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Community Providers' Views of Alcohol Problems and Drug Problems

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Abstract

This study contrasts community health and social service providers' views on alcohol vs. other drug abuse. A probability sample of 457 social work and other providers from a county's public and private medical and mental health clinics, welfare and criminal justice systems, and substance abuse programs, as well as clergy, private therapists, and physicians were interviewed. For both alcohol and drug problems, providers thought only of severe dysfunctions, which suggest that less severe forms of these problems may evade detection. In addition, drug problems were viewed as more harmful than alcohol problems, which may result in providers minimizing alcohol problems.

Keywords

Alcohol and drug problems; providers' views; attitudes; definitions

INTRODUCTION

Individuals with alcohol and/or drug problems are more likely to see a range of community providers for problems related to their substance abuse rather than attend specialty treatment (Denny, Sedula, Holtzman, & Nelson, 2003; Marlatt, Tucker, Donovan, & Vuchinich, 1997; Rose, Zweben, & Stoffel, 1999; Zweben & Barrett, 1997). As a result, police officers, clergy, social workers, eligibility workers, nurses and physicians have valuable opportunities to identify and respond to substance abuse problems.

At the same time, a large body of literature suggests that community providers' and societal responses are significantly shaped by their perceptions of alcohol and drug problems (Farmer & Greenwood, 2001; Friedmann, McCullough, Chin, & Saitz, 2000; Hill & Hinton-Anderson, 1995; Kandall, 2000; Miller, Sheppard, Colenda, & Magen, 2001; Schwartz & Taylor, 1989; Williams, 1999). However, we know little about their perceptions or whether they perceive alcohol problems differently than other drug problems. If they are viewed differently, then what are the implications for identification and handling of such problems in the community? This study contrasts how health and human service providers understand alcohol and other drug problems in their day-to-day work; in particular, we examine their definitions of alcohol and drug problems, as well as differences in attitudes and perceptions of severity. Provider views on alcohol and other drug problems that can pose a barrier to giving help are: failure to understand/agree with the medical model of addictive diseases (Miller et al., 2001), a view that persons with these problems cannot be helped (Geller, Levine, Mamon, Moore, Bone, & Stokes 1989), a view that such services lie outside their responsibilities (Miller et al., 2001; McCrady, Richter, Morgan, Slade, & Pfeifer, 1996), and

pessimism about working with alcohol or other drug abusing clients (Drummond, 1997; O'Connor & Schottenfeld, 1999).

The policy and treatment histories of the alcohol and drug field in the U.S. suggest that society sees differences between alcohol and other drug problems. Early 19th century public policy addressed alcohol problems through the Temperance Movement (Gusfield, 1963; Levine, 1983); however, since then, public policy has emphasized drugs other than alcohol (reflected in a series of "drug wars"; Reinarman & Levine, 1989). For instance, both alcohol and other drug use by pregnant women can harm fetal development, with actually a larger body of published research on the effects of alcohol. More children are born alcohol-exposed than drug-exposed (Barth, 1993). However, public policy sanctions have focused on perinatal opiate abuse rather than alcohol use (Amaro, Fried, Cabral, & Zuckerman, 1990; Jessup, 2000).

In the U.S. a major distinction between alcohol and other drugs is their legal status. Drug use and possession has been criminalized, but alcohol is not only legal for adults, but educational campaigns and federally funded research have promoted the benefits of moderate drinking (Coate, 1993; Rimm, 1999; Turner, Bennett, & Hernandez, 1981). A social movement about the health concerns of alcohol is growing, but it has targeted only special populations such as youth, including college students, and pregnant women through educational campaigns and warning labels on beverage containers (Greenfield, Graves, & Kaskutas, 1993; Kaskutas, 1995; NIAAA, 2002).

At the same time, epidemiologic research shows a trend toward combined alcohol and drug use, especially among younger individuals. As the population has aged, combined use makes up a larger proportion of the population needing treatment (Gerstein & Harwood, 1990; Norton & Noble, 1987; SAMHSA, 1994). Combined use patterns have encouraged the alcohol and drug treatment systems to merge, and a new vocabulary combines drug and alcohol abuse and dependence into "substance abuse" and "chemical dependency."

