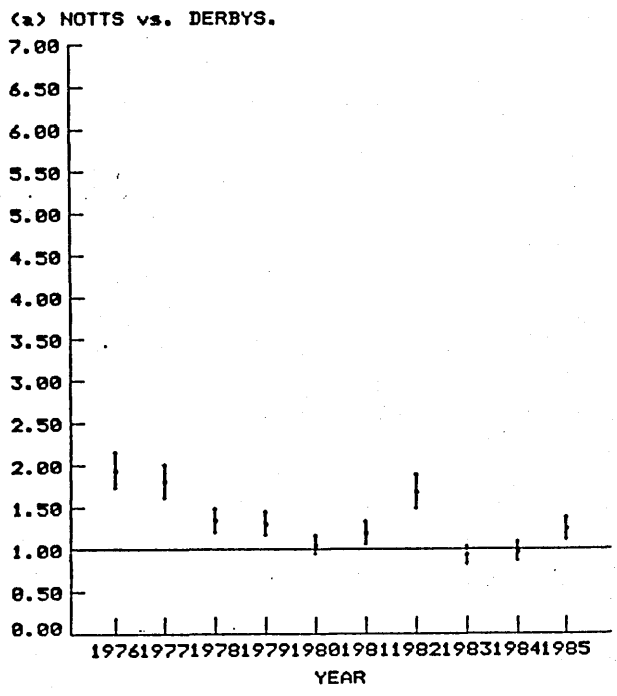
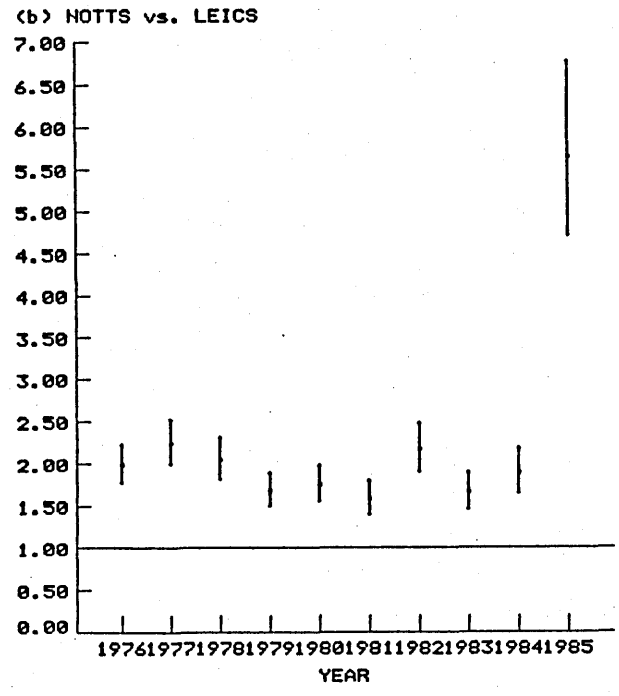


Fig. S2 RELATIVE RISKS of Arrest for Drunkenness (exc. Drink/Driving)





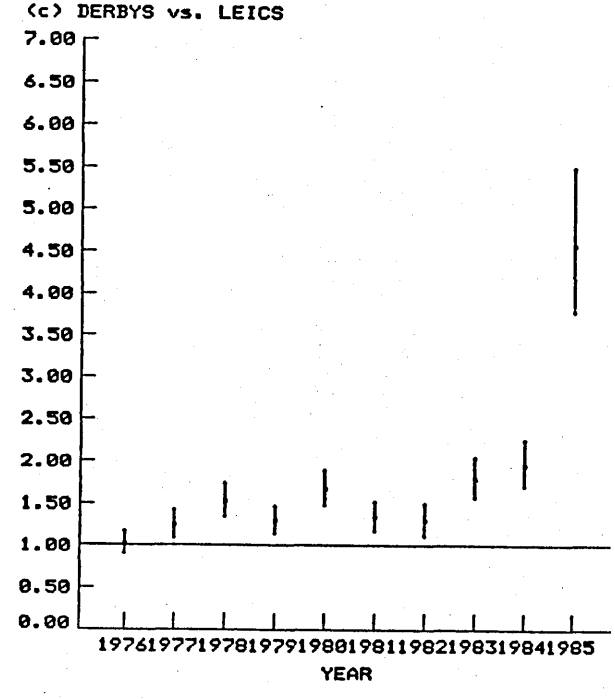


Figure 6.2., the referral rates into the Alcohol Advisory Services of the three counties, shows rates in Notts. and Derbys following parallel paths (although Derbys. starts two years later) whereas Leics., starting a year before Notts. shows differing, higher rates.

Figure 6.3 shows the rates of Discharge and Death from Mental Hospitals for Alcoholic Psychosis, Alcohol Dependence and Non-Dependent Alcohol Abuse (I.C.D. Codes (8) 291, 303; (9) 291, 303, 3050). This shows Notts. as most different, with its rates starting highest and falling over the study period. Rates in Leics. are always below Notts. and almost constant whereas in Derbys. they begin flat then rise towards the end of the study period.

Figure 6.4 shows the rates of Discharge and Death from General Hospitals for Alcoholic Psychosis, Alcohol Dependence and Non-Dependent Alcohol Abuse (I.C.D. Codes (8) 291, 303; (9) 291, 303, 3050).On this indicator, the changes in rates over time for Derbys. and Notts. become parallel and rising, whereas in Leics. although rising at first, the rates flatten off around 1980 and then fall compared with both other counties.

Figure 6.5 shows the rates of Discharge and Death for Hepatic Cirrhosis and Chronic Liver Disease (I.C.D. (8) 571, 573; (9) 571, 572.2 to 572.8, 573, 573.3 to 573.9). In all three counties they show a rising trend through the study period, but in Leics. the rise is less steep than in its neighbours.

Figure 6.6 shows the rates of Discharge and Death for an aggregate of Liver (as above) and other systemic disorders associated with heavy alcohol consumption (I.C.D. (8) 261, 262, 263, 281.2 (9) 265, 266, 281.2: (8

and 9) 577.0, 577.1. This follows a similar time-pattern to Cirrhosis alone, but the differences are more marked.

Figure 6.7 shows Mortality Rates from Cirrhosis and Chronic Liver Disease (I.C.D. Codes 571, 573).These show much greater year by year variation (because the numbers are only a tenth of those for hospital activity), But what is notable is that from 1984 onwards, the rates in the three counties separate out in parallel, with Notts. highest, Derbys. in the middle and Leics. lowest.

Figure 6.8 shows Mortality Rates for Carcinoma of Oesophagus (I.C.D. Code 150). These show rates in Leics. effectively constant over the study period but in Derbys. and Notts. the trend is one of gradual increase. Again, the numbers are small so there is much individual variation.

Figure 6.9 shows rates of arrest for Simple Drunkenness and Drunk and Disorderly (Home Office Codes 140 and 141) Rates in Notts. start higher than in its neighbours and drop over the years. There is little change in rate in Derbys. Leics.'s rates drop markedly towards the end of the study period.

Figure 6.10 shows rates of arrest for Drunken Driving and Failing to be Tested (Home Office Code 922). Here, there is little difference in the rates in 1976-77, but from 1978, there is clear separation, with rates in Leics. rising slowly but consistently below Notts. The rates in Derbys. start below Leics. but rise rapidly during the study period, so from 1981 they are above Leics. and from 1984 above Notts.

What these data show is that there is a very large number of differences in the relative risks of a wide range of indirect indicators of alcohol problems in these three counties. More importantly, there are also differences in the time patterns of the rates of these indicators between the three counties suggesting that the counties have differing influences operative within them.

