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COMMENTARY

Primary Health Care and the Addictions: where to start and where to go*

BENNO POLLAK. F.R.C.G.P.

Beech Cottage, Gibson's Hill, London SW16 3EP, United Kingdom

Summary

The development of community services for problem drinkers is briefly traced over the last 40 years. The numbers of drinkers in need of advice and treatment far exceeds the available resources. Family practice would be an ideal place in which to further primary care and prevention but lack of time, knowledge and motivation for probing into patients' drinking habits detract from the potential. A pilot study of opportunistic screening in general practice is described whereby a yellow label affixed to a patient's medical record card registers the average weekly alcohol intake. In a sample of 400 patients, 16% were high or intermediate risk drinkers. Each high risk drinker presented with a medical condition which could, in either aetiology or management, be related to high consumption. By discussing this, patients were often motivated to drink less or abstain. Various suggestions are made how better medical training and education could improve the diagnosis and treatment of drinking problems.

Where to Start

Development of Community Services in Alcoholism

The 1950's might be described as the Dark Ages. For example, in 1951, a consultant psychiatrist applying for funding to attend a WHO scientific meeting on alcoholism, was informed by the DHSS there was not enough alcoholism in the U.K. to warrant such funding.[1] However, in 1954, Parr[2] managed to participate in such a meeting in Holland entitled 'The prevention and treatment of alcoholism'. He noted that at no time during the 2 week conference was the family doctor ever mentioned. This stimulated him to send a questionnaire to 480 British G.P.s asking about the number of alcoholics in their practices. The results were surprising. No less than a fifth of the G.P.s did not know of even a single case in their practice. A factory doctor, responsible for 12,000 employees, stated he had never seen a case in 11 years. Parr estimated from the replies there were not more than 35,000 alcoholics in the Country—an overall figure, for England and Wales, of 1.1/1000 adults, with a sex ratio of 2.2/1.

The 1960's saw the formation of a variety of statutory and voluntary bodies, together with specialist units in hospitals. For example, the National Council on Alcoholism, local Councils on Alcohol and the Medical Council on Alcoholism all came into being during this time.

In the 1970's the Government surprised alcohol specialists with a circular[3] calling for community services for alcoholics. This stated "The development of treatment facilities will be ineffective without a complementary development of community services".

Two years later the DHSS set up an Advisory Committee on Alcoholism in the Community which was chaired by Professor Neil Kessel. The Maudsley Pilot Project, under Dr Terry Spratley,

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was also funded. Both were given the task of recommending means by which the alcoholics in the community could be reached. Kessel's committee analysed the problems of prevention, treatment, education and training. The core of their three reports[4–6] was a blueprint for the establishment of co-ordinated yet flexible systems of care involving community based statutory, voluntary, social and primary care services.

Part of the Maudsley project[7] was a random sample of Probation Officers, Social Workers and GPs in Camberwell. Spratley and his colleagues questioned the soundness of putting problem drinkers into their care before assessing their suitability for the task. Finding that, in the main, none of these groups had confidence in or motivation for dealing with alcoholics, specialized support units called CAT (Community Alcohol Teams) were suggested to train and advise primary care workers to deal with alcoholics and drink problems in the community.

CATS have been created in scattered parts of the country, often with wide, structural variations from the original proposals. Clement[8] studied such a scheme in Salford and found complaints by some of the primary care workers that, whilst CAT was ready with advice, they proved reluctant to become involved in individual cases. On the other hand, many GPs were only too happy to refer cases to CAT but were unwilling to take part in educational and inter-disciplinary sessions planned by the team. In fact, two practices referred more cases than the 80 social workers in the area.

The 1980's broadened perspectives and policies. For example Kendell,[9] in his Pollak lecture unequivocally stated that "any policy designed to reduce consumption of the heaviest drinkers would only eliminate a relatively small proportion of the adverse effects experienced by the community as a whole". Furthermore, he argued: "for most common disorders, preventive policies based on a change in behaviour by the population as a whole are more effective than those based on the identification of high risk subgroups. It is the drinking habits of the millions which must be changed if we are ever to make any real impact". Thus prevention was put on the map.

In the meantime, the Government, had not been idle. It summarily withdrew funding from NCA (National Council on Alcoholism) FARE (Federation of Alcohol Rehabilitation Establishments) AEC (Alcohol Education Centre) and MCA (Medical Council on Alcoholism) since they