A long-term follow-up evaluation of the Leicestershire community alcohol services: the effect of self-determined therapeutic goals for people with alcohol problems

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A LONG-TERM FOLLOW-UP EVALUATION OF THE LEICESTERSHIRE
COMMUNITY ALCOHOL SERVICES
The effect of self-determined therapeutic goals
for people with alcohol problems

by

EDMUND PAUL CHARNLEY

A Master's Thesis submitted in partial fulfillment
of the requirements for the award of

Master of Philosophy of the Loughborough University of Technology

10th December 1994

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I DEDICATE THIS THESIS TO JOHANN
ACKNOWLEDGEMENTS

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ABSTRACT

THESIS TITLE:

A long-term follow-up evaluation of the Leicestershire Community Alcohol Services - The effect of self-determined therapeutic goals for people with alcohol problems

The study of problematic drinking behaviour and related therapeutic provision is divided into two schools of thought: those who see problem drinkers as suffering from the disease of alcoholism and who should as such abstain, and those who see problem drinkers as differing from other people only in their drinking behaviour, and who could in principle learn to drink moderately. The Leicestershire Community Alcohol Services (L.C.A.S.) work with a neutral policy towards these two schools of thought and people with drinking problems are encouraged to determine their own therapeutic goals; they are free to attempt either abstinence or controlled drinking as they wish.

This thesis examines the effectiveness of this therapeutic philosophy by comparing the long-term outcomes of the L.C.A.S. research subjects with another cohort reported in the literature who had been advised to abstain. In order to do this, interviews and all available information were sought in 1992/93 concerning 162 customers who had originally been assessed in 1981/82 as being in need of therapy from the L.C.A.S.

The findings of this study indicate, within the limitations of the research design and the available data, that the L.C.A.S. long-term outcomes were indeed better in terms of both the incidence of abstinence and controlled drinking, in comparison with the study where abstinence alone was advocated.
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<td>A.A.C.</td>
<td>Alcohol Advice Centre</td>
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<td>A.A.</td>
<td>Alcoholics Anonymous</td>
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<tr>
<td>A.T.U.</td>
<td>Alcohol Treatment Unit</td>
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<td>C.A.T.</td>
<td>Community Alcohol Team</td>
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<tr>
<td>Cohort</td>
<td>A group of Research Subjects</td>
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<td>E.E.C.</td>
<td>European Economic Community</td>
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<tr>
<td>G.P.</td>
<td>General (Medical) Practitioner</td>
</tr>
<tr>
<td>Heminevrin</td>
<td>A drug used in alcohol detoxification</td>
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<td>N.H.S.</td>
<td>National Health Service</td>
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<td>L.C.A.S.</td>
<td>Leicestershire Community Alcohol Services</td>
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<td>L.R.U.</td>
<td>Leicester Resettlement Unit, Glen Parva</td>
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<tr>
<td>L.S.D.</td>
<td>Lysergic acid diethylamide - an hallucinogenic drug</td>
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<tr>
<td>O.P.C.S.</td>
<td>Office of Population Censuses and Surveys</td>
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<td>R.G.N.</td>
<td>Registered General Nurse</td>
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<td>&quot;Repeated Measures&quot; - questions asked at follow-up interview which were identical or very similar to the questions asked at assessment in 1981/82</td>
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<td>U.S./U.S.A.</td>
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1. INTRODUCTION TO THE THESIS

The introduction to this thesis is a brief description of my work experience and personal motivations for carrying out this research, followed by an outline of the objectives of this study, and the hypothesis.

My experience and motivations for carrying out this research

My professional background is one of nursing. I qualified first as a State Registered Nurse (now Registered General Nurse) and then went on to qualify as a Registered Mental Nurse. My interest in people with alcohol problems began when I was allocated to "Woodleigh", an Alcohol Treatment Unit (A.T.U.) in Warwick during my R.M.N. training, and was subsequently offered a post there. The philosophy at Woodleigh was that of the "disease" model of alcoholism, i.e. that patients were "alcoholics" on the basis of diagnosis by a psychiatrist, that this was a progressive disease and that life long abstinence was the only option open to them. They were admitted to a specialized unit of a psychiatric hospital: the therapy given was entirely directed towards the goal of abstinence and consisted of detoxification, group therapy sessions led by members of staff, individual counselling sessions and attendance at Alcoholics Anonymous meetings.

It was wonderful to talk with people who had genuinely succeeded in abstinence. They often told of how bad things had been for them, and how good they were now by comparison. The terms used in the literature which has described the "disease" model fitted these patients perfectly. They had had severe alcohol problems with a wide range of physical, psychological, social, legal and economic consequences. They had "hit rock bottom" and then recovered by becoming abstinent.
I was however disappointed at the "success rate". Few patients were able to remain abstinent following discharge even though they had been selected for hospital admission on the basis that they agreed with the philosophy of "alcoholism" as a disease and with their diagnosis. Some drank during the course of treatment itself, in secrecy for fear of immediate discharge from the unit and censure from the staff and other patients. Thus behaviour which had been identified as a problem severe enough to merit admission was then used to justify discharge. The relationships between the staff and patient were damaged in such cases; the very behaviour which they were struggling to eliminate could not be spoken of truthfully if they were currently drinking. Patients who were drinking were seen as being in the wrong, as failures due to an illness which they could not or would not accept. The community support linked to the unit following discharge carried with it the same philosophy. The result was that such patients frequently dropped out of contact and were only seen again if they deteriorated to such an extent that they sought readmission in crisis. This cycle was repeated many times by some patients and was seen by the staff as being part of the nature of alcoholism.

After two years on the unit I accepted a job as a Community Nurse with the Leicestershire Community Alcohol Team despite warnings from the staff of Woodleigh that this was a service which "promoted" controlled drinking. My experience with the Community Alcohol Team within the Leicestershire Community Alcohol Services (L.C.A.S.) was a very great contrast to the experience described above. The L.C.A.S. was primarily a community based service and did not necessitate hospital admission purely on the grounds of an alcohol problem. The term "customer" was used rather than "patient" as the people who contacted the service with alcohol related problems were seen as being free to determine to a great extent the goals they set for themselves and the route they took to achieve them. I saw roughly the same
number of customers aiming at and succeeding in abstinence i.e. people who although currently "relapsing" identified themselves as being "alcoholic" in their own terms and who attended A.A. meetings, as I had on the A.T.U.

However it was with customers who chose to continue drinking but wished to reduce their consumption and change their drinking pattern that I realized a new potential. For the first time I was able to counsel people in a truly non-directive manner. My role was no longer primarily to convince the customers that life-long abstinence was the only solution open to them.

After three years with the L.C.A.S. I left to go and live in Holland for personal reasons. I had greatly enjoyed my experience there, so I kept in contact with colleagues and took the chance to visit my former work place whenever I was on holiday in England.

I felt intuitively that the L.C.A.S. policy of free choice in the goal of therapy was better than that of a general policy of abstinence. When I was subsequently offered a voluntary placement as a post graduate student with the L.C.A.S. to coordinate and record this follow-up project, I knew that this was an opportunity to find out if this was indeed the case.

The background to the research and why it was carried out

The main aim of this research was to compare the long-term outcomes of a cohort of 162 customers of the L.C.A.S. with those of another long-term study which had taken abstinence as the only goal to assess how effective the L.C.A.S. therapy had been. In order to do this it would first be necessary to describe the L.C.A.S. cohort as it was in 1981/82. As many of the customers as possible were traced and interviewed, and related information was gathered from a wide range of sources. The data derived
needed to be set within the context of the wider literature on the use and abuse of alcohol. It would then be possible to describe and evaluate the L.C.A.S. therapy as it had been given in practice, and to draw conclusions concerning the effects of the therapy and the implications for service provision.

The key issue, then, was the relative effectiveness of various forms of therapy. However, the term "therapy" in relation to people suffering from alcohol problems is very difficult to define. This issue is discussed more fully in the following Chapters. Briefly, the difficulty arises because the behaviour to which the therapy relates, the use and misuse of alcohol, is itself hard to define and quantify. Alcohol problems are highly individual to each person and their current circumstances. They are to some extent determined, caused, and exacerbated by a wide range of interactive factors. The recovery from alcohol problems is also very complex and therapy is but one of the factors involved.

It is possible that more moderate forms of drinking could be achieved more frequently if people were not "fed", as part of their therapy, ideas about their situation and drinking behaviour which were exclusively orientated towards a goal of abstinence, but instead were allowed openly to choose their goals, and were able to change these over time to suit their current needs and wishes.

It would seem to follow that a form of therapy which is able to offer the customers the widest range of options in combination with goal flexibility is likely to be the most successful, not only in terms of the overall quantities of alcohol consumed and the pattern of consumption, but also in terms of the total life adjustment of the customers in terms of their relationships, work, general health etc. This argument forms the basis of
the hypothesis of this research project.

THE HYPOTHESIS OF THE STUDY

The hypothesis of this study is that:

Clients who present to a service which offers a range of treatment goals including moderated consumption rather than an abstinence-only goal are more likely to show a moderated consumption and/or stable abstinence at long-term (10 - 12 year) follow-up.

The purpose of the study is to test this hypothesis by comparing the long-term outcomes of clients of the L.C.A.S. with the long-term outcomes reported in a study where the therapeutic ideology was disease-concept orientated with abstinence as the only therapeutic goal.
2. LITERATURE REVIEW

INTRODUCTION

This Chapter is a review of some of the most pertinent literature concerning the phenomenon of heavy and problematic drinking and is divided into three Sections.

The first Section is a discussion of the most controversial issue in this field of research: the debate between those who see heavy drinkers as suffering from a disease and those who see them as differing in terms of the amount they drink and possible related consequences, but not as forming a genus on pathological grounds. These points of view are shown to divide this field of research.

The influence these viewpoints have on the provision of services for people with drinking problems in Britain are discussed in Section 2. They are shown to have a profound effect on selection criteria for therapeutic programmes, the objectives of therapy and the definitions of success which are used. The process of recovery from alcohol problems and the role which various forms of therapy can play are then discussed. Attention is drawn to ways which may make therapeutic interventions more effective. The need to provide comprehensive services which are responsive to the needs of a wide range of people with drinking problems - including women, ethnic minorities and the homeless - is emphasized.

In Section 3 the findings of two long-term follow-up studies are reviewed. One of these, the paper by Nordström (1989) is described in some detail to allow for comparison with the L.C.A.S. findings.
SECTION 1

THEORIES WHICH SEEK TO EXPLAIN PROBLEMATIC DRINKING BEHAVIOUR

In this Section the wide differences in the cultural attitudes to alcohol use are highlighted. The difficulties of defining what is "normal" and "socially acceptable" in alcohol drinking behaviour are discussed. The division between the "disease" model and "non-disease" model approaches to excessive drinking are then outlined from an historical perspective and the cases for both sides of the argument are stated.

Cultural norms and the use of alcohol

There are large differences in cultural attitudes towards the use of alcohol. In many Islamic nations for example, the production, possession and use of alcohol are strictly forbidden. Penalties are applied which most observers in the West find quite shocking. In the countries where alcohol is tolerated there is a wide range of attitudes at national level. These attitudes determine what is and is not acceptable in terms of law and social policy towards the use of alcohol. Within these national attitudes there are wide variations according to local culture, origin, class and sex. These attitudes also vary over time.

To gain an insight into the differing relationships which various nations have with alcohol it is necessary to look at a range of data concerning the amount of alcohol consumed per capita, the laws concerning alcohol availability and control and the incidence of alcohol related diseases, particularly cirrhosis of the liver. Three countries have been chosen as examples: France, Sweden, and Great Britain.
Two books have been taken as primary sources for these comparisons. Klingemann (1992) comprises a series of articles, each written by an author familiar with his or her own national and cultural norms concerning alcohol use and the interpretation of abuse. P. Davies (1983) addresses similar issues but within a framework which allows comparisons to be made on national data relating to drinking on the basis of a series of measures which include the relative price of alcohol and mortality from liver cirrhosis. Liver cirrhosis, while being only one of the many alcohol related disorders, is often taken to be a good indicator of alcohol related harm within populations.

i. France

France has a reputation as being relaxed and non-interventionist in its attitude to alcohol use. Alcohol forms an integral part of daily life for the majority of people. It is drunk during the day and with meals. Alcohol is relatively cheap in France both in comparison with other commodities and the price in other lands. The wine and spirits industries have an international reputation, are large employers and have powerful political lobbies to protect their interests. These factors are reflected in the per capita amount of alcohol consumed, the highest in Europe, being 20.8 litres of pure alcohol per year for people aged 15 of over in 1979. (P. Davies, 1983: p. 267).

In recent years there has been in France a noticeable increase in the support of measures aimed at reducing alcohol related harm, the most significant of these being the introduction of random breath testing for drink-driving in 1978 (P. Davies 1983).
The incidence of death from liver cirrhosis was very high, 30.4 deaths per hundred thousand, and ranked third behind Italy (in 1976) and Austria (P. Davies 1983: p. 267). These figures may not be a true representation of the level of alcohol related harm in France. Mossé (1992: p. 214) reported:

"Despite repeated efforts to improve the system, the statistics concerning morbidity in general and alcohol-related morbidity in particular remain of poor quality".

Mossé (1992) also noted an unwillingness of medical personnel to give overtly alcohol related diagnoses. In view of these discrepancies, it may well be that the incidence of alcohol related harm in France is far higher than the available statistics indicate.

ii. Sweden

In sharp contrast to France, Sweden has without doubt the most restrictive laws in Europe concerning the availability and use of alcohol. The production, importation and retailing of alcohol in Sweden is for the greater part controlled by a state monopoly. The licensing laws are very strict, licences are difficult to obtain and checks are made to ensure that the regulations are met. There are no bars or public houses which are exclusively drinking establishments; food must be served on the premises. Although rationing was abolished in 1955, off-licence sales are still restricted to state-owned shops.
The price of alcohol is regulated by the state to discourage its use in general; alcohol is very expensive in Sweden. A large price differential is maintained through taxation in favour of lower rather than higher strength beverages.

The reported consumption of alcohol per capita is one of the lowest in Europe, 7.1 litres per year (1979). Deaths from liver cirrhosis are below the mean for Europe at 12.2 deaths per hundred thousand, although well above that of the lowest, Ireland, at 3.6. (P. Davies 1983: p. 287). The available literature failed to mention the role of home brewing and "black-market" sales of alcohol, both of which are reputedly widespread. The discrepancy between the reportedly low level of consumption per capita and the level of liver cirrhosis may be linked to this.

iii. Great Britain

British policies on alcohol use fall between those of France and Sweden. The production and retailing of alcohol is restricted by law, but to a far lesser extent than in Sweden. Alcohol is available in supermarkets for example, and is moderately expensive. The "pub" in particular is seen as being a focus of social life for many,

"a quintessential element of the English cultural landscape, along with the village church and the village pond".

(Hunt et al., 1992: p. 112).
On the other hand alcohol does not play quite such a large role in daily life as it does in France. Consumption per capita was 9.8 litres (1979), only slightly above that of Sweden but less than half that of France. The reported incidence of liver cirrhosis mortality is also relatively very low at 4.2 deaths per hundred thousand (P. Davies 1983: p. 267).

From the above it is clear to see that attitudes concerning alcohol use vary greatly between nations. These attitudes also vary greatly over time within each nation.

The change of attitudes over time

The rise of political motivation which led to the "Road Safety Act 1967" in Britain is a good example of how attitudes towards drinking behaviour, in this case towards drinking and driving, can change over time. The course of events and research findings which led to this issue finding a place on the political agenda and the implementation of this legislation was well documented by Baggott (1990). Few people were aware of the dangers of drinking and driving in the 1950's. Today drinking and driving is considered to be anti-social and is a crime. This Act of Law has not only proven to be popular, it has also been very successful:

"It was estimated that between 1967 and 1974 5,000 lives were saved, and 200,000 injuries prevented, by the Road Safety Act of 1967." (Baggott 1990: p. 142).
A further example is that of the prohibition of alcohol between 1919 and 1933 in the U.S.A. by amendment of the Constitution. Originated largely by the temperance movement and enacted with a degree of public support, this legislation is now widely regarded as a disaster. As noted by Fingarette (1988: p. 17):

"The ban (on alcohol) proved impossible to implement and provoked an especially malevolent form of nationwide gangsterism."

The temperance doctrine, although ultimately rejected as a policy for all the inhabitants of the U.S.A., formed the basis of the ideology of Alcoholics Anonymous which was founded there in 1935. The influence of this ideology is discussed further below.

The boundary between culturally acceptable and unacceptable drinking behaviour

The norms which govern the use of alcohol throughout the world are highly indicative of the cultures they represent. These norms are more elusive than for example, licensing laws or the quantity of alcohol consumed per head of population, but they have none the less a profound effect on drinking behaviour. Drinking wine while singing folk songs on street terraces may be considered an enjoyable pastime in France, but such behaviour would be unacceptable in Sweden.

Cultural norms in alcohol drinking behaviour dictate not only what is acceptable but also what is unacceptable. By implication they determine where the lines are drawn concerning the justification of punishment and
therapy. There are no absolute levels of consumption or forms of drinking behaviour which determine reliably the boundary between the culturally acceptable and the unacceptable. It is essential to keep this in mind when considering the international literature on heavy and problematic drinking.

Differences aside there are people who drink to excess and behave in unacceptable ways by whatever norm. How these people can be classified with a view to assisting them is now addressed.

The debate as to the nature of excessive drinkers

There are two broad schools of thought concerning the nature of people who drink to excess. There are some differences within these two schools as to the definitions used, but for the sake of argument these are referred to here as the "disease" model and the "non-disease" model.

The "disease" model - Alcoholism

The "disease" model in its classic form sees people with severe drinking problems as being addicted to alcohol. These "alcohol addicts" are distinguishable from problem-free abstainers, moderate drinkers and "habitual symptomatic excessive drinkers" on the basis of their symptomatology, drinking patterns and in that they "lose control" over their drinking (Jellinek 1960). This loss of control is seen primarily as having an organic basis. The disease is progressive in nature and passes through identifiable stages. Under this model life-long abstinence is the only realistic therapeutic goal.
The "non-disease" model

The "non-disease" model sees people with severe drinking problems as differing from other people in the amount they drink and in the symptoms and consequences they experience. The term "addiction" is generally avoided. The excessive drinking behaviour and related symptoms are not taken as forming a pathological condition, but are seen as secondary and reactive to other problems of the individual or in their socialization. Most variations of this model identify excessive drinking as a form of learned behaviour rather than as the result of an organic condition. Under this model a return to moderate or "controlled" drinking is possible in principle.

The background to the "disease" model

i. Temperance and prohibition in the United States

Historically, alcohol abuse has been seen as a vice. In documenting the colonial period in the U.S.A. and the rise of the temperance movement, for example, Clayton-Rivers (1994: p. 8) noted:

"The notion that the community frowned on drinking was a form of social control".

This period was characterized by contrasts in drinking behaviour over time and by location; some communities were abstinent or drank moderately, while others were characterized by widespread drunken violence. The latter was not unique to the frontier towns. The temperance movement grew over the
decades as a reaction to these problems and held the belief that alcohol drinking was implicitly evil and the cause of many social problems. The use of alcohol should therefore be prohibited at every level of society. Ultimately this led to the prohibition of alcohol in 1919.

The temperance movement in U.S.A. had a parallel movement in Great Britain. While prohibition of alcohol was never introduced, this movement was active within the community and held a powerful political lobby which influenced the revision of licensing laws in the early part of this century (Baggott 1990). The Salvation Army and the Methodist Church are but two examples of religious groups who were particularly active in combating poverty and the effects of alcohol abuse at that time.

With the repeal of U.S. prohibition in 1933 came the realization that it had been a mistake to place a blanket ban on alcohol. It was the greatest political "U-turn" of the century on policy towards the use and control of alcohol:

"Once the fervor died down, people recalled that Europe and the United States had a long cultural tradition of moderate social drinking and that the vast majority of social drinkers did not become habitual drunkards. Clearly, many people were capable of drinking alcohol without falling victim to it" (Fingarette 1988: p. 17).
ii. Alcoholics Anonymous

A minority of people did, of course, still have drinking problems. New life was given to the temperance ideology in 1935 by the founders of Alcoholics Anonymous (A.A.). The temperance ideology was adapted and made more appropriate to the post-prohibition era. Under the new, adapted ideology the majority of people could drink without getting into difficulties, but certain people were seen as having a biological vulnerability to the effects of alcohol. Those who succumbed to this disposition had only two outcomes - insanity or death - unless they were able to abstain totally. In order to achieve and maintain abstinence it was necessary to submit to a "higher power", the nature of the power not being specified but left to the interpretation of the individual. A.A. provided mutual support and the opportunity of confession within the confidence of people who had similar problems and accepted the ideology. In the 1940's A.A. grew modestly, but remained a small sectarian movement.

iii. The work of Jellinek

The "disease" model concept in its classic form is synonymous with the name of E. Jellinek, a research professor in applied physiology at Yale University, U.S.A., bio-statistician and later an international researcher in Alcohol Studies for the World Health Organization (W.H.O). Jellinek did not invent the "disease" model; concepts such as "dipsomania" can be traced back well into the last century. What he did was to make a series of publications based on data derived from questionnaires returned from attenders of A.A. and on his research findings into cultural differences in drinking. These have been taken as the basis of the "disease" model outlined above, the most influential being Jellinek's papers of 1952a&b, one of which was written for the W.H.O. Jellinek reviewed his work and
clarified his definitions in his book of 1960, "The Disease Concept of Alcoholism".

The work of Jellinek had three profound effects on this field of research and health care provision. Firstly, it lent scientific credence to the ideology of A.A. which helped it to become an international movement in its own right. Secondly, it established the "disease" model within medical and other professional circles; the theory implied the need for diagnosis, treatments and therapies. Thirdly, it was taken up by the media which established the popular belief that people with drinking problems were diseased. The work of Jellinek is often quoted out of context; his findings were never presented as proven scientific fact and he was most careful to raise points which he felt needed further research. His work however formed the foundation of the "disease" model as it is today.

iv. The work of Vaillant

It would be difficult to improve on the case for the "disease" model made in the book "The Natural History of Alcoholism" (1983) by Vaillant. Much of the literature which supports this model tends to be selective in its own interests. By contrast Vaillant met each possible criticism which could be made against the model head on, most notably that of the difficulties in finding a satisfactory definition of alcoholism. He justified his arguments not only from the available literature on clinical studies, but more significantly from his own findings from large general population studies.
Vaillant (p. 308 - 309) recognized that:

"Where along the continuum of alcohol related diseases one makes the cutting off point for the diagnosis of alcoholism is obviously arbitrary."

but he argued that:

"Patterns of alcohol use vary enormously, but the further along the continuum of alcohol-related problems individuals find themselves, the more they resemble alcoholics"

The kernel of Valliant’s argument is best illustrated in his comparison of alcoholism with hypertension (chronic raised blood pressure).

Hypertension may be caused by organic and genetic factors, by environmental factors such as diet and stress, or an interaction of both. Blood pressure varies by the minute according to physical activity and as a reaction to mental stress. There is a great variation between individuals; some population groups suffer from a far higher incidence than others. Many people do not realize they have this condition. Some are able to reduce their blood pressure without medical treatment by, for example, taking up exercise and eating less salt and saturated fats. Other people despite these measures need medical intervention with drugs to keep it under control.
There is, however, a consensus as to what the ideal blood pressure is, the associated symptoms, the level at which health risks increase and the value of taking steps to reduce it. Most people would accept hypertension as being a disease. Vaillant's argument is that similarly it is reasonable to accept alcoholism as a disease in view of the symptomatology and consequences which are associated with it.

This theme was continued by Vaillant in his paper of 1988, "What can long-term follow-up teach us about relapse and prevention of relapse in addiction"? The research reviewed in this paper included "heroin addicts" as well as alcoholics, and made an analogy of the need to prevent relapse in diabetes with that of addictions.

v. Alcohol Dependence Syndrome - a modified "disease" model

There are several "disease" models which are modifications of the model as put forward by Jellinek. Probably the most influential of these, particularly for British research, is that of "Alcohol Dependence Syndrome" proposed by Prof. Edwards and his team at the Addiction Research Unit of the Institute of Psychiatry in London in conjunction with M. Gross (Edwards & Gross 1976, Hodgson et al, 1978). This model is more flexible in its definition than that of Jellinek and takes advantage of the developments which have taken place in this field of research.

The term dependence is used within this definition of addiction. Whereas addiction implies a helplessness and compulsion, dependence takes into account the motivational aspects of the drinking behaviour. The term syndrome is used in place of disease as a syndrome can encompass a range of conditions and symptoms, although each shares the same causal root. Edwards argues that this approach lends itself more readily to "Multivariate
analysis", behaviour being measured along and between continuums rather than as a system of categorization with cut-off points (Taylor et al. 1986). In other words, the way forward is to measure and statistically analyse a wide range of factors related to alcohol drinking behaviour to gain insight into causes and, more importantly, into the routes to successful and unsuccessful outcomes.

It is to the credit of Prof. Edwards that he has devoted much of the literature he has written to the study of people who were proven to have severe drinking problems but who were able to return to various forms of moderate drinking even though the therapy they received was abstinence orientated. This is well illustrated by a single case history of one of the patients of his team: "Normal drinking in a recovered alcohol addict", (Edwards et al. 1986). However this theory remains quite definitely within the "disease" model camp. The only goal of therapy which is recommended is that of abstinence, and the concept of disease is retained as being essential:

"The syndrome of Alcohol Dependence is given expression, and, in various ways, both facilitated and hindered by an individual's personality and general circumstances but remains, nevertheless, a unitary syndrome" (Stockwell et al. 1979: p. 79).

The strengths and weaknesses of the "disease" model

The "disease" model gave identity to those who had severe drinking problems and wished to abstain. It could be seen as an advance in that such people
were labelled as diseased rather than as being depraved and deserving
punishment. It served to highlight the plight of heavy problematic
drinkers.

The "disease" model turns on the concept that people with severe drinking
problems experience "loss of control" over their drinking and that this had
an organic, or at least a constitutional, basis. Heather and Robertson
(1981: p. 128 - 129), following an extensive review of the findings of
hospital and community follow-up studies, concluded that "loss of control"
as postulated by Jellinek could not be justified:

"The concept of loss of control is
either descriptively inaccurate,
explanatorially tautologous and
scientifically meaningless, or
translatable into terms which are not
specific to alcoholics and do not imply
an irreversible process".

and:

".... loss of control and craving can
no longer constitute a sound theoretical
underpinning for the therapeutic
requirement of total and life-long
abstinence".

It appears from the literature that the "disease" model as a theory,
certainly as far as "loss of control" is concerned, has little evidence to
support it. The idea that drinking problems have an organic or
constitutional basis is also doubtful to say the least, although this was
another of the corner stones of the "disease" model.
Fingarette (1988), in his review of some of the literature concerning studies of identical twins who were separated at birth, concluded that there was no convincing evidence to support this; nor could he find any good evidence of significant primary differences in the metabolism of alcohol between problem drinkers and other people, although differences may have developed as a result.

Even strong supporters of the "disease" model (Kessel and Walton 1989: p. 82 - 63) stated:

"This theory (of physical causes or allergic reaction) has never found favour among physicians, because there is no convincing evidence to support it".

On possible genetic links:

"Whether a tendency to alcoholism is inherited genetically, rather than by example or by other forms of cultural tradition, is not known for sure".

This amounts to a genetic vs. environmental debate. There is no doubt that damaging effects of alcohol can occur long before birth, the most noticeable of these being Foetal Alcohol Syndrome (Camberwell Council on Alcoholism 1980, Little and Ervin 1984). It is not known if the very early environmental influence of alcohol in itself, in other words the effect of prenatal exposure to alcohol on the foetus, leads to an increased risk of the development of alcohol problems in later life. There appears to have
been no research into this, at least as far as I could find by computer search. Little ground is likely to be gained in this debate until the entire human genome has been mapped and the relative weight of genetic and environmental factors can be assessed, including those of recessive genes. It appears that problematic drinking is, on the basis of the research findings to date, more of a learned and acquired behaviour than a genetic disorder.

None the less, the “disease” model persists as a major force in research, in systems of diagnosis, (e.g. the Diagnostic and Statistical Manual of Mental Disorders, The American Psychiatric Association 1987), in forms of therapy such as the “Minnesota model” (Klingemann 1992) and of course in A.A itself. It is also enshrined in the mental health legislation of many countries. Most important of all, it has entered popular belief.

The background to “non-disease” models

1. The work of D. Davies

In the early 1960’s, ironically when the “disease” model of alcoholism was at its height, papers began to appear which called into doubt every aspect of it. The controversy began with the publication by D. Davies of the paper “Normal drinking in recovered alcohol addicts” (1962). This paper reported normal patterns of drinking in patients who had previously been diagnosed as suffering from alcoholism by the W.H.O. definitions of the time, i.e. those of Jellinek. Davies was not the first to report such findings, but he was the first to devote an entire paper to the subject and use a title which would draw attention to this issue (Fingarette 1988).
D. Davies had carried out a follow-up study of 93 patients who had been discharged from the Maudsley hospital, London, before 1955. The paper was not a follow-up of the entire cohort, but concerned a sub-group of 7 men who were selected as having been able to drink normally for periods of 7 to 11 years following their discharge. Each of these patients had been treated to some extent with "Antabuse", a drug developed to cause a nauseous reaction following the ingestion of alcohol and psychiatric consultations. He referred to this therapy as being "holistic" as several therapeutic angles had been used as opposed to purely psychiatric or purely drug orientated interventions. Information was gathered from multiple sources, including social work notes and data from conversations with significant family members. The use of multiple sources of data as a means of verification was novel in this field of research at the time.

D. Davies reported that although these men had had problems severe enough to merit hospital admission lasting between 2 and 5 months, and had been advised to abstain from alcohol following a diagnosis of alcoholism, they were all able to resume drinking of "a normal kind". "Normal drinking" was defined as:

"their use of alcohol (had) never gone beyond the limits regarded as permissible in the cultural groups from which they were drawn". (p. 95)

D. Davies noted that in the 7 to 11 years prior to follow-up none of these men had ever been drunk. He concluded:
"Complete cures do occur as the outcome of a treatment programme based on a holistic approach to the patient and his present problems". (p. 103).