There were some baseline differences on these indicators prior to the establishment of the natural experiment of the alternative styles of Alcohol Services. But there were significant changes during the study period. In general, on every indicator compared with one or both of its neighbours, concomitant with a burgeoning usage of Leicestershire's Community Alcohol Services, there has been a flattening off or an actual reduction in morbidity and criminality as evidenced by a number of indirect indices of alcohol abuse. The same trend is shown by mortality from Hepatic Cirrhosis and Carcinoma of Oesophagus, but the former of those effects appears to have a time-lag of some two years.

e) SYNOPSIS OF RESULTS

1. "The Leicestershire Community Alcohol Services" were instituted in 1978 and provided for a population of just under one million a non-abstinence oriented, multidisciplinary community-based service with an emphasis on education of primary care workers and individualised intervention for presenters with alcohol problems. They attempted to maintain the "customers" in their own environment and to reinforce their beliefs in their own essential normality and continuing responsibility for personal conduct.

2. The services therefore represented the first attempt to operate the major alcohol treatment resource of a whole community along the lines of the changes noted in the Introduction. (See Synopsis on Pages 70 - 71)

3. Referral rates into these services have risen greatly since the services's inception. They usually receive between 700 - 800 referrals per annum with men outnumbering women by approximately 2:1. The mean age of referrals was just under 40 years.

4. Mean consumption per drinking day was the alcohol equivalent for men of a bottle of spirits, for women a bottle of fortified wine (Sherry, Martini).

5. Thus those using the service were notably typical in terms of the demography and alcohol use of users of alcohol services in Britain generally.

6. "Customers", at the time of presentation to the services, appeared to show a high degree of insight into their drinking and other problems, and felt personally responsible for both.

7. A short-term uncontrolled follow up study of a sample of users of the Leicestershire Services was carried out. There was a high rate of attrition from the study, particularly of less stably housed men.

8. The study appeared to indicate that six months after cessation of contact, consumption of alcohol had either ceased (24.4%) or reduced to approximately half reported intake at initial assessment.

9. Patterns of consumption had changed from all-day solitary facultative drinking to drinking in the company of family and friends in the evening.

10. At follow-up, 'customers' saw themselves as 'ex-problem drinkers', whether they continued to drink or not, and continued to feel responsible for their conduct.

11. Indirect indices of alcohol problems were compared using a natural experiment, comprising three counties in the East Midlands of England, with similar demography and drinking patterns, but different styles of Alcohol Services: Derbyshire (effectively generic only), Nottinghamshire (In-patient Alcohol Treatment Unit and 'outreach') and Leicestershire (Community Alcohol Services).

12. Using a mathematical modelling method of data analysis that incorporated change over time as a factor, significant differences in the time series between the three counties were found. Some baseline differences were present. But with the development of the alternative styles of alcohol services, further significant changes over time occurred.

13. In general, compared with one or both of its neighbours, concomitant with a burgeoning usage of Leicestershire's Community Alcohol Services, there has been a flattening off or an actual reduction in alcohol related morbidity, mortality and criminality.

Chapter 7: DISCUSSION

It is appropriate to return to the declared purpose of this study, which was to describe a particular style of service delivery for people with drink related problems in a specific geographic area, and its possible impact upon the prevalence of such problems in that area.

The most notable suggestion in this thesis is that after a decade of community based alcohol services operating in Leicestershire there may be the beginnings of a discernible treatment effect manifest by a comparative reduction in the prevalence of alcohol related problems in the county.

But there are also less remarkable findings. That "*The Leicestershire Community Alcohol Services*" were developed and are still operating is evident from these results and is, perhaps, worthy of comment. By the very fact of their continuing existence and of the ever - increasing demands being placed upon them some ten years after their inception, it could be argued that they must be providing a useful service.

But the fact that a service is being used is, in itself no recommendation. Services are used where there is no alternative; where there is a third party demand upon somebody to avail themselves of it or where the user, at the point of contact, is ignorant about the service's ineptitude. Further, all services, however 'crackpot' will have some spectacular successes. As examples of the above, many people go to their nearest General Practitioner because they feel ill and there is no accessible medical alternative. (Indeed, some drinkers go to their local pub for the same reason!) Prisons have been known for a very long time to be somewhat worse than

useless at rehabilitating the offenders they contain and yet in Britain in the last quarter of the twentieth century, they are more popular than ever before. Similarly, every fringe medical cult has its enthusiastic following.

Also, in these areas of human services, 'The Rule of One Third' would predict that regardless of the intervention, one third would improve, one third would remain unchanged and one third would deteriorate further. So, visible demand and some satisfied customers could be claimed as measures of success by almost any agency. Yet, it tends to be at that particularly basal level that many agencies, particularly in the Voluntary Sector, are judged. The Statutory Services are frequently not even subjected to that degree of evaluation and are allowed for many reasons, including those mentioned above, to go on doing what they have always done.

It needs to be made clear that the data presented as Results do not represent a comprehensive evaluation of the work of the Leicestershire Community Alcohol Services over the decade of their existence. Rather, they represent a number of available 'snapshots' which give some images of the services from which it is possible to build up some idea of what a particular style of clinical service has and has not achieved.

a) REFERRAL RATES

The data on referral rates into the Alcohol Advisory Services were limited by not being a true reflection of the work undertaken in the total community with drinkers in difficulty. It did not include the work of General Practitioners, Health Visitors, Community Psychiatric Nurses, Social Workers, Probation Officers and Non-

statutory Counsellors of many complexions, including Alcoholics Anonymous. Also, it did not include the work undertaken with Outpatients with alcohol problems by General Psychiatrists which is not collated in an available way. Therefore these data show only those who have contact with a Designated Problem Drinkers' Community Resource. There is little doubt that many drinkers will choose to avoid contact with these agencies simply because they are so designated. Also, there are no readily available data to indicate how many clients of these agencies are also 'on the books' of other services and are being recorded multiply.

But they do provide corroboration for a statement in a recent review of Community Alcohol Teams (C.A.T.'s) commissioned by the (English) Department of Health:

"In common with other forms of community team, a major success of C.A.T.'s has been in making specialist services more accessible to people who need help. C.A.T.'s have been quicker to respond and better at engaging clients in treatment than have hospital services." (Stockwell, T. & Clement, S. 1989)

However, Stockwell and Clement then go on to say:

"Again, in common with other community teams, C.A.T.'s have created <u>new</u> business, both for themselves and existing hospital and psychiatric services."

The experience in Leicestershire has not conformed to that. Whilst there has indeed been the creation by the services of 'new business' for the services themselves, that does not seem to have led to greater demands upon existing inpatient generic psychiatric services, as can be seen in Figure 6.3. That might be a comment about the

size and longevity of the Leicestershire services, and about the prevalence in the county of alcohol problems. The Leicestershire Community Alcohol Team is the largest (Stockwell, T. & Clement, S. 1989) and 'longest living' in Britain; and it operates in an area deemed to be low in alcohol problems. (Wilson, P. 1980) It is possible that because the service is relatively big and the level of problems relatively low, The Leicestershire Services are able to deal rapidly and comprehensively with many of the problem drinkers that present to them without recourse to the services of other agencies, whereas in other areas the C.A.T.'s may be able to do no more than 'find' the clients in sufficiently large numbers to outstrip their domestic resources, a problem similar to that of non-statutory Alcohol Advice Centres (See below).

In Leicestershire, this high referral rate does not extend to the ethnic minorities, who are relative under-users of the services. Only 5.9% of the 1981-1982 sample were of Asian extraction and nobody at all was of Afro-Caribbean origin. On the grounds of numbers of these groups in Leicestershire, the Services are attracting approximately half the number of ethnic minority customers that would be expected. This is a common finding, and occurs in other areas of health care. But, it is possible that it is more marked in the area of alcohol problems for three reasons. These are that there is actually less drinking going on. Certainly, Muslims are meant to be abstinent. But Muslims are a minority of those from the ethnic groups resident in Leicester (4.3% of the city's population). The majority group is Hindu, and they are drinkers. The second reason is that alcohol problems may be more stigmatising in those cultures, and are therefore maintained covertly for longer. The third reason could be that the Community Alcohol Services, being predominantly staffed by white people, are not seen

as an appropriate response to alcohol problems within and by the ethnic minority groups. There are no data available to clarify the issue.

