

DOCTORS AND DRINKERS

*An Exploratory Study of the Therapeutic Commitment
of General Practitioners in Longford/Westmeath
towards working with Problem Drinkers*

by

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SUMMARY

Alcohol and alcohol related problems are the major public health issues in Ireland and in many other countries in the Western World. In Ireland, and internationally health policy makers have promoted the public health perspective on alcohol problems, incorporating a community response, an emphasis on primary care, and an active role for general practitioners in working with problem drinkers. The rationale for the involvement of general practitioners in this work is underpinned by a range of factors. The most important of these, are the reconceptualization of alcohol problems as a broad spectrum disorder, the evidence that patients with alcohol problems visit their general practitioner more often than other patients, and the evidence for the relative effectiveness of brief interventions, by general practitioners in comparison to intensive specialist services.

A number of barriers, both attitudinal and organizational have been identified, that affect the involvement of general practitioners with problem drinkers. Research evidence suggests that general practitioners have what is called low therapeutic commitment towards working with drinkers, because of lack of counselling skills, knowledge, experience and support. The purpose of this exploratory study, was to establish the level of therapeutic commitment of 35 general practitioners, members of the Irish College of General Practitioners in Longford/Westmeath towards working with problem drinkers using the AAPPQ questionnaire (Cartwright 1978). The general practitioners were found to have low therapeutic commitment towards working with problem drinkers.

Paradoxically the respondents felt they had the right to engage drinkers (role legitimacy) and that they had the knowledge and skills (role adequacy) to carry out this work. Despite expressed feelings of role adequacy, respondents were found to have limited experience, training, education, and support in relation to alcohol problems. It is suggested that general practitioners need education training and support, in order to increase their therapeutic commitment towards working with problem drinkers. However the structural and situational constraints under which they work, represent major barriers to general practitioners receiving this education and training.

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CHAPTER 1

INTRODUCTION

Alcohol and alcohol related problems are the major public health issues of our time in the western world. Alcohol as a public health issue overshadows more conspicuous public health problems, such as tobacco and illicit drug use. (Royal College of Psychiatrists, 1986) (World Health Organisation 1987).

Health, social services, transportation, the criminal justice systems and the workplace carry the burden of alcohol related harm. The World Health Organisation (1993) estimate that the economic burden of alcohol related problems accounts for 2 to 3 per cent of Gross National Product (GNP) and alcohol can be responsible for 8 to 10 per cent, of deaths in the age range 16 to 74 in Europe.

In Ireland overall per capita consumption of alcohol increased by over 100 per cent between 1950 and 1982. This increased consumption has been attributed to increased economic prosperity, growth in disposable income, reduction in the actual cost of alcohol in relation to disposable income, and a substantial increase in consumption, and frequency of drinking by women and young people (Walsh 1987).

It is well established that there is a close relationship between national per capita consumption, and the extent of alcohol related problems (WHO 1993). The Irish experience validates this perspective with increased prosecutions for drunkenness and increased death rate from cirrhosis of the liver and a marked increase in admissions to psychiatric hospitals for alcohol problems.

The most significant aspect of the Irish response to alcohol problems has been the admission of problem drinkers to psychiatric hospitals for treatment. In 1965 there were 1,638 admissions for alcohol related problems, and in 1985 the figures were 7,272 admissions. This was in part, it can be argued, because an alcohol related problem was defined as a disease or condition that required treatment and the psychiatric hospital was perceived as the appropriate location for this treatment.

At theoretical, scientific and policy levels a discourse has been developing around the validity of current perceptions, definitions, and responses to alcohol problems. The basis for this discourse is the increasing scepticism about the usefulness of traditional concepts such as the disease model, the notion of treatment, and the value of specialist services.

International research (Institute of Medicine 1990) suggests that alcohol problems are best conceptualized as a broad spectrum rather than a unitary disorder. Further empirical research (Miller 1991) (Moos, Finney and Cronkite 1990) has demonstrated that specialist treatment approaches have overall disappointing outcomes.

Drawing on the work of the World Health Organisation health policy makers in Ireland (Planning for the Future 1984) have proposed that the locus of concern for alcohol problems should be shifted to primary health care settings. Despite this policy commitment to primary health care treatment of alcohol problems, the proportion of admissions to psychiatric hospitals for alcohol problems remains high. The 1982 alcohol related admissions accounted for 26 per cent of the total; this has reduced to 23 per cent of all admissions for 1988.

It can be argued that these figures demonstrate the need to develop primary health care services for problem drinkers; it can also be asserted that for some as yet unknown reasons the primary health care of problem drinkers does not exist.

The key primary health care worker is the general practitioner who has a pivotal role in providing help for problem drinkers. It is well established that general practitioners have more contact with individuals with alcohol problems than other primary health care workers (Royal College of Physicians 1987). This assertion is supported by Barbour et al (1986) who found that excessive drinkers suffer more ill-health than the general population and are therefore more likely to attend their general practitioner.

Despite the policy rhetoric and the commitment to primary health care, and the critical role of the general practitioner, the evidence suggests that doctors in general fail to recognise alcohol misuse in their patients, and when they do, they feel there is little they can do about it.

Shaw (1978) drew particular attention to the known prevalence of alcohol problems and the minimal proportion that receive help. Focusing on this discrepancy, he argued that this lay as much with the attitudes of the helpers as with the attitudes of the drinkers.

Cartwright (1975) has addressed this attitude problem of primary health care workers towards working with problem drinkers; he proposed that a causal relationship exists between various individual and situational factors, such as training, knowledge, skill, support, experience, self esteem, and increased role legitimacy and role adequacy, which he argues would in turn enhance therapeutic commitment.

Using the Alcohol and Alcohol Problems Perception Questionnaire (AAPPQ) 1975, Cartwright has provided a reliable means of measuring the therapeutic commitment of primary health care workers towards working with problem drinkers.

In the light of the increased commitment to primary care already noted and the focus on the critical role of the general practitioner, the limited effectiveness of specialist treatment, it is proposed to investigate the commitment of general practitioners, who are members of the Irish College of General Practitioners in Longford/Westmeath towards working with problem drinkers.

If the expectations of the primary health care policy on alcohol are to be fulfilled it is necessary to find out the level of commitment of doctors to drinkers, and to this kind of work.

This is the main aim of this study in Longford/Westmeath, a study which has not been done in Ireland until now.

The major hypothesis is that general practitioners have low therapeutic commitment towards working with problem drinkers.

An attempt is made to answer questions such as:

- Are general practitioners motivated to work with problem drinkers?
- Do general practitioners have an expectation of satisfaction in working with problem drinkers?
- Do general practitioners feel that it is legitimate for them to work with problem drinkers?
- How do general practitioners feel about the adequacy of their knowledge and skills in working with problem drinkers?
- What is the self esteem of general practitioners in relation to working with problem drinkers?
- How experienced are general practitioners in working with problem drinkers?
- Do general practitioners feel supported in working with problem drinkers?
- What knowledge and training have general practitioners on alcohol problems?

Rationale

As discussed, the case for primary health care intervention on alcohol problems is well established at policy levels. general practitioners have more contact with the general population, than any other primary health care worker.

Figures from Europe, North America and Australia suggest that 80 per cent of the population visit their general practitioner annually. Thus general practice offers great potential for the identification and treatment of alcohol problems.

However, regardless of the positive empirical findings concerning general practitioner interventions, there is a substantial body of evidence (Clement 1986) that general practitioners have reservations about taking on alcohol problems as part of their case load, and that they do not derive much satisfaction from working with problem drinkers.

If the identification and management of alcohol problems is to become a recognised part of the remit of the general practitioner it is argued here that it is important and timely to examine the barriers or resistances to this happening.

Over recent years researchers drawing on the work of the Maudsley Alcohol pilot project (Cartwright 1975) have argued that low therapeutic commitment - a commonly found attitude profile, is a critical factor in affecting the response of primary health care workers to problem drinkers.

The Maudsley Alcohol pilot project, developed a model to explain the development of therapeutic commitment, which proposed that professionals, in this case general practitioners experienced role insecurity when confronted with drinking clients, because they lacked the skills and the knowledge required to help (role adequacy) and were uncertain as to whether their professional colleagues or their patients accepted they had a role to play in this area.

Using the AAPPQ (Cartwright 1975) it was decided to assess the therapeutic commitment of members of the Irish College of General Practitioners in Longford/Westmeath towards working with problem drinkers.

The catchment area has a population of approximately 80,000 and is predominantly rural with 2 county towns, Mullingar and Longford. General practitioners from Athlone were excluded from the survey as they are members of a Western branch of the College of General Practitioners.

The specialist services for alcohol problems are provided by the psychiatric services of the Midland Health Board, primarily by Addiction Counsellors working in community settings, and by the acute psychiatric services in St Loman's Hospital, Mullingar.

The argument then is that with the focus on Community Services, including specialist community services, general practitioners have potentially a major role in the identification and treatment of alcohol problems. This potential, as previously noted, may not be realised unless and until it can be established why

it is that general practitioners have low therapeutic commitment. Understanding the basis for this low therapeutic commitment, allows for the possibility of interventions to change this attitude profile.

Research Instrument

It is well established that attitudinal factors play an important role in determining the response of primary health care workers to clients with alcohol problems (Shaw et al 1978).

Given the questions and reservations from a sociological perspective on attitude measurement, it is important that any such attitude profile such as therapeutic commitment, be underpinned by a theoretical understanding of how the attitudes measured relate to behaviour.

The AAPPQ has a well developed theoretical basis (Anderson and Clement 1987), and this is the research instrument chosen here. In the UK it is the most popular form of assessing agents' attitudes towards working with problem drinkers. Studies (Gorman and Cartwright 1991) have demonstrated the basic reliability of the AAPPQ.

The AAPPQ is designed in three sections A, B and C. Section A poses 14 questions concerning background information such as age, number of years working as a general practitioner and the amount of training and education received on alcohol problems.

Section (B) consists of 29 general statements to which respondents indicate the extent of their agreement or disagreement on a 7 point scale ranging from strongly disagree to strongly agree. These 29 items can be added together to form a composite scale of therapeutic attitudes.

The 29 items can also be divided into 5 subscales, 2 of the subscales - role legitimacy and role adequacy - are concerned with role security, with the general practitioners' perceptions of the adequacy of their skills and knowledge in relation to problem drinkers, and how appropriate it is for them to engage in work with such patients.

The other subscales, willingness to work with problem drinkers, expectations of satisfaction in working with drinkers, and professional self esteem in working with drinkers are related to the general practitioner's therapeutic commitment. This is essentially the degree to which they seek to work with problem drinkers and the extent to which this work is rewarding at a professional and at a personal level (Gorman D, Cartwright A, 1991).

Section (C) of the questionnaire is concerned with attempting to assess how much general practitioners know about alcohol problems and contains 15 items.

The complete questionnaire can be found in Appendix 1.

Procedure

The research proposal was discussed with the tutor of the East Midland Branch of the College of General Practitioners, the professional training organization for general practitioners. It was felt that general practitioners who were part of an ongoing continuing education programme would be supportive of the research. The proposal was endorsed by the College of General Practitioners and the Midland Health Board.

A mailing list of members of the Irish College of General Practitioners, together with a covering letter, was provided by the regional medical tutor. The complete list of general practitioners, 38 in all, were sent the questionnaire by post, with a free post return envelope on 4 July 1994. A letter explaining the purpose of the research and requesting the co-operation of the respondents and the immediate return of the completed questionnaire was included with the documentation. The respondents were assured of complete confidentiality and anonymity. A follow up letter was sent to all participants 2 weeks after the initial contact. Copies of the contact and cover letters are provided in Appendices (2, 3, 4, 5, 6).

Study Population

The study population as noted included the total list of members of the Irish College of General Practitioners of the East Midland Region numbering 38 in all.

Editing and Coding of the Questionnaires

On return of the questionnaires, the data for each section was coded and where appropriate, scoring was carried out. This was done using the handscoring instrument developed by Cartwright for the AAPPQ (see Appendix 7).

The study also relied on theoretical positions and research based conclusions from the literature.

Organisation of the Study

As noted, the main aim of the study is to investigate the commitment of general practitioners, members of the Irish College of General Practitioners, towards working with problem drinkers.

Chapter 2, the literature review, provides a context for the study. Relevant information on overall consumption of alcohol in Ireland is reviewed and discussed. The relationship between overall per capita consumption and the level of alcohol related problems is examined and statistics on the prevalence of alcohol problems are presented.

Having reviewed levels of consumption of alcohol and the various indices of alcohol related harm, the literature and the evolution of conceptual models of alcohol problems is reviewed and discussed.

The origins of the notion of addiction as a disease are explored, together with the influence of the temperance movement and Alcoholics' Anonymous. The

social learning model and the public health model are presented and compared with the dominant disease model. Drawing on the influence of the conceptual models, public policy and research, existing responses in terms of treatment are reviewed. It is established that most specialist treatment responses are unsupported in controlled trials.

The public health model, incorporating a continuum of alcohol problems, emphasising a major role for primary health care - in this case general practitioners - is presented as a more effective response.

The evidence for the effectiveness of general practitioner interventions is presented, and drawing on the research literature, previous studies of the therapeutic commitment of general practitioners are examined.

Chapter 3 involves presentation of the findings where the actual results will be used to validate or otherwise the main hypothesis, and an attempt will be made to answer the questions posed at the outset. Use is made of the handscoring instrument (Cartwright 1978) for scoring the AAPPQ.

In Chapter 4 the findings are discussed and the main conclusions summarised. The thesis is concluded with recommendations for education, training and future research.

As discussed, the general practitioner is in a unique, yet underdeveloped position to intervene with problem drinkers. The attitude profile of low

of general practitioners to intervene with problem drinkers. This study attempts to establish if this is true for members of the General College of General Practitioners in the East Midland Region.

Assuming the hypothesis that the study group has low therapeutic commitment is validated, it will be asserted that in order to enhance therapeutic commitment, general practitioners require:

- (a) Knowledge about alcohol problems
- (b) Training in therapeutic skills
- (c) Support and consultancy from specialist services.

However, despite the value of (a), (b) and (c) it will be argued here that structural and situational constraints, a focus on curative medicine by doctors and patients, conceptual confusion on the nature of alcohol problems are factors that also affect therapeutic commitment.

CHAPTER 2

LITERATURE REVIEW

INTRODUCTION

The purpose of this chapter is to provide a background context for the study, to demonstrate the significance of the study and to clarify the relationship between this study and previous work on the subject.

This here will involve a critical review of the relevant literature.

In general terms this study is concerned with the commitment of general practitioners towards working with problem drinkers. This gives the study a specific focus; therefore it is necessary to start by limiting the scope of the review, and delineating the topics for review and discussion.

Firstly, the focus of the review is on the prevalence of drinking and drinking problems in Ireland. In this section statistical data on alcohol consumption and alcohol related problems in Ireland will be reviewed and discussed and compared with international statistics on alcohol consumption and alcohol related problems.

Secondly, given the conceptual confusion surrounding what constitutes an alcohol problem, the development of conceptual models of alcohol problems will be reviewed and discussed.

Thirdly, drawing on the discussion of conceptual models as noted, public policy and research influences, the treatment responses to alcohol problems will be examined.

Sharpening the focus of the review to the area of study, the literature on general practitioners' interventions with drinkers will be reviewed and discussed.

Finally, studies of the therapeutic commitment of general practitioners, using the AAPPQ will be reviewed and discussed. Each of these topics is dealt with in an individual section.