There is evidence that in the merged treatment programs, alcohol problems receive less attention than do drug problems (Gossop, Marsden, Stewart, & Rolfe, 2000; Simpson, 1997). Do community providers also prioritize drug problems, as do public policy and many treatment programs? If so, what are the implications for identification and helping persons seen in community agencies? The purpose of this study was to address these questions by interviewing a representative sample of community providers in one California county. The sample was composed of providers from medical, mental health, criminal justice, welfare, and substance abuse programs, and clerics, therapists, and private practice physicians. In-person interviews were used with structured and open-ended questions that allowed for a comparison of definitions, attitudes, and level of concern about alcohol and other drug disorders.

METHOD

This study used data from the 1995 Survey of Health and Human Service Providers, a study of the Alcohol Research Groups Community Epidemiology Laboratory (CEL). The study was conducted in a Northern California county with a population of approximately 900,000. A county was chosen for study, because in many states services are organized at that level and referrals between agencies and systems typically occur at that level. The particular county was selected on the basis of diversity in its population characteristics and mix of rural and urban areas. The county's generalizability in relation to other U.S. areas on alcohol and drug problems and treatment policy has been examined for over fifteen years through the CEL, and as the U.S. site of the World Health Organization's Study of Community

Response to Alcohol (Greenfield & Weisner, 1995; Kaskutas, Weisner, & Caetano, 1997; Schmidt, Weisner, & Wiley, 1998; Weisner, Kaskutas, Hilton, & Barile, 1999; Weisner & Schmidt, 1992, 1995). A great deal of attention in the CEL has been addressed to representation of measures, treatment system characteristics and relationship between substance use and problems through the National Alcohol Study, National Household Survey on Drug Abuse and other regional studies.

Design and Procedures

The Providers Survey involved a two-stage probability sample of county service providers and private practitioners in the county. An exhaustive list of the county's public and private health and human service organizations, as well as private practitioners in solo and group medical and psychotherapy practices, was developed using telephone and resource directories. To enumerate the sample, 20-minute telephone interviews were conducted with each agency to obtain information on size, ownership, and type of organization. From a resulting listing of over 2000 organizations, 117 agencies were randomly selected (adjusted for size and ownership) within the following six strata: alcohol and drug treatment agencies, criminal justice agencies, mental health centers and solo therapists, public and private hospitals in conjunction with freestanding medical services and solo physicians, religious-related, and social welfare settings. For each organization selected, we obtained a comprehensive listing of all full- and part-time non-technical staff employed by the agency. Within each selected organization type, we drew a random sample of provider staff proportionate to agency size. We also enumerated physicians and psychotherapists working in solo and group practices throughout the county, and drew separate probability samples of each. A total of 457 provider staff were interviewed out of the 549 selected. The overall response rate was 73 percent, ranging from 70 percent in the hospital/medical services/solo physician stratum to 97 percent in the alcohol and drug treatment agencies stratum. Data are weighted to reflect nonresponse and the sampling distributions within and across strata.

Trained interviewers conducted in-person one-hour interviews. The subjects were interviewed in private locations where they worked. The instrument included structured questions about respondents' personal and professional background, current work situation, caseload, attitudes and beliefs, and experiences working with clients with alcohol and other drug problems. Open-ended questions on how they defined alcohol and drug problems were also included. Participation in the study was voluntary, and information collected was kept strictly confidential, including that from agency directors and other staff at the agencies where the providers worked.

Measures

Definitions of alcohol and drug problems—Respondents were asked, "If you had to choose, would you say alcoholism (with a second question asking for drug addiction), is mostly a genetic problem (something a person is born with), a social problem, or a psychological problem or can't choose because two or more causes are equally important."

Open-ended questions included, "What definition of alcohol problems (and also of drug problems) do you use?" We purposely did not ask participants whether participants defined alcohol and drug problems differently because this wording implied that differences exist. Answers were entered verbatim by the interviewer on the questionnaire, and entered into a computer text-based program that allowed for text searching by embedded codes. Narratives were coded according to whether content addressed physical, social, or psychological aspects of alcohol and drug problems. If respondent stated their definition of drug problem was identical to their definition of alcohol problem then a check box was marked that indicated "same as that used for alcohol problem."

