ALCOHOL USE AND THE AVAILABILITY OF SUPPORTIVE SERVICES IN A WHITE URBAN COMMUNITY.

BY

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S U M M A R Y .

This study identifies the alcohol intake patterns of 274 white patients attending an Urban General Practice. The average consumption rate was 6,5 drinks per person per week (d/p/w). 40% of the surveyed group did not consume any alcohol. The drinkers averaged 11 d/p/w. 72% of the males drank and 50% of the females drank. 4,3% of the population surveyed were drinking more than 28 d/p/w. Marital status made no real difference to consumption rates but unemployment (16 d/p/w) and being a manual labourer (11.7 d/p/w) did. People who had lost either their occupation (11,7 d/p/w) or a close family member (9,3 d/p/w) in the preceeding year had higher than average (6,5 d/p/w) consumption levels and these were increased further if they had identified an alcohol abuser in their family.

This study also identifies the useful supportive services available to this particular community and its health care workers with a brief discussion of the type of service provided and method of access to the service. The appendix contains a list of the services with the relevant address, telephone number and where possible the name of a contact person.

INTRODUCTION.

The aim of this study is to identify the amount of alcohol consumed by patients on a weekly basis. During a conventional history taking, we may ask how much alcohol patients consume but we have no idea of the significance of their answer since there is no given figure for safe drinking.

The study aims also to identify any characteristics about our patients that can be related to a particular pattern of consumption. If there are any such characteristics, then interviewing of patients must highlight these, so that we may be more aware of alcohol as a risk factor in their lives.

Medical practitioners are usually unaware of the services available in their particular area. The study thus aims to identify supportive services available to the patients, their families and their attending medical practitioner and the method of referral to these services. These services will then be listed in the form of a guide so that they are available as an easy source of reference to the family practitioners who are faced with the problem of who, when, where and how to refer patients with alcohol related problems.

OBJECTIVES.

1. To determine the alcohol intake patterns in a selected white urban medical practice and to identify any associations between intake levels and certain personal characteristics of the patients.

2. To identify the supportive services available to this community, their accessability and the type of services each offers.

3. To make recommendations in respect of the findings of the first two objectives.

COLLECTION OF DATA FOR OBJECTIVE 1.

DEFINITION OF CRITERIA.

1. White Urban Community: The White community represented by those patients attending the Researcher's General Practice.

2. Researcher's General Practice: An Urban General Practice situated at 1002 Durdoc Centre in the central business district, seeing patients from the City of Durban, bounded by the area of Durban North to the north, Westville to the west and the Bluff to the south.

3. Adult: Any person who is 18 or more years of age.

4. Alcohol Unit: 1 Unit of alcohol is the equivalent of 25 mls. of spirit or 1 glass of wine or 1 bottle of beer.

5. Personal Characteristics of Subjects: Age, sex, marital status, occupation and whether actively religious.

6. Change in Personal characteristics: Any change in the above during the preceeding year.

7. Alcohol Abuser: Anyone whose physical or social wellbeing is adversly affected by the amount of alcohol consumed.

METHOD OF DATA COLLECTION FOR OBJECTIVE 1.

The prospective study was carried out in which every person in the sample group (see "reduction of bias") was given a self-administered questionnaire (appendix A) to fill in while waiting for their appointment. The study took place during the 3 week period from 1st July to 21st July 1985 inclusive. The questionnaire for all persons was identical. Any incomplete questionnaires were discarded as the fragments of information on them was considered to be unreliable. The information from the 274 patients was manually collated and analysed by the researcher.

REDUCTION OF BIAS FOR OBJECTIVE 1.

The sample used included every white adult that consulted the Researcher in his consulting rooms during the period from 1st July to 21st July 1985 inclusive. No control group was needed for the purposes of the survey. Bias was reduced by using a standard questionnaire that needed filling in. No name was required on the questionnaire and so confidentiality was maintained and hopefully a more accurate response obtained from the respondents. Defined criteria were strictly adhered to.

LIMITATIONS OF THE STUDY.

The practice surveyed comprises predominantly English speaking patients as this is the Researcher's home language. The Afrikaans speaking patients answered the survey in English. The survey thus represents both language groups and no conclusions can be drawn from it about the either of the two language groups in the white community. Patients were asked to write down their consumption rates in units of alcohol consumed per week. They seemed to estimate predominantly even numbers and multiples of 7. They thus appeared to be extrapolating from a daily consumption figure. This may have introduced some error into the average rates, as estimates were obviously used and not the actual figure consumed. There is no way of knowing the actual figure each person consumed without observing them for the week.

RESULTS OF OBJECTIVE 1.

1.Alcohol Consumption of Sample Group.

In this survey 274 sets of results were analysed. There were 107 males (42,7%) and 167 females (57,3%)(see fig.1a). The 274 people surveyed collectively consumed 1,783 drinks a week or 6,5 drinks per person per week (d/p/w). Of the people surveyed (table 1) 112 (40%) were non-drinkers, and therefore 162 (60%) people consumed the 1,783 drinks, and the average for drinkers was thus 11 d/p/w.

Grouped weekly consumption rates is shown in table 1.

12(4,3%) of the population surveyed is consuming more than 28 drinks a week(see fig.1b).

FIG.1A SEX DISTRIBUTION OF SAMPLE GROUP.