SECTION I

THE PREVALENCE OF DRINKING AND DRINKING PROBLEMS

Consumption

The issue of alcohol consumption as a public health matter has gained increasing importance for international policy makers (WHO 1993) and national governments over the past 10 years.

In the European Region of the World Health Organisation, member states have the highest alcohol production, export, trade and consumption in the world. In all countries, levels of per capita consumption are strongly correlated with health, social and economic problems that result from alcohol use. The review of the evidence by Bruun et al (1975) supports this correlation.

Therefore, the issue of overall alcohol consumption in the Republic of Ireland is of significance and importance to the government, policy makers, health workers, researchers, economists and the drinks' industry.

It is also important at the individual level with an increased rise of health problems corresponding to increases in consumption - the so-called dose response relationship (WHO 1993).

Per Capita Consumption

The level of alcohol consumption in a population is usually expressed in terms of per capita consumption - that is the amount the average person drinks. To estimate this the total consumption of the population is derived from production and sales figures of alcoholic beverages. It is then translated into an equivalent volume of absolute alcohol based on the percentage volume of absolute alcohol contained in each type of alcoholic drink. Per capita consumption is then calculated by dividing the total national consumption of absolute alcohol by the number of people in the adult population.

Another measure used to calculate per capita consumption is the proportion of personal expenditure on alcohol (Shaw et al 1978).

These measures of per capita consumption, as outlined above, and the personal expenditure measure have been subject to criticisms which are briefly discussed here. It has been argued that such a complex matter as the prevalence of alcohol related problems could not be determined by per capita consumption alone. This particular criticism focuses on the inability of national statistics to show up different patterns of drinking amongst groups and individuals, and the distribution of consumption.

The other measure used to calculate per capita consumption is the proportion of personal expenditure spent on alcohol as noted.

Until relatively recently it was assumed, based on this approach, that 12 to 13 per cent of personal expenditure in Ireland was spent on alcohol - the highest in western Europe (Walsh D, 1987).

Conniffe et al (1990) have argued convincingly that these figures are misleading for comparative purposes. The Irish statistics include all spending in public houses, whereas in most European countries a proportion of spending on alcohol is attributed to services or entertainment. In summary overall personal expenditure on alcohol in Ireland only appears exceptional because of differences of classification.

While acknowledging the limitations of per capita consumption theory, there remains compelling evidence showing a very powerful relationship between consumption and problems.

Alcohol Consumption in the Republic of Ireland 1950-1980

Walsh (1987) has described the historical background of alcohol consumption and alcohol problems in Ireland.

Alcohol consumption was heavy towards the end of the eighteenth century, declined early in the nineteenth century, and increased again before the first world war.

These fluctuations in levels of consumption have been described as long wave changes. From 1929 until 1950 consumption was low and as a result alcohol problems were few.

Nineteen fifty represented a turning point, and over the next thirty years a typical long wave increase in consumption of alcohol occurred. This increase in consumption mirrored the country's economic performance, and was reflected in the various indices of alcohol related harm, including drunkenness, death from cirrhosis and admissions to psychiatric hospitals. The relationship between alcohol consumption and the various indices of harm is outlined in Table A.

TABLE A

Relationship between Alcohol Consumption and Various Indices of Harm

	Consumption: litres of 100 per cent alcohol per head of population aged 15 or over	Drunkenness: Number of prosecutions for drunkenness per 100,000 persons aged 15 or over	Cirrhosis Deaths: Death rate per 100,000 population aged 15 and over	Admissions to Psychiatric Hospitals and Units Number of admissions with a Primary Diagnosis of Alcoholism or Alcoholic Psychosis
1950	4.7	152.0	2.9	
1951	4.9	151.0	2.8	
1952	5.2	152.0	3.3	
1953	4.5	163.0	2.2	
1954	4.7	143.0	2.3	
1955	4.7	151.0	3.2	
1956	4.8	157.0	3.3	
1957	4.7	137.0	3.1	
1958	4.5	120.0	3.6	
1959	4.4	118.0	3.1	
1960	4.6	121.0	2.9	
1961	5.2	133.0	3.4	
1962	5.7	135.0	4.1	
1963	5.5	163.0	3.2	
1964	5.8	177.0	3.9	
1965	6.1	188.0	4.5	1638
1966	6.1	176.0	2.9	1757
1967	6.1	178.0	3.8	2013
1968	6.4	179.0	4.6	2526
1969	6.8	158.0	5.1	2886
1970	7.4	144.0	4.8	3073
1971	7.5	163.0	3.6	3720
1972	8.2	161.0	5.4	4143
1973	8.8	218.0	5.1	4846
1974	9.7	178.0	5.6	5355
1975	10.2	183.0	4.5	6003
1976	10.1	176.0	5.6	6101
1977	10.5	221.0	4.7	6765
1978	11.3	221.0	5.4	7293
1979	10.3	220.0	4.3	7158
1980	10.0	207.0	5.6	7021
1981	9.4	202.0	4.8	7345
1982	9.0	197.0	4.3	7189

Source - Medico-Social Research Board (unpublished)

These figures demonstrate the close relationship between overall per capita consumption, and the extent of alcohol related harm, as measured by a range of indicators in the Irish Republic during that period.

Contemporary Consumption Issues

In the early 1950's, per capita consumption was 5 litres per person aged 15 years and over. This peaked in the 1970's at 11 litres and has now levelled off at just under 9 litres (Walsh B, 1989). This last figure is in conflict with figures from the British Brewers' Society cited by Conniffe et al (1990) in a report to the Department of Health. Conniffe and colleagues argue that consumption of Alcohol in Ireland is low at 5.8 litres per head of total population and that consequently the level of alcohol problems must be low. These figures are low by European standards as 15 of 26 countries exceeded 8 litres of pure alcohol per head of population.

However, as noted by Harrison and Hill (1992), figures that are based on the total population rather than the population of drinking age depress the overall estimates of mean adult consumption, particularly in countries like Ireland which have a high percentage of the population aged 15 years and under. Central Statistics Office (1989) figures are broadly confirming of Walsh's figures and the figures do not support the thesis advanced by Conniffe et al, that there is no evidence of high levels of alcohol consumption and as a consequence no evidence of alcohol related problems.

Since the 1990's per capita consumption of alcohol in Ireland has levelled off at just under 9 litres of pure alcohol per person aged 15 years and over (Walsh B 1989). Ireland ranks behind countries such as France, Spain, Italy and Germany in terms of average alcohol intake.

Consumption in Ireland is as high, and sometimes higher than many wealthier countries such as the United States, the Scandinavian countries and the United Kingdom (Walsh B 1989).

In summary it can be argued that there is a relatively high average consumption of alcohol per head of population aged 15 years and over, and consequently a relatively high level of alcohol related harm. As noted by Walsh (1989), the intake of alcohol in Ireland is not accounted for by regular use with food, which may suggest that drinking is a separate social activity, episodic and probably more problematic.

General Population Studies

The major weakness of per capita consumption as noted is the inability of national statistics to show up different patterns of drinking amongst groups and individuals and the overall distribution of consumption.

Because of this, studies of the general population relying on self-reports of alcohol consumption have been used to find out about the drinking habits of the population.

As noted by Walsh D, (1987) research on alcohol consumption in Ireland is meagre. Market research is, of course, carried out by the drinks' industry for their own purposes, but results are not available for analysis.

The sole recent Irish study of a large random sample of the population was done in 1980 (O'Connor and Daly, 1985). This study found that prevalence of drinking varies considerably, principally between males and females, different age groups, occupational groupings and urban rural areas. Over three-quarters of the study population drank, and a further 17 per cent never took alcohol, and 7 per cent consumed more than the recommended safe limit - 4 pints per day, and drunkenness was confirmed as a frequent aspect of Irish drinking patterns.

The study also found a high level of alcohol related problems with 13 per cent of male drinkers classified as problem drinkers, as were 4 per cent of females.

In terms of international comparisons, Harrison and Hill (1992) state that comparable data exists on the scale of alcohol problems in Ireland and the United Kingdom (O'Connor and Daly 1985) (Goddard 1986).

The evidence of both studies suggests broadly similar prevalence levels of psychological and physical alcohol related harm in Ireland and the United Kingdom. A significant difference was that Irish men who drink are more likely to drink at high risk levels.

Certain key issues emerge from the studies quoted, and the O'Connor and Daly study in particular.

Firstly, the findings on the health of different types of drinkers in the O'Connor and Daly study (1985) suggest that health problems are distributed in severity along a continuum of increased alcohol consumption.

These findings are of significance to the proposed study, in that drinkers are not as healthy as non drinkers and are therefore more likely to attend their general practitioner.

Secondly, the criteria used to differentiate between different levels of drinking, as recommended by the Royal College of Psychiatrists (1979-1986) can be queried.

These recommendations propose upper limits for men of 50 units of alcohol per week and 35 units for women. Other expert bodies, notably the Health Education Authority in the United Kingdom, suggest that individuals are at risk at less than 20 units for men, and less than 15 units for women. While the experts differ, the whole notion of limits is arguably a contentious area, especially with the implicit assumption inherent in the safe limits concept that the drinking population can drink up to these limits in the belief that it is safe to do so.

While accepting that those who drink over the suggested limits are at high risk of harm, this group represents only a small percentage of the totality of alcohol related harm. The greater part of that harm derives from the moderate drinking group, a paradox identified by Kreitman (1986). So focusing on those who drink above the "safe limits" and identifying them as problem drinkers is necessary but not sufficient. The concept of a broad spectrum of alcohol related problems distributed along a continuum, it is argued here, represents a more valid understanding of alcohol problems.

In concluding this section on the prevalence of drinking and drinking problems, it has been established that alcohol consumption in the Republic of Ireland doubled between 1950 and 1980. This pattern of consumption was closely related to the country's economic development. The various indices of alcohol related harm as noted, all rose as a result of increased consumption. Therefore the prevalence of alcohol problems and alcohol related harm is invariably determined by overall per capita consumption. It is further asserted here that there is an established relationship between national consumption, individual consumption, and problems, and consequently all the drinking population are at risk.

These arguments have considerable implications for the governing images, the prevailing conceptual models, and the responses to alcohol related problems. These arguments raise some important questions. One such question is:

How can the number of individuals diagnosed as having a disease, that some believe they were born with, go up and down with the amount of alcohol consumed in society? (Shaw 1978)

This, and other questions, are pertinent to the next section where the development of conceptual models will be reviewed and discussed.

SECTION II

CONCEPTUAL MODELS OF ALCOHOL PROBLEMS

INTRODUCTION

It is beyond the parameters of this study to engage in an extensive review and discussion of the development of conceptual models. What follows is a relatively brief and necessarily selective review of the major concepts that have influenced popular and professional thinking on alcohol problems.

The effects of alcohol physically, psychologically and sociologically as we have seen, are best understood as being on a continuum. The effect of this is that alcohol can produce a range of different effects. This distribution of effect has led to a lack of consensus about what exactly is problematic drinking.

It may be that, as already noted in Section I, distinctions between high and low risk drinking are arbitrary. Shaw et al (1978) have argued that people have gone to extraordinary lengths to construct definitions, classifications and typologies, in order to distinguish problem drinking, whether classified as an illness, a disease, an addiction, a syndrome, or a learned behaviour, from non-problematic drinking.

The confusion around definitions and terminology in relation to alcohol problems results in a lack of precision and consistency in the terms used across the literature. Various terms, such as problem drinking, alcoholism dependence and so forth, are variably defined by different authors, in addition to terms

approved by the World Health Organisation, namely hazardous alcohol consumption and alcohol related problems. These terms are used interchangeably throughout the review, under the organising concept of the alcohol problems perspective (Institute of Medicine 1990).

The record shows that so many definitions and reclassifications of alcohol problems have been made that no criteria have ever been established to support these distinctions satisfactorily (Shaw et al 1978). The notion of imposing arbitrary divisions on a continuum, and selecting specific criteria for conditions that overlap from a medical, sociological, or psychological perspective, contributes to the overall lack of consensus in the field.

Taking on board these criticisms of the typologies classifications and definitions, it is argued here that a review of conceptual models of alcohol problems is relevant to this study. This is because intervention efforts are of necessity guided by how a problem is defined, classified, or conceptualized.

Furthermore, the way drinking problems are defined has the biggest impact on who is deemed responsible for treating them. It is also important, given the increasing scepticism about the effectiveness of the disease model, the whole notion of treatment, and the value of specialist services as outlined in Chapter 1.

Room (1985) provides a useful interpretive framework for understanding alcohol problems from a social constructionist perspective. He outlines 3 approaches as follows:

1. The first way is simply to take dependence, addiction or alcoholism as given, whether it is deemed a psychiatric, psychological or biological problem.
2. The second way is to leave out the given and consider to what extent socio-cultural factors are part of what has to be explained.
3. The third way is to move from the disease or condition and shift to the question of how concepts such as disease addiction problem drinker or alcoholism arise.

All three ways of understanding concepts of alcohol problems will be acknowledged in this review, but greater emphasis will be given to the third approach, which is a social constructionist approach.

Gergen (1985) has identified 4 assumptions inherent in the social constructionist approach.

In the first instance the way we go about studying something, in this case alcohol problems, is determined by available categories, concepts and methods. The overall effect of this is that a certain way of an inquiry is in a sense dictated and accepted and alternative approaches to inquiry are excluded. An example here would be the acceptance of the notion of addiction, while the alternative could be the assertion that there is no such condition.

Secondly, the concepts, definitions and categories used vary over time. Concepts such as inebriety, temperance, addiction and so forth have varied in their meanings at different points historically and culturally.

Thirdly, the popularity or persistence of a concept or method depends more on its political usefulness than on its validity.

Drawing on this social constructionist approach, a developmental history of conceptual models of alcohol problems is outlined.

The History of Conceptual Models

Until relatively recent times, that is 200 years ago, excessive drinking and the changes associated with it, was seen as the outcome of deliberate choices made by individuals. Habitual drunkenness did not need to be explained, other than from a moral position, and it was not regarded as a compulsion.

This relatively benign normalised perspective on alcohol use changed dramatically between 1785 and 1850. This paradigm shift (Levine 1984) transformed alcohol from being the "good creature of God" to being a dangerous and destructive drug. It will be argued here that contemporary views of alcohol problems have a natural history that is continuous with this paradigm shift.

Room (1985) Heather and Robertson (1985) and Levine (1984) all concur that a paradigm shift did occur. The focus moved from the person to the substance;

alcohol was identified as the cause of many problems - poverty, crime, violence, broken families and a range of health problems. This perspective developed in North America and was quickly accepted in Ireland, England and Northern Europe.

This transformation in attitudes towards alcohol has been attributed to a range of influences. The most important of these are the emergence of the first important medical work on habitual drunkenness by Rush (1785) in the United States, and by Trotter (1788) in Scotland.

These doctors described habitual drunkenness as a disease and an addiction, and recommended abstinence as the only cure. It can be argued then, that the role of the medical profession was critical in facilitating this revolutionary change in attitudes towards alcohol. In particular Rush's work provided the first model of addiction; it provided medical and scientific evidence of the dangers of alcohol and it facilitated the medical profession taking an active and leading role in defining and responding to alcohol problems.

Drawing on the work of Rothman and Foucault Levine (1984) develops the thesis that the notion of addiction had its origins in the particular organisation of American society in the late eighteenth century. He argues that the rise of the middle class was a pre-condition for this paradigm shift.