The main point of interest raised by this paper is that in spite of the abstinence oriented treatment these men had received, they had chosen to resume drinking and were reported to have done so without adverse consequences.

This was tantamount to heresy. The "Journal of Studies on Alcohol" which published D. Davies' paper received numerous highly critical reactions to the paper. Seventeen of these were published in subsequent issues, an unprecedented number in this usually sober field of research. Many of the critical remarks were subsequently reprinted in the popular press.

ii. A subsequent follow-up of the subjects of D. Davies by Edwards

In 1985 Edwards, noted above as being in favour of an adapted "disease" model, published a follow-up study reporting on the same group of seven men researched by D. Davies (1962). This extended the total follow-up period to approximately 32 years. Information was again gathered from a wide range of sources, including Davies' original research documentation. Six of the seven subjects were still alive and five of these were interviewed.

The findings suggested that only two of the seven subjects had maintained moderate drinking, and one of these was found to have been only slightly dependent on alcohol at the time of the original project, although he had been admitted to hospital. None of the remaining five had been able to maintain moderate drinking. Two were drinking heavily and suffered from
physical alcohol related health problems, but without social incapacity. One was found to have been drinking heavily in a fluctuating pattern and currently had physical intolerance of alcohol. The remaining two patients were both found to have suffered severe physical and severe social consequences; one of them had developed Wernicke-Korsakoff syndrome (a form of dementia related to vitamin B deficiency and alcohol abuse) and could not be interviewed. Three of the heavy drinkers had also used prescribed medication heavily.

Edwards (1985: p.190) concluded:

"There is no good reason for claiming that return to normal drinking is impossible or improbable, either spontaneously or with treatment. On the other hand, with such perplexity as to the sharpness of our case definitions, the soundness of our methodologies and the heuristic value of our theories, it would be unwise to claim that a return to normal drinking among recovering alcoholics is either a common occurrence or an easy treatment goal, especially with more severely dependent patients."

Edwards (1985) highlighted the difficulties in finding satisfactory working definitions of "alcoholism" and "normal drinking" in long-term research projects of this kind. These case histories served to show how greatly an individual's drinking behaviour can vary over the course of thirty years. He pointed out that we do not know what happened to the remaining 86 of the
group of 93 subjects who formed Davies' original group, and therefore statistical conclusions could not be drawn.

The paper by D. Davies is one of the most widely quoted in the literature relating to problematic drinking. Although some flaws were highlighted by the subsequent research by Edwards (1985) it none the less led to a reappraisal of the theories concerning alcohol abuse. However, Davies did no more than observe and publicize the fact that some "alcoholics" went on to drink moderately. In fact he emphasized that abstinence was of paramount importance as a therapeutic goal by ending his paper of 1962 with the words:

"... the generally accepted view that no alcohol addict can ever drink normally again should be modified, although all patients should be advised to aim at total abstinence" (D. Davies 1962: p. 103).

iii. Other research findings which supported the "non-disease" model

Heather and Robertson (1981) in their book "Controlled Drinking" reviewed a series of papers which reported the findings of research into "Normal drinking" in "Former alcoholics". They noted the steps which researchers took in the light of the criticisms which had been made against the work of D. Davies (1962) to ensure that the subjects they reported met the necessary diagnostic criteria. They concluded that:

"The description of normal drinking in former alcoholics as a rare event can no longer be justified by the evidence".
and:

"Compared with abstainers normal drinkers have been found to constitute substantial minorities in several studies and to be the majority in others".(p. 74).

iv. The work of Sobell and Sobell

The next progression in the history of the "non-disease" model was to take the implications of the research findings concerning the occurrence of "controlled drinking" in former problem drinkers and apply them to clinical practice. Sobell and Sobell designed one of the first therapeutic research programmes in the late 1960's which included "controlled drinking" as an explicit goal of therapy. They used what they called "Individualized Behaviour Therapy" - therapeutic methods designed to "change behavioral repertoires". These were based on a social learning theory rather than on the theory that the patients had a genetic or constitutional disposition to drink excessively. The patients were pre-selected, on the basis of previous drinking behaviour and motivation, to succeed in controlled drinking rather than abstinence. Their findings, first published in part in 1972, were fully described in their book "The Behavioral Treatment of Alcohol Problems - Individualized Therapy and Controlled Drinking" (1978).

The therapy was carried out in a behavioural research laboratory which had a homely atmosphere and was equipped with video and sound systems to record behaviour, and also in out-patient settings. It involved a number of techniques which included "training in problem-solving skills", "establishing behavioral repertoires", and "contingency management".
In other words, these techniques aimed to teach people to cope with their problems rather than to withdraw into alcohol intoxication, to take up more moderate drinking habits, and to handle social pressures to drink. Much of their work aimed to define and classify various forms of "Controlled Drinking". Sobell and Sobell found that many of the patients they had selected could drink in a controlled manner. Their findings added fuel to the debate.

Once the border is crossed into what I have called the "non-disease" models, attempts at making definitions of what does or does not constitute a disease, the need to specify "cut-off points" and draw continuums becomes less important. The key issue of therapeutic goals is addressed more fully in the following Section. It must for now suffice to say that some of the "non-disease" models, that of Sobell and Sobell (1978 & 1993) being a good example, retain the belief that on the basis of predictive factors some drinkers can be encouraged to control their drinking while others should be urged to abstain.

v. The work of Orford

Probably the most significant and well argued example of a "non-disease" model was put forward by Orford. His book "Excessive Appetites: a psychological view of addictions" (1985) aroused much debate when it was first published and has for many replaced the vacuum left by the "disease" model.

The great advantage of the "non-disease" model is that it readily allows parallels to be drawn with other forms of behaviour which are taken to extremes by a minority and can carry severe consequences. In this book the phenomenon of excessive drinking is addressed, together with psychoactive
drug use and other behaviours which can become excessive but are not substance misuse based, such as excessive eating and sexuality.

Orford did not attempt to give strict definitions of each of these forms of behaviour, but instead described and compared them thoroughly. He started from the premise that:

"there exists a range of appetitive activities which can become excessive" (p. 319)

of which those covered in the book were but a few. Under this model the degree of a person's involvement in each of these behaviours has multiple interacting determinants, which include personality, social factors, cultural attitudes and availability. Such behaviours are not seen as being static or inherently progressive, but do frequently change over time.

He pointed out, in terms of learning theory, the benefits of these behaviours and the motivations which under-pin them. Attachment can result from cumulative practice and exposure, and can also (particularly with substance use) lead to altered biological responses. He emphasized the rather obvious fact that in any distribution in the frequency of a behaviour within a given population there will always be those who partake more than others. Under this model the relative position on such a continuum is not the basis for the diagnosis of a disease.

vi. The work of Fingarette

Other variations of this model deny every premise of the disease theory, its value in research and clinical practice, and call for its abandonment. An example of this is the book "Heavy Drinking - the myth of alcoholism as a
disease" by Fingarette (1988). Fingarette discussed why it is that the "disease" model persists in the U.S.A. despite the wealth of research findings which call it into doubt. He held that this was due to economic pressures within the alcohol industry, service provision, alcohol research and a public which has been misinformed over many years. He noted that:

"No one has plotted an evil conspiracy to keep vital information secret; no one has censored information - indeed, the scientific literature (which contradicts the disease concept) fills the book shelves" (p. 28).

On the alcohol industry he wrote:

"The classic disease concept admirably suits the interests of the liquor industry: by acknowledging that a small minority of the drinking population is susceptible to the disease of alcoholism, the industry can implicitly assure customers that the vast majority of people who drink are not at risk" (p. 27).

He noted that over $1 billion is spent annually on various forms of therapy for people with alcohol problems and that this section of the health care industry funds advertising which propagates the disease theme. Alcoholism is promoted as being a disease for which medical care is appropriate, which in turn helps to retain this field of research under medical funding:
"Researchers whose work falls under a medical category are most likely to receive sustained major support. Thus the public relations and advertising undertaken by the treatment lobby serves the research community's ends by authenticating, at least in the public's mind, the claim that alcoholism research is medical research". (P. 25).

He concluded that on the basis of the information which the public has received over the years it is hardly surprising that the "myth" of alcoholism as a disease persists, rather than as a highly complex interplay of cultural, social, psychological and physiological factors which lead some individuals into problem drinking.

The strengths and weaknesses of the "non-disease" model

The "non-disease" model has the advantage of being more flexible than the "disease" model, both in terms of the criteria which are taken to constitute drinking problems and in the definition of recovery. Under this model problem drinkers are not labelled as being "diseased"; long-term abstinence is seen as being only one form of recovery.

A criticism which is frequently made against this model by supporters of the "disease" model is that it could encourage people with drinking problems to continue drinking when it would be better for them to abstain. For example:
"Some patients with alcoholism return to normal social drinking. However, since it is impossible to predict who will manage it, the advice must be to aim for abstinence". Kessel and Walton (1989: p. 142).

Supporters of the "non-disease" model would argue that since individuals differ in terms of their motivations for drinking, moderating their consumption or abstaining, such a blanket approach is inappropriate.

The consensus between the models

The differences between the "disease" model and the "non-disease" model as described above emphasize the differences for the sake of argument. There is in fact a great deal of consensus within this field of research.

Both schools of thought accept the importance of cultural differences and contexts. They acknowledge the large differences which exist between individuals. People with alcohol problems are no longer seen in isolation on the basis of their behaviour, but within the context of their family and social setting (Dulfano 1992, R. Moos et al. 1990, Fingarette 1988). And the causes of alcohol problems are not seen as being solely the responsibility of the individual, but also as the result of social conditions and political policy on alcohol control (Baggott 1990).

Those researchers who still prefer to use the "disease" model are prepared openly to publish findings which show that controlled drinking does sometimes occur in former problematic drinkers, even those who had the most severe of problems (Edwards et al. 1986, Vaillant 1983).
THEORIES WHICH SEEK TO EXPLAIN PROBLEMATIC DRINKING BEHAVIOUR

CONCLUSIONS

The social norms which determine what is acceptable and unacceptable in drinking behaviour vary between cultures, sub-cultures and over time.

The model of alcoholism as proposed by Jellinek is no longer widely accepted by those carrying out research in this area. It was, after all, only an hypothesis which attempted to explain the often perplexing behaviour of problem drinkers and was never presented by him as being proven fact.

The main effect which this debate has had is to divide into two schools the therapies available to problem drinkers. The first of these is based broadly on the "disease" model and demands total life-long abstinence; the second is of the "non-disease" model and is prepared to aim for controlled drinking in some or all cases. The relative values of these are discussed in the following Section.
SECTION 2
THE RECOVERY PROCESS AND THE ROLE OF THERAPY

In this Section the most frequently occurring needs of people with alcohol related problems are outlined. The value of abstinence and controlled drinking as therapeutic goals are outlined, followed by a list of the range of services which are available in Britain to people with alcohol related problems. This leads into a discussion of the role which therapy plays in the process of recovery from drinking problems.

The needs of people with alcohol related problems

Alcohol causes or is implicated in a wide range of physical diseases. Examples of these are Cirrhosis of the liver, Gastritis, Stomach Cancer and Pancreatitis. Korsakoff’s Syndrome and Wernicke’s encephalopathy (dementias and neurological disturbances, see Henderson and Gelespie 1969), Peripheral Neuritis and Neuropathy can all be related to excessive alcohol consumption and vitamin B12 deficiency. Withdrawal from alcohol can lead to psychotic states and epileptic fits. It is associated with and can exacerbate forms of mental illness.

Alcohol is associated with accidents on the roads, in the workplace and in the home. It is also linked with crime (Baggott 1990, Faculty of Public Health Medicine 1990). Much of the harm attributable to alcohol goes unrecorded. Many people suffer from the consequences of alcohol without experiencing problems in their personal lives and relationships to a degree which make them visible to the health services and other social institutions. Those who fall victim to alcohol related problems are not invariably "problem drinkers". These facts need to be kept in mind when the range of services for people with alcohol related problems is considered.
From the alcohol related problems outlined above, which are but a few of the most frequently occurring problems, it is clear just how wide the needs of people with alcohol related problems really are. These range from Alcohol Education, simple advice and counselling to acute traumatic care, specialized long-term care for dementia and terminal care for cancer.

Therapeutic goals

As shown in Section 1, people who drink to excess and wish to change can aim for one of two things in the longer term; they can aim to stop drinking or they can aim to moderate their drinking.

Abstinence is a useful goal for people who are "black and white" thinkers, people who at some point decide they wish to stop. Those who wish to remain abstinent and are able to identify with the "disease" model are welcomed at A.A. meetings and at treatment centres where abstinence is the goal; there they can receive mutual support from like minded people. Abstainers are able to measure their success in terms of the length of time they have remained "dry".

Abstinence is the only option open to people who are severely damaged by alcohol misuse e.g. those suffering from cirrhosis of the liver, if they wish to extend their life expectancy.

Controlled drinking as a therapeutic goal, on the other hand, has the big advantage that drinking is still possible; the social aspects and pleasure of alcohol drinking do not have to be ruled out. It does not necessitate the person being labelled as an "alcoholic" or as a failure if they have so much as one drink. Some people who aim for controlled drinking in the long-term begin with a period of abstinence.
The range of services available

For the sake of clarity the range of services which are involved with problem drinkers has been divided into "General" and "Specialized" services. (Figure A).

**FIGURE A**

The range of services available to problem drinkers in Britain

**General Services**

- N.H.S. General and Psychiatric Hospitals
- N.H.S. Community Services including General Practitioners
- N.H.S. Mental Health Services
- Private Hospitals and Services
- Occupational Health departments in Industry
- Voluntary Services such as "The Samaritans"
- Social Services
- Resettlement Units
- Night Shelters
- The Police
- The Probation Service
- The Prison Service

**Specialized Services**

- N.H.S. Alcohol Treatment Units
- N.H.S. Community Alcohol Teams
- Alcohol Advice Centres
Day Centre type services
Hostel and Residential type services
Private Hospitals and Services
Alcoholics Anonymous
Services from the churches and religious movements, for example the Salvation Army
Other "Self-Help" Groups
Projects which coordinate with local Drugs Services

There are approximately two hundred and fifty specialized services of one kind or another within England and Wales with a similar range of services in Scotland (Hunt et al. 1992, Alcohol Concern 1993). If movements such as A.A. are included, almost every town in Britain has some form of provision.

The majority of specialized services are abstinence orientated; others aim at controlled drinking and some offer both (Alcohol Concern 1993). Histories and an examination of these types of services are given by Stockwell and Clement (1987), Collins (1990), and within an international context by Klingemann (1992). From the above it would appear that the British public is reasonably well provided for in terms of specialized services. There are however major failings in Alcohol Service provision in Britain; as pointed out by Hunt et al. (1992: p. 126):

"The last forty years have witnessed a radical change and substantial increase in treatment facilities for problem drinkers. ...... Nevertheless, there is still no unified treatment system, largely because of the government's unwillingness to develop a comprehensive
system of care for people suffering from alcohol problems or to fund research into treatment and prevention".

Not only is there no national policy on therapy and research, but there is little coordination between the existing services at local level and no means of evaluating their efficiency and effectiveness in relation to each other. While there has been a growing awareness of the need to manage health and social service resources more efficiently over the last few years, most notably within the N.H.S. (Perrin 1988), the aspect of consumer choice has been neglected (Green et al. 1990). People who have drinking problems have very little access to the information they need to differentiate between the services and the implications of the therapeutic models they work to. Most people with alcohol problems receive support and therapy not according to their individual needs, but according to what by chance happens to be available in their area.

Only a small number of people with drinking problems are informed enough to be able to "vote with their feet" and exercise choice in terms of the therapy they receive and the goals they aim for.

**Forms of therapy for people with drinking problems**

The therapy given to people with drinking problems is very difficult to describe. Each book or research paper works to a different definition according to the particular field of therapy or research to which it pertains and the model which is taken. Since a description of the therapy which was given by the L.C.A.S. is detailed in the results Chapter of this thesis - and is a good example of how therapy works in practice - the description presented here is only in outline form.
At this point it is worth noting that all the forms of therapy and support given below are based on the principle that they are practised and received with the informed consent of the individuals concerned. The belief that compulsion in therapy or "treatment" is of value is being increasingly questioned throughout the world. In Britain it has no real support from the health and social work professions or any other of the national institutions. It is specifically excluded by the Mental Health legislation, the only grounds for compulsory hospital admission being secondary to alcohol abuse, such as psychotic states associated with withdrawal. The "primary" aim of therapy is of course to help the individual concerned to stop drinking or to drink more moderately, but this cannot be viewed in isolation from the "secondary" aims which affect the well-being and adjustment of the individual in his or her social environment.

The forms of therapy outlined below have been grouped under four headings; Alcohol Education, Psychotherapy, Aversion Therapy, and the management of withdrawal.

i. Alcohol Education

Alcohol Education can be seen as having two aspects: the prevention of alcohol related harm and the reduction of harm in people who are already affected.

An example of Alcohol Education as a means of prevention would be the "That's the limit" campaign of the 1980's by the Health Education Council. This campaign consisted of publicity in the media and a pamphlet which was available free of charge from a wide range of outlets such as G.P. practices and libraries. It was aimed at the general public rather than at "problem
drinkers" and gave advice on the strength of alcoholic beverages, the "safe" limits and how to reduce the risks (Health Education Council 1984). Campaigns against drinking and driving can be categorized under Alcohol Education (Howe 1989) as can the use of "self-help" manuals and telephone contact (Savage et al. 1990, Heather et al. 1990).

The reduction of harm is an integral part of therapy for those who have been identified as having drinking problems (Heather and Robertson 1981). The therapy of such people includes not only advice and support to stop or reduce drinking, but also to avoid some of the consequences and speed the process of recovery, e.g. by eating an adequate diet.

**ii. Psychotherapy**

Psychotherapy is very difficult to define, the most appropriate and concise definition I have found is:

"to facilitate exploration of the individual's own thoughts and feelings and to assist the individual in arriving at his or her own solutions" (Atkinson et al. 1981: p. 508).

What I have chosen to call psychotherapy here is also identified as counselling (Davidson 1991). This may be done on a "one to one" professional basis, for example with a psychiatrist, nurse or social worker and in a variety of settings including the home. It can also be in a group setting under professional
leadership within a multi-disciplinary framework as is common practice on A.T.U.s, at day centres and within residential housing projects and hostels (Cook 1975). In the most liberal definition of the term, attendance at A.A. meetings, other "self-help groups", or support from "The Samaritans" could also be regarded as being psychotherapeutic.

The involvement of family and other significant people in therapy is now recognized as being of great importance (Dulfano 1992), although the privacy and wishes of the problem drinker must always be borne in mind.

iii. Forms of aversion therapy

Aversive forms of therapy are therapies which attempt to associate unpleasant experiences with alcohol drinking. These involve giving the individual electric shocks (Sobell and Sobell 1978, Emrick 1975) or giving them drugs such as "Antabuse", either in tablet form or by implantation of a capsule under the skin, which induce nausea when alcohol is ingested (Heather and Robertson 1981). Both these practices are still used and there is some evidence that they reduce the incidence of drinking (R. Moos et al. 1990).

Aversive therapies can be very unpleasant to witness, and in the case of aversion by chemical means can be very dangerous for the patient as interaction with alcohol can be unpredictable, lead to a state of collapse and drastically elevate blood pressure. Such methods have been used to abuse patients (Emrick 1975). Sobell and Sobell (1978) had used such methods as part of their
therapies aimed at controlled drinking but noted:

"Recently researchers have seriously questioned the efficacy of electrical aversion conditioning; specifically, it has been suggested that when positive effects do occur they are not the result of conditioned aversion. Aversion conditioning by chemical and covert sensitization methods has been similarly suspect, but clear empirical tests of the efficacy of these procedures have not been reported. Given the questionable efficacy of aversive procedures, it would seem that they should not be the treatment of choice, except in exceptional circumstances". (p. 207).

Apart from very rare instances where customers have opted to take aversive medication to bolster their will-power in the full knowledge of the risks they were taking, I personally have always been strongly opposed to such methods.

iv. Management of withdrawal by detoxification

The greatest short term consequences of drinking are not always apparent while the individual is intoxicated, but only appear during withdrawal. The symptoms of alcohol withdrawal are in many cases far more severe than those of opiates for example, and can produce epileptic fits and psychotic states. There are
several medications available on prescription (and on the "black-market") which act as central nervous system depressants. These can be used to replace the alcohol and be reduced over a number of days. This can be done in a hospital or on an A.T.U., but is also possible in the community if adequate support is given. Such therapy gives the individual a "new start" at abstinence or controlled drinking.

Withdrawal can also be carried out by reducing the quantity of alcohol drunk over a number of days. The management of withdrawal is discussed further in the following Chapters.

The role of therapy in the recovery process

People who have drink-related problems tend to experience consequences which take the form of personal crises, social problems, physical deterioration and accidents, which then lead them into contact with one or more of the services. The therapy provided by "specialized" services is, then, not really so specialized at all. Once the issues of abstinence or control of drinking and detoxification have been addressed, the remainder of the "therapy" involves such basic things as encouraging the individual to talk to his or her relatives, promoting a nutritious diet, ensuring that wounds are dressed and infections treated, giving vitamin injections and liaising with other services.

For those people who are already suffering the more severe consequences of alcohol abuse such support does little more than keep them alive in the hope that at some point a process of recovery will begin.
In attempting to define the nature of alcohol problems, as shown above, it is important to consider the cultural context of the individuals concerned, and the "model" which is taken. The definitions as to what constitutes recovery from an alcohol problem are determined by similar factors.

Definitions of recovery

Workers and researchers in this field who adhere to the "disease" model measure recovery in terms of abstinence. Thus for people who attend A.A. it is the length of time since the last drink which counts. In terms of "success rates" for the clinical cohorts of abstinence orientated therapy programmes, it is the percentage of people who remain abstinent for a given length of time that determines the level of success.

Those who prefer to take a "non-disease" model accept in principle that some of the people who have had drinking problems can learn to drink in a controlled way. They hold that drinking patterns change over time and that periods of heavy drinking may occur en route to recovery. Under this model definition of recovery is more difficult than under the "disease" model.

The definitions of recovery are based on the amount of alcohol consumed within a given period, the social adjustment of the individual concerned and the acceptability to others of his or her drinking behaviour. Abstinence is seen as being only one form of successful recovery.

The recovery process

A wide range of interactive factors are involved in the causes of alcohol problems; the factors which lead to recovery are equally complex (Taylor et al., 1985 & 1986). Orford (1985), for example, stressed the importance of personal crisis, inner conflict, decision making and the spiritual aspects
of giving up behaviour which is excessive.

How these factors operate in the lives of people who had severe drinking problems are particularly well illustrated by "single case studies" of Edwards et al. (1986) and Booth (1990). These meticulously documented case histories serve to complement the findings from clinical cohorts and general population studies which dominate this field of research.

It is certainly not the case that all people who suffer from alcohol problems receive therapy; in fact most do not (Emrick 1975). Nor do they all need intensive forms of therapy (Heather et al. 1990, Savage et al. 1990). Furthermore, not all those who do receive therapy attribute their recovery to it, or see it as a major influence. An example of this is reported in the paper "Outcome of alcoholism: the structure of patient attributions as to what causes change" (Edwards 1987: p. 536). This paper reported the replies to a 70 item questionnaire relating to the factors which patients endorsed as being important in their recovery following an abstinence-oriented therapeutic programme with psychiatric input.

The 66 patients who responded placed:

"wanting my self respect"

and,

"Determination not to be beaten by drink"

in joint first place above:

"what a psychiatrist said or did".

The majority of the rest of the replies were also to do with adjustment and ways of coping in general.
There is evidence which suggests that the incidence of chronic alcohol problems reduces to some extent simply with age. Middleton-Fillmore (1987), for example, reported findings on two large general population studies (as opposed to clinical cohorts) in the U.S.A. She concluded:

"These data have confirmed the hypothesis that the incidence of heavy drinking and alcohol problems decreases with age and that the chronicity of alcohol problems is highest in the middle years of life". (p. 81).

Another approach which gives some insight into the recovery process is the research into people who recovered but received very little or no therapy. Tuchfeld (1981) in his paper "Spontaneous Remission in Alcoholics" reported findings on the

"life histories of 35 men and 18 women who resolved their chronic drinking problems without professional or formal treatment". (p. 626).

The emphasis of his research was to determine by what means "spontaneous" recovery occurs. Part of the paper dealt with the problem of definition of "alcoholics" and the methods of selection he used. All those selected met reasonable criteria as having had a severe drinking problem under whatever model, had had little or no therapy and yet recovered into abstinence or controlled drinking.
His findings were that "spontaneous" recovery certainly does occur and may not be a rare phenomenon. He noted a wide range of factors which the patients associated with their recovery and reached three main conclusions:

"1. Acceptance of the "alcoholic" label is not a crucial factor to persons who resolve their alcohol problems without the aid of treatment.

2. Persons who alter their alcohol related social and leisure activities increase the likelihood of maintaining a state of problem resolution.

3. Informal social controls are necessary to the resolution of alcohol problems". (p. 639).

van Kalmthout (1991) also addressed this issue in his paper "Spontaneous remission of addiction". Similar conclusions were reached to those of Tuchfeld and once again the importance of social support in recovery was stressed.

Both these papers detailed in length, with illustrative quotes from the patients concerned, the significance of "turning points" and "life events" in the recovery process. These were seen as being specifically alcohol related in some cases, the classic "hitting rock bottom" in terms of the "disease" model, but were in many cases more general in nature, such as becoming pregnant or beginning a new relationship. Other examples of "turning points", where dilemmas and crises which were not always directly
alcohol-related ultimately led to a change in drinking behaviour, were addressed by Ruscombe-King and Hurst (1993).

van Kalmthout (1991) set the phenomenon of the recovery of people with drinking problems into the context of the wider natural recovery process which occurs in some conditions, for example the spontaneous regression of cancer. Sadly there is very little literature available on this subject, as he went on to note:

"Studies directed at discovering the psychological processes involved in cases of spontaneous remission are rare." (p. 6).

The significance of therapy in the recovery process

The exact role which therapy plays in the recovery process is very difficult to specify. There is however a broad consensus in this field of research, embracing both schools of thought concerning the nature of the phenomenon, that "therapy" in its broadest sense is effective.

The paper by Emrick (1975) summarized and evaluated the reported findings of 384 publications from a wide variety of therapeutic programmes, all of which had an element of clinical psychology. His research compared the changes which took place between those who received intensive forms of therapy, more minimal forms and no therapy at all.
The following conclusions were reached from this comprehensive study:

"1. Many alcoholics can drink less or stop altogether with no or minimal treatment.

2. Untreated alcoholics change as much as those receiving minimal treatment." (p. 97).

Emrick found that more intensive forms of therapy appeared to increase an alcoholic's chances of reducing the problems associated with drinking. He took comfort from the fact that many "alcoholics" improve without formal treatment, since few of them get treated. The type of therapy given was not found significantly to affect the outcome after a period of six months or more; all forms of therapy included within this study were found to be equally effective. The process of change in drinking behaviour was found to differ little inside or outside treatment, indicating once again that recovery from an alcohol problem is part of a more general process.

Emrick noted that:

"Abstinence rates did not differ between treated and non-treated alcoholics, but more treated than non-treated alcoholics improved". (p. 88).

He concluded:

"Treatment agencies should feel not only comforted but heartened to see some
Indication that treatment is effective in helping alcoholics improve. Clearly the sizable expenditure of human and financial resources for alcoholism treatment has not been in vain." (p. 99)

The effectiveness of therapy should not be overstated however. As Orford (1985) wrote in the conclusion to his book "Excessive Appetites":

"Besides the naturally occurring processes, modern forms of expert treatment play a modest part in excessive appetite behaviour change. There exists a very wide range of treatment rationales and procedures but they produce rather similar and modest results in the short term, although careful research suggests they have some effectiveness. Evidence suggests that factors common to different treatments, such as the client’s engagement in attending to behaviour, positive engagement in a treatment programme, the feeling of being listened to and understood, involvement of family and the expectation of change, are the more effective ingredients". (p. 323).
Or, as Edwards (1989: p. 20) put it:

(In the long-term) .... it is absurdly medico-centric to suppose that "treatment efficacy" is the single important question. Treatment is more accurately conceived as being at best a nudge or whisper in a long life course"

Therapy then is only one of many factors which act to produce recovery in some people. It may be seen as a catalyst which serves to enhance the more general process of recovery. I liken the research findings into the effectiveness of therapy to the "signal to noise ratio" problem when trying to receive short wave radio broadcasts. The signal you hope to hear is there alright, but at times it gets lost amongst other signals and interference.

Making therapy more effective

Therapy does then appear to make some difference to people with drinking problems. The main force in this field of research is of course to make the therapy as effective as possible. The movement over the last few decades has been away from blanket forms of therapy in which everyone is diagnosed as having the same condition, is put through a set programme and is expected to work towards the same goals. The drive is on to make therapy more appropriate to those who need it.

The supporters of the "disease" model have been active in the search for predictive factors and in the development of diagnostic systems. The aim of this is to identify those who are most likely to abstain, the more implicit
objective being to concentrate the available therapy on those who are most likely to abstain (Edwards et al. 1988, Nordström and Berglund 1987a&b).

The more liberal supporters of this model also accept that appropriate forms of therapy should be available for those who do not wish to maintain total abstinence:

"Even though the ex-patients who attempted to drink in a moderate manner were less than totally successful, we believe that programs for moderating problem drinking should be available" (Finney and Moos 1981: p. 103).

The "non-disease" camp on the other hand, seeing abstinence as but one form of recovery, has responded to the challenge by designing forms of therapy which at least attempt to fit the individual needs of all problem drinkers. The diversity of services in Britain and the number of services which aim at controlled drinking or include it as an option of therapy reflect this (Alcohol Concern 1993, Stockwell and Clement 1987), although there remain several areas which are in need of attention.

