

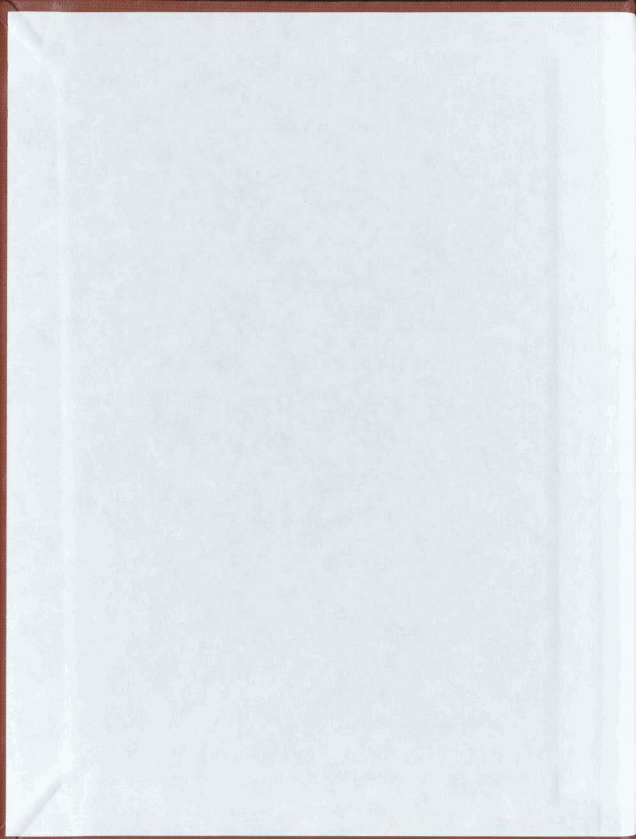
PUBLIC PERCEPTIONS OF ALCOHOL PROBLEMS,
TREATMENT POLICIES AND TREATMENT SERVICES:
A NEWFOUNDLAND PERSPECTIVE

CENTRE FOR NEWFOUNDLAND STUDIES

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GEORGE WILLIAM NEWMAN SKINNER, B.Sc., B.S.W.



PUBLIC PERCEPTIONS OF ALCOHOL
PROBLEMS, TREATMENT POLICIES AND
TREATMENT SERVICES: A NEWFOUNDLAND PERSPECTIVE

BY

© George William Newman Skinner, B.Sc., B.S.W.

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requirements for the degree of
Master of Social Work

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Abstract

Alcohol abuse has been under serious investigation particularly in the past forty years. This study explores and describes public perception and beliefs regarding alcohol problems; specifically it explores the association between these perceptions and beliefs and the public's willingness to utilize psychosocial treatment services; and it describes public expectation of treatment services and treatment personnel. Within this context, the study also investigated the impact of information regarding the competence of social workers in psychosocial treatment of problems related to alcohol abuse, in increasing the respondents' expressed willingness to utilize social workers as professionals in primary care for alcohol problems.

The review of the literature indicates that an understanding of the use of alcohol in any population requires a knowledge of drinking behaviour and cultural interpretations of drinking and drinking problems within the population (Ablon, 1980). The perceptions of various facets of society in which the individual functions such as the family, the work setting and the community at large must be considered in order to arrive at an understanding of alcohol use, abuse and treatment.

Recent studies have demonstrated the limitations of a unitary concept, that is the disease concept of "alcoholism" and have turned toward multi-dimensional factors relating to alcohol problems which require various forms of rehabilitative services (Mendelson and Meillo, 1985). Ward (1980) suggested that alcohol problems be viewed as a symptom of a complex interactional process of the individual and his/her environment.

With respect to professional social work responsibilities in the area of alcohol problems, it is important to consider that approximately 15-35% of clients who use various social services exhibit at least a secondary problem related to alcohol abuse (Kimberley, 1985). Considering specific addictions programs, social workers are responsible for a broad range of intervention, including psychosocial intervention and therapy within hospitals, psychiatric services, outpatient clinics, residential centres and private practice (Kimberley, 1985).

This study focuses on an urban population utilizing a descriptive design with the target population being the male or female head of families within the city of St. John's, Newfoundland. The sample was a stratified random sample consisting of a survey population of two hundred households

selected randomly from one of five census tracts as described by Statistics Canada.

The findings of this study support a psychosocial orientation to the intervention with persons with alcohol problems. The family, workplace and community are seen as the agents severely affected by alcohol problems and as being agents for change in the intervention of drinking problems. Medical practitioners, social workers and psychologists were identified as potential care givers for individuals and families experiencing problems with alcohol. The results are discussed in relation to their implications for policy and program development. Recommendations are formulated on the basis of the survey results.

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CHAPTER 1
ALCOHOL PROBLEMS AND THEIR TREATMENT
IN A COMMUNITY CONTEXT: A REVIEW

Alcohol abuse has been under serious investigation, particularly in the past forty years. While it may be said that significant progress has been achieved in recent years, much has yet to be learned concerning the phenomenon. As in many endeavours of scientific inquiry, hypotheses must be formulated, tested, proven, rejected or refined for further exploration.

Since the early sixties, research in the field of alcohol abuse has increased substantially. Issues pertaining to alcohol problems, including etiology, prevention and treatment, have been controversial. Many questions remain unanswered allowing various beliefs and ideologies to co-exist as numerous groups and individuals promote their varying perspectives and practice wisdom. Researchers, professionals and other interested individuals have advocated various theories of causation, progression, intervention, and prevention with respect to alcohol abuse problems. Outstanding issues such as the lack of conceptual clarity and confounded knowledge in the area of addictions make systematic and coherent treatment service planning

difficult. Policy coherence is difficult if not impossible at present.

The sixties and seventies saw the development of several theories. Various positions were advocated with missionary and political zeal, each with a strongly argued rationale based on experience, practice wisdom and research.

For purposes of this report, the author will review, discuss and examine the positions within the alcohol abuse field from several perspectives: the moral, medical, behavioral-social learning and psychosocial. Examination of these perspectives is important in the consideration of possible models of intervention. Of specific concern is a community's willingness to utilize various treatment services. From information currently available, it appears that various models and theories have evolved which reflect the vested interests of the behavioral model of psychologists, the medical model of physicians and the disease model of those most affected such as members of Alcoholics Anonymous. Reid (1979) suggests that treatment programs operative throughout Canada reflect a variety of programs usually based on one of the traditional models.

The literature does not present a clear and definitive model for the future. The confusion is compounded by

heightened emotions associated with advocates of various models. Considerable research is necessary before many of the current questions can be answered. The author takes the position that an understanding of each perspective is required if those responsible for policy development and service planning are to comprehend variations in both the public's expectations of and willingness to utilize services.

MORAL PERSPECTIVE

The earliest and most basic perspective on alcohol use and abuse is the "moral" perspective. According to Gusfield (1963), the loss of control of consumption in addictions is linked with moral degeneracy, the most concrete demonstration of which is the Temperance Movement. This Movement promoted abstinence since the use of alcohol was considered "evil" and alcohol abuse as evidence of "weak will". Community support for the Temperance Movement and related religion based definitions of reality were instrumental in bringing about prohibition of the production and distribution of beverage alcohol especially in the United States, in the early 1920's (Gusfield, 1963).

In the experience of this author, the moral perspective of alcohol abuse still has considerable support within Newfoundland. Public debate often reflects a moral

orientation to alcohol problems. Among some religious groups, the notion of alcohol use as being evil and immoral is quite common. While the moral perspective may have prevented alcohol abuse on the part of some individuals by its refusal to excuse alcohol use, it is noted as not having contributed to a scientific understanding of alcohol abuse and alcoholism. While the perspective appears to have been the forerunner in terms of focusing societal attention on the problems of alcohol abuse, it's emphasis on the individual's behavior contributes to the strong stigma which still remains for those experiencing alcohol problems. According to Tarter and Sugerman (1976) the moral model assumes that the individual who abuses alcohol is a "willful sinner" who freely chooses to drink. The problematic drinking is completely within the control of the individual and not the product of physical, psychological or social factors.

MEDICAL PERSPECTIVE

The disease concept of alcoholism has probably been the most significant factor that accounts for increased public acceptance of some social responsibility for the treatment of alcohol problems. Official acknowledgement of the problem, associated with the perceived high status of the medical profession, has contributed to this change in public

perception. E.M. Jellinek is known throughout the field as the father of the disease concept which is the basis for the medical model (Kissin, 1977). Jellinek worked in Canada with the Addiction Research Foundation and subsequently promoted the medical model in Canada (Jellinek, 1960). Subsequently, the medical model was adopted by the World Health Organization.

The medical model focuses on the biological and physical effects of alcohol abuse and relates these to psycho-biological correlates. As a result, treatment is commonly associated with the use of medication such as tranquilizers for stress reduction and Antabuse or Temposil as antagonists (Kissin & Berglerter, 1977). Dependence on medication as a primary treatment, combined with the limited training of most physicians in the area of alcohol dependency and addictions counselling, has prompted serious reservations as to the viability of the model (Kissin & Berglerter, 1977). The disease metaphor focuses largely on the physical, biological, psychological effects of alcohol; counselling and therapy are relegated to a tertiary intervention status.

The medical model, as practiced in most general hospitals, contributes to alcohol abuse being defined as a secondary problem rather than a presenting and primary

problem. As a result the alcohol problems remain undetected and untreated (Kissin & Berglerter, 1977). Therefore, one might argue that diagnostic problems in hospitals reflect a lack of professional education in the area of addictions at best, and a confounding of the moral and medical models at worst.

The medical perspective is credited with raising the public perception and acceptance of alcohol problems during the past twenty years. The disease notion has enabled those encountering alcohol problems to seek help and reduce the stigma associated with treatment. The network of physicians which exists throughout most areas, enables the alcohol abuser to have ready access to professional help. Unfortunately, the medical perspective, compounded with the disease concept, focuses attention solely on the individual, and has been said to have delayed advances in the field. It has also tended to limit or dismiss the role of external factors in terms of etiology of alcohol problems.

BEHAVIORAL - SOCIAL LEARNING PERSPECTIVE

The behavioral-social learning model of alcohol abuse is in direct contrast to the disease concept. Rather than defining "alcoholism" as a condition, this model assesses drinking behavior as learned and interventions are based on

the premise that alcohol abuse behaviors may be unlearned and abuse prevention behaviors may be learned (Denzin, 1987). Ward (1980) asserts that the model is based on behavioral psychology and proposes reinforcement as the dynamic accounting for drinking behavior. Heavy or problematic drinking is viewed as being reinforced by the social approval of peers and psychological relief from anxiety and stress. Some behaviorists advocate that heavy or problematic drinking can be eliminated through negative reinforcement being introduced immediately following the drinking behavior. The treatment most commonly referred to as behavior modification, includes aversive conditioning: chemically induced nausea or vomiting following drinking, electric shock and antabuse (Ward, 1980).

On the other hand, positive reinforcement is included in the sphere of behaviour interventions related to control of alcohol use. The approach considers alcohol abuse or problem drinking as learned from the interaction of the individual with his/her physical and social environment. Individual behavior is seen as being reinforced by the use and effect of alcohol, through the escape from unpleasant, stress producing situations. Also, the physiological effects of alcohol on the body are pleasurable, which reinforces the ingestion of alcohol (Beigel and Gherther, 1977). Consequently the drinking behavior is reinforced by euphoria

and subsequently drinking reoccurs. Treatment based on social learning theory assumes an acceptance of the client by the therapist in a non-moralistic milieu. Support, insight, and encouragement are offered to the client as positive reinforcers to not drink. Coping and social skills are taught and positively reinforced, as alternative behaviours to dealing with feelings of stress and human relations problems. Similarly, Tarter and Edwards (1988) suggest that improvement in social skills and reduction of anxiety are effective strategies for alcoholics. Positive feedback provided by staff and other clients, to a problem drinker demonstrating abstinence and "mature" behaviour, reinforces the non-drinking behaviour (Kissin & Berglerter, 1977).

With due consideration to the limits of traditional behavioral models, Marlett (1985) proposed a cognitive behavioral model of alcohol dependence. The need to rely on alcohol is viewed as behaviorally based within the individual. Common factors associated with excessive alcohol use are feelings of frustration, anger, inability to resist social pressures to drink, anxiety, depression, loneliness and boredom. These limitations are linked with such factors as level of stress, sense of control and self-worth, and positive expectations the individual has of the effects of alcohol.

The behavioral model, while recognizing the significant role of the individual, does not exclude or minimize social or other external factors. Further, the evolution of this model has contributed significantly to the overall development of a scientific approach to the investigation of alcohol problems. However, these scientific endeavours have raised controversial issues such as "controlled drinking" and "various aversion therapies."

PSYCHOSOCIAL PERSPECTIVE

The psychosocial model utilizes current knowledge and brings together multiple dimensions of life functioning to deal with a complex phenomena. The psychosocial perspective has recently been described within the context of social work practice in the addictions field (Kimberley, 1985) and alcohol abuse and the elderly (Zimberg, Wallace & Blume, 1978). According to Pattison (1982) individuals vary in terms of presenting alcohol problems. Some have developed problems intermittently from their first drink, while others develop alcohol problems in response to various life crisis or disturbances. Individual backgrounds, drinking behaviour, personality traits, education, socio-economic status have all been shown to vary considerably amongst alcoholic clients. Psychosocial issues relative to alcohol problems are referenced regularly in current research (Fengarette,

1988; Earls, Reich, Jung and Cloniger, 1988; Barbor, Dolinsky, Rounsaville and Jaffe 1987). Begleiter and Poyes (1988) concluded that alcoholism was not the product of a single biological or behavioral factor, but resulted from intricate interactions of both biological and behavioral factors in combination with environmental influences.

Sadava (1987) indicates that within a culture where drinking alcohol exemplifies masculinity, social acceptance, relief of tension and the ultimate status, it may also be perceived as positive psychosocial development. Therefore, when alcohol problems develop, the intervention should include changes in various psychosocial and behavioral factors. It is not sufficient to focus on a change only in drinking behavior. Abstinence, for example, is not always associated with psychosocial well being.

Classification of alcohol problems of the elderly found distinctions between alcoholics with and without an organic mental syndrome. These distinctions necessitate a difference in programs and treatment approaches. Some develop alcohol problems prior to aging while others only become alcoholic in later years (Zimberg, Wallace & Blume, 1978). Those who are alcoholic for an extended period of time often demonstrate characteristics similar to younger alcoholics; however, those who develop alcohol problems later in life

usually do so in association with depression, marital stress, physical illness, and/or retirement. The significance of the interaction of emotional, behavioral, cognitive, relational and situational factors applies equally to alcohol problems at all age levels.

The impact of alcohol problems on the family and the interactive effects in reinforcing the problem is well documented (Bepko & Krestan, 1985; Cork, 1969; Kaufman & Kaufmann, 1979; Davis, 1987; Leikin, 1986). The impact on children is also documented (Cork, 1969). Alcohol abuse or alcoholism does not occur in isolation. Its impact will be felt on individuals, their families, the communities in which they live and the larger society. Kissin (1977) suggests that intervention should be ecological, sociological, familial and individual. Any approach to intervention which omits one of these dimensions is seen as limited. A psychosocial perspective of alcohol abuse takes into consideration the significant variance among individuals who experience alcohol problems. Recognition and appreciation of individual differences is more congruent with what is known about alcohol abuse and with effective intervention. Meeks (1984) in F. Turner (1984) reviews the benefits of an individualized, psychosocial perspective for a social work treatment approach.