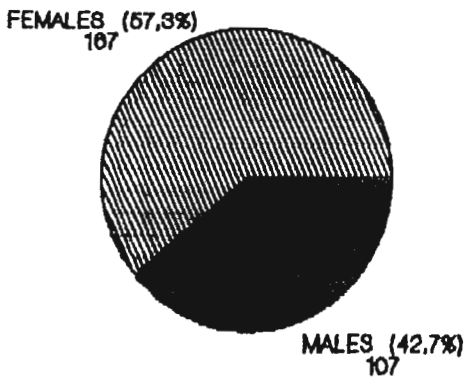
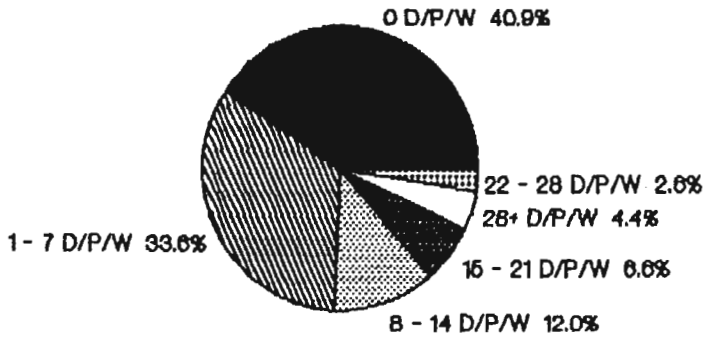


FIG.1B WEEKLY ALCOHOL CONSUMPTION FOR ALL PEOPLE SURVEYED.



274 PEOPLE (100%)

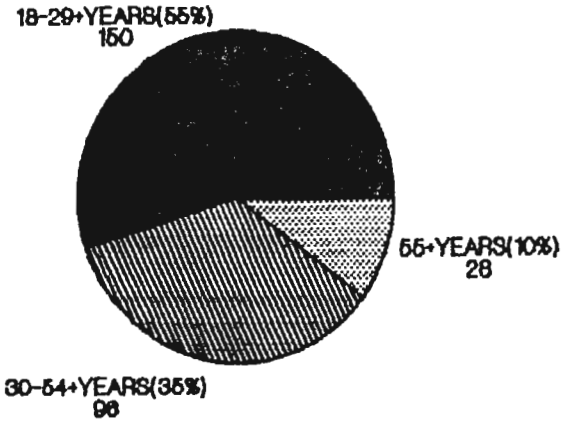
2.Consumption of Alcohol According to Age Group and Sex.

The younger age group (18 to 29+ years) had 150(55%) responders, the middle age group (30 to 54+ years) had 96(35%) responders and the older group (55+ years) had 28(10%) responders(see fig.2).

For the survey, the total male population averaged 11,4 d/p/w and the total female population averaged 3,3 d/p/w (table 2). 85(80%) men surveyed and 78(50%) women consume alcohol, so the average consumption for male drinkers is 13 d/p/w as compared with that of 7 d/p/w for female drinkers.

The rates are similar for males in the younger (10,5 d/p/w), middle (12,5 d/p/w) and older (13,9 d/p/w) age groups. The rates for females are 4 times higher in the middle group (5,8 d/p/w) than the younger group (1,4 d/p/w).The older females averaged 4,6 d/p/w. The male average (11,4 d/p/w) was 3,5 times the female average (3,3 d/p/w) (see table 2.).

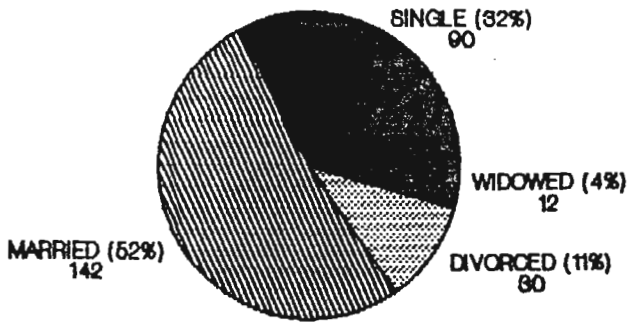
FIG.2 AGE DISTRIBUTION OF SAMPLE GROUP.



3.Consumption of Alcohol According to Marital Status and Sex.

The consumption rates for the different marital status's is shown in fig. 3. Married males (13,2 d/p/w) drink more than the male average. (11,4 d/p/w). Married females (3,0 d/p/w) drink less than the average for females (3,3 d/p/w) but divorced (6,7 d/p/w) and widowed (8,1 d/p/w) females drink more than double the female average. Married males (13,2 d/p/w) drink more than divorced males (10,9 d/p/w) -see table 3.

FIG.3 MARITAL STATUS DISTRIBUTION OF SAMPLE GROUP.



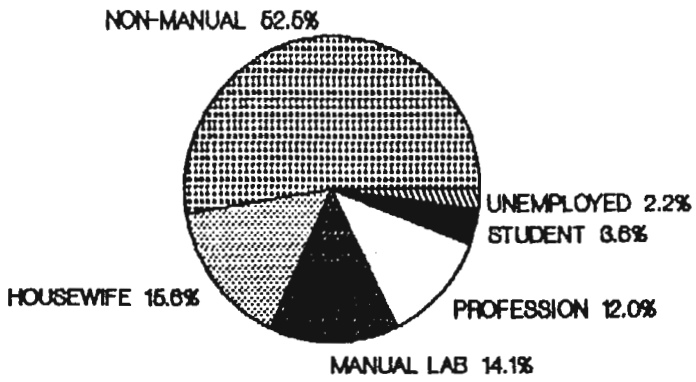
4.Alcohol Consumption According to Age Groups and Marital Status.