Addressing specific needs

I have outlined below three areas, which in my opinion, would benefit greatly from a more coordinated approach in research, service provision and Alcohol Education. These have been chosen because they are particularly neglected areas at national level and are also highly pertinent to the aims and objectives of the L.C.A.S. They concern the needs of ethnic minorities, of women, and of the homeless.
i. Ethnic minorities

The importance of cultural context and its implications for people with alcohol problems have already been outlined in the early Sections of this Chapter. The situation is even more complex for people who move between cultures and for the generations which follow. Ethnic minorities are failed to a great extent by Community Services. Language barriers, different cultural norms, needs and expectations can block access to services and reduce their effectiveness (Fernando, for "Mind", 1991).

Providers of services for people need to be aware of these difficulties and take steps to overcome them. The monitoring of the representation of minorities within service case loads, campaigns to target provision and the implementation of equal opportunities policies for staff are but three ways this can be done.

ii. Women

Research and treatment provision have traditionally been focused on male problem drinkers:

"In 1975 an interdisciplinary group of researchers defined the area of alcohol and drug abuse in women as a "nonfield", with few acknowledged experts and virtually no specialized literature" (Wilsnack and Beckman 1984: Preface ix).
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"In 1975 an interdisciplinary group of researchers defined the area of alcohol and drug abuse in women as a "nonfield", with few acknowledged experts and virtually no specialized literature" (Wilsnack and Beokman 1984).
The cultural norms which determine what is acceptable drinking behaviour differ greatly in their applications to men and women; behaviour which is acceptable in men is not always acceptable for women. The issues which concern women and lead them into problem drinking differ to some extent from those of men, as do the factors which lead to recovery (Camberwell Council on Alcoholism 1980).

Women are also more vulnerable than men to the effects of alcohol per unit consumed (Health Education Council 1984). These factors need to be kept in mind if the forms of therapy which are offered are to be effective.

iii. The homeless

Homeless problem drinkers, particularly those who have long-term unsettled lives, often lack health care as they are not registered with a G.P. They tend to be poorly nourished, prone to accidents and to have criminal records (Cook 1975). They represent the least attractive aspect of this field for many therapists and providers of care.

It is of the utmost importance for specialized alcohol services to be aware of the needs of this group and to liaise with local agencies which provide food, shelter and resettlement.

An evaluation of the effectiveness of the L.C.A.S. in meeting the needs of these three groups is given in the results Chapter.
THE RECOVERY PROCESS AND THE ROLE OF THERAPY

CONCLUSIONS

The range of needs which people with alcohol related problems have is very wide and leads to demands being made on every form of institutional and community provision.

For those people who are identified as having a drinking problem there is a range of specialized services, although there is an almost total lack of national policy regarding these services and coordination between them is poor. The therapeutic aims of these services differ according to the model taken to describe the phenomenon of problematic drinking behaviour. These difficulties are compounded as those who use specialized services are for the most part unaware of the implications of these differences and so are unable to exercise choice.

The therapy for people with alcohol problems consists mainly of psychotherapy in the broadest sense of the word, with some specialized support concerning alcohol related problems and the management of withdrawal. For the rest, the therapy is very general in nature.

There is a broad consensus that the process of recovery for people with alcohol problems can be assisted by therapy. The exact role which therapy plays is difficult to assess and tends to be overestimated. Recovery from an alcohol problem involves more than just becoming abstinent or cutting down on drink; it involves considerable adjustment in terms of personal identity and social functioning.

Both service provision and research have concentrated almost exclusively on the most visible of problem drinkers, white males from settled backgrounds.
The measure of success for an alcohol service is how it addresses the specific needs of those who tend to miss out: ethnic minorities, women, and the homeless.
SECTION 3
THE FINDINGS OF OTHER LONG-TERM FOLLOW-UP STUDIES

In this Section the strengths and weaknesses of the long-term follow-up as a research method are briefly addressed. Summaries of the findings of two long-term follow-up research projects which are of particularly comparative value to the L.C.A.S. follow-up are then presented.

Long-term follow-up studies - strengths and weaknesses

While methods which depend on the observation of drinking behaviour in a controlled research or institutional environment have produced some valuable data, (Sobell and Sobell 1978, Emrick 1975), it is the long-term follow-up which has proven to be the best indicator of how drinking patterns change over time. Both these methods suffer from the inherent weakness that the attempts at research itself may affect the behaviour which is being observed, or at least how it is perceived and reported by those who are followed-up - the so called "observer effect". For reasons which are all too obvious it is impossible in daily life to follow people around constantly and record their behaviour. Long-term follow-up studies therefore rely on self reported data, which is then, wherever possible, corroborated by data derived from a range of other sources.

All that can be done is to ensure that the data collected is as reliable as possible, and that any bias in the data collected is highlighted at publication.

The most frequent cause of bias in the findings of long-term follow-up studies is that of people who are "lost" from a research cohort, i.e. people who either cannot be traced, or if traced refuse to participate in the
research. This issue was specifically addressed by Mackenzie et al. (1987) in his paper "The characteristics of alcoholics frequently lost to follow-up". Mackenzie reported the findings of an 8 year follow-up of 85 "alcoholic" men. This follow-up is unique in that 93% of the cohort were either interviewed or confirmed to have died, with no other contact having been made in the intervening period apart from follow-up interviews at 1 - 3 years. These men were analysed to see what bias would have resulted if those who were identified as being difficult to locate for follow-up, or those who less willing to be interviewed, had been missing from the data.

Mackenzie et al. (1987) reached two conclusions:

"Subjects who are difficult to locate, or who in the extreme will go missing, tended to have poorer social functioning prior to intake and be residentially unstable during the follow-up period, characteristics that tended to correlate with worse drinking outcome". (p. 119).

"Subjects difficult to interview, in contrast to those difficult to locate, had high residential adjustment, were slightly older and had high interpersonal adjustment". (p. 123).

Nor did these two forms of bias cancel each other out for the cohort as a whole:
"Our findings indicate that, in evaluation studies, data loss due to failure to locate difficult cases is not balanced by data loss resulting from an inability to interview unwilling subjects. This is apparent from a comparison of the drinking characteristics of the two groups". (p. 123).

These findings need to be kept in mind when considering the reported outcomes of the L.C.A.S. and other long-term follow-up studies.

Two studies which are comparable to the L.C.A.S. long-term follow-up

The findings of two studies are summarized below. These are of follow-ups reported by Taylor et al. (1985) from the team led by Edwards and of Nordström (1989). These two studies were chosen in particular because they were both based on clinical populations and had follow-up periods of at least ten years. They took what could be described as a "disease" model in that the subjects of these cohorts were advised to abstain, abstinence being seen as the only goal of therapy. However forms of "controlled" drinking, i.e. drinking which was not problematic, were defined and reported in these publications.

Although the cohorts of these studies were the closest to those of the L.C.A.S. there were still major differences; women were not included and, in the case of Nordström, the cohort was of Swedish and not British men.
A. Long-term follow-up - C. Taylor et al. (1985)

This study was a 10 year follow-up of an original cohort of 99 men, of which 68 gave follow-up interviews. 18 were found to have died, and 13 were "lost" to follow-up. The methodology used was very similar to that of other studies, with multiple sources of data used to verify the self-reported data gathered at interview.

The outcomes of the interviewed subjects were rated into and between the following three categories: (p. 46)

i. **Troubled drinking**

"Troubled drinking, defined as meeting any of these criteria:
- drinking more than five pints of beer or their alcohol equivalent on any day during the month,
- OR,
- experiencing any dependence symptoms,
- OR,
- experiencing other adverse consequences"

ii. **Light social drinking**

Light social drinking, defined as drinking, but never more than five pints of beer, or their alcohol equivalent, in any day of the week, and this for at least three successive months without experiencing dependence symptoms or other adverse consequences.
iii. Abstinence

Complete abstinence from alcoholic beverage, or any scattered, trivial drinking not covered in category 1 or category 2; e.g. drinking less than five pints occasionally, but not frequently enough to count as light social drinking

[Five pints of beer are the approximate equivalent of 10 to 15 units of alcohol depending on the strength of beer].

This categorization system highlights the difficulties common to all classification systems of drinking. It is difficult to have one system which takes into account the overall amount of alcohol consumed within a given length of time as well as shorter but heavier episodes of drinking. This system uses days in the month for "troubled drinking", and days of the week within three successive months for "light social drinking". The definition of abstinence is also rather vague, "less than five pints occasionally" being very different from total abstinence during the entire follow-up period. Dependence symptoms and alcohol related consequences were included in this categorization. This could be said to reflect the influence of alcohol more fully, but would be difficult to replicate.

These difficulties aside, this paper did report a slight increase in the incidence of "social" drinking and "abstinence" during the 10 year follow-up period, consistent with most other follow-up studies. Although an exact breakdown of the initial and final figures was not given, the data was illustrated by a graph which is reproduced as Figure 1.
B. Long-term follow-up - Nordström (1989)

In 1989 Nordström published a paper, "successful non-abstinent adjustment in a long-term follow-up of alcoholics". The aim of this study was to investigate the patterns of "successful" long-term adjustment in a cohort of men who had been previously diagnosed with a "lifetime diagnosis of alcohol dependence". The cohort was drawn from a clinical population of 1312 people, 324 of these met criteria that they were male, were born after 1916, had been first admitted to hospital between 1949 and 1967, and were living in the province of Scania on January 1st, 1981.

In order to ensure that this cohort had a large proportion of people with "successful" outcomes, the subjects were further selected on the basis of good health records as indicated by "cash benefit days" paid in social security, and on the basis of records showing stable employment, that they were not known to the "temperance board", had no criminal records, were married and judged to be socially stable.

55 men out of the original 1312 people met all of the above criteria. These men were taken to form the cohort reported upon in this paper; they were followed-up regularly for at least 16 years, 36 being followed-up for 20 years. Records from a range of sources were used to validate the self reported data.

The outcomes of this cohort were rated into four categories, purely on the quantity of alcohol they consumed rather than on symptomatology, using a system devised by Sobell and Sobell (1978). The system is described more fully in the results Chapter of this thesis, but needs to be briefly stated here.
This classification system takes into account daily and monthly drinking behaviour in blocks of a whole calendar year. Under this system people who drink problematically are classified as "typical abusers". Each individual is assumed to be in "typical abuse" unless proven otherwise by self-reported data and other records.

People who still have periods of excessive drinking but show some improvement were classified as "Atypical Abusers". This category is intended for people who abstain or drink moderately most of the time but who have periodic "binges".

People who are able to drink moderately are classified as "Social drinkers", although actually the social context of the drinking was not taken into account in this classification system, only the amount consumed in a given period.

Abstinence under this model is very strict; it must be total and last one calendar year or more.

At the start of the follow-up period all the subjects were categorized as being in "typical abuse", i.e. as having severe alcohol problems. By the end of the first year however this had changed, with 87.3% in "typical abuse" and 27.3% being "abstinent". Only small numbers of people were reported to be in "atypical abuse", (1.6%) and "social drinking" (3.6%).

Over the years the cohort was shown to improve, so that in the 10th year only half of the cohort (50.6%) was in "typical abuse", 12.7% being "atypical", 21.8% being social and 14% being abstinent. By the 20th year only a minority of the cohort were drinking problematically, 25% were in "typical abuse" and, 13.3% were in "atypical abuse". Quite a sizable
majority were found to be free from drinking problems, 13.9% being "abstinent", and 47.2% drinking "socially". (The figures for the 20th year were based on the findings of 36 subjects, 19 having been "lost" to follow-up. It is unclear if these subjects died or simply refused to partake).

Figure 2 reproduced from Nordström (1989) illustrates this data.

The main finding of this study was:

"..... the confirmation of stable, successful, non-abstinent adjustment as a possibility for dependent alcoholics. The quantitative importance of such patterns of adjustment needs to be further elucidated. Whether or not treatment with non-abstinence goals is likely to be successful cannot be answered by the present study. The subjects were treated using abstinence as a goal, and early improvement was generally related to initial abstinence". (p. 124).

From the findings noted above it is quite clear that after 20 years the large majority of those who were traced and interviewed were ignoring the advice of their therapists to remain abstinent. Half, in fact, appeared to be drinking moderately, and this in a culture which is noted for its conservative attitudes to drinking and therapeutic services influenced by temperance ideals.
The findings of Nordström (1989) were chosen for comparison with the L.C.A.S. follow-up findings for two reasons. Firstly, these findings posed a great challenge in that the very high rate of recovery was, by design, determined by the stringent pre-selection of the subjects who composed the cohort. Secondly, the classification system by which the findings were presented was by far the most clearly defined of all the systems in the literature, and therefore the most simple to use for comparative research.

The categorization of the L.C.A.S. findings was designed to meet as closely as possible the conditions required by both Sobell and Sobell (1978) and Nordström (1989), although the therapy offered by the L.C.A.S. was a "non-disease" model and the customers were not in any way pre-selected.

In view of the cultural difference and the absence of women from the cohort of Nordström, these findings could not be taken to constitute a control group to the L.C.A.S. interviewed customers; they were only of value in terms of broad comparison between the therapeutic models used.

THE FINDINGS OF OTHER LONG-TERM FOLLOW-UP STUDIES

CONCLUSIONS

Serious bias can result from subjects being "lost" to long-term follow-up studies. This bias must be kept in mind when conclusions are drawn concerning the level of recovery in a cohort.

It is difficult to compare the reported findings of long-term follow-up studies due to lack of compatibility in the rating systems used; in effect almost every set of follow-up data comes with its own novel rating system.
LITERATURE REVIEW

CONCLUSIONS

From the literature it is clear that some people who experience severe alcohol problems recover, and that therapy can help in this. Recovery can take the form of abstinence, or a reinstatement of more moderate drinking.

This field remains divided by theories which seek to explain the nature of heavy and problematic drinking. These theories have had and continue to have a profound effect on research and service provision.

Although researchers and caring professionals play valuable roles in helping to understand and assist problem drinkers, they have not traditionally afforded them the right to choose their own paths to recovery nor their own forms of recovery. Chapters 4 and 5 of this thesis attempt to evaluate the effects of self-determined therapeutic goals for people who have drinking problems.
INTRODUCTION

This Chapter describes the methodology which was used to gather and collate the data for this long-term follow-up study and allow for comparison with the findings of another study. It is divided into five Sections.

In Section one a description of the Leicestershire Community Alcohol Services is given followed by a brief description of the customers on which the study is based.

In Section two the methodology which was used in designing of the documentation and in the collection of the self-reported data in 1981/82 is outlined, followed by a description of the pilot interviews which were carried out to ensure the clarity of the questions asked at interview and the accuracy of the information gained at the follow-up interviews in 1992/93. Descriptions are then given of the "face to face" and telephone interview techniques which were used, the Postal Questionnaire, and the sheets which were used to collate data relating to deceased customers.

The ethical, confidentiality and copyright issues relating to the study are raised in Section three, followed by a descriptions of the methods and the wide range of sources which were used in the gathering information and its use in the tracing of customers for interview. The information gathered on those customers who refused to be interviewed, defaulted, or could not be traced is presented.
In Section four the standard letters which were used to contact the customers for the follow-up are described, together with the procedure which was used in attempting to gain an interview with them.

In Section five the methods of collating the data into a form which allowed it to be analysed and then compared are described.
SECTION 1
A DESCRIPTION OF THE LEICESTERSHIRE COMMUNITY ALCOHOL SERVICES AND THE RESEARCH COHORT ON WHICH THE STUDY IS BASED

The philosophy of the services

The L.C.A.S. have for more than a decade been offering a "customer-demand generated, non-abstinence oriented, community based service", which in the short term (six months) appeared to enable a substantial number of drinkers to moderate their drinking (Cameron, 1986). The services were established on the basis of this philosophy, and this study is an evaluation of it.

The word "customer" is used to refer to people who have contact with the services as it describes accurately the process whereby people use the services as they would a shop or business, and is free from the clinical and social work associations of other words which are used in this field of service provision such as "patient" and "client".

"Customer demand generated" means that the customers are able to choose from the options that are open to them, to set their own goals, and to change their goals over the course of time if they wish. The L.C.A.S. provide the non-directive counselling and specialized advice to allow them to do this.

"Non-abstinence oriented" means that the customers do not have to modify their drinking habits in a way prescribed by the L.C.A.S., nor do they have to choose abstinence, although they may do so if they wish.

"Community based" means that the customers are assessed and counselled at a place of their own choice, such as in their own home or at the Alcohol Advice Centre (A.A.C.) by members of a multi- and inter-disciplinary
Community Alcohol Team. They can refer themselves directly to the services, or be referred by other agencies e.g. by a General Practitioner or by the Probation Services.

The structure of the services

The structure and history of the services has been described in greater detail elsewhere (Dodd 1985, Cameron 1991) but a brief description of the structure of the L.C.A.S. is necessary to understand the nature of the group of people who form the basis of this research project.

By 1981 the L.C.A.S. had evolved into a structure which has remained largely unchanged to this day. The services comprise three autonomous organizations: the Alcohol Advice Centre (A.A.C.), the Community Alcohol Team (C.A.T.), and Hastings Hostel. These organizations have different functions but the same philosophy and work closely together to provide a very comprehensive service.

The Alcohol Advice Centre

The A.A.C. was established as the service of the Leicester and Leicestershire Council on Alcoholism, and in 1990 moved under the auspices of the Leicester Action for Youth Trust, and has a charitable status. It receives funding from Leicestershire Social Services. The A.A.C. provides a city centre "shop front" for the L.C.A.S., acts as a clearing house for referrals and as an Alcohol Education resource centre, as well as providing a telephone advice service. Staffed by a service director, a counsellor and a secretary, and working in conjunction with a member of the C.A.T. on a rotational basis, the A.A.C. is able
to provide a rapid advice and assessment service which is confidential and directly accessible to the public. Customers (and their relatives and friends) can telephone for an appointment and are usually seen at the A.A.C. within a couple of days. Referral from a third party, such as from a G.P. for example, is not necessary, although of course such referrals are accepted. Domiciliary visits can also be arranged if requested.

The Community Alcohol Team

The Community Alcohol Team (C.A.T.) is based at Drury House in Narborough, Leicestershire, and comprises a consultant psychiatrist, a social worker, a technical instructor, a senior clinical psychologist and six community psychiatric nurses. Funded jointly by the National Health Service and Social Services, the C.A.T. provides individual intensive intervention to people who have alcohol problems. Therapy is usually given in the customers' homes by a member of the team who has opted to take on the case, but can take place anywhere they feel comfortable. Supervision of the team member providing the therapy, and reassessment of the customer, are provided by the team member who carried out the initial assessment.

Hastings Hostel

Hastings Hostel has a charitable status and is funded largely through Social Services. It provides supervised self-catering "bed-sit" accommodation in contrast to the communal lodging typically associated with residential services for people with alcohol problems, the focus being on the personal adjustment of
the customer rather than on alcohol consumption alone. It is open to women as well as men. Many of the customers who use Hastings Hostel are homeless and are working towards a more settled life, but the hostel also provides an alternative to hospitalization for people with a wide range of alcohol related difficulties and in some instances a sheltered environment for detoxification. Each customer has a "key worker" member of staff allocated to them for counselling and support, and there are also group meetings to provide mutual support and for the discussion of the domestic arrangements.

The research team of the L.C.A.S.

Since 1986 the L.C.A.S. has had a small research team to provide on-going evaluation of various aspects the services. It is based at Drury House and headed by Dr. M. Christie, a Senior Clinical Psychologist specialized in the research of alcohol and drug related service provision. Dr. Christie was originally appointed in 1981 to carry out a short-term evaluation of the effectiveness of the services and her findings were subsequently taken as the basis for this long-term follow-up study.

The follow-up team

A sub-team was established to carry out the follow-up study because of the heavy work-load associated with the tracing of information and the arrangement and carrying out of interviews; team work is common practice in this field of research.
The follow-up team comprised:

Dr. M. Christie. Head of the Research Team.
Dr. D. Cameron. Consultant Psychiatrist to the team.
Mr. P. Charnley. Post-graduate research student to lead and coordinate the follow-up project.
Mrs. T. Arrindel. Research Information Services Officer.

A brief description of the cohort

Every year approximately 2,000 people contact the L.C.A.S. regarding counselling, advice and support, Alcohol Education, and housing issues. Approximately 450 of these are assessed as being in need of therapy from the C.A.T. The cohort (the customers taken as the research sample) on which this project is based comprised all the referrals to the L.C.A.S. who were assessed as being in need of therapy from the C.A.T. between 1st September 1981 and 31st January 1982. This cohort is described more fully in the results Chapter but a brief description is appropriate here.

The cohort consisted of 162 people, 113 males and 49 females, with a mean age of 39.6 years. One third were single, one third married and the rest separated, divorced or widowed. 51.2% were unemployed, 36.4% employed and the rest were of other status e.g. houseworkers or retired. They rated their drinking problem as serious and two thirds of the customers stated that it had been problematic for more than five years. Their mean typical weekly consumption of alcohol units per week was 203.6, which is approximately equivalent to 7 bottles of spirits or 100 pints of ordinary strength beer.
The cohort of this study was typical of referrals of the C.A.T. in terms of the amounts of alcohol consumed and the problems associated with it and to those of other specialized alcohol services. In comparison with other long-term follow-up cohorts it was unusual in that it included women and a relatively large proportion of people from unsettled residential backgrounds.
SECTION 2

THE METHODOLOGY OF DATA COLLECTION USED IN THE STUDY

The methodology which had been used in designing the documentation and in the collection of the self-reported data in 1981/82 is presented, followed by a description of the pilot interviews which were carried out to ensure the clarity of the questions asked at interview and the accuracy of the information gained at the follow-up interviews in 1992/93. Descriptions are given of the "face to face" and telephone interview techniques which were used, the Postal Questionnaire, and the sheets which were used to collate data relating to deceased customers.

The assessment form of 1981/82

The assessment form of 1981/82 was designed with two purposes in mind. Primarily it was designed to act as an interview schedule to give a comprehensive and systematic assessment of each customer's present situation in life, together with the necessary background information and personal history, while specifically addressing the amount of alcohol consumed and the perceived problems associated with it. The information which was gained in this way was used to guide the team in matching the therapy and support offered by the C.A.T. to the current predicament and wishes of the customer. The form was also designed to provide a source of research data from which the effects of the service could be evaluated.

Briefly the form was divided into the following sections:

- Details of name, age, sex, and referral agent.
- Medical background, alcohol related health and social problems
- and other agencies contacted.
Details of present problem drinking and associated withdrawal phenomena.

Drinking history.

Home environment and relationships.

Present employment and employment history.

Legal involvement.

Self concepts and appraisals in terms drinking behaviour, personal responsibility and self-esteem.

Perceived needs.

The form comprised a series of tick-boxes, rating scales and open questions, together with "open" sections where the wishes, opinions and experiences of the customer could be recorded, the aim being to combine both quantitative and qualitative measures to give a comprehensive and reliable assessment. This form is given in Appendix 2.

The pilot interviews of the follow-up assessment form

The initial assessment form was adapted and enlarged for the purposes of the follow-up. Five pilot interviews were carried out with customers who were contemporary with the members of the follow-up cohort and who kindly volunteered to help in the adaptation of the form in order to identify and eliminate any problems with it. Two questions which were found to be open to misinterpretation were re-worded.

Description of the follow-up form

The follow-up assessment form was based on the original assessment form that had been used in 1981/82, most of the questions being identical to allow for a "repeated measures" research design, i.e. a direct comparison between the
answers which were given then and now. This form is given in Appendix 3.

The most significant changes to the form were as follows:

A "drinking diary" in terms of alcohol units consumed per day over the last week replaced the series of questions concerning the current levels of drinking, as it has been found to be more readily understood by the customers.

Several sections were added to allow for a detailed description of drinking patterns over the preceding ten years, and the events and changes that accompanied them.

Questions were added relating to ethnic origin.

Questions on general health, tobacco smoking, dieting and exercise were added.

A series of questions were added relating to the quality and perceived helpfulness of the service that had been provided, any failings it may have had and how it could have been improved.

A modified form of the Severity of Alcohol Dependence Questionnaire (T. Stockwell, 1979) was included. This questionnaire in its original form was designed to assess the severity of an individual's current dependence on alcohol based on withdrawal symptomatology, amount consumed and drinking behaviour. This was included to indicate the present level of dependence for the L.C.A.S. follow-up cohort. As this questionnaire was not used as part of the 1981/82 assessment, 16
of the 20 questions were modified and asked separately, not in the context of the current level of drinking but in terms of what the customer identified as being the "worst ever" period of their drinking. This gave an indication of how their dependence, as measured by this questionnaire, had changed over time.

The structure of the "face to face" interviews

The follow-up interviews were designed to last approximately one hour and were carried out in the customers' homes at times which were convenient for them.

It was decided that two members of the follow-up research team should be present at each interview. This was done to attempt to eliminate any bias which may have resulted from one person carrying out an interview in isolation, and to ensure that the interview technique was as far as possible the same for all the interviews. It was also felt to be safer for the interviewers to work in pairs.

The interviewers made a point of ensuring that they were as well acquainted as possible with the history of each customer before setting out on an interview, for example by reading any available notes, and where appropriate made brief pencil notes on the form. This helped the customers if they could not, for example, remember the name of the person they had seen ten years previously, or were unsure of the agency which had referred them. It also served to show that the member of the research team carrying out the interview had a genuine interest in them.
The interviews normally began with an informal conversation to allow the customer and the interviewers to become acquainted, and the customers were told why we had sought to interview them, that the results would be treated in the strictest confidence and that any published results would be general in nature so that they could not be personally identified.

The interviewers attempted to keep the interview as comfortable and flexible for the customer as possible, so that if, for example, a customer began by talking about a section which related to the questions at the end of the form, the assessor would usually turn to that section, returning later to the beginning of the form, rather than interrupt the customer and then attempt to prompt the necessary information later in the interview. The interviewers attempted to complete the form with rather than at the customer, so that the customer could see what was being written down and so was in full agreement with it. One or both interviewers would help the customer if they had difficulties with the questions which were asked of them; for example, a few of the customers found the ten-point rating scales difficult to understand at first.

Partners and relatives who were at home during the interview were invited to be present if this was acceptable to the customer, but no attempt was made to trace or carry out "collateral" interviews with partners or relatives of the customers alone, as this was felt to be ethically unacceptable.

The structure of the telephone interviews

The address and telephone number of Drury House was given in the letter headings of all correspondence sent to customers and the secretarial staff were aware of the need to transfer calls concerning these letters to a member of the research team. A member of the research team was always
available during office hours to take these calls, and a telephone answering machine was used outside office hours so that customers could leave messages and a member of the follow-up team could return any calls if necessary.

The team kept follow-up assessment forms close at hand in case a telephone interview was possible when a customer telephoned to say they were unwilling to be interviewed in person, but were willing to be interviewed over the phone, as such information was recognized as being valuable. In these cases every attempt was made to follow the structure of the "face to face" interviews as closely as possible, although the interviewer often had to make on the spot decisions about which questions to ask and which to drop in order to keep the interview brief. Questions given priority were concerned with the customers' current level of drinking and drinking over the follow-up period, how they felt about their drinking, if it was interfering with their life at present, what kind of a drinker they would call themselves now, and how they rated the contact with the L.C.A.S.

Description of the Postal Questionnaire

In cases where no other contact had been established or was otherwise inappropriate, a letter was sent to the customer in which a brief five item questionnaire and a stamped addressed envelope were enclosed. These five questions were identified as being most important in that they related to their present level of drinking, how they felt about it, if their current level of drinking was interfering with their life, what kind of drinker they would call themselves now, and how they rated their contact with the L.C.A.S. The questionnaire was designed to be answered within a few seconds by the use of tick boxes and rating scales to cause the minimum amount of inconvenience to the customer and so have the greatest chance of being completed. This questionnaire is given in Appendix 4.
Description of the sheet for deceased customers

The team recognized the importance of tracing information relating to customers who were known to have died. Equal priority was given to this area of tracing as the causes of death for this sub-group might well be alcohol related and were seen as being vital to the accuracy of the outcome of the follow-up cohort as a whole.

Although the follow-up team was allowed access to N.H.S. notes which were stored in various hospitals in the county relating to customers who were known to have died, it was not always possible to have them sent to Drury House. Rather, members of the team had to go to the relevant records offices, search out the notes and extract the relevant information there. A sheet was designed to collate this information, which included the time, place, circumstances and cause of death, together with the last address, all of which were important in the tracing of death certificates.
SECTION 3
ETHICAL ISSUES. THE GATHERING OF BACKGROUND INFORMATION AND ITS USE IN THE TRACING OF CUSTOMERS

The ethical, confidentiality and copyright issues relating to the study are raised, followed by descriptions of the wide range of sources and methods which were used in gathering information and in tracing customers for interview. Some information was gathered on members of the cohort who refused to be interviewed, defaulted, or could not be traced.

Ethical, confidentiality and copyright issues

University Registration

Before beginning this research project, full details were submitted for approval to the Leicestershire Health Authority Committee on the Ethics of Clinical Research Investigation. This was given unreservedly. However, on attempting to trace and interview customers the follow-up research team kept in mind the fact that consent to take part in a long-term follow-up study had not been sought at initial assessment in 1981/82.

As I had previously worked for three years with the L.C.A.S. I was already familiar with its philosophy and working practices. I was granted an honorary contract from the Leicestershire Health Authority, Mental Health Services Unit to work on this project and to allow my access to the records of the L.C.A.S. and N.H.S. notes. During the research period the Mental Health Services Unit became an N.H.S. Trust. The project was unaffected by this change.
Permission to use the Severity of Alcohol Dependence Questionnaire was kindly given by its author, Prof. G. Edwards. He placed no copyright restrictions on the use of this questionnaire.

I was registered as a post graduate research student at Loughborough University by the Board of Studies for the School of Human and Environmental Studies. This research was carried out under the supervision of Mr. A. Gould, Senior Lecturer in Social Policy and Administration in the Department of Social Sciences.