HISTORICAL CONTEXT WITHIN THE PROVINCE OF NEWFOUNDLAND

Problems related to the abuse of alcohol are major public and social health issues. No other single social problem is seen to have such a devastating impact upon society; the people of the province of Newfoundland and Labrador are no exception. Here public concern began to be expressed formally approximately forty years ago with various groups and individuals advocating temperance and abstinence. Community action and further examination of issues began in 1950 with the formation of the Newfoundland Temperance Federation later to become known as the Newfoundland and Labrador Council on Alcohol Problems.

Historically, formal intervention, both public and private has been limited throughout the Newfoundland. Prior to 1982, policies had not been developed to ensure the establishment of effective programs of prevention, education, and treatment to deal with alcohol misuse and associated problems.

In 1970, the Alcohol and Drug Addiction Foundation (A.D.A.F) was incorporated as a private agency. Its constitution supported a mandate to implement programs of prevention, education, and rehabilitation. Due to a lack of resources, its focus was limited to education and public

awareness. Throughout the seventies, various community advocacy groups were operative within the province under the co-sponsorship of the ADAF. Their action focused on encouraging the provincial government to increase support in the areas of the prevention and the management of alcohol and other drug problems. In these initial stages, while some valuable community work was accomplished, limited professional and material resources did not permit any level of sophistication in the development of interventive services.

Recognizing the significance of the need, in 1982, the province enacted legislation to address problems of alcohol and other types of abuse when it established the Alcohol and Drug Dependency Commission of Newfoundland and Labrador (ADDC). The Commission has a mandate for the development and co-ordination of prevention, education and rehabilitation programs encompassing a range of drug abuse problems. The Commission is an agency of the provincial government and reports directly to the Minister of Health.

In its early years the Commission focused its resources on the development of a management system, and the enhancement of community education and awareness. Within the Commission the treatment of alcohol abuse received little formal attention until 1985 when the provincial government

provided some needed resources for the development of treatment services.

The few alcohol specific programs that exist in the province operate in relative isolation from one another with both limited missions and narrow program foci. These services often developed in response to a specific identified need in a particular location. Prior to the formation of the Commission, a mechanism to facilitate coordination and program improvement was not in place. The Commission's mandate includes coordination of existing services and long range planning for the further development and implementation of services.

Individuals and families are hurt by problems related to alcohol abuse, and within this context the community shares the problem. The problems exhibited by individuals, families, and communities are costly in both social and economic terms. In addition to impacting on individuals and their families, alcohol problems take their toll on existing health and social services. Similar to other jurisdictions, alcohol problems impact negatively upon the work place resulting in significant financial loss through poor job performance and lost productivity. It has been conservatively established that the cost of alcohol abuse to Newfoundland society is \$56,379,083 per annum (Cake, 1984).

The author concludes that alcohol and other drug abuse has far reaching effects upon the lives of the people of Newfoundland and Labrador.

Policies and programs must be expanded and refined, if the province is to meet its social responsibility to provide effective treatment for individuals and families affected by alcohol abuse. This study is intended to shed some factual light on questions of the public perception regarding the what, the who, the how, and under what conditions treatment services for alcohol problems should be developed and implemented. Such information is necessary to inform service and other policy planning.

CHAPTER 2
A STUDY TO INFORM ALCOHOL TREATMENT
POLICIES AND PROGRAMS

This study is a survey of public perception and beliefs regarding alcohol problems. Findings from such a study will provide a basis to support informed policy and social program development pertaining to psychosocial treatment services for individuals with alcohol problems and their families - services that transcend the limits of the medical model. Research in this area is of significance to the field of addictions and the province's efforts in developing this area of public service. This survey is timely because the development of addiction-specific treatment service has been established as a priority for the Alcohol and Drug Dependency Commission of Newfoundland and Labrador.

The author's interest in the area of treatment of alcohol related problems evolved early in his career. The graduate practicum for the M.S.W. consisted of experiential learning within the context of policy development and treatment programs and involved brief internships with five addiction treatment programs in Ontario.

The addictions field is in its early stages of development in Newfoundland and Labrador. The ADDC was

established in 1982, with a mandate to coordinate, develop and implement services within the area of alcohol and drug dependency for the people of the province. Over the past three years, the issue of treatment services has received increased attention. Local research in the area is lacking, particularly with respect to treatment and rehabilitation for individuals and families experiencing problems with alcohol or other chemicals.

PURPOSE

The purpose of this survey is to explore and describe public perception and belief regarding alcohol problems and their treatment within a Newfoundland context. The study also examines the public's perception of the competence of social workers in the psychosocial treatment of problems related to alcohol abuse, and the extent to which they are receptive to utilizing social workers as professionals for primary care of alcohol problems.

It is hoped that the results of this survey will influence policy formulation, planning and administrative decision making with respect to the development of psychosocial treatment services for individuals and families experiencing alcohol problems.

GOALS

In the interest of informing: alcohol treatment programme planning; the development of treatment policy; and the provision of community education, this study is intended:

To describe the respondents' perceptions of alcohol abuse as a problem of the individual, family, work setting and community.

To describe the respondents' perceptions regarding the ownership and attribution of etiology of the alcohol problem (i.e. is the individual, family, work setting or community defined as being, at least partially responsible for the problem?)

To determine the respondents' willingness to use psychosocial treatment programs and psychosocial therapy.

To determine the respondents' acceptance of various addiction counsellors with special reference to professional social workers as a source of primary assistance with personal and family problems associated with alcohol misuse.

Study Objectives

1. Individual Oriented:

To determine the extent to which respondents define alcohol abuse as solely an individual's problem.

To describe how respondents account for the development of an alcohol problem in a family member.

To determine the respondents' perception of the criteria for improvement of an individual who has an alcohol problem.

To determine the respondents' definition of alcohol problems.

2. Family Oriented:

To establish the extent to which respondents define as their personal responsibility, actions to help a family member obtain assistance with an alcohol problem.

To determine the degree to which respondents define alcohol problems as originating within the context of family dynamics.

To determine the respondents' awareness of and willingness to use individual and family counselling services.

To determine the degree to which respondents are willing to participate in family counselling.

3. Community Oriented:

To determine the extent to which respondents define alcohol abuse as a community problem.

To determine the level of social responsibility for the treatment of alcohol problems and what is seen as appropriate.

4. Employer Oriented:

To establish the degree to which respondents assign some

responsibility to the employment situation in either promoting or reinforcing alcohol abuse.

To determine the respondents' perception of the cost of alcohol problems to the employer.

To determine the respondents' perception of the most effective way employers should manage alcohol problems.

To determine the extent to which respondents perceive that the employer should assume some responsibility in the intervention of alcohol problems.

To determine the respondents' perception of how an individual's alcohol problem impacts upon the employer.

5. Social Workers as Primary Care Professionals:

To determine the respondents' awareness of and willingness to use professional social workers who offer individual and family counselling.

To determine the respondents' awareness of the contribution that a social work professional can make to help individual and families manage an alcohol problem.

To determine the degree to which respondents are willing to participate in counselling sessions conducted by a social worker.

To determine if additional information regarding professional social workers impacts upon respondents' perceptions.

6. Respondents' Preference for Particular Service Models

To determine the respondent's acceptance of a moral definition of alcoholism.

To determine the respondents' acceptance of a medical definition of alcoholism.

To determine the respondents' acceptance of a disease definition of alcoholism.

To determine the respondents' acceptance of a behavioral definition of alcohol problems.

To determine the respondents' acceptance of a psychosocial definition of alcohol abuse.

THEORETICAL BASIS OF GOALS

GOAL ONE

PUBLIC PERCEPTION OF ALCOHOL ABUSE AS A PROBLEM OF THE INDIVIDUAL, FAMILY, WORK SETTING AND COMMUNITY.

Ablon (1980) asserts that the understanding of the use of alcohol in any population requires a knowledge of drinking behavior and cultural interpretations of drinking and drinking problems within the population. Cultural factors have been recognized as necessary for the understanding the occurrence, symptom, expression, and treatment of various disorders and social problems. Low (1984) argues that cultural information can assist in the development of service programs and "systems" which address the broader dimensions of client issues relative to family and community.

According to Steinglass (1987) the World Health Organization (WHO) bases its current definition of alcoholism on a social-cultural dimension. The WHO definition is as follows:

Drug dependence of the alcohol type may be said to exist when the consumption of alcohol by an individual exceeds the limits that are accepted by his/her culture, if he consumes alcohol at times that are deemed inappropriate within that culture, or his/her intake of alcohol becomes so great as to injure his/her health or impair his/her social relationships.

How a population defines problems of alcohol abuse will impact significantly on many issues related to the incidence and type of intervention. Indeed, public perception determines whether alcohol abuse is considered problematic and the degree to which it is considered problematic, resolvable and what forms of personal and social interventions are acceptable. Public policy analysis and development concerning community response to alcohol problems must consider public perception of the nature of alcohol problems.

Shallow (1941) infers that what is reasonable and well balanced behavior in one culture may be viewed quite differently in another. Intervention or treatment must be sensitive to the cultural context of the problem in order that the client may optimally relate to therapy. In support of the importance of cultural factors, he further stressed that alcohol is a cultural artifact where the type and context of drinking alcoholic beverages are culturally defined. Further, the importance of culturally sensitive treatment for black alcoholic families has been most recently described by Ziter (1987).

As a further illustration of the role culture plays in alcohol dependency, Negrete (1973) verified that psychosocial "symptomatology" of the condition differs

according to the background of the client. His research has shown that factors such as unemployment, marital maladjustment and criminal activity were not experienced in the same way by persons with alcohol problems from three different cultural backgrounds. In addition, Westermeyer (1974) emphasized the need for cultural studies of alcohol use to provide an appropriate perspective to facilitate the development of treatment and rehabilitation programs. The context in which alcohol is used and the cultural perception of the nature and basis of alcohol problems impacts upon the perceived suitability and acceptability of the treatment process. Cultural differences in defining problems, expectations of treatment and in subsequent compliance, are associated with cultural variations in belief and norms of culturally accepted and expected behaviour.

With respect to mental illness, culture has been considered etiological through child rearing practices, stressful roles and culture change (Leighton and Hughes, 1961). The very process used to define and identify mental health and illness is related to cultural background (Favazza, 1978). What a society considers to be problematic or hazardous drinking is affected by our culturally determined values and definition of reality.

GOAL TWO

PUBLIC PERCEPTION REGARDING THE OWNERSHIP OF THE ALCOHOL PROBLEM. IS THE INDIVIDUAL, FAMILY, WORK SETTING OR COMMUNITY, DEFINED AS BEING, AT LEAST PARTIALLY RESPONSIBLE FOR THE PROBLEM AND ITS RESOLUTION?

Throughout his professional career, the author has witnessed an array of perspectives on the origin of alcohol problems. It has been his experience that many view such problems as being clearly within the realm of the individual with respect to problem origin, continuation, responsibility and potential for meaningful change. Options for treatment are significantly limited if public expectations are focused solely on the individual. This leaves responsibility with the individual resulting in limited intervention until s/he decides to act. In reality, such unilateral action quite often does not occur. For example, in studies of American Indians with alcohol problems, it was found that the chance of successful rehabilitation of the individual was significantly enhanced through participation by the family, workplace and community (Mendelson & Mello, 1985).

Through studies involving twins and adoptees, a major argument supporting an individual origin of alcohol abuse has been that of heredity or genetic factors in the causation of an individual to abuse alcohol. Genetic studies appear inconclusive, however this may be attributable to the

limitations thus far in the study of genetics (Goodwin, 1985). However, results from adoption studies have given some support to the existence of a genetic or heredity factor. Sons of alcoholics are seen to be four times more likely to be alcoholic than are those of non-alcoholics (Goodwin, 1979). Both the genetic and adoption studies support a possible genetic predisposition to alcoholism. Further research is required to establish the extent to which genetic factors account for both the development and progression of an alcohol problems within various populations.

Knowledge of family lifestyle and behavior can provide a basis for assessment and effective therapeutic intervention. Research has consistently indicated group variance between children of alcoholics and nonalcoholics. Familial studies concerning the diagnostic process are described in Mendelson & Mello, (1985); Bepko & Krestan, (1985).

Considerable research exists illustrating the negative effects which alcohol abuse can have upon a family. Beginning with conception, excessive alcohol ingestion by the mother can severely endanger the health of the fetus (Mendelson & Mello, 1985). Fetal Alcohol Syndrome develops when a mother consumes alcohol in various amounts during

pregnancy. This syndrome is characterized by facial abnormalities, growth retardation, developmental retardation and intellectual delay (Nadel, 1985; Blume, 1985; Giunta and Streissguth, 1988). Following birth, children raised in a home with an alcohol abusing parent often experience shame, guilt, isolation, rejection, anger, frustration, loneliness and emotional neglect (Cork, 1969; Wallace, 1988; Tarter and Edwards, 1988).

Denial of the existence of a problem is common in families where there is an alcohol problem (Bepko, 1985). The refusal to accept reality is to some degree attributable to the social stigma which so strongly exists in society. This denial, while sometimes unconscious, is a major impediment to treatment. The family denies the extent of the alcohol abuse and reinforces it and related behaviour by "covering up" for the member with the drinking problem.

Alcohol abuse impacts significantly upon the family. With family member interactions being confounded in the individual's drinking pattern, the involvement of the family is considered important in effective intervention (Kaufman and Kaufman, 1979).

Community ownership of alcohol problems is clearly demonstrated through prevailing social and cultural

attitudes towards alcohol (Linsky, 1970, 1972, Mendelson & Mello, 1985). The effects of alcohol abuse are demonstrated throughout the community by lost productivity, crime, family breakdown, health and social service costs (Coke, 1984; Kimberley, 1985). Community support is considered important if community policies, programs and coordination in the interest of treating alcohol problems is to be effective. A program must have some community "sanction" and meet the specific needs of the community if it is to be utilized effectively. Where resources or programs do not match community needs, resources may be used inappropriately and those requiring service may not receive it. Within this perspective, Catanzaro and his associates (1968), argue it is necessary to approach alcohol treatment services from the perspective of the community.

Community demographic characteristics have been correlated with the levels of alcohol consumption within populations. Cahalan (1970) et. al. have indicated through national surveys that the extent of drinking was correlated with age, sex, socioeconomic status, ethnic background, education, occupation, and degree of urbanization. Similarly, Leland (1980) cited factors of a social and cultural nature contributing to drinking problems among American Indians. War, political oppression, forced migration, loss of traditional culture, unemployment, low

income and relatively inferior education are also seen as significantly correlated with increases in the incidence of alcohol problems. The importance of culture and community values in understanding alcohol abuse is further explored by Nofz (1988) who suggests that alcohol problems of the American Indian must be assessed and treated with reference to the context in which they occur.

It is argued by some that responsibility must rest with the community given its endorsement of the use of alcohol as the legalized drug of choice. Promotion through lifestyle advertising, sporting events and governmental distribution are but a few reasons cited as the community's responsibility to provide services for those afflicted by the abuse of alcohol.

In addition to relevance from the perspective of contributing to the problem then the community has relevance from the standpoint of intervention as well. Ferguson (1968) described higher treatment success rates when clients acquired steady employment or became involved in the community. Similarly, Mendelson and Mello (1985) indicated that within the intervention and treatment process, vocational rehabilitation, family and peer support, and community involvement are key components for maximizing intervention effects. Therefore, a comprehensive continuum

of treatment services should include all of these areas as vital components.