"Grounded in the optimistic weltanschauung of the enlightenment, the middle classes assumed that evil need not exist, and that problems were solvable or curable. The conditions of a free society meaning individual freedom to pursue one's interests required shifting social control to the individual level."

(Levine 1978, pp 163-165)

Social order depended then on self-control. Therefore, loss of control of one's behaviour in relation to alcohol was a serious threat to the social order. It can be argued from this perspective that the central tenet of addiction, that is loss of control, is essentially a social construct, albeit a medically validated one.

The paradigm shift in attitudes towards alcohol was in itself a precondition for the emergence of a major social movement - the temperance movement. Drawing on the work of Rush, himself a temperance supporter, the temperance movement blamed alcohol for a whole range of personal, social and economic problems. This simplistic analysis had broad political support: the medical profession, the churches and the middle classes and the business and political elite. (Levine 1984).

It is hardly surprising that the temperance movement was committed to total abstinence. This was originally through moral suasion as in Ireland, through Father Matthew and Father Cullen and the pioneers. In the United States moral suasion gave way to legislative coercion, culminating in prohibition.

As the coercive legislation of prohibition fell into disrepute with increased lawlessness, the law was repealed, ironically for the same reason that it had been instituted.

This sustains the social constructionist argument that the popularity of persistence of a concept depends more on its political usefulness than on its objective validity.

THE ALCOHOLISM MOVEMENT

The period following prohibition in the United States was characterised by increased consumption and conceptual confusion. A new explanatory model in the form of the disease model emerged. This model was developed by a new self help movement - Alcoholics' Anonymous - in 1935. It was based on the personal experiences of 2 alcoholics - a doctor and a businessman, the founders of the movement. Generalising from their own experiences they asserted the universality of their experiences of alcoholism and their recovery methods.

Describing the condition as a disease they outlined the main tenets of the disease model in what was to become the bible of AA, the Big Book. Alcoholism was described as a disease, a unique and progressive condition that is qualitatively and quantitatively different from normality. Alcoholics were described as substantially different from non-alcoholics; they possessed a condition that rendered them incapable of controlling their drinking. This disease was incurable, irreversible, but could be arrested through abstinence. (Alcoholics Anonymous, 1976).

The widespread acceptance of the disease model, it is argued here, was primarily because of its advantages socially and politically, and not because of its scientific validity. The AA analysis of the alcohol problems differed fundamentally from that of the temperance movement, in that moderate drinking was seen as possible for those who did not have the disease.

Miller (1989) has provided a convincing rationale around the acceptance of the disease model:

- (a) It served as a useful transition from the period of prohibition.
- (b) It was beneficial to problem drinkers. It justified humane treatment. They were absolved of responsibility for their condition.
- (c) It appealed to other drinkers in that it implied that only alcoholics were at risk and non alcoholics could drink as much as they liked.
- (d) The Drinks' Industry were pleased with the model as it shifted the emphasis away from alcohol itself and towards the alcoholic.
- (e) It asserted that alcoholism was not caused by alcohol; it was an inherent physical/psychological defect.
- (f) The medical profession embraced the idea of alcoholism as a disease requiring treatment.

The growth of AA self help groups, the Big Book of AA, and the "scientific" support of E M Jellinek (1951), a researcher at Yale University, were crucial to the dissemination of the disease concept.

AA and by extension the disease movement, increased in popularity when it received what was represented as objective scientific support from Jellinek at the Yale Centre of Alcohol Studies. This research, that so influenced the growth of the disease model, has been subject to a substantial amount of criticism. Heather and Robertson (1985) and Fingarette (1988) refer to the inadequacy of Jellinek's research. All of his findings were based on data obtained from AA members. AA designed the questionnaires and distributed them. Sixty questionnaires of the total of 158 were excluded as the respondents had pooled their responses. Crucially Jellinek excluded all questionnaires filled out by women as their answers differed from men's.

While Jellinek acknowledged the limitations of his research, this seminal work that so critically influenced the disease model, and served to endorse it with the scientific communities was based on 98 male members of AA. It is probable that this population of alcoholics was atypical and represented the extreme end of the continuum rather than being distinctly different.

In critiquing the disease concept it is necessary to query 2 major assumptions inherent in the disease concept. The first assumption asserts that the alcoholic is inherently different from other drinkers. The second assumption is that the alcoholic's inability to control his/her consumption is permanent, and normal drinking cannot be resumed.

Substantial research (Shaw 1978) has failed to support an all or none distinction between alcoholics and others, or any biochemical or personality type which

makes some people unable to control their drinking. There is, then, no substantial evidence to support the disease concept of alcohol problems.

So whither the disease concept? Despite being theoretically and therapeutically suspect, it can be argued that the disease concept has been socially beneficial in humanitarian terms. Glatt (1991), an apologist for the disease concept, supports the view that the disease concept was underpinned by social and humanitarian considerations, including access to treatment and care. The expansion of AA (of the United States adult population 9 per cent have been to an AA meeting) and the focus on the treatment response based on AA principles have, it is asserted here, been crucial to the creation of the public image of alcoholism. That image is of the chronic alcoholic, who is suffering from a progressive, incurable, irreversible disease, that he/she was born with, a disease that can be arrested through abstinence, but paradoxically is not caused by alcohol.

As noted by Shaw (1978) it is proposed here that its popularity is totally at variance with the evidence on its validity. It will be argued here that its continuing popularity is a major obstacle to progress in responding to the range of alcohol problems.

The disease concept has, in a sense, created a mystique around drink problems for individuals and helpers. One effect of this is that an individual's drinking had to be seriously problematic before either themselves or helpers could respond. The disease concept is also exclusive and as such is incompatible with

the notion of the continuum of problems. This allows for a whole range of drinking problems and their consequences to be ignored until a person is diagnosed as being an alcoholic. As discussed, this excludes the moderate drinking group who generate the greater part of alcohol related harm (Kreitman 1986).

The disease concept also makes problem drinking a speciality, with the assumption that this is a special condition that can only be treated by specialists. The effect of this, as noted by Shaw (1978), is that it disenfranchises the non specialist primary health care worker from responding to drinking problems.

The disease concept has many other disadvantages which cannot be addressed within the limits of this review. The most important of these are the whole notion of being labelled an alcoholic, and its self-fulfilling prophecy effect, the focus on treatment as opposed to prevention, and the disadvantages for theory and research.

Drawing on the social constructionist perspective it can be argued that the disease concept has political acceptability for the drinks' industry, governments and the whole of society. One basic function of the theory is to provide an alibi for the drinking of the majority of people, and hide the role of alcohol in the creation of drinking problems by "blaming" the victim (Beauchamp 1980).

Having argued that despite its popularity the disease model is essentially redundant, it is further asserted here that the disease concept limits the involvement of primary care workers with problem drinkers.

Given the key role of the medical profession historically in defining and responding to drinking problems and given their ongoing contact with problematic drinkers as part of their case load, it can be asked if the medical profession can embrace alternative concepts of alcohol problems. This begs the question of what alternatives can be proposed to the disease model.

These represent the next questions which are explored under the general description of non disease concepts.

NON DISEASE CONCEPTS

It has been argued in the preceding discussion that an important outcome of the disease concept was the diversion of attention away from the extent and variety of problems in the general population. It could also be argued that the existence of the disease concept over the past 50 years facilitated increased per capita consumption by locating society's drinking problems with a subgroup of alcoholics. There was then no need to control the drinking of the majority; consequently consumption increased, as did the numbers requiring treatment. It can be inferred then that the disease concept defined the problem, facilitated the development of the problem, and provided the treatment.

The flawed "two population theory" espoused by the disease model adherents has focused the attention of the scientists, educationalists and clinicians on alternative explanatory models of alcohol problems. This has resulted in a range of theory driven scientific models deriving from the introduction of scientific method to the alcohol field. These methods include follow-up studies, controlled laboratory investigations and general population surveys.

These new explanatory models emphasise epidemiological, psychological and sociological influences.

Social learning represents an approach that has been subject to a substantial amount of research with promising outcomes (Miller 1991). It is also supported by Heather and Robertson (1986) and the Royal College of General Practitioners (1986).

In summary, social learning theory recognises the environmental and social determinants of drinking behaviour; people drinking are conceptualised as being on a continuum as opposed to discrete categories, and change is recognised as a naturally occurring process and a variety of drinking goals are possible.

Social learning theory redefines drinking problems as social behaviour, instead of a disease. This conceptualisation of alcohol problems does not make specialised treatment, attendance at AA, or abstinence essential to responding to a drink problem. Furthermore, problem drinking is reversible and continued drinking does not necessarily result in progressive deterioration.

As described, social learning theory is almost the antithesis of the disease concept; there is no place in social learning theory for the notion of a minority group of alcoholics, or that the general population can drink without harm. These perspectives on the basis of the evidence reviewed so far have validity.

Social learning theory also emphasises the broad base of determinants of drinking behaviour, painting a more complex picture but essentially a more accurate one, that includes social, cultural and environmental factors, together with the psychological and the physiological.

Social learning theory has widespread popular appeal with the research and psychological communities, and no other theory has been subject to controlled scientific evaluation with promising results (Heather and Robertson, 1985).

It remains, despite its aspiration to theoretical complexity, essentially a behavioural psychological model of alcohol problems, but on the basis of scientific method it goes some way towards a scientific understanding of alcohol problems.

However, it does not yet provide sufficient knowledge from which to make precise deductions about the nature of problem drinking and the best way of responding to it.

In summary, social learning theory provides an alternative way of conceptualizing alcohol problems. It is clearly theoretically and scientifically

sounder than the disease model and significantly, in relation to this study, it is supported by the Royal College of General Practitioners (1986).

THE PUBLIC HEALTH MODEL

As discussed, society's attempts to classify and conceptualise alcohol problems has varied over time, from locating the problem within the individual to the substance, and latterly in social learning and socio cultural concepts, the focus has moved to environmental, economic and cultural factors.

All of these models can be understood as emphasising one factor to the exclusion of others. There is no integration of the personal, the substance and the environment. While the social learning and socio cultural concepts are somewhat integrationist it can be argued that they do not go far enough.

The public health model, the last to be considered here, offers the opportunity for integration and comprehensiveness. This public health concept represents a convergent integrationist approach which is leading to new perspectives in medicine and psychology (Gentry 1984).

The public health model promoted by the World Health Organisation draws heavily on epidemiological research and considers 3 causal factors in understanding alcohol problems: the agent, the host, and the environment. The critical significance of the public health approach is the emphasis on the person, the drink and the environment, in a broader transtheoretical framework.

Bunton (1990) identifies 3 features of the public health perspective:

- (a) A broader definition of problems associated with alcohol.
- (b) A non-segregationist (continuum) conception of alcohol problems.
- (c) A community focus and an increasingly broad array of interventions.

(Bunton 1990)

Miller (1984) makes the case for the public health perspective elegantly thus:

"Within the alcohol field a public health approach acknowledges that alcohol is a hazardous drug, (a temperance proposition) which places anyone at risk who consumes it unwisely or beyond moderation. It also recognises that there are significant differences in susceptibility to alcohol problems mediated by factors such as heredity, tolerance and metabolic rates. Finally it stresses the importance of environmental factors in determining rates of alcohol use and related problems, attending to influences such as the availability and promotion of alcohol products."

(Miller and Hester, p 10 1989)

A change in the form and shape of research, it is argued here, was crucial to the development of the public health model of alcohol problems. Research on drinking problems and problem drinkers had typically focused on special populations, recovering alcoholics, persons in hospital, in prison and so forth. The overall effect of this research was to reinforce existing stereotypes of problem drinkers (Strauss 1986).

Epidemiological research, general population studies over the past 20 years have substantially altered previously held conceptions of alcohol problems and provide the rationale for the promotion of the public health model (Institute of Medicine 1990).

In summary the epidemiological research over the past 20 years (Institute of Medicine 1990) suggests that some people have multiple alcohol problems, and most people who have alcohol problems have a small number of such problems. Because the moderate drinking group have quantitatively more problems, they are likely to seek help from their doctor for the consequences of their drinking, for nerves, gastritis and so forth, without recognising the critical role that alcohol plays in such problems.

This assertion raises 3 important issues. Firstly, the individual needs to know that alcohol is causing problems, and secondly the doctor needs to know that alcohol is causing the problem, and thereby the doctor needs to be able to deal with the problem. This suggests that the matter of a person's drinking is a critical aspect of their lifestyle that affects their health, and that routine questioning in this area is as valid as discussing smoking, diet and so forth.

For humanitarian reasons it was necessary to focus on those with serious drinking problems; for reasons of public health it is now necessary to focus on all drinkers. The issue is no longer a question of whether the person is an alcoholic or not. The question now is: is this person's drinking causing them or others? harm?

In concluding this section on conceptual models of alcohol problems, it has been established that attitudes towards alcohol problems have varied depending on the era, the society where the drinking takes place, and the influences of politics, religion, economics and medicine. It can be argued that society's

attitude has never been rational, logical or consistent, or concerned with the scientific validity of addiction. Responses to alcohol problems have primarily been matters of social and political expediency.

All of the conceptual models outlined, with the exception of the public health model, emphasise either the agent alcohol, the host, the person, or the environment.

The temperance movement focused on the alcohol, the disease model on the person, and socio-cultural and social learning models emphasise the environment.

The public health model emphasises all these elements in a comprehensive integrated model. Alcohol is acknowledged as a dangerous drug which places anyone who consumes it at risk. Recognition is also given to individual differences in susceptibility to alcohol problems, mediated by heredity and so forth. Finally, the public health approach stresses the importance of environmental factors in determining rates of alcohol use and alcohol related problems. This allows for a focus on community services and an emphasis on primary care. The key primary health care worker, as asserted in this study, is the general practitioner who is ideally placed to address alcohol problems, given the rationale of the public health approach.

SECTION III

TREATMENT RESPONSES

INTRODUCTION

In this section treatment responses to alcohol problems from policy and practice perspectives are reviewed in a chronological format. The research on treatment responses is briefly reviewed, and finally, drawing on the public health perspective and the research based conclusions, an alternative perspective on alcohol problems is outlined involving the general practitioner.

There are a range of strategies for containing the extent of alcohol related harm, notably national alcohol policies, education, and the major response in Ireland, treatment of problem drinkers.

Within the treatment response in Ireland the trend over the past 20 years has been towards greater specialisation, often in in-patient settings, an approach that has been questioned in terms of its effectiveness in focusing on the more severely dependent drinkers, and in terms of excluding the primary health care workers from working with problem drinkers (Planning for the Future 1984).

In order to provide a context for a critical analysis of current treatment responses, it is argued here that it is necessary to understand these responses in their historical context. The starting point for any chronological review of treatment responses is the work of 2 members of the medical profession, Rush (1785) in the United States, and Trotter (1788) in Scotland. Both described

habitual drunkenness as a disease and recommended abstinence as treatment. They introduced to society 3 critical elements that have a resonance in contemporary treatment: the notion of habitual drunkenness as a disease, the notion of loss of control, and the prescription of abstinence as a cure or treatment.

It has been argued by Shaw (1978) that these medical and scientific works became confused with the moral reform of the temperance movement, and laid the basis for the controversy and confusion that surrounds the definition of alcohol problems (Jellinek 1960). The public could not differentiate between treatment in medical and scientific terms and temperance reform.