The alcohol consumption according to age groups and marital status is shown in table 4. The younger age group divorced people (10,6 d/p/w) have double the consumption of the younger group (5,0 d/p/w) as a whole. Divorced people in the middle age group (7,8 d/p/w) have a lower consumption than the middle age group average (8,4 d/p/w). The consumption rates for the middle (8,4 d/p/w) and older (7,2 d/p/w) age group is similar, but both are higher than the younger groups (5,0 d/p/w). The significance of the high figures for the middle age groups single (25 d/p/w) and widowed (42 d/p/w) persons is limited by the small number of people in each group.

5.Alcohol Consumption According to Occupational Category.

Alcohol consumption rates for the different occupational categories is shown in table 5. The unemployed (16 d/p/w), followed by the manual labourers (13 d/p/w), have the highest consumption rates. The other categories are below the average (6,5 d/p/w) for the whole group. Fig.4 shows the occupational category distribution of the sample group.

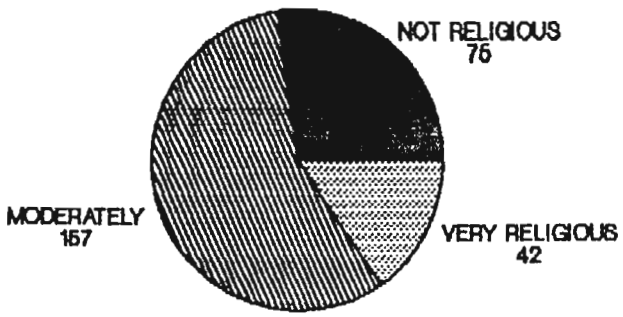
FIG.4 OCCUPATIONAL CATEGORY DISTRIBUTION OF SAMPLE GROUP.



6.Alcohol Consumption According to the Degree of Religious Observance.

Alcohol consumption rates for the varied degrees of religious observance is shown in table 6. The very religious (5,8 d/p/w) show almost the same average consumption as the overall group (6,5 d/p/w), and the non-religious observance group (9,5 d/p/w) has a higher than average consumption. Distribution of the sample group according to degree of religious observance is shown in fig.5.

FIG.5 DISTRIBUTION OF SAMPLE GROUP ACCORDING TO RELIGIOUS OBSERVANCE.



7.Alcohol consumption pattern in people who had lost either a family member, or their occupation, or both, in the preceding year.

People who had lost a family member (9,3 d/p/w) or their occupation (11,7 d/p/w) had a higher than average (6,5 d/p/w) consumption rate(see table 7). People who had lost a family member and their occupation in the preceeding year consumed 23,7 d/p/w.

8.Consumption Patterns of Persons in whose Family an Alcohol Abuser was Identified in Addition to the Loss of occupation and/or a Family Member.

There were 53(19%) people amongst those surveyed who had identified an alcohol abuser in their family. These people consumed an average 10,3 d/p/w compared to the group average of 6,5 d/p/w. Correcting for the 16 non-drinkers out of the 53, the drinkers in this group consumed an average 14,7 d/p/w (figure for all drinkers surveyed was 11 d/p/w). A person who had identified an abuser in his/her family, was therefore consuming more than the average amount.

Loss of a family member (12,8 d/p/w) or occupation (12,5 d/p/w) showed similar consumption, but persons who had lost a family member and their occupation in the preceeding year and who had identified an abuser in their family were consuming 28,3 d/p/w or 4,3 times the group average of 6,5 d/p/w.(see table 8). This last group was comprised of 3 females and therefore their average of 28,3 d/p/w was 8,5 times the average for females (3.3 d/p/w).

DISCUSSION

A number of relevant findings were identified in the course of this study. The first is the obvious difference in alcohol consumption between the sexes. Part of the reason may be in the fact that men-only bars predominate in South Africa, and that it is generally socially acceptable for a man to drink, while it is frowned upon for a woman to do likewise. The other consideration is that many women may not have accurately disclosed their drinking habits even though the questionnaire was anonymous, as many women alcoholics will not face the fact of their alcohol abuse, even to themselves (*1).

The information regarding the consumption of alcohol by young divorced women and middle aged widows is limited by the small number of cases. However, it is interesting to speculate that the relatively isolated, unsupported lifestyle may promote greater alcohol consumption(*2).

An interesting finding in the pattern of alcohol consumption, occurs in the relationship of unemployment to alcohol consumption. Although the increase in consumption is obvious, it is not possible to assume a cause and effect relationship, since it is possible that each factor was responsible for the occurance of the other. There are a number of possible reasons why unemployment should lead to alcohol abuse, including depression, isolation, boredom and escapism. It can quickly become a financial and emotional

viscious circle (*2 page 102). The association between alcohol usage and marital status and occupation has been documented by the Department of Health (*3).