With respect to the work setting, it has been estimated that between 10 - 15% of employees will encounter problems with alcohol. Alcohol problems are associated in the work setting with higher accident rates, sick leave and lower productivity. Alcohol abuse has been estimated to cost industry billions of dollars each year. Cake (1984) estimated that Newfoundland loses approximately \$20,000,000 a year in lost productivity due to alcohol problems.

The workplace provides an excellent forum for optimal intervention with the individual experiencing problems with alcohol. Early identification and referral of such employees, based on the decline of work performance, affords the workplace with the opportunity to constructively confront and refer such individuals to treatment. Mendelson and Mello (1985) assert that the development of comprehensive community resources should include programs within the workplace.

Employee Assistance Programs (E.A.P.) have evolved in many workplace settings during the past decade. Trice, (1981) et. al. have documented the area of E.A.P. from an intervention perspective affording the opportunity for early

detection and referral of the employee experiencing difficulty with alcohol. Contact with the employer can assist to maintain a job position to provide continuity, support and opportunity for the individual following rehabilitation. The employer can also be instrumental in maximizing the client's motivation for treatment sometimes for no other reason than the threat of job loss.

GOAL THREE

RESPONDENTS' WILLINGNESS TO USE PSYCHOSOCIAL TREATMENT PROGRAMS AND PROFESSIONAL PSYCHOSOCIAL THERAPY.

Many theories have been presented on the etiology of alcohol problems, but no single theory or model can account for both its development and maintenance. A psychosocial model avails of the present knowledge base and brings together multiple models to deal with a multiple phenomenon. Psychosocial factors may be classified into categories which include the following dimensions: cultural, environmental, interpersonal, and intrapersonal influences. These psychosocial factors will influence the individual's decision to drink initially or to continue use, (i.e. onset of drinking, problematic drinking, progression of the problem, abstinence or controlled drinking, maintenance of

improvement and relapse).

Alcohol abuse and dependence do not occur in isolation. In order for intervention to be effective, it should be ecological, sociological, familial and individual (Kissin, 1977). Any approach to intervention which omits one or more of these areas is limited in meeting individual needs and in serving the public.

During the last fifteen years, research has demonstrated the severe limitations of the unitary concept. For example, the disease concept has turned towards multi-dimensional factors associated with alcohol problems which require various forms of rehabilitative services Mendelson & Mello, (1985). Pattison (1982) has felt that such a unitary concept has limited research and development in the field. He and others have developed a multi-variate model in the treatment of alcohol problems.

Ward (1980) suggests that alcohol problems should be viewed as a symptom of a complex interactional process of the individual and his/her environment. Factors within the individual include psychological development and conflicts, and the degree of physiological addiction. Environmental factors include primarily the family, but also the employer, friends, professional helpers and the attitudes about

drinking behavior within the society. Bepko and Krestan (1985) and Kaufmann (1985) et. al. describe the interrelationship of family factors. Bales (1962) et. al. also describe such cultural factors. Ward (1969) et. al. note that many treatment programs focus all their attention upon the alcoholic, often ignoring or even excluding significant other members of the family despite the fact that a broader approach has been recommended for quite some time.

The public perception of alcohol problems will have a bearing on the population's willingness to accept the psychosocial model. Since unitary approaches have been widely promoted throughout the years, often single or narrow approaches to rehabilitation are desired. If one considers the problem as being caused by or solely within the control of the individual, then a psychosocial approach to treatment would be difficult to implement. Correlatively, abstinence from alcohol has often been cited as the sole indicator of successful rehabilitation. But Cork (1969), describes situations where abstinence actually precipitated more family difficulties. A psychosocial approach to treatment requires an indication of improvement in a number of life skill areas. The belief of a community that successful rehabilitation rests solely in the individual abstaining

from the use of alcohol undermines the adoption of a psychosocial approach (Kimberley, 1985).

In the absence of formal education and awareness concerning the etiology and manifestations of alcohol problems, unitary perspectives of alcohol problems are quite common. The view that one who develops a problem with alcohol should simply cease from any further ingestion of the beverage is seen by this author as one which is widely held in Newfoundland. In many instances, judges, supervisors, and physicians simply order individuals with alcohol problems to refrain from drinking in order to avoid further trouble with the law, at work or in terms of medical problems.

It is important that the public give support to a broader view which includes the acceptance of psychosocial therapy. It has been the author's experience that many people are reluctant to avail of counselling and therapy for alcohol related problems. A commonly held view is that an individual should be able to "cope" or "deal" with his/her personal problems and that seeking counselling or therapy is an indication of personal weakness.

GOAL FOUR:

PUBLIC'S ACCEPTANCE OF VARIOUS ADDICTION COUNSELLORS WITH SPECIAL REFERENCE TO PROFESSIONAL SOCIAL WORKERS AS A SOURCE OF PRIMARY ASSISTANCE WITH PERSONAL AND FAMILY PROBLEMS ASSOCIATED WITH ALCOHOL MISUSE.

Undergraduate professional social workers receive in excess of 700 hours of clinical practice experience as part of their education for professional practice.

Social Workers are proficient in direct counselling techniques as well as most facets of the psychosocial intervention process. Also, Schmidt, Smart and Moss (1968) in their study of the relationship between social class and the treatment of alcoholism, found that social workers treated equally high proportions of all three socio-economic groups studied. The authors attributed this lack of class difference in the clients of social workers to the overall adaptiveness of this profession to the particular client needs. Depending on the skill levels of the client, the social worker therapists will modify the approach taken within the therapeutic process. Their results also indicated that social workers treated a significantly more clients from a cross section of socio-economic groups than did general practitioners and psychiatrists. Study results lend

support to the view that social workers are qualified to treat individuals and their families with alcohol problems.

Weir (1981) in a national public opinion survey, in the United States, found that social workers were considered to be those who gave advice and assisted people in difficulty. They were considered as professionals trained to solve personal and family problems. For the most part, they were viewed as workers who helped families solve problems or cope with living. A very large proportion of the respondents felt strongly that social workers should help people cope with emotional problems. Very high percentages of those polled felt that social workers should be largely involved in the helping process, e.g., emotional problems, mental handicaps, disabled persons. Weir concludes that social workers have a positive image in the community. According to Weir, 60% of those people who had personally visited a social worker were satisfied with the assistance provided them. Twenty-six percent of respondents had come in contact with a social worker through their work environment.

Social workers are commonly employed in various social services and social programs where it has been estimated that between 15-35% of clients exhibit at least a secondary problem related to alcohol abuse (Kimberley, 1975). In the area of addictions programming, social workers are

responsible for a broad range of intervention, including psychosocial intervention within hospitals, psychiatric services, outpatient clinics, residential centres and private practice (Kimberley, 1985). Leikin (1986) described the role of social workers in the identification and treatment of alcohol problems as a vital aspect of community service.

In view of such research relative to social workers, their responsibilities and their utilization by the public, it is important to ascertain the Newfoundland public's perception of social workers and their willingness to utilize professional social workers as a professional resource when confronted with an alcohol problem. Given the professional status of baccalaureate education in social work, given the public acceptance of social workers for personal, family, addictions counselling and therapy, then the most cost-effective professional intervention for addictions problems is probably a social work service.

CHAPTER 3

METHODOLOGY

This study used a survey design which included the distribution of a questionnaire to a random sample of residents of St. John's, Newfoundland within five census tracts. In the interest of answering specific research questions, stratified sampling procedures were also applied. The net result was that two hundred (200) responses were utilized from a potential of 6,575 respondents who met the study criteria.

The instrument used for data collection was a "hand distributed" questionnaire (See Appendix A). The questionnaire consisted of eighty questions soliciting information regarding the respondent's perceptions of various aspects of alcohol problems, his/her willingness to use various services and acceptance of various addiction counsellors/therapists with special attention given to professional social workers. Demographic data concerning the sample population was collected. The questionnaire took approximately thirty minutes to complete.

This study focused on an urban population, as this population was more accessible and less costly for preliminary study. It was the hope of the author that

further refinement of the method, design and procedures could then be applied to a rural context in future studies. In addition, program development can be expected to be different for an urban area in comparison with a rural area and existing services, and access to them would possibly differ in an urban versus a rural community.

Survey Design and Procedures

The conceptual population was the population of households in St. John's, Newfoundland (population 1981: n=15,560). The study population, based on five census tracts was 6,575 households. The instrument was delivered to 375 qualified respondents. The results of this study are based on 200 responses. Qualified respondents were male or female "heads of families - - "heads of households". Husband-wife family household refers to a husband and a wife, with or without children, including common-law relationships, living in the same dwelling (Statistics Canada, 1981).

The author reviewed census information through the reports of the 1981 Census. Statistics Canada divides the City of St. John's into approximately twenty census tracts which are geographic entities. The census information was reviewed for all census tracts with focus on selecting those tracts which included representation of family households

based on considerations of family income and religion. It was possible to select five such tracts which collectively represented the socio-economic profile of the city as a whole. The census tracts selected for the research project were CT-003; CT-004; CT-006; CT-014; and CT-015.02 (See Appendix B).

Moser and Kalton (1972) describe this type of sampling as "area sampling", typically involving a number of stages. Accordingly, this method involves dividing the area, to be surveyed, into smaller areas from which a sample is selected randomly. Moser and Kalton indicate that such area sampling is a form of multi-stage sampling using maps or geographic areas to serve as the sampling frame. The sampling procedures in this study were based on geographic boundaries of the various census tracts and on listing of streets and addresses through the city directory for St. John's

Using the street index of the 1981 census, all streets and households within each census tract were identified. The total number of households in each tract was determined. A series of random numbers was generated by computer for each census tract ranging from one(1) to the specific total of households in each census tract. Each number would then correspond to a particular house on a particular street within a census tract. Once the house was identified a

resident (potential respondent) was then identified by using the city directory. Following the identification of the male or female resident, an address was located as well as a phone number and a determination was made regarding family household status, as defined by the study. Once identified, male and female respondents for each household were chosen alternately. This process was followed to generate in excess of forty households per census tract. This procedure was continued until a quota of two hundred questionnaires were returned comprising at least forty from each of the five census tracts and one hundred males and one hundred females.

Once selected, each household was contacted by mail informing them of the survey. The content of this correspondence described the purpose of the survey and endorsed the study on behalf of the School of Social Work of Memorial University (See Appendix C). In the letter, support and co-operation in completing a questionnaire was requested. It stressed that their input was critical to the development of treatment services and programs. The respondents were also informed that the survey was sanctioned by the Alcohol and Drug Dependency Commission (See Appendix D). Their responses would be used to assist in the formulation of policy and subsequent development of treatment services. Confidentiality of the responses was ensured and every effort made by the researcher to maintain

anonymity of the respondents. The letter also indicated that a researcher would be contacting them by phone, in a few days, to ask for their co-operation.

The potential respondents were contacted by telephone within three to four days of receiving the letter. The research assistant, a fifth year social work student, introduced him/herself and explained that they were calling with respect to the correspondence previously forwarded to them from the School of Social Work. The particular respondents co-operation was solicited emphasizing the importance of the research to the improvement and expansion of treatment services. The confidentiality of the responses was again emphasized to the respondents (See Appendix E).

Those individuals who consented to participate in the survey were hand-delivered a research packet consisting of a questionnaire, a stamped addressed envelope, and an instruction sheet. The respondents were asked to complete the questionnaire within twenty-four hours. They were further asked to then return the completed questionnaire in the stamped addressed envelope at the earliest opportunity (See Appendix F.) Follow-up phone calls were made within a week to remind respondents to forward their completed questionnaires. This process was continued until two hundred questionnaires had been returned to the researcher. Over

half of the sample responded without reminder. Only a few required a second reminder. All data were collected within a four week period.

CHAPTER 4

RESULTS

The study involved a distribution of questionnaires within five census tracts as defined by Statistics Canada for the city of St. John's, Newfoundland. The sample was composed of the first two hundred (200) respondents who completed and returned their questionnaires to the researcher. These comprised one hundred male and one hundred female respondents, totalling forty (40) per census tract. Half of both the male and female respondents received information pertaining to social work and social work education (WSW) and one half did not (NSW). The composition of the sample is illustrated in Table 1.

The response rate per census tract based on a total population of 6,575 households was as follows:
CT-003 (78.5%); CT-004 (50.6%); CT-006 (47.3%);
CT-014 (71.4%); and CT-015.02 (72.3%). The overall response rate was 61.9%.

Age

The mean age of the respondents was 48.6 years. The mean age for females was 46.4 years and males 51.7 years. The age range was 59 with the youngest respondent being 21

TABLE 1

Sample Categories According to Census Tract, Gender and Social Work Information

CENSUS TRACT	M/WSW	M/NSW	F/WSW	F/NSW	TOTAL
CT-003	10	10	10	10	40
CT-004	10	10	10	10	40
CT-006	10	10	10	10	40
CT-014	10	10	10	10	40
CT-015.02	10	10	10	10	40
TOTAL	50	50	50	50	200

years of age and the oldest 80 years. These results compare with Statistics Canada results for 1981 for St. John's as follows: age range containing most females was 25-34 years; age range containing most males was 25-34 years.

Marital Status

As the study focused on "family" households, it is not surprising that 93.5% (n=186) of the respondents were married, 3% (n=6) were single and 1.5% (n=3) separated or divorced.

Income

Thirty-six point five percent (n=73) of the respondents reported a family income of \$40,000.00 or more per year. Nineteen percent 19.0% (n=38) reported a family income of between \$30,000-\$39,000. The next largest family income cited was between \$20,000-\$24,999 with 11.5% (n=23) of the respondents in this range.

While the sample includes representation from all income groups, when compared to the census, the sample in this study has two groups which are over represented, four

groups that are under represented and two which are close to expectations. Table 2 provides further descriptive data on family income.

Religious Affiliation

The distribution of religious affiliation was relatively representative of the general population with 46.5% (n=93) and 45.0% (n=90) of the respondents being Roman Catholic and Protestant respectively (See Table 3).

Experience with Alcohol Problems

The survey contained three questions concerning the respondents personal experience with alcohol problems: "Have you personally ever experienced an alcohol problem?" "Has anyone in your immediate family (mother, father, brother and/or sister) ever had an alcohol problem?" "Has your husband/wife/partner ever experienced a drinking problem?" These findings must be considered within the context of alcohol problems being defined as "a range of drinking problems up to and including what you would call alcoholism"? Table 4 summarizes the responses to each of the above questions.

TABLE 2
Reported Family Income of Respondents

INCOME	FREQUENCY	SAMPLE PERCENT	CENSUS PERCENT
Under \$5,000	4	2.0 %	5.9%
\$5,000-9,999	6	3.0 %	9.4%
\$10,000-14,999	14	7.0 %	12.2%
\$15,000-19,999	17	8.5 %	13.5%
\$20,000-24,999	23	11.5 %	14.9%
\$25,000-29,999	18	9.0 %	12.4%
\$30,000-39,999	38	19.0 %	17.3%
\$40,000 or more	73	36.5 %	14.4%
Missing	7	3.5 %	-

TABLE 3
Reported Religious Affiliation of Respondents

RELIGION	FREQUENCY	SAMPLE PERCENT	CENSUS PERCENT
Roman Catholic	93	46.5%	47.8%
Protestant	90	45.0%	48.3%
Jewish	1	0.5%	0.12%
Other	6	3.0%	0.35%
No Preference	5	2.5%	1.8 %
Missing	5	2.5%	-

TABLE 4
Reported Incidence of One or More
Types of Alcohol Problem

ALCOHOL PROBLEM	YES (%)	NO (%)
Personal Problem	28 (14%)	171 (85.5%)
Family Problem	76 (38.0%)	119 (59.5%)
Spousal Problem	21 (10.5%)	177 (88.5%)

Personal Alcohol Problems

Twenty-four percent (n=24) of the male and four percent (n=4) of the female respondents indicated a personal alcohol problem. Twenty point five percent of those indicating a personal alcohol problem reported an annual income of between \$10,000-\$20,000 per year. While 9.6% (n=7) reported an annual family income of \$40,000 or more. In terms of education, the largest category (22.5%) reporting a personal alcohol problem was within the vocational/trade school category. The smallest category (8.3%) of respondents indicating a personal alcohol problem was those with "some university" education. An examination of religious affiliation showed that 22.6% (n=21) of the Roman Catholic respondents indicated they had personally experienced an alcohol problem while almost 7% (n=6) of the Protestants responded "yes" to this question.