Levine (1984) has credited the temperance movement in the United States with developing the first treatment by organising societies of reformed drunkards. These groups, it is asserted here, represented the forerunners of AA and contemporary treatment. The other development to be discussed here is the role of the insane asylums in treating drunkards. Since being set up in the late eighteenth and early nineteenth century, they had filled up with drunkards, which led the asylums' doctors to speculate on a connection between drunkenness and insanity.

This resulted in the setting up of inebriate asylums, which could be considered the first Alcoholism Treatment Units. These asylums legitimised addiction to alcohol as a medical speciality.

The temperance movement and the insane asylums played major roles in responding to alcohol problems in Ireland. Asylum administrators attributed up to 10 per cent of their admissions to intemperance (Finane 1981). The Inebriate Act of 1898 defined habitual drunkenness as a disease and gave the medical profession responsibility for treatment.

The commitment to treatment in early twentieth century Ireland was ambivalent, as is evidenced from conclusions of the Intoxicating Liquor Commission of 1925. The commission concluded that primary responsibility for alcohol problems ought to rest with the criminal justice system; punishment, not treatment, was what was required.

This was all about to change with the arrival of AA and the invention of the new improved disease model.

Contemporary approaches to treatment of alcohol problems can be traced back to AA (1935), and in the 1940's and early 1950's the incorporation of AA philosophy into treatment, and the emergence of recovering alcoholics as counsellors.

This para-professional counselling role was further developed in treatment centres such as Hazelden in Minnesota. These treatment approaches ultimately evolved into what is now known as the Minnesota model, a blend of behavioural science and AA (Institute of Medicine 1990).

Returning to the situation in Ireland of the 1940's, 2 significant developments merit consideration. Firstly, the Mental Treatment Act (1945) reinforced the role of the asylum in treatment by making provision for compulsory admission and detention of alcoholics as addicts. The second development of significance was the arrival of AA in Ireland in 1946. AA, through the disease concept, promoted the notion of treatment, and the asylum provided the setting. The first major expansion in residential treatment for alcoholics took place in the private hospitals, following the decision by the Voluntary Health Insurance Board in 1957 to provide cover for treatment.

By 1966 the disease concept of alcohol problems, and by extension treatment, was endorsed by the World Health Organisation, the Commission of Inquiry on Mental Illness and The Irish National Council on alcoholism. By the late 1960's the disease model and treatment were institutionalised in Ireland. The growth of the treatment response had started (see Table A).

The treatment response, it is argued here, was established and sustained by a range of influences.

The most important of these are:

- (a) The arrival of AA and the disease concept in Ireland (1946).
- (b) The support of the medical profession for the disease concept and the idea of treatment.
- (c) The 1945 Medical Treatment Act.

- (d) The endorsement of the disease concept, treatment, and the extension of treatment services for alcoholics by the Commission of Inquiry on Mental Illness 1966.
- (e) The promotion of the disease concept by the Irish National Council on Alcoholism.
- (f) The overall rise in per capita consumption.

By the mid 1970's a new form of treatment response, a non-medical response that ironically espoused the disease model, had been introduced to Ireland, with the Rutland Centre and Stanhope Street treatment centres promoting the Minnesota model approach, and using counsellors as therapists. The use of counsellors to counsel problem drinkers received the recognition of the Department of Health who approved the training of counsellors by the Irish National Council on Alcoholism.

By 1986 there were 3 principal types of formal treatment for alcohol problems:

- Those in private psychiatric hospitals
- Those in public psychiatric hospitals
- Those in non-medical treatment centres.

Despite the treatment service development, and the development of the counsellor role, at policy levels major changes of emphasis were occurring. These found expression in the 1984 review of the psychiatric services which

questioned the effectiveness of specialised treatment and proposed community based services with an increased emphasis on primary length care.

Since that report and the subsequent Green Paper on Mental Health (1992), the thrust of treatment for alcohol problems had moved towards community setting, with the addiction counsellor as the primary therapist. In support of this contention the Directory of Alcohol and Drug Services (1992) shows that the majority of services are out-patient, a somewhat lesser amount are combined services, and just 4 services are exclusively in-patient. The Green Paper proposed that the general practitioner has a key role in resolving alcohol problems, and that the role of the specialist service was to support the general practitioner.

This clearly fits the response to drinking problems within the remit of the general practitioner. Yet no directives were given as to how general practitioners should go about fulfilling this role, for which they might not be trained, and might not be committed to, which is the basis of this study.

Research on Treatment Responses

Overall international research (Miller 1992) reveals some very disappointing results for the outcome of treatment. There is no treatment approach that is effective for all persons with alcohol problems, and it cannot be assumed that progress has been made as overall success rates have not increased substantially in 50 years. In a critically acclaimed longitudinal study over 40 years Vaillant (1983) found that men with alcohol problems showed comparable remission

rates whether or not they had ever received treatment. Further studies with a one year follow up rate show a favourable outcome (abstinent or improved) of only one in 4 cases.

This hardly justifies treatment, given the estimate that one in 5 cases will improve over the same time span without treatment. The traditional treatment components, including group therapy lectures, counselling, attendance at AA and so forth, are not supported in the research.

A substantial amount of treatment for drink problems is being provided for which there is no evidence of any benefit, and which is unsupported in the literature. Arguably this should not be happening given the established principle that treatments are not admitted to practice unless there is demonstrated evidence of their effectiveness (Miller 1991).

Despite these gloomy findings, there are some reasons for optimism. The effectiveness of brief interventions by primary care workers towards a broader population has been demonstrated as being as effective as more intensive treatment. Brief and effective interventions can be provided to a larger population than can be done by specialist services, which suggests that an alternative perspective on defining, classifying and responding to alcohol problems is needed.

Towards Changing Responses

It was established on the basis of evidence presented in Section I that there exists a range of alcohol problems in Ireland, distributed along a continuum. It was also established that the treatment response, that of specialist treatment, predominates, but that there is no evidence that this response is any better than brief intervention. The focus of treatment effort has been with the more severe problem drinker, with very little concern with people who have less severe problems.

Given the theoretical weakness of the disease model in conceptualising alcohol problems in terms of a continuum, it is argued here that a reconceptualisation of problems is necessary to guide and inform treatment and intervention. Attention has already been drawn to the public health perspective, as an alternative conceptual model. Drawing on this model and the work of the Institute of Medicine (1990), it is asserted here that the target of therapeutic endeavour should be alcohol problems that arise in individuals because of their drinking. This is a deliberately broad focus. In keeping with this broader definition of the focus of treatment, the focus of treatment is also broad. Simply put, treatment is herein defined as those activities undertaken to deal with a drink problem, and with the individual with the problem.

The target population comprises all who experience, or are likely to experience a problem with alcohol. Essentially this reconceptualisation of drinking

problems, in the words of the Institute of Medicine (1990), broadens the base of treatment. The brief intervention strategy by the general practitioner represents the greatest degree of broadening the base of treatment as noted by the Institute of Medicine (1990).

Issues that are pertinent to this are discussed in the next section.

SECTION IV
GENERAL PRACTITIONER INTERVENTIONS AND
THERAPEUTIC COMMITMENT

INTRODUCTION

Drawing on the public health perspective on alcohol problems, primary health care and the current concern with health promotion (WHO 1986) there has been an increased emphasis on the role of the general practitioner in the detection and management of harmful alcohol consumption - support for this has come from the World Health Organisation (1986, 1992), the Royal College of Practitioners (1986) and Planning for the Future (1984) and more significantly from empirical studies (Drummond et al 1990).

The literature (World Health Organisation 1986) (Roche Saunders and Guray 1991) provides a convincing rationale for general practitioner intervention with problem drinkers. It is argued here that the general practitioner is the most accessible of primary health care workers; over 80 per cent of patients consult their general practitioner annually, and empirical evidence suggests that patients have a high level of acceptance of advice from their general practitioner. Further support for general practitioner involvement with drinkers is based on the evidence that persons with alcohol related problems are more likely to visit their general practitioner with a range of physical conditions arising from their alcohol consumption, and the research evidence that brief general practitioner interventions are as effective as specialist in-patient or out-patient care and less stigmatising.

Despite the support for interventions by general practitioners with problem drinkers from the policy and professional arenas, and from empirical studies, the evidence (Roche et al 1991) is that doctors neglect this area and that they do not derive much satisfaction from working with problem drinkers. Possible explanations include inadequate training, conceptual confusion, and the particular focus of this study - low therapeutic commitment.

In the first part of this section the relevant research on brief interventions and general practitioner intervention is reviewed briefly, arguing for the management of alcohol problems in general practice.

The second part of the review focuses on the barriers or resistances to this happening, with particular reference to the literature on the therapeutic commitment of general practitioners towards alcohol problems.

General Practitioners and Intervention

Just as there exists a continuum of drinking and associated problems, there exists a continuum of interventions (Institute of Medicine 1990). Roche et al (1991) outline a framework of 3 tiers of potential intervention by the general practitioner. Thus, in general practice intervention may be started at the level of primary prevention before a problem arises, secondary intervention aimed at containing or reducing harm, and tertiary intervention which is aimed at managing an established alcohol problem.

Primary Intervention

In primary intervention, the general practitioner is identified as a health promoter, as opposed to dealing with ill health, focusing on lifestyle factors such as diet, smoking, weight and alcohol use as health risk factors. However, at this level therapeutic commitment is weaker in relation to alcohol than other risk factors (Rush 1992).

Secondary Intervention

This approach, also known as early intervention, is underpinned by the conceptual shift to a public health perspective, as discussed. The development of early intervention has also emerged from the poor outcome studies for standard specialist treatment, the failure to address the needs of non-dependent drinkers, and the evidence from longitudinal studies that many problem drinkers recover without treatment.

A further critical influence, it is argued here, was the seminal research by Oxford and Edwards (1967).

This research, the most cited in the literature, established that the outcome for 100 problem drinkers randomly assigned to intensive specialist treatment or given a simple advice session was broadly similar.

The efficacy of brief interventions has also been demonstrated in general practitioner settings (Wallace et al 1988) (World Health Organisation 1992). Wallace et al (1988) demonstrated that a greater proportion of patients given

a single counselling session reduced their overall consumption of alcohol, compared with a control group. This large trial involved 909 patients from 47 group practices in England and Scotland.

The largest study reported in the literature of the effectiveness of brief intervention is the World Health Organisation multi centre trial of brief interventions in primary health care (1992). This trial assessed the effectiveness of early intervention in 10 countries around the world in various cultures and primary health care settings. Results showed reduction in average weekly alcohol intake and in intensity of drinking in subjects allocated to brief advice or counselling, compared with a control group. Other smaller trials show broadly consistent results.

Finally, consideration is given to tertiary intervention, that is the management of established alcohol problems in general practice as recommended by the Institute of Medicine (1990). The most recent evidence of outcome from general practice intervention with this most difficult group is promising. With support from a specialist clinic, the outcome was as good as that achieved by more intensive specialist treatment (Drummond et al 1990).

The evidence presented indicates that less intensive treatment can be as good as intensive treatment. Secondly, brief interventions can lead to a reduction in drinking in general population and clinical samples. General practitioner interventions can reduce alcohol consumption by heavy drinkers, and lastly

general practitioners can produce treatment outcomes as good as a specialist service, if supported by a specialist service.

The World Health Organisation (1992) provides a model for intervention, based on the primary, secondary and tertiary intervention as discussed.

TABLE B: A MODEL FOR INTERVENTION

Risk level (Target population)	Intervention	Role of primary health care physician
Low (People with low consumption)	Primary prevention	Health promotion Advocacy Role Model
Elevated (People with hazardous, harmful consumption)	Brief intervention	Identification Assessment Brief counselling Follow-up
Substantial (People dependent on alcohol)	Specialized treatment	Identification Assessment Referral Follow-up

World Health Organisation 1992

This model suggests that the more a person drinks the more at risk they are of developing a drink problem. A role is outlined for the general practitioner at each level, highlighting a proactive as well as a reactive role in the prevention and management of alcohol problems.

It has been established that there is a strong commitment from the Royal College of General Practitioners (1986), The Institute of Medicine (1990), the World Health Organisation (1992) to the crucial role of the General

Practitioner in dealing with alcohol problems. The empirical research supports the value of general practitioner interventions.

Despite all the compelling reasons for general practitioner interventions, the reality is that general practitioners do not identify problem drinkers on their case load and when they do they feel there is little they can do about it. Some of the reasons for this set of circumstances are now explained.

THERAPEUTIC COMMITMENT OF GENERAL PRACTITIONERS

Despite the research evidence outlined on the types of interventions which general practitioners could offer patients, and despite the fact that drinkers have more contact with general practitioners than others, the evidence (Shaw et al 1978) is that their drinking rarely receives recognition or a response. More recent studies (Reid et al 1986) have found that of 2,288 self identified heavy drinkers only 28 per cent were identified as being at risk. This low level of involvement and awareness has been a consistent finding in several countries (Roche et al 1991).

A number of explanations have been offered as to why this situation exists. These explanations have focused on the patient, the circumstances or situation that the general practitioner works in and also on the attitude and behaviour of the general practitioner.

The explanation that general practitioners' lack of interest in helping drinkers is explicable in terms of the stereotypical behaviour and personality of drinkers

is considered first. This explanation implies that drinkers lack motivation, are secretive, deny their problems and lack willpower. These stereotypes derive from popular conceptions of alcohol problems deriving from the disease model. The research (Roche et al 1992) indicates that patients are satisfied with their doctor raising questions about the drinking; American and Australian studies (Kamerow et al 1986) and (Moore et al 1989) suggest that general practitioners are the preferred source of information and advice on alcohol and other drug issues.

So while the doctors may have difficulties with the patients in dealing with alcohol problems, the evidence implies that patients are quite receptive to general practitioners' interventions, and patient centred explanations of the lack of recognition and response to alcohol problems are not sufficient.

The focus moves back to doctors and the structural and situational constraints under which they work. There is a paucity of information in the literature on this area; the major situational constraints relate to the increased burden being placed on general practitioners as the main health professional gatekeepers, working alone as independent contractors, constrained by time and lacking backup, and with no particular incentive, financial or otherwise, to add to their busy schedule.

Acknowledging the limiting effect of situational constraint as described, and the positive attitudes of patients to doctors raising alcohol issues with them, it is argued here that the inadequate response of general practitioners is best

understood in terms of the attitudes and behaviour of doctors (Shaw et al 1978).

Quantitative studies (Clement 1986) (Lightfoot and Orford 1986) have supported the original studies of Shaw et al 1978, that an agent, in this case a general practitioner who shows high therapeutic commitment, is likely to show role security based on experience, support and knowledge of alcohol and alcohol problems. Qualitative studies based on focus groups are also consistent with these studies (Rush 1992).

As noted the seminal work in this area is that of Shaw et al (1973, 1978). This study researched the attitudes of 85 community agents, general practitioners, social workers and probation officers using the AAPPQ (Cartwright 1978) as noted, and interviews. The major outcome of this study was that the majority of community agents, including general practitioners, failed to recognise or respond to alcohol problems as a result of their own anxieties. This anxiety was related to 3 main themes:

1. **Anxiety about role adequacy:** the agents felt unable to make a useful response to drink problems because of lack of training, lack of knowledge of alcohol problems, and an inability to assess or counsel drinkers, and they felt that all they could offer was referral to specialist services.
2. **Anxiety about role legitimacy:** the agents were anxious about their role legitimacy in responding to drinking problems, which required skills generic to their own profession but other professions too. This anxiety

focused on the way drinking problems have medical and social elements and the agents, rights, responsibilities and levels of competence. The study group were reluctant then to work in areas where they felt unable to manage.