The effect of religion on the pattern of consumption is noted. It is interesting to note that moderate and intense religious affiliation does not decrease the consumption of alcohol from the group average, despite the fact that most religous institutions prohibit, or almost prohibit, the use of alcohol. There is marked alcohol consumptive increase associated with loss of family and occupation. The factors related to unemployment hold true in this respect also, but other possible reasons for this increase include the marked stress factor (as indicated in life change units in which both loss of family and loss of occupation rate very highly as stress factors(*4), as well as the probability of reactive depression. A further interesting finding, and one which can be used for its predictive and preventative value, is the fact that identification of a family member as an alcohol abuser, is associated with a markedly increased alcohol consumption. It is presumably this factor which motivates the rationale of support groups such as ALANON and ALATEEN (see second part of this project).

Possible factors associated with this increased consumption may be the stress of having an alcoholic abuser in the immediate family, or alternatively, the social and domestic environment of the abuser may have been a contributing factor in the aetiology of alcohol abuse. The most effective way to

stimulate excessive drinking is by the power of example. If a child consistently sees one of his parents inebriated he is unlikely to develop the normal social disapproval of drunkeness and will be more likely to drink in a similar excessive way. This has been described in an article by Aronson(*5) in which children of alcoholics were studied and it became clear that the sons of alcoholics were more prone to become drinkers than other boys.

The findings of this survey contribute to the practitioners dilemma in dealing with patients who abuse alcohol. It becomes evident that there is no quantitative level below which alcohol consumption is considered safe. The Royal College of Psychiatrists initially set a limit of 4 pints of beer, or 8 glasses of wine a day as a safe limit, but this has recently been revised to 2 pints of beer, or its equivalent in wine or spirits, per day(*6). A survey of 70 people in the U.K.(*7) who are actively involved in alcohol research, were asked to define a safe upper limit for men and women.

The recommendations ranged from between less than 6 up to 62 units per week - reflecting the lack of consensus on what level of consumption constitutes abuse. Comparing this to table 1 shows how pointless it is for a general practitioner to enquire of his patients how much alcohol he consumes, if he consumes any, as it is impossible in the absence of other information to evaluate the answer. It is of far greater value to estimate the effects of alcohol on lifestyle by

conducting an interview using the MAST (*8) or CAGE (*9) type questionnaire. This method was found to identify 93% of excessive drinkers. CAGE consists of 4 questions which is considered the minimum that would give a useful response.

The question are:-

1. Have you ever felt you ought to Cut down on your drinking?
2. Have people Annoyed you by criticizing your drinking?
3. Have you ever felt bad or Guilty about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (Eye opener)?

The questions are used in the history taking to alert the clinician to the possibility of alcoholism. Even one positive answer calls for further enquiry.

Another important factor for the practitioner dealing with a patient with alcohol induced problems, is to estimate the degree of pathological damage due to alcohol, as estimated by laboratory tests of alcohol induced biochemical changes.

The serum gamma glutamyl transpeptidase (gamma g.t.) has proved to be the most sensitive test, but not sensitive enough to qualify as a screening test (*10).

Having identified the patient as being a potential or actual alcohol abuser, the doctor's role now involves intervention and support.

TABLES OF RESULTS

TABLE 1.

WEEKLY ALCOHOL CONSUMPTION FOR ALL PEOPLE SURVEYED

DRINKS/WEEK	NUMBER OF PEOPLE	%
0	112	(40,8)
1-7	92	(34,0)
8-14	33	(12,0)
15-21	18	(6,5)
22-28	7	(2,5)
28+	12	(4,3)
TOTAL	274	(100)

TABLE 2

CONSUMPTION FOR DIFFERENT AGE GROUPS ACCORDING TO SEX

AGE GROUP	MALE	(%)	D/P/W	FEMALE	(%)	D/P/W	TOTAL	(%)	D/P/W
18-29	61	(40)	10,5	89	(60)	1,4	150	(100)	5,0
30-54	38	(39)	12,5	58	(61)	5,8	96	(100)	8,4
55+	8	(28)	13,9	20	(72)	4,6	28	(100)	7,2
TOTAL	107	(39)	11,4	167	(61)	3,3	274	(100)	6,5

TABLE 3

ALCOHOL CONSUMPTION ACCORDING TO MARITAL STATUS AND SEX

MARITAL STATUS	SEX				TOTAL	
	MALE		FEMALE			
	NO.	(%) D/P/W	NO.	(%) D/P/W	NO.	(%) D/P/W
SINGLE	47	(52) 9,7	43	(48) 1,1	90	(100) 5,0
MARRIED	48	(34) 13,2	94	(66) 3,0	142	(100) 7,1
DIVORCED	12	(40) 10.9	18	(60) 6,7	30	(100) 8,3
WIDOWED	0	(0) 0	12	(100) 8,1	12	(100) 8,1
TOTAL	107	(39) 11,4	167	(61) 3,3	274	(100) 6,5

TABLE 4

ALCOHOL CONSUMPTION ACCORDING TO AGE GROUPS AND MARITAL STATUS.

MARITAL STATUS	AGE GROUPS					
	18-29		30-54		55+	
	NO. (%)	D/P/W (MEAN)	NO. (%)	D/P/W (MEAN)	NO. (%)	D/P/W (MEAN)
SINGLE	86(58)	4,7	4 (4)	25,0	0 (0)	0,0
MARRIED	59(39)	5,1	69(72)	11,8	14(50)	8,6
DIVORCED	5 (3)	10,6	22(23)	7,8	3(11)	9,0
WIDOWED	0 (0)	0,0	1 (1)	42,0	11(39)	5,1
TOTAL	150(100)	5,0	96(100)	8,4	28(100)	7,2

TABLE 5

ALCOHOL CONSUMPTION RATES ACCORDING TO OCCUPATIONAL CATEGORY.