Familial Alcohol Problems

Thirty-six percent (n=36) of the male and 40% (n=40) of the female respondents indicated they had experienced an alcohol problem with their father, mother, brother or sister. Respondents with an income of less than \$9,999 reported the highest incidence of familial alcohol problems

with 60% (n=60) responding "yes". The remaining income levels (10,000-19,999; 20,000-29,999; 30,000-39,000; 40,000 or more) were evenly distributed in the range between 32% and 40%, respectively, of those indicating an alcohol problem within their "family of origin". Between thirty and forty percent of individuals from the remaining income levels indicated an alcohol problem within their family of origin.

Familial alcohol problems were evenly distributed across six categories of educational achievement of respondents. Approximately 44% (n=11) of the respondents, of those having Grade nine education or less, indicated an alcohol problem within their family of origin while 46.2% (n=18) of those with at least one University degree reported they had experienced such a problem.

Roman Catholic respondents indicated more familial alcohol problems, 45.2% (n=42) acknowledged an alcohol problem within their family of origin compared with 33.3% (n=30) of the protestant respondents. There were too few respondents representing other Religious groups to allow for further analysis.

More female than male respondents, 13% (n=13) and 8% (n=8) respectively acknowledged having a spouse with a drinking problem.

Further results concerning the personal, family and spousal alcohol problems experienced by respondents are presented in Table 5.

Alcohol Problems in Context

The presence of an alcohol problem within an individual or other family member may have negative repercussions upon the entire family. It may also affect individual perceptions and attitudes toward the nature, cause and treatment of alcohol problems. Within this section, analyses are presented examining the significance of selected observed differences in the respondents' perceptions related to the problem and its treatment.

Respondents Indicating A Personal Alcohol Problem

Respondents who reported having a personal alcohol problem were more likely to report alcohol problems within their "family of origin" and or with a "spouse". Of twenty-eight respondents reporting a personal alcohol

TABLE 5

Number of Respondents who Indicated Personal Contact
with Alcohol Problems, by Sex, Income, Education and Religion

	N	Personal Alcohol Problem	Family Problem	Spousal Problem
Sex				
Male	100	24% (24)	36% (36)	8% (8)
Female	100	4% (4)	40% (40)	13% (13)
Income				
Up to 9,999	10	20% (20)	60% (6)	30% (30)
10,000-19,999	31	27.5% (7)	32.2% (10)	9.7% (3)
20,000-29,999	41	12.7% (5)	36.7% (15)	14.6% (6)
30,000-39,999	38	18.4% (7)	39.5% (15)	15.8% (6)
40,000 or more	73	9.6% (7)	39.7% (29)	4.1% (3)
Education				
Grade 9 or less	25	12% (3)	44% (11)	16% (4)
Some High School	13	15.4% (2)	46.2% (6)	7.6% (1)
Completed High School	45	13.3% (6)	40% (18)	13.3% (6)
Vocat/Trade School	40	22.5% (9)	35% (14)	7.5% (3)
Some University	36	8.3% (3)	25% (9)	11.1% (4)
One University Degree	39	12.8% (5)	46.2% (18)	9.5% (3)
Religion				
Roman Catholic	93	22.6% (21)	45.2% (42)	15.1% (14)
Protestant	90	6.7% (6)	33.3% (30)	5.6% (5)
Other	12	0% (0)	16.7% (2)	16.7% (2)

problem 19 people or 67.9% also reported such problems within their family of origin. Of 171 respondents indicating no personal alcohol problem, 57 people or 33.3% reported having an alcohol problem within their family of origin (See Table 6). The observed differences between these two groups, when tested with chi square, supports the conclusion that the differences are significant ($\chi^2 = 29.9$, $df=2$, $p < .05$). This finding is consistent with genetic research indicating that alcohol problems are often evident across generations of families.

As illustrated in Table 6 in presenting data, one option is to display missing values, but not include missing values in calculations. This option has been chosen in presenting the results of this study. The level of significance adopted is .05.

Of respondents who reported having a personal alcohol problem ($n=28$), 6 people or 21.4% also reported that they had a spouse with a drinking problem. In comparison, of respondents who acknowledge no personal drinking problem ($n=171$), 14 people or 8.2% reported that they had a spouse with a drinking problem.

The observations reported in Table 7 indicate that

TABLE 6

The Relationship Between Personal Alcohol Problems
and Family Alcohol Problems

		Personal Alcohol Problem			
		YES	NO	MISSING	TOTAL
Family Alcohol Problem	YES	19	57	0	76
	NO	5	113	1	119
	DON'T KNOW	3	1	0	4
	MISSING	1	0	0	1
TOTAL		28	171	1	199

Observed differences were evaluated using chi square and using a .05 level of confidence with Stats Pac Gold Statistical Software.

TABLE 7

The Relationship Between Personal Alcohol Problems
and Spousal Alcohol Problems

		PERSONAL ALCOHOL PROBLEM			TOTAL
		YES	NO	MISSING	
Spousal Alcohol Problem	YES	6	14	0	20
	NO	21	156	0	177
	DON'T KNOW	1	1	1	3
	MISSING	0	0	0	0
	TOTAL	28	171	1	200

respondents who had an alcohol problem, when compared with those who did not, were more likely to indicate that their spouse also had an alcohol problem ($\chi^2 = 15.4$, $df=4$, $p<.05$).

Individuals who had personal alcohol problems were more likely to support the argument that environmental or external factors account for the development of alcohol problems than were those who acknowledged no personal alcohol problem. Of 28 individuals who experienced such personal problems, 20 people or 71.4% of these respondents disagreed with the statement that "alcohol problems develop due to factors completely within the individual". However, of 171 respondents who did not have drinking problems 97 people or 56.7% disagreed with this statement (See Table 8). The difference between the two groups was found to be significant ($\chi^2 = 11.04$, $df=4$, $p<.05$).

Families of respondents with alcohol problems had greater involvement with professional counselling than families of respondents who acknowledged no alcohol problems. Of 28 respondents reporting a personal alcohol problem, 11 people or 39.3% also indicated that a member of their family had received professional counselling for a personal problem. In contrast, of the 171 respondents acknowledging no alcohol problem personally, 42 people or 24.6% reported that a member of their family had received

TABLE 8

The Relationship Between Personal Alcohol Problems
and Factor Within the Control of the Individual

PERSONAL ALCOHOL PROBLEM

		YES	NO	MISSING	TOTAL
Factors Within the Control of the Individual	AGREE	3	58	0	61
	DISAGREE	20	97	0	117
	DON'T KNOW	5	15	1	21
	MISSING	0	1	0	1
	TOTAL	28	171	1	200

professional counselling for a personal problem (See Table 9), ($\chi^2 = 13.8$, $df=2$, $p<.05$).

Respondents Indicating An Alcohol Problem Within Their Family of Origin

Of 76 respondents reporting having a mother, father, brother or sister who had a drinking problem, 14 people or 18.4% also reported having had a spouse with an alcohol problem. This compares with 119 respondents who did not experience a drinking problem with their mother, father, brother or sister. Of these, only 6 people or 5% reported a drinking problem within their spouse (See Table 10), ($\chi^2 = 34.9$, $p<.05$).

Moreover, of 76 respondents indicating they had a family member with an alcohol problem, 23 or 30.3% also reported that they had received counselling for some personal problem (not necessarily an alcohol problem). In comparison, of those respondents with no family member having an alcohol problem, 14 people or 11.8% reported having received counselling for a personal problem (not necessarily related to alcohol), (See Table 11). The observed difference between these two groups was evaluated and found to be significant ($\chi^2 = 17.8$, $df=9$, $p<.05$).

TABLE 9

Personal Alcohol Problems in Relation to a Family
Member Having Received Professional Counselling

PERSONAL ALCOHOL PROBLEM		YES	NO	MISSING	TOTAL
Family Member Having Received Professional Counselling	YES	11	42	1	54
	NO	12	122	0	134
	DON'T KNOW	5	7	0	12
	TOTAL	28	171	1	200

TABLE 10

Alcohol Problems Within Family of Origin
as Associated with a Spouse with an Alcohol Problem

Family Member With an Alcohol Problem

	YES	NO	MISSING	DON'T KNOW	TOTAL
Spousal	14	6	0	1	21
Alcohol	61	113	1	2	177
Problem	1	0	0	1	2
TOTAL	76	119	1	4	200

TABLE 11

Alcohol Problems Within Family of Origin
as Associated With Having Received Individual Counselling

Family Member With an Alcohol Problem

		YES	NO	MISSING	DON'T KNOW	TOTALS
Counselling for a Personal Problem	YES	23	14	1	2	40
	NO	53	102	0	2	157
	DON'T KNOW	0	1	0	0	1
	MISS	0	2	0	0	2
TOTAL		76	119	1	4	200

Of 76 respondents indicating they had a family member with a drinking problem, 16 people or 21.1% also reported that their families had been involved in family counselling with a professional social worker. Of 119 respondents who reported no family member with a drinking problem 7 people or 5.9% reported that their families had participated in family counselling with a social worker (See Table 12). The observed differences between these two groups was evaluated and found to be significant ($\chi^2 = 23.1$, $df=9$, $p<.05$).

Respondent's Spouse with an Alcohol Problem

Of 21 respondents who indicated having a spouse with an alcohol problem, 11 people or 52.4% reported that they had participated in personal counselling. Of 177 respondents who reported not having a spousal alcohol problem, 28 people or 15.8% reported that they had sought personal counselling (See Table 13). The observed differences were evaluated and found to be significant ($\chi^2 = 16.9$, $df=4$, $p<.05$).

Also, of 21 respondents who indicated having a spouse with an alcohol problem, 9 people or 42.9% reported that a member of their immediate family had participated in counselling provided by a professional social worker. Of 177 respondents who reported not having a spousal alcohol problem, 15 people or 8.5% indicated a family member had participated in counselling provided by a professional

TABLE 12

Alcohol Problems Within the Family of Origin
as Associated with a Family Member Having Received
Counselling From a Social Worker

Family Member With an Alcohol Problem

		YES	NO	MISSING	DON'T KNOW	TOTALS
Family Counselling With a Social Worker	YES	16	7	0	1	24
	NO	55	109	0	1	165
	DON'T KNOW	5	3	0	2	10
	MISS	0	0	1	0	1
TOTAL		76	119	1	4	200

TABLE 13

A Spousal Alcohol Problem as Associated With
Having Sought Personal Counselling

Spousal Alcohol Problem

		YES	NO	DON'T KNOW	TOTAL
Sought Personal Counselling	YES	11	28	1	40
	NO	10	146	1	157
	DON'T KNOW	0	1	0	1
	MISSING	0	2	0	2
	TOTAL	21	177	2	200

social worker (See Table 14). The observed differences between the two groups were evaluated and found to be significant ($\chi^2=32$, $df=6$, $p<.05$).

Perceptions and Opinions Concerning Alcohol Problems and Addictions Treatment

Responding specifically to the theory that alcohol problems develop due to factors completely within the control of the individual, 58.5% (n=117) of the sample disagreed with this notion. Similarly, 59% (n=119) agreed with the statement "alcohol problems develop due to a lack of self control".

Responses to more specific and focused questions were indicative of strong public support for social environmental etiological patterns. In contrast, 91.5% (n=183) perceived that social pressure may contribute to alcohol abuse, similarly, 85.5% (n=71) agreed that an alcohol problem may begin due to a life crisis such as the death of a spouse or marriage breakdown. Almost 90% (n=179) agreed that alcohol problems could develop due to stress.

TABLE 14

Spousal Alcohol Problem in Association With Family
Counselling With A Professional Social Worker

Spousal Drinking Problem		YES	NO	DON'T KNOW	TOTAL
Family Counselling With A Social Worker	YES	9	15	0	24
	NO	10	154	1	165
	DON'T KNOW	2	7	1	10
	MISS	0	1	0	1
TOTAL		21	177	2	200

Of those surveyed 94% (n=188) consider alcohol a drug and 71% (n=142) were aware that beverage alcohol is a depressant. One is led to conclude that public recognition of alcohol as a drug is high and as a depressant drug is moderately high.

Eighty percent (n=158) of the respondents indicated that public funds should be used to finance community based treatment services for individuals with alcohol problems. Moreover, 71% (n=142) agreed that an added tax should be placed on alcohol products which would be designated to finance addictions treatment and addictions education programs.

Ninety-five percent (n=190) believed the court should offer treatment to individuals who repeatedly commit crimes while under the influence of alcohol. Similarly, mandatory treatment of offenders with alcohol problems was supported by 95% (n=190) of the respondents to the survey. Both of the above should be considered within the context that the majority of the respondents, 59.5% (n=119), believed an individual committing a crime under the influence of alcohol is "just as guilty" as someone who has not been drinking.

Impaired Driving

Respondents believed that impaired driving offenders should be required to participate in education or treatment programs. Ninety-two and a half percent (n=185) believed multiple convictions of impaired driving should result in the offender being required to attend an alcohol treatment program. As well, 91% (n=182) of the respondents indicated such multiple impaired driving offenders should be required to attend an alcohol education program.

Work and Well-Being

The respondents believed that employers have a definite role in facilitating intervention with alcohol problems. Approximately 77% (n=154) of the sample agreed that employers should offer assistance to employees who develop alcohol problems. Similarly, 64.5% (n=149) believed that individuals who have lost control of their drinking should not be terminated from their employment in spite of the fact that 99.5% (n=199) held the view that an alcohol problem can cause poor job performance. Eighty-seven percent (n=174) took the position that employers have a responsibility to refer such employees for professional help.

The Heredity Issue

Sixteen and one-half percent (n=33) of the respondents agreed that alcohol problems are passed on from one generation to another. Sixty-two percent (n=124) disagreed that alcohol problems are passed genetically from one generation to another. Twenty-one percent (n=42) responded "don't know" to this question.

Multiple Problems of Families

Eighty-five and a half percent (n=181) believe that an alcohol problem exists when drinking causes family breakdown. Acts of abuse, particularly spousal and child abuse were seen as being related to alcohol problems by the respondents as 90% (n=180) and 80% (n=160) consider spousal and child abuse committed under the influence of alcohol were indicative of an alcohol problem. Alcohol problems were defined by 92% (n=190) of the respondents, as "family problems" in that such problems were seen as having a destructive effect upon the entire family. As noted earlier from the reverse angle, 76% (n=152) of the respondents agreed that family stresses lead to or reinforce drinking problems.