3. Finally, the community agents felt they lacked role support, through having nowhere to seek help or advice when they were unsure as to whether or how to respond.

Drawing on these findings (Shaw et al 1978) devised an overall theoretical term that conceptually combined the 3 interacting components of the inadequacy of response by community agents to drink problems. This term was described as role insecurity. It was proposed that agents were insecure because they did not know their role with drinkers, how it could be carried out and who could help and support them. It was asserted that role insecurity was essentially caused by deficiencies in training or work situation.

Being unable to respond to drinking problems emotionally, intellectually and situationally was termed low therapeutic commitment. It was asserted by Shaw et al, 1978, that low therapeutic commitment was a safeguarding strategy to protect professional self-esteem - and was manifested through avoiding drink problems, getting rid of drinkers from their caseload, blaming the drinker, regarding drink problems as untreatable and intolerance of excessive drinking.

In comparison, studies with alcohol specialists, Cartwright (1980), generalists including general practitioners showed far greater evidence of role insecurity and low therapeutic commitment. Other differences emerged between specialists and generalists. Generalists lacked basic role requirements; that is they had very little experience of working with drinkers, their clinical knowledge was poor, they had not received any relevant training in basic therapeutic skills and they had little sense of being able to turn to others who had knowledge, skill and experiences for support. (Cartwright and Gorman 1993).

The question then arises: what can be done to develop role security and therapeutic commitment. Shaw et al (1978) found that the key to understanding this process was by examining the characteristics of community agents (including general practitioners) who displayed high therapeutic commitment. These agents had 4 major characteristics:

- Experience in working with drinkers
- Role support, ie agents who felt supported, either have support now, or had experienced it in the past
- Training in counselling, usually a formal course
- Clinical knowledge of alcohol problems.

All of these factors interacted; for example, individuals with high levels of knowledge of alcohol problems, but little experience, still felt role inadequacy. All factors were then of different relative strengths, and the critical factor was role support. Role support, education and training, while necessary, were insufficient to develop therapeutic commitment. It is argued here that on

the basis of the evidence presented, education and training alone are insufficient to increase therapeutic commitment. However, it is also argued that therapeutic commitment can be increased through a combination of education, experience, and role support, but that this can be contingent on situational constraints operating within an agent's occupational context.

In summary, Section I described the wide range and prevalence of drinking and associated problems in Ireland. Section II, in describing the evolution of conceptual models of alcohol problems, asserted that the disease model had diverted attention away from the range and variety of drinking problems, and was inadequate and redundant as an explanatory model. The public health model as a broad overarching framework, was presented as an alternative conceptual model, emphasising a continuum of alcohol use and associated problems, and a focus on primary care. In Section III it was established that existing specialist responses are largely unsupported in the literature and that policy and research and the emphasis on public health point to the involvement of general practitioners in intervening with problem drinkers.

Finally, looking at the potential role of general practitioner, interventions and brief interventions are as effective as intensive specialist care. The doctor's dilemma is that, despite all this evidence, the policy rhetoric, and so forth, doctors do not want to work with drinkers. This lack of therapeutic commitment has been discussed and arguments put forward as to how this could be improved.

This exploratory study is an attempt to assess the overall commitment of general practitioners in Longford/Westmeath towards working with drinkers, and to find out about the levels of knowledge, skills, training, experience and support that they have in relation to working in this area.

the results of this study, using the AAPPQ as noted, are presented next.

CHAPTER 3

EMPIRICAL STUDY

MAIN FINDINGS

INTRODUCTION

The study population as noted in Chapter one included the total list of members of the Irish College of General Practitioners East Midlands region.

Thirty eight questionnaires were posted, 2 respondents made contact stating that although members of the Irish College of General Practitioners, they worked as specialists. Another letter was received on behalf of one other General Practitioner, who had moved abroad. This reduced the overall study group to 35. Twenty one questionnaires were returned giving a response rate of 60 per cent.

The findings are presented under 3 main headings, that derive from the AAPPQ, the research questionnaire used.

Section A is primarily concerned with background information, on age, education, experience and training.

In section B the findings on general practitioners' attitudes towards working with problem drinkers are presented.

In section C the findings on general practitioners' knowledge of alcohol and alcohol related problems are presented.

Section A

The AAPPQ was returned by 17 males (81%) and 4 females (19%). Eleven respondents were between 41 and 50 (52%). Two respondents were between 51 and 60 (10%). One respondent was over 60 (5%).

Twenty respondents (95%) had been in general practice for more than 10 years, with just one general practitioner with less than 10 years' experience.

Formal Education and Training on Alcohol Problems

The general practitioners were asked about their formal education on alcohol and alcohol related problems. Six respondents (29%) had no alcohol education. Eleven had received education at undergraduate level (52%). Nine had received College of General Practitioners' education (43%). Seven had received other forms of formal education (33%).

TABLE C - TOTAL ALCOHOL EDUCATION DAYS

	Nos	%
None	6	29%
One day or less	1	5%
Two to five days	5	24%
Five to six days	6	28%
Eight to fourteen days	0	0
More than fourteen days	3	14%

While a majority of general practitioners have had between one and 6 days education on alcohol problems, almost 30 per cent have not received any education at all.

COUNSELLING TRAINING COURSES ATTENDED

General practitioners were asked if they had attended any training courses to help them counsel problem drinkers.

Eighteen (86%) said no.

Three (14%) said yes.

Number of patients with alcohol related problems seen/counselled

General practitioners were asked to state approximately how many patients with alcohol problems they had worked with; 9 general practitioners (43%) had worked with over 100 patients. Four general practitioners (19%) had worked with between 50 and 100 patients. Two general practitioners (9%) had worked with between 50 and 100 patients. Two general practitioners (9%) had worked with between 25 and 50 such patients. Four general practitioners (19%) had worked with between 11 and 25 such patients, and 2 general practitioners (10%) had worked with between one and 10 such patients.

Two general practitioners (10%) had experience of working in a specialist unit for alcohol related problems, whilst the vast majority (90%) had no such experience. Sixteen of the general practitioners (76%) had never received supervision from a more experienced person while 5 (24%) had.

Section B

Attitudes towards working with drinkers

General practitioners were asked to indicate how far they agreed or disagreed with a series of statements on a 7 point scale ranging from strongly agree to strongly disagree. The scale measures the intensity of attitude, a high score indicates a positive therapeutic attitude and a low score a negative attitude. Negatively phrased items are converted to a positive score by subtracting the raw score from 8. A score of 5 on the scale, equivalent to agree is taken as positive therapeutic attitude.

As noted by Cohen (1990), it is probable that more can be learned from what we can see than what we compute, therefore the data collected here is displayed with the responses for each scale collapsed into 3 categories, agree, uncertain, disagree. The calculation of the basic scores was done using the AAPPQ handscoring instrument. The mean basic scores and the range of such scores are also presented.

TABLE D - GENERAL PRACTITIONERS TASK SPECIFIC SELF ESTEEM

		Nos	%
I feel I am able to work with drinkers as well as others	Agree Uncertain Disagree	15 2 4	71 10 19
* On the whole I am satisfied with the way I work with drinkers	Agree Uncertain Disagree	8 8 5	38 38 24
All in all I am inclined to feel a failure with drinkers	Agree Uncertain Disagree	3 4 14	14 19 67
I wish I could have more respect for the way I work with drinkers	Agree Uncertain Disagree	5 7 9	24 33 43
I feel I do not have much to be proud of when working with drinkers	Agree Uncertain Disagree	0 3 18	- 14 86
At times I feel I am no good at all with drinkers	Agree Uncertain Disagree	9 1 11	43 5 52

Mean basic score for task specific self esteem is 4.6
Range - 4.9

A score of 5 indicates positive therapeutic attitude.

As can be seen from the results in the above table only 38 per cent of the general practitioners are satisfied with the way they work with drinkers, which implies that they do not expect much satisfaction from this work. This issue of satisfaction is considered next.

TABLE E - GENERAL PRACTITIONERS' EXPECTATIONS OF SATISFACTION IN WORKING WITH DRINKERS

		Nos	%
I often feel uncomfortable when working with drinkers	Agree	8	38
	Uncertain	3	14
	Disagree	10	48
In general one can get satisfaction form working with drinkers	Agree	7	33
	Uncertain	9	43
	Disagree	5	24
* In general it is rewarding to work with drinkers	Agree	4	19
	Uncertain	7	33
	Disagree	10	48
In general I feel I can understand drinkers	Agree	14	67
	Uncertain	5	24
	Disagree	2	9
In general I like drinkers	Agree	6	29
	Uncertain	8	38
	Disagree	7	33

Mean basic score for expectations of satisfaction is 4.0
Range - 3.8.

A score of 5 indicates a positive therapeutic attitude.

* As can be seen from Table E, only 4 general practitioners believe that it is generally a rewarding experience to work with drinkers. This raises the question of motivation.

The findings on motivation are presented in Table F.

TABLE F - MOTIVATION TO WORK WITH DRINKERS

		Nos	%
I feel that the best I can personally offer drinkers is referral to somebody else	Agree	7	33
	Uncertain	7	33
	Disagree	7	34
I feel there is little I can do to help drinkers	Agree	1	5
	Uncertain	13	62
	Disagree	7	33
Pessimism is the most realistic attitude to take towards drinkers	Agree	2	10
	Uncertain	3	14
	Disagree	16	76
I feel I have a clear idea of my responsibilities in helping drinkers	Agree	14	67
	Uncertain	5	24
	Disagree	2	9
I am interested in the nature of alcohol related problems and the responses that can be made to them	Agree	15	71
	Uncertain	2	10
	Disagree	4	19
* I want to work with drinkers	Agree	7	33
	Uncertain	7	33
	Disagree	7	34

Mean basic score 4.7

Range 5.6.

A score of 5 indicates a positive therapeutic attitude.

* As can be seen above, only one third of general practitioners (7) are motivated to work with drinkers.

All the scales, described, task specific self esteem, satisfaction and motivation are now combined to provide a composite scale of therapeutic commitment, the details of which are presented next on Table G.

TABLE G - GENERAL PRACTITIONERS' ROLE ADEQUACY

		Nos	%
I feel I have a working knowledge of alcohol and alcohol related problems	Agree	17	81
	Uncertain	3	14
	Disagree	1	5
I feel I know enough about the causes of drinking problems to carry out my role when working with drinkers	Agree	15	71
	Uncertain	4	19
	Disagree	2	10
I feel I know enough about the alcohol dependence syndrome to carry out my work with problem drinkers	Agree	15	71
	Uncertain	4	19
	Disagree	2	10
I feel I know enough about the psychological effects of alcohol to carry out my work with drinkers	Agree	17	81
	Uncertain	4	19
	Disagree	0	0
I feel I know enough about the factors that put people at risk of developing drinking problems	Agree	14	67
	Uncertain	6	28
	Disagree	1	5
I feel I know how to counsel drinkers over the long term	Agree	10	48
	Uncertain	3	14
	Disagree	8	38
I feel I can appropriately advise my clients about drinking and its effects	Agree	20	95
	Uncertain	-	-
	Disagree	1	5

Mean basic score on role adequacy 5

Range 5.8.

A score of 5 indicates a positive therapeutic attitude.

* As described in Table G the majority of general practitioners feel that they have a working knowledge of alcohol problems.

The findings on whether general practitioners feel that they have the right to raise the matter of a patient's drinking are presented in Table H.

TABLE H - GENERAL PRACTITIONERS' ROLE LEGITIMACY

		Nos	%
I feel I have a clear idea of my responsibilities in helping drinkers	Agree	14	67
	Uncertain	5	24
	Disagree	2	9
I feel I have the right to ask patients about their drinking when necessary	Agree	21	100
	Uncertain	-	-
	Disagree	-	-
I feel that my clients believe I have the right to ask them questions about drinking when necessary	Agree	13	62
	Uncertain	5	24
	Disagree	3	14
* I feel I have the right to ask a patient for any information that is relevant to their drinking problems	Agree	19	90
	Uncertain	1	5
	Disagree	1	5

Mean basic score on Role Legitimacy 5.6

Range 5.

A score of five indicates positive therapeutic attitude.

* As can be seen above general practitioners feel that it is legitimate of them to discuss drinking with their patients.

All scales presented are combined to create an overall attitude scale, this is outlined next in Table I.

TABLE I - OVERALL ATTITUDES

In the analysis used here the scales measuring therapeutic commitment and role legitimacy and role adequacy are combined to create an overall attitude scale.

TASK - Specific self esteem	4.6
Satisfaction	4.0
Motivation	4.7
Role adequacy	5.0
Role legitimacy	<u>5.6</u>
	23.9

$$\text{Overall therapeutic attitude} \quad \frac{23.9}{5} = 4.78$$

The theoretical model suggests that overall therapeutic attitude is related to other factors, role support, experience, self esteem and knowledge. These are basic role requirements, and a critical aspect of the theory underpinning the AAPPQ is that changes in basic role requirements should lead to increased therapeutic commitment. The findings on these basic role requirements are presented next.

TABLE J - GENERAL PRACTITIONERS' ROLE SUPPORT

		Nos	%
If I felt the need when working with drinkers I could easily find someone with whom I could discuss any personal difficulties	Agree	15	71
	Uncertain	0	0
	Disagree	6	29
If I felt the need when working with drinkers I could easily find someone who would help me clarify my professional responsibilities	Agree	14	67
	Uncertain	1	5
	Disagree	6	28
* If I felt the need I could easily find someone who would be able to help me formulate the best approach to a drinker	Agree	15	71
	Uncertain	1	5
	Disagree	5	24

Mean basic score 5

Range 7.

A score of 5 indicates positive therapeutic attitude.

* As can be seen above the majority of general practitioners feel that they could generally find someone to discuss the management of a drink problem.

The next basic role measure considered is the experience that general practitioners have of working with drinkers. The results are presented in Table K.

TABLE K - EXPERIENCE

The scores from Question 10, Section A are used here.

General practitioners were asked how many people with alcohol related problems they had spent more than 10 hours counselling.

	Nos	%
(a) None	9	43
(b) 1-10	5	24
(c) 11-25	3	14
(d) 26-50	3	14
(e) 50-100	1	5
(f) 100 +	0	0

Despite the evidence of 40 per cent of general practitioners having worked with over 100 patients as noted in Section A, it can be seen above that overall, general practitioners have not done any long term work with drinkers.

TABLE L - SELF ESTEEM

		Nos	%
I feel I have a number of good qualities	Agree	20	95
	Uncertain	1	5
	Disagree	0	0
I am able to do things as well as most other people	Agree	21	100
	Uncertain	0	0
	Disagree	0	0
I feel I am a person of worth at least on an equal plane with others	Agree	21	100
	Uncertain	0	0
	Disagree	0	0
At times I think I am no good at all	Agree	5	24
	Uncertain	5	24
	Disagree	11	52
I feel I do not have much to be proud of	Agree	2	0
	Uncertain	0	10
	Disagree	0	90
All in all I am inclined to think I am a failure	Agree	1	5
	Uncertain	0	0
	Disagree	20	95

Mean score 5.6

Range 3.5.

A score of 5 indicates positive therapeutic attitude.

The final basic role requirement, information, is considered next and the questionnaire findings are presented.

INFORMATION

Knowledge about alcohol and alcohol problems was assessed by a series of multiple choice questions, part C of the AAPPQ. The maximum score possible on this scale is +35. The mean score for the study group was 23.