OCCUPATION	PEOPLE NUMBER	(%)	DRINKS MEAN D/P/W
STUDENT	10	(3,6)	4,3
UNEMPLOYED	6	(2,1)	16,0
HOUSEWIFE	43	(15,6)	4,0
MANUAL LABOURER	39	(14,2)	13,0
NON-MANUAL LABOURER	145	(52,9)	5,2
PROFESSIONAL	33	(12,0)	6,4
TOTAL	274	(100)	6,5

TABLE 6

CONSUMPTION RATES FOR DEGREE OF RELIGIOUS OBSERVANCE

	NO.OF PEOPLE	MEAN D/P/W
NOT RELIGIOUS	75	9,5
MODERATELY RELIGIOUS	157	5,2
VERY RELIGIOUS	42	5,8
TOTAL	274	6,5

TABLE 7

ALCOHOL CONSUMPTION RATES AGAINST LOSS OF FAMILY MEMBER AND/OR OCCUPATION IN THE PAST YEAR.

	NO. OF PEOPLE	MEAN D/P/W
LOSS OF FAMILY MEMBER	28	9,3
LOSS OF OCCUPATION	19	11,7
LOSS OF FAMILY MEMBER AND OCCUPATION.	7	23,7

TABLE 8

CONSUMPTION RATES FOR THOSE WHO HAVE AN ALCOHOL ABUSER IN THEIR FAMILY AND HAVE LOST A FAMILY MEMBER AND/OR THEIR OCCUPATION IN THE PAST YEAR.

	NO. OF PEOPLE	MEAN D/P/W
LOSS OF MEMBER FAMILY	9	12,8
LOSS OF OCCUPATION	7	12,5
LOSS OF OCCUPATION AND FAMILY MEMBER	3	28,3

COLLECTION OF DATA FOR OBJECTIVE 2.

DEFINITION OF CRITERIA.

1. Supportive Services: State, Provincial, Municipal, Welfare or Private organisations or institutions offering help in any way to the alcohol abuser, his/her family or medical personnel involved in his/her care.

METHOD OF DATA COLLECTION FOR OBJECTIVE 2.

Supportive services were identified through the Durban telephone directory (*11), the MIMS Services Directory(*12), and by discussion with people involved in the management of patients with alcohol related problems.

The important facilities were visited personally by the author and the others were telephonically contacted.

RESULTS OF OBJECTIVE 2.

SOUTH AFRICAN NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDANCE (SANCA).

Headquarters are in AMSTERDAM HOUSE. There is a trained information officer to deal with the incoming telephone calls. Attached to the SANCA information office is the Penthouse Clinic which offers outpatient counselling facilities.

Penthouse Clinic has a part-time medical officer who examines and treats the new outpatients. The counselling is done by Social Workers only. The cost is R100 a year and treatment includes a one-month intensive counselling course of 2 -3 hours a day and then follow-up visits on an irregular basis. This is ideal for the working person who does not require in-patient management and who is motivated.

SANCA encourage the A.A. group to see the patient at the same time and to take over the long term treatment. Patients have to be given a booking to see a social worker before they can attend the lecture and counselling sessions. This is a serious drawback, as there is then a delay in initiating therapy. SANCA information officers conduct lectures at the request of any organisation and factory and distribute pamphlets to staff members. Key personnel from factories can be trained by SANCA on how to identify the alcoholic in the workplace, and how to refer him for therapy. SANCA has its own printing press producing information pamphlets that are

freely available to the public.

LLULAMA.

LLULAMA is the in-patient centre for SANCA. It is situated at 194 Percy Osborn Rd. It is staffed by Social Workers and they offer a 28 day in-patient regime of rehabilitation. A Social Worker does the initial assesment and arranges for admission of the patient. Llulama will not take patients who are currently drinking. All patients have a full medical examination on admission which is always on a Friday. The Medical Officer then sees them on a weekly basis for any ongoing medical problems.

A consultant Psychiatrist is available for any problems that may arise and so is a Clinical Psychologist, but they are not actively involved unless requested to do so by the social worker. Trained Nursing staff are present 24 hours a day to look after the 29 in-patients. There are lecture halls and occupational therapy-type workshops for use by in-patients and out-patients who report here for medium-term follow up. A.A. visit here to initiate contact with the in-patients and hold follow up meetings here in the evenings as well. Meetings are also held for relatives of patients. The program is very intensive and regimented and includes daytime as well as evening activities.

The cost of the in-patient treatment is R20 a day. The majority of medical aids today will pay the costs involved, but if the patient does not have medical aid cover, they can

pay the amount off over a period of time.

WINDSOR CLINIC.

Windsor Clinic is a privately owned clinic situated at 193 Wakesleigh Rd. in Bellair. The telephone number is 45-3030 and it is staffed 24 hours a day by psychiatrically trained nursing staff. Patients are admitted by psychiatrists or medical practitioners who can look after their own patients or refer them to Dr. Gillmer, the resident psychiatrist, who will initiate therapy. The clinic will take patients in the acute stage for detoxification, as it has the nursing facilities to do so. Medical aid rates are charged for the bed, and medical aids will pay if a diagnosis such as "Depression" is used. If a diagnosis relating to alcoholism is used, the medical aid society can refuse to pay. Payment to the doctor is separate. Patients can be referred for admission at any time of the day and any day of the week. A.A also visit here to initiate contact with the patients and they maintain contact and do all the follow up.