Models of Alcoholism

There was support for the concept of alcohol problems progressing from social drinking to the disease of alcoholism 68.5% (n=137). This would appear to indicate public support for the "progressive stages" concept of alcoholism. Within the context of a medical model, 78% (n=156) agreed successful rehabilitation requires the problem drinker to abstain from alcohol for the rest of his/her life. Reduction in the amount consumed was not sufficient as an indication of rehabilitation, 55% (n=110) disagreed that for a person who has an alcohol problem, reducing the amount of alcohol he/she drinks indicates improvement. However, 66.5% (n=133) respondents acknowledged that one might still expect individuals with alcohol problems to have "a relapse" sometime following their rehabilitation.

Family Support

Respondent answers to many of the preceding questions indicate the importance of individual responsibility but also strongly support family "ownership" of the problem.

The importance of the family in the intervention and treatment of alcohol problems received considerable support from the survey. For example, The statement "Counselling services for individuals with alcohol problems should involve other family members" was supported by 87.5% (n=175) of the respondents. Ninety-four percent support the statement that "Family members should take some responsibility for helping a member with an alcohol problem". Similarly, "Family counselling is one method of helping a family member who abuses alcohol" was supported by 91% (n=183) of the sample. From another perspective, the idea that an individual with a history of alcohol problems can be rehabilitated without involving other family members was disagreed with by 68.5% (n=137) of those responding.

A substantial number of respondents and members of their family had sought counselling for a personal problem. For instance 20% (n=40) had sought counselling for a personal problem and 27% (n=54) responded that a member of their family had sought such counselling in the past.

As well, 96.5% (n=193) of those surveyed believed that individuals with alcohol problems require family members and/or friends for support. While 96.5% (n=193) of those surveyed agreed that individuals with alcohol problems can be rehabilitated, 64% (n=128) believed that an individual

cannot stop drinking on his/her own. There was willingness on behalf of 85% (n=170) of the respondents to participate in family counselling if a family member had an alcohol problem. Consistent with the indication of support for family intervention noted above, 8% (n=16) of the respondents had received counselling from a professional social worker and 12% (n=24) had family members who had received counselling from a professional social worker.

The concept of "an increase in self-worth" was supported by the respondents as a criteria for successful rehabilitation. For example, "an increase in positive feeling towards oneself", was judged by 85% (n=170) of respondents as an indication of rehabilitation for an individual who has an alcohol problem. Similarly an increase in self-confidence was seen as an indicator of successful rehabilitation by 76% (n=152) of respondents.

The survey attempted to determine the respondents' willingness to use inpatient or outpatient treatment programs including professional psychosocial counselling and therapy. Table 15 presents the findings on respondent's preference for or willingness to use specific treatment options for alcohol problems.

TABLE 15

Respondents' Willingness to use Specific Treatment
Options for Alcohol Problems

TYPE	PERCENT LIKELY TO USE
Family Counselling	85.0 (n=170)
Self-Help	79.5 (n=159)
Private Counselling Services	78.5 (n=157)
Group Counselling	65.0 (n=130)
Outpatient Counselling (Hospital Based)	51.0 (n=102)
Inpatient Program (Hospital Based)	47.0 (n= 94)
Inpatient Program (Residential)	46.0 (n= 92)

This study also examined the respondents' acceptance of various counsellors to treat individuals with alcohol problems or other types of personal problems. It is important to note that even though most family doctors have no specialized training in individual or family counselling 80% of respondents, expressed a willingness to encourage a family member to participate in individual or family counselling a family physician. Seventy-two percent of respondents expressed a willingness to utilize psychologists, 70.5% psychiatrists and 65.5% social workers (who do have specialized training in individual and/or family counselling). In contrast, the clergy received

moderate support (57.5%) while registered nurses received a low level of support (14.5%).

In Newfoundland the development of Social Work as a professional practice is relatively recent. For this reason it was assumed that the public perception of social work would be influenced by misinformation or lack of information. In order to explore the possibility that an informed public would be more willing to utilize professional Social Workers in a counselling and therapeutic capacity, half of the respondents (comprised of fifty males and fifty females) received additional information concerning the profession of social work. The information was in the form of five statements. The respondents were asked to indicate whether or not they had been aware of the information prior to reading the particular statement. The distribution of responses from the sub-sample of one hundred are given in Table 16.

Respondents provided with this additional information concerning the profession of social work showed a significantly higher level of awareness than the comparison

TABLE 16
 Respondents' Awareness of Social Work Practice
 and Social Work Education
 Social Work Statement

STATEMENT	AWARE	NOT AWARE
1. A professional social worker at Memorial University must complete five years of formal education.	62% (n=62)	38% (n=38)
2. A professional social worker educated at Memorial University must complete 700 hours of field internships.	30% (n=30)	70% (n=70)
3. The largest group of professional counsellors and therapists in North America are Social Workers.	30% (n=30)	70% (n=70)
4. The largest group of professional family counsellors and therapists are social workers.	44% (n=44)	56% (n=56)
5. Professional social workers are among the largest group of professional treatment personnel in alcohol and drug treatment.	41% (n=41)	59% (n=59)

group of respondents who were not provided the additional information. For example, when asked if professional social workers are qualified to counsel individuals with alcohol problems, 57% (n=57) of those who received the supplementary information concerning social work agreed with that statement compared with 38% (n=38) of the uninformed comparison group. The observed differences between the two

groups was statistically significant ($\chi^2 = 12.9$, $df=4$, $p < .05$).

Seventy-one percent ($n=71$) of the respondents who received the information concerning the profession of social work indicated that they were likely to participate in family counselling offered by a social worker. Fifty-nine percent ($n=59$) of those who did not receive the supplementary information agreed with this notion. The observed differences between the two groups was statistically significant at the .05 level ($\chi^2 = 15.9$, $df=5$, $p < .05$).

Local Alcohol Treatment Services

The majority of the respondents correctly identified five of eight of the most prominent addictions treatment services in Newfoundland. Table 17 lists the programs cited in this study and indicates the level of the respondents' recognition in each instance (presented in rank order). It is interesting to note the validity of this question as indicated by the response to Vanity House (which does not exist).

TABLE 17
 Respondents' Recognition of Treatment Services

SERVICE	YES (%)	NO (%)
Alcoholics Anonymous	95.5 (n=191)	4.5 (n=9)
Harbour Light Center	86.0 (n=172)	14.0 (n=28)
Alcohol & Drug Dependency Commission	59.5 (n=119)	40.5 (n=81)
Waterford Hospital Addictions Program	53.0 (n=106)	47.0 (n=94)
St. Clare's Day Care Program	45.5 (n=91)	54.5 (n=109)
General Hospital Psychiatric Day Care	45.0 (n=90)	55.0 (n=110)
Talbot House	43.0 (n=86)	57.0 (n=114)
Donwood Institute (Ontario)*	16.0 (n=32)	84.0 (n=168)
Vanity House	2.5 (n=5)	97.5 (n=195)

* The Donwood Institute was included because at the time of this study, some Newfoundland residents were being sent out of the Province to this service.

Gender

To this point in the presentation of data, responses have not been differentiated by "gender". The gender differences described below were evaluated using chi-square and adopting a .05 level of significance.

Fifty-one point five percent (n=55) of females disagreed with the idea that alcohol problems are passed from one generation to another compared with 73% (n=73) of the males who disagreed with this notion ($\chi^2 = 10.8$, $df=2$, $p<.05$).

Twenty percent (n=20) of the male respondents disagreed with the notion of abstaining from alcohol for the rest of ones life as an appropriate resolution to an alcohol problem, however, only 10.1% of the females disagreed with this statement ($\chi^2 = 7.12$, $df=2$, $p<.05$).

Of particular interest was a significant difference between the sexes in response to the statement "An alcohol problem exists when it results in family breakdown". Eighteen percent (n=18) of the males disagreed with this statement as compared with only 7% (n=7) of the females ($\chi^2 = 8.82$, $df=2$, $p<.05$)

There was also a significant difference in the number of males who reported having a personal alcohol problem compared to the number of females. Twenty four percent (n=24) of the males reported having a drinking problem as compared with 4% (n=4) female respondents ($X^2 = 17.4$, $df=2$, $p<.05$).

Twenty-six point three percent (n=26) of males compared with 15% (n=15) of females agreed that a person who commits a crime under the influence of alcohol is not as guilty as a person who commits the same crime but has not been drinking ($X^2 = 7.36$, $df=2$, $p<.05$).

In respect to the statement that "a reduction in the amount that a person, with an alcohol problem, consumes is an indicator of rehabilitation" 63.5% (n=63) of the male respondents disagreed with the statement, while only 47.5% (n=47) of female respondents disagreed. The observed difference was significant between these two groups ($X^2 = 5.77$, $df=2$, $p<.05$).

A significant difference was also reported between male and female responses to the statement "alcohol problems develop due to a lack of self-control" ($X^2 = 9.51$, $p<.05$) and "a person who has an alcohol problem can stop drinking on

his/her own" ($\chi^2 = 8.71$, $df=2$, $p<.05$). In addition, in the instance of the don't know category in each of the two previously cited questions, 11 people or 11.0% and 14 people or 14.1% respectively of the females responded don't know; this is in contrast to 1 or 1% and 3 or 3% respectively of the male respondents. It is important to note that in all questions women used the "don't know" category much more than men. Observed differences between these two groups were significant at or below .05.

Of 21 people who responded don't know whether or not they would encourage a family member to receive counselling from a social worker for a personal problem, 16 people or 16.3% were female compared with 5 people or 5% of the males ($\chi^2 = 7.05$, $df=2$, $p<.05$).

Of 31 respondents who disagreed with the statement "alcohol acts as a depressant", 21.2% ($n=21$) were male as compared with 10.1% ($n=10$) were female ($\chi^2 = 8.74$, $df=2$, $p<.05$).

Education

Of 25 respondents with grade nine or less education, nineteen or 76% agreed that alcohol problems develop due to

a lack of self-control. Of 39 respondents with at least one university degree only 17 or 43.6% agreed with this statement. The observed differences were significant ($\chi^2 = 21.3$, $df=10$, $p<.05$)

Similarly of the twenty-five respondents with grade nine or less education, twenty or 80% agreed that an individual is solely responsible for controlling his/her alcohol problem while of the 39 respondents with one university degree 20 or 51.3% of the respondents agreed that an individual is solely responsible for controlling his/her alcohol problem. The observed difference for these two groups was significant ($\chi^2 = 18.6$, $df=10$, $p<.05$).

Of 39 respondents with one university degree, six people or 15.4% respondents indicated they would not likely encourage a family member to receive counselling from a psychiatrist for a personal problem. However, of 45 respondents who had completed high school, 14 people or 31.1% indicated that they would not likely refer such a family member to a psychiatrist. The observed difference between groups was significant ($\chi^2 = 19.01$, $df=10$, $p<.05$).

Religion

Religion was associated with differences in the responses given to certain questions or statements. Of particular interest were those variables indicating significant differences between respondents with a Roman Catholic as compared with a Protestant background.

For example, of 93 Roman Catholic respondents, 49.5% agreed with the statement "alcohol problems developed due to a lack of self-control", while out of 90 Protestant respondents 63 people or 70% agreed with this statement. The observed differences between these groups were significant ($\chi^2 = 27.8$, $df=16$, $p<.05$).

Family Income

Family income was associated with significant differences in response to various questions. For example, of 41 respondents with family income of less than \$20,000, 31 people or 75.6% agreed with the statement that alcohol problems can result in family breakdown, while of 151 respondents with family income of more than \$20,000, 134 or 88.8% agreed with this statement. The observed difference

between these groups was significant ($\chi^2 = 28.44$, $df=14$, $p<.05$)

With regard to family income and the respondents' willingness to encourage a family member to receive counselling from a social worker for a personal problem, of forty-one respondents with family income of less than \$20,000, eight or 19.5% indicated they were not likely to encourage a family member. Of 151 respondents with a family income of \$20,000 or more, 40 people or 26.5% indicated that they would not likely encourage a family member to receive such counselling. The observed difference between these groups was significant ($\chi^2 = 25.4$, $df=14$, $p<.05$)

Age

With regard to questions concerning the profession of Social Work "age" was a factor in providing significant differences in responses. Of 53 respondents between the age of thirty-five and forty-four, 8 or 15.1% indicated that they had personally received counselling from a professional social worker. Of 41 respondents over the age of sixty-five, none had reported receiving counselling from a professional social worker. The observed difference between groups was significant ($\chi^2 = 9.9$, $df=4$, $p<.05$).

Non-Significant Differences

While the study demonstrated certain significant differences between variables, also of importance are results where significant differences were not evident. Such results can provide valuable information for policy and program planning.

Of particular interest was the lack of significant difference in the responses provided by male and female respondents. There was no significant difference between the sexes in terms of precipitating factors related to alcohol problems, i.e. social pressure, life crisis, and stress. The study did not demonstrate any difference between male and female responses with respect to preference of treatment modality, i.e. inpatient, outpatient, hospital, non-hospital. As well, both males and females were willing to participate in individual and family counselling for a personal problem.

There was no difference between religion and the preference of counsellor. All religious affiliations were prepared to utilize the various professionals for family counselling.

Similarly, there was no significant difference between level of education and likelihood of using various treatment professionals. In addition, education does not appear to be a factor in the willingness to use outpatient, inpatient, hospital, or non-hospital treatment facilities.

CHAPTER 5

CONCLUSIONS AND DISCUSSION

Method, Design, Procedures

The procedure used to collect data in this study contributes to confidence in the results even within the context of a sample of two hundred. The generation of a series of randomized numbers used to identify households from a series of census tracts, previously selected for their apparent representativeness of the city population, supports the notion that the data collected represents a set of valid observations.

There was some difficulty incurred in obtaining the sample data in order to acquire the desired two hundred (200) questionnaires consisting of one hundred (100) male and one hundred (100) female respondents. For example, despite using the most recent edition of the City Directory for St. John's, some have passed away and others declined participation. However, the latter were minimal and most accepted enthusiastically. In limited instances, some questionnaires were mislaid by the respondents. Such instances required a repeat of the procedure to identify additional randomized households. The repetition of this

procedure to select two hundred respondents lends further confidence to the results although the response rate of 61.9% should be improved by at least eight percent in any repeat of this study.

A predetermined goal was to focus the survey on family units or households with at least a male and female married, or living within a common-law relationship; hence, the over-representation of married respondents. However, the procedures followed enabled surveying a cross-section of the population based on income, age, religion and sex. Alternating between male and female from household to household allowed for an equal representation from each sex. Consequently, the resulting sub-samples were randomized and without researcher bias. The decision to pursue equal representation from male and female respondents is supported when the reader considers the differences in responses between men and women, one of which is the female bias in favour of using the "don't know" category. This supports the findings of other research in terms of male/female responses. Females may readily reply "don't know" if they are uncertain or do not know an answer whereas males may risk a response even if they actually "don't know".

Further indications of representativeness are that three of the potential respondents who were selected had recently passed away and another respondent was unable to read and yet another was blind, but both were willing to complete the questionnaire with some assistance. (In one instance arrangements were made for an interviewer to read the questionnaire to one of the individuals to which a verbal response was recorded.) The author believes that the lower rate of response to complete the questionnaire in the census tracts evidencing lower socio-economic levels, is possibly related to higher rates of illiteracy and unemployment compounded with generally lower levels in education. If anything, the argument would be that the responses of those who did not respond would have been similar to those who did respond and if any differences were predictable on the basis of the literature it would be expected that the problem oriented items (e.g. problems with alcohol either personally or in immediate family) would exhibit more prevalence.