The Leicestershire Data were somewhat different from the neighbouring comparable counties in that its Alcohol Advice Centre is, in part, a 'front' for a large well resourced statutory service which, as a matter of operational policy, diverts through the Advice Centre doors referrals which in other areas would in the first instance be dealt with by others. The Alcohol Problems Advisory Services in the other counties are much more independent and therefore isolated.

But it remains a fact that the Leicestershire Alcohol Advice Centre has, relative to others, both in the neighbouring counties and elsewhere in the country, a very high referral rate. The only way that it has been able to deal with that is because it is backed up by the Community Alcohol Team, and the vast majority of the counselling work is done by that team away from the Centre. Alcohol Advisory Services without such back - up are organisationally very likely to run into difficulties. To justify their own existence, they need to demonstrate a high referral rate but if they succeed in encouraging that, they end up having their own resources stretched into less and less rapid and competent responding. They have the choice of being victims of either their own success or their own failure.

In 1985, for example, the Leicestershire Services were contacted by only 0.158% of the general population in the catchment area, and not all those were converted into 'cases'. That figure is of the same order of magnitude as the 0.16% of Camberwell's population who were reported as "being treated for alcoholism by a

psychiatric service of any kind" in 1975. (Cartwright, A.J.K. et al. 1975). Between District comparisons at different times are, of course, likely to be misleading. Camberwell, containing, as it does the Maudsley Hospital and the Institute of Psychiatry, is one of the best resourced areas of psychiatric provision in the country whereas Leicestershire is one of the worst. The very low baselines from which the Leicestershire Services took off are a reflection of that.

All that seems to have happened is that the Leicestershire Community Alcohol Services have become, so to speak, 'major shareholders in the responding to alcohol problems business'. They are not monopoly shareholders: the vast substructure of community agents and others undertaking work with people with alcohol problems remains.

Nonetheless, over a longer time-frame, the services have made contact with a large number of drinkers. By December 31st 1989, the Alcohol Advice Centre had been contacted by 6970 individual problem drinkers, that is 0.789% of the general population. Longitudinal studies in the United States have demonstrated that an individual's alcohol problems may take up to two decades to emerge and then run a stormy course for a decade or more before either resolving or fulminating. There is an argument about what proportions do what and when, but there is agreement that the time - scales are very long. (Vaillant, G. 1983) That being so, it can be argued that if the 1985 referral rate is simply maintained the Services will eventually be contacted by the majority of the 3½% of the general population estimated to be "suffering from significant problems from drinking" (Cartwright, A.J.K. et al. 1975) during the life - history of the episode of problematic use.

b) CLIENT CHARACTERISTICS

Perhaps the major difficulty with this section is that all these data are self report , subject to all the inherent problems of that manner of data collection. It is particularly relevant when descriptions of current drinking patterns are described. Biases work, however, in both directions. Some people wish to minimise the extent of their drinking and difficulties whereas others wish to over emphasise them by way of a 'ticket' into Services. It is not possible to discern at initial assessment in which way, if either, the bias occurs.

The sample of 162 subjects described at length was not completely representative of the total spectrum of users of the services. It was of people who wanted more than just advice or information, who wanted some form of intervention in their lives, however pressurised into so wanting. People, however much in need of such intervention, whom the services had failed to contact and assess, even though they had become aware of their existence were not included. People could default before initial interview. But as can be seen by comparing those 162 with the data on all referrals to the advice centre, the profiles of the two populations are strikingly similar.

From these data, however, it can be established that the Leicestershire Community Alcohol Team was dealing with a population of presenting drinkers who were notably 'ordinary'. They were not a collection of mildly distressed moderate drinkers. Their reported mean level of consumption of the equivalent of a bottle of spirits per drinking day for men and a bottle of Sherry for women and the frequency of drinking days together meant that the majority of them were at substantial risk of

developing harmful long - term sequaelae of 'excessive consumption'. And they were isolated, internally driven drinkers: at initial assessment three quarters of the sample did claim that their drinking was determined predominantly by internal negative feeling states and that they were solitary drinkers who on drinking days had started by noon. Also, in terms of age, sex and social stability they were reasonable representatives of the kinds of people availing themselves of Alcohol Services in Britain at that time.

The high referral rate did not lead to the services being contacted by a greater proportion of 'early problem drinkers' or people with shorter histories of alcohol problems, or, indeed, people at a younger age. Penetration deeper into the 'sump' of alcohol problems in this community just revealed more of the same. This is exactly the same conclusion as is reached by Stockwell and Clement:

"Nor is there any evidence that this extra custom is anything other than "more of the same" i.e. mainly from people with severe and longstanding difficulties with alcohol. There does not appear to have been any advance in offering interventions at an <u>earlier</u> stage through C.A.T.'s."

(Stockwell, T. & Clement, S. 1989)

There are conceptualisation problems here, which will be elaborated in the next section. To believe in the need to find early problem drinkers is to believe in the concept of Inexorability unless some formal or informal intervention occurs. If the Alcohol Problems model was to have as a core component Reversibility, then problems would be mild, or severe. They would not be early or late, except in the temporal ' drugtaking career' sense.

If the people using the Leicestershire Services appear unusual, it is predominantly because some of the questions asked of them were unusual.

They revealed a high degree of insight into their drinking, its determinants and its consequences, readily reporting both the positive and negative effects, and readily claiming, in most cases, to be responsible for it. That is, they did not see themselves as victims of some serious disorder over which they had no control, but as responsible for their plight. They did, however construe themselves as drinking too much or that their drinking was out of control. They gave no explanation for that apparent paradox.

Similarly, they had a very clear idea of what they thought would be helpful to them. The requests made were also very 'ordinary'. Only one subject in the thousands that have been in contact with the services has asked for shares in a brewery! Despite being somewhat drink preoccupied at initial assessment, they also saw that other aspects of their lives were in need of attention. How much these results were the consequence of the initial interview being undertaken by an agency specialising in alcohol problems is a matter of conjecture.

c) TREATMENT

The small number of mismatches between the Therapists' perception of needs and the Customers' are interesting and suggest that the therapists adopted a much less drink - preoccupied position than did their clients. This could be a consequence of the Author's attitudes expressed while the team ethos developed.

Fortunately, the therapists also showed themselves to be negotiable. They therefore ended up simply erring on the side of permissiveness.

The data on treatment efficacy represent the 'weakest' in the whole of the Results. The attrition rate was very high and selective. Only one of the resettlement unit sample was available for follow - up. Thus there is a bias away from these socially unstable bout- drinking men who tend to wander the country, away from cases who became involved in more protracted interventions and away from unstably housed Leicestershire residents. This was clearly a follow-up reserved for quickly dealt-with 'good bets only'!

There is also the question of the independence of the follow - up Assessors. Even though they had had no previous involvement with the Customer, they were clearly interested in the functioning of the Community Alcohol Services and as the majority of the follow - up sample appeared to have reduced their drinking and their related problems, it would be likely that they would be appreciative of the Services's efforts, even if the reported improvements were nothing to do with them. This is the same phenomenon that leads to most people thinking that their General Practitioners are splendid, for many of the diseases that they 'treat' are self - limiting anyway.

Thus these striking looking results are perhaps best regarded as those of an uncontrolled trial of intervention on the stablest of their customers by a drinking - permissive service. It is, perhaps, not the percentage of people who reported doing well at follow - up that should be dwelled upon, but the reported <u>pattern</u> of alcohol use at follow - up that is worthy of note.

Their claimed halved gross consumption was of more dilute beverages, was taking place in the same places, but later in the day, normally starting in the early evening. Also, it was occurring more frequently in the company of friends and/or family and drinking sessions were for a shorter length of time. In other words what they were reporting was a resumption of drinking behaviour much nearer "normal social drinking", if normal is used in the statistical sense.

In his major survey of Drinking in England and Wales, Wilson (Wilson, P. 1980) found, also as a result of self - report questionnaires, that men engaged in drinking in public places (66%) whereas women drank in their own or a friend's home (52%), mostly in the company of others (87% for men, 98% for women) and in the early evening. (69% for men, 76% for women)

Where Customers drinking did remain abnormal was in reported levels of consumption which were substantially higher than the norm. None of Wilson's East Midlands general population sample of women reported consumption above 20 units per week and only 20% of the men. There are no comparable data on beverage choice.