Problem rating—Respondents were asked to rate twelve problems (racial troubles, homelessness, crime, unemployment, drug use, alcoholism, air/water pollution, domestic violence, cigarette smoking, discrimination against women, welfare cheating, government corruption) for their county by level of seriousness. The response options for each problem were “one of the most serious,” “fairly serious,” “not too serious,” and “not really a problem.” They were also asked to rank which problem was the most serious affecting the county.

Substances clients have problems with—In addition to questions about alcohol, respondents were asked, “What are the main drugs that your clients seem to have problems with?” Eleven substances (crank, other types of speed or amphetamines, crack, cocaine, sedatives, heroin, methadone, other opiates, MDA, psychedelics, marijuana) were listed with yes/no categories, as well as an “other specify” category.

Caseload prevalence of alcohol and drug problems—Respondents were asked, “if you had to guess, about what proportion of the clients you see have an alcohol problem (and what proportion have a drug problem)?”

Caseload prevalence of specific background characteristics—Respondents were asked what percentage of their clients fell into the following groups: African-Americans, Latinos, women, and people below the poverty level.

Analysis

Categorical data were compared using chi-squared two-tailed test of proportions. We report p-values and 95% confidence intervals. A word-processing software program (Nota Bene) was used to examine the narrative definitions of alcohol and drug problems. We compared alcohol and drug problem definitions and report the overall thematic similarities and distinctions within each coded category (physical, social, and psychological).

RESULTS

Sample Characteristics

The subjects consisted of 457 individuals. Fifty-eight percent of the overall probability sample of providers were women; 74 percent were over age 40; 80 percent were white, 7 percent were African-American, 4 percent were Asian, 4 percent were Hispanic, and 5 percent were from other ethnic groups; 50 percent had a postgraduate degree, 22 percent had a college degree, 21 percent had at least some college, and 7 percent had a high school education or less. The educational background of providers was biological sciences, including physicians, nursing, and dentistry (40%); counseling or therapy (17%); criminology, social science, or liberal arts and education (13%); no advanced degree (11%); theology or divinity (8%); social work (6%); and business, management or law (5%).

Quantitative Data

Table 1 presents responses to structured questions about definitions of alcoholism and drug addiction. Twenty-four percent of providers defined alcoholism as genetic, while only 10 percent defined drug addiction as such ($p < .001$). Half of the respondents considered drug addiction a social problem, compared to one-third considering alcoholism as such ($p < .001$). Equal proportions (30%) of providers defined alcoholism and drug addiction as psychological problems. Fourteen percent reported that alcoholism (and 9% that drug addiction) had two or more causes. A sub-analysis by setting (i.e., strata) revealed that compared to drug addiction, a significantly larger percentage of providers in health care (i.e.,

public and private hospitals, freestanding medical services, and solo physicians), mental health centers and solo therapist, and welfare settings defined alcoholism as primarily genetic. Compared to alcoholism, a significantly larger percentage of providers in health care and welfare settings defined drug addiction as a social problem (not shown).

Table 2 presents providers' rating of the seriousness of community problems. Differences were found in the ranking of alcohol versus drug problems. The highest percentage of respondent considered unemployment (26%) and crime (26%) to be the most serious problem. Drug use was ranked the most serious by nearly as many (21%), while only 7 percent ranked alcohol as such. Differences were also found in the ratings of "one of the most serious" problems. In this case, drug use was rated second (after crime) with 49 percent re-peating it as one of the most serious, while alcoholism was fourth (following unemployment), with 38 percent reporting it as one of the most serious. A sub-analysis showed that only among those at faith-based settings were there a significantly larger proportion of providers who rated alcoholism as a more serious community problem than drug use and addiction.

Ninety-eight percent of providers reported they had clients with alcohol problems. Almost half (48%) of the providers reported their clients had problems with crack and 45 percent said they had problems with crack and cocaine. Forty-four percent reported client marijuana use and 27 percent reported they saw clients with heroin problems.

Table 3 presents the proportions of providers who reported high (> 75%) prevalence of alcohol and drug problems among their caseload by ethnicity and gender of their clients, as well as whether they were below the poverty level. Of providers who reported over half their caseload were African-American, a significantly larger proportion (58%) reported seeing a high prevalence of drug problems ($p < .05$). A sub-analysis by type of work setting revealed the responses of providers who worked in criminal justice agencies accounted for this finding ($p < .01$). Of providers who reported over half their clients are below the poverty level, a significantly larger proportion (90%) said they see a high prevalence of drug problems ($p < .05$). A sub-analysis by type of setting showed the responses of providers working in mental health centers and solo therapists account for this finding ($p < .05$).