Limitations of this Study

Possibly the most significant limitation of this study is that of sample size. A larger sample size would allow for more detailed sub-analysis of the data and more confidence in its application to similar populations. A larger study

of this nature should contain a province wide focus, thereby allowing for the possibility of regional multiple analyses and community comparisons.

While the sample in this study may not be representative of the population of St. John's, as indicated by Statistics Canada in the 1981 Census, the observations contained herein concerning problems associated with alcohol are at least equal to what would be expected in the under represented groups. In most instances the responses given are so definitive with regard to direction, that even an optimally representative sample would not likely alter the results appreciably.

Limitations of Chi Square X^2

As is the case with most statistical tests, there are certain limitations associated with its use. There are two such primary limitations in the case of chi-square. First each observation or frequency must be independent of all other observations. According to Runyon and Haber (1971):

a fundamental assumption in the use of X^2 is that each observation or frequency is independent of all other observations. Consequently, one may not make several observations on the same individual and treat each as

though it were independent of all the other observations. Such an error produces what is referred to as an inflated N, that is, you are treating the data as though you had a greater number of independent observations than you actually have" (p. 252).

Second, when the number in a particular category or grouping is small or when the expected outcome for a particular cell is small, the calculated chi-square may not be a reliable measure. The adopted principle has been that expected frequencies in any one cell should not be less than five (Besag 1985). What this means in terms of this study is that some of the comparisons made that included cells with small "n's" will not benefit from as high a confidence level as do other comparisons.

Recommendations for Future Research

Future research in this area should consider several factors in order to improve upon this study. The sample size should be larger to increase the validity of the results. In particular the sample should be large enough to determine if women who have a spouse with a drinking problem are more likely to seek counselling than men who have a spouse with a drinking problem. This would imply an additional question such as:

If your spouse has a drinking problem, have you sought personal counselling?

Also a larger sample would allow for the examination of whether or not people who had alcohol problems in their family of origin and who had a previous alcohol problem themselves were more likely to have received counselling. Such information would allow for the exploration of other meaningful associations in terms of the nature of the impact of an alcohol problem.

Further research should examine the possibility of an association between factors such as spousal alcohol problems, marital satisfaction and unemployment. These variables are of major interest, especially within the Newfoundland context; any resulting associations would have direct implications for intervention strategies. Furthermore, in the case of an alcohol problem it would be helpful to explore whether or not the respondent believed that the alcohol problem caused the unemployment or the unemployment resulted in the alcohol problem. In a Province where unemployment is the highest in the country such information would be helpful in planning intervention strategies and other employment options. The following

additional questions are suggested if future research is pursued:

Is your spouse employed full time?

Is your spouse unemployed full time?

Is your spouse employed part time?

To what degree do you believe that his/her drinking problem?

(a) has been caused by being unemployed?

(b) contributed to the unemployment?

A major issue in the field of addictions is the role of heredity in the development of alcohol problems. A future study should more fully explore public beliefs regarding this issue than was done in this study, with special attention being paid to differences between male and female respondents. Additional questions may include the following:

There is a "genetic factor" in determining who will develop a drinking problem.	SA	A	D	SD	DK
---	----	---	---	----	----

An individual is born with the potential of being an alcoholic.	SA	A	D	SD	DK
---	----	---	---	----	----

In the exploration of public opinion concerning impaired driving, additional items regarding such issues as incarceration, license suspension and community service for

impaired driving offences could be explored. There are at least four additional questions:

Bartenders should be trained concerning the hazards of excessive alcohol use as it pertains to their role as servers of beverage alcohol.	SA	A	D	SD	DK
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People who are convicted of impaired driving should have their vehicles taken from them by the courts.	SA	A	D	SD	DK
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Individuals convicted of impaired driving should be ordered to carry out some related community service as part of sentencing.	SA	A	D	SD	DK
--	----	---	---	----	----

Friends and relatives should learn to take some responsibility for confronting an impaired friend or relative who risks driving impaired.	SA	A	D	SD	DK
---	----	---	---	----	----

Additional questions should be asked concerning community-based services for the treatment of alcohol problems; specifically what the public perceives as its expectation in developing and providing such services and their perception of the community's responsibility in developing and providing such services. In the case of government departments, it would be important to clarify the

public perception of the auspices of such services.

Additional questions may include:

Community-based treatment programs should provide professional services through an appropriately trained staff.	SA	A	D	SD	DK
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In the case of participation in "professional counselling from a doctor, social worker, or a psychiatrist", it would be important to determine if such respondents found the counselling helpful -- did they receive any benefit perceived from it. Suggested additional questions include:

If you have received professional counselling from a doctor, to what extent was it helpful.	VH	H	NH	DK
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If you have received professional counselling from a social worker, to what extent was it helpful.	VH	H	NH	DK
--	----	---	----	----

If you have received professional counselling from a psychiatrist, to what extent was it helpful.	VH	H	NH	DK
---	----	---	----	----

In the case of an individual having participated in counselling it should be clarified as to whether or not the counselling occurred after the marriage with the current

spouse and if the current or previous spouse experienced an alcohol problem. The questions suggested are:

Has your current spouse ever had an alcohol problem? Yes _____ No _____

Have you ever sought counselling to deal with your current spouse's alcohol problem? Yes _____ No _____

Have you ever had a spouse who had an alcohol problem? Yes _____ No _____

With respect to the instrument as designed for this study, it should be a goal in future studies to move towards standardization and to establish at least test-retest reliability. This action would support the utility of the instrument in giving direction to treatment services policy in other jurisdictions.

While respecting the limitations identified and discussed above, the author presents the following conclusions from this study.

Results and Their Implications

The study describes several factors concerning the respondents' perceptions, attitudes, knowledge and preferences with respect to alcohol problems and

respondents' responsibility regarding treatment. The research investigated four primary goal areas:

- . the respondents' perception of alcohol abuse as a problem of the individual, family, workplace and community.
- . the respondents' perception regarding the ownership and attribution of etiology of alcohol problems (ie. is the individual, family, work setting or community defined as being, at least partially responsible for the problem?
- . the respondents' willingness to use psychosocial treatment programs and professional psychosocial therapy.
- . the respondents' acceptance of various addiction counsellors with special reference to professional social workers as a source of primary assistance with personal and family problems associated with alcohol misuse.

Given the opportunity in this study to juxtapose medical-disease model interpretations with psychosocial consideration, the respondents' perception of alcohol abuse can be described as favouring a psychosocial orientation. The individual is acknowledged to be the primary focus, however, the interaction among the community, individual, family and work setting is strongly identified as being related to the development, reinforcement and management of alcohol problems in both individuals and their families. The individual's responsibility for his/her actions and problem (e.g. criminal acts committed under the influence of alcohol

and ultimate responsibility for treatment) is acknowledged but there is also support for the position that some people need supportive help (i.e. they just can't/don't stop drinking on their own). The implication is that the individual is viewed in a social context and that the respondents accept that some responsibility for the problem and its amelioration rests outside the individual.

Respondents attributed alcohol misuse and related problems as being determined by both environmental factors and intrapsychic factors as well as the relationship between the two. Such psychosocial factors and related environmental factors as the family, work setting and social environment are seen as both experiencing the effects of alcohol problems as well as contributing to their etiology. Such environmental and related psychosocial factors as stress, life crisis and marriage breakdown are viewed as playing a role in alcohol abuse as well as a role in intervention.

An interactive process is supported by the responses to the survey; the respondents believed that external factors beyond the control of the individual contributed to an alcohol problem. However, some credence was given to the prospect of an individual controlling his/her behaviour as well. One contradiction was that it was not generally

believed that alcohol problems developed because friends and associates encourage people to drink. This dichotomy may exist because the respondents perceive a dual source of causation. As in the case of diabetes, the success of treatment rests largely with the individual's willingness to comply with the prescribed treatment i.e. self-control to follow a diet and compliance with prescriptions for insulin even though the etiology of diabetes is multi-factorial.

The community acknowledges the impact of negative experiences that affect individuals and which might be precipitating factors in the development of alcohol problems. Examples of such factors include marital stress, death of a spouse, financial crisis and loss of employment. It is not surprising that the respondents expect the individuals, their families and the community, including professionals and the government, to assume responsibility.

Crimes such as impaired driving, child and spousal abuse, homicide, vandalism, break and entry were readily associated with alcohol problems. In addition to retribution and justice, the respondents overwhelmingly endorsed the education and treatment of offenders convicted of alcohol related offenses. These are significant community problems compounded by the abuse of alcohol. Alcohol related offenses

are over represented within the criminal justice system. There is much room for improvement of justice and correctional services in terms of preventive intervention and treatment.

The respondents in this study acknowledged that many social problems which affect community well-being are associated with persons and families experiencing alcohol problems. The use of public funds to finance community-based treatment services is supported overwhelmingly; this is a strong indication that the community is prepared to accept considerable responsibility for action with respect to the problem. Such ownership includes responsibility for funding including support for a designated tax; the provision of medical and psychosocial treatment services, policies and programs within the justice system and some initiative through places of employment. The implications for social policy are expanded in the final section.

While the community accepts ownership and responsibility for alcohol problems, the community also clearly assigns responsibility to individuals exhibiting the problem and to family members directly affected. The respondents indicate that they perceive the community as being accountable with respect to reinforcing alcohol

problems. Social pressures (defined for example as occupational, marital, financial, interactional) were perceived overwhelmingly as a contributor to the abuse of alcohol. The rapid pace social environment associated with today's lifestyle is seen as adding many stressors which impact upon the individual and family. A legal, very accessible drug which acts as an effective "social lubricant" is a very viable option for many trying to deal with situational and socially demanding circumstances defined as stressful. It was overwhelmingly perceived that alcohol problems develop at least in part due to social-environmental stress and intrapsychic stress. The implication is that society has a responsibility to set policies and to take action to reduce stress, that personal, if not familial lifestyles must change to reduce stress and that changes are needed in the work environment to reduce interpersonal stress and factors that are associated with intraphysic stress. The implication is that counselling and therapy must address issues of social, relational, personal and financial stress.

The community was also perceived as having a major responsibility in the provision of treatment services. Such services were seen as community-based and funded through the public purse. The courts were viewed as having a

responsibility to refer individuals, with demonstrated alcohol problems, to rehabilitation. This was particularly judged to be the case for multiple offenders of impaired driving. The respondents clearly recognized the judicial system's potential role in constructively intervening in alcohol problems.

The individual is acknowledged as the focal point of alcohol problems. The results support the position that factors interact in promoting and reinforcing alcohol problems, the individual must accept ultimate responsibility for his/her actions and for the treatment. The respondents perceived that an individual who had been drinking (and who is presumably impaired) prior to committing a crime is just as guilty as someone who had not been drinking and committed the same crime.

The majority of respondents supported the notion that alcohol problems develop in part due to some lack of self control. This perception would appear to reflect a moralistic perspective of alcohol problems. This perspective was also supported by the majority of respondents believing that a person is solely responsible for his/her drinking problem. Support for a moral perspective of alcohol problems is not surprising when one considers the relatively short

time since the end of the active role of the Newfoundland Temperance Federation in the early sixties. The activity of the church in the teachings of the evils of alcohol has also contributed to the moralistic perspective.

Support for public responsibility through the tax system is juxtaposed to individual responsibility through a designated user tax. A user pay concept was endorsed by the respondents through support for a specific tax on alcohol products to be used for treatment programs and alcohol education. In a province in which the public is very heavily taxed, it is worthy of note that respondents are willing to accept an additional designated tax to support such services.

The respondents' support for a disease-oriented understanding of alcohol problems is considerable even though it is juxtaposed to a psychosocial concept. The disease concept is synonymous with a public health or community health problem. Life-time abstinence, alcoholism as a progressive illness and the utilization of family physicians for both medical/physiological and psychosocial aspects of the problem are strongly related to a disease concept/medical model orientation. All three of these

interpretations of reality were supported by a significant number of the respondents.

Responses represent a range of positions on successful treatment. Some Respondents expressed the idea that the individual should abstain from alcohol as a desirable goal. It was also believed that a person who has an alcohol problem cannot stop drinking on his/her own but requires various supports through the rehabilitative process. It is indicated consistently throughout this research that assistance and support to the individual must be available through the individual's family, employer and the community at large. Implied is the "faith" that counselling/therapy treatment can be rehabilitative.

Respondents supported the notion of a two way interaction between the "alcoholic" and his/her family. On the one hand the family is identified as being severely negatively affected by the existence of an alcohol problem. On the other hand family dynamics are believed to contribute to the development or maintenance of alcohol problems and their correlates, which in turn have a destructive effect upon the entire family. Specifically, spousal and child abuse are readily associated with the existence of alcohol problems. Similarly, it was recognized that marriage dissolution and

other life crises are both seen as precipitated by and facilitating alcohol problems. In various circumstances alcohol abuse can either be the cause or the result of various stressors upon the individual.

Consistent with the above, the family is also viewed as being important in the intervention and treatment of alcohol problems and that non-alcoholic family members must take some responsibility for helping the "alcoholic" family member, particularly through participation in family counselling. The inclusion of the immediate family was strongly advocated within counselling services for individuals with alcohol problems. It is not surprising that counselling and therapy for alcohol problems that includes family members received very high support from the respondents. The strong association with "the family", in many aspects of an alcohol problem, is consistent with the literature of the past decade that supports treatment services for the family and its members. It is important to note the target population's strong association with familial issues and its overall significance in treatment and rehabilitation.

The respondents recognized that alcohol problems impact negatively upon both the employer and the employee. The

workplace is viewed as encountering problems as a result of alcohol abuse; respondents strongly recognized the impact of an individual's alcohol problem on job performance. The loss of one's job due to drinking is seen as being problematic for the employee and the employer. Also, when the employee loses financial security, through an increase in alcohol consumption. The exacerbation of problems for the employee and his/her prospects for future employment can be enormous. The workplace is negatively affected by alcohol abuse as verified by the considerable loss in productivity and considerable concern over safety. Employers across Canada lose millions of dollars each day due to alcohol abuse. It is, therefore, encouraging to note the respondents' recognition of the negative effect upon industry and its employees. The workplace has a problem and must play a role in intervention.

The workplace is also seen as creating problems or stressors for some individuals that might be associated with increased alcohol abuse. Employee Assistance Programs have evolved over the past decade as a viable approach to "troubled" or "problem" employees. The concept has informed the development of meaningful services within various types of work settings across the country. The number of work settings with active Employee Assistance Programs has grown

considerably in Newfoundland during the past five years. The notion of "firing" an individual for having an alcohol problem is no longer acceptable in many centres, unless it can be demonstrated that appropriate "help" or assistance was offered the individual. Respondents strongly rejected the notion of "firing" individuals with alcohol problems but rather supported employment based programs to intervene in the alcohol problems of their employees with due consideration to the impact on other workers and the workplace. The notion that employers should refer individuals with alcohol problems for professional help was overwhelmingly endorsed. Employee Assistance Programs are the most common form of service in the workplace supported by management, unions and workers. It is not surprising that the respondents supported an Employee Assistance Program type of referral and treatment orientation in the workplace. In future study it would be important to explore the public's perception of the need for systematic change to promote work and well-being.

This survey demonstrated certain preferences for treatment services and modalities which the respondents felt they would use if they or a family member encountered an alcohol problem. Private family counselling received consistently more support among those surveyed, than with

inpatient or other residential treatment. The preference for family services could be partially explained by the strong bias in favour of "family" evident in the Newfoundland culture.