Examination of Responses

The mean score for respondents aged 50 plus was 8. The mean score for respondents aged 41 to 50 was 26. The mean score for respondents aged 31 to 40 was 26.

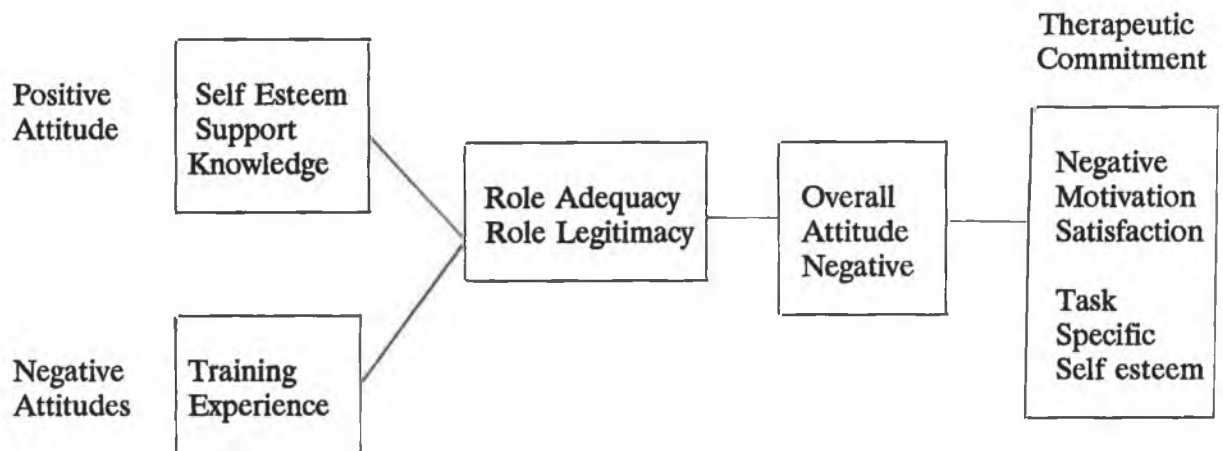
Sixty two per cent of the study group did not know which drink out of a specified group contained the same amount of alcohol as one pint of beer. Nineteen per cent of the study group felt that the direct action of alcohol on the brain was that of a stimulant. Fourteen per cent of the study group believed that antabuse was often used to relieve alcohol withdrawal symptoms.

Twenty four per cent of the study group achieved a mean score of 10 and significantly less education averaging 2.6 days in total.

TABLE M

The relationship between basic role requirements, overall therapeutic attitude and therapeutic commitment in the study.

Basic role requirements



Low therapeutic commitment, it is proposed, is causally related to overall negative therapeutic attitude, which is related to basic role requirements.

The critical variables here are role support and experience which are independently related to overall therapeutic attitude. In this study, role support, self esteem and knowledge are associated with positive attitude, but training and experience achieve low scores that affect overall therapeutic commitment.

CHAPTER 4

DISCUSSION AND CONCLUSIONS

INTRODUCTION

In this chapter the study findings will be discussed, and the main conclusions summarized.

In the discussion the significant findings will be considered in the light of the theoretical framework, and the research in the literature. The discussion will also consider the extent to which the study answered the questions posed. The questions that derive from the theoretical framework, and the main hypotheses are used here to guide the discussion.

The other issues addressed include the limitations of the study, and the implications of the study for further research.

Response

The study was completed over one month from July to August, a holiday period. The questionnaire was long and detailed and taking all the foregoing into account the overall response rate of 60 per cent was quite satisfactory. This response rate corresponds with that of other studies involving general practitioners (Clement 1986). The response itself is indicative of a level of interest by general practitioners in research and alcohol related problems. The support of the Irish College of General Practitioners for the project, and

the endorsement of the project by the Midland Health Board, probably had a significant influence on the overall response rate.

Respondents

The respondents, as noted, were in the main a group of middle aged males - there were just 4 females; comparable studies (Clement 1986) achieved a similar level of response in terms of male/female ratio.

The overall profile is of an older and more experienced group than in English studies (Clement 1986). The general practitioners live and work in small towns and rural communities, whereas in the English studies the general practitioners lived and worked in large cities and urban areas. One effect of this is that general practitioners in this study are familiar with their patients' private, personal and social lives and as such are more likely to be familiar with the drinking behaviour of their patients, without having to identify or screen for alcohol problems. It is against this overall profile of the respondents, and the context of their practices, that this discussion is located.

As outlined in Chapter 1 the main aim of the study was to find out the level of commitment of general practitioners towards working with drinkers. While overall therapeutic commitment was found to be low, it is necessary to explore the factors that determined this outcome.

Three questions posed in Chapter 1 determine overall therapeutic commitment. Each question and the responses given will be discussed in turn.

The first question posed was:

Are general practitioners satisfied with the way they work with drinkers?

The results here - that general practitioners are not satisfied with the way they work with drinkers - are consistent with the research studies in the literature (Clement 1986). While expressing this dissatisfaction, the general practitioners are at the same time rejecting of any insinuation in the negatively phrased items, that suggests that they are not personally competent. This ambiguity in the response reflects what Shaw (1978) says is an attempt to protect professional self-esteem.

The second question used to measure overall therapeutic commitment is concerned with the expectation of satisfaction general practitioners have in working with drinkers. Not surprisingly the respondents do not have an expectation of satisfaction in working with drinkers, a finding which is consistent with the research studies (Shaw 1978). Shaw's argument was that general practitioners see drinkers as hopeless cases, a perspective that derives from stereotypes of alcoholics in the popular consciousness as defined by the disease model. This attitude towards drinkers allows the general practitioners to opt out of helping the drinker.

It is asserted here that while education may not change attitudes general practitioners need to know about current concepts of alcohol problems in order to address the low expectation of satisfaction attitude problem. This put the focus on the attitude of the general practitioners as opposed to the attitude of the drinker.

The third question asked that measures therapeutic commitment was:

Are general practitioners motivated to work with drinkers. Only one-third of general practitioners are motivated to work with drinkers, while at the same time over 70 per cent of the general practitioners state that they are interested in alcohol and alcohol related problems. This discrepancy between low level of motivation, and high expressed levels of interest again reflects the concern that general practitioners have with their own professional role and self esteem. However, the expressed level of interest in alcohol and alcohol problems is consistent with the overall response rate, and suggests a level of interest that could provide opportunities for education and training purposes.

Taken together the responses to the 3 questions demonstrate that this study group have, as predicted, a commonly held attitude profile called low therapeutic commitment. This finding is consistent with the theoretical framework and the research studies (Clement 1986). This means that the general practitioners surveyed are unable to respond to drinkers and their

problems, and this low therapeutic commitment has the function of protecting the general practitioners' self esteem.

In the original study Cartwright (1978) hypothesised that the 2 scales measuring role adequacy and role legitimacy were critical factors in determining therapeutic commitment. In practical terms the relationships between role adequacy and role legitimacy and therapeutic commitment are so high that they can be considered as one major dimension. This is the approach taken here by adding role adequacy, role legitimacy and therapeutic commitment to create an overall attitude scale.

The 2 questions that relate to role legitimacy and role adequacy are considered next.

How do general practitioners feel about the adequacy of their knowledge and skills in working with drinkers? The majority feel that they have a working knowledge of alcohol problems and that they have the necessary skills in working with drinkers. However, the evidence from Section A on the limited amount of education that general practitioners received, and the evidence that over 80 per cent never attended any counselling to help them deal with drinkers, suggest that the general practitioners tend to overestimate their skills in this area. The evidence from Section A on knowledge is more consistent with general practitioners perception of their role adequacy, but over 60 per cent did not know which drink out of a specified group contained the same

amount of alcohol as one pint of beer. Role adequacy, as expressed, was inconsistent with the evidence on knowledge skills and training, and again reflects the maintenance of professional self esteem.

The final question on the overall attitude scale is concerned with whether general practitioners feel that it is legitimate for them to work with drinkers. Consistent with Shaw (1978), Clement (1986) the vast majority of general practitioners feel that they have the right to work with drinkers. Despite lacking motivation to work with drinkers, and regarding it as an unsatisfying experience, general practitioners feel that they have the knowledge, the skills and the right to do so. In terms of overall attitude the outcome is a negative therapeutic attitude.

The next questions to be discussed relate to basic role requirements. It is hypothesised by Shaw (1978) that basic role requirements influence therapeutic commitment and overall therapeutic attitude (Cartwright and Gorman 1993).

The first question relates to the extent to which general practitioners feel supported in working with drinkers. The question of support is seen by Shaw (1978) as of critical significance in relation to all other role requirements and as a consequence therapeutic commitment. Shaw argues that role support and supervision are prerequisites to all other role requirements.

The general practitioners in this study feel that they could find support if they needed it to help them manage a drink problem. They do, however, have low therapeutic commitment, which suggests that their responses on role support need to be interpreted with caution.

Given the situational and structural constraints that general practitioners work under as individual professional contractors, it is highly unlikely that they have close supervision or support. Data from the questionnaire shows that the vast majority of general practitioners have never experienced supervision in relation to alcohol problems. Alternatively, the assertions by the general practitioners that they could get support, may reflect the ongoing contacts and networks that they have with the Community Alcohol and Drug Counselling Service in Longford/Westmeath.

The second question to be considered on basic role requirements is concerned with the amount of knowledge and training that general practitioners have on alcohol problems.

As noted in the responses on role adequacy, general practitioners believe they have the knowledge and skills to help drinkers. The evidence presented does not support this belief, with only half of the population having undergraduate training, and one third having no alcohol education at all.

In summary this suggests that general practitioners overstate their competencies and skills sometimes in areas where they have no training at all. On the basis of the evidence presented, there is not sufficient support for the general practitioners own beliefs that they have sufficient knowledge and skills in this area.

Consideration is now given to the experience that general practitioners have in working with drinkers. Previous studies (Bush and Williams 1988) have found an association between the number of drinkers worked with and therapeutic commitment.

The findings here create the impression of an experienced group of general practitioners, but closer examination of the scale reveals that only 4 per cent of general practitioners had worked over 10 hours with patients with alcohol problems. In practice it appears that general practitioners are aware of patients on their case loads with problems, and they claim to have worked with them; this work may not have been in relation to their drinking, and suggests that overall experience of working with drinkers, or drinking problems, for any length of time is quite limited, an interpretation that is congruent with their low therapeutic commitment.

The issue of general practitioners' self esteem was addressed and aligned to the concern with professional self esteem; almost all general practitioners present a profile of high self esteem.

In summary, certain key issues emerge from the discussion. The general practitioners are not committed towards working with drinkers despite acknowledging that they have the right to do so, and that they have the knowledge and skills to do so.

There is some ambiguity in the latter findings given the other evidence in the findings that suggest that general practitioners have inadequate training and education on alcohol issues. It is also probable that general practitioners subscribe to the popular stereotypes given their low expectation of satisfaction and motivation in relation to working with drinkers. There are also discrepancies between stated and actual knowledge, skills, support and experience, which are according to the therapeutic model explicable in terms of the general practitioner's role and need to protect professional self esteem.

An overview of the study, together with the main conclusions and recommendations, is presented next.

CONCLUSIONS

Limitations

In interpreting the findings of this exploratory study it is necessary to draw attention to the following limitations:

- The study was confined to a small group of general practitioners in 2 countries and no claims can be made in terms of generalising from the findings.
- The study is exploratory and the findings are used to test the main hypothesis and the questions that derive from the theoretical framework.
- Given the boundaries of the study the relationships between the various attitude variables are not examined.

It has been established that alcohol problems are major public health issues. and that there is a close relationship between overall levels of consumption and the various indices of harm. The Irish experience validates this relationship. Treatment of problem drinkers has been a significant aspect of the Irish response to alcohol problems. The basis for this response is the classification and defining of an alcohol problem as a condition requiring treatment. It has also been established that the dominance of the disease model conceptualization of alcohol problems underpins the notion of treatment, popular stereotypes of 'alcoholics', and a specialist approach to alcohol problems.

This conceptualization of alcohol problems and treatment response has broad appeal to drinkers, to problem drinkers, the drinks' industry, and is sustained more by its political usefulness to society than any objective validity. This assertion is supported by the confusion over defining and describing a drink problem and the evidence that overall, specialist treatments have overall disappointing outcomes. In this thesis the usefulness of the disease model, the notion of treatment and the value of specialist services have been called into question.

An alternative perspective, it is concluded, is required and drawing on the epidemiological research and public policy (Planning for the Future 1984) the public health model is offered as an alternative to the disease model.

This model acknowledges alcohol as a dangerous drug, which places anyone who consumes it at risk. Recognition is also given to individual differences in susceptibility to alcohol problems and recognition is given to environmental factors. This allow for a focus on community services and an emphasis on primary care. It is concluded here that the key primary health care worker is the general practitioner. The evidence in the literature shows that patients with alcohol problems have more contact with their general practitioner than the rest of the population. Further evidence cited shows that brief interventions by general practitioners can be as successful as more intensive approaches. There is compelling evidence in support of the contention that general practitioners could work effectively with drinkers.

There is also strong commitment from their own professional bodies (Royal College of Practitioners, 1986 and The Institute of Medicine, 1990). Despite this generally accepted conclusion, the evidence from this study, and the literature shows that general practitioners have low therapeutic commitment to this task, despite believing it to be a legitimate area for them to work in and feeling that they have the knowledge and skills to do so. The general practitioners surveyed have no special qualifications, no counselling training, and lack role support, despite believing that they could find this support if needed.

All of these basic role requirements, together with experience, are the critical determinants of this attitude profile called low therapeutic commitment.

Recommendations

The question then arises as to how can overall therapeutic commitment be increased. It appears from the evidence in the literature, and the findings in the study, that prequalification training on alcohol problems for general practitioners is inadequate, and based on an outmoded medical model. The inadequacy of this training and education denies the issue of alcohol problems a legitimacy that is carried forward on qualification into the work place. Therefore it is proposed here that role legitimacy and role adequacy in relation to dealing with alcohol problems are best initiated at undergraduate level by giving priority to knowledge and skills training as part of basic professional education.

Without an increased emphasis on education and training at undergraduate level, it is unlikely that general practitioners will be prepared to deal with alcohol problems. As noted by the World Health Organisation (1992) undergraduate education should be co-ordinated by the academic departments of general practice on public health and on community medicine.

At post graduate level, vocational training provides an appropriate vehicle for more extensive education and skills training. This ideally should include counselling and motivational interviewing skills.

Adult learning methodology should guide the form and shape of learning, invoking group work, experiential exercises, and role play, in order to address knowledge and attitudinal factors. This approach is more likely to influence attitudes and behaviour, which are critical to developing therapeutic commitment. The brief educational training course is insufficient, and has little impact on attitudes and behaviour. The third area for education and training is continuing education through the Irish College of General Practitioners continuing education programmes.

All education should include the following:

- an understanding of the behavioural and social determinants of alcohol use and alcohol-related problems;
- a knowledge of the medical, psychological and social consequences of alcohol use, and their diagnosis and management;

- an understanding of the role of the individual, family, community, medical and related professions, and government dealing with alcohol problems; and
- a knowledge of the principles and methods of health promotion, disease prevention and screening.

World Health Organisation 1992

The issue of support for general practitioners acting as independent contractors, with an autonomous professional role is in the context of this study the most difficult to address. The general practitioners in the study are affected by many situational constraints, time, resources, caseload, and as such the opportunity for consultation and support is limited.