Narrative Open-Ended Responses

Providers were asked to define alcohol and drug problems in their own words. The majority of providers who worked in AOD settings offered identical definitions of alcohol and drug problems (59%) compared to only 37 percent of those who did not work in AOD settings ($p < .07$). A sub-analysis revealed that 81 percent of respondents in criminal justice, 54 percent in mental health centers and solo therapists, 59 percent in health care, and two-thirds in social welfare and religious-related settings differed in their definitions of alcohol versus drug problems.

Overall, respondents who used physical or medical definitions did not distinguish between alcohol and other drug problems. When asked to elaborate, "What definition of alcohol problem and drug problem do you use?" providers seldom characterized either alcohol or drug problems by disease model terminology, such as loss of control or craving. They often described both alcohol and drug problems as medical or psychiatric conditions emerging from excessive or inappropriate use. Some providers referred to chronic diseases that resulted from heavy drinking or drug use, such as "mental illness," "organic brain syndrome," and "liver hepatitis." Others described acute physical conditions such as "seizures," "blackouts," "overdose," and "drug interactions." On the whole, they referred to physical manifestations of heavy drinking, drug use or dependency, including the "smell of alcohol," "poor physical hygiene," "glassy," "red," or "dilated" eyes, "coughing," and skin

conditions like “needle marks,” “abscesses,” “rashes,” and “broken blood vessels.” Some providers referred to criteria from diagnostic classification systems as indicative of alcohol or drug problems such as “physical dependency,” “tolerance,” and “withdrawal.” In this response dimension, there was a clear emphasis on severe and objective signs and symptoms of addiction.

Those providers who relied on social problem characterizations of alcohol or drug problems said both caused various behavioral problems, i.e., “marital, familial, and employment difficulties” or “the money goes to drugs instead of food.” Recurring themes were legal conflicts, economic hardships, neglect, and domestic violence. However, these providers distinguished drug from alcohol problems in one common and fundamental way: drug problems meant “illicit” use, and that alone constituted a problem. In contrast, drinking was considered problematic only in particular contexts (e.g., underage drinking, drinking and driving), or patterns of use (e.g., binge, daily, morning, covert), and when resulting in specific harm (e.g., violence). No provider said alcohol consumption alone was sufficient to define a problem.

Attitudes toward drugs varied somewhat by type of drug. Some providers considered marijuana a less harmful drug. Drugs such as crack, crack, and cocaine were explicitly identified with serious events such as child abuse or neglect, or criminal offenses committed to obtain drugs.

Overall, providers who used psychological explanations did not differentiate between alcohol and drugs. They characterized use of substances as a way of managing emotional states. For instance, they reported that problem users consumed alcohol or drugs to “lift spirits,” “gain confidence,” “cope,” “escape,” “fill emptiness,” “calm oneself,” “avoid feelings,” “to forget,” and to “rebel.” Some providers referred to “psychological dependence” to characterize both substance problems.

DISCUSSION

This study examined the views on alcohol and drug problems in a probability sample of service providers and private practitioners in a Northern California county. Our research questions examined whether providers think of alcohol problems differently than other drug problems, and if so, what are the implications for the identification and response to these problems in the county.

The data show that the majority of the providers do see the two problems differently. Significant proportions of providers working in health care, mental health, including private practitioners, and welfare settings viewed alcoholism as primarily a genetic problem, and significant numbers of providers working in health care and welfare settings considered drug addiction as primarily a social problem. With the exception of providers in religious-related venues, providers viewed drug addiction as a more serious problem than alcoholism in their community.