There was a major concern regarding confidentiality, as indicated by the preference to use private counselling services on an out-patient basis. The preference for private counselling services within an individual or family context supports the importance of confidentiality in service delivery. A related factor is the stigma which is still very much associated with an alcohol problem. The likelihood of using a residential program either within a hospital or other setting was supported by less than half of the respondents. It could be argued that the threat to confidentiality is perceived as greater within an inpatient milieu and hence the chance of stigmatization greater.

The respondents' choice of care-giver was also worthy of note. It is not surprising that a very high proportion indicated a strong likelihood of approaching their family doctor for family counselling. Historically, identification with the family physician, within the province, has been quite strong and the doctor has traditionally been a source of help and a confidant to many Newfoundland homes. As many

physicians have a very limited knowledge of counselling or alcohol problems this has major implications for training and continuing education of physicians, in the area of alcohol treatment. The likelihood of participating in family counselling offered by either a professional psychiatrist, professional social worker or professional psychologist was comparable. As a result, an avenue that could be explored to improve service would be to educate physicians in order to promote their confidence in referring a patient for counselling by a professional social worker or psychologist.

It is significant that the respondents who were provided additional information pertaining to the profession of social work, were much more likely to participate in family counselling offered by a social worker. The respondents otherwise were not as well informed of the counselling expertise of social workers as could be the case. The Newfoundland Association Social Workers has a significant task to undertake.

The professionalization of social work services in the province of Newfoundland has taken place at a slow pace, many years after social workers in the rest of North America have become the prime source for family counselling, mental health counselling and addictions counselling. In this

regard the author expected that respondents' perceptions of social workers would be reflective of the recent past, where the majority of persons using the title "social worker" were in fact not professional social workers. In fact the majority who use the title "social worker" had no formal education or internship that would qualify them as either counsellors or therapists. The results in this study demonstrate that when the respondents are given a modest amount of information regarding social workers their education and their services competencies, the respondents are prepared to use such professionals for individual or family counselling and therapy associated with alcohol problems. It is essential for the profession of social work to educate the general public concerning its clinical expertise. The professionalization of social work services is relatively new for the province and it is probable that considerable mis-inforamtion exists as to the service potential and expertise of professional social workers. One problem in this regard is that social work counselling is not covered by public medical "insurance" programs or by private supplementary medical coverage. Another problem is that professional social workers and the Newfoundland public do not have the benefit of registration for the profession of Social Work.

Recommendations and Policy Considerations

Since the inception of this study, it was the wish of the author that the results provide informed direction to one or more constituencies responsible for policies and programs related to alcohol problems. Most of the recommendations and policy considerations which follow are stated in terms which facilitate the development of position or policy statements for those institutions which have a responsibility in the area of alcohol problems.

The results provide a basis for policy formulation and revision in several areas of the "alcohol dependency" field. These include the financing of services, programs and education for clients and their families, professionals and the public-at-large.

Recommendations

In consideration of the results of this study, it is recommended that the following actions be taken in various dimensions of policies and programmes cited below:

1. Individual and Family Services

- that the Alcohol and Drug Dependency Commission research, develop and adopt a psychosocial model of

assessment for individuals and families who are experiencing alcohol problems.

- that the Alcohol and Drug Dependency Commission develop and expand psychosocial treatment services for individuals and their families experiencing alcohol problems, especially out-patient services utilizing family and group counselling.
- that the identification, assessment, treatment and referral of individuals with alcohol problems involve the spouse and other family members whenever and wherever feasible.
- that the Department of Justice in consultation with the Alcohol and Drug Dependency Commission establish policies throughout the criminal justice system to assess, refer and treat individuals suspected of having an alcohol problem.
- that the Alcohol and Drug Dependency Commission include, in its public awareness and education material, current information on the issue of "genetic" disposition to alcohol problems.

2. Employment

- that the Alcohol and Drug Dependency Commission, in co-operation with the Worker's Compensation Commission, undertake a study to determine the impact of alcohol problems on employment-related disability and compensation.
- that the Alcohol and Drug Dependency Commission increase its involvement with employers to raise awareness with respect to the impact of alcohol problems in the workplace.
- that the Alcohol and Drug Dependency Commission investigate ways and means of increasing its efforts in the area of promotion and facilitation of "Employee Assistance" initiatives within the work environment.
- that the Alcohol and Drug Dependency Commission consult with Unions regarding model policies that are pro-employee.

3. Community and Public Support

- that the Alcohol and Drug Dependency Commission help organize a network of community agencies responsible for clients having alcohol problems in order to provide optimal collective service to this client population.
- that the Alcohol and Drug Dependency Commission initiate an extensive public awareness strategy to increase knowledge and change public attitudes concerning alcohol problems.
- that the Alcohol and Drug Dependency Commission research the "concept of a designated tax" on alcohol products for purposes of financing alcohol treatment, prevention and education services.
- that the Alcohol and Drug Dependency Commission help communities to develop and expand psychosocial treatment services for individuals and their families experiencing alcohol problems.

4. Professional - Specific Addiction Services

- that that Alcohol and Drug Dependency Commission implement an ongoing training strategy to ensure optimal knowledge and skill development within services providing specialized services to individuals and their families experiencing alcohol problems.
- that the Alcohol and Drug Dependency Commission ensure that appropriate treatment staff within addiction specific services are proficient and skilled in the latest techniques of assessment, family therapy, group counselling skills and relapse prevention.
- that the Alcohol and Drug Dependency Commission establish an appropriate process of value clarification and self-attitude appraisal for staff working directly with alcohol dependent clients.

5. Professional

- that the School of Social Work of Memorial University develop and implement "skill development" courses, possibly as continuing education offerings, in the area of addiction counselling including addiction specific group and family therapy skills.

- that the School of Medicine of Memorial University develop and implement a detailed course of studies in the area of alcohol dependency, emphasizing appropriate medical management, identification, assessment and referral of such patients for professional counselling and therapy.
- that the Newfoundland Association of Social Workers, in consultation with the School of Social Work of Memorial University, develop a comprehensive awareness and promotion campaign designed to educate and otherwise inform the public of Newfoundland about the profession of social work, including the ability of professional social workers to deal with addiction problems.
- that the Schools of Nursing throughout the province develop and implement relevant nursing education in the area of alcohol dependency, emphasizing the psychosocial nature of dependency and the role of the nurse within the context of appropriate intervention and referral.
- that addiction specific professional development and training in the area of alcohol problems should be provided to all persons within the criminal justice system (e.g. parole officers, classification officers, probation officers and judges) to more effectively intervene with those who have committed alcohol related offenses.
- that addiction specific professional development and training be provided to all social service and health care professionals and para-professionals whose area of responsibility involves transactions with persons who may have alcohol problems.
- that the School of Social Work at Memorial University ensure that its addictions treatment course is offered, at least annually, and is supplemented by specialized workshops in the area of alcoholism treatment.

Summary

This study examined perceptions of alcohol problems, treatment policies and treatment services.

A review of the literature concerning treatment and treatment programing was undertaken. This review had, as its primary goal, the identification of contemporary knowledge and writings concerning the treatment of alcohol problems and the determination of trends in this area. The review of the literature resulted in the formation of four study goals for this research which gave direction to this survey.

In the interest of informing alcohol treatment program planning, the development of treatment policy and the provision of community education, this study had the following objectives:

- to describe the respondents' perceptions of alcohol abuse as a problem of the individual, family, work setting and community.
- to describe the respondents' perceptions regarding the attribution of etiology is the individual, family, work setting or community defined as being, at least partially responsible for the problem.
- to determine the respondents' willingness to use psychosocial treatment programs and professional psychosocial therapy.

- to determine the respondents' acceptance of various addiction counsellors with special reference to professional social workers as a source of primary assistance with personal and family problems associated with alcohol misuse.

The study involved a survey of a sample of households in St. John's, Newfoundland. A questionnaire was distributed, utilizing a stratified randomization technique for sample selection. The sample population included households comprised of family units consisting of a male and female married couple. In alternating cases, the male or female was asked to complete the questionnaire.

The households were selected from five census tracts as determined by Statistics Canada consisting of at least forty respondents from each tract. In all, two hundred questionnaires were completed and analyzed for purposes of this study. While the sample size is small and thereby limited in its generalization, in most instances the responses given are so overwhelmingly skewed in a given direction, that the limitations would not reduce the confidence in many decisive results.

The results indicate clear support for certain perceptions and preferences by the respondents with respect to the nature of alcohol problems, the treatment of such problems and the willingness to use certain addiction

counsellors. The respondents indicated overwhelming support for family involvement in the treatment of alcohol problems, complemented with a significant preference for private and confidential counselling on an outpatient basis for such problems. Inpatient treatment was least preferred by the vast majority.

The family physician was cited as the professional to whom most would go for advice and family counselling for an alcohol problem. Social workers, psychologists, and psychiatrists were rated relatively equal with respect to a reasonably large number of respondents expressing a willingness to receive counselling from such professionals.

The respondents indicated support for a psychosocial orientation to the etiology and treatment of alcohol problems. The basis of such problems was seen as cultural, environmental, psychological and biological. Successful intervention was equally viewed as being multivariate with approaches being made in several areas of life functioning. The individual, family, work setting and community at large were all seen as having a role to play in providing optimal intervention for alcohol problems. The results and their implications are discussed, and recommendations are made with regard to policies and programmes.

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SURVEY INSTRUCTIONS

PLEASE READ CAREFULLY BEFORE COMPLETING THE QUESTIONNAIRE

- . Read each instruction and question before answering.
- . It is very important to the completeness of the study that you answer all questions.
- . Please complete the questionnaire within twenty-four (24) hours and return it in the enclosed stamped self-addressed envelope.
- . To ensure that your identity remains unknown please do not put your name or return address anywhere on the questionnaire or envelope.

Please Read The Following
Statement And Answer Questions A,B,C,D AND E
Before Completing The Main Questionnaire

These statements were written to inform you about professional social workers and their education because many people have misconceptions regarding professional social workers. (If you already knew this information before reading these statements then answer by checking (X) "yes". If not, please check (X) "no").

Did you know that:

- A. A professional social worker educated at Memorial University must complete five years of formal education.

Yes _____ No _____

- B. A professional social worker educated at Memorial University must complete 700 hours of field internships.

Yes _____ No _____

- C. The largest group of professional counsellors and therapists in North America are social workers.

Yes _____ No _____

- D. The largest group of professional family counsellors and therapists are social workers.

Yes _____ No _____

- E. Professional social workers are among the largest group of professional treatment personnel in alcohol and drug treatment services.

Yes _____ No _____

**Survey of Public Perceptions Regarding Treatment
Treatment Services for Alcohol Problems**

Please do not write your name or identify yourself in any way on this questionnaire. In this survey the term "alcohol problem" is used to describe a range of drinking problems up to and including what you would call "alcoholism".

The following statements relate to the treatment of alcohol problems. (For each statement, please indicate your level of agreement or disagreement. After reading the statement carefully, please circle the symbol which most clearly represents your opinion.) For example: if you strongly agree with a statement circle "SA".

CIRCLE ONE SYMBOL ONLY

It is important that you answer all questions

Strongly Agree	= SA
Agree	= A
Disagree	= D
Strongly disagree	= SD
Don't Know	= DK

- | | | | | | |
|--|----|---|---|----|----|
| 1. Social pressure may contribute to the abuse of alcohol. | SA | A | D | SD | DK |
| | 4 | 3 | 2 | 1 | 0 |
| 2. Individuals who personally experience alcohol problems can be rehabilitated. | SA | A | D | SD | DK |
| 3. Individuals who continually commit crimes while under the influence of alcohol should be offered alcohol treatment as part of the court's decision. | SA | A | D | SD | DK |
| 4. Individuals convicted of two or more offenses of impaired driving should be required to attend an alcohol treatment program. | SA | A | D | SD | DK |

Strongly Agree - SA
 Agree - A
 Disagree - D
 Strongly disagree - SD
 Don't Know - DK

- | | SA | A | D | SD | DK |
|--|----|---|---|----|----|
| 5. Public money should be used to finance community based treatment services for individuals with alcohol problems. | 4 | 3 | 2 | 1 | 0 |
| 6. Family counselling is one method of helping a family affected by a member who abuses alcohol. | SA | A | D | SD | DK |
| 7. Individuals convicted of two or more offenses of impaired driving should be required to attend an alcohol education program before having their license reinstated. | SA | A | D | SD | DK |
| 8. A person who commits a crime while under the influence of alcohol is not as guilty as a person who commits the same crime, but who has not been drinking. | SA | A | D | SD | DK |
| 9. Alcohol problems develop because of factors completely within the control of the individual. | SA | A | D | SD | DK |
| 10. An individual with a history of alcohol problems can be rehabilitated without involving other family members. | SA | A | D | SD | DK |
| 11. A person whose mother or father has an alcohol problem, has a greater chance of developing a drinking problem than a person whose parent(s) do not. | SA | A | D | SD | DK |

Strongly Agree	= SA
Agree	= A
Disagree	= D
Strongly disagree	= SD
Don't Know	= DK

- | | | | | | |
|--|----|---|---|----|----|
| 12. Professional social workers are qualified to counsel individuals with alcohol problems. | SA | A | D | SD | DK |
| | 4 | 1 | 2 | 1 | 0 |
| 13. Alcohol problems develop due to a lack of self-control. | SA | A | D | SD | DK |
| 14. Counselling services for individuals with alcohol problems should involve other family members. | SA | A | D | SD | DK |
| 15. A person who has an alcohol problem can stop drinking on his/her own. | SA | A | D | SD | DK |
| 16. The money needed for alcohol treatment and education programs should come from an added tax on beer, wines and liquor. | SA | A | D | SD | DK |
| 17. Family members should take some responsibility for helping a member with an alcohol problem. | SA | A | D | SD | DK |
| 18. An alcohol problem may begin due to a life crisis, e.g. death of a spouse, a marriage breakup. | SA | A | D | SD | DK |

Strongly Agree = SA
 Agree = A
 Disagree = D
 Strongly disagree = SD
 Don't Know = DK

- | | | | | | | |
|-----|---|---------|--------|--------|---------|---------|
| 19. | Most people who have had an alcohol problem can be expected to have a "slip" (relapse) sometime following their rehabilitation. | SA
4 | A
3 | D
2 | SD
1 | DK
0 |
| 20. | A drinking problem exists if an individual abuses his/her child after drinking alcohol. | SA | A | D | SD | DK |
| 21. | Alcohol problems usually progress from social drinking to the disease of alcoholism. | SA | A | D | SD | DK |
| 22. | For a person who has an alcohol problem, cutting down on the amount of alcohol he/she drinks indicates improvement. | SA | A | D | SD | DK |
| 23. | An increase in positive feelings towards oneself is an indication of rehabilitation for an individual who has an alcohol problem. | SA | A | D | SD | DK |
| 24. | Employers should offer assistance to employees who develop alcohol problems. | SA | A | D | SD | DK |
| 25. | An alcohol problem exists if an individual commits serious crimes, (e.g. rape, assault) while under the influence of alcohol. | SA | A | D | SD | DK |

Strongly Agree	= SA
Agree	= A
Disagree	= D
Strongly disagree	= SD
Don't Know	= DK