But, at follow-up, the Leicestershire Services' Clients drinking could be construed as social too, inasmuch as they reported no longer drinking in response to internal determinants but now to external factors, such as the presence of friends.

The image created is of these customers, at the time of presentation to the services, being 'in the grip' of a high drive-state towards drinking which at follow - up had gone , leaving them as heavy but otherwise unexceptionable drinkers.

d) IMPACT ON THE COMMUNITY

These data are most interesting. Although correlation can never prove causality, these highly significant trends do appear to discriminate Leicestershire from its neighbours. If the most major difference that can be detected between the three counties is the style of provision of services for people with drinking problems, then here is presented data which may show a community-based style of alcohol problems intervention having a measurably greater impact upon the prevalence of these problems in its population than other more conventional in-patient alcohol treatment unit or generic provision. Another recent study which suggests a positive treatment effect on the total community (Mann, R.E. et al. 1988) uses only one indirect indicator, admissions to hospital for Hepatic Cirrhosis in Ontario. It suggests that a treatment effect, due to increased provision, might be causing a greater drop in problems than the fall in consumption alone would account for.

The more obvious arguments against the contention that the differences in these indirect indicators in the East Midlands of England may have occurred in some way because of the presence of the Leicestershire Community Alcohol Services are enumerated below:

1. That the populations under study are so small and the variations so great as to render these results meaningless. These three counties between them contain a population which is of the same order as a number of Scandanavian Countries and states/provinces in the U.S.A./Canada, which are widely quoted in epidemiological studies in this field. Further, even despite the relatively small numbers, the trends reported are

consistent over time and highly significant statistically.

2. That the trends shown in Leicestershire are heavily influenced by the presence of the ethnic minority groups, who do not drink like the indigenous population. All three counties do have large concentrations of minority groups, and Leicestershire's were present in those numbers since 1972-3, that is before the study period. So, if there was a significant effect of this kind, it should have been present right at the beginning of the period, influencing the 1975 figures. There is no such influence.

3. That Gross Per Capita Consumption in Leics. is following trends which are atypical. It is very difficult to get data which could confirm or refute that because producers or retailers of alcoholic beverages are loathe to declare publically their commercial performance and/or they tend not to break down their sales statistics into suitable geographic areas. However there is one brewery in Leicestershire whose tied estate is virtually confined to within the county boundaries, and whose beer sales are predominantly there. The Author obtained data on that company's barrelage and it is shown as % change from 1975/6 compared with the National Production (excluding exports) as Figure 7.1. Although these are exceptionally 'soft' data they are the best that could be obtained and do suggest that the trend in Leicestershire is, if anything, towards greater beer consumption.

4. That Leics. Hospital Services are progressively refusing to admit drinkers despite the morbidity being present. Again, there is no evidence for this, and the total number of beds available for all medical and psychiatric purposes was remarkably constant over the

Beer production - expressed as % of 1975/6 totals

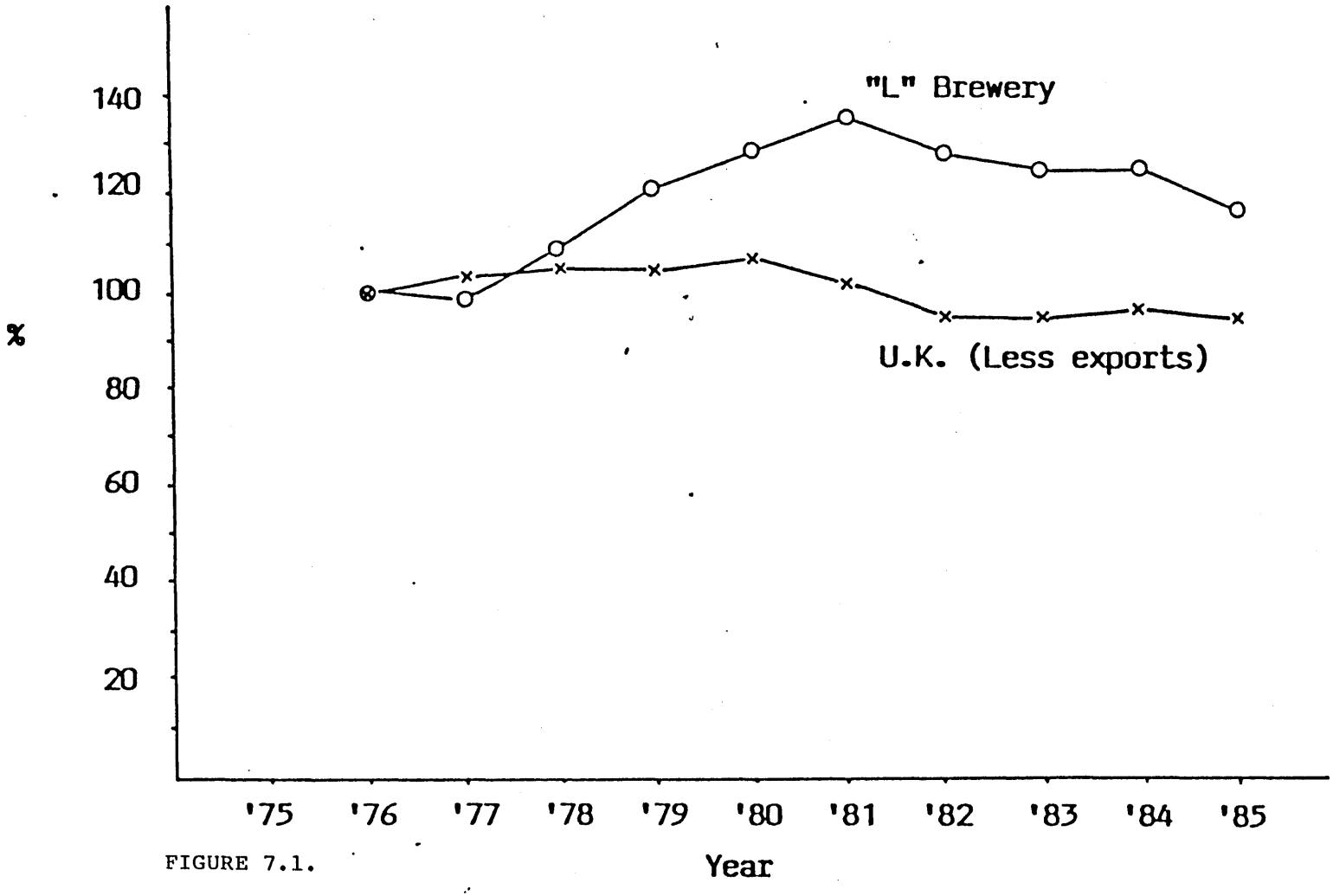


FIGURE 7.1.

study period. Presumably, if that kind of medical deprivation was occurring, it would be reflected in higher mortality from alcohol related illness. There is no evidence of that.

5. That Leicestershire 'exports' its problem drinkers with complications to other Regions. In the South and West of the County, there is some 'leakage', particularly of General Medical and Surgical Admissions, towards the Oxfordshire and the West Midlands Regional Health Authorities but over the decade this 'leakage', starting at no more than 10%, has progressively reduced. If anything this would tend to operate against the trends shown in these data. Any 'exporting' taking place between the study counties is accounted for by using 'by place of residence' data as all three are in the same [Trent] Regional Health Authority.

6. Examination of the possibility that there are differing policing practices between the three Counties was inconclusive. Such differences might explain the Criminal Statistics. For instance, in recent years, the Nottinghamshire Constabulary has operated a particularly vigorous anti-drinking and driving policy .

These data are rather like faces of a diamond. It does not matter which face is examined, much the same image can be seen. By themselves, each and every one of these indicators could have alternative explanations. Their cumulative effect is greater. There appears to be something different happening in Leicestershire.