In many ways, the findings reflect the historical differences between public alcohol and drug policy in the U.S. The narrative data showed that providers tend to focus on extreme conditions and the illegality of other drugs. Providers shared with interviewers a view of alcohol problems largely defined by drinking in prohibited contexts (e.g., under age, driving). In recent decades, public policy has devoted more resources to drug problems than to alcohol problems, which parallels providers’ prioritization of drug addiction as a more serious community problem than alcoholism. The latter is unfortunate because alcohol problems are a more prevalent public health problem than drug use (Edmunds et al., 1997; SAMSHA, 2000). Furthermore, the high prevalence of African-Americans with drug

problems reported by providers in criminal justice agencies is troubling because it parallels the disproportionate numbers of African-Americans in U.S. prisons for drug-related offenses (Beck & Gilliard, 1995; Johnson & Jones, 1998; National Center on Addiction and Substance Abuse, 1998). Based on our sample, it appears that drug problems carry much more stigma because of their association with criminal behavior. When community providers view drug use primarily as illicit behavior, this encourages a punitive response rather than a response more helpful to the drug user. It also often has implications for identifying and responding to alcohol problems: they may not receive timely attention.

The data suggests that because providers largely rely on objective evidence to identify alcohol and drug problems, such problems may be under-identified. Unfortunately, valuable opportunities to intervene are thus lost, even when alcohol or drug use may have motivated contact with the provider in the first place. Because of how providers define alcohol versus drug problems, even identified alcohol problems may be taken less seriously unless they occur in a particular context (e.g., under-age drinking, pregnant women drinking, drinking while driving). These implications are relevant for various non-alcohol and drug community providers, but especially for social workers because they work in a wide range of settings, including criminal justice agencies, mental health centers, hospital, and social welfare agencies (Bureau of Labor Statistics, 2001; Gibelman & Schervish, 1997).

CONCLUSION

Because they work in diverse settings, social workers are well positioned to educate community providers about how to identify and respond to clients with alcohol and other drug problems. Information to providers on the prevalence of both problems in their work setting and its relationship to many health, social, financial and occupational problems may educate and motivate them to address the problems. Systematic identification of both alcohol and drug problems across settings requires the use of structured screening instruments. Most available instruments, for example the CAGE questionnaire (Ewing, 1984), the SMAST (Selzer, Vinokur & van Rooijen, 1975), and the AUDIT (Babor, de la Fuente, Saunders & Grant, 1992), screen for alcohol problems, but more screening tools for drug problems are being developed. The CAGE-Adapted to Include Drugs (CAGE-AID) and the SMAST-AID are modified versions of the CAGE and SMAST that simultaneously assess alcohol and drug problems (McPherses & Hersch, 2000). Providers require more than one option for responding to clients with identified substance problems, and their responses may range from brief interventions (SAMHSA, 1999; NIAAA, 2003) to referral for more intensive evaluation and treatment (Zweben & Barrett, 1997). Brief interventions, in particular, were designed for use in non-substance abuse community settings. Screening and interventions for AOD problems must be integrated into organizational systems if their implementation is to become routine and sustainable (Graham & Fleming, 1998). Social workers are in key positions to develop and initiate screening and intervention across community settings and their involvement may mean that many clients with substance use problems that would ordinarily go undetected, will have their problems addressed.

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TABLE 1Definitions of Alcoholism and Drug Addiction (in percent)^a

	Alcohol	Drug	CI (95%)
Genetic	24	10 ^{**}	1.77–3.40
Social	32	51 ^{**}	0.52–0.72
Psychological	30	30	0.83–1.23
Other	14	9 [*]	1.09–2.32

^an = 451.^{*}p < .01.^{**}p < .001.

TABLE 2

Rating of Social and Health Problems (in percent)

	<u>Most Serious^a</u>	<u>One of the Most Serious^b</u>
Unemployment	26	43
Crime	26	55
Drug Use	21	49
Alcoholism	7	38
Air/Water Pollution	5	24
Homelessness	5	35
Racial Troubles	3	17
Domestic Violence	3	27
Cigarette Smoking	2	14
Discrimination Against Women	.5	7
Welfare Cheating	.5	10
Govt. Corruption	.5	8

^a
n = 302.^b
n = 452.

TABLE 3

Providers Report on Clients with Alcohol and Drug Problems by Other Background Characteristics (in percent)

> 75% Client with a Problem			
	Alcohol n = 45	Drug n = 40	CI (95%)
> 50% of clients are:			
Ethnicity			
African-American	36	58	*.38–0.99
Latino	18	17	.41–2.62
Gender			
Women	42	45	0.58–1.52
Economic			
Below Poverty Level	74	90	*.67–1.00

*
p < .05.