The gathering of background information and its use in the tracing of customers

Although the primary objective was to trace and interview as many of the cohort as possible to allow for comparison with the results of another long-term follow-up study, the team also attempted to gather as much information as possible on the customers of this study from every available source, with the aim of collating the maximum alcohol related data concerning the entire cohort.

The advantage of having information from one or more sources is that it can be used in the "cross checking" of information. This is of the utmost importance regarding names and addresses in a follow-up study such as this where it is essential that the confidential letters which are sent in attempting to contact the customers go to the correct people. It is also useful in the validation of data, where a customer reports for example that he or she has not experienced any alcohol related problems during the follow-up period but hospital records indicate a series of admissions for detoxification.
The filing system for customer notes and completed assessment forms

When gathering case notes and other data relating to a large group of people from a wide variety of sources, some with names similar to each other, it is important from the outset to have a reliable filing system to avoid confusion. A four-drawer filing cabinet was therefore used to store customers' notes in alphabetical order as they were traced and sent to Drury House for the purpose of the follow-up study, together with all other relevant information including completed follow-up forms as the customers were interviewed.

The computer database

A computer database was created for the follow-up study, and was designed to be of use both in the tracing of customers and in the compilation and analysis of the data.

All 162 customers had files within the database which could be accessed by members of the follow-up team in a variety of ways. Each file contained fields for the details necessary to trace each customer, and for the data derived from the quantitative repeated measure items from both the assessment form of 1981/82 and the follow-up assessment forms. The data from the entire cohort was thus in a convenient form for analysis. Data was entered into this database as it was gathered making it possible to see, for example, how many people had already been traced during the follow-up.

Sources of information

The following sources of information were used to trace customers and/or to confirm data that had already been gathered:

86
National Health Service records

The N.H.S. files containing the 1991/82 assessment forms were located, together with other relevant records such as psychiatric and general hospital notes.

A.A.C. records

The A.A.C. has a card index system which gives details of all referrals, re-referrals and advice sessions which the service has ever given.

Team memory

As several of the founding members of the C.A.T. were still working on the team, their memories of these customers provided one of the most valuable sources of information.

Drug Advice Centre

Some customers had had contact with the Drug Advice Centre, a sister organization to the A.A.C. If this was known to be the case, N.H.S. notes were requested from the D.A.C.

Hastings Hostel

The staff of Hastings Hostel were helpful in tracing several customers who had been in contact with this section of the L.C.A.S.
Electoral roll

The electoral roll proved to be a frustrating and time consuming method of tracing, as registrations are not listed in alphabetical order. The voting population of each county is divided into a large number of wards, each ward having a separate book or books which is sub-divided by areas and streets and each individual is listed according to his address. Although the electoral role has of late become a less valuable source of information due to the avoidance of local government tax, it did help in tracing and in the confirmation of several addresses.

The telephone directory

This was a valuable source of information, mostly to confirm addresses that were already known.

Newspapers

Several members of staff read the local newspapers each day and cut out any items which refer to known customers, such as reports of alcohol related accidents, court appearances and cases of suicide.

The Leicester Resettlement Unit

The Leicester Resettlement Unit (L.R.U.) in Glen Parva is funded directly from central government. It provides temporary shelter and a range of facilities for homeless men with a view to
helping them establish a more settled life. Such units are usually very busy in the winter months when it is unpleasant and dangerous to sleep out of doors. The L.C.A.S. has a very good working relationship with the L.R.U.

A list was compiled of customers who had been living at the resettlement unit at the time of their 1981/82 assessment. This list was sent to the unit every few months during the research period together with a letter explaining the nature of our follow-up study. We asked that if any of the men on the list were currently living at the unit or were known to the staff they should contact us. Several customers were traced in this way.

*The Office of Population Censuses and Surveys*

For the remaining customers where all the above methods of tracing had failed, such details as we had were sent to the Medical Research Department of the Office of Population Censuses and Surveys. The O.P.C.S. maintains the National Health Service Central Register of all N.H.S. patients and G.P. registrations in England and Wales, and has links with the General Register office for Scotland which has a similar function. It provides a medical research tracing service for epidemiological research. In this way it is possible to confirm on the basis of name, date and place of birth and any other known relevant details, for example, that an individual is alive and currently registered with a G.P., is known to have left the British Isles, or to have died.
In the case of customers who had died, it was possible to request copies of death certificates which gave not only the primary cause and date of death, but also supplementary information relating to any other factors which were known to be related to the cause of death. For the purpose of this study, all information relating to alcohol use and misuse was requested. The information gathered in this way could not be used to trace the customers or their relatives for ethical reasons, but proved to be invaluable in the evaluation of the outcome for the cohort as a whole.

Customers who refused, defaulted or could not be traced

The procedure which was used to contact the customers is outlined below, and this was followed unless it was already known that a customer did not wish to be contacted by the service, or following one of our letters had contacted us to say he or she did not want to take part in the follow-up study.

Several customers wrote letters giving details of their drinking and present situation although they were unwilling to be interviewed. Others ignored all our letters and were not at home when visited. Many customers could not be traced for interview, and any details such as we had were sent to the medical research department of the O.P.C.S.

Data from all other sources was gathered on customers who refused to be interviewed, defaulted or could not be traced as this information was of value in evaluating the outcome of the cohort as a whole.
SECTION 4

THE PROCEDURE USED TO CONTACT THE CUSTOMERS

The standard letters which were used to contact the customers for the follow-up are described, together with the procedure which was used in attempting to gain an interview with them.

The standard letters introducing the follow-up

Standard letters were written to customers who had been traced. They were tactfully worded in view of the fact that we were attempting to contact these customers after such a long time and on such a difficult and personal topic. Correspondence was entered into if it was necessary, for example, to arrange an appointment at a convenient time for a customer.

The procedure used

For those customers who were traced the procedure outlined below was followed in an attempt to gain an interview. All correspondence was marked “Confidential. To be opened by addressee only”, and carried the return address of Drury House on the reverse side.

Initial letter

A letter was sent to the confirmed address of each customer reminding them of our previous contact, outlining the nature of our research and requesting their cooperation.
Second letter

Approximately two weeks later a second letter was sent, again outlining the nature of the research, and giving details of a daytime appointment when we intended to visit and carry out an interview. The letter stated that the appointment could be changed if it were inconvenient, and that evening visits were possible.

First visit

A visit was made to the confirmed address to carry out an interview.

Third letter with second appointment

If the customer was not at home when we called, a third letter was sent giving details of a second appointment to visit.

Second visit

A visit was again made to carry out an interview.

Fourth letter with Postal Questionnaire

If the customer was not at home on the second visit, and if no other contact had been established or was otherwise inappropriate, a final letter was sent in which "Postal Questionnaire" and a stamped addressed envelope were enclosed.
SECTION 5

THE COLLATION OF THE DATA

The methods of collating the L.C.A.S. long-term follow-up data into a form which allowed it to be analysed and then compared with other long-term studies are presented.

The computer data base

As has already been described above, the computer data base which was created at the outset of this project was designed to allow the numerical data to be compiled as it was gathered. The data base was made using a statistical software package so that data from all the cohort of the study could be analysed by a range of statistical techniques and the results displayed as graphs and tables.

Sheets designed for the compilation of data

Two sheets were designed to collate the large amount of information which had been gathered concerning the individual customer's patterns of drinking during the follow-up period in such a manner as to allow comparison with the results of other long-term follow-up studies.

The "Self-reported drinking pattern" sheet

Page 6 of the follow-up assessment form related to self-reported changes in patterns of drinking and the reasons behind the changes, and so called "life events". This section of the form allowed changes to be recorded against a time-scale of the years of the follow-up study. The design of Page 6 formed the basis of a sheet which was used to collate the information from all
sources, i.e. the self reported data from the assessments of 1981/82, the follow-up assessments of 1992/93, any other C.A.T. assessments during the 10 - 12 year follow-up period, information from all N.H.S. notes and any other sources. (This is given as the "Self-reported drinking pattern" sheet in Appendix 5). This sheet proved to be an effective way of charting changes in each customer's drinking pattern and life events which were related to it.

The "L.C.A.S./Nordström comparisons" sheet

Once the data had been collated onto one sheet for each interviewed customer their drinking patterns over the follow-up period became clear. In order to allow for the comparison of the long-term follow-up findings of the L.C.A.S. customers with the findings reported by Nordström (1989) a second data compilation sheet was designed, as it was necessary to rate each customer who had been interviewed into one of four categories at assessment in 1981/82, at follow-up interview in 1992/93 and for each year in between, on the basis of all the available data. (This is given as the "L.C.A.S./Nordström comparisons" sheet in Appendix 6). The four categories were "Abstinence", "Social drinking", "Atypical abuse" and "Typical Abuse" as used by Nordström (1989) using a categorization system designed by Sobell and Sobell (1978). This categorization was done by members of the follow-up team, Dr. M. Christie, Dr. D. Cameron, and myself together with Dr. B. Farid, an independent consultant psychiatrist who was not part of the follow-up team. It was then possible to produce a compounded graph of the drinking patterns of the interviewed customers which could be compared directly with the work of Nordström (1989).
It was possible to reach unanimous agreement on all but one of the 39 customers who were interviewed. The difference of opinion concerned a customer who was clearly in "typical abuse" during the entire follow-up period apart from one year he had spent in prison. Sobell and Sobell (1978) specified several sorts of abstinence depending on the social setting; abstinence as a choice in daily life, while in prison or in hospital. Nordström (1989) did not specify whether forms of abstinence in institutional settings had been included in his interpretation and utilization of this system. The three members of follow-up team felt that this customer could best be rated as being in "typical abuse", while the independent consultant felt that this constituted a year of abstinence.

The graph of compounded drinking patterns for the interviewed customers (Figure 25) was drawn assuming that this one customer had been in "typical abuse" for the entire follow-up period. If this graph had instead been drawn assuming this customer had been totally abstinent the year he had spent in prison, the graph would have been only very slightly "better". The most important data relating to drinking patterns of the cohort at follow-up would not have been affected.
METHODOLOGY

CONCLUSIONS

The L.C.A.S. provide a very comprehensive range of specialized services which provide help to people with alcohol related problems and those concerned about them, alcohol education, and residential support. The services have a strong commitment to research as well as to service provision.

The methods which were used to set up this project, gather the necessary information from a wide range of sources, trace and interview the customers and present the results in a way which can be compared with the findings of a similar research project were relatively straightforward, although very time consuming.
4. THE RESULTS

INTRODUCTION

The results of this study are presented in six Sections.

In Section 1 the cohort is described as it was in 1981/82, by a range of general and alcohol related factors. The customers were found in general to be drinking very heavily and suffering a wide range of consequences.

In Section 2 the forms and goals of therapy which the cohort received are given. These are shown to be wide ranging, flexible and wherever possible set by the customers themselves.

In Section 3 the entire cohort is described as it was found to be at follow-up in 1992/93 on the basis of the data gathered from all available sources. The level of alcohol consumption was found to have substantially reduced, as were the consequences related to drinking. The customers who were found to have died during the follow-up period are then discussed, alcohol having played a major role in their mortality in many instances.

In Section 4 the results of a statistical analysis are presented which indicated that the customers who were interviewed were broadly representative of the entire cohort. The findings of the interviewed customers at follow-up are then compared with the findings from assessment in 1981/82. The interviewed customers as a whole were found to have greatly improved on a wide range of measurements. Data from the postal responses to the research are included as appropriate.
In Section 5 the alcohol related outcomes of the L.C.A.S. interviewed customers as a whole are presented using a system of classification which allows for direct comparison with the findings of Nordström (1989). The findings of both studies indicated reduced levels of alcohol consumption over time, but the findings of the L.C.A.S. interviewed customers are shown to have improved to a greater extent than those of patients reported by Nordström (1989). Four short case histories are outlined to illustrate the changes in drinking patterns which occurred during the follow-up period.

In Section 6 the opinions of the customers are given concerning the quality of the therapy which they received from the L.C.A.S., followed by their suggestions for ways they felt the service could be improved. The factors to which the customers attributed the reductions in their drinking are then presented, followed by the role which they felt the L.C.A.S. had played.
A detailed description of the L.C.A.S. cohort is necessary for two reasons: firstly, to define the condition of the customers on a wide range of measures as recorded in 1981/82 to allow for comparison with the same measures at follow-up in 1992/83, and secondly to allow for the comparison of the data with the initial conditions and reported outcomes of other long-term follow-up studies.

The cohort comprised 162 consecutive referrals to the L.C.A.S. between 1st September 1981 and 31st January 1982 who had been assessed by members of the C.A.T. as being in need of therapy. This description of the cohort as it was in 1981/82 is based on an unpublished evaluation of the L.C.A.S. by members of the L.C.A.S. research team.

The numbers of customers recorded as having given responses to questions varies with each question. This is because many of the questions were highly personal in nature and were omitted from the assessments, at the discretion of the assessor, they were felt to be inappropriate or likely to cause the customer embarrassment. Other data were missing, for example, where customers were too distressed or intoxicated to give a comprehensive interview. The numbers of customers recorded as having given responses to each question are given in the text in brackets and also with the appropriate tables and figures. Where appropriate to ensure consistency, supplementary and validating data gathered for the follow-up study have been included in the description as presented here.
A total of 27 "fields" from the assessment form of 1981/82 have been compiled to form the basis of the findings given in this Section. These are presented under 23 sub-headings, as it was possible to group some together.

**Age**

The L.C.A.S. were accessible to people of a wide range of ages. The youngest customer included in the cohort was 16. The oldest was 76. The mean age of the cohort was 39.6 (S.D. 12.7, N = 162). Figure 3 illustrates the age distribution of the cohort within bands of 10 years.

**Sex ratio**

The L.C.A.S. cohort was unusual in that it included a large proportion of women. 113 of the cohort were male (69.7%) and 49 were female (30.3%). In contrast, the cohorts of most comparable long-term follow-up studies comprised only men. (N = 162)

**Place of birth**

The majority of the customers (68.5%) were born in England. 5.4% were born in Asia. Apart from one customer who was born in Eastern Europe, the rest of the customers were born in Scotland, Ireland or Wales. Most of the customers with Celtic backgrounds were men living at the L.R.U. There were no customers of African, Oriental or West Indian birth despite the multi-racial population of Leicestershire. (N = 162)
Type of housing

Approximately 75% of the cohort were from settled residential backgrounds (N = 162). The rest were either from unsettled backgrounds such as hostels, came from institutions or were "of no fixed abode"; this reflected the L.C.A.S. policy of targeting services at the homeless and liaising with the local Resettlement Unit and other agencies concerned with them.

Original sources of referral

There was a wide range of referral sources. These are given in Table 1. The 21.9% of customers recorded as "Self referrals" were customers who contacted the L.C.A.S. directly without prior involvement with another agency, or social pressure from family or friends (N = 160). All customers, from whatever source, contacted the L.C.A.S. in principle voluntarily. None of the customers was under court order to refer him/herself. There were no direct referrals from Alcoholics Anonymous, the clergy, police, prisons or landlords/landladies.

Other agencies contacted prior to referral

39.9% of the customers reported that they had not had any previous help for drink related problems prior to referral at the L.C.A.S. (N = 143). Of those customers who had had previous help from one or more agencies, half of these had been broadly medical in nature, such as contacts with their G.P. or hospital admission. The rest were with a range of agencies such as the Probation Service, Social Services, and voluntary agencies.
10.5% of the customers had had previous L.C.A.S. contact.

Civil status

Civil Status of the cohort showed an even division between single, married, and divorced or separated persons, with approximately 30% falling into each category. 4.9% were widowed. (N = 162)

Domestic relationships

The customers were asked to rate the amount of conflict that they experienced within the relationship which they felt to be their most important. In most cases this was with their spouse. A rating scale of 1 - 10 was used, 1 being no conflict and 10 a great deal. The mean figure given was 6.2. (N = 112). Figure 4 illustrates the distribution of responses to this question. It would appear that many of the customers found their domestic situation unsatisfactory, and a sizeable minority found it to be acutely stressful.

In order to assess the perceived quality of domestic relationships from a positive aspect the customers were asked a second question - to rate the overall quality of their domestic relationships. This question included immediate family members such as children. A ten-point rating scale was used, 1 being "poor" and 10 being "excellent". The mean of the figures given was 6.3. (N = 109) which indicates that the quality of the domestic relationships for the cohort as a whole was far from perfect, and that the conflict was not confined to their partner
but also affected other members of the family. Figure 5 illustrates the distribution of responses to this question.

**Employment status**

The majority of customers were unemployed (51.2%, \( N = 162 \)). The rate of unemployment appears to have been inflated by the men of the L.R.U., all of whom were unemployed. 36.4% described themselves as being in paid employment; 4.3% described themselves as houseworkers. 3.7% received sickness benefit, 2.5% were students, and 1.9% were retired. 25% of the customers who were unemployed had become so relatively recently. These data are illustrated by Figure 6.

**Legal charges**

The customers were asked three questions concerning legal involvement up to the time of assessment in 1981/82. These concerned the total number of charges made of whatever nature, specifically alcohol related charges and drink driving charges. The data derived included charges pending at the time of assessment, previous charges which may or may not have been pressed although mentioned by the customers at the time of assessment, and all convictions (\( N = 141 \)).

The incidence of criminal behaviour in general appeared to be very high. Only 47.5% of the cohort reported that they had never had any legal charges made against them. The majority of the cohort, 52.5%, had had some form of legal involvement to an extent which led to one or more charges being made. 32.6% of
the cohort had had one legal charge made; the rest (19.9%) had had two or more charges, the highest total reported being 10 charges. Figure 7 illustrates the distribution of this data.

The role that alcohol played in this high level of criminality can be seen in the context of the following two measures. Most of the criminal behaviour appeared to be linked to drinking (N = 141). Almost half of the cohort, (45.4%) had had one or more alcohol related charges, either single charges for being "drunk and disorderly" for example, or where multiple charges had been made with alcohol cited as a factor. Figure 8 illustrates distribution of the number of charges which were directly related to alcohol.

22.6% of those who responded to questions relating to drink driving had had one charge (N = 133), again a very high proportion considering the seriousness of the offence and the social consequences which it carries. 4.5% had had multiple drink driving charges made against them. Figure 9 illustrates the distribution of drink-driving charges.

Quantity of alcohol consumed

As part of a series of questions relating to the customers' drinking behaviour in the weeks leading up to assessment, the customers were asked to estimate the amount they drank. They were asked to estimate it in a way that was meaningful and appropriate to their drinking pattern, for example in pints of beer or bottles of spirits consumed in the days before the assessment interview. They were also asked if this amount was
typical for them. From the answers given it was possible to estimate the quantity of alcohol consumed in a typical week, which was then expressed in "units" to allow comparisons to be made, 1 "unit" being the equivalent of 10ml or 8.0g of pure ethyl alcohol. This data proved to be highly descriptive of the customer's drinking behaviour.

The customers were, as a whole (N = 157), drinking very heavily. With the exception of two customers the entire cohort reported drinking in excess of 20 units per week, the level at which risks to health and social functioning substantially increase. 7.7% were drinking between 51 and 100 units per week. The overwhelming majority of the customers (91.1%) were drinking very heavily indeed, in excess of 100 units each week.

The mean number of units consumed per week was 203.6 units, and the median and mode were both 210. For comparison, a half pint of ordinary strength beer or a single measure of spirits contain approximately one unit of pure alcohol, and one bottle of spirits contains approximately 30 units. The customers were therefore drinking on average the approximate equivalent of one bottle of spirits each day, a level of consumption certainly on a par with the cohorts of other long-term follow up studies.

The distribution of this variable was very wide. One customer had been abstinent for six months prior to assessment and had referred to the L.C.A.S. because of obsessive thoughts concerning alcohol drinking and the desire to maintain abstinence. One customer reported drinking 20 units each week but experienced alcohol related consequences severe enough to
cause referral to the L.C.A.S. At the other extreme, one customer consumed in excess of 500 units per week, the equivalent of more than two bottles of spirits each day.

The data relating to "typical" weekly alcohol consumption are illustrated by Figure 10.

**Beverage choice**

The customers were asked about the forms of alcoholic beverages which they preferred to drink (N = 160). 30% of the customers reported primarily drinking spirits, and the same percentage reported drinking beers. 20% drank cider, wines or fortified wines such as sherry. 19.4% had no particular preference, their choice of beverage being determined by availability and circumstances. This "mixed" category included four customers who drank non-beverage alcohols such as surgical and methylated spirits if beverage alcohol was not available. Only one customer (0.6%) reported drinking primarily non-beverage forms of alcohol.

**Time of day when drinking began**

The customers were asked the time of day that they had typically begun to drink in the weeks leading up to assessment (N = 153). The majority of the customers (52.9%) began drinking in the morning. 21.6% began drinking at noon or in the afternoon, and 19.0% began drinking in the evening. 6.5% had no regular time of day for starting to drink.
In view of the average quantity of alcohol consumed by the customers, the fact that the majority of them began drinking in the morning is indicative of severe alcohol problems. These data are highly descriptive on an individual level when set within the context of other measures and assessment notes. For example, some customers woke in the morning but abstained from alcohol until later as a means of control; others began later because that was when they awoke from the previous night's drinking.

**Place of drinking**

The customers were asked about their typical places of drinking in the weeks leading up to assessment (N = 157). The most frequently reported place was at home (41.4%). 33.1% drank in licensed premises. 21% had no particular preference, i.e. they had drunk in more than one of these environments in the weeks leading up to referral.

7 customers (4.5%) reported that they drank "anywhere", a category which included customers who drank in open public spaces such as park benches and in derelict buildings. No customers reported drinking in a place of work. These data are illustrated by Figure 11.

**Social setting**

The majority of the customers tended to drink alone in the weeks leading up to assessment (N = 152). 78.9% reported primarily they drank in licensed premises without socializing with the
other clients, or that they drank in complete isolation. Only 7.3% reported that they drank with their spouse, family or friends. 13.8% reported that they drank both alone and in a variety of social settings.

**Behavioural and mood effects**

The customers were asked to describe the behavioural and mood effects which they experienced when they drank, and which they associated with their alcohol use (N = 147). This question did not relate to withdrawal symptoms. The customers described a wide range of effects. A majority (60.6%) reported positive mood effects such as feeling more "happy", "confident" or "calm", or feeling stable and normal.

22.5% of the customers reported negative effects from their drinking, for example they associated with aggressive thoughts, volatility and violent behaviour. 3 (2.0%) customers felt "edgy", "nervous" or "agitated" or had experienced paranoid ideas. The remainder of the customers reported effects which cannot be categorized as positive or negative as they are highly subjective and individual. These included changes in consciousness and the induction of sleep.

The largely positive effects reported could be seen as motivating factors in drinking and the more negative effects as being consequences of it.
Reasons given for drinking

In order to gain some insight into the motivation which the customers had for drinking, they were asked to give their reasons for drinking (N = 150). Only 5 (3.4%) of the customers reported drinking primarily for enjoyment. The rest of the customers who were able to express why they drank gave reasons for drinking which they saw as being negative, for example "loneliness, depression, lack of confidence" (22.6%) and "reduction of tension and anxiety" (13.3%). The reasons the customers gave are in Table 2.

Interference with life

The customers were asked to rate the extent to which their level of alcohol consumption and its consequences were interfering with their lives (N = 146). A rating scale of 1 - 10 was used, 1 being little or no interference and 10 being a great deal. The majority of the customers rated it highly or very highly (mean 7.7, median 9, mode 10). 70.6% rated their perceived level of interference from alcohol at 8 or above, i.e. they identified their drinking as a serious problem. Figure 12 illustrates the distribution of responses to this question.

What was perceived as being wrong with their drinking

The customers were asked to describe in what way they felt that alcohol was interfering with their lives (N = 137). This question related to the one above. Rather surprisingly in view of the other findings and reported consequences, 20 (14.6%) of
the customers reported that there was nothing wrong with their drinking. The rest of the customers felt that there was something seriously wrong with their drinking. 61.3% of the customers felt that their drinking was out of control or excessive. Other reasons included, for example, the consequences for health (4.4%), the financial cost (3.7%), the effect on future prospects (2.1%), and the declining positive effects from alcohol due to increasing tolerance (2.1%).

**Personal responsibility for drinking**

The customers were asked to rate on a scale of 1 - 10 how responsible they felt they were for their drinking behaviour, 1 being "not at all" and 10 "completely" (N = 144). The majority of the customers (51.4%) rated this at 10. The rest of the ratings were fairly evenly distributed between 1 and 9. The average response of the cohort was was 7.9 (median and mode 10).

It appears that most of the customers felt they were responsible for their behaviour rather than being purely the victim of circumstances.

**Self esteem**

The customers were asked to rate how they felt about themselves, in other words to rate their self-esteem (N = 134). They were asked to express this on a ten-point scale, 1 being "poor" and 10 being "good". At the time of assessment the customers in general had a low opinion of themselves. 58.2% rated their self-esteem at 3 or less, the mean score being 4 (median 3,
mode 1). The distribution of responses to this question is
illustrated by Figure 13.

Withdrawal symptoms experienced

The customers reported that in the period leading up to
assessment they had suffered from a wide range of symptoms which
they associated with alcohol withdrawal (N = 162). These
symptoms were commonly reported to occur on waking in the
morning, and at other times when alcohol had not been recently
consumed. Many customers reported multiple symptoms. The most
frequently reported symptoms were "shakes", 43.8%, "sweating",
37.7%, "nausea", 32.1%, "headaches", 23.4%, and "hangovers"
25.3%. 21% reported having suffered from "blackouts", the
jargon used to describe the inability to recall events which
occurred while drinking. This is an indication of neurological
disturbance due to acute alcohol intoxication.

Medical complications and other associated phenomena

The customers reported suffering from a wide range of neuro-
physiological and medical complications, often together with
other phenomena (N = 162). These symptomatic phenomena were
associated with alcohol use in general, as opposed to the more
specific withdrawal symptoms given above. Many of these
symptoms were not only unpleasant, but were obviously
detrimental to well-being and functioning in everyday life.
34% reported incidents of short term memory loss which occurred even when not drinking. 13% reported tingling sensations in the limbs, a possible sign of neuritis. Almost half (47.5%) associated their drinking with depression. 37% associated it with various forms of anxiety and 6.2% reported more specific phobic states. The customers associated their alcohol drinking with a range of signs and symptoms which indicate poor general health, the most frequent being "poor appetite" 50%, "poor sleep" 44.4%, and "weight problems", i.e. obesity or emaciation 17.9%.

A significant number of customers reported suffering from severe neuro-physiological and psychiatric conditions such as "paranoia" 12.3%, "disorientation" 9.8%, "hallucinations" 8% and "epileptic fits" 3.1%.

A DESCRIPTION OF THE COHORT AS IT WAS IN 1981/82

CONCLUSIONS

It is very encouraging for the L.C.A.S. that it was accessible to a wide age range of customers. That a large proportion of these were women is also very important, many alcohol services in the past having concentrated only on men.

The findings clearly show that the customers of this cohort were probably without exception all in a deep personal crisis at the time of their assessment. Apart from a few notable exceptions they were all drinking very heavily, a high proportion of this being spirits, and some non-beverage alcohols. Their drinking patterns included many people who began drinking in the morning or upon wakening, which is not a typical pattern of drinking.
in Britain. Not only was their drinking very heavy and by and large continuous, it was also to a large extent done in isolation and carried with it the wide range of withdrawal symptoms and organic problems commonly caused by alcohol abuse. This behaviour was associated with unemployment and criminality. The customers generally accepted responsibility for their drinking. They clearly identified it as being excessive and as a major interference in their lives.

It is above all else the psycho-social findings of this Section which show clearly the predicament of the customers at this time. They experienced a great deal of unhappiness and conflict in their relationships against a background of low self-esteem.

The fact that the large majority of customers had sought contact with other agencies with their drinking problems prior to referral provides a useful link with the next Section, a description of the therapy which the customers received. The therapy provided by the L.C.A.S. was for most of the customers only one factor among many which eventually acted to produce the improvements shown in the follow-up findings.
SECTION 2

THE FORMS OF THERAPY GIVEN TO THE CUSTOMERS FOLLOWING ASSESSMENT IN 1981/82

It was a relatively straightforward matter to describe the data derived from the interviews of this research. These were basically two sets of measurements taken at an interval of 10 to 12 years. It was a far greater challenge effectively to describe the therapy which the customers received. This difficulty is common to all long-term follow-up studies of people with alcohol problems. The literature almost invariably concentrates on the initial description and outcome of client groups. The starting and ending points are easy to describe; the process of change which occurs between these points is more elusive.

The professional input from the L.C.A.S. is described here as "therapy", although this is only for want of a better word. "Treatment", a word which is widely used in this field of research implies more drug orientated intervention than was usual for the L.C.A.S. "Help" is too general; other more specific professional terms such as "social work" or "nursing care" are inappropriate for this multi- and inter-disciplinary team.

In the description and evaluation of therapies for other conditions, for example in the trial of drugs against organic diseases such as arthritis, controlled trials are possible with exact doses of a specified chemical being given. While all other factors may vary, the variable under research can at least be replicated consistently. This is impossible with the therapies for people with alcohol problems; such therapies are largely social, interactive, and subjective in nature.
The therapy which was given by the L.C.A.S. was not confined to one single episode. Although some customers had a short period of therapy and subsequently remained out of contact until follow-up, the majority of the customers had several contacts with the services during the follow-up period. To complicate matters further, the professional input which the customers received did not come from the L.C.A.S. alone. As can be seen in Section 4 of this Chapter, many other agencies gave input of one sort or another to the customers during the follow-up period.

The aim of this Section is to specify what the role of the L.C.A.S. was. The descriptions given in this Section are based on data taken from the case-notes. The case notes of 41 customers were used to give a representative sample of the therapy given to the entire cohort. These included 34 customers who subsequently gave follow-up interviews and 7 customers who were known to have died during the follow-up period.

A description of the L.C.A.S. therapy

In order to understand the context in which the therapies were set and the results which related to them, the therapeutic working methods of the L.C.A.S. during the follow-up period need to be briefly described.