However, there is a need for closer co-operation between the Community Alcohol and Drug Counselling Services and general practitioners, not just on the issue of referral but on a consultative basis. One approach could be the designation of one member of the Community Alcohol and Drugs team to act as liaison person with the general practitioners to provide information, to offer means of screening for alcohol consumption and to advise on brief interventions.

It is further recommended in the light of the government strategy for effective health care (1994) emphasising health promotion, that general practitioners:

1. Routinely ask patients about their alcohol consumption

2. Be aware of harmful and hazardous consumption
3. Give brief advice supplemented by a booklet
4. Provide brief motivational counselling matched to readiness to change.

World Health Organisation (1993)

This suggests, as outlined in Table B, a proactive as well as a reactive role for the general practitioner.

As this is the first study using the AAPPQ in the Republic of Ireland it would be important to replicate the research using a larger sample and covering a broader area. Consideration could be given to examining the differences between urban/rural responses, and other rural responses, for comparative purposes.

In conclusion the public health approach to alcohol problems involves broadening the base of intervention to include the general practitioner. This thesis has argued in favour of general practitioners taking on that role, and has addressed the barriers to that happening, and makes recommendations to help change general practitioners' attitudes to increase their confidence and enhance their skills. This then is the challenge, and the choice is as described by Shaw et al (1978) quite clear:

"Are we content to allow the majority of people with drinking problems to remain unrecognised and unhelped or do we wish to encourage more active intervention?"

Shaw et al 1978, p 253

If we decide on the latter - and this thesis argues that we should - then unless and until general practitioners receive education, training and support it is probable that general practitioners will retain a low level of therapeutic commitment towards working with drinkers, and the potential of general practitioner primary care for problem drinkers will not be realised.

Providing that education, training and support to general practitioners represents a challenge to the Department of Health, the Academic Institutions, the Irish College of General Practitioners and the individual doctors. If there is to be any consistency between health policy rhetoric and general practice then this challenge must be addressed.

APPENDIX 1

AAPPQ QUESTIONNAIRE

BACKGROUND QUESTIONS.

A.I.
Please
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1. Sex:

(a) Male

(b) Female

9

2. Age:

(a) Under 25

(d) 41-50

(b) 26-30

(e) 51-60

(c) 31-40

(f) 61 and
over

10

3. Professional or Voluntary Group that brings you into contact with clients who have alcohol related problems.

(Please specify) _____

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

11 12

4. How many years have you been part of your professional or voluntary group? (Please put a cross in one box)

(a) less than one year

(b) 1 - 5 years

(c) 6 - 10 years

(d) More than 10 years

13

5. Have you received any education in alcohol or alcohol related problems?
(Please put a cross in any boxes applicable to you).

- (a) No
- (b) Yes, Undergraduate Training
- (c) Yes, College of GPs Seminars
- (d) Yes, other

Please
Leave
Blank

14

If (d) applies to you, please specify:

15

6. Have you received any other educational lectures, seminars, courses, etc. on alcohol and alcohol related problems?
(Please put a cross in one box)

- (a) No
- (b) Yes

16

If (b) applies to you, please specify:

17

7. In total, about how many hours of education on alcohol and alcohol related problems have you received? (Please put a cross in one box).

- (a) None
- (b) One day or less
- (c) Two to five days
- (d) Five to seven days
- (e) 8 to 14 days
- (f) More than 14 days

18

A3.
Please Leave
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8. Have you ever attended any training courses to help you counsel people with alcohol related problems?

- (a) Yes
- (b) No

19

If (a) applies to you please specify below

20

9. With approximately how many people with alcohol related problems have you worked? (Please put a cross in one box)

- (a) None
- (b) 1 - 10
- (c) 11 - 25
- (d) 25 - 50
- (e) 50 - 100
- (f) More than 100

21

10. Approximately how many people with alcohol related problems have you spent more than 10 hours counselling?

- (a) None
- (b) 1 - 10
- (c) 10 - 25
- (d) 26 - 50
- (e) 50 - 100
- (f) More than 100

22

11. When working with drinkers, do you presently receive supervision from a more experienced person?

- (a) Yes
- (b) No

23

If (b) applies to you please specify below

12. When working with drinkers have you ever received any on-going supervision from a more experienced person?

(a) No

(b) Yes

If (b) applies to you please specify below:

13. Do you presently work for an agency or group which specialises in working with people with alcohol related problems?

(a) No

(b) Yes

If yes, (b) applies to you, which agency or group?

14. Have you ever worked for an agency or group which specialises in working with people with alcohol related problems?

(Please put a cross in one box)

(a) No

(b) Yes

If (b) applies to you, could you please specify:

(i) Which agency or group.

(ii) For about how long a period

Study Number

1 2 3

Card Number

Subject No.

4 5

A4.
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25

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27

28

29

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31

SECTION B.

Below is a series of statements about working with drinkers. Please show how far you agree or disagree with each statement by circling the appropriate figure on each line.

In this section the term 'drinker' is used to refer to a person with alcohol related problems and the term 'client' is used to describe a person with whom you deal. As a doctor, please read 'patient' in this context.

The term 'profession' is used to refer to the main professional group of which you are a part. Please answer questions about your 'profession' from your perspective as a G.P.

	Strongly agree	Quite Strongly Agree	Agree	Neither agree nor disagree	Disagree	Quite Strongly Disagree	Strongly Disagree
1. I feel I have a working knowledge of alcohol and alcohol related problems	7	6	5	4	3	2	1
2. I feel I know enough about the causes of drinking problems to carry out my role when working with drinkers.	7	6	5	4	3	2	1
3. I feel I know enough about the alcohol dependence syndrome to carry out my role when working with drinkers.	7	6	5	4	3	2	1
4. I feel I know enough about the psychological effects of alcohol to carry out my role when working with drinkers.	7	6	5	4	3	2	1

B 1.
Please
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9

10

11

	Strongly Agree	Quite Strongly Agree	Agree	Neither agree nor Disagree	Disagree	Quite Strongly Disagree	Strongly Disagree	Please Leave Blank.
16. I feel I am able to work with drinkers as well as others.	7	6	5	4	3	2	1	<input type="text"/> 24
17. I want to work with drinkers	7	6	5	4	3	2	1	<input type="text"/> 25
18. All in all I am inclined to feel I am a failure with drinkers.	7	6	5	4	3	2	1	<input type="text"/> 26
19. I wish I could have more respect for the way I work with drinkers.	7	6	5	4	3	2	1	<input type="text"/> 27
20. I feel that I have something to offer to drinkers.	7	6	5	4	3	2	1	<input type="text"/> 28
21. I feel that the best I personally can offer drinkers is referral to somebody else.	7	6	5	4	3	2	1	<input type="text"/> 29
22. I feel I do not have much to be proud of when working with drinkers.	7	6	5	4	3	2	1	<input type="text"/> 30

	Strongly Agree	Quite Strongly Agree	Agree	Neither agree nor disagree	Disagree	Quite Strongly disagree	Strongly disagree	Please Leave Blank.
23. I feel that there is little I can do to help drinkers.	7	6	5	4	3	2	1	<input type="text"/> 31
24. I often feel uncomfortable when working with drinkers.	7	6	5	4	3	2	1	<input type="text"/> 32
25. Pessimism is the most realistic attitude to take towards drinkers.	7	6	5	4	3	2	1	<input type="text"/> 33
26. I feel I have a number of good qualities for work with drinkers.	7	6	5	4	3	2	1	<input type="text"/> 34
27. At times I feel I am no good at all with drinkers	7	6	5	4	3	2	1	<input type="text"/> 35
28. In general, one can get satisfaction from working with drinkers.	7	6	5	4	3	2	1	<input type="text"/> 36
29. In general, it is rewarding to work with drinkers.	7	6	5	4	3	2	1	<input type="text"/> 37

	Strongly Agree	Quite Strongly Agree	Agree	Neither agree nor disagree	Disagree	Quite Strongly Disagree	Strongly disagree	Please Leave Blank.
30. In general, I feel I can understand drinkers.	7	6	5	4	3	2	1	<input type="text"/> 38
31. In general, I like drinkers	7	6	5	4	3	2	1	<input type="text"/> 39
32. On the whole I am satisfied with the way I work with drinkers.	7	6	5	4	3	2	1	<input type="text"/> 40
33. On the whole I am satisfied with myself.	7	6	5	4	3	2	1	<input type="text"/> 41
34. At times I think I am no good at all.	7	6	5	4	3	2	1	<input type="text"/> 42
35. I feel I have a number of good qualities.	7	6	5	4	3	2	1	<input type="text"/> 43
36. I am able to do things as well as most other people.	7	6	5	4	3	2	1	<input type="text"/> 44
37. I feel I do not have much to be proud of.	7	6	5	4	3	2	1	<input type="text"/> 45
38. I certainly feel useless at times.	7	6	5	4	3	2	1	<input type="text"/> 46

SECTION C.

Study Number
 1 2 3

Card Number
 4 5

Subject Number

C1.

Please
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Blank.

This section is to help assess how much people know about alcohol and alcohol problems. Some of the questions can probably only be answered by specialists, and it is unlikely that anyone will be able to answer all the questions confidently. Even so it is important that you attempt each question.

Questions 1 to 7 have only one correct answer, so please put a cross in the box alongside the answer you think is correct.

1. Which drink contains approximately the same amount of alcohol as 1 pint of ordinary beer?
Please put a cross in one box.

- | | | | | |
|-----|-----------------------------|--------------------------|--------------------------|----|
| (a) | 1 small glass of table wine | <input type="checkbox"/> | <input type="checkbox"/> | 9 |
| (b) | 1 small glass of sherry | <input type="checkbox"/> | <input type="checkbox"/> | 10 |
| (c) | 1 single tot of whisky | <input type="checkbox"/> | <input type="checkbox"/> | 11 |
| (d) | 1 double tot of whisky | <input type="checkbox"/> | <input type="checkbox"/> | 12 |

2.

The direct action of alcohol on the brain is that of a:
(Please put a cross in one box)

Tranquilliser

13

Stimulent

14

Hallucinogen

15

Antacid

16

C.2.
Please
Leave Blank.

3.

What is the usual effect of drinking heavily over a period
of years on a person's tendency to become intoxicated?

(Please put a cross in one box)

(a) It gradually takes much less alcohol intake to
make a person intoxicated, but this eventually
might reverse.

17

(b) It gradually takes slightly less alcohol intake
to make a person intoxicated, but eventually
this might reverse.

18

(c) It gradually takes more alcohol intake to make a
person intoxicated, but eventually this might
reverse.

19

(d) Over a period of years, the amount of alcohol
intake required to make a person intoxicated
fluctuates enormously.

20

C.3.
Please
Leave Blank.

4. The D.T.s are most likely to be experienced:

(Please put a cross in one box).

- | | | | |
|--|--------------------------|--------------------------|-----|
| (a) As alcohol consumption increases. | <input type="checkbox"/> | <input type="checkbox"/> | 21. |
| (b) When blood alcohol concentration is at its maximum possible level. | <input type="checkbox"/> | <input type="checkbox"/> | 22. |
| (c) Immediately after the drinker stops consuming alcohol. | <input type="checkbox"/> | <input type="checkbox"/> | 23. |
| (d) Within a few days after stopping drinking alcohol. | <input type="checkbox"/> | <input type="checkbox"/> | 24. |

5. Which drug is often used to relieve some of the alcohol withdrawal symptoms?

- | | | | |
|----------------|--------------------------|--------------------------|-----|
| (a) Antabuse | <input type="checkbox"/> | <input type="checkbox"/> | 25. |
| (b) Penicillin | <input type="checkbox"/> | <input type="checkbox"/> | 26. |
| (c) Valium | <input type="checkbox"/> | <input type="checkbox"/> | 27. |
| (d) No drug | <input type="checkbox"/> | <input type="checkbox"/> | 28. |

6. Compared to others, people who have parents medically diagnosed as alcoholics are:

(Please put a cross in one box)

- | | | | |
|---|--------------------------|--------------------------|-----|
| (a) Much less likely to develop drinking problems themselves. | <input type="checkbox"/> | <input type="checkbox"/> | 29. |
| (b) Less likely to develop drinking problems themselves. | <input type="checkbox"/> | <input type="checkbox"/> | 30. |
| (c) No more likely to develop drinking problems than anyone else. | <input type="checkbox"/> | <input type="checkbox"/> | 31. |
| (d) More likely to develop drinking problems themselves. | <input type="checkbox"/> | <input type="checkbox"/> | 32. |

C4.
Please
Leave Blank.

7. Which statement correctly describes Al-Anon?

(Please put a cross in one box).

- | | | | |
|---|--------------------------|--------------------------|-----|
| (a) Al-Anon is an organisation for alcoholics who have recovered and left A.A. | <input type="checkbox"/> | <input type="checkbox"/> | 33. |
| (b) Al-Anon is an organisation for the spouses of alcoholics who wish to keep their spouses' drinking a secret. | <input type="checkbox"/> | <input type="checkbox"/> | 34. |
| (c) Al-Anon is an organisation for the spouses of alcoholics who wish to help themselves and each other cope with their spouses' drinking problems. | <input type="checkbox"/> | <input type="checkbox"/> | 35. |
| (d) Al-Anon is an organisation formed by doctors to help A.A. over any medical problems. | <input type="checkbox"/> | <input type="checkbox"/> | 36. |

Questions 8 - 15 are supplied with a varying number of possible answers. Any number of answers may be correct or none may be correct. Please put a cross in any boxes alongside answers you think are correct.

8. Which of these are known sometimes to be long term physical consequences of high alcohol consumption?

(Please put a cross in any number of boxes).

- | | | | |
|--|--------------------------|--------------------------|-----|
| (a) Increased sexual potency. | <input type="checkbox"/> | <input type="checkbox"/> | 37. |
| (b) Increased resistance to chest infection. | <input type="checkbox"/> | <input type="checkbox"/> | 38. |
| (c) Increased consumption of solid food. | <input type="checkbox"/> | <input type="checkbox"/> | 39. |
| (d) Physical addiction to alcohol. | <input type="checkbox"/> | <input type="checkbox"/> | 40. |
| (e) Brain damage. | <input type="checkbox"/> | <input type="checkbox"/> | 41. |

C.5.
Please
Leave
Blank.

9. Which of these feelings are likely to be reported by patients medically diagnosed as alcoholics?
(Please put a cross in any number of boxes).
I feel that.....
- (a) when I start drinking I find it difficult to stop. 42
- (b) I am having consistently deeper sleep than ever before. 43
- (c) it would be impossible to live without drink. 44
- (d) I am now more relaxed than ever before 45
10. Do people medically diagnosed as alcoholics commonly report experiencing any of these types of drinking behaviour?
(Please put a cross in any number of boxes)
- (a) Gulping drinks rather than sipping them 46
- (b) Never drinking drinks with a low alcohol content. 47
- (c) Starting to drink upon waking up in the morning. 48
- (d) Drinking extra drinks between rounds when in company. 49
- (e) Concealing drinks from other people. 50
11. Which of these occupations produce an above average proportion of people who become medically diagnosed as alcoholics?
(Please put a cross in any number of boxes).
- (a) Draughtsmen. 51
- (b) Publicans. 52
- (c) Travelling Salesmen. 53
- (d) Midwives. 54
- (e) Toolmakers. 55
- (f) Journalists. 56
- (g) Car Assembly Workers. 57
- (h) Company Directors. 58
- (i) Seamen 59

C.6.
Please
Leave Blank.