ALCOHOLICS ANONYMOUS.

Alcoholics Anonymous (A.A.) is situated on the 3rd floor of Poynton House, Gardiner Street. A.A is a self-help group working on a voluntary basis with no payment requested for any services. At the first interview a 20 item questionnaire

is used to decide whether the person has a drinking problem or not. The questions are similar to the M.A.S.T. questionnaire. The rationale of A.A. membership lies in group therapy. Members relate their personal ability to have overcome alcohol dependance as support and incentive for new members. New members are encouraged to read pamphlets and the Big Book which is a handbook of case studies as well as the history of A.A.movement(*13). Religious conviction is included as part of the support struture. There are no trained counsellors (such as social workers, etc.,) in the A.A. movement, but every A.A. member who is "dry", is a counsellor. A.A's main function is the emotional side of rehabilitation. A.A. Members also visit schools to lecture and hand out pamphlets. The offspring of A.A. is ALANON and ALATEEN which are self help groups for the families and children of alcoholics. The ALANON telephone number is 304-1826 and they are situated at 533 Westwalk, West Str. There are A.A. meetings in every suburb of Durban on most nights of the week and the A.A. members will bring new members to these meetings as part of their approach to treatment.

BILL'S ROOMS

Bill's Rooms are at 31 Bazley Ave., in Sydenham. It is a multiracial self help "clinic", for men who cannot afford the cost of a recognised institution. There are A.A. members

available 24 hours a day to help with in-patients. They have facilities for 10 in-patients, but at times up to 22 people are crammed in. There is no trained staff available, but the patients are taken to a local medical practitioner if they convulse while going through detoxification. Patients can be sent there day or night and cannot be turned away as it is under the wing of the A.A. who bear its running costs. The patient contributes nothing towards costs. The majority of the patients are brought in by the police.

ADDINGTON HOSPITAL

The Addington Hospital on the South Beach is a Provincial hospital that will not attend to any patients who are on a medical aid. They will not admit patients under the influence of alcohol per se, but will admit to their Psychiatric wards, those who are suffering the psychiatric sequelae of alcohol abuse.

PRIVATE HOSPITALS.

St. Augustines and Entabeni Hospitals are private hospitals situated on the Berea that have psychiatric wards for the use of patients of private Psychiatrists and General Practitioners. The private practitioner has to arrange a bed-booking and attend to his own patients.

LIFE LINE.

Life line is a telephonic "crisis intervention" service. Trained counsellers are available by telephone for advice. Patients who contact life line will be given the telephone number of either A.A. or SANCA . Life line do not do long term counselling.

SALVATION ARMY

This welfare centre caters for those who are down and out. Patients can be referred here if they have no accomodation and no employment. They will be given accomodation and board.

DUTCH REFORM CHURCH

This religious organisation operates a welfare service through the Christelike Maatskaplike Raad. Patients with alcohol problems can be referred to their social workers for management.

OTHER RELIGIOUS ORGANISATIONS

The ministers of all religious organisation have been trained in counselling and many patients or their families use their local minister as their first line of help.

DISCUSSION OF OBJECTIVE 2

A General Practitioner sitting in his consulting rooms with a patient who is under the influence of alcohol has to decide what facility must be used, and how to get that patient into that facility. There are some guidebooks produced by the Department of Health and Welfare that give an overview of the types of facilities available country wide but includes only the registered government institutions(*14). The practitioner has to take into account the financial status of his patient, and whether he needs detoxification and/or rehabilitation, before deciding on which facility to use. The second main objective of this project was to identify the facilities available to white alcohol abusers and the type of service these facilities provide. This project makes available the relevant information about each facility. A summary of all the relevant information about each facility can be found at the end of this project. See Appendix B. The second part of the project indicates the very limited in-patient facilities available to cope with this rather extensive problematic population. The total of beds available at the 5 institutions visited is less than 100. As a result, it falls to the community, and most especially the A.A., to provide out-patient facilities as supportive therapy for alcohol abusers. The A.A. is a community based institution which offers a service to the community by the community, and follows the principles of primary care.

CONCLUSION

This survey indicated the wide range of alcohol consumption which was consumed by a cross section of patients in an average general practice.

The average alcohol consumption was greater than previously accepted norms, as defined by the Royal College of Psychiatrists(*7) and the Mayo clinic findings(*15). Of the group surveyed, 40% were non-drinkers, but 23% of those who drank and 13.5% of the whole group surveyed, exceeded these definitions of the "safe" limit.

Consequent on these findings, it is apparent that the alcohol related problems which general practioners deal with, are fairly numerous. Extrapolation of this 13.5% to Durban's white population gives some indication of the enormity of the problem.