The staff of the L.C.A.S. and those working within the C.A.T. in particular, provided therapy in pairs. Each customer referred to the A.A.C. was assessed by one member of the C.A.T.; a second took the customer onto his or her case-load to provide the therapy. This system had several advantages over therapists giving therapy in isolation. As two members of the team were familiar with each customer they could give each other advice and support. The acting assessor could cover for the therapist in his or her absence. Most important of all, the customers were given several
opportunities to state their needs, to air their views on the therapy that was given and to evaluate their relationship with their therapist. This helped to maintain high professional standards. It also provided a wealth of research data on the progress of the customers.

The L.C.A.S. provided a comprehensive "menu" of therapies from which each customer could create his or her own "Therapy Package". The customers could within reason choose as many of the options as they felt they needed. They could set their own goals and methods of therapy in discussion with their assessor and therapist. They could readily change these as appropriate. They could determine the time and place of therapy. Furthermore the service itself was led by the demands of the customers. If the L.C.A.S. workers received requests for a form of therapy which was not currently available, within the resources which were at their disposal they took steps to provide it.

The open policy of the L.C.A.S. meant that the customers could continue in therapy as long as they felt they needed it. They were free to re-establish contact with the services at any time during the follow-up period, which could range from advice over the phone by the staff of the A.A.C., to re-assessment and possibly to further or more intensive therapy.

Nine specific "fields" were chosen to describe the most important aspects of the L.C.A.S. therapy. The data derived from each field is presented under a separate sub-heading together with a brief interpretation of the data and explanations of the terminology used, which was specific to the L.C.A.S.
Alcohol Education

Alcohol Education in the broadest sense of the term was given as part of the therapy to all of the customers. Typical examples of this would be informing the customers on the number of alcohol "units" contained in their chosen beverages, and the importance of adequate nutrition.

Controlled drinking advice and training

Three quarters of the customers opted for therapies with the goal being controlled drinking. The customers were advised on ways to reduce their drinking and avoid the health and social consequences which it carried.

The therapists frequently negotiated with the customers to reach a schedule for the planned reduction of alcohol consumption. The amount the customer was drinking at the time, the form of withdrawal symptoms experienced in the past, what he or she anticipated or feared, the social setting and commitments of the customer, the time-scale desired and the final goal the customer wished to set were all taken into account. Community support, mostly in the form of home visits, was given together with support over the phone.

Abstinence oriented advice and training

One quarter of the customers opted for therapies were abstinence was the goal. These included both customers who were working towards abstinence as a long-term ambition and those who saw
abstinence as an intermediate stage in returning to moderated drinking. Where necessary detoxification was provided first. The customers were encouraged to develop their own ways of maintaining abstinence. This sometimes included teaching the customer ways of refusing alcoholic drinks in social situations, for example by the therapist meeting with them in a pub.

Drury House Day Unit

12.2% of the customers had had one or more referrals to the Day Unit at Drury House. A great deal of general support was given here, although this was largely informal in nature. The Day Unit was staffed primarily by an Industrial Therapist. The main aim of the therapy given at the day unit was in the structuring of time through social support.

Hastings Hostel accommodation

12.2% of the customers lived for some length of time in Hastings Hostel, the residential wing of the L.C.A.S. The customers were free to set their own goals of abstinence or controlled drinking while resident there.

Detoxification

Detoxification as described here is where prescribed medication was taken which in effect replaced the alcohol as a psychoactive substance. Courses of Heminevrin were prescribed on a reducing dosage scale. The individual undergoing a detoxification should completely stop drinking alcohol and instead take the course of
medication, which suppresses the withdrawal symptoms and is then itself reduced to zero over a number of days. Detoxification carries with it certain risks, the most common being the drinking of alcohol with the medication. This can result in severe and unpredictable reactions such as coma; in the longer term it can also lead to multiple-substance dependence. Adequate supervision during detoxification is therefore of the utmost importance. Detoxification was given in three settings: in the customer's home, in hospital, or at Hastings Hostel.

*Home*

22% of the customers had had one of more home based detoxifications. From the notes that are available for the customers who were found to have died during the follow-up period, it appears that these customers tended to have had several detoxifications during the follow-up period.

Detoxification was carried out by prescription of Heminevrin for the customer by the G.P. and not from the medical staff of the L.C.A.S. Detoxification at home involved the therapist visiting the customer frequently, often on a daily basis, to ensure that the customer was safe, reasonably comfortable, taking the medication as agreed, and was not drinking.
Hospital

31.7% of the customers were admitted one or more times to a general or psychiatric hospital for detoxification at some point during the follow-up period. This was arranged whenever a structured and sheltered environment was needed during the detoxification. Examples from the case notes would be customers who showed signs of liver damage and malnutrition, had a history of epileptic fits, or were known to have abused prescribed medication. All hospital admissions were "informal" under mental health legislation. Heminevrin was prescribed by the medical staff of the ward and was administered by the nursing staff. Support for the ward staff was given through visits to the ward by the L.C.A.S. therapist, the emphasis being on the return to the community of the customer following detoxification. Community support was continued following the discharge of these customers.

Hastings Hostel

7.3% of the customers received detoxification at Hastings Hostel. This was only given if their physical and mental condition did not call for the more intensive supervision available in hospital. The course of Heminevrin was prescribed by the customers' G.P.s and was, as with detoxification at home, given to the customer to take under their own
responsibility with support from a visiting therapist.

Psychotherapy

9.8% of the customers received what could be described as "psychotherapy", i.e. therapy from one or more member of the L.C.A.S. staff for psychiatric or psychological problems.

If advice and counselling are included in this category all the customers could be said to have received it, as this was an integral part of the initial assessment. The notes indicate that the counselling primarily concerned alcohol use, but it also encompassed a wide range of other issues which were not directly related to alcohol use. These included assertiveness and social skills training, leisure and job counselling, advice on welfare rights, relaxation techniques, and help with accommodation.

Referral on

9.8% of the customer were referred on to other agencies. Referral did not necessarily exclude further L.C.A.S. contact.

"Not at home"

2.5% of the customers following assessment did not keep further appointments or were not at home for therapy following initial assessment.
THE FORMS OF THERAPY GIVEN TO THE CUSTOMERS FOLLOWING ASSESSMENT IN 1981/82

CONCLUSIONS

The therapy given by the L.C.A.S. was very comprehensive in nature. It was also very flexible and geared to the individual need of each customer. The main aims of the service in providing community support were met. Where appropriate, hospital, residential and Day Units based therapy was also provided.
A description is presented here of the entire cohort of 162 customers in terms of their tracing status at follow-up. While the remaining Sections of this Chapter concentrate on the results of the 39 interviewed customers, this Section is devoted to data which were gathered concerning the 123 customers who did not give full interviews. Particular emphasis is placed on the customers who were known to have died.

Figure B below gives the breakdown within seven categories of the customers in terms of their tracing status at follow-up.
FIGURE B

Tracing status of the L.C.A.S. cohort at follow-up

<table>
<thead>
<tr>
<th>Method</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive &quot;face to face&quot; or telephone interview obtained</td>
<td>39</td>
<td>24.0%</td>
</tr>
<tr>
<td>Brief &quot;face to face&quot; interview obtained</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Postal Questionnaire or letter returned</td>
<td>6</td>
<td>3.7%</td>
</tr>
<tr>
<td>Traced and contacted but gave no response or refused further involvement</td>
<td>21</td>
<td>12.9%</td>
</tr>
<tr>
<td>Confirmed alive but living outside Leicestershire</td>
<td>8</td>
<td>5.0%</td>
</tr>
<tr>
<td>Deceased: death certificate and available files obtained</td>
<td>33</td>
<td>20.4%</td>
</tr>
<tr>
<td>No trace made - Lost to follow-up</td>
<td>54</td>
<td>33.4%</td>
</tr>
</tbody>
</table>
The fact that only 24% agreed to participate fully is at first sight rather disappointing. This was however to a large extent inherent in the research design. On the other hand, only 33.4% of the customers were lost entirely to the follow-up. Some information was available on the rest, if not by interview, in the form of hospital records, completed Postal Questionnaires, letters or at the very least confirmation that they were alive or dead. Many of the customers who were lost to the follow-up were men who were living in "bed and breakfast" accommodation or at the resettlement unit and who gave insufficient details at assessment in 1981/82 to allow tracing.

The customers who died during the follow-up period

20.4% (33) of the customers were found to have died during the follow-up period (N = 162). It appears that about half of these deaths were to a greater or lesser extent related to alcohol abuse, although the exact role that alcohol played was not always clear.

9.3% (15) of the cohort died from causes which were certainly linked to alcohol. This was confirmed by the data gathered from the death certificates where alcohol or alcohol related conditions were specifically mentioned and other supplementary information such as final entries in case notes. 8 of these customers died as a result of chronic alcohol abuse, for example from Hepatic Failure secondary to Liver Cirrhosis. 4 customers died of "misadventure" while under the influence of alcohol, two examples being "acute alcohol poisoning", and of the shock of falling into a river in winter. One customer died of acute methanol poisoning and had a history of alcohol abuse.
Several of the customers may also have died from conditions which were related to their alcohol use, although the words "alcohol" or "alcoholic" did not appear on their death certificates. One customer for example died of "Status Epilepticus", a condition where the patient enters a prolonged series of convulsions. In view of the known drinking history of this customer, this may well have been as a result of alcohol withdrawal.

One customer was in contact with the L.C.A.S. at the time of his death shortly before the follow-up began. From the case notes and an interview with the therapist it was clear that this customer had been drinking fairly heavily for many years although he was able to function well. His drinking increased following a bereavement. This customer was drinking up to three quarters of a bottle of spirits each day in the weeks leading up to his death, despite frequent visits from his therapist, hospital admissions and support for Hastings Hostel.

There appeared to be no striking differences between those customers who died and those who survived but two of the more obvious possible differences, those of units of alcohol consumed in a "typical" week and age, were analysed more closely. The customers who died were found to have been drinking on average exactly the same quantities of alcohol as those who survived, 203 units in a typical week at assessment in 1981/82 (N = 157). A t-test showed no statistically significant difference in the distributions between these samples at the 5% level. Although the mean age of the customers who died was slightly higher than those who survived - 43.3 as opposed to 38.8 - a t-test revealed no significant difference in the distributions at the 5% level (N = 162). On the basis of these findings it would not have been possible to identify with any degree of certainty those customers who were more likely to die.
It is difficult to compare the rate of mortality found in this follow-up with those of other studies. Many follow-up studies in the literature are based on pre-selected sub-groups of original cohorts, e.g. Nordström (1989), which makes comparison with other studies impossible. Two of the few studies which did report rates of mortality are those of Taylor (1985), and Mackenzie (1987). Taylor reported that 18 of a cohort of 99 men were found to have died during a 10 year follow-up (18%), a slightly lower figure than the 20.4% of the L.C.A.S. On the other hand Mackensie, reporting on an 8 year follow-up, found that 25 out of an original cohort of 85 had died, approximately 29%.

A DESCRIPTION OF THE COHORT AS IT WAS AT FOLLOW-UP IN 1992/93

CONCLUSIONS

Some information was gathered on the large majority of customers, although only a quarter of the original cohort was traced and willing to be interviewed. While the following Sections of this Chapter concentrate on the findings of the customers who survived and were interviewed, it must not be forgotten that 20.4% of the customers were found to have died. Alcohol obviously played a large part in this level of mortality. This finding serves to emphasize the fact that alcohol abuse, however it is viewed, remains for many a debilitating and life threatening behaviour.
The follow-up interviews were carried out between 8th February 1992 and 2nd August 1993. As with the 1981/82 interviews, the numbers of customers recorded as having given responses to questions varied with each question. Those customers who refused to be interviewed "face to face" but agreed to give a telephone interview were only asked the most pertinent questions in order to keep the interview as short as possible. The numbers of customers recorded as having given responses to each question are presented in the text in brackets and also with the appropriate tables and figures.

A total of 32 "fields" from the follow-up assessment were taken to form the basis of the findings described in this Section. 22 of these "fields" were "repeated measures", i.e. they were identical or very similar to the questions asked at assessment in 1981/82. This allowed comparisons to be made between these two sets of data. These "repeated measures" data "fields" are marked as such, (R.M.), within the text.

10 novel "fields" were also included within the data. These gave an indication of the level of adjustment and well-being of the customers, and supplemented the questions of the assessment which were directly related to alcohol. The 32 "fields" used in this Section are presented under 27 subheadings.

Only 39 of the original 162 customers who comprised the entire cohort gave extensive "face to face" or telephone interviews. It was therefore necessary to validate data derived from the 1981/82 interviews against those of the follow-up interviews of 1992/93, i.e. to check using statistical techniques that those customers who were traced and interviewed were broadly
representative of the cohort. Data derived from other sources such as the three Postal Questionnaires which were returned and the letters which were received in connection with the follow-up are included and discussed as appropriate.

VALIDATION OF THE OUTCOMES

Four "fields" of data were chosen to validate the outcomes of the 39 customers who were interviewed in 1992/93 with the corresponding data derived from the 162 interviews of 1981/82. These "fields" were the typical number of alcohol units consumed per week, the ages of the customers, the sex ratios, and the original sources of referral.

Quantity of alcohol consumed

The distributions of the numbers of units consumed in a "typical" week were chosen as being the most reliable indication of the customers' drinking behaviour. The mean number of units consumed by the interviewed customers in 1981/82 was 204.8 (N = 38). The comparable figure for the rest of the cohort was slightly less, 194.9 (N = 119). The interviewed customers were therefore originally drinking on average slightly more than the rest of the cohort.

A t-test was carried out on the distributions of these two sets of data. No statistically significant difference was found at the 5% level.
Age

The relative ages of the customers were chosen as being a good general indicator of the variance of distribution between the two data sets. The distribution of the ages of the 39 interviewed customers was compared with the age distribution of the 123 customers of the cohort who did not give comprehensive follow-up interviews. This comparison was of the ages at assessment in 1981/82 (N = 162).

The mean age of the interviewed customers in 1981/82 was 37.1. The mean age of the rest of the cohort was slightly less, 36.8. A t-test was carried out on these data sets. No significant difference was found in terms of the age distributions between those customers who were interviewed and the rest of the cohort.

Sex ratio

51.3% of the interviewed customers were men and 48.7% were women. By contrast the entire cohort in 1981/82 comprised 69.8% men and 30.2% women (N = 162). A chi² test was carried out. The interviewed sample (N = 39) was found to contain significantly more women than men in comparison with rest of the cohort (N = 123) at the 5% level.

Original sources of referral

The data concerning the original sources of referral were chosen because customers who refer themselves or who are referred by a relative or friend would be expected to be more
motivated to recover than those who were referred from medical sources or from another professional agency. In order to test this statistically, a chi² test was carried out, the data being grouped into the three groups given above for both the interviewed customers and the rest of the cohort \((N = 160)\).

A chi² test indicated that there was significant difference at the 5% level. Further examination of the data showed that while the numbers of customers who were referred from medical agencies were very similar for both the interviewed customers and the rest of the cohort, 36.8% and 37.7% respectively, the main difference was indeed in the relative number of self-referrals. 44.7% of the interviewed customers were "self-referrals" as opposed to 24.6% among those who were not interviewed.

**Interpretation of the validations**

In terms of "typical" drinking units per week and age, the interviewed customers appeared to be representative of the cohort. A major difference was found in the relative proportions of women among the interviewed customers, as many more men than women had been lost to the follow-up. The interviewed customers may also have been people who were more motivated to improve, as they tended to be people who referred themselves. Quite what effect these differences had on the findings of this research is difficult to assess, but they are worth keeping in mind for any future comparisons of the L.C.A.S. findings with those of other long-term research.
Other Agencies contacted during the follow-up period (R.M.)

At some point during the follow-up period the large majority of customers experienced alcohol related difficulties which were sufficiently severe to lead them to contact one or more agencies ($N = 23$). Many of these contacts were broadly medical in nature; for example, 82.6% of the customers sought support from their G.P. at some point and 26% had had contact with rehabilitation agencies such as Alcohol Treatment Units and Resettlement Units.

Another indicator that the interviewed customers as a whole were not totally free of alcohol related problems, particularly in the early years of the follow-up period, is that 30.4% reported having had some contact with the police, probation or prison services at some point. A more precise indication of the level of criminality based on the reported number of charges is given later in this Section.

78.3% of the customers had had one or more further contacts with the L.C.A.S., indicating that the initial period of therapy provided by the services was in itself insufficient to "solve" their drinking problems. However, the fact that so many customers felt able to re-refer themselves shows that the customers felt that the service was helpful and accessible.
These findings support the supposition that the reported changes in the customers' drinking behaviour were the result of a process over time, in many cases involving multiple agencies, rather than the result of one single input of therapy from the L.C.A.S.

Current civil status and reported changes (R.M.)

The proportion of customers interviewed who were married had increased from 29.6% in 1981/82 to 43.4% at follow-up interview. 24.4% described themselves as divorced or separated. 18.7% had remained single, and 13.5% were widowed (N = 37).

Almost half of the customers (48.4%) reported that their domestic situation had changed; for example they had re-married or were living with someone else (N = 31). The extent to which the customers' drinking behaviour during the follow-up period had led to this reported level of change was not asked.

Domestic relationships (R.M.)

The customers were asked to rate the amount of conflict that they experienced within their current domestic relationships on a scale of 1 - 10, 1 being little or no conflict and 10 a great deal. The customers appeared to be reasonably happy in their relationships, 75% rating the level of conflict at 3 or below, in sharp contrast to the high level of conflict reported in 1981/82 (N = 24). The mean figure given was 2.8, a substantial reduction on the comparable figure at assessment in 1981/82, which was 6.2. The comments related to this rating which were
recorded on the assessment forms bear this out. The distribution of responses to this question are illustrated by Figure 14 which is comparable with Figure 4.

The customers who had a partner and/or a family were asked to assess their perceived quality of their relationships on a ten-point scale, 1 being poor and 10 being excellent \( (N = 30) \). Half of the customers who gave responses to this question rated their relationship at 10, the mean being 8.4. The quality of their relationships had improved, the comparable figure from 1981/82 being 6.3. None of the customers rated the quality of their relationships at lower than 4 at follow-up. The data derived from this question is illustrated by Figure 15 and is comparable with the data given in Figure 5.

**Partners' opinion of the customers' drinking behaviour**

The customers were asked to rate the opinion of their partner or closest family member concerning their drinking behaviour, on a ten-point scale, 1 being poor and 10 being good \( (N = 31) \). A large majority of customers (64.7%) gave ratings of 10. The mean response given was 7.9 (Median and mode 10). It would appear that most of the customers felt that their partner was happy with their drinking behaviour.

**Number of changes of address**

In order to gain some indication of the level of social stability of the interviewed customers, they were asked to give the number of changes of address that they had had within the
follow-up period (N = 31). The large majority of the customers were socially stable, 29% not having moved at all, and 38.8% having moved between one and three times.

Not all of the customers were socially stable however. 22.6% had moved between 4 and 6 times. 9.6% (3) had had no fixed abode during the entire follow-up period, one of these estimating the number of changes at between 70 and 80. The other two were unable to give an estimate as they had spent much of the time "sleeping rough" or in hostel type accommodation.

Employment status (R.M)

Only 25% of the customers at follow-up were in paid employment, as opposed to 36.4% in 1981/82. Those who described themselves as being unemployed fell from 51.2% to 16.8%. No customer rated him/herself as a student. The remaining categories, which in 1981/82 accounted for only 9.9% of the customers, were all found to have increased in proportion. 30.6% were receiving sickness benefit and 13.8% were retired. 13.8% described themselves as "house-workers" as opposed to 4.3% in 1981/82. (N = 36).

These numerical data are difficult to interpret in terms of the group as a whole, but examination of the information on an individual basis shows that much of the change in the distributions between categories can be accounted for by time and maturation alone. Many customers who were employed at initial assessment continued to be so during the entire follow-up period, and others re-entered paid employment. The students moved on into other categories, and the older customers went
into retirement. Many customers, particularly women, gave up paid employment to work at home, or preferred to identify themselves as "house-workers" rather than thinking of themselves as "unemployed". Probably the most significant finding is the very large increase in those customers who classified themselves as being in receipt of sickness benefit, from 3.7% in 1981/82 to 30.6% at follow-up. Although it is not clear exactly what role alcohol played in this, it would appear that a large proportion of these customers were unable to work because of the long-term health consequences of excessive drinking. These data are illustrated by Figure 16 and are comparable with Figure 6.

Number of jobs held, working relationships and job satisfaction

The customers were asked how many jobs they had had in the follow-up period as an indication of social stability, "house-work" being included as a form of job (N = 27). 33.3% had had one job, 22.2% two jobs and 29.6% had had 3, 4, or 5 jobs. The remaining 14.9% all had between 10 and 20 jobs. The mean number of jobs held during the follow-up period was 3.9, (Median 2, Mode 1). These data indicate a core of customers who were stable in their employment forms, with a minority who were more transient.

The customers were asked to rate the quality of their relationships with their co-workers and colleagues on a scale of 1 - 10, 1 being poor and 10 being excellent (N = 14). House-workers were also asked this question in relation to other family members they worked with. The customers appeared to be reasonably happy with their working relationships. All of those
who responded to this question rated these relationships at 8 or above, and the large majority rated them at 10 (Mean 9.4, Median and Mode 10).

The customers were asked to give a rating of their level of job satisfaction on a ten-point scale, 1 being poor and 10 being excellent (N = 22). The majority of the customers (59.1%) rated it at 8 or above, almost half of the customers (45.5%) rated it at 10. The mean rating for this question was 7.7 (Median 9, Mode 10). Not all of the customers found their work satisfying however, 27.3% rated it at 4 or 5 on the scale, and 13.6% at 1.

**Legal Charges (R.M.)**

The customers were asked the same three questions concerning legal charges as at assessment in 1981/82, but in relation to the follow-up period. These concerned the total number of charges made of whatever nature, specifically alcohol related charges, and drink driving charges.

In sharp contrast to the data of 1981/82 where the majority of the cohort had had one or more legal charges made against them (52.5%), only 25.6% of the interviewed customers reported having had any legal charges made against them in the follow-up period (N = 39).

Not only had the total number of customers with one or more charges halved, but the relative proportion of charges linked to drinking had reduced even more (N = 39). 45.4% had had one or more alcohol related charges prior to 1981/81, as opposed to
20.5% in the follow-up period.

The proportion of drink driving charges was also found to have reduced drastically \((N = 39)\). 10.3% of the customers reported having had one or more such charges during the follow-up period as opposed to 27.1% prior to assessment in 1981/82.

In interpreting this data it must be kept in mind that the follow-up period was in effect shorter than the period which preceded it. The follow-up period was of 10 to 12 years, but the data derived from the assessments of 1981/82 related to all the charges up to that date, the average age of the cohort being 40. As the lengths of time are not equal and relate to more mature phases of the customers' lives, direct comparison of these two sets of data is not possible. However, in view of the many other findings which indicate reduced levels of drinking and associated problems, it would be reasonable to assume that the general level of criminality for the interviewed customers had reduced considerably, and that the number of alcohol related charges had reduced proportionately even more.

*Figure 17* illustrates the distribution of the number of legal charges admitted by the customers of whatever nature at follow-up, *Figure 18* illustrates specifically alcohol related charges, and *Figure 19* drink driving charges. The data for the period up to assessment in 1981/82 are illustrated by *Figures 7, 8 and 9.*
Quantity of alcohol consumed (R.M.)

The typical number of units consumed by the interviewed customers in the weeks leading up to follow-up showed a very substantial reduction in comparison with the recorded levels of consumption at assessment in 1981/82 (N = 38).

34.2% of the customers, the largest single segment of the distribution, reported that in a typical week they abstained from alcohol. At assessment in 1981/1982 only 0.6%, one customer out of the entire cohort, reported abstinence. A further 28.3% at follow-up reported that they drank up to, but not in excess of, 20 units in a typical week. The majority of the customers (60.5%) therefore reported either abstaining or drinking moderately in a typical week. 5.3% reported that they drank heavily, i.e. between 51 and 100 units. 18.4% reported that they drank very heavily, i.e. at levels in excess of 101 units. The mean consumption rate was 80.8 units per week as compared with the 203.8 in 1981/82. The median figure was 13.5 units per week.

This is one of the most impressive findings of the project. An overall reduction in alcohol, when taken within the context of the other findings which are almost invariably positive, indicates a profound improvement in the customers.

A "typical week" is however a short period of time and is a relatively liberal measure; it may fail to reveal serious drinking problems. A example would be of "binge" drinkers who may abstain or drink moderately for long periods of time, but
suffer severe alcohol related consequences at times when they are drinking heavily. For this reason a categorization of the customers' drinking behaviour within periods of one year on the basis of more strict criteria was used in the following Section.

It is interesting to note that while the vast majority of the customers appear to have reduced their levels of drinking, one customer at follow-up reported drinking in excess of 550 units in a typical week, an increased level of consumption in comparison with the highest recorded figure of 1981/82. In spite of the L.C.A.S. therapy and support from a wide range of services during the follow-up period, this customer among several others continued to have a severe alcohol problem.

While the customers had reduced their alcohol consumption overall, it must not be forgotten that 39.5% of the customers were still drinking in excess of 20 units each week and most of these were drinking far more than this. The L.C.A.S. were clearly unable to effect a "cure" in every case, as is common with all forms of therapy for people with alcohol problems.

The distribution of these data are illustrated by Figure 20. These data are comparable with Figure 10.

Three of the customers who did not wish to be interviewed completed Postal Questionnaires. Two of these indicated on the form that their drinking was "a lot better" than it had been ten years ago, and the third that it was "better". Three customers also wrote letters in response to the request to help with this
research. One of these had been abstinent for a number of years following a period of gradual reduction, the other two did refer specifically to their level of alcohol consumption, although one claimed to be "coping well with my problem".

Beverage choice (R.H.)

Several changes were noted in the distribution of forms of alcoholic beverage consumed at follow-up in comparison with 1981/82 (N = 29). The proportion of beer consumed had increased from 30% to 41.4%. The proportion of spirits had reduced slightly from 30% to 27.5%. The proportion of cider halved (3.5% from 7.5%), but the proportion of customers drinking wine almost doubled (12.5% to 24.1%). One notable change was in the "mixed" category, the proportion of customers who reported no particular preference for one form of beverage, from 19.4% to just 3.5%. This category in 1981/82 included customers who reported drinking non-beverage forms of alcohol; none of the customers at follow-up reported drinking non-beverage forms of alcohol, either as a primary forms of intoxication or in desperation if other forms of alcohol were not available.

It would appear that the relative reduction in the proportion of spirits consumed was linked to the increase in beer consumption for the customers in general. The apparent switch from cider to wine may be linked with the reduction in the price of wine relative to other alcoholic beverages during the follow-up period due to the "harmonization" of taxes on wine within the E.E.C. More customers had a clear preference for one particular form of beverage. The absence of customers drinking non-
beverage forms of alcohol, considering the adverse effects on health which this carries, was a very positive finding.

Time of day when drinking began (R.M.)

In 1981 the majority of the customers (52.9%) reported that they began drinking in the morning. At follow-up this proportion had almost halved to 28%. The proportion who began drinking at noon or in the afternoon had increased from 21.6% to 32%. 28% began drinking in the evening as opposed to 18% in 1981/82. Those who reported drinking at "anytime", i.e. without a regular time for starting, increased from 6.5% to 12%.

These data related to those customers who reported that they did sometimes drink alcohol (N = 25), this question of course being irrelevant to the customers who identified themselves as abstainers.

These findings indicate an improvement in the drinking pattern of the customers. Far fewer customers reported drinking in the morning, a possible indication of reduced dependence upon alcohol. Comments noted on the forms indicate that many of those who began drinking in the afternoon did not see this as a problem. The proportion of customers who drank first in the evening had also increased. Those customers who drank "anytime" tended to do so spontaneously and within a social context, at a party for example, but otherwise would not have a set time to begin drinking each day.
In spite of the general improvement of the interviewed customers on this measure, 28% of the customers did still begin drinking in the morning and these customers tended to be the heavy drinkers.

**Place of drinking (R.M.)**

The customers were asked about their typical places of drinking in the weeks leading up to the follow-up assessment (N = 29). Customers who reported drinking primarily at home reduced from 41.4% to 27.6%, but the incidence of drinking in licensed premises increased from from 33.1% to 51.7%. One customer (3.5%) reported drinking anywhere, for example on park benches. These changes in the proportions of given places of drinking support the proposal that the customers who were drinking at follow-up were doing so in a more social manner rather than in isolation. These data are illustrated by Figure 21 which is comparable with Figure 11.

**Social setting (R.M.)**

The most striking finding concerning the social setting of drinking at follow-up was the large reduction in the reported incidence of solitary drinking (N = 39). In 1981/82 the large majority (78.9%) reported that they drank in licensed premises without socializing with the other clients or in complete isolation. In sharp contrast only 18% reported solitary drinking patterns at follow-up. The majority of the customers (51.3%) reported drinking with their family or friends. It was
necessary to add a "not applicable" category as 28% of the customers were unable to give a typical social setting for their drinking as they never drank or drank infrequently. A further 2.7% reported drinking in a wide variety of social settings.

These findings confirm that the level of drinking had reduced overall, but more importantly that those customers who were drinking tended to do so within a "social" setting, i.e. with family or friends, as opposed to more solitary forms of drinking.

**Behavioural and mood effects (R.M.)**

As at assessment in 1992/93 the majority of customers (56.4%) reported positive effects from drinking such as feeling "relaxed", "calm", "confident" or "happy". The responses given fitted into fewer categories than in 1981/92 (N = 23). Customers who drank infrequently or abstained did not of course give responses to this question.