12. Which of these diseases are thought by medical authorities to be at least partly caused by high alcohol consumption?
(Please put a cross in any number of boxes)
- | | | | |
|----------------------------|--------------------------|--------------------------|----|
| (a) Hypertension. | <input type="checkbox"/> | <input type="checkbox"/> | 60 |
| (b) Peptic Ulcer | <input type="checkbox"/> | <input type="checkbox"/> | 61 |
| (c) Gastritis | <input type="checkbox"/> | <input type="checkbox"/> | 62 |
| (d) Pancreatitis | <input type="checkbox"/> | <input type="checkbox"/> | 63 |
| (e) Peripheral Neuropathy | <input type="checkbox"/> | <input type="checkbox"/> | 64 |
| (f) Disseminated sclerosis | <input type="checkbox"/> | <input type="checkbox"/> | 65 |
13. Which of these problems occur more amongst the families of alcoholics than amongst other families?
(Please put a cross in any number of boxes).
- | | | | |
|--|--------------------------|--------------------------|----|
| (a) Emotional disturbance in children. | <input type="checkbox"/> | <input type="checkbox"/> | 66 |
| (b) Nocturnal enuresis in children. | <input type="checkbox"/> | <input type="checkbox"/> | 67 |
| (c) Physical violence within the family. | <input type="checkbox"/> | <input type="checkbox"/> | 68 |
| (d) Breaking up of the family. | <input type="checkbox"/> | <input type="checkbox"/> | 69 |
14. There is evidence that persons medically diagnosed as alcoholics are more likely than the rest of the population to die from.....
- | | | | |
|---|--------------------------|--------------------------|----|
| (a) A traffic accident whilst driving. | <input type="checkbox"/> | <input type="checkbox"/> | 70 |
| (b) A traffic accident whilst a pedestrian. | <input type="checkbox"/> | <input type="checkbox"/> | 71 |
| (c) Accidents in the home. | <input type="checkbox"/> | <input type="checkbox"/> | 72 |
| (d) Sporting accidents. | <input type="checkbox"/> | <input type="checkbox"/> | 73 |
| (e) Suicide | <input type="checkbox"/> | <input type="checkbox"/> | 74 |

15. Which of these psychiatric conditions are more common amongst people medically diagnosed as alcoholics than amongst the rest of the population.
(Please put a cross in any number of boxes)

- (a) Anxiety state.
- (b) Anorexia Nervosa.
- (c) Depressive state.
- (d) Hebephrenia
- (e) Attempted suicide

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

C.7.
Please
Leave
Blank.

<input type="checkbox"/>	7
<input type="checkbox"/>	7
<input type="checkbox"/>	7
<input type="checkbox"/>	7
<input type="checkbox"/>	7

APPENDIX 2

EXPLANATORY LETTER ON QUESTIONNAIRE



MIDLAND HEALTH BOARD
COMMUNITY ALCOHOL & DRUGS SERVICES, BISHOPSGATE STREET MULLINGAR CO WESTMEATH TELEPHONE (044) 48289 / 41630

RESEARCH PROJECT.

ST. PATRICK'S COLLEGE, MAYNOOTH / COMMUNITY ALCOHOL
AND DRUGS SERVICES.

Survey of Members of The Irish College of General
Practitioners in Longford / Westmeath.

This questionnaire has the endorsement of the I.C.G.P.
It is designed to establish what G.P's know about
Alcohol and Alcohol-Related Problems and what their
opinions are on certain issues.

For many of the questions there is no correct answer
and it is important that you try to answer as closely
as possible to how you feel.

This questionnaire is a research instrument, and it is
important that you attempt every question.

Thank you for your kind co-operation.

Jimmy Connolly,

APPENDIX 3

LETTER TO GENERAL PRACTITIONERS



MIDLAND HEALTH BOARD

COMMUNITY ALCOHOL & DRUGS SERVICES, BISHOPSGATE STREET, MULLINGAR CO WESTMEATH TELEPHONE (044) 48289 / 41630

4th July, 1994.

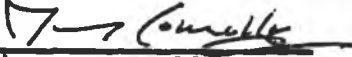
Dear

I am writing to you requesting your co-operation and participation in a research project, on the attitudes of G.P.'s towards working with problem drinkers. The enclosed questionnaire is a research instrument that has been used extensively in the U.K. The study has the endorsement of the I.C.G.P. (see enclosed letter). It should take approximately 20 minutes to complete. The study is part of an M.A. Thesis that I am now completing. The questionnaire contains no identifying mark or number and respondents are guaranteed full confidentiality.

I am requesting your co-operation, in completing the questionnaire and returning it to me, immediately in the enclosed S.A.E.

If you have any queries please contact Jimmy Connolly, at 044-48289/41630.

Yours sincerely,


Jimmy Connolly,
Education Officer.

APPENDIX 4

**COVER LETTER FROM THE IRISH COLLEGE OF GENERAL
PRACTITIONERS'
TUTOR**

Colaiste Dhochtuir
Teaghlaigh Eireann



The Irish College of
General Practitioners

East Midland & Longford/Roscommon Continuing Education Scheme

Dunganstown, Delvin, Co Westmeath Tel (044) 64405

SUPPORTED BY THE POSTGRADUATE MEDICAL & DENTAL BOARD

Dear Colleague

I am writing to you to request your cooperation with the enclosed questionnaire compiled by Mr. Jimmy Connolly of the Midland Health Board's Alcohol and Drug Abuse Counselling Service.

You may recall me mentioning this questionnaire to you at CME. It is essential that Mr. Connolly gets a good response to his questionnaire as in time the results may well influence the Health Board's attitude to the type of service available to our patients.

I earnestly request that you complete the enclosed questionnaire. I hope that when the results are to hand I may arrange that Mr. Connolly to resource a small group meeting on the most pertinent subject of drug and alcohol abuse.

Yours sincerely,

DR. BRENDAN MAHON
C.M.E. TUTOR

Sponsored by



Klinge Pharma
A Co

APPENDIX 5

LETTER OF ENDORSEMENT FROM MIDLAND HEALTH BOARD



MIDLAND HEALTH BOARD

CENTRAL OFFICE, ARDEN ROAD, TULLAMORE, CO. OFFALY TELEPHONE (0506) 21868 TELEX 60830 FAX (0506) 51760

14th July, 1994.

Mr. J. Connolly,
Education Officer,
Community Alcohol & Drugs Services,
Bishopsgate Street,
Mullingar,
Co. Westmeath.

Dear Mr. Connolly,

I have now had an opportunity of examining your proposed Research Project in which you intend examining the attitude of General practitioners in the Longford/Westmeath Community Care Area towards dealing with and treating problem alcohol drinkers.

I am pleased to advise you that the Midland Health Board is pleased to endorse and approve the Project and I look forward with interest to studying its findings.

Yours sincerely,

D. O'Dwyer,
Programme Manager Community Care.

D.O'D/HD

APPENDIX 6

FOLLOW UP LETTER



MIDLAND HEALTH BOARD
COMMUNITY ALCOHOL & DRUGS SERVICES. BISHOPSGATE STREET MULLINGAR CO. WESTMEATH TELEPHONE (0441) 48289

19th July, 1994.

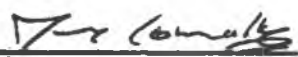
Dear Dr.

You will recall receiving a questionnaire on July 5th, approx. two weeks ago.

If you have returned the completed questionnaire, I would like to thank you for your kind co-operation in doing so. If not, I would appreciate if you could do so, as soon as possible.

Many thanks for your help with this project.

Yours sincerely,


Jimmy Connolly,
Education Officer.

APPENDIX 7

HANDSCORING THE AAPPQ VERSION 4

HANDSCORING THE AAPPQ VERSION 4

INTRODUCTION

The AAPPQ was specifically designed to test a number of hypotheses about factors affecting the attitudes various agents adopt to working with drinkers. The major hypotheses are described in our book 'Responding to Drinking Problems'. The major dependent variable is Therapeutic Commitment which concerns the extent to which the agents have positive attitudes towards working with drinkers. In this version of the AAPPQ 3 scales are utilised which measure Therapeutic Commitment, these are:

1. Motivation to work with drinkers.
2. Expectations of work satisfaction with drinkers.
3. Task specific self-esteem with drinkers.

On the basis of the psychotherapy literature and limited studies with alcoholics it can be assumed that agents who score poorly on these scales will not be successful in working with drinking clients.

The major hypothesis is that low therapeutic commitment is the result of feelings of Role Insecurity. There are 2 scales in the AAPPQ to measure Role Insecurity, these are:

1. Role adequacy.
2. Role legitimacy.

The higher an agent's score on the scales on Role Insecurity, or its converse as high scores measure role security, the higher it is predicted the scores on the scales of therapeutic commitment will be. The research has not only indicated that this is indeed the case, but that whilst it is possible to conceptualise the therapeutic commitment and role insecurity scales as measuring separate aspects of the agent's experience of themselves in this role, in practical terms the relationships between role insecurity and therapeutic commitment are so high as to lead one to really consider them as one major dimension. Thus, in some analysis of the AAPPQ an agent's score on the five scales measuring insecurity and therapeutic commitment, are added together to create an Overall Attitude Scale.

The theoretical model suggests that the overall therapeutic attitude is related to 4 factors which are also measured in the AAPPQ. Each of these 4 factors is in principle amenable to change either by training programmes, or by organisation within the helping agency. The four factors are:

1. Role support - a scale that measures the extent to which an agent feels able to turn to others for clarification of various areas of their work with drinkers.
2. Experience with working with drinkers - questions 9 and 10 in Part A of the AAPPQ are designed to measure the agent's experience of working with drinkers. Of the 2 questions 10 is the more important question, and it will

be discovered that the greater the reported experience with drinkers the more positive the overall therapeutic attitude.

3. The third factor related to the overall therapeutic attitude is a person's self-esteem.
4. Knowledge about alcohol and alcohol related problems can also be important and Part C of the AAPPQ scale is provided which measures knowledge. The scale was initially developed and validated around the responses of summer School tutors, then the number of questions were reduced by selecting only those questions which tended to discriminate between low and high scores on the original scale.

These studies have suggested that knowledge and training with which it is highly correlated do not appear to become effective determinants of therapeutic attitudes unless the agent has considerable levels of either support or experience.

Other areas measured in Part A of the AAPPQ do not related directly to overall therapeutic attitudes, but may strongly relate to the four basic role requirements described above. The reason why people who work in specialist environments are seen to have stronger overall therapeutic attitudes is largely because they tend to report greater levels of experience, support and information. Research studies on the Summer School have shown that agents who increase levels of support and experience tend to increase their overall

therapeutic attitudes, while those who do not change levels of supportive experience do not change in their therapeutic attitudes.

As mentioned earlier the general theoretical perspective used is described in 'Responding to Drinking Problems', and a more detailed description of the analysis of the AAPPQ data can be found in a paper forthcoming in the British Journal of Addiction - Attitudes of Helping Agents toward the Alcoholic Client; The Influence of Experience, Support, Training and Self-Esteem. Final corrections to this paper should be completed by the Autumn of 1979 when copies will become available. This paper uses standardised scores for the analysis, and details of how to calculate standardised scores are contained below.

Calculation of the Basic Scores for the AAPPQ

Apart from the information scales which is found in Part C of the questionnaire and the experience scale which appeared in Section A, questions 9 and 10, all the scales used in the analysis are found in Part B of the AAPPQ. Question numbers in the text below refer to the numbers in the left hand side of Part B. The score numbers to be added are those which are found in boxes which the respondent should have run.

1. Therapeutic Commitment

- (a) Task Specific Self-Esteem in Working with Drinkers - add together the scores for questions 16 and 32, then add together the scores for

questions 18, 19, 22 and 27, then subtract this last sub-total from 32 and add the remainder to the first sub-total.

(It will be noted that questions 18, 19, 22 and 27 are phrased in a negative fashion, consequently a low score on these questions is indicative of higher self-esteem. By subtracting the scores on each question from 8, or for the 4 questions combined, 32, these scores are then converted to the equivalent positive scores).

- (b) **Expectations of Satisfaction of Working with Drinkers** - add together the scores for questions 24, 28, 29, 30 and 31.
- (c) **Motivation to Work with Drinkers** - subtract scores of 21, 23 and 25 from 8 and then add to scores of 15 and 17.

2. Role Security

- (a) **Role Adequacy** - add together the scores of questions 1, 2, 3, 4, 5, 6 and 7.
- (b) **Role Legitimacy** - add together the scores of questions 8, 9, 10 and 11.

3. Basic Role Requirements

- (a) **Role Support** - add together the scores on questions 12, 13 and 14.#
- (b) **Experience** - the scores from question 10, Part A, are used here.
- (c) **Self-Esteem** - add together the scores of 35, 36 and 39, then add together the scores on 34, 37 and 41; subtract the latter sub-total from 24 and add the remainder to the first sub-total.

(d) Information - the information score is calculated in Section C. One point is given for a correct answer, and one point subtracted for an incorrect answer. Correct answers are referred to below. The numbers refer to those on the right hand side of the questionnaire, eg correct answers to question 1 is d, which is box 12. If this answer is correct, add one to the total score, if it is incorrect take one from the total score.

Question 8 - 15 have more than one correct answer. The correct answers to question 8 are d and e in boxes 40 and 41. If the respondent has marked boxes 37, 38 or 39, subtract one point for each box. If the respondent has not answered boxes 40 and 41, also subtract one point. Thus the person who scored 40 and 41 would get 2 points, but a person who scored 39 and 41 would get minus one point; this scoring system is used to overcome the problems created by guess-work in this type of questionnaire.

Thus the correct answers are 12, 13, 19, 24, 27, 32, 35, 40, 41, 42, 44, 46, 48, 49, 50, 52, 53, 56, 58, 59, 61, 62, 63, 64, 66, 67, 68, 69, 70, 71, 72, 74, 75, 77 and 79.

Calculating Standard Scores

Standard scores have been calculated for the scales of therapeutic commitment and role security. A standard score has a mean of zero and a standard deviation of one. In any population 66 per cent will lie between a score of +1 and -1, and 95 per cent between a score of +1.96 and -1.96. The standard

scores quoted below are based upon the responses of the students attending the basic, evaluation and counselling courses conducted by the Alcohol Education Centre in 1977. A standard score is calculated by subtracting the mean of the sample score from the individual respondent's score and dividing by the sample standard deviation.

Thus, to calculate the standard score on the motivation scale of a respondent who scored 33, you would subtract from this 28.05, giving a score of 4.95, and then divide this by 4.3, giving a score of 1.13 standard deviations. Roughly interpreted this would mean that only 15 per cent of those who attended the Summer School in 1977 will have scored more highly than this person.

- (a) Motivation - subtract 28.05 from the respondent's score and divide by 4.3.
- (b) Expectations of Satisfaction - subtract 23.89 from the respondent's score and divide by 5.5.
- (c) Task Specific Self-Esteem - subtract 28.2 from the respondent's score and divide by 5.5.
- (d) Role Legitimacy - subtract 21.62 from the respondent's score, and divide by 4.46.
- (e) Role Adequacy - subtract 31.9 from the respondent's score and divide by 8.87.
- (f) Information - subtract 24.541 from the respondent's score and divide by 4.452.

To calculate the overall attitude score used in the paper forthcoming in the British Journal of Addiction, add together the 5 standardised scores described above and divide by 5. A score of zero on that scale is referred to as the minimal acceptable therapeutic attitude.

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