We are only seeing the tip of the iceberg in our practices as regards the number of alcoholics around. Parr(*16) in 1957 questioned 480 General Practitioners about alcoholics in their practices. 20% did not know of a single case of alcoholism in their practice. A London doctor said that he had not had even 1 case asking for treatment in 30 years practice. It is difficult to believe that these responses spring entirely from the alcoholics reluctance to approach a doctor. The doctor's attitude must be of equal importance. For example one doctor wrote to Parr: "Generally speaking, I

suggest alcoholics avoid doctors, and doctors in the main try to avoid alcoholics". Such attitudes arise from inadequacies in our under graduate medical school training. If doctors are only partially informed about alcoholics then what about the general public? This is a factor that SANCA is tackling. They produce pamphlets for distribution about the fallacies and misconceptions about alcohol, and run employee assistance programs to do with alcohol in industry. A.A. produce similar pamphlets including one aimed at the medical profession entitled 'A.A. as a resource for the medical profession'. THe Academy of Family Practice/Primary Care also realise their responsibility to continuing education of general practitioners and have produced a handbook on alcoholism with a list of the A.A. telephone numbers included.(*17)

Bligh(*18) summarises the general practitioner's role in relation to drinking as follows:

1.Awareness of drink related problems.

2.Offer advice when appropiate.

3.Seek opportunity to offer advice in any consultation.

4.Advise on how to cut down or stop drinking.

5.Supplement advice with literature.

6.Follow up attempts to reduce drinking.

7.Be aware of own attitude to drinking.

8.Make appropiate use of referral agencies.

An informed doctor using the resources available to him, should by earlier detection and intervention, prevent progression and the need for hospital based management. This

will eventually have a positive effect on the health and economic profile of our community.

Health for all by the year 2000 will not be achieved if our community continues to consume alcohol at its present rapidly increasing rate(*19).

RECOMMENDATIONS.

1. Under-graduates at medical school should be made aware of the size of the pool of alcoholics in a community.
2. Under-graduates must be educated on the disease "alcoholism" and how to recognise and manage it.
3. Medical personnel need to be made aware of the pitfall in asking a person how much they consume. They must learn to use and interpret a CAGE or MAST type questionnaire.
4. Medical personnel must be made aware of the community based resources available to them and the functions of these resources.
5. Community must be made aware of the community resources available for its own members.
6. High risk groups identified (i.e. unemployed and family members of identified alcoholics) must be advised of support facilities, and re-educated in terms of the negative effects of alcohol.
7. The media must be used to inform the public of the hazards of excessive consumption.

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BIBLIOGRAPHY

*1 . Kessel N, Walton H. ALCOHOLISM. 1st ed. Great Britain: Penguin Books, 1965:

*2 . Director-General. Women, Alcohol and Medicine. Department of Health and Welfare 1982:7-8.

*3. Dept. of Health and Welfare. Sixth Report of the National Advisory Board On Rehabilitation Matters For The Period 6 December 1981 to 31 December 1983. Government Printer.

*4. Bakal DA. Psychology and Medicine. London:Tavistock Publications, 1979:96-97.

*5. Aronson H, Gilbert A. Pre-adolescent sons of male alcoholics. Archives of General Psychiatry 1963;8:235-237.

*6. Kreitman N. As quoted at the British Medical Association Scientific Meeting at Oxford in 1985.

*7. Anderson P, Cremona A, Wallace P. What are safe levels of alcohol consumption? Br Med J 1984;286:1657-1658.

*8. Powers JS, Spickard A. Michigan Alcoholism Screening Test to Diagnose Early Alcoholism in a General Practice. Southern Medical Journal July 1984;77: 852-855.

*9. Ewing JA. Detecting Alcoholism - The CAGE Questionnaire. JAMA 1984;252 1905-1907.

*10. Bernadt MW, Mumford J, Taylor C, Smith B, Murray RM. Comparison of Questionnaire and Laboratory Tests in the Detection of Excessive Drinking and Alcoholism.

The Lancet 1982;February 6:325-328.

*11. Durban Corporation Directory. Durban:Directory Publications,1985.

*12. Van Den Berg ADP. MIMS Services Directory. Pretoria: Mims,1983: 7-10.

*13. Alcoholics Anonymous. 3rd Edition. A.A.World Services Inc. 1976.

*14. Dept. of Health and Welfare. Facilities and Services For The Treatment of Alcoholics And Drug Dependants In South Africa. Publication no. 3 of 1980. Government Printer.

*15. Hurt RD, Morse RM, Swenson WM. Diagnosis of Alcoholism with a Self Administered Alcoholism Screening Test. Mayo Clin Proc 1980;55: 365-370.

*16. Parr D. Alcoholism in General Practice. British Journal of Addiction 1957;54: 25-26.

*17. South African Academy Of Family Practice/Primary Care and The Medical Association. Alcoholism A Handbook For The General Practitioner. Supplement To S.A. Med. J.,18 April 1981.

*18. Bligh J. The general practitioner's role in the detection of alcohol misuse in the community. Br J Clin Pract 1984;36 29-35.

*19. Moser Joy. Alcohol Policies in National Health And Development Planning. WHO offset Publication no. 89. WHO

APPENDIX A

SURVEY ON THE CURRENT TRENDS IN ALCOHOL CONSUMPTION IN THE COMMUNITY.

Please answer the following questions honestly.

AGE _____in years.

SEX_____male/female.

MARITAL STATUS_____(single/married/divorced/widow)

OCCUPATION_____(student/unemployed/housewife/ manual worker/non-manual worker/ professional.)