None of the customers reported feeling "stable or normal" as a result of drinking; neither did they report effects which could be categorized as "violent, aggressive, volatile" or "agitated, edgy, nervous or paranoid" in contrast to the recorded responses from 1981/82. The proportion of customers who reported suffering from negative effects from their drinking such as "feeling sad" reduced from 22.5% to 13.1%. The remaining customers gave responses which could not be categorized as positive or negative.
It appears that those customers who were drinking largely experienced positive effects from it. In keeping with the overall reduction of alcohol consumption the most severe reported effects, such as tendencies to violence, have disappeared, at least as a category of response to this question. A minority of customers however still reported negative effects on their mood as a direct result of drinking.

Reasons given for drinking (R.M.)

As at assessment in 1981/82, only a small minority of the customers at follow-up reported drinking for enjoyment (3.4%). Approximately the same small percentage reported this at follow-up (3.2%). The rank order of the responses given at follow-up had changed, but the primary motivations for drinking were still to provide relief, for example the reduction of anxiety and to cope with situations they found stressful. Customers who abstained did not give responses to this question (N = 31).

The motivations for drinking appeared to have changed little over the follow-up period. What had changed was the quantity of alcohol used to achieve these effects - on average far less than at assessment in 1981/82. Equally important was that the customers in general did not feel that drinking for these reasons was a problem.
Interference with life (R.M.)

The customers were asked to rate the extent to which their level of alcohol consumption and its consequences was interfering with their life. A rating scale of 1 - 10 was used, 1 being little or no interference and 10 being a great deal (N = 37). In sharp contrast to the findings of 1981/82 where 70.6% of the customers rated their perceived level of interference from alcohol at 8 or above, only 16.2% of the customers did so at follow-up. The majority of the customers (64.9%) rated it at 1 on the scale, i.e. that they did not see their alcohol drinking as being an interference at all.

The change in the distribution of responses given to this question is illustrated by Figure 22, which is comparable with Figure 12.

Of the three customers who completed Postal Questionnaires, two gave ratings of 2 on the scale and the third gave a rating of 1. In response to a question concerning how they felt about their drinking now, one was "very satisfied", another was "satisfied" and the third was "not sure". These appear to be consistent with the findings of the interviewed customers.

What was perceived as being wrong with their drinking (R.M.)

The customers were asked to describe in what way they felt that alcohol was interfering with their lives (N = 34). This question related to the one above and included customers who abstained or drank very infrequently. The large majority of
customers who responded to this question (70.6%) felt that there was nothing wrong with their drinking, in contrast to 14.6% in 1981/82 (N = 34).

The minority of customers who did feel that there was still something wrong with their drinking gave responses which fitted into one of three categories: the possible consequences for their future prospects (14.7%), the consequences for their family and social life (8.8%), and the risks for their health (5.9%).

The customers at follow-up therefore appeared in general to be much more comfortable with their drinking, but for a minority it was still seen as the cause of difficulties.

Personal responsibility for drinking (R.M.)

The customers were asked to rate on a scale of 1 - 10 how responsible they felt they were for their drinking behaviour, 1 being "not at all" and 10 being "very responsible" (N = 35). While half of the customers at assessment in 1981/82 had rated this at 10 (51.4%), this had increased at follow up to 88.5%. Two customers rated it at 1 (5.7%), i.e. still very low, and another two at 3 and 6 on the scale respectively. The large majority of the customers therefore felt responsible for their drinking.
Self esteem (R.H.)

The self esteem of the customers was found to have improved markedly at follow-up. The customers were asked to express how they felt about themselves on a ten-point scale, 1 being "poor" and 10 being "good" (N = 35). The customers in 1981/82 in general rated themselves low on the scale, 58.2% at or below 3. The shape of the distribution pattern at follow-up had reversed, 60% of the customers giving ratings of 8 or above. The mean rating given was 7.1. 25.8% however still rated their self-esteem at 3 or less.

The customers at assessment in 1981/82 were in a personal crisis severe enough to lead them to contact the L.C.A.S. At follow-up they were contacted for the purpose of this research project. It is therefore not surprising that their self-esteem was found to have improved, but it is reassuring to find such a major improvement. This is an indication of improved well-being in the customers which was not specific to alcohol use. These data are illustrated by Figure 23 which are comparable with Figure 13.

Withdrawal symptoms experienced (R.H.)

The relative incidence in all but two categories of withdrawal symptoms in the weeks leading up to follow-up assessment was reduced in comparison with the findings of 1981/82, in most instances very substantially (N = 39). For example, 25.3% of the customers in 1981 reported that they suffered from hangovers, compared to the 5.1% at follow-up. 43.8% reported
"shakes" in 1981/82 as opposed to 18% at follow-up. These findings are consistent with a general reduction in alcohol consumption.

Two categories had increased very slightly relative to the 1981/82 findings. These were "stomach pains" 23% as opposed to 22.2%, and "palpitations" 13% as opposed to 11.8%. These small increases in effect indicate that the incidence of these two forms of symptoms remained largely unchanged for the interviewed customers as a whole. Quite why these two categories in particular remained unchanged while the others had all reduced is unclear.

Medical complications and other associated phenomena (R.M.)

The range of medical symptoms reported by the customers at follow-up was unchanged, but again the reported incidence was in most instances was greatly reduced (N = 39). For example 12.3% had reported feelings of "paranoia" in 1981/82 as opposed to 5.1% at follow-up, and the incidence of poor sleep reduced from 44.4% to just 2.6%. The largest and most notable improvement was in the category "poor appetite" which reduced from 50% to 2.6%. These findings amongst a range of others indicate that the health of the interviewed customers was greatly improved for the group as a whole. However a relatively small minority of the customers continued to have medical problems which they associated directly with their alcohol use.
The reported incidence of some symptoms however had increased in real terms at follow-up. The largest of these was "weight problems", specifically concerns over obesity, which rose from 17.8% to 51.5%. The incidence of general forms of anxiety rose from 37% to 41%. Those who reported specific phobic states trebled from 6.2% to 18%. The incidence of epileptic fits increased from 3.1% to 5.1%.

Examination of the data within the context of the other measures taken may help to explain these changes. The notable reduction in the incidence of alcohol related symptoms appears to be linked beyond all reasonable doubt to the general reduction in alcohol consumption.

Many of the customers who were previously drinking heavily and had little appetite no longer had this problem at follow-up. It is interesting to speculate that they were spending money on food instead of alcohol, and even that they may have been eating to compensate for their reduced intake of alcohol, thus accounting for the increased incidence of concerns over obesity. The interviewed customers were in any case more than ten years older than at initial assessment, so they would tend to gain weight as a population aside from the effects of alcohol, even though the weight gain may have been attributed to it.

The increase in the reported incidence of various forms of anxiety may also be in keeping with a reduced intake of alcohol. It could be that some customers have paid for their abstinence or moderated drinking with increased levels of anxiety which they were previously trying to suppress with alcohol. Further
research into this would be of interest, particularly into the strategies customers use instead of alcohol to cope with the anxiety they experience. The extent to which other psychoactive substances are used instead of alcohol, namely prescribed and illegal drugs, are also of interest. The increase in the reported incidence of epilepsy may also be directly attributable to the reduction, or rather to attempts at reduction, in the level of alcohol consumption by individual customers. Alcohol related epileptic fits tend to occur in the days following the cessation of heavy drinking. They are less likely to occur in individuals who continue drinking heavily, reduce their consumption slowly, drink moderately or abstain. This increase could be a possible side effect of attempts to stop drinking in a small minority of the customers who were susceptible to epilepsy on withdrawal.

**Happy with present drinking**

The customers were asked to rate how happy they were with their present drinking on a scale of 1 - 10, 1 being "unhappy" and 10 being "very happy" (N = 36). If they had reported drinking heavily but were happy with it, or if they drank little or abstained but were still troubled, they were free to express this here without judgement or prompting from the assessor. The majority of the customers (63.8%) gave ratings at between 8 and 10; almost half of the customers, (47.2%) gave the highest rating of 10. A minority of the customers gave low ratings however; 18.7% gave a rating of 1 on the scale. The mean response given was 7.3, the median 9 and the mode 10.
These findings are broadly in line with the other findings of this project, i.e. that the majority of the customers are now happy or very happy with their drinking. This is another indication of the successful adjustment to lower levels of drinking or abstinence by the majority of customers. Once again however a minority of the customers, in this instance quite a sizable one, were found to be most unhappy with their drinking and the associations which it carried.

Drinking identity

In order to assess something of how the customers perceived themselves in relation to drinking they were asked the question "what kind of drinker would you call yourself now"? (N = 36). A very wide range of responses was given. 22.2% of the customers identified themselves as "moderate social drinkers" and 19.4% as "light social drinkers". 11% identified themselves as "abstainers"; a further 8.3% as non-drinkers. 8.4% identified themselves as "heavy drinkers" or "heavy social drinkers". A total of 13.9% identified themselves as either "alcoholics" or "recovering alcoholics". One customer adopted the label "dipsomaniac". None of the customers identified themselves as a "controlled drinker".

The success of the L.C.A.S. policy of neutrality regarding the diagnosis of alcohol problems as a disease and in the placing of labels on customers is clearly shown here. Most of the customers who were drinking less than they were at assessment in 1981/81 preferred to identify themselves broadly as "social" drinkers. The customers who felt they were still drinking...
heavily identified themselves by and large as "heavy drinkers". However, those customers who preferred to use terms such as "alcoholic" and "recovering alcoholic" had no qualms about doing so at follow-up interview; they were if anything notable as being particularly verbal as to why this diagnosis was appropriate and the advantages that it had for them.

The customers who responded with a Postal Questionnaire to this question gave the following responses: "abstainer. I dare not have a drink", "heavy social" and "moderate social".

All the responses given to this question by the interviewed customers are listed in Table 3.

S.A.D.Q. results

Both the original and a modified form of the Severity of Alcohol Dependence Questionnaire (Stockwell et al. 1979) were used at follow-up interview. The S.A.D.Q. in its original form was designed to assess the severity of an individual's current dependence on alcohol based on withdrawal symptomatology, amount consumed and drinking behaviour. This particular questionnaire is one of the most widely used in this field of research. It was included in the follow-up interview primarily to give an indication of the current level of dependence for the interviewed customers both on an individual level and as a cohort. It also proved to be effective in indicating the level of change of alcohol dependence over time.
The S.A.D.Q. in its original form comprises two separate sets of questions which when added together gave the appropriate score (Stockwell et al. 1979, Edwards 1989). The first series relate to their current situation; the second series concern the individual's reaction, based on his or her previous experience, to an imaginary situation where he or she had abstained for several weeks and then resumed heavy drinking. This second section, being imaginative, is not dependent on time.

The S.A.D.Q was not used as part of the 1981/82 assessment, so a direct comparison of scores from 1981/82 and 1992/93 could not be made. In order to give some indication of changes in the level of dependence over time for the follow-up customers, 16 of the 20 questions from the first section of the S.A.D.Q. were modified and asked in addition to the original questions. These modified questions were not asked in the context of the current level of drinking, but in terms of what the customer identified as being their "worst ever" period of drinking. The data from these modified questions when added to the scores from the "imaginative" questions gave an indication of their "worst ever" level of dependence.

The two final scores derived were therefore:

i. The S.A.D.Q. score relating to the customer's level of alcohol dependence at follow-up.

ii. The score derived from the modified S.A.D.Q. relating to the "worst ever" episode of drinking in the opinion of each individual customer.
A total score of 30 or more is considered to be a "positive" result for both questionnaires, i.e. an indication of severe alcohol dependence.

Only 6.3% of the customers tested "positive" in relation to their drinking at follow-up, the overwhelming majority, 93.7%, tested "negative" (N = 32). It would appear from this result that the large majority of interviewed customers were not dependent on alcohol at the follow-up. This finding was consistent with the other major findings of this study.

The results from the S.A.D.Q. which was modified for the purposes of this research also gave results which were consistent with the case notes and other sections of the follow-up interview. 46% of the customers were found to be "positive" in their "worst ever" drinking period (N = 32). At interview the customers were almost invariably able to identify exactly when their "worst ever" period of drinking was. They related this to life events and the consequences which they had suffered as a result of drinking. Almost every customer could remember clearly, for example, how much they were drinking, what time of day they started and if they had experienced withdrawal symptoms such as "shakes". The customers found it interesting to see the contrast between their current and retrospective scores.

There is little reason to doubt the validity of the findings of the adapted form of the S.A.D.Q. A large reduction in the level of alcohol dependence over time is indicated by these results.
People with special needs - were their needs met by the L.C.A.S.?

In the literature review the needs of three groups were identified as being indicative of the effectiveness of specialized alcohol services: those of ethnic minorities, women and the homeless. These are briefly considered below.

**Ethnic minorities**

Ethnic minority groups were conspicuous by their absence in this follow-up study. Only 5.4% of the entire cohort in 1981/82 were born outside Europe. This finding in 1982 ultimately led to the monitoring of the representation of ethnic minorities within the case-load of the service and an awareness of the need to increase the accessibility of the L.C.A.S. services to these groups. None of the interviewed customers was from an ethnic minority background.

The L.C.A.S. over the last decade has taken some steps to meet this challenge. Information on the L.C.A.S. and Alcohol Education is now available as pamphlets in a range of languages, and one specialist worker has been appointed to this field.

There has been a slight increase in the rate of referrals from this section of the community, the figures for 1992/93 being 6.6%.
The women

As approximately one third of the cohort of 1981/82 were women, it appears that the L.C.A.S. were reasonably accessible to women. Women have always been well represented within the staff of the services, and if a woman expresses the need to have a female therapist it is always arranged.

There were no striking differences in the drinking patterns of the women as compared to the men, either in their outcomes at follow-up or in the routes they took. The only difference which was worthy of note was the reduced incidence of "home based" drinking among the women. 83% of the women reported drinking predominantly at home in 1981/82 (N = 47). 50% of the women who gave follow-up interviews reported drinking primarily at home; a further 12.5% reported abstinence (N = 16).

When seen against the background of the general reduction of consumption for the interviewed customers and the other changes noted above, this may well be an indication of a movement away from "home based" drinking amongst the women towards social forms of drinking such as drinking in pubs and clubs.

The homeless

Approximately 25% of the cohort was composed of people from unsettled backgrounds who were, for example, living in hostels or institutions or had "no fixed abode" (N = 182). This reflected the policy of the L.C.A.S. in attempting to meet the needs of the homeless by working closely with organizations.
involved in this area and in the specialized services offered from Hastings Hostel. Customers from unsettled backgrounds were given equal priority to the rest of the customers, which would appear to account for many of the customers who were "lost" to the follow-up.

Five of the customers from unsettled or institutional backgrounds were traced and gave follow-up interviews; two of these re-appeared at the L.R.U., were currently homeless and reported having serious drinking problems. The remaining three had settled addresses but reported drinking heavily.


CONCLUSIONS

The most impressive finding of this study must be the huge drop in the level of reported alcohol consumption in a "typical" week. This finding was repeatedly borne out by the other findings; that relatively more beer was being drunk in place of spirits and that none of the customers reported drinking non-beverage forms of alcohol. Drinking when it occurred tended to be in a social context rather than in isolation. The incidence of morning drinking had reduced. The customers suffered far less from withdrawal symptoms and physical complications. The amount of reported domestic conflict had reduced, while self esteem had risen. The amount of criminal behaviour appeared to have decreased, particularly those charges associated with alcohol or where drinking and driving were involved.

The customers were able to decide on their identity, they felt free to use the support and terminology of A.A. if they found it appropriate or to identify themselves according to a range of other "labels" such as "moderate
"social" drinkers. The large majority were found not to be dependent on alcohol according to a questionnaire which is respected within this field of research. Most were happy with their abstinence or pattern of drinking.

While these findings are very encouraging, it must not be forgotten that quite a large minority of customers still had drink problems. These were the customers who had changed little or not at all. This is a common finding of long term follow-up studies.

The fact that the interviewed customers as a whole had improved would be hard to dispute on the basis of these findings. The issue of how well the L.C.A.S. interviewed customers had fared in comparison with the findings of another research project is addressed in the following Section.
SECTION 5


The rating system in practice

The outcomes of the interviewed customers were rated using a system which allowed for comparison with the findings of Nordström (1989). Nordström based his rating system on the system designed by Sobell and Sobell (1978). This system has the major advantage that it takes into account daily and monthly drinking behaviour in blocks of a whole calendar year.

Under this system customers who continued in problematic drinking were classified as "Typical Abusers". All customers were assumed to be in "Typical Abuse" unless proven otherwise by self-reported data and other records. If the data from records such as hospital notes contradicted self-reported data, the data of the records took precedence for those years.

Customers who still had periods of excessive drinking but showed some improvement were classified as "Atypical Abusers". This category was particularly useful for occasional "binge drinkers".

Customers who were able to drink moderately were called "Social Drinkers", although actually the social context of the drinking was not taken into account in this classification system. Customers who abstained totally for at least one calendar year were classified as "Abstainers".

The classification system was used by the raters of the L.C.A.S. data in the form of a flow chart as presented in Figure C below. The U.S. measures and beverage alcohol concentrations given in the book by the Sobell and Sobell
(1978) were converted into the equivalent "Alcohol Units" which were familiar to the raters.

In 1981/82 all the customers of the L.C.A.S. cohort had drinking patterns which gave them classifications of "Typical Abuse". All the patients of the cohort reported by Nordström were also at the outset of the follow-up rated as being in this category.

**FIGURE C**

The classification system used to rate the L.C.A.S. follow-up findings based on the system designed by Sobell and Sobell (1978)

Did the customer:

- Drink 8 units or more most days of the year?  
  or
- Drink 8 units or more 4 or more days in any one month?  
  YES "Typical"  
  or
- Drink 8 units or more several days in a row, even if otherwise "social" or "abstinent", the total number of days in the year being greater than 15?
If none of the above then:
- Drink 8 units or more between 1 and 3 days in any one month?

or
- Drink 8 units or more several days in a row, even if otherwise "social" or "abstinent", the total number of days in the year being 14 or less?

If none of the above then:
- Drink up to but not more than 7 units per day? (May drink up to this amount any number of days in a year).

or
- Drink very occasionally more than 7 units per day, i.e. less than once a month?

If none of the above then:
- Abstain from alcohol for at least one full calendar year, i.e. beginning from January. Even one incident of drinking, no matter how little, leads to categorization as a "Social Drinker" for that year.

The findings of Nordström (1989)

The paper of Nordström (1989) reported on the findings of a 20 year follow-up project. The cohort showed definite signs of improvement in terms of their drinking behaviour which increased in proportion to time.
The data from the 11th year were used for comparison with the L.C.A.S. findings as these data were the closest in terms of the length of follow-up.

FIGURE D
The findings of Nordström (1989) at the 11th year of follow-up
N = 55

"Typical Abuser" 58.2%
"Atypical Abuser" 9.1% (Problem drinkers 67.3%)
"Social Drinker" 21.8%
"Abstainer" 10.9% (Non-problematic drinkers 32.7%)

The pattern of change over time between these four categories up to the 11th year of the follow-up by Nordström (1989) are illustrated by Figure 24. Table 4 gives the numerical data which were used to draw Figure 24.

The L.C.A.S. findings

FIGURE E
The L.C.A.S. outcomes at follow-up in 1992/93
N = 39

"Typical Abuser" 51.3%
"Atypical Abuser" 7.7% (Problem drinkers 59.0%)
"Social Drinker" 29.2%
"Abstainer" 12.8% (Non-problematic drinkers 41.0%)
The pattern of change over time between these four categories between assessment in 1981/82 and follow-up interview in 1992/93 are illustrated by Figure 25 which is comparable with Figure 24. Table 5 gives the numerical data which were used to draw Figure 25.

Interpretation of these data

Differences were found between the findings of Nordström and the L.C.A.S. interviewed customers both in terms of their ratings at follow-up and in the pattern of change during the follow-up period.

i. The findings at 11 years

These long-term findings are very encouraging for the L.C.A.S. If these data are considered as two groupings, those of customers who have continued to suffer from alcohol related problems and those who are now free from problems either through abstinence or by controlled drinking, then the L.C.A.S. customers appear to have done markedly better.

The most striking difference was the relatively high number of customers classified as "Social Drinkers" at 11 years, 28.2% of the customers falling into this category, 6.4% more than the comparable figure from Nordström. Most of the L.C.A.S. customers who were classified as "Social Drinkers" were well below the "7 unit" limit both in terms of the amount consumed each day and in the number of days on which they drank.
The long-term outcomes of those who were classified as "Abstainers" also appeared to be better than those of Nordström, 12.8% of the customers being abstinent, 1.9% more than Nordström. This improvement was rather surprising considering the neutral policy of the services concerning abstinence as a therapeutic goal. Any criticism which could be made against this policy in that it may have encouraged customers to drink rather than abstain was certainly not borne out by these findings. On the contrary, it appears that the free choice and flexibility which the customers were offered during their therapy led to increased levels of abstinence in the long-term.

Another difference was in the proportions of customers rated in the "Atypical Abuser" category: the L.C.A.S. data contained 1.4% less customers rated as "Typical Abusers" in comparison with the findings of Nordström. From these findings it appears L.C.A.S. customers had a comparatively low incidence of "binge" drinking or of drinking which was somewhat improved. They were for the most part abstaining, drinking in ways which did not constitute a problem, or else had quite definite alcohol problems.

This rating system was particularly hard on "weekend drinkers", a fairly typical British pattern of drinking. Several customers who abstained during the week but drank four pints of beer or the equivalent on Friday night and again on Saturday or Sunday, were very happy with this and reported no negative consequences. They were, however, quite clearly over the "7 unit" daily limit and the uneven distribution of their drinking placed them in the "Typical Abuser" category.
ii. Differences in the patterns of recovery between the subjects of Nordström and the L.C.A.S. customers.

Two differences were apparent in the patterns of change during the follow-up period. Firstly, the predominant form of recovery amongst the subjects reported by Nordström in the early years was "abstinence", whereas for the L.C.A.S. customers it was more evenly divided between "abstinence" and "social drinking". This may well be the result of the differences in the therapeutic goals, i.e. that the subjects of Nordström had been advised to abstain whereas the L.C.A.S. customers were able to opt for social drinking if they wished.

Secondly, the speed of recovery appears to have been slower for the L.C.A.S. customers as compared with the findings of Nordström. If the figures for "abstinence" and "social drinking" are added together, then Nordström's subjects appeared to have been more successful than those of the L.C.A.S. for the first 7 years. Only in the last 4 years were the L.C.A.S. combined findings for recovered customers better than those of Nordström.

Due to the many differences between the L.C.A.S. cohort and that of Nordström it was not possible to compare statistically these two sets of data. These cohorts were similar only in that they were both of people who had severe drinking problems; they differed greatly in almost every other aspect. The objective of Nordström's paper was to show that heavy drinkers who at one point conformed to strict definitions of alcoholism could indeed recover, i.e. cease to drink problematically, in a number of ways other than by abstaining. In order to increase the chance of finding such people
Nordström selected a sub-group from his entire cohort to form a "Good Social Adjustment" group on the basis of good health records and full-time employment and social stability.

In sharp contrast the L.C.A.S. customers were simply all referrals to the service who were assessed as needing therapy. The L.C.A.S. cohort included a large proportion of women as well as considerable number of customers who were not living in fixed accommodation and who had particularly bad social adjustment. No attempt was made at follow-up or in the analysis of the data to discriminate between customers on the basis of social adjustment. On the contrary, these customers were of interest as they had been particularly targeted by the services as being in need of attention. Every effort was made to trace them for interview. Bearing this in mind, the L.C.A.S. interviewed customers appear to have done remarkably well in comparison with the "good social adjustment group" of Nordström.

Four L.C.A.S. Case Histories

Four short case histories are presented below, which illustrate the categorization system and show something of the routes taken by the interviewed customers in their drinking careers during the follow-up period. Details have been changed to ensure confidentiality, but the drinking patterns themselves are accurate representations.

_Sally_

Sally was drinking very heavily indeed at assessment in 1981, five bottles of sherry on a typical day. This level of drinking was associated with a range of social and health problems. The therapy from the
L.C.A.S. only helped to slightly reduce her level of drinking; although it was welcomed at the time it had only a transient effect on her drinking. After a few visits from her therapist she discontinued her therapy and remained out of contact for the rest of the follow-up period.

Sally continued drinking heavily for several years, until one day she felt so ill, and so ashamed, she decided to stop. With the full support of her family she has remained abstinent ever since. At follow-up assessment she was adamant that she would never drink again, and was proud that she was trusted to "baby sit" with her grandchildren while her daughters were at work.

Sally was classified as being an "Abstainer".

Phillip

At assessment in 1981 Phillip was drinking heavily, up to one and a half bottles of spirits most days of the week. The initial therapy from the L.C.A.S. did little to reduce this at the time. Phillip's drinking remained unchanged during most of the follow-up period, although he remained in regular contact with the L.C.A.S.

In 1989 he reduced his drinking to 2 or 3 "doubles" each night (8 units). He was not sure why this
change occurred. In 1991 he started to live with a lady friend and became involved in her hobby, golf. At this time his drinking reduced still further. Phillip recalled having drunk only one "short" in the months prior to follow-up. At interview he appeared to be the picture of health, and was very happy with his situation in life.

As Phillip reported drinking, even very occasionally, his classification at follow-up was that of "Social Drinker".

**Angela**

At assessment interview in 1981 Angela was drinking up to a bottle of spirits each day. She found the support of the L.C.A.S. helpful but after the first few weeks, once the crisis was resolved, she discontinued contact and remained out of contact during the follow-up period.

Angela's drinking pattern remained unchanged throughout the follow-up period. In a typical month she reported being totally abstinent, drinking only the occasional glass of wine every few months in a social setting. Once a year however, for reasons which she did not understand, she would begin drinking socially and then continue drinking in isolation at home. At such times she reported drinking up to a bottle of spirits each day for two
or three days. Over the last two years she has created a support network for herself so that if she does start drinking heavily she can minimize it. Her daughter also visits her regularly, which she feels gives her moral support.

Angela was classified as an "Atypical Abuser".

Alan

Alan reported drinking very heavily throughout the entire follow-up period, between 15 and 25 pints at least four days in the week and often more, depending on his finances. He dropped out of contact with the L.C.A.S. after a relatively brief contact in 1981. He associated his drinking with aggression and has several convictions for alcohol related crimes.

Alan was classified as being a "Typical Abuser".


Both the findings of Nordström (1986) and the findings of the L.C.A.S. interviewed customers indicate that the majority of people who have alcohol problems at one point continue to have problems for at least a decade. However, a minority do show signs of improvement in the long-term; about 40% of the L.C.A.S. interviewed customers overcame their problems by either
becoming abstinent or learning to drink more moderately. As shown by the literature, when recovery does occur it can take several forms; it cannot always be clearly linked to the therapy which was given.

The long-term outcomes of the L.C.A.S. interviewed customers appeared to be better than those reported by Nordström although the speed of recovery appeared to be slower.
SECTION B

THE ATTRIBUTIONS FOR CHANGE REPORTED BY THE CUSTOMERS
AND THE ROLE OF THE L.C.A.S.

This Section has three aims. Firstly to list the opinions expressed by the interviewed customers on the service which they received and how they felt it could be improved; secondly, to state the factors to which the customers attributed the changes in their drinking pattern during the follow-up period; thirdly, to attempt to isolate the role which the L.C.A.S. therapy played from the other factors which led to the improvement of the interviewed customers.

The replies to the final series of nine questions on the interview form were taken as the basis of the sub-sections given below, although comments which were appropriate from the rest of the interview have also been included. The emphasis in this Section is to list and clarify the opinions which were expressed by the customers rather than to concentrate on numerical data derived from rating scales.

Memorability and popularity of the L.C.A.S.

Customers who could remember L.C.A.S. contact

As a guide to the reliability of this series of questions, and indeed to all the questions of the interview schedule, the customers were asked to say if they remembered their contact with the L.C.A.S. 97.3% said that they did remember their contact with the services (N = 38).
Most of the customers who said they could remember their contact with the services were able to describe in detail what happened and how they felt at the time.

One customer could not initially remember any contact, but then went on to say how helpful Hastings Hostel had been and to speak of continued informal support from the staff there. This example serves to highlight the confusion which some of the customers had regarding the different sections of the service.

Another customer claimed to be able to remember contact with the services, but appeared to be confusing it with A.A. Only one customer could not remember contact. This customer had had very many contacts with various agencies for alcohol related problems throughout the follow-up period.

One customer gave a brief face to face interview. As little useful data was derived from this he was not included with the interviewed customers. This customer could not remember contact with the L.C.A.S.

Willingness to recommend the L.C.A.S.

An indication of the popularity of the services was gained from the responses to the question "Would you recommend the service to anyone else?" The large majority of the customers (90.6%) felt that they would recommend the services to someone else who was in need of it; in fact two customers said that they had done so (N = 32).
Only 3 customers (9.4%) said they would not recommend the service. One of these was very annoyed that the Day Unit at Drury House had been closed and felt that the Day Unit had never been used to its full potential while open. This customer also felt that contact with his prime therapist was not continued for long enough, and felt "abandoned" by the services in consequence.

The second customer had multiple problems related to traumatic childhood experiences. This customer did not feel the L.C.A.S. therapy had been helpful or was sympathetic. Unfortunately this customer had been given L.S.D. therapy at Drury House some years before this building became the office base of the C.A.T. It was not clear at interview how far this customer was able to dissociate this from the L.C.A.S. therapy which was subsequently given from the same address.

The third of these customers was not pleased that controlled drinking had been suggested by the prime therapist and felt this suggestion had delayed a decision to become abstinent. This was the only customer who felt that the L.C.A.S. therapy had caused harm. This customer was a regular attender of A.A., had abstained from alcohol for seven and a half years prior to follow-up, and was rightly very proud of this. All the other "negative" comments which are listed below in this Section are failings in that the customers felt that more could have been done to help them, rather than feeling that the options they had been given were harmful.
Rating of contact with L.C.A.S.

The customers were asked to rate their contact with the service on a scale of 1 - 10, 1 being "unhelpful" and 10 being "very helpful". The large majority of the customers were very positive about the service they had received (N = 30). A large majority (73.3%) gave ratings at or above 8 on the scale. The mean response was 7.4, the median and mode were both 8.

