

13 TREATMENT-SEEKING POPULATIONS AND LARGER REALITIES

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At least in the United States, everyone who has worked in the epidemiology of alcohol problems must at one time or another have been asked the question, 'but how many alcoholics are there in the population?' It is, in fact, a source of considerable frustration to such researchers that this seems to be the only question that seriously interests policy-makers in their work. And it is a source of even greater frustration to policy-makers that the researchers often decline to come back with a single concrete figure.¹

The present chapter is about this issue of numbers and the other issues that it raises, and more generally about the relation between a treatment system and those who might need its services. It will draw mostly on US experience. But this parochial approach may still have relevance for other societies, for there are a number of ways in which the US experience is instructive. Not the least of these is to examine what may happen if the issue of numbers is taken seriously by a society. For, albeit in a halting and half-conscious way, the US has tried over the last 35 years to do just this, to patch together a treatment system that is capable of treating alcoholism wherever it is found in the population. Whatever its shortcomings and peculiarities, there is now in the US a very large treatment system for alcoholism, and this represents an astonishing social change in a relatively short period of time. Although the figures in Table 13.1 are rough and incomplete, they give a concrete sense of the magnitude of the change in the US in the space of one generation: an increase of at least 20-fold in the caseload treated for alcoholism in what may be broadly construed as health institutions.

The Alcoholism Movement and the Treatment Establishment

This change did not come about by accident or inadvertence, but because of the efforts of a sustained social movement, the alcoholism movement, which has dominated thought and action about alcohol problems in the United States since the early 1940s. When we think of this movement, we normally think in terms of its governing image,² the

205

Griffith Edwards and Marcus Grant, eds.,
Alcoholism Treatment in Transition.
London: Croom Helm, 1980.

Table 13.1 Alcoholism Treatment Caseload in the US, 1942 and 1976 (partial and approximate figures)

	1942	1976
State mental hospitals	10,461 ^a	106,615 ^c
Private mental hospitals	4,754 ^b	10,827 ^c
Public and other general hospitals	22,147 ^b	481,000 ^{c,d}
Special institutions for alcoholics	6,689	federally-funded alcoholism programmes (except CMHCs and drinking driver) 308,929
Veterans Administration hospitals	3,886	95,000
Small numbers for Alcoholics Anonymous, outpatient programmes, non-medical institutions (missions, rehabilitation farms, etc.)		Community mental health centres 121,300 ^c Drinking driver programmes 49,472 ^c Military programmes 40,000 Indian hospitals 137,000 Halfway houses Alcoholics 36,000 Anonymous 320,000
Total US resident population	133 m	214 m

Notes:

- a. 1940.
- b. Incomplete returns.
- c. 1975.
- d. Apparently does not include 89,057 psychiatric caseloads in general hospital services.

Sources: 1942: Corwin, E.H.L. and Cunningham, E.V., 'Institutional Facilities for the Treatment of Alcoholism', *Quarterly Journal of Studies on Alcohol*, vol. 5, (1944).

1976: Mental Hospitals: 'President's Commission on Mental Health', Appendix, vol. II (1978), p. 102; all other figures: 'PCMH', Appendix, vol. IV (1978), p. 2096.

classic disease concept of alcoholism, as initially reshaped from available cultural materials by Alcoholics Anonymous^{3,4} for the fellowship's own internal therapeutic purposes, and later translated into scholarly terminology by Jellinek^{5,6} and others. In accordance with this governing image, all alcohol problems, or at least all problems of concern to public health policy, could be subsumed under and regarded as symptoms or manifestations of a single disease entity characterised by the experience of loss of control over drinking.

But the alcoholism movement came to have not only a governing

image but also a plan of action that extended beyond the self-help efforts and personal proselytism of the Alcoholics Anonymous fellowship. In the early 1940s a few recovered alcoholics with public relations expertise, aided by the scholar-entrepreneurs of the Yale Center of Alcohol Studies, set out on a programme to establish alcoholism as a public health concern of the society. The disease concept, in their view, carried implications beyond its therapeutic utility for individual alcoholics:

Sickness implies the possibility of treatment. It also implies that, to some extent at least, the individual is not responsible for his condition. It further implies that it is worthwhile to try to help the sick ones. Lastly, it follows from all this that the problem is a responsibility of the medical profession, of the constituted health authorities, and of the public in general.⁷