That something is not easily explained. The findings may carry with them the suggestion that if large numbers of people can be encouraged to use even minimal intervention community - based counselling services, then

those services do provide what is in reality a secondary preventive service for the long - term sequaelae of high levels of consumption. But as mentioned previously, that effect might only be visible in Leicestershire because, by national standards, there the alcohol related morbidity is relatively small and the community response relatively large.

Whether these data provide some evidence to support the hypothesis that these 'penetrative' services might actually be distorting a community's (lognormal) consumption curve by compressing its right - hand (heavy - drinking) tail is much more contentious, for it depends upon an acceptance of the validity of the 'prohibitionist - reductionist' argument outlined in the Introduction (Pages 67 - 69) when these data may well not support it.

If it is possible to find major and significant differences occurring over a decade in these indices in broadly similar counties of the same region of one country, and if it is possible that these differences came about because of the behaviour of a couple of dozen individuals, namely the staff of the Community Services (who total less than 0.003% of the general population), then what meaning can one realistically give to comparisons across nations or even continents where the attitudes and responses to people with alcohol problems vary from the hostile to the indifferent to the caring, with radically different resources devoted to them.

It is also possible that these changes might be occurring in Leicestershire because, for whatever reason, Primary Care Agents are managing their own patients/clients with alcohol problems. How much the response of those people has been influenced by education, co-working and by having in their midst an

agency which responds very rapidly to a referred drinker is unknown. It is possible that the message from the Community Alcohol Services to "have a go", giving permission to fail is now quite widespread in the county. The Indirect Indices differences may just possibly be an education effect rather than any sort of direct treatment effect. Much more evaluative work would be needed to untangle that.

One further related possibility, although at this stage it is even more speculative, is that in some way the presence and attitudes of the Leicestershire Community Alcohol Services have permeated the public consciousness of the people of the county such that they no longer believe (if they ever did) in problem drinkers being diseased and on inexorable downhill paths. The population are no longer so contaminated by the self-fulfilling prophesy of the classical disease concept. That could possibly have had a community-enabling effect. Of course, a whole series of before and after studies with control populations would have had to be undertaken to be able to elucidate that.

As always with somewhat novel findings, the results presented here raise more questions than they provide answers. Indirect Indicators of Alcohol Problems may possibly be telling us more about local attitudes and services than about the actual prevalence of Alcohol Related Disabilities.

b) THE MODELS REAPPRAISED

Can anything be learned about models of Alcohol Problems from these results?

The first question to be asked is: 'Did the Leicestershire Community Alcohol Services deliver the model of care that the Author originally envisaged?' The answer to that is 'No!' It was not possible; for the services could not both start 'where the client was' and operate the model that is conceptualised as Figure 4.5 for the very straightforward reason that at the time of presentation, the customers did not report seeing themselves in that way. Their consensual view was that there was, indeed, something seriously wrong with much of their drinking and that they were abnormally under the influence of a force or forces which led them towards excessive or out of control drinking. That is that they were, in that regard, abnormal. Nonetheless, they did, as the nameless model profiled in Figure 4.5. infers, believe themselves to be responsible, even if they were now seeking expert assistance. So the consensual view of the customers of the Services was very close indeed to the Profile of Alcohol Dependence, shown as Figure 3.2., differing only in the matter of the degree of perceived personal responsibility, where they felt a greater burden of responsibility than the profile accounted for. They saw themselves therefore not so much as 'Dependent Drinkers' but as wilfully excessive potentially or actually problematic drinkers. They saw themselves as ***'Determined Drinkers'***.

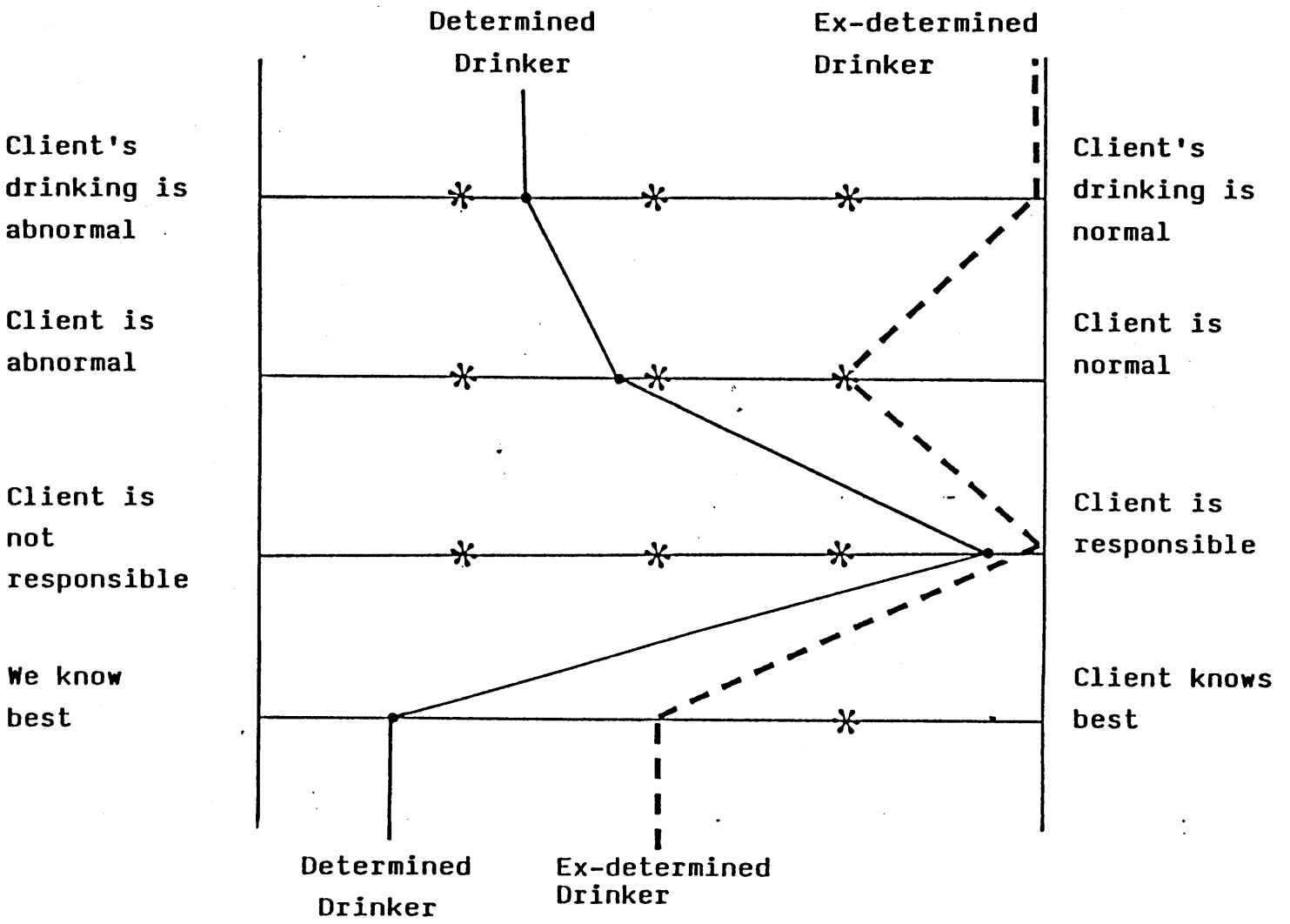
However, at reassessment , they saw themselves very differently again. At this point they saw their drinking as once again back to normal, themselves as somewhat abnormal (the ex-problem drinker status), even nearer

totally responsible and at a more equivocal mid-point with regard to who knows best. They had certainly shifted to the right away from the "I'm in trouble, please help me!" passive position, where 'doctor knows best'. Just how far across they have moved could not be determined on the basis of the data available and further work would need to be undertaken to clarify that. Some saw their ***Determined Drinking*** as a thing of the past. The Profiles of these Models of ***Determined Drinker*** and ***Ex - Determined Drinker*** are both shown in Figure 7.2.