A list is given below of the comments of the interviewed customers in relation to how helpful they found the service. These have been grouped into positive and negative reactions. In some instances these reactions have been paraphrased, but care has been taken to represent accurately the meaning of these comments.

i. Positive reactions

56.4% of the interviewed customers gave positive reactions (N = 39):

"It was nice to be able to talk with an independent service".
"There was someone there to listen and be helpful"
"They were understanding people you could relate to and who understood"
"I found it very supportive"
"Keeping in touch helped"
"They listened without shouting, unlike my family!"
"(My therapist was) a sympathetic person who enjoyed
a drink himself"
"Hastings Hostel was very Helpful"
"(I think of the service) with friendly thanks and affection".
"Someone to talk to who really understood"
"I was told I was not an Alcoholic"
"Very friendly (therapist)"
"They could not have done more, very helpful"
"Useful chats about drinking"
"Very helpful"
"(They were) there to give support"
"Helpful as I was willing to change (myself)"
"It helped to talk at the time"
"I never met such a caring group of people in my life. My counsellor was nice and very patient. The contact in the first place was particularly good"
"(I remember) playing pool at the day unit and the horrible sandwiches! It helped me to come off (the drink) at the day unit as I could not go to the pub"
"They are always there. It helps to know someone cares and will visit. They are non-judgmental"

One customer who responded to the request to help with this research by writing a letter wrote:

"The initial aid was swift and reassuring. I send all my wishes for your wonderful work"
Reading through these comments it appears that the most memorable factor of the therapy for the customers that they were shown respect and were given caring professional attention. The customers were invariably more concerned about the immediate service they had received at the time rather than the long-term difference it had made to them. This highlights a major difference between the expectations of the customers and the aim of this study.

\textit{ii. Negative reactions}

The customers were also asked to name the "bad bits" of their experience of the service. 20.5\% of the interviewed customers gave responses to this question ($N = 39$).

"The follow-up care was not much good"

"(My therapist) was not very interested, but did try!"

"Controlled drinking was not for me"

"Tended to pry too much"

"Have to wait too long to get a visit"

"I was very upset at the closure of the day unit, but I pulled myself together afterwards"

"There was not enough to do at the day unit"

I was discharged from hospital too soon. After that I wanted to dry out at home but they would not do this. I was only visited once or twice"

"I did not like the advice given to reduce my drinking. They gave me a blood test and then I went to the pub"
The following response was taken from a letter from a female customer who did not want to be interviewed:

"I personally found the sessions at Drury House were geared to men who needed company and occupation"

Two of the three customers who completed Postal Questionnaires gave ratings on a ten point scale of 1 and 3 respectively, 1 being "unhelpful and 10 being "very helpful". The third did not give a numerical rating.

Any agency which asks its customers to comment on the service provided is bound to receive negative as well as positive responses. From these comments it appears that there were no serious failings of the service. In view of the dangers to which heavy drinkers expose themselves, the demands which they can make on a service, and blame which they are reputed to attach to those who attempt to intervene, these negative comments are surprisingly mild. Within the context of the notes it appears that the main source of dissatisfaction was where the customer and therapist were not well matched in terms of personality and the goals they were working towards.

The last two comments on the list from the interviewed customers appear to be serious when seen in isolation, but are not so bad when seen within the context of the wider therapy which was provided. The first of these was a customer who was admitted to hospital for detoxification by arrangement of the L.C.A.S. and who resumed heavy drinking immediately on discharge from
hospital. This in combination with a history of withdrawal related epilepsy made a further home-based detoxification impossible due to the risks involved. The second of these appears to be a rather flippant remark from a well known customer of the services. This incident did not deter him from a series of referrals to all parts of the services throughout the follow-up period.

Suggestions for service improvement

The interviewed customers were asked to give suggestions as to how they felt the services could be improved, and 12 of them did so (30.8%, N = 39). Several of these tie into the negative comments given above.

"Help outside of office hours and at weekends"
"The staff could be more forceful in giving advice"
"The service does not have much specifically for women, a creche at the day unit for example"
"Transport to the services, and out-of-hour services"
"More activity at the day unit, something to do with your hands"
"Make the A.A.C. more cosy, like a living room"
"A purpose built in-patient facility, the Towers Hospital is not ideal (for detoxification)"
"A letter (from the L.C.A.S.) was used to get me out of my home. It would be better to write to the customers without using a letter heading" [This was a comment relating to a divorce]
"Speed up the response time"

"More fear tactics are needed on the harmful effects of alcohol. Reprimands"

"Videos on the results of drinking, physical consequences and broken homes"

"Male and female recovering alcoholics on the team would be a good idea - only they can know what you're going through"

Many of the points raised by the interviewed customers are not new ideas to the services. There has always been an awareness within the services, for example, of the need to provide a rapid and appropriate response. The response time of the L.C.A.S. is excellent in comparison with most other health and social service provisions although the service is provided by appointment rather than as a form of crisis intervention. The L.C.A.S. currently have a working arrangement with the Leicestershire Community Drugs Services to provide an out-of-hours telephone service staffed by trained volunteers.

It is safe to say that none of the workers would wish the service to become more directive in its advice, or to use "fear tactics" in place of Alcohol Education. The need for more specialized services for women is part of an ongoing debate within the services, as is the debate between the allocation of resources between inpatient, day care, residential and community based services. The Day Unit at Drury House was in fact closed in 1991.
The suggestion to utilise the experience of former customers is probably the most controversial. Many of the staff have reservations about how these customers would be supported and the role they would fulfil.

**Attributions for change**

86.7% of the interviewed customers gave clear responses when describing the factors to which they attributed improvements in their drinking (N = 39). These have been given to illustrate something of the process of change which occurred to this group of people over time. They have not been grouped according to their corresponding reported levels of alcohol consumption at follow-up, but rather by the general type of response, or at least the primary reason given.

The responses appeared to fall into four broad groups; starting a significant relationship, health and/or socially related concerns, getting a new job, and those who stopped or reduced for no particular reason. The responses have been have again been paraphrased in some instances:

1. **Starting a significant relationship**

   "I met my wife and settled down"

   "I grew up. I got married in 1985 and had other things to spend money on"

   "I met my present boy-friend. I also got a job at about that time. I was abstinent during my pregnancy"
"I got married"
"I met my wife"
"I lived with a moslem. I also had liver pain"
"I met my friend and gave up the sherry"
"I met my friend in 1988. We had financial constraints. When I did drink I no longer felt guilty about it"

ii. Health and/or socially related concerns

"I was frightened for my health"
"My drinking was causing family problems"
"Health and family worries"
"I didn’t want to become an alcoholic"
"It was making me ill. I got anti-depressants from the doctor"
"My health"
"I got fed up with the hangovers"
"I had alcoholic poisoning. I look after my granddaughter now, the responsibility keeps me abstinent"
"Family and physical problems"
"It reduced gradually. My son came back from boarding school"
"I was prescribed pain killers. They would interact with drink, but I had no desire for it anyway"
"I had six months dry. I was concerned about my work, family and health"
iii. Getting a job

"I got a job as a dinner lady"

"I got a voluntary job" [Subsequently turned into secure paid employment]

iv. Customers who stopped or reduced their drinking for no particular reason

"I just decided to stop"

"I didn’t feel like it any more"

"I had to do it myself after all"

"To save money and pay the bills. I wanted to ease off anyway. It helped to not see my drinking friends"

These statements reflect the adjustment and adaptation which appears to have taken place in the lives of the customers. Many of these changes were seen as "turning points" in their lives; although these were general in nature they often indirectly but profoundly changed drinking behaviour.

The role of the L.C.A.S. therapy

To try an isolate the differences which the L.C.A.S. therapeutic input had made as opposed to the more general changes given above, the customers were asked "Looking back did the services make any difference?" (N = 39). 53.9% (21 customers) felt quite definitely that it had:
"It brought me to my senses"

"I was dry for 11 months, the service must have helped in this"

"I realized I had a problem"

"It stopped me drinking and gave me guidance for the right direction"

"It made me think about my drinking. It did me a lot of good"

"I do not regret it. It was very helpful during a difficult patch"

"Admission to hospital made me more aware"

"The counselling helped at the time, but in the end I did it myself"

"I didn't know Mike (M) was a psychiatrist. I wasn't brought up to talk to doctors. This was the start of me accepting myself"

"It was someone to watch over me. It helps you to keep to a standard and shows you you can do it"

"I proved to my social worker I was not an alcoholic (with L.C.A.S. support)"

"They helped by being there"

"I only had a bit of contact but it was all I needed"

"(The Day Unit) built up my confidence. It broke up the day for me. I lost my agoraphobia"

"It was helpful, but I left it too late to ask for help"

"It did help eventually, but it took time. I would have died without help, but in the end it was up to me" [Found by a team member following an overdose]
"The Day Unit keeping me occupied during the day so I was too tired to go out at night"

"It helped to support me and was useful"

"It drew attention to my drinking that was becoming excessive"

"My drinking began to change (during early contact)"

"Meeting other people and staff at the day unit"

Not all of the interviewed customers felt that their therapy had made a difference however; 28.2% stated that it had not helped. Only one customer specified exactly why it had not helped, and these remarks have been included in the "negative comments" Section. 17.9% did not give responses to this question.

One customer who completed a Postal Questionnaire wrote:

"(The therapy was) helpful at the time but at the end of the day it's up to the person themselves"

THE ATTRIBUTIONS FOR CHANGE REPORTED BY THE CUSTOMERS

AND THE ROLE OF THE L.C.A.S.

CONCLUSIONS

The therapy provided by the L.C.A.S. appears to have been memorable. With a very few notable exceptions it was also remarkably popular. The therapy provided by the L.C.A.S., in the broadest sense of the word, helped a great deal during times of crisis. It appears that this was also a contributory factor in the long-term improvement of the interviewed customers as a whole.
The 162 customers who comprised the cohort were in deep personal crisis at their assessment in 1981/82. They had all been drinking heavily in the months leading to assessment and suffered a wide range of physical and social consequences as a result.

They received forms of therapy from the L.C.A.S. which were in general very popular. Some of the customers had more than one contact with the service.

Over the follow-up period the pattern changed from that of a homogeneous group of heavy drinkers to that of a distribution; those who stopped or drastically reduced their drinking, those who remained the same, and those somewhere in the middle. Where exactly the lines are drawn in terms of improvement is largely a matter of opinion, but this change is none the less quite clear from the data obtained for this study.

Those customers who continued to drink heavily had the same wide range of problems they had at initial assessment. They also appear to have greatly increased their chances of premature death. Those who reduced or stopped largely avoided these risks.

Many factors interacted to produce the outcomes of the follow-up customers, and it could not be claimed that the therapy provided by the L.C.A.S. was the single most important factor in the rate of improvement. The literature of long-term follow-up studies indicates that there is a tendency for some people who have had alcohol problems to improve over time, which was borne out by these findings. Meeting the "right" person in life, for example, appears in many instances to succeed where many hours of professional
therapy fail.

In view of the popularity of the therapy which was provided by the L.C.A.S. it is reasonable to assume that much of the improvement which occurred, over and above that which would have occurred anyway, was due to the L.C.A.S. therapy.

The L.C.A.S. was not giving an effective service to people from ethnic minority backgrounds in 1981/82, although it has clearly noted these failings and taken steps to correct this. On the other hand, the L.C.A.S. has a tradition of good service provision to women and to those from unsettled backgrounds. The implications of these findings for service provision and further research are discussed in the following Chapter.
5. DISCUSSION AND CONCLUSIONS

INTRODUCTION

The final chapter of this thesis is a discussion, within the context of the literature which was reviewed in Chapter 2, of the results of the research described in this thesis, followed by the conclusions of this research project.

THE L.C.A.S. RESULTS RELATED TO THE LITERATURE CONCERNING PROBLEMATIC DRINKING AND THE RECOVERY PROCESS

1. Points of interest concerning the L.C.A.S. cohort of 1981/82

The cohort of 1981/82 appeared to be a typical sample of the L.C.A.S. clientele; this is important in terms of the L.C.A.S. service provision. The cohort also appeared to be very similar to many other cohorts reported in the literature in terms of the quantities of alcohol consumed and the social, legal and health related consequences. Exact comparisons are impossible due to the lack of standardization of measures within this field of research, but it does not appear that the good rate of recovery among those customers who took part in the follow-up was due to the cohort being composed of people with less severe forms of alcohol problems.

The fact that 30.3% of the cohort were women is an indication that the L.C.A.S. were accessible to them.

As the figures for "Type of housing" indicated, 25% of the cohort were from unsettled or institutional backgrounds. It is worth noting that the cohort did not include the customers who were at Hastings Hostel at the time of
assessment in 1981/82, many of whom would have been direct referrals. The true accessibility of the L.C.A.S. to people of unsettled backgrounds cannot therefore be estimated from these figures, but it is if anything even better than is apparent from the data.

Only 5.4% of the cohort were of Asian birth, and no customer was of African, Oriental or West Indian birth. Nor did the cohort contain people who were born in Britain but were from ethnic minority backgrounds. Although the L.C.A.S. is a county wide service, the majority of referrals are from Leicester and the suburban areas surrounding it, and as approximately 25% of this population is from ethnic minority backgrounds it appears that in 1981/82 the L.C.A.S. was failing badly in its accessibility to this section of the population. In my experience ethnic minority groups suffer from alcohol problems as much as the rest of the population. This lack of accessibility has to some extent been corrected over the years, largely as a reaction to these figures. There is certainly now a greater awareness of the need to make the L.C.A.S. accessible and effective for all sections of the community: a specialist worker has been appointed and ethnic monitoring has been included both as part of the customer assessment interviews and in the appointment of staff.

ii. The L.C.A.S. Therapy within the Context of the Literature

The literature concerning theories which seek to explain problematic drinking behaviour has been shown to be divided into two schools of thought, those which support the "disease" model and those which do not. One issue which is rarely raised within this field of research and service provision is the relationship between the patient (customer) and the helping professionals. Under the "disease" model it has been the health and social care professionals, particularly psychiatrists, who have set the agenda in
terms of the definition of various forms of "alcoholism" and diagnosis and who have strongly recommended the goal of abstinence. And under the "non-disease" models it was still the professionals who set the agenda, recommended the goals - which could be "controlled drinking" - that individuals should take, and made judgements on behalf of the patients as to which form of therapy would best match their needs.

The L.C.A.S. therapy differs greatly from the forms of therapy which stem from both these models. It does not support the construct of "alcoholism" and the implicit need to abstain; as such it must be classified as a "non-disease" model. On the other hand, it does not seek to pre-select customers on the basis of their ability to control their drinking. The philosophy of the L.C.A.S. has been that the therapists should be flexible and non-directive concerning the goals of therapy, and that the customer should be able to determine as far as possible the therapy which he or she receives. From the data concerning the various forms of therapy which the customers received during the follow-up period and how the customers identified themselves it appears that the L.C.A.S. did succeed in incorporating "consumer choice" into their service provision. From Table 3 it is clear that the interviewed customers felt free to choose their own "labels" and few saw themselves as failures - a very positive finding.

The L.C.A.S. also appeared to be successful in keeping as much of the therapy as possible within the community, i.e. self referral to the service without the need of referral from a G.P., psychotherapy and detoxification at home, specialised care for people with accommodation problems and day unit provision. The aim of avoiding hospital admission wherever possible appears to have been met.
While most areas of the service have expanded during the follow-up period, one part of the service was closed down - the day unit at Drury House. In 1981/82 the day unit was thriving and formed an integral part of the therapeutic "menu", but over the years it was increasingly marginalised. In 1989 it was closed and the resources reallocated to other parts of the services. This closure was regretted by some of the interviewed customers and also by those customers who agreed to give pilot interviews to help with the design of the follow-up interview form. The closure of the day unit was probably the most unpopular move ever made by the managers of L.C.A.S. Fortunately the staff of Hastings Hostel has recently taken the initiative and a few months ago opened a day unit there. This may well prove to be more convenient for customers than the former day unit as it is situated in the centre of Leicester instead of at the C.A.T. base in Narborough.

iii. The recovery process of the L.C.A.S. customers

The literature describes the process of recovery from alcohol problems as being very complex; changes in drinking behaviour are secondary to maturation and life events. Recovery can be either in the form of abstinence or a return to controlled drinking. Therapy appears to work indirectly by enhancing the process of recovery which would take place anyway - it assists a natural process. The paths taken to recovery by the L.C.A.S. customers did not appear to differ greatly from those of other cohorts reported in the literature, although the interviewed customers tended to identify themselves and their drinking behaviour as being other than "alcoholic", i.e. not of the "disease" model.

According to the findings of this study some customers appear to have recovered, and many others have improved but to a lesser extent. This is clear not only from the quantities of alcohol consumed in a "Typical
and the data which was categorized to allow comparisons to be made with the work of Nordström (1989), but also from a wide range of other measures such as reductions in the perceived level of interference of alcohol, more social drinking rather than drinking in isolation, improvements both in domestic and working relationships and higher self-esteem. These findings are just as important as the figures concerning the quantity of alcohol consumed, but although the findings concerning the quantities of alcohol consumed can be compared with the reported findings of other studies, comparisons in terms of social adjustment are much more difficult, once again due to the lack of standardisation of measures within this field of research.

It is clear that the rate of recovery for the interviewed customers cannot be attributed to the L.C.A.S. therapy alone. Approximately 40% of the cohort had had previous contact with other agencies before referral in 1981/82 to the L.C.A.S, and more than 80% of customers had contact with other agencies for alcohol related problems during the follow-up period. "Life events" played a major role in the recovery process of the L.C.A.S. customers, as would be expected from the literature.

iv. The L.C.A.S. follow-up data

The methodology which was used in this follow-up is fairly standard within this field of research; basically it involved gaining interviews with as many people as possible and gathering all available information within ethical considerations.

Although only 24% of the original cohort gave extensive interviews, the interviewed customers as a group appeared to be representative of the entire cohort in terms of alcohol consumption and age, but it included significantly more women than the original cohort. The interviewed
customers may also have been more motivated to recover than the customers who were not traced and interviewed. In view of the findings of Mackenzie (1987) it is not safe to extrapolate the rate of recovery found amongst the interviewed customers to that of the entire cohort. The fact that most other follow-up studies suffer from the same forms of bias does not stop this being a serious flaw in this research project. This being said, long-term follow-up studies are good indicators of the changes which occur in populations of drinkers when compared with other research methods such as the observation of drinking in hospital settings. Although the results of this project may well have been distorted by the loss of interview data, to some extent this has been corrected by the inclusion of data from other sources such as the O.P.C.S. The only possible compensation for the loss of interview data in this form of long-term follow-up was that, because contact for research purposes was not maintained with the customers during the follow-up period, "observer effects" were avoided.

v. The follow-up findings concerning the provision for people with special needs

Ethnic minorities

As none of the customers from ethnic minority backgrounds who was traced was willing to give a follow-up interview, this study can contribute little in research findings concerning this section of the community.
Almost half of the interviewed customers were women. There were no striking differences in the drinking patterns of the women as compared to the men nor in their routes taken to recovery, although the reduced incidence of "home-based" drinking at follow-up was worthy of note. Any data concerning the long-term drinking patterns of women is very unusual within this field of research and as such is particularly valuable.

According to the literature, problem drinkers with unsettled backgrounds are one of the most difficult groups to help, as they often have multiple problems and run greater risks in terms of accidents and disease than settled heavy drinkers. They are frequently omitted from long-term follow-up studies, presumably because of their poor prognosis compared to people of settled backgrounds and because they tend to be difficult to trace.

As five of the customers who had unsettled or institutional backgrounds gave follow-up interviews and all of these reported drinking heavily, it would appear that the L.C.A.S. despite its commitment to this section of the community was not particularly successful. However, two of them did have settled addresses at follow-up; one had received a considerable amount of help and support from Hastings Hostel and was reasonably happy with his drinking which, although heavy, was very much reduced from what it had been at assessment in 1981/82. The fact that one formerly homeless customer was living a settled life at the time...
of follow-up could be seen as a success for the L.C.A.S., regardless of his drinking pattern.

As noted above, the cohort of 1981/82 did not include the then residents of Hastings Hostel, so these data may well underrepresent the effect which the total L.C.A.S. provision had on this section of the community.

vi. The customers who were known to have died and the incidence of morbidity

In this research project every effort was made to give equal priority to the tracing and reporting of data concerning customers who had died, and to those who were traced and agreed to give interviews. This approach has shown quite clearly that while a proportion of the interviewed customers did recover, approximately 20% of the cohort was found to have died and that heavy drinking played a major role in this level of mortality. I am reasonably confident with the accuracy of the data concerning the level of mortality among the L.C.A.S. cohort because death certificates could be traced by the O.P.C.S. with as little data as a name, date and place of birth.

The literature concerning long-term follow-up studies tends to concentrate on subjects who could be traced and agreed to give interviews. It is very surprising in view of the mortality which is associated with alcohol abuse that such studies only mention in passing, if at all, the number who were found to have died. The role which alcohol played in these rates of mortality is also frequently neglected. As no comparable data is available it is impossible to draw any firm conclusions concerning the effectiveness of the L.C.A.S. therapy in reducing alcohol related mortality and morbidity.
However, from the L.C.A.S. data concerning alcohol related health consequences and the number of customers in receipt of sickness benefits, it is clear that alcohol abuse, despite the best efforts of the L.C.A.S., remains for many customers a life threatening and debilitating condition.

Although the effects of bereavement are not appropriate to this follow-up study it is worth noting here that specialised counselling from the L.C.A.S. is available to relatives and friends of deceased customers and that the death of a customer can be a very distressing aspect in this area of work.

vii. The L.C.A.S. follow-up interview results within the context of the literature

The rating system as devised by the Sobell and Sobell (1978) and used by Nordström (1989) proved to be a very effective way of categorising and illustrating the pattern of change for the L.C.A.S. interviewed customers during the follow-up period as well as the final outcomes. The fact that an almost total consensus was reached between the four people who rated the L.C.A.S. data according to this system, one of whom was independent from this research project, adds credibility to these findings.

The findings of Nordström (1989) indicated that amongst those people with alcohol problems who survived and gave interviews there was a tendency towards recovery in the long-term, and that amongst subjects who had been advised to abstain as part of a "disease" model therapeutic philosophy a minority chose to ignore this advice without dire consequences. The fact that the long-term outcomes of the L.C.A.S. customers were better than those of Nordström was a very satisfactory result; as the cohort which was taken by Nordström was very highly selected on the basis of good health and social adjustment - the creme de la creme of a large clinical population - these
findings are even more remarkable. Although the outcomes for the last years of the L.C.A.S. follow-up were better than those of Nordström, the speed at which subjects entered recovery was higher amongst Nordström’s subjects. Why this was the case is not clear, but it may well have been the result of the pre-selection, all of Nordström’s subjects having been married, employed and healthy at initial assessment, the ideal conditions in which to begin recovery, in sharp contrast to many of the L.C.A.S. customers.

The forms of recovery of the L.C.A.S. interviewed customers included both long-term abstainers and controlled drinkers. Considering the L.C.A.S. philosophy, a greater incidence of controlled drinking may have been expected. However, 12.8% of the interviewed customers were in long-term total abstinence. What is not clear from the figures but is quite striking when looking through the compiled data sheets is that periods of abstinence lasting, for example, a few weeks or several months did occur quite frequently, even with those who otherwise were drinking heavily; abstinence was not a rare phenomenon amongst the interviewed customers. It would appear that the L.C.A.S. policy of self-determination of therapeutic goal did not deter those who wished to abstain from doing so, although one customer reported that it had delayed him from taking a decision to enter long-term abstinence.

Although this research project concentrated mainly on the long-term outcomes of the customers, one of the things the customers valued most was a rapid response to their request for help. The customers were not concerned about what their situation would be ten or twelve years in the future; through their eyes a rapid response was an indication of a high quality service. If therapy does indeed enhance a natural process of recovery, as is indicated by the literature, it may well be that the L.C.A.S. therapy, given at a time of crisis, empowered some of the customers to resolve their problems in a
way which was appropriate to them as individuals, if not at once or even after multiple contacts with the L.C.A.S. and other agencies, but in the long-term.

It is not possible to "prove" that the L.C.A.S. therapy was one of the most significant factors in the good long-term rate of recovery among the interviewed customers, but it is strongly supported by 53.9% of the interviewed customers responding that it quite definitely had made a positive difference to their drinking behaviour. This data would seem to be reliable as all but one of the customers could remember their first contact with the L.C.A.S. Although popularity is not in itself an indication of therapeutic effectiveness it is also encouraging that 90.6% of the customers would recommend the services to someone else who was in need of them.

FINAL CONCLUSIONS

The findings of this follow-up, in common with the findings of other long-term research, indicate that the therapy offered by the L.C.A.S. helped the natural process of recovery. These findings, within the limitations of the research design and the available data, support the hypothesis that the range of therapeutic goals offered by the L.C.A.S. led to a higher incidence of both abstinence and moderated forms of drinking in the long-term in comparison with the findings of Nordström (1989). As the cohort which was taken by Nordström was very highly selected on the basis of good health and social adjustment, the findings relating to the L.C.A.S. interviewed customers are even more remarkable.
On the basis of the findings of this research, I wish to make the following recommendations:

i. The open therapeutic policy of the L.C.A.S. appears to be highly effective in the rate of recovery it produces in the forms of both abstinence and moderated forms of drinking. This policy should not be changed.

ii. Through the eyes of the customers a rapid response is an indication of a high quality service. The response time of the L.C.A.S. has always been very good indeed in comparison with many other forms of health and social services provision. However this issue needs to be kept on the agenda in the context of the latest N.H.S. and S.S. reforms. While the L.C.A.S. have never been and should never be purely an emergency or crisis intervention service, the rapid response time needs to be maintained, monitored and if at all possible improved upon.

iii. If the L.C.A.S. have a weak point, it must be that of service provision to ethnic minorities. The L.C.A.S. needs to review its policy towards ethnic minorities. At the very least more consultation is needed with these sections of the community; the L.C.A.S. need to foster specialism in this area.

iv. The L.C.A.S. have over the last few years provided a "help-line" which gives telephone support outside office hours. Commitment to this service needs to be maintained.
v. Several customers spoke of how helpful they found the day unit to have been to them, and the role that activity and occupation played in their recovery. It is good that after several years without a day unit, one has recently been opened by Hastings Hostel. The specific needs of women need to be kept in mind within the context of L.C.A.S. day unit provision.

vi. It is clear from the results produced and the opinions of the customers that the L.C.A.S. are, in contrast to many other areas of health and social provision, both accessible and popular; they should be defended in the face of any changes which the future might hold.

vii. It is essential that the L.C.A.S. continues its commitment to research and evaluation of the service it provides if it is to defend the range of services it has and maintain its excellence in the coming years.
APPENDIX 1

TABLES AND FIGURES NOT INCLUDED WITHIN THE TEXT
<table>
<thead>
<tr>
<th>Original sources of referral</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practitioner</td>
<td>24.4%</td>
</tr>
<tr>
<td>Self referral</td>
<td>21.9%</td>
</tr>
<tr>
<td>Housing agencies/L.R.U.</td>
<td>16.3%</td>
</tr>
<tr>
<td>Hospital</td>
<td>13.1%</td>
</tr>
<tr>
<td>Spouse/Relative/Friend</td>
<td>7.5%</td>
</tr>
<tr>
<td>Social Services</td>
<td>6.2%</td>
</tr>
<tr>
<td>Probation</td>
<td>5.5%</td>
</tr>
<tr>
<td>Legal agency/Court</td>
<td>1.9%</td>
</tr>
<tr>
<td>Voluntary agency</td>
<td>1.3%</td>
</tr>
<tr>
<td>Other</td>
<td>1.3%</td>
</tr>
<tr>
<td>Prison service</td>
<td>0.6%</td>
</tr>
</tbody>
</table>
## TABLE 2

**Reasons given for drinking - 1981/82**

\( N = 150 \)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loneliness, depression, lack of confidence</td>
<td>22.6%</td>
</tr>
<tr>
<td>Reduction of tension and anxiety</td>
<td>13.3%</td>
</tr>
<tr>
<td>Boredom, something to do</td>
<td>12.6%</td>
</tr>
<tr>
<td>Habit</td>
<td>11.4%</td>
</tr>
<tr>
<td>Social and family related pressure and stress</td>
<td>8.7%</td>
</tr>
<tr>
<td>General life, need for oblivion</td>
<td>8.7%</td>
</tr>
<tr>
<td>Employment related pressure and stress</td>
<td>6.0%</td>
</tr>
<tr>
<td>Enjoyment</td>
<td>3.4%</td>
</tr>
<tr>
<td>Avoidance withdrawal symptoms</td>
<td>0.6%</td>
</tr>
<tr>
<td>Other reasons</td>
<td>3.4%</td>
</tr>
<tr>
<td>Did not know why</td>
<td>9.3%</td>
</tr>
</tbody>
</table>
**TABLE 3**

"What kind of drinker would you call yourself now" - 1992/93

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate social</td>
<td>22.2%</td>
</tr>
<tr>
<td>Light social</td>
<td>19.4%</td>
</tr>
<tr>
<td>Abstainer</td>
<td>11.0%</td>
</tr>
<tr>
<td>Non-drinker</td>
<td>8.3%</td>
</tr>
<tr>
<td>Alcoholic</td>
<td>8.3%</td>
</tr>
<tr>
<td>Heavy social</td>
<td>5.6%</td>
</tr>
<tr>
<td>Recovering alcoholic</td>
<td>5.6%</td>
</tr>
<tr>
<td>Heavy drinker</td>
<td>2.8%</td>
</tr>
<tr>
<td>Problem drinker</td>
<td>2.8%</td>
</tr>
<tr>
<td>Moderate drinker</td>
<td>2.6%</td>
</tr>
<tr>
<td>Dipsomaniac</td>
<td>2.6%</td>
</tr>
<tr>
<td>Very light social</td>
<td>2.6%</td>
</tr>
<tr>
<td>Social</td>
<td>2.8%</td>
</tr>
<tr>
<td>Light to moderate social</td>
<td>2.8%</td>
</tr>
</tbody>
</table>
TABLE 4
Nordström (1989) - reported outcomes for the first 11 years of follow-up
"Good Social Adjustment Group"
N = 55