While Alcoholics Anonymous emphasised self-help and declined external assistance or alliances, this outward-directed face of the movement adopted a very different programme. Its major strategy for social action very early became focussed on the classic public health approach to the problem: the involvement of the state in alcoholism treatment. Under the movement's impetus, by 1952, 38 states had 'passed laws recognising alcoholism as a public health problem and creating boards or commissions to establish programs'.⁸ In the 1960s the focus turned to the federal level, resulting eventually in the creation of the National Institute on Alcohol Abuse and Alcoholism in 1970, with a system of incentives that also forced the establishment of a 'single state agency' to handle alcoholism in every state.

The thought and work of the alcoholism movement thus largely underlie the persistent question, 'How many alcoholics are there in the population?', with which this chapter started. The movement's governing image of alcohol problems as a single disease entity, 'alcoholism', leads to a focus on a single figure which will represent the number of 'alcoholics'. The movement's emphasis on state action has resulted in the attention to the overall size of the problem as a system planning need, and indeed has created the alcoholism agency bureaucrat who is asking the question.

General Population Studies and the Issue of Numbers

While the question of the number of alcoholics arose early, those studying drinking patterns and problems in the general population were long shielded from having it posed to them by the popularity of answers in terms of simply-derived indirect estimates, notably in terms of the Jellinek formula. But as the news of the untenability of that formula's assumptions percolated out in the late 1950s and 1960s, the questioning of those engaged in general population studies of drinking became more frequent and indeed insistent. At the federal level, the most formal expression of this to date resulted from a Congressional mandate to build a 'needs' estimate into the formula for allocating federal alcoholism services money between the states, in response to which a survey-derived estimation procedure, developed by the National Center for Health Statistics, was promulgated in federal regulations.^{9,10}

When systematic work on studies of drinking practices and problems in the US general population was getting under way around 1960, however, researchers were not under a great deal of pressure to address immediate policy agendas, and thus often felt free to define and measure their variables in their own way. In the eclectic and atheoretical tradition of survey research in general, the common solution was to collect a variegated series of actual and potential problems with drinking, along with measures of drinking behaviour, reasons for drinking and abstaining, and attitudes about drinking. In analysis, researchers would commonly take the plunge toward relevance and identify some summary scale of the items as a 'problem drinking' or 'alcoholism' score.

Although researchers to a greater or lesser extent would tiptoe up to the prevalence of alcoholism question somewhere in their analysis, this was by no means the focus of their analysis, and it was not until the 1970s that any survey-based estimates of the number of alcoholics gained general currency. Meanwhile, the researchers were occupied with the description of drinking behaviours and problems as they found them in the general population.

While the summary measures varied from one study to another, they tended to draw on a common pool of underlying items, which varied only in detail in their expression in individual studies. This was because, with whatever variations a study team found desirable for clarity or originality, the studies, carried out by survey researchers then generally fairly new to the alcohol field, drew on common traditions. For

drinking behaviour and reasons for drinking, there was a survey research tradition dating back to Straus and Bacon¹¹ and Riley and Marden.¹² For drinking problems and 'alcoholism' measures, the source was the disease concept of alcoholism, as interpreted conceptually by Jellinek in the WHO definition or by Keller, and as represented in concrete items by the AA-designed questionnaire and Jellinek's proposed version of it in the 1946 Grapevine Study. Although researchers thus had varying degrees of commitment to the disease concept, they found themselves willy-nilly making their general population measures with items defined in its terms. Often without any systematic intention, the researchers thus found themselves in a position to compare 'symptoms of alcoholism' as manifested in the general population with those manifested by alcoholics in clinics.

General-population Alcohol Problems Versus Clinical Alcoholism

Often by accident, and sometimes without realising the implications of their findings, general-population researchers thus stumbled into several puzzling or provocative discoveries about 'alcoholism' as manifested in the general population, in comparison with alcoholism in clinical populations.

In the first place, the rate of alcohol problems in the general population varied considerably by the indicator chosen, and for most criteria and samples was very much greater than the clinical caseload of 'alcoholics'. Clark¹³ neatly demonstrated that the rate could be varied within very wide limits according to the criteria chosen. Furthermore, there was no natural cutting point which distinguished 'normal drinkers' from 'alcoholics': any particular cutting point was thus inherently arbitrary.