At this moment in the pursuance of the argument, it does not matter to the Author whether these views held by the clients of the services about themselves are true or false, reasonable or ridiculous. All that matters is that, for better or worse, they seem to hold them. If that is so, the next question to be asked is: 'Can these views be explained in terms of the framework of Models shown in Table 3.1 and used recurrently in this Thesis?'

First, when these people presented to a 'permissive' interviewer, the model that was presented was very close to that of the Alcohol Dependence Model, the profile of which has already been derived from the pure models (Pages 34 - 38).

The ***Ex-determined Drinker*** Model, however is very different. It is another hybrid model, meaning that it is not one of the existing models by another name. It is an entirely new one, and it cannot be reproduced by summating any combinations of the existing pure models, which could be done by assuming, for instance that the clients have failed to incorporate into their belief systems, say the bad habit, faulty learning model. The nearest one can get to it within the existing framework is a combination of conspiracy theory, psychological


Determined Drinker
Ex-determined Drinker
Client's drinking is abnormal
Client is abnormal
Client is not responsible
We know best
Client's drinking is normal
Client is normal
Client is responsible
Client knows best
Determined Drinker
Ex-determined Drinker

disturbance and the moral (wicked) model. Interesting though that concept is, it does not fit closely enough. It is not sufficiently 'to the right' of the figure. In particular, it does not profile current drinking as normal.

Apart from introducing some new assumption such as discriminative weightings on the various models, which the philosophical rules of the exercise have not permitted because it would then cease to have any predictive function, there is only one other possible explanation. That is that there is a model missing.

To move from ***Determined Drinker*** to anything like the required profile would require the existence of a model so outrageous that at first thought, it would appear untenable. It would need to be an ultra-conspiracy theory model. It would need to be a model of drinkers and drinking which portrayed them as supernormal, a model that did not convey a drinker as ordinary, but as extraordinary and drinking as life enhancing. It is the model of the ***Enthusiastic Drinker,*** which is so extreme that it would actually force redefinition of the right hand boundary of the dimensional diagram. Surely such a model could not exist?

In fact, in the Models of Madness series of papers, there is described one model which is akin to this. It explicitly states that to be or to have been mad is to have been enriched, and therefore that the experiences of the mad are to be sought by the sane. Thus, the duties of members of society towards such people should include learning from them. That is R.D. Laing's model of madness and has been termed the Psychodelic model (Siegler, M., Osmond, H. & Mann, H. 1969) But that is the only recognisable equivalent of what would be required.

Perhaps it was because it is all around us and within us that the Author did not notice it earlier. Advertisments are full of it. It is the *He*n*k*n reaches parts that..., I bet he drinks C*rl*ng Bl*ck L*b*l..., That's M*rt*n*..* model. It is the model that made a hero of Dylan Thomas and created 'The Legend of the Holy Drinker'. It is that set of beliefs that exists in many of us that states that Drinking actually does make us feel and function better, that states that our self-confidence, enjoyment of music, religious understanding and attractiveness are enhanced by intoxication, and which on some drinking occasions gets validation. Many of the statements made about the effects of alcohol by the customers at initial assessment are consistent with that view (Page 135).

It is hardly a surprise, then, that clients of Alcohol Services, once they achieve some degree of re-exposure to the feelings and beliefs of the drinking cultures from whence they came should become permeated with those powerful and entrenched cultural beliefs and leave their previous short entry into the sick or quasi-sick role behind. The implications of that are far - reaching. It might go some of the way to explaining why in-patient units, which carry within them a set of beliefs a long way removed from the ***'Enthusiastic drinker'*** model, have difficulty in maintaining the impact of their treatment efforts once their patients are discharged. Once discharged from an Alcohol Treatment Unit the patients enter 'another country'. That may also explain the widely quoted attitude of some Alcoholics Anonymous adherees that 'Drinking is great, but not for me!'

How can eclectic community services, which claim to operate in this 'other country' hope to help their customers to modify, perhaps even to cease their alcohol

use? There is some assistance already coming from changes in our overall cultural attitudes to alcohol. Non-consumers are increasingly accepted, even 'trendy'. They do not drink, not because they are 'diseased' but because they choose not to. Despite that gradual shift in public attitude, it appears that the protective 'mantle' of diseased or dependent status is generally insufficient protection against the cultural climate.

It is now appropriate to compare and contrast Alcohol Dependence and ***Determined Drinking***. The differences between these concepts appear slight, but they are crucial. They exist in two areas. The first has already been mentioned and that is the issue of personal responsibility, with Alcohol Dependence maintaining a position of less inferred culpability. The other concerns the core Disease Concept idea of Inexorability. The Alcohol Dependence Syndrome has within it the concept of 'Reinstatement after Abstinence' whereas ***Determined Drinking*** has no such prediction attatched. Admittedly, Edwards and Gross are vey open - minded about this, saying 'Relapse into the previous stage of the dependence syndrome then follows an extremely variable time course' (Page 28). ***Determined Drinking*** is something that can be engaged in and then abandoned as internal and external determinants change. It is akin to a state of temporary and therefore reversible Alcohol Dependence and is therefore a description of a state, psychological, social or physical. It is not a description of a person.

It is important to repeat that at this stage the Author is not attempting to say that the ***Determined Drinking*** Model is the right one and the others are wrong. He has not a scrap of evidence to support, or indeed to refute that contention. The whole basis of this exercise is that those kind of judgements are not made. What he is

saying, however, is that, as best as he can interpret it through the philosophical framework that he has created, that is what the Users of the Services are claiming about themselves, and as a position, theirs is not far from the existing consensual view of the Alcohol field. . Further, it is just as capable as 'Alcohol Dependence' of generating hypotheses that could be tested.

From a practical point of view, ***Determined Drinking*** has the advantage of not undermining an individual's personal responsibility which it is neccessary to support and validate if an intervention is to be worthwhile. It does not require the therapeutic production of a 'mantle'. Indeed, the issue of choice over, and control of, personal conduct, seems crucial. Very few (3.9% at Reassessment, 6.8% at Follow-up) of the findable customers of the Leicestershire services claimed after intervention to be still not controlling their drinking, regardless of their levels of consumption. The rest felt back in charge. Whether that was a spurious feeling does not matter, for unless that feeling is engendered, change is less likely to occur. Individuals must feel that they are in charge and that they can, indeed, change things for themselves. That is called self-efficacy.

It would appear that the Author, as creator of Ethos of the Leicestershire Community Alcohol Services, in attempting to pull as clear as feasible from the classical Medical Model, stumbled unwittingly over the therapeutic value and customer-acceptability of enhancement of personal responsibility with its correlate of self-efficacy. That is consistent with the present British cultural climate. For better or worse, it is a view which currently thrives in this 'other country'.

c) IMPLICATIONS FOR CLINICAL SERVICES

While it is just feasible that ***Determined Drinking***, or something not unlike it may in the future become the next 'single frame of the long running motion picture' (Page 38), it is presented here more as an attempted look into the future than as a major conclusion of this study. The findings of this study are much more mundane and practical than that. They concern the lessons that may or may not be extracted from the 'Leicestershire Experiment'.

The first is a replication of a sentiment expressed by the Author after his first - ever Controlled Drinking Group, and that is to report that 'Nothing Awful Happened!' Thus, over the past decade, the Community Alcohol Services in Leicestershire have delivered to nearly seven thousand presenters an eclectic non-abstinence oriented community based service. They have formed an integrated service, linking statutory and non-statutory agencies. The Services appear to provide a reasonable degree of 'customer satisfaction'.

The second is that it is possible to develop and maintain an ethos within community based services which enables some consistency of response. In brief, the Leicestershire Community Alcohol Services have a view of people with alcohol problems which sees them as responsible rather than victim and as people who have finite episodes of 'bother' related to their use of alcohol. The job of the services is to minimise those episodes of 'bother' when they occur and increase the length of time between the episodes, hopefully indefinitely.