- | | | | | | |
|---|---------|--------|--------|---------|---------|
| 26. Individuals who have lost control of their drinking should be fired from their jobs. | SA
4 | A
3 | D
2 | SD
1 | DK
0 |
| 27. Drinking problems develop because friends and associates encourage people to drink. | SA | A | D | SD | DK |
| 28. An alcohol problem in a family member can develop due to marital or other family problems. | SA | A | D | SD | DK |
| 29. An increase in self-confidence, for an individual with an alcohol problem, is an indication of successful rehabilitation. | SA | A | D | SD | DK |
| 30. A drinking problem has a destructive effect upon the entire family. | SA | A | D | SD | DK |
| 31. Successful rehabilitation from an alcohol problem requires the problem drinker to abstain (not drink alcoholic beverages) for the rest of his/her life. | SA | A | D | SD | DK |
| 32. An alcohol problem exists when it causes family break-down (separation/divorce). | SA | A | D | SD | DK |

Strongly Agree = SA
 Agree = A
 Disagree = D
 Strongly disagree = SD
 Don't Know = DK

- | | | | | | |
|---|----|---|---|----|----|
| 33. An individual's alcohol problem can cause poor job performance. | SA | A | D | SD | DK |
| | 4 | 3 | 2 | 1 | 0 |
| 34. An alcohol problem exists when an individual loses his/her job as a result of drinking. | SA | A | D | SD | DK |
| 35. People who have alcohol problems require family members and/or friends for support during rehabilitation. | SA | A | D | SD | DK |
| 36. A person has an alcohol problem if he/she abuses his/her spouse after drinking alcohol. | SA | A | D | SD | DK |
| 37. Alcohol problems are passed on from one generation to another by heredity. | SA | A | D | SD | DK |
| 38. Alcohol is a drug. | SA | A | D | SD | DK |
| 39. An alcoholic and a drunk are the same. | SA | A | D | SD | DK |
| 40. Alcohol problems can develop due to stress. | SA | A | D | SD | DK |

Strongly Agree = SA
 Agree = A
 Disagree = D
 Strongly disagree = SD
 Don't Know = DK

- | | | | | | |
|---|----|---|---|----|----|
| 41. A person has an alcohol problem if he/she has two or more impaired driving convictions. | SA | A | D | SD | DK |
| | 4 | 3 | 2 | 1 | 0 |
| 42. Alcohol acts as a depressant. | SA | A | D | SD | DK |
| 43. Employers should send individuals with alcohol problems for professional help. | SA | A | D | SD | DK |
| 44. A person is solely responsible for controlling his/her alcohol problem. | SA | A | D | SD | DK |
| 45. Counselling services for alcohol problems should include the individual's immediate family. | SA | A | D | SD | DK |

SOME QUESTIONS IN THE NEXT SECTION YOU MAY VIEW AS DEALING WITH PERSONALLY SENSITIVE ISSUES. IT IS IMPORTANT TO TREATMENT PLANNING THAT WE HAVE YOUR IDEAS AND INFORMATION. PLEASE ANSWER ALL QUESTIONS AS ACCURATELY AS POSSIBLE WITH THE KNOWLEDGE THAT YOUR ANSWERS WILL BE TREATED AS ANONYMOUS.

Please circle the ONE symbol which best indicates your answer.
 CIRCLE ONLY ONE SYMBOL PER QUESTION

Yes =Y
 No =N
 Don't Know =DK

- | | | | |
|--|---|---|----|
| 46. Have you ever sought counselling for a personal problem? | Y | N | DK |
| | 1 | 2 | 0 |

- | | | | |
|--|--------|--------|---------|
| 47. Has a member of your family ever sought professional counselling for a personal problem? | Y
1 | N
2 | DK
0 |
| 48. Have you ever received counselling from a professional social worker? | Y | N | DK |
| 49. Have you personally ever experienced an alcohol problem? | Y | N | DK |
| 50. Has anyone in your immediate family (mother, father, brother and/or sister) ever had an alcohol problem? | Y | N | DK |
| 51. Has a member of your immediate family received counselling from a professional social worker? | Y | N | DK |
| 52. Has your husband/wife/partner ever experienced a drinking problem? | Y | N | DK |
| 53. Please indicate (x) the alcohol treatment services below of which you are aware.
(Please check all that apply). | | | |

General Hospital Psychiatric Day Care	()
Harbour Light Center	()
Alcoholics Anonymous	()
Talbot House	()
Alcohol and Drug Dependency Commission	()
Vanity House	()
Waterford Hospital Addictions Program	()
Donwood Institute	()
St. Clare's Hospital Day Care	()
Other (Please Specify) _____	()

The statements below may appear to be repetitious, but it is important that you consider each carefully. Using the following scale please indicate the likelihood of your doing what the statement indicates if you or a family member had an alcohol problem. ONLY CIRCLE ONE RESPONSE PER QUESTION.

Very Likely
Likely
Not Likely
Most Unlikely
Don't Know

VL
L
NL
MU
DK

- | | | | | | |
|--|---------|--------|---------|---------|---------|
| 54. I would seek professional help for a personal drinking problem. | VL
4 | L
3 | NL
2 | MU
1 | DK
6 |
| 55. I would use a self-help group e.g. Alcoholics Anonymous; Alanon; Alateen if a family member or myself developed an alcohol problem. | VL | L | NL | MU | DK |
| 56. I would use an outpatient counselling service e.g. family services or an out-patient psychiatry service if a family member or myself developed an alcohol problem. | VL | L | NL | MU | DK |
| 57. I would use a hospital based inpatient program if a family member or myself developed an alcohol problem. | VL | L | NL | MU | DK |
| 58. I would use a non-hospital inpatient program e.g. residential treatment center if a family member or myself developed an alcohol problem. | VL | L | NL | MU | DK |
| 59. I would use private counselling services, e.g. family doctor, professional social worker, professional psychologist if a family member or myself developed an alcohol problem. | VL | L | NL | MU | DK |

Very Likely	VL
Likely	L
Not Likely	NL
Most Unlikely	MU
Don't Know	DK

- | | | | | | |
|--|---------|--------|---------|---------|---------|
| 60. I would participate in a group counselling session with others who had an alcohol problem. | VL
4 | L
3 | NL
2 | MU
1 | DK
0 |
| 61. I would participate in family counselling if a family member had an alcohol problem. | VL | L | NL | MU | DK |
| 62. I would participate in family counselling offered by a family doctor. | VL | L | NL | MU | DK |
| 63. I would participate in family counselling offered by a professional social worker. | VL | L | NL | MU | DK |
| 64. I would participate in family counselling offered by a professional psychologist. | VL | L | NL | MU | DK |
| 65. I would participate in family counselling offered by a professional psychiatrist. | VL | L | NL | MU | DK |
| 66. I would participate in an inpatient treatment program if I developed an alcohol problem. | VL | L | NL | MU | DK |
| 67. I would participate in a rehabilitation program if I developed an alcohol problem. | VL | L | NL | MU | DK |

Very Likely	VL
Likely	L
Not Likely	NL
Most Unlikely	MU
Don't Know	DK

- | | | | | | | |
|-----|---|----|---|----|----|----|
| 68. | I would encourage other members of my family to participate in family counselling for a personal problem. | VL | L | NL | MU | DK |
| | | 4 | 3 | 2 | 1 | 0 |
| 69. | I would encourage a family member to receive family counselling from a social worker for a personal problem. | VL | L | NL | MU | DK |
| 70. | I would encourage a family member to receive counselling from a family doctor for a personal problem. | VL | L | NL | MU | DK |
| 71. | I would encourage a family member to receive counselling from a professional psychologist for a personal problem. | VL | L | NL | MU | DK |
| 72. | I would encourage a family member to receive counselling from a psychiatrist for a personal problem. | VL | L | NL | MU | DK |
| 73. | I would encourage a family member to receive counselling from a minister or priest for a personal problem. | VL | L | NL | MU | DK |
| 74. | I would encourage a family member to receive counselling from a registered nurse for a personal problem. | VL | L | NL | MU | DK |

IT IS IMPORTANT TO OUR STUDY THAT YOU PROVIDE BASIC PERSONAL INFORMATION. PLEASE DO NOT PUT YOUR NAME ANYWHERE ON THIS QUESTIONNAIRE. THIS WILL ENSURE YOUR PRIVACY AND CONFIDENTIALITY.

75. Are you? Male () Female ()

76. How old are you? _____

77. Are you presently?

Single ()
 Married/Common Law ()
 Separated/Divorced ()
 Widowed ()
 Other: Specify _____

78. What is the highest level of formal education that you have attained?

Grade 9 or less ()
 Some high school ()
 Completed high school ()
 Vocational or Trades School ()
 Some University ()
 Completed one University Degree ()

79. Which one of the following categories best describes your family's income?

Under \$5,000 ()
 \$5,000 - 9,999 ()
 10,000 - 14,999 ()
 15,000 - 19,999 ()
 20,000 - 24,999 ()
 25,000 - 29,999 ()
 30,000 - 39,999 ()
 40,000 or more ()

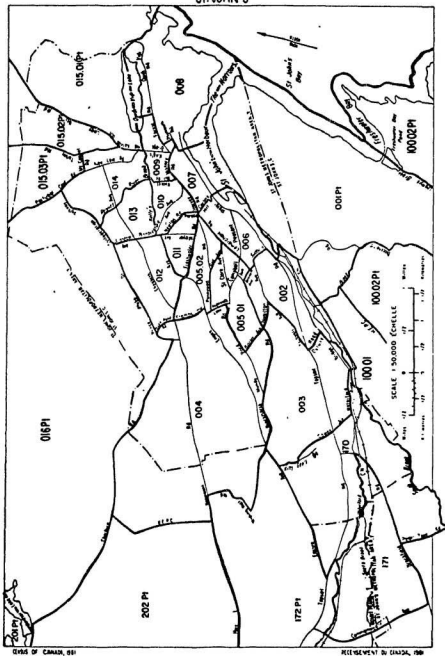
80. What is your religion?

Roman Catholic	()
Protestant	()
Jewish	()
Other	()
No religious preference	()

The ADDC and the School of
Social Work at M.U.N. Thank you
For Your Participation And
Interest In This Project

Appendix "B"

ST. JOHN'S





MEMORIAL UNIVERSITY OF NEWFOUNDLAND

St. John's, Newfoundland, Canada A1B 3X8

School of Social Work

Telex: 016-4101

Tel.: (709) 737-8165

1987 10 26

Dear Resident:

The Alcohol and Drug Dependency Commission and the School of Social Work of Memorial University of Newfoundland are currently conducting a survey of selected residents of St. John's to gather information about people's opinions regarding alcohol problems, services for the treatment of alcohol problems, and professional treatment personnel.

This study is being conducted by Mr. George W.N. Skinner, B.Sc., B.S.W., under the supervision of Dr. M. Dennis Kimberley, C.S.W. The findings of this study will be of significant benefit in planning for the coordination, development and implementation of various treatment services and public education programs in the St. John's area. I encourage your support and participation.

As your name was randomly selected from the St. John's City Directory, Mr. Skinner or an assistant (a 4th year Social Work student), will telephone you within two weeks to determine if you will consent to participate in the survey by completing a questionnaire and returning it in a stamped envelope (provided). Your name will not be identified or appear in the research report, and in no way will the information obtained identify your responses. If you choose to participate in this study by completing the questionnaire, this will be taken as an indication that you consent to have the information you provide used in the survey and included in research reports derived from the study.

Also, arrangements will be made to drop off the questionnaire to you at your home. (The questionnaire will take approximately thirty (30) minutes to complete).

If you have any questions please call Mr. Skinner at 737-3600 (B) or 722-4434 (H). It would be very helpful if you completed the questionnaire within twenty-four hours and returned it in the enclosed stamped envelope. This will ensure that your identity will remain unknown.

Thank you for your anticipated cooperation.

Sincerely yours,

Dr. Frank R. Hawkins
Director

Appendix "D"

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**Alcohol & Drug
Dependency
Commission of
Newfoundland
& Labrador**

Provincial Office: Suite 105, Prince Charles Building, 120 Torbay Road,
St. John's, Newfoundland, A1A 2G8 (709) 737-3600

October 05, 1987

Dear Respondent:

The Alcohol and Drug Dependency Commission of Newfoundland and Labrador is currently conducting a needs assessment within the St. John's area. Specifically, we are assessing treatment issues for alcohol and other drug problems.

This assessment will review the present service delivery potential, establish methods of improved co-ordination and identify areas in need of improved or additional programs.

As part of the overall examination of treatment, the Commission is also endorsing a survey concerning the public perception of alcohol problems, services for the treatment of alcohol problems and treatment personnel. We are interested in receiving your views on many issues. It is our belief that feedback from the community will be important to the Commission's assessment of treatment services and the manner in which treatment needs should be most appropriately addressed in the future.

We are now asking for your co-operation in completing the attached questionnaire and return it to the researcher, Mr. G. Skinner, B.Sc.; B.S.W. We thank you for your assistance and co-operation.

Yours sincerely,

E.R. Davis
Vice-Chairman

ERC/mmh

REGIONAL OFFICES

ST. JOHN'S REGION
P.O. Box 10072, Stn. "B"
St. John's,
Newfoundland,
A1A 4L5
(709) 737-5055

EASTERN REGION
Box 339,
Harbour Grace,
Newfoundland,
A2A 2H0
(709) 596-3982

CENTRAL REGION
P.O. Box 724,
Grand Falls,
Newfoundland,
A2A 2K2
(709) 489-2986

WESTERN REGION
P.O. Box 884,
Corner Brook,
Newfoundland,
A2H 6G1
(709) 634-4506

LABRADOR REGION
P.O. Box 1060, Stn. "B"
Goose Bay,
Labrador,
A0P 1E0
(709) 896-5303

Appendix "E"

FOLLOW-UP COMMUNICATION: TELEPHONE

I am calling regarding a letter which was recently mailed to you. You may recall it was concerning research regarding alcohol problems and treatment services. I would like to know if you would consent to complete the questionnaire as described in the letter? (If the individual declined the investigator would thank the individual for his/her time and end the call appropriately.)

If yes, or ambivalent: I would like to explain the survey further. This is a survey of St. John's residents which will be used to assist in the development of policy regarding services for individuals and their families encountering problems related to alcohol abuse. This research is endorsed by the Alcohol and Drug Dependency Commission, and the Memorial University School of Social Work.

Your name has been randomly selected from the residents of St. John's to participate in the survey. I would appreciate your assistance, and ask that you complete a questionnaire which will take approximately thirty minutes of your time, but will contribute to the development of appropriate

programs for public education and treatment services.

I will have a questionnaire packet delivered to you within the next twenty-four (24) hours, and ask that you complete it within twenty-four (24) hours and return it to us in the stamped, addressed envelope provided. The results of the study will be published, but your responses will be summarized with those of over two hundred others, in such a fashion as to protect your anonymity.

I assure you that the responses will be held in strictest confidence and once the study has been completed, the questionnaire will be destroyed by the researcher. Thank you for agreeing to participate, and I look forward to meeting you.

Appendix "F"

INSTRUCTIONS TO THE RESEARCH ASSISTANT WHEN DELIVERING THE
QUESTIONNAIRE PACKET TO THE RESPECTIVE HOUSEHOLDS

The research assistant would introduce him/herself and ask for the specific individual respondent. He/she would provide the respondent with the packet including the questionnaire. The respondent was asked to complete the questionnaire within twenty-four hours and return it in the stamped, addressed envelope. The research assistant then thanked the individual for his/her co-operation and again assured the respondent of anonymity and absolute confidentiality of the responses.