The fact that rates shown by general-population measures of drinking problems were higher than the clinical caseload excited little surprise in the US. For one thing, the patchwork quality of the US health services makes an unduplicated count of treated alcoholics impossible to attain. For another, Jellinek formula estimates had established a climate of expectation that general-population rates of 'alcoholism' would be at least three per cent. Most importantly, the finding fitted an already prevalent rhetoric which proposed that 'hidden alcoholics' far outnumbered those identified and treated as alcoholics^{14,15} — a rhetoric which was related to the purposeful de-emphasis of skid row as a locus of alcoholism¹⁶ and the assumption, drawn from

AA experience, that alcoholics would deny their problem until they 'hit bottom'.¹⁷

Despite the political acceptability of the relatively high rates of 'alcoholism' implied by general-population surveys, estimates based on surveys, though they can occasionally be found earlier, did not come into vogue in the US until the 1970s. Discrepancies between estimates based on surveys and other estimates were often regarded in the US as a vague source of embarrassment rather than as a matter for comment and investigation. It was actually British researchers who most systematically drew attention to the differences between survey prevalence estimates and treated prevalence, as measured in reporting agency studies.^{18,19} Both Edwards and Wilkins noted that estimates based on questionnaire data showed far higher rates of alcoholism than estimates based on records in reporting-agency studies.

Following this lead, Edwards and co-workers actually empirically measured the overlap between a reporting-agency study and a survey in the same district, and found that only somewhere between one in four and one in nine of those identified as 'problem drinkers' by the survey were known to agencies.^{20,21}

In the US, at least, it was the survey researchers themselves who were most acutely uncomfortable when their results were interpreted as prevalence rates of alcoholism. The researchers were too well aware of the arbitrariness of definitions and cutting points involved in any survey-based measure of 'alcoholism'.²² On a variety of occasions, they pointed out that plausible-sounding definitions could yield 'problem drinker' rates ranging up to one-third of the male population. The usual response of interpreters of their findings was to ignore such inconveniently large estimates.

In the second place, alcohol problems in the general population looked different from the picture in clinical populations. The first systematic report using comparable questions on general and clinical populations was published by Mulford and Wilson.²³ On the basis of data published in this report, it could be seen that the patterns of response of hospitalised alcoholics differed from those of general-population samples.²⁴ Further, a sample of non-institutionalised known alcoholics gave reports different from and intermediate between the clinical and general-population samples — a finding which Mulford and Wilson tended to regard as a methodological difficulty, but which could also be seen as having substantive implications.

In the work in the tradition of Knupfer,²⁵ Clark¹³ and Cahalan²⁶ the question of the dissimilarity of alcohol problems in clinical and

general-population samples was somewhat obscured by the researchers' concomitant argument for a 'drinking problems' perspective rather than an 'alcoholism' perspective. Certainly by the early 1970s, however, the argument was being made very explicitly that alcohol problems in the general population not only did not match the classic disease concept of alcoholism but also did not resemble alcoholism as it empirically appeared in clinical samples.²⁷

In general, the picture which emerged in general-population data was of alcohol problems much more diffuse and sporadic than the clinical picture had suggested. While the classical descriptions of the disease concept of alcoholism had presented it as an accumulation of symptoms in a determinate order (a characterisation which overstated the case even for clinical populations²), in the general population a particular problem with drinking was only modestly associated with other drinking problems and provided only a modest prediction of future problems.

In part, this finding could be seen as resulting from the criteria for 'problem drinking' or 'alcoholism' used in general population studies. The classical descriptions of alcoholism were conjunctive: alcoholics had symptom A *and* symptom B *and* symptom C. But, although researchers struggled to maintain some element of conjunctivity, the criteria they settled on were largely disjunctive: item A *or* item B *or* item C. The problem with attempting to use a fully conjunctive definition, as Mulford found, was that 'to employ indicators for *all* the descriptions of the species of alcoholism given by Jellinek soon eliminates virtually all cases'.²⁸

Again, while it was easy to see this problem as a methodological embarrassment, it also held substantive complications. Perhaps what was being measured as alcoholism or drinking problems in the general population was qualitatively as well as quantitatively different from alcoholism as it appeared in the clinic. Somewhat tentatively, researchers began to think in terms of the 'two worlds of alcohol problems',²⁹ clinical and general-population.