The services do not see themselves as responsible for their customer's conduct, including drinking conduct. Therefore the services can function in a community setting. Were the staff in the services attempting to suppress people's drinking against their wishes, they would fail. Even in in-patient Alcohol Treatment Units (or indeed prisons!), if drinkers wish to go on drinking, they can usually find ways of doing that. In the community such suppression is clearly impossible. For the Leicestershire Services, it is not even desirable. Thus the customers are enabled to make their own decisions, to operate free choice and to 'live with the consequences of so doing'. The task of the therapists in that setting is thus rather different. It is as supporters, advocates, information givers, arbitrators, and facilitators of change. That means that the staff have to give people the right to make mistakes and not to reject them if they do.

However, that perception of their customers does mean that these services do not always appeal to referring agents, whose lives would often be made much easier if the alcohol services somehow or other managed to get their clients to cease drinking absolutely, instantly and permanently. This area of conflict is most clear in two areas. First in the area of criminality, probation officers find that the services' unwillingness to take their clients on with a condition of treatment imposed by the courts reduces their disposal options. For them, medicalisation is more appropriate than criminalisation, a view not shared by the workers in the alcohol services. The second group are general physicians, having to deal with patients whose bodily health has been seriously damaged by alcohol. Clearly, both they and workers in the alcohol services would agree that for those customers, cessation of drinking is a totally appropriate goal. The differences in attitude lie

in the means by which that end can be achieved, and in the management of customers who reject that goal. Discovering for themselves that more illness follows on resumed drinking is appropriate, though potentially costly, learning. Also, the services have instituted a system, used for very few customers, of planned six-monthly admission for detoxication. This is simply to give to these people, who have not the slightest intention of changing their lifestyle, episodic respite from the effects of their drinking. It appears to be cost-effective inasmuch as that it reduces emergency admissions. But it could be construed as collusion. It is enabling people to go on 'getting away with' damaging drinking styles.

But, while such a style of service delivery is realisable and maintainable, its overall efficacy is very hard to evaluate. This, in part, is because alcohol use and alcohol problems are so intrinsic a part of everyday life that to evaluate properly, one would need to look at almost every aspect of societal functioning.

The evaluation study on 162 'good bet' customers in 1981-2 presented in the Results section shows short-term abstinence rates which are as good as those which abstinence oriented programmes achieve. For the rest, reduction by half of quantities consumed per drinking day, still means that they are drinking well above what the current consensus of what 'safe limits' are. (Consensus Statement of the Royal Colleges, 1987) Certainly, some of the services' customers who would be regarded as successes will in due course, even if their current levels of consumption are maintained, develop long term physical and other problems. But some will not: and it is arguable that were the services not the style

they were, these people would not have received even minimal intervention.

If these Services were somehow responsible for the changes in the reported indirect indices, it is encouraging. In terms of offset costs, the flattening off or reduction in numbers of these problems has very great implications. For instance on hepatic cirrhosis alone, the savings in offset costs can be roughly quantified. If one works on a figure of £ 20,000 per patient for the total cost of medical management of hepatic cirrhosis from presentation to death, and one assumes that, on Figure 6.5. Leicestershire should have been in the middle point, between Derbyshire and Nottinghamshire, then in Leicestershire in 1985, 0.35 people per 10,000 did not get Cirrhosis who would be expected to. That means 31 people in the county did not start accruing medical costs, an offset saving of over £600,000. Assuming that that has happened because of the presence of the Community Alcohol Services, then the services have more than paid for themselves on that indicator alone, for over the decade 1976 - 1985, the sum involved, using those same current prices is £ 2¾ million!

Such economic arguments are, of course, highly contentious. For they end up by putting hard cash values on services whose impact is poorly evaluated to begin with. Also, when account is taken, say, of lost earning capacity caused by premature death, the figures become truly spectacular. For instance, it has been estimated that every death on the road has an overall cost of over £ 200,000. (McDonnell, R. & Maynard, A. 1985) The assumptions upon which the economists base their econometric appraisals are, of their own account, highly questionable. Further, given that the levels of alcohol consumption of some of the Leicestershire Services'

successes remain in the realms of potentially damaging, it is possible that all that these services have done is delayed for a while the development of consequential problems of alcohol use, with longer term cost implications.

Nonetheless, it can be claimed that the Leicestershire Services cost no more to run than more 'conventional' responses, and do attempt to intervene in the lives of large numbers of their county's citizens. At that basal level of evaluation (See page 147), they are a success. And if, by processes which are far from clear, they really do act in a secondarily preventive way for the whole community, they are a great success.

Clearly, a more comprehensive evaluation of this model of service is justified to judge whether 'The Leicestershire Experiment' is worth replicating elsewhere, particularly in areas with very different prevalences of alcohol related disabilities.

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APPENDIX 1

Initial Assessment Form

INITIAL ASSESSMENT FORM - ALCOHOL

DATE: ASSESSOR: WHERE?:

FILE: AAC NO: D/Hse No:

PRIME THERAPIST: CO-OP SUPERVISOR:

NAME:

ADDRESS:

TEL NO:

Current Type of Accommodation _____

How long at this address? _____
How long in Leicestershire? _____

DOB (AGE): PLACE OF BIRTH:

SEX (M/F): MARITAL STATUS:

EMPLOYED: YES/NO

REFERRAL DETAILS

Who referred? By: Tel/Letter/in person

Relationship to client:

Address:

Tel No:

MEDICAL DETAILS

GP (Name):

Surgery Address:

Tel No:

Knowledge of problem? YES/NO
Knowledge of referral?YES/NO

Can Services contact GP (if needed)? YES/NO

Current medical treatment(s) for drink-related problems (include ANY prescribed medication):

1 How would they describe their ethnic origin?

[]	British/Irish	[]	Other European
[]	African	[]	Carribean
[]	Indian	[]	Pakistan
[]	Bangladesh	[]	East African Asian
[]	Mixed	[]	Other
[]	Not known		

2 a) What religion are they?

[]	Christian	[]	Hindu
[]	Muslim	[]	Sikh
[]	Rastafarian	[]	Other
[]	Not relevant	[]	Not known

b) Are they still practising?

3 What is the main language spoken at home?

[]	English	[]	Other European
[]	Bengali	[]	Gujarati
[]	Hindu	[]	Punjabi
[]	Urdu	[]	Other
[]	Not known		

I _____ do hereby give my consent for any information or records pertaining to me to be transferred within the Leicestershire Community Alcohol Services. The nature of these services have been explained to me to my satisfaction and I understand that such information will remain confidential within these services.

Signed: _____

Date: _____

RECENT DRINKING PATTERN

1 How much have they had to drink in the last 7 days?:
(work backwards with them from the day prior to assessment)

QUANTITIES & BEVERAGE TYPES	Weekday: (eg Mon, Tues)	1	2	3	4	5	6	7 yesterday
	Morning							
	Afternoon							
	Evening							

2 Was this (above) a typical week for them in terms of their drinking?
YES/NO

Comments:

Other Agencies contacted (for drink related problems)

		DATES			DATES
☐	GP	____	☐	Probation*	____
☐	Private Doctor	____	☐	Social Services*	____
☐	Alcohol Treatment Unit	____	☐	Voluntary Agency (specify, eg, AA):	____
☐	Gen/Psychiatric Hosp (specify):	____			
			☐	Prison	____
☐	Other (specify):	____	☐	None	

Details of above:

*Social Worker's Name:
Area:

*Probation Officer's Name:
Area:

PRESENTATION AT ASSESSMENT: (eg, appearance, mood, intelligence etc)

PROBLEM DRINKING PATTERNS

Preferred Beverages:

Frequency: How often do they typically drink? (please circle)

DAILY/2-3 DAYS PER WEEK/EVERY WEEKDAY/WEEKENDS ONLY/BINGES

Type of user: (please circle)

HABITUAL/REGULAR/OCCASIONAL - BINGER/RECREATIONAL

How long has this been problematic? _____ years/months/days (delete as appropriate)

Amount (per day/week/month)on average? _____

Behavioural/mood effects of alcohol (ie what do they get out of it)?:

Where, and with whom (predominantly) are they drinking?:

What do they think triggers or cues them to drink (ie reasons for drinking)?:

When are they starting to drink (eg morning, evening)?