<table>
<thead>
<tr>
<th>Year</th>
<th>&quot;Typical Abuse&quot;</th>
<th>&quot;Atypical Abuse&quot;</th>
<th>&quot;Abstinence&quot;</th>
<th>&quot;Social&quot;</th>
<th>&quot;Abst + Soc&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>100.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>1</td>
<td>67.3%</td>
<td>1.8%</td>
<td>27.3%</td>
<td>3.6%</td>
<td>30.9%</td>
</tr>
<tr>
<td>2</td>
<td>65.5%</td>
<td>3.6%</td>
<td>27.3%</td>
<td>3.6%</td>
<td>30.9%</td>
</tr>
<tr>
<td>3</td>
<td>60.0%</td>
<td>3.6%</td>
<td>29.1%</td>
<td>7.3%</td>
<td>38.4%</td>
</tr>
<tr>
<td>4</td>
<td>50.9%</td>
<td>12.7%</td>
<td>27.3%</td>
<td>9.1%</td>
<td>36.4%</td>
</tr>
<tr>
<td>5</td>
<td>50.9%</td>
<td>14.6%</td>
<td>25.4%</td>
<td>9.1%</td>
<td>34.5%</td>
</tr>
<tr>
<td>6</td>
<td>52.7%</td>
<td>12.8%</td>
<td>23.6%</td>
<td>10.9%</td>
<td>34.5%</td>
</tr>
<tr>
<td>7</td>
<td>50.9%</td>
<td>14.6%</td>
<td>18.1%</td>
<td>16.4%</td>
<td>34.5%</td>
</tr>
<tr>
<td>8</td>
<td>54.5%</td>
<td>14.6%</td>
<td>14.5%</td>
<td>16.4%</td>
<td>30.9%</td>
</tr>
<tr>
<td>9</td>
<td>50.9%</td>
<td>18.2%</td>
<td>16.3%</td>
<td>14.6%</td>
<td>30.9%</td>
</tr>
<tr>
<td>10</td>
<td>50.9%</td>
<td>12.7%</td>
<td>14.6%</td>
<td>21.8%</td>
<td>36.4%</td>
</tr>
<tr>
<td>11</td>
<td>58.2%</td>
<td>9.1%</td>
<td>10.9%</td>
<td>21.8%</td>
<td>32.7%</td>
</tr>
</tbody>
</table>
TABLE 5
L.C.A.S. findings for the follow-up period

Interviewed Customers

N = 39

<table>
<thead>
<tr>
<th>Year</th>
<th>&quot;Typical Abuse&quot;</th>
<th>&quot;Atypical Abuse&quot;</th>
<th>&quot;Abstinence&quot;</th>
<th>&quot;Social&quot;</th>
<th>&quot;Abst + Soc&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>100.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>1</td>
<td>79.4%</td>
<td>2.6%</td>
<td>10.3%</td>
<td>7.7%</td>
<td>18.0%</td>
</tr>
<tr>
<td>2</td>
<td>74.3%</td>
<td>2.6%</td>
<td>15.4%</td>
<td>7.7%</td>
<td>23.1%</td>
</tr>
<tr>
<td>3</td>
<td>61.6%</td>
<td>5.1%</td>
<td>17.9%</td>
<td>15.4%</td>
<td>33.3%</td>
</tr>
<tr>
<td>4</td>
<td>61.6%</td>
<td>5.1%</td>
<td>15.4%</td>
<td>17.9%</td>
<td>33.3%</td>
</tr>
<tr>
<td>5</td>
<td>64.2%</td>
<td>5.1%</td>
<td>12.8%</td>
<td>17.9%</td>
<td>30.7%</td>
</tr>
<tr>
<td>6</td>
<td>66.7%</td>
<td>5.1%</td>
<td>10.3%</td>
<td>17.9%</td>
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<td>5.1%</td>
<td>12.8%</td>
<td>20.5%</td>
<td>33.3%</td>
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<td>5.1%</td>
<td>15.4%</td>
<td>25.6%</td>
<td>41.0%</td>
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<tr>
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<td>7.7%</td>
<td>15.4%</td>
<td>25.6%</td>
<td>41.0%</td>
</tr>
<tr>
<td>10</td>
<td>51.3%</td>
<td>7.7%</td>
<td>12.8%</td>
<td>28.2%</td>
<td>41.0%</td>
</tr>
<tr>
<td>11</td>
<td>51.3%</td>
<td>7.7%</td>
<td>12.8%</td>
<td>28.2%</td>
<td>41.0%</td>
</tr>
</tbody>
</table>
FIGURE 1
Taylor (1985) - Reported outcomes over 10 year follow-up

N = 68
FIGURE 2

Nordström (1989) - Reported outcomes over 20 year follow-up

"Good Social Adjustment Group"

N = 55, see note

N = 55 for years 0 - 18
For the last four years N = 49, 46, 39, and 36 respectively.
FIGURE 3

Age distribution of the cohort - 1981/82

N = 151
FIGURE 4

Reported conflict in domestic relationships - 1981/82
Ten-point rating scale

N = 112
FIGURE 5

Quality of domestic relationships – 1981/82
Ten-point rating scale

N = 109
FIGURE 6

Employment Status - 1981/82

N = 162

<table>
<thead>
<tr>
<th>Employment Status</th>
<th>%</th>
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<tbody>
<tr>
<td>Unemployed</td>
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<tr>
<td>Employed</td>
<td>36.4</td>
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<tr>
<td>Sickness ben.</td>
<td>3.7</td>
</tr>
<tr>
<td>Houseworker</td>
<td>4.3</td>
</tr>
<tr>
<td>Student</td>
<td>2.5</td>
</tr>
<tr>
<td>Retired</td>
<td>1.9</td>
</tr>
</tbody>
</table>
FIGURE 7

Total number of legal charges prior to assessment in 1981/82

N = 141
FIGURE 8

Alcohol related charges prior to assessment in 1981/82

N = 141
FIGURE 9

Drink-driving charges prior to assessment in 1981/82

N = 133
FIGURE 10
Distribution of alcohol consumption
Typical number of units consumed per week
1981/82 N = 157

1 "unit" is the equivalent of 10ml or 8.0g of pure Ethyl Alcohol.

N.B. An uneven scale has been used to illustrate this data.
Band 1 = abstinence, band 2 = 1 - 20 units, band 3 = 21 - 50 units.
Consumption in excess of 51 units is given in bands of 50.

218
"Pubs" includes public houses, hotels, wine bars and social clubs.
FIGURE 12

Alcohol consumption as an interference in life - 1981/82
Ten-point rating scale

N = 146
FIGURE 13

Rating of self-esteem - 1981/82
Ten-point rating scale

N = 134
FIGURE 14

Reported conflict in domestic relationships - 1992/93
Ten-point rating scale

N = 24
FIGURE 15
Quality of domestic relationships - 1992/93
Ten-point rating scale

N = 30
FIGURE 16

Employment Status - 1992/93

N = 36

<table>
<thead>
<tr>
<th>Employment Status</th>
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</thead>
<tbody>
<tr>
<td>Sickness ben.</td>
<td>30.6</td>
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<tr>
<td>Employed</td>
<td>25.0</td>
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<tr>
<td>Unemployed</td>
<td>16.8</td>
</tr>
<tr>
<td>Houseworker</td>
<td>13.8</td>
</tr>
<tr>
<td>Retired</td>
<td>13.8</td>
</tr>
<tr>
<td>Student</td>
<td>1.0</td>
</tr>
</tbody>
</table>

222
FIGURE 17
Total number of legal charges during follow-up period
1992/93 N = 39
FIGURE 18

Alcohol related charges during follow-up period

1992/93 N = 38
FIGURE 19
Drink-driving charges during follow-up period
1992/93 N = 39

No of charges

Percentage

0 7 10+

90 80 70 60 50 40 30 20 10 0
FIGURE 20

Distribution of alcohol consumption

Typical number of units consumed per week

1992/93 N = 38

1 "unit" is the equivalent of 10ml or 8.0g of pure Ethyl Alcohol.

N.B. An uneven scale has been used to illustrate this data.
Band 1 = abstinence, band 2 = 1 - 20 units, band 3 = 21 - 50 units.
Consumption in excess of 51 units is given in bands of 50.
FIGURE 21
Place of drinking - 1992/93
N = 29

<table>
<thead>
<tr>
<th>Place</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pubs</td>
<td>51.7</td>
</tr>
<tr>
<td>Home</td>
<td>27.6</td>
</tr>
<tr>
<td>No pref</td>
<td>17.2</td>
</tr>
<tr>
<td>Anywhere</td>
<td>3.5</td>
</tr>
</tbody>
</table>

"Pubs" includes public houses, hotels, wine bars and social clubs.
FIGURE 22

Alcohol consumption as an interference in life—1982/83
Ten-point rating scale

N = 37
FIGURE 23

Rating of self-esteem - 1992/93
Ten-point rating scale

N = 35
FIGURE 24
Nordström (1989) - reported outcomes for the first 11 years of follow-up
"Good Social Adjustment Group"
N = 55
FIGURE 25
L.C.A.S findings for the follow-up period

Interviewed Customers

N = 38

%
APPENDIX 2

THE ASSESSMENT FORM OF 1981/82
INITIAL ASSESSMENT FORM

DATE: 
FILE: 
PRIME THERAPIST: 
URGENCY: Not at all 1 2 3 4 5 6 7 8 9 10 Very

ASSESSED BY: 
AAC No: 
CO-OP-SUPERVISOR:

WHERE: 
D/Thm No: 

NAME: 
ADDRESS: 
TEL. NO. 
HOW LONG AT THIS ADDRESS?

DATE OF BIRTH/AGE: 
SEX (M/F): 
EMPLOYMENT: YES / NO

PLACE:
MARRITAL STATUS: S / M / U / Sep / W

REFERRAL: 
Who referred? Self / Other (specify): 
Address:

Does referral agent want cont'd contact?

Agency of first contact: AAC / D/Hau / HASTINGS 
By: Telephone / Letter / In person

MEDICAL: 
G.P. Name: 
Address: 
Knowledge of problem? YES / NO 
Knowledge of referral? YES / NO

Current Medication:

Previous hospital admissions or medical contact for drink-related problems?
Where? When? For how long? What for?

Other contact with self-help/social agencies (e.g. A.A., Social Services, etc)
for drink-related problems? YES / NO

If YES, where & when:
PRESENTATION:

Drinking prior to interview? YES / NO
Comments:

Physical appearance:
Mood:
Intelligence:
Comments:

PRESENT PROBLEM DRINKING:

Beverages:
Amount (per day/week/month/) on average:
When starting to drink (e.g. early morning, lunchtimes, etc):
How long does a typical drinking session last?
Where drinking (predominantly): With whom (predominantly):
How long has drinking been problematic? ___ years/months/days
Behavioural/mood effects of alcohol (i.e. what do they get out of it):

What do they think triggers or cues them to drink?

What circumstances have led to their referral for a drink problem?

General comments:
<table>
<thead>
<tr>
<th>WITHDRAWALS</th>
<th>COMPLICATIONS</th>
<th>ASSOC'D PHENOMENA</th>
</tr>
</thead>
<tbody>
<tr>
<td>( ) Hangovers</td>
<td>( ) Poor appetite</td>
<td>( ) Anxiety</td>
</tr>
<tr>
<td>( ) Headaches</td>
<td>( ) Poor sleep</td>
<td>( ) Depression</td>
</tr>
<tr>
<td>( ) Nausea/vomiting</td>
<td>( ) Memory problems</td>
<td>( ) Sex problems</td>
</tr>
<tr>
<td>( ) Stomach pains/Cramps</td>
<td>( ) Disturbed perceptions</td>
<td>( ) Sudden mood changes</td>
</tr>
<tr>
<td>( ) Shakes</td>
<td>( ) Disorientation</td>
<td>( ) Frequent minor illnesses</td>
</tr>
<tr>
<td>( ) Sweating</td>
<td>( ) Paranoid</td>
<td>( ) Phobias/fears</td>
</tr>
<tr>
<td>( ) Palpitations</td>
<td>( ) Hallucinations</td>
<td>( ) Tinnitus (ringing, buzzing in ears)</td>
</tr>
<tr>
<td>( ) Blackouts</td>
<td>( ) Epileptic fits</td>
<td>( ) Missing work/appointments</td>
</tr>
<tr>
<td>( ) Tingling (fingers, toes)</td>
<td>( ) Weight problems (over/under)</td>
<td>( ) Accidents through drinking (specify)</td>
</tr>
<tr>
<td>( ) Others (specify):</td>
<td></td>
<td>( ) Hypertension</td>
</tr>
</tbody>
</table>

Comments:

DRINKING HISTORY:

Age when started: ___ years old
Preferred drink then: Beer / Cider / Wine / Spirits / Other (specify):
Early patterns: Perceived as problematic? YES / NO
Description (general):

Periods of non-problematic drinking (describe):

Ever abstinent since problem drinking began? YES / NO
For how long on average: When?
Problems:
Circumstances (i.e. why):
HOME ENVIRONMENT:

Marital status: __________________ For how long? __________________

With whom living?

Type of housing: House / Caravan / Flat / Bedsit / Lodgings / Hostel / N.F.A. / Other:

CHILDREN: How many? ______

AGES: Girls: ______ Boys: ______

Knowledge/attitudes to drink problem:

Extent of marital/familial conflict:

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

How much of this conflict is unrelated to drink? ___

Comments:

Partner's or Significant other's:

(1) Knowledge of problem? YES / NO
(2) Knowledge of referral? YES / NO
(3) Willingness to help with therapy? YES / NO
(4) Attitudes to drink problems:

Overall quality of marital/familial relationship:

Poor 1 2 3 4 5 6 7 8 9 10 Excellent

Comments:

Is anyone presently at risk? YES / NO

If YES, who?
EMPLOYMENT - PRESENT:

Present job/position:
(if unemployed, what is their trade or profession)

How long in present position?

In danger of losing job? YES / NO. If YES, is it drink-related? YES / NO

COMMENTS:

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

Very badly

Extremely well

Comments:

Overall job satisfaction:

Poor

Excellent

Comments:

EMPLOYMENT HISTORY:

Number of jobs over the last year (include casual employment): ___

Can you estimate the degree of job stability over their adult life?

Unstable

Stable

Comments:

Does drinking their present amount significantly affect their finances? YES/NO

Comments:

LEGAL INVOLVEMENT:

Ever involved with the police? YES / NO If YES, approx. how many charges?

1. How many of these charges involved drinking beforehand? ___

2. How many of these charges were actual drinking offences? ___

Number of charges within the last year ___

- any pending? YES/NO

- any fines pending? YES/NO

On probation now? YES / NO

If YES, Probation Officer's name & address:
SELF CONCEPTS/APPRaisalS:

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

1. In terms of it interfering with their life, how serious does the client
   consider his/her drinking to be?
   Not at all 1 2 3 4 5 6 7 8 9 10 Very

2. What is wrong with their drinking according to them?

3. How do they label themselves or describe themselves in terms of their
   drinking?

4. To what extent does he/she feel responsible for their drinking?
   Not at all 1 2 3 4 5 6 7 8 9 10 Completely
   If less than '10', who or what else do they think is responsible for it?

5. How does he/she feel about themselves (i.e. what is their self-esteem
   rating)?
   Negative 1 2 3 4 5 6 7 8 9 10 Positive
   Can they explain why?

Is their self-esteem drink-related?
   Explain:

General comments:
CLIENT'S PERCEIVED NEEDS AND PROBLEM AREAS:

ASSESSMENT CONCLUSIONS & SUGGESTED TREATMENT FOCI:
<table>
<thead>
<tr>
<th>REVIEWS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLIENT'S NAME:</td>
</tr>
<tr>
<td>PRIME THERAPIST:</td>
</tr>
<tr>
<td>CO-OPERATOR:</td>
</tr>
</tbody>
</table>

* 1 month review date: __________
* 3 month review date: __________

Assessment continued ......
APPENDIX 3

THE FOLLOW-UP ASSESSMENT FORM OF 1992/92
COMMUNITY ALCOHOL SERVICES
FOLLOW-UP

AAC NO: ..........  D/HSE NO: ..........  ASSESSED BY: .........................
DATE: .........................

CLIENT'S NAME: ETHNICITY: □ white
□ black - carib.
□ black - african
□ black - other
□ indian
□ pakistani
□ bangladeshi
□ chinese
□ other asian
□ other
□ refused
□ not asked

ADDRESS:

TELEPHONE NO:

How long at this address? ....... months/years
How many changes of address in the last 10 years? .........

Preferred language .....................

MEDICAL

Current Medication □ None
□ barbiturates □ anti-depressant
□ minor tranx □ opioids
□ major tranx □ other(s)
□ heminevrin

Any long term medication? (> 6 months) ...........

General Health Checklist:

□ Poor appetite □ Anxiety
□ Poor sleep □ Depression
□ Memory problems □ Sex problems
□ Disturbed perceptions □ Sudden mood changes
□ Disorientation □ Freq. minor illness(es)
□ Paranoia □ Tinnitus (ringing, buzzing in ears)
□ Hallucinations
□ Epileptic fits □ Missing work/appts.
□ Weight problems □ Accidents through drink
(over or under) (specify):
HEALTH

What is your weight .................

What is your height .................

Please CIRCLE the answer which you think most nearly applies to you. Please Circle only ONE answer for each question.

IN THE LAST MONTH:
have you smoked any cigarettes? YES NO

If YES:
About how many cigarettes have you smoked a day?
1-4 5-14 15-24 25 or more

IN THE LAST MONTH:
have you been dieting to lose weight? YES NO

If YES:
How many pounds have you managed to lose?
0 1-3 4-7 8 or more

IN THE LAST MONTH:
have you been exercising to get fit/to keep fit? YES NO

If YES:
On average, how many days per week have you been exercising?
1-2 3-4 5-6 Everyday
Other agencies contacted in last 10 years for drink-related problems?

Details:
(eg. when, where, what for, etc)

Summary

- GP
- Private doctor
- Accident & Emergency
- General Hospital
- Psychiatric Hospital
  (including day facilities)
- Other Medical
- Probation
- Social Services
- Voluntary Agency
- Prison
- Alcohol Treatment Unit (ATU)/Alcohol Day Centre
- Alcohol Therapeutic Community/Rehabilitation
- Community Alcohol Services
**RECENT DRINKING PATTERN**

What is your present drinking like?

How much has the client had to drink in the last 7 days: (work backwards with them from the day prior to assessment)

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<th>WEEKDAY: (eg Mon, Tues)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7 Yesterday</th>
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<td>Morning</td>
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<tr>
<td></td>
<td>Afternoon</td>
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<tr>
<td></td>
<td>Evening</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
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<tr>
<td><strong>GRAND TOTAL UNITS</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Was this a 'typical week' (in last month)  □ Yes □ No

If no, what is typical?

Beverage type ................. Amount ............. per day/week (delete)

When are you starting to drink? □ early morning □ evenings □ mid-day □ anytime

Where drinking (predominantly)?

With whom drinking (predominantly)?

What effects do you get from your drinking now? (behavioural/mood effects)
What do you think ‘triggers off’ or ‘cues’ drinking now?

Are you happy with your present drinking pattern?

1 2 3 4 5 6 7 8 9 10

Not at all happy

very happy

PHYSICAL CONSEQUENCES CHECKLIST

☐ headaches ☐ palpitations
☐ nausea/vomiting ☐ blackouts
☐ stomach pains/cramps ☐ tingling (fingers, toes)
☐ shakes ☐ other(s) (please specify)
☐ sweating

General Notes
Has you drinking gone through many changes over the past 10 years?
Tell me about it (approx no. of changes in patterns and reasons behind the changes).

Any periods of abstinence over the last 10 years?

☐ Yes  ☐ No

How long did it typically last?

Why did you stop drinking?
SEVERITY OF ALCOHOL DEPENDENCY QUESTIONNAIRE

1. During your worst heavy drinking period did you wake up feeling sweaty?
   
   ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS
   
   At the moment do you wake up feeling sweaty?
   
   ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

2. During your worst heavy drinking period did your hands shake first thing in the morning?
   
   ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

   At the moment do your hands shake first thing in the morning?
   
   ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

3. During your worst heavy drinking period did your whole body shake violently first thing in the morning if you didn’t have a drink?
   
   ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

   At the moment does your whole body shake violently first thing in the morning if you don’t have a drink?
   
   ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

4. During your worst heavy drinking period, did you wake up absolutely drenched in sweat?
   
   ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

   At the moment do you wake up absolutely drenched in sweat?
   
   ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

5. During your worst heavy drinking period did you dread waking up in the morning?
   
   ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

   At the moment do you dread waking up in the morning?
   
   ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS
6. During your worst heavy drinking period were you frightened of meeting people first thing in the morning?

   ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

   At the moment are you frightened of meeting people first thing in the morning?

   ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

7. During your worst heavy drinking period did you feel at the edge of despair when you awoke?

   ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

   At the moment do you feel at the edge of despair when you awake?

   ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

8. During your worst heavy drinking period did you feel very frightened when you awoke?

   ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

   At the moment do you feel very frightened when you awake?

   ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

9. During your worst heavy drinking period did you like to have a morning drink?

   ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

   At the moment do you like to have a morning drink?

   ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

10. During your worst heavy drinking period did you always gulp your first few morning drinks down as quickly as possible?

    ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

    At the moment do you always gulp your first few morning drinks down as quickly as possible?

    ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS
11. During your worst heavy drinking period did you drink in the morning to get rid of the shakes?

   ALMOST NEVER   SOMETIMES   OFTEN   NEARLY ALWAYS

   At the moment do you drink in the morning to get rid of the shakes?

   ALMOST NEVER   SOMETIMES   OFTEN   NEARLY ALWAYS

12. During your worst heavy drinking period did you have a very strong craving for a drink when you awoke?

   ALMOST NEVER   SOMETIMES   OFTEN   NEARLY ALWAYS

   At the moment do you have a very strong craving for a drink when you awake?

   ALMOST NEVER   SOMETIMES   OFTEN   NEARLY ALWAYS

13. During your worst heavy drinking period did you drink more than a quarter of a bottle of spirits per day (4 doubles or 1 bottle of wine or 4 pints of beer)?

   ALMOST NEVER   SOMETIMES   OFTEN   NEARLY ALWAYS

   At the moment do you drink more than a quarter of a bottle of spirits per day (or equivalent)?

   ALMOST NEVER   SOMETIMES   OFTEN   NEARLY ALWAYS

14. During your worst heavy drinking period did you drink more than half a bottle of spirits per day (or 2 bottles of wine or 8 pints of beer)?

   ALMOST NEVER   SOMETIMES   OFTEN   NEARLY ALWAYS

   At the moment do you drink more than half a bottle of spirits per day (or equivalent)?

   ALMOST NEVER   SOMETIMES   OFTEN   NEARLY ALWAYS

15. During your worst heavy drinking period did you drink more than one bottle of spirits per day (or 4 bottles of wine or 15 pints of beer)?

   ALMOST NEVER   SOMETIMES   OFTEN   NEARLY ALWAYS

   At the moment do you drink more than one bottle of spirits per day (or equivalent)?

   ALMOST NEVER   SOMETIMES   OFTEN   NEARLY ALWAYS
16. During your worst heavy drinking period did you drink more than two bottles of spirits per day (or 8 bottles of wine or 30 pints of beer)?

ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

At the moment do you drink more than two bottles of spirits a day (or equivalent)?

ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

IMAGINATIVE SITUATIONS:

1. You have been COMPLETELY off drink for a FEW WEEKS
2. You then drink VERY HEAVILY for TWO DAYS

HOW WOULD YOU FEEL THE MORNING AFTER THOSE TWO DAYS OF HEAVY DRINKING?

17. I would start to sweat

NOT AT ALL  SLIGHTLY  MODERATELY  QUITE A LOT

18. My hands would shake

NOT AT ALL  SLIGHTLY  MODERATELY  QUITE A LOT

19. My body would shake

NOT AT ALL  SLIGHTLY  MODERATELY  QUITE A LOT

20. I would be craving for a drink

NOT AT ALL  SLIGHTLY  MODERATELY  QUITE A LOT
HOME ENVIRONMENT

Present Civil Status:

- [ ] single (never married)
- [ ] divorced
- [ ] married/co-hab
- [ ] widowed
- [ ] separated

For how long? ..........

Any changes in people with whom living (from 10 years ago):

Children: Any additions in the family?  [ ] Yes  [ ] No

If YES, who?

Overall, how well do you (all) get on together?

1 2 3 4 5 6 7 8 9 10

Poor

Is there much conflict in your relationship(s)/home life?

1 2 3 4 5 6 7 8 9 10

None at all

What does your partner's (significant other's) think of your present drinking pattern:

1 2 3 4 5 6 7 8 9 10

Totally unhappy

Totally happy

EMPLOYMENT

Present employment status:

- [ ] paid employment
- [ ] unemployed
- [ ] voluntary worker
- [ ] houseworker
- [ ] student
- [ ] retired
- [ ] sick/invalidity

How many different jobs in the past decade? ..........

Any periods of not working?  [ ] Yes  [ ] No  For how long? ..........

Generally, how well do you get on with your co-workers?

1 2 3 4 5 6 7 8 9 10

Very badly

Extremely well
Overall job satisfaction if employed/houseworker?: □ not applicable

1 2 3 4 5 6 7 8 9 10

Poor Excellent

LEGAL INVOLVEMENT

Any police involvement over the past 10 years? □ Yes □ No

If YES, how many charges? □

What proportion of these involved drinking beforehand? □ %

What proportion of these involved drink driving? □ %

SELF CONCEPTS/APPRaisalS

The following scales are to be rated by the client and not by the assessor, unless absolutely necessary (please indicate if you have done so).

1. In terms of it interfering with your life, how serious a problem do you consider your drinking to be now?

1 2 3 4 5 6 7 8 9 10

Not at all Very problematic

If greater than '1', with what is your drinking interfering?

2. What remains to be wrong with your drinking pattern?

3. What kind of a drinker would you call yourself now?

□ abstainer (teetotaller)  □ problem drinker  □ other
□ light social  □ heavy drinker
□ moderate social  □ alcoholic
□ heavy social

4. To what extent do you feel personally responsible for the way your presently drink?

1 2 3 4 5 6 7 8 9 10

Not at all Very

If less than '10', to what do you attribute responsibility for your drinking?
5. How do you feel about yourself now (i.e., self-esteem rating)?

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

Can you attribute these feelings to anything specific?  Yes  No

Please explain:

General Notes

GENERAL INFORMATION

1. Do you remember being in contact with the Services?  Yes  No

2. What do you remember of it?

3. What were the good bits you remember about our contact with you?

What were the bad bits?

Looking back, did the Services make any difference?
4. Would you recommend the Service to anyone else?  □ Yes  □ Maybe  □ No

5. Overall how was your contact with us?
   1  2  3  4  5  6  7  8  9  10
   very
   helpful
   very
   unhelpful

6. How could we have improved our Service?

7. What sorts of things are you aiming for in life now?
APPENDIX A

THE POSTAL QUESTIONNAIRE
1. COMPARE WITH 10 YEARS AGO, HOW IS YOUR DRINKING NOW?

<table>
<thead>
<tr>
<th>a lot worse</th>
<th>worse</th>
<th>no change</th>
<th>better</th>
<th>a lot better</th>
</tr>
</thead>
</table>

COMMENTS:

2. HOW DO YOU FEEL ABOUT THIS?

<table>
<thead>
<tr>
<th>very dissatisfied</th>
<th>dissatisfied</th>
<th>not sure</th>
<th>satisfied</th>
<th>very satisfied</th>
</tr>
</thead>
</table>

COMMENTS:

3. DOES YOUR CURRENT DRINKING INTERFERE WITH YOUR LIFE?
(please circle one number)

| not at all | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | very much |

COMMENTS:

4. WHAT KIND OF A DRINKER WOULD YOU CALL YOURSELF NOW?

- abstainer (teetotaller)
- light social
- moderate social
- heavy social
- problem drinker
- heavy drinker
- alcoholic
- other (specify)

COMMENTS:

5. OVERALL, HOW WAS YOUR CONTACT WITH THE COMMUNITY ALCOHOL SERVICES? (please circle one number)

| very unhelpful | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | very helpful |

COMMENTS:

THANK YOU.
APPENDIX 5

THE "SELF-REPORTED DRINKING PATTERN" SHEET
### Self reported drinking pattern

<table>
<thead>
<tr>
<th>Year</th>
<th>D.H. Number</th>
<th>Typical units per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>1981/82</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Description:**

Recall of drinking:

<table>
<thead>
<tr>
<th>Year</th>
<th>Significant events</th>
</tr>
</thead>
<tbody>
<tr>
<td>1982</td>
<td></td>
</tr>
<tr>
<td>1983</td>
<td></td>
</tr>
<tr>
<td>1984</td>
<td></td>
</tr>
<tr>
<td>1985</td>
<td></td>
</tr>
<tr>
<td>1986</td>
<td></td>
</tr>
<tr>
<td>1987</td>
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<td>1988</td>
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<tr>
<td>1989</td>
<td></td>
</tr>
<tr>
<td>1990</td>
<td></td>
</tr>
<tr>
<td>1991</td>
<td></td>
</tr>
<tr>
<td>1992</td>
<td></td>
</tr>
</tbody>
</table>

**1992/93 Follow-up:**

Typical units per week... Description:.................................

.................................................................
APPENDIX 6

THE "L.C.A.S./NORDSTROM COMPARISONS" SHEET
<table>
<thead>
<tr>
<th>L.C.A.S./Nordström comparisons</th>
</tr>
</thead>
</table>

Name of rater: 

Drury House number: 

Paul's rating:  

--- | --- | --- | ---

--- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |

Comments from Paul: 

Tick box if you agree with the above: [ ]

Your own rating if you disagree:  

--- | --- | --- | ---

--- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |

Your comments if you wish: 

---
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