It might be noted that a similar development occurred in measuring the prevalence of psychiatric disorders in the general-population. In the Midtown Manhattan study, researchers concluded that 23 per cent of the population were 'impaired', which was seen as 'analogous to patients in psychiatric therapy'. But later research suggested that such criteria included many cases less 'severe' than the typical clinical case.³⁰ Again, the diagnostician's tendency to define clinical categories inclusively, so as to avoid all risk of false negatives, seems to have played into the survey researcher's need to have a workable number of 'positive' cases.

But if alcohol problems in general populations look different from

clinical samples of alcoholics, the question arises of how many people in the general population resemble those in clinics in their drinking behaviour and problems? This, it might be argued, is the true population of 'hidden alcoholics', and not the much larger number projected from survey drinking-problems scores.

It appears that there are no really satisfactory answers to this question yet, although work under way, for instance on the World Health Organisation study of Community Response to Alcohol-related Problems, will help provide some answers. In a general population study in San Francisco, it was found that the criterion in terms of tangible consequences of drinking has to be made very stringent to yield a general-population sub-group with a distribution on amount of drinking similar to clinical samples of alcoholics. About one per cent of the population met this criterion.³¹ A finding in the work of Armor *et al.*³² provides some corroboration. Their group of 'problem drinkers', identified out of general-population surveys with a criterion partly based on consumption, comprised only about three per cent of the general population, and yet the males reported only about half the daily consumption of alcohol reported by a male sample of clinical alcoholics.

If only about one per cent of the general adult population drink as much as those in treatment for alcoholism this puts the problem of the 'hidden alcoholic' in a new light. With a treatment system for alcoholism in the US that is now serving maybe one million clients in the course of a year,³³ the number of people in the general population who resemble those in clinical populations may be no larger than the number in treatment or recently out of it.

In the third place, problem drinkers in the general population show a different demographic profile from clinical alcoholics. Armor *et al.*'s³² comparisons show a number of differences in a convenient form; we will zero in here on a couple which seem especially implicative.

(1) The clinical alcoholic population is much more likely to be employed or to be in marginal jobs, and to be divorced or separated. These general characteristics of clinical alcoholics can be found repeated in any number of studies. One-half of all clients in US alcoholism treatment facilities are separated or divorced, and about 60 per cent are currently not employed. These characteristics are not unique to alcoholism treatment populations: similar patterns can be found for other institutionalised populations such as mental hospital patients. The similarities in demography across institutionalised populations suggest that alcoholism treatment may be simply one among a number of

alternative dispositions for spare and awkward people, so that the increase in treatment for alcoholism in the last 40 years in the US needs to be fitted into a larger framework including, for instance, the decline in tuberculosis hospital and mental hospital caseloads in the same period.³⁴

To some extent, then, those in treatment for alcoholism differ from problem drinkers in the general population in being 'spare people' individuals who are no longer tied to conventional work and family roles. We may suspect that the process of entering treatment is to some extent a process of extrusion from the general population, that many clients come to treatment after having exhausted their moral credit with employers and families, and seek to gain from the treatment a re-establishment of their moral credit. It should be noted that the moral credit seems to be harder to rehabilitate than the drinking behaviours which presumably resulted in the discrediting. Armor *et al.*³² found little effect of alcoholism treatment on employment, earnings, or marital status.

(2) The clinical alcoholic population is much older than the general-population problem drinking population, particularly among males. In Armor *et al.*'s³² data, the clinical population's median age is twelve years older among males, and four years older among females. That heavy drinking^{35,36} and all kinds of drinking problems^{24,37} are heavily concentrated among young males is one of the best established patterns in general-population data. It was recognised quite early that this pattern differed sharply from the pattern for samples of treated alcoholics, which typically are concentrated in the age range of 35-60.

Again, that treated alcoholics are in their 40s and 50s supports the conception of treatment as the end-point in an often lengthy process of compounding of drinking problems in different life areas. At first glance, that clinical alcoholics are older than general-population problem drinkers also provides some support for the notion that these are simply two stages of the same population: that the general-population problem drinkers of today are the alcoholics in treatment of tomorrow. As it has gradually become clear that drinking problems in the general population are not simply clinical alcoholism writ large, this notion of the relation between the two populations has become widely accepted. The assumption of a close coupling between the two populations has also become a major justification for case-finding and intervention among general-population problem drinkers.

The flaw in these perspectives is that the linkages between the populations are not particularly close. This is especially true for the

time linkage among males: the distribution of drinking problems by age in the general population is quite discontinuous with that in the clinical population: one peaks before age 25 and the other in middle age. There is also a great disparity in numbers: as we have noted above, the problem drinking population is very much larger than the population of treated alcoholics. Thus most people reporting drinking problems in the general population never go on to receive treatment for alcoholism. Furthermore, while aggregate rates of drinking problems in the population are relatively stable, there is a great deal of turnover from one year to the next in who is manifesting the problems. Filmore *et al.*³⁸ have shown this also to be the case over the longer term: experiencing drinking problems as a college student is not a very powerful predictor of drinking problems in middle age. It even seems in this data set that those with the most florid problems as college students are more likely than some other groups to 'mature out' of their problems. All these findings imply that catching and treating young problem drinkers is not likely to be an efficient way of forestalling clinical alcoholism — even if we are convinced we have an effective treatment for youthful drinking problems.

Problems in Defining and Measuring Need for Services

Our general conclusion from these various comparisons of drinking problems in the general population with clinical samples of alcoholics, thus, is that alcohol problems outside the clinic are not simply the projection on to a larger population of alcohol problems inside the clinic. A treatment system that is proposing to move toward active case-finding and tackling alcohol problems in the larger society is therefore going to need not only larger resources but also new strategies and methods of approach. Nevertheless, survey-based estimates of rates of drinking problems in the population are now firmly established in the US as a basis of defining need for services in an area. Thus a paper by Marden³⁹ describing a simple synthetic estimation procedure which adjusts Cahalan's²⁶ national rates to a treatment catchment area on the basis of demographic composition, has at times been routinely sent out with application kits for federal treatment grants.

Such an estimation procedure equates two populations, treated alcoholics and general-population problem drinkers, who are in many ways incommensurate. But it seems to me that the problems with such procedures extend beyond this, and beyond their questionable

assumption of the invariability of the relation of drinking problems and demographics in different places. A major problem lies in the ambiguous meaning of the word 'need' when we talk of need for services. Who is to define what constitutes a need for service? To base the definition upon existing data is to put it in the hands of a survey researcher who had quite different considerations in mind on constructing the scales and cutting-points. To tie survey criteria more closely to diagnostic standards, as has been the practice of Guze, Robins and co-workers at St Louis or Weissman at New Haven, transfers the definition of need into clinical hands. But this does not bring us any closer to an estimate of the likely queue outside if a clinic opens its door. As mentioned earlier, the clinician in his or her work is properly more concerned about false negatives than false positives, and in the alcohol and mental health areas it is clear that the general population is often tolerant of deviations in behaviour a clinician would regard as needing immediate treatment. Self-definition of need, or definition of need by significant others, are both quite different from a clinician's definition of need — or from definitions of need by other important actors, such as the merchant on whose doorstep the drunk is sitting. Behind the term 'need', thus, lies a whole agenda for investigation rather than assumption about the circumstances in which people come into treatment — as well as important ethical issues about rights to treatment and to non-treatment.

Some Features of the US Treatment System

As noted at the outset, the recent US history of alcoholism programmes is in a way an experiment in what happens when the treatment capacity is greatly expanded in a society. Even at the risk of resorting to the anecdotal and speculative, it seems worth making some observations on what appear to be some results of the experiment.

One obvious result is that many people identified as alcoholics are getting care and assistance who in former times would have received neither. Observers have often commented on the paradox that, while the alcoholism movement emphasised the disease nature of alcoholism the era of the movement's triumph has seen an explosive growth in free-standing alcoholism treatment centres rather than an integration of alcoholism treatment into general health and mental health services. This development did not happen by accident, or indeed often as a first choice. As resources started becoming available for alcoholism treatment,

the initial approach, for instance by Loran Archer in California, was to buy a place for the treatment in existing health and mental health systems. The hard experience was that the systems took the money but did not provide the equivalent services: frequently the alcoholic remained underserved and unwanted. As Shaw *et al.*⁴⁰ and Robinson⁴¹ have documented in the British health system, along with a formal referral system often goes an informal system of discouragement and disowning. To a considerable extent, the construction of a separate alcoholism treatment system in the US was a gesture of despair about the reorientation of the general health and mental health systems towards providing humane and effective service to alcoholics.

One striking feature of alcoholism treatment services in the US is that, although they are largely government-funded, they operate with a strongly entrepreneurial flavour. Whether the funding is through direct appropriations, grants, or contracts, there is a great deal of explicit competition for resources in the system. This has produced a great emphasis on public relations, on glossy brochures and optimistic reports and evaluations. It has also meant that treatment organisations are very sensitive to the winds of funding change, and many are quite flexible about treating whatever is the policy priority of the moment — teenage alcoholics, pregnant heavy drinkers, battered wives, urban Indians. The administrators of the organisations are, in fact, experts in discovering precisely the niches in their funding and service environment which will be most advantageous to their organisation. Thus the system as a whole can change its character and orientation quite rapidly. In the late 1960s California discovered that a greater leverage on federal funds could be obtained by characterising alcoholism as a vocational disability. As a result, for a while in California, if you didn't have what could qualify as a vocational disability you couldn't be treated for alcoholism.

This adaptability and entrepreneurial orientation has resulted in a considerable differentiation of treatment services for alcohol problems, as treatment organisations discovered opportunities attached to particular institutions or social problems. The funding from a highway safety agency would result in a drunk driver treatment programme, corporate concerns about alcohol-related loss of productivity would result in an industrial alcoholism programme, urban development funds would result in a public inebriate programme, and law enforcement concerns about alcohol and crime would result in a criminal diversion treatment programme.

In the initial stages of this differentiation, the programmes were

conceptualised as conventional alcoholism treatment programmes which were simply being carried out in different environments. Often, indeed, the programmes were justified as especially efficient and effective ways of finding and treating alcoholics. But as time has passed, the programmes have responded to the very different populations and circumstances they each encountered, and the hegemony of a unitary disease concept of alcoholism as the definition of what was being treated has begun to fade. Programme managers are gravitating towards a 'disaggregated' model of alcohol problems, where each particular kind of problem is treated in its own terms — a model which originally derives from the survey studies of drinking problems in the general population.

The differentiation of alcohol problem treatment services and the drift towards conceptual disaggregation perhaps also reflects some realities about the client population which emerged, at least as a private knowledge of those in the treatment agencies, as the system expanded. The treatment system began to run short of people to treat — at least people who fit the conventional disease concept of alcoholism. Observers report that people in the agencies use such euphemisms as 'political realities' to refer to the need to undertake active scrounging for new cases to keep the beds full. In the 'private sector' of treatment, primarily funded by job-based group health insurance coverage, programme entrepreneurs are more direct about their basic necessity — it is 'bed-selling'.

Finding the Clients to Fill the Beds

There have been at least four kinds of response to the problem of filling the treatment slots, often pursued in combination with each other. One has been to make the treatment more attractive to the clients. This is a welcome direction for any government-funded health and welfare activity to take, and has resulted in the halting first signs of a consumer satisfaction literature for alcoholism treatment.⁴² But often what the clients directly want — for instance, a 'wet hotel' where skid row folk can do their drinking off the street — a government-funded service cannot provide, for moral and ethical reasons. And sometimes the result has been that the treatment service becomes a travesty, as for instance where the main function is as a laundromat for clients.

A second response has been to seek out new 'underserved' demographic segments of the population and provide special alcoholism

treatment services for them. This response has been notably applied for various ethnicities, for women and for youth. Such an approach has undoubtedly broadened the scope and coverage of the treatment system. But to require that clients be from special demographic categories potentially exacerbates the problem of filling the treatment slots. Thus when Chaucey⁴³ set out to study the 'teenage alcoholics' in the programmes set up in response to a wave of public concern in the last few years, he found himself studying instead how something gets defined as a social problem, when there are essentially no cases which show up for treatment in the programmes designed to meet the problem.

A third response has been diversification into treatment of specific problem areas already mentioned. Orientation of a programme around a specific problem-area potentially draws in a client who could not fit a global 'alcoholism' criterion (although to meet the administrative necessity of maximum inclusiveness such global criteria, as in the NCA criteria, have often been stretched very wide). In fact, as the diversification proceeds, the target group increasingly becomes the whole general-population drinking problems spectrum rather than the classical alcoholic. Depending on the area and case-selection methods involved, special-area treatment populations may come much closer to resembling the general-population problem drinkers than clinical alcoholic samples. This has been a common experience, for instance, with drinking driver treatment programmes. Thus the drinking-driver clients looked so different from the other alcoholism treatment clients in the federal treatment monitoring system that the RAND report analysts dropped the drinking-drivers from their analysis.³²

A major problem with the trend towards treating particular drinking problems rather than alcoholism is the frequent lack of developed rationales around which to organise the treatment. How, for instance, does one treat a drunk driver for his or her drink-driving problem, if the driver does not fit a classical alcoholism model? Except for some behaviour therapists, few treatment theoreticians or researchers have perhaps faced this general issue.

Roizen⁴² found that in the absence of other ideas, and with a strong *in their* AA presence on their staff and another ideology, many treatment agencies fall back on a watered-down classical alcoholism treatment strategy even in the most unpromising situations. The first step, as always, is thus to attempt to convince the client that he or she has an alcoholism problem.

A fourth response is the resort to compulsion in one form or another.

This response is perhaps the most pervasive but the least noticed, since the forms of compulsion have diversified beyond the traditional court commitment for treatment or police arrest for public drunkenness. Formally, at least, the client is usually offered a 'choice', though the incentives are often so heavily weighted that the offer cannot rationally be refused. One knowledgeable probation officer in Southern California offered the estimate that 80 per cent of the people in treatment for alcohol-related problems were there under some kind of court coercion.

Kindly or other coercion has always played a large part in the process of coming into treatment for alcoholism. Over half of the calls to alcoholism referral agencies are from relatives or other interested parties rather than from the potential client himself or herself; threats and ultimata from worried or fed-up spouses propel many alcoholics in the clinic door. But the growth of resort to coercion as a means of filling the treatment slots has some new and worrisome features to it. And the lack of public discussion of coercion into treatment as an issue has meant that ethical dilemmas involved have not been faced.

Roizen reports that at some alcoholism treatment agencies there is a saying that clients come into treatment because of the 'four Ls' – liver, lover, livelihood and the law. Leaving aside the undoubted truth that many people come into treatment for alcoholism because they feel very sick, and concentrating on the other three Ls, perhaps the most explicit discussions of coercion are in the 'livelihood' area. 'Constructive coercion' or 'confrontation' was explicitly discussed as a technique in industrial alcoholism programmes as early as 1967.⁴⁴ The high rate of success claimed for such programmes is often attributed to the effectiveness of the threat being held over the client's head. But in the industrial field, there are some limits on the coercion: there is a general norm that a company should be concerned only with work performance, and not with what employees do in their spare time if it does not affect performance; there are often legal protections of job security imposing due-process requirements; and labour unions frequently act as advocates for the interest of the potentially coerced client. In the area of 'lovers' – family coercion – there are, of course, no such procedural safeguards, nor would most of us desire them. But this offers an open field for the operation of an entrepreneurially-inclined agency seeking to fill its beds. Consider, for instance, the following scenario for the routinised 'intervention' efforts of a corporation offering hospital treatment for alcoholism in a nationwide chain of facilities, usually paid for by health insurance coverage. The spouse – let's say the wife – who has called in response to a brochure arguing that such a call is an act of

love is encouraged to come in. After a staff assessment of the problem, she is coached on assembling a bill of facts (rather than judgement) to present to her husband on his problems from drinking, and encouraged to bring other significant parties – the children, and sometimes the employer – to a formal rehearsal where each is coached on the ultimatum they are prepared to give and follow through on if the husband does not enter the treatment programme. The session at which these prepared positions are presented is attended also by the corporation staff person involved.

This scenario is worrying on several counts. No amount of rhetoric about 'tough love' can obscure that the results of this intervention will sometimes break the Hippocratic injunction that treatment should 'do no harm'. The corporation is potentially using the ambiguity of who is the client and the cover of family informality to break the drinker's privacy with regard to his employer. Most problematically, the process of intervention and constructing a coercive situation is a matter of direct economic significance to the treatment staff.

Such routinised and explicit procedures may not exist at directly government-funded treatment facilities in the US. Nevertheless, we may surmise that the general strategy of using the spouse as a coercive technique to fill the beds is not unknown in such environments. The ethical and practical dilemmas of such an approach to case-finding need to be faced and discussed.

The most prominent involvement of 'the laws' in coercion into treatment is for drunk driving. 'Counter-measures' programmes involving one or another method of diversion from criminal penalties or driver's licence removal into alcoholism treatment have grown apace in recent years. Recently, alcoholism treatment systems have been moving also into the area of court diversion for non-alcohol-specific crimes – robbery, assault, etc. Ironically, this latter development occurs just as the winds of neoclassic criminology are eliminating treatment and rehabilitation as an aim of the general penal and probation system, so that it has been said that in California alcohol and drug diversion procedures are the last refuge of a treatment ideology in the criminal law system. In another irony, the development comes just as the 'disinhibition' theory of the action of alcohol, which underlies beliefs that drinking causes crime, has come under attack.^{45,46}

Much of the court diversion is done informally and sometimes extralegally, on the initiative of individual judges. Often it is in the form of conditions of probation, which the 'client' can refuse only if he or she is willing to choose a stiff sentence. Routinely, such probation

conditions reflect the predilections of the judge about what constitutes an effective cure for alcoholism. For instance, a common condition, besides entry into a treatment programme, is that the 'client' should totally abstain during the term of probation. In American law, there are few limitations on what a judge can choose to impose as a condition of probation.

So far, this trend has been little noted or discussed. Treatment agency staff have paid little attention to the potential conflict between their ethical responsibilities to their client and their institutional responsibilities to the legal system. There is only a scattered literature on the practical and ethical problems of treating alcohol or drug problems under compulsion.⁴⁷⁻⁵⁰ Those with an interest in a humane and effective alcoholism treatment system should be greatly worried about the long-term effects on the system of the drift towards a clientele there under compulsion.

Too Much Treatment?

A tentative summary of the American experience with expansion of the alcoholism treatment system might be that the treatment-seeking population has turned out to be smaller than the conventional rhetoric of 'hidden alcoholism' might have led one to expect. As the system has nevertheless expanded, it has diversified into a number of specific-problem programmes and moved into more active case-finding and intervention. Some problems have been pointed out with what is usually regarded as a praiseworthy development, and one might ask whether a formal treatment system is the most appropriate, humane and effective method of solving many of the problems now coming in the clinic door. One possible conclusion from the American experience for a society with limited resources to spend on alcoholism treatment was voiced in the US as long ago as 1964:

It is a safe estimate that in most communities between one-third and one-quarter of all alcoholics (using Jellinek-type estimate) are in contact with and labelled as problem drinkers by one or more of the following: mental hospitals, psychiatric clinics, general hospitals, welfare and social agencies, police departments, prison officials and public health nursing agencies. Clearly just attempting to care for and manage these alcoholics adequately is an immense job. There is more than enough work to be done without spending great effort on

the so-called 'hidden' alcoholics. The known alcoholics in any community generally will be those with the most severe problems, and also those placing the greatest financial drain on the community. In addition, the known alcoholic is more likely to lack familial resources to assist him and his family in coping with his drinking problem and with the social and other damage resulting from it than is the case with the hidden alcoholic. I would also argue that the principal responsibility of a tax-supported program is to serve those persons and families who are least able to provide for themselves. Since public facilities are necessarily limited in their size and scope their primary obligation probably should be to assist persons and families who are in the poorest position to fend for themselves.⁵¹

Perhaps the most astonishing thing about the American alcoholism treatment system and its social ecology — where its clients come from, under what conditions, and who and what it misses — is how little has been studied. As has been mentioned the discussion given in this chapter has often been based on anecdote or speculation. Under its national alcohol research centre grant from the National Institute on Alcohol Abuse and Alcoholism, the Social Research Group is beginning on the task of filling in the blanks. In association with the World Health Organisation study of Community Response to Alcohol Problems, the Group is undertaking an empirical study of the relation of a passage between general and clinical populations and of the social ecology of the alcoholism treatment system in the US, in a comparative frame with the international study directed by David Hawks.

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