RECENT LOSS OF CLOSE FAMILY MEMBER_____yes/no (in past year)

RECENT LOSS OF OCCUPATION_____ yes/no (in the past year)

RELIGIOUS _____ yes very/moderately/not at all

ARE THERE ANY CLOSE MEMBERS OF YOUR FAMILY WHO ABUSE ALCOHOL AT PRESENT._____yes/no

THE AMOUNT OF ALCOHOL THAT YOU CONSUME OVER A PERIOD OF ONE WEEK(7 days)_____1beer or tot of spirit or 1 glass of wine are equivalent please write the total consumed per week.

Thank you for the information.

APPENDIX B

SUMMARY LIST OF THE AVAILABLE FACILITIES

SANCA -South African National Council On Alcoholism and Drug Dependance

9th floor Amsterdam house

353 West St.

Durban.

Tel. 304-9631 office hours only

Contact person: Mrs Clark.

LLULAMA

194 Percy Osborne Rd.

Morningside.

Durban.

Tel. 303-1285 24 hour service

Contact person: Social worker or Sister on duty

WINDSOR CLINIC

193 Wakesleigh Rd.

Bellair.

Durban.

Tel. 45-3030 24 hour service

Contact person: Sr. Schoonbee or Sister on duty

ALCOHOLICS ANONYMOUS (A.A.)

3rd floor Poynton House

Gardner street (over the road from Central Post Office)

Durban.

Tel. 301-4959 during office hours.

Answering machine after hours gives phone no. of whom to contact.

Contact person: Pat.

BILLS ROOMS.

31 Bazley Ave.

Sydenham.

Durban.

Tel. 28-5930 24 hr. facility

Contact persons: Krish, Joe or Colin.

LIFE LINE.

38 Adrian rd.

Stamford hill.

Durban.

Tel. 232323 24hr. facility

ADDINGTON HOSPITAL.

Hospital Rd.

South Beach.

Durban.

Tel. 373333

ENTABENI HOSPITAL

148 South Ridge Rd.

Berea.

Durban.

Tel. 811344

ST. AUGUSTINES HOSPITAL

107 Chelmsford Rd.

Berea.

Durban.

Tel. 211221

SALVATION ARMY

114 St Georges St.

Durban.

Tel. 3012095

APPENDIX C

PROTOCOL

ALCOHOL USE AND THE AVAILABILITY OF SUPPORTIVE SERVICES IN A WHITE URBAN COMMUNITY.

P R O B L E M.

Current trends in alcohol consumption and the availability and accessability of supportive services to patients and their families and health personnel.

O B J E C T I V E S

1. To determine the alcohol intake patterns in a selected white urban medical practice and to identify any correlations between intake levels and certain personal characteristics of the patients.
2. To identify the supportive services available to this community, their accessability and the type of services each offers.
3. To make recommendations in respect of the findings of the first two objectives.

DEFINITION OF CRITERIA.

1. White Urban Community: The White community represented by those people attending the Author's General Practice.
2. Author's General Practice: An urban General Practice situated at 1002 Durdoc Centre in the central business district, seeing patients from the City of Durban bounded by the area of Durban North to the north, Westville to the west and the Bluff to the south.
3. Adult: Any person who is 18 or more years of age.
4. Alcohol Unit: 1 Unit of alcohol is the equivalent of 25 mls. of spirit or 1 glass of wine or 1 beer.
5. Personal Characteristics of Subjects: Age, sex, marital status, occupation and whether actively religious.
6. Change in Personal characteristics: Any change in the above during the preceeding year.
7. Alcohol Abuser: Anyone whose physical or social wellbeing is adversly affected by the amount of alcohol consumed.
8. Supportive Services: State, Provincial, Municipal, Welfare or Private organisations or institutions offering help in any way to the alcohol abuser, his/her family or medical personnel involved in his/her care.

SELECTION OF SAMPLE GROUP.

The sample will include every white adult consulting the

author in his consulting rooms during the survey period. No control group is needed for the purposes of the project.

REDUCTION OF BIAS

Bias will be reduced by having a standardised questionnaire to fill in (appendix a). No name will be required on the questionnaire and so confidentiality will be maintained and hopefully a better response obtained from the respondents.

METHOD OF DATA COLLECTION.

The prospective study will be carried out in which every person in the sample group will be given a self-administered questionnaire to fill in while waiting for their appointment. All institutions will be identified from telephone directories and by consultation with voluntary agencies. All identified supportive services will be visited and the relevant information recorded.

TIME BARRIERS

Final protocol.	By 19-06-85
Survey of sample group.	From 1-7-85 to 21-7-85
Collation and analysis.	By 1-9-85
Identify institutions.	By 1-9-85
Visit institutions.	From 1-9-85 to 30-11-85

1st Draft By 1-2-86

Final draft. By 30-9-86

APPRAISAL OF LITERATURE

Ongoing throughout study.

COLLATION AND ANALYSIS OF DATA.

The information will be manually collated and analysed by the author.

EVALUATION OF DATA.

Data will be evaluated and associations between the personal characteristics of subjects surveyed and the quantity of alcohol consumed will be identified.

ADVANCEMENT OF HYPOTHESES.

Hypotheses based on the findings will be advanced and included in the published findings.

PUBLICATION.

A dissertation report will be produced on completion of the study and submitted in partial fulfilment of the requirements for Part 2 of the M.PRAX.MED(Primary Care) of the University of Natal. Subsequent to the above submission a paper on the findings will, if required, be submitted for publication in the professional press.