How long does a typical drinking session last?

_____Hours or _____Days.

Is this their current drinking pattern?: YES/NO

If NO, give details:

WHY HAVE THEY PRESENTED FOR HELP NOW?
(eg circumstances and reasons for referral)

DRINKING HISTORY

What was their drinking like before it became problematic (eg age started, preferred beverage, early patterns etc):

Any periods of NON-PROBLEMATIC DRINKING since problem started? YES/NO

If 'YES', describe:

Ever totally ABSTINENT since problem drinking began? YES/NO When? _____

If 'YES', describe:

If problem drinking not continuous, why does problem drinking recur?:
(ie reasons, triggers etc)

Have they noticed any specific consequences (1) after stopping drinking, (2) while drinking? YES/NO
If 'YES' specify below (without prompting):

1 2		1 2		1 2	
() ()	Headaches	() ()	Poor appetite	() ()	Anxiety
() ()	Nausea/vomiting	() ()	Poor sleep	() ()	Depression
() ()	Stomach pains/cramps	() ()	Memory problems	() ()	Sex problems
() ()	Shakes	() ()	Disturbed perceptions	() ()	Frequent minor illnesses
() ()	Sweating	() ()	Disorientation	() ()	Phobias/fears
() ()	Palpitations	() ()	Paranoia	() ()	Tinnitus (ringing/buzzing in ears)
() ()	Blackouts	() ()	Hallucinations	()	
() ()	Tingling (fingers, toes)	() ()	Epileptic Fits	() ()	Missing work/appointments
() ()	Positional alcohol nystagmus (whirling pits)	() ()	Weight problems (over or under)	() ()	Accidents through drink (specify):
				() ()	Hypertension

OTHER(S):

COMMENTS:

HOME ENVIRONMENT

Civil Status: _____ For how long?: _____

With whom living?: _____

CURRENT RELATIONSHIPS

Number of children ___ Ages:

Are they: living with client/with relatives/in care/other: (specify)

_____

Extent of marital/familial conflict:

None at all . . . . . Extreme
1 2 3 4 5 6 7 8 9 10

How much of this conflict is unrelated to present drinking? _____%
(ie, other than drinking what is the conflict about?)

Comments:

Partner's/Significant Other's:

1) Alcohol/drug use? YES/NO Details:

2) Knowledge of problem? YES/NO
3) Knowledge of referral? YES/NO
4) Willingness to help with therapy? YES/NO
5) Attitudes to client's drink problems:

discourages it . . . . . encourages it
1 2 3 4 5 6 7 8 9 10

OVERALL QUALITY of marital/familial relationship:

poor . . . . . excellent
1 2 3 4 5 6 7 8 9 10

COMMENTS:

RISK FACTORS

Is anyone currently at risk? YES/NO If 'YES', specify:

EMPLOYMENT

Job History: School leaving age: _____

No of jobs over the last 12 months (include casual employment) _____

In the last 12 months for how long were they in employment?_____weeks/months

CURRENT JOB STATUS: EMPLOYED/UNEMPLOYED For how long?:_____

TRADE/PROFESSION: _____

Is this position likely to change? YES/NO If 'YES' is it drink related? YES/NO

Generally speaking, how well did/do they get on with their co-workers?

very badly . . . . . extremely well
1 2 3 4 5 6 7 8 9 10

Overall job satisfaction:

poor . . . . . excellent
1 2 3 4 5 6 7 8 9 10

Summary of job stability:

unstable . . . . . stable
1 2 3 4 5 6 7 8 9 10

How much money do they spend on alcohol on average per week? £_____

Can they afford this? YES/NO

LEGAL HISTORY

Nature of Offences:

How dealt with:*

Current legal involvement:

---

*court case pending - on bail/in custody
custodial sentence/probation order/care order/suspended sentence/deferred sentence/
community service order/fines pending/other/not known

SELF CONCEPTS/APPRAISALS

[The following scales are to be rated by the client him/herself and NOT to be estimated by the assessor unless absolutely necessary]

Perception of Problem

1) In terms of it interfering with their life, how serious does the client consider his/her drinking to be?

not very . . . . . very
1 2 3 4 5 6 7 8 9 10

2) What is wrong with their drinking, according to them?

Locus of Control

3) To what extent do they feel responsible for their drinking?

not at all . . . . . completely
1 2 3 4 5 6 7 8 9 10

4) How important are external factors to their drinking?

not at all . . . . . completely
1 2 3 4 5 6 7 8 9 10

5) What are these external factors?:

Self-Esteem

6) In terms of their general self-esteem how do they presently feel about themselves?

negative . . . . . positive
1 2 3 4 5 6 7 8 9 10

Explanation of above rating (self esteem) ie why?:

8) What was their self-esteem prior to their drinking problem?

negative . . . . . positive
1 2 3 4 5 6 7 8 9 10

Explain any difference between past and present scores:

GENERAL COMMENTS

Appendix: 1

CLIENT'S PERCEIVED NEEDS AND PROBLEM AREAS:

ASSESSMENT CONCLUSIONS AND SUGGESTED TREATMENT FOCI

APPENDIX 2

Follow-up and Re-assessment Form

Interview ☐
Postal ☐
Phone ☐

Re-assessment Form - Alcohol

Name _____ Address _____

Date _____ _____

1) In the last six weeks,

Have you been in contact with any other agency for help with your drinking?

YES/NO (circle)

If yes, which ones:

2) Current Drinking Pattern (past week only)

Beverage type: NOTHING
BEER/LAGER
CIDER
(circle) WINE/SHERRY/VERMOUTH/BARLEY WINE
SPIRITS
METHS/SURGICAL SPIRIT

Frequency: EVERY DAY/2-3 DAYS PER WEEK/MOST DAYS/ WEEKENDS ONLY/BINGES (circle the most appropriate)

Time of day Starting to Drink:

MORNINGS/MIDDAY/AFTERNOON/EVENINGS (circle)

Where Drinking?:

PUBS/CLUBS/HOME/FRIENDS/WORK/PARKS/ANYWHERE (circle)

With whom?: _____

For how long per day: _____ hours

Amount per day _____

What are the reasons for your drinking now?

What does your present drinking do for you?

How do you feel the next morning after drinking? (specify)

3 Current Relationships

Marital Status: S/Mar/Wid/Div/Sep (circle)

How well do you get on with the people you live with?

extremely badly	badly	OK average	well	extremely well	not applicable
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

Has any one of your family or friends been involved in helping you with your drinking?

(tick)

- [ ] No
- [ ] Parents
- [ ] Partner
- [ ] Children
- [ ] Relatives
- [ ] Neighbour
- [ ] Friends
- [ ] Other (specify: _____)

4 Current Employment

Are you presently:

(tick)

- [ ] Employed
- [ ] Unemployed
- [ ] Retired
- [ ] Houseworker
- [ ] Sick
- [ ] Student
- [ ] Other (specify: _____)

How happy are you in your present work circumstances? (tick)

very unhappy	unhappy	OK average	happy	extremely happy
[ ]	[ ]	[ ]	[ ]	[ ]

5 Legal Status

Have you been involved with the law since I last saw you?

YES/NO
(circle)

6 Self Concepts

How much of a problem is your present drinking? (tick)

extremely bad	very bad	bad	a bit	not at all
[ ]	[ ]	[ ]	[ ]	[ ]

What is wrong with your present drinking?

What sorts of things influence your drinking?

How do you presently feel about yourself as a person?

1 2 3 4 5 6 7 8 9 10
(circle)

very negative — very positive

Compared to six weeks ago, do you feel that your present drinking is:

a lot worse	a bit worse	the same	a bit better	a lot better
☐	☐	☐	☐	☐

What do you think of the Drury House treatment approach to your problems relating to drinking?

very unhelpful	somewhat unhelpful	OK	somewhat helpful	very helpful
☐	☐	☐	☐	☐

How could we improve our services?

Any Other Comments

Thanks for your time: Please return in the pre-stamped envelope or to:

Drury House, 50 Leicester Road, Narborough, Leicester. LE9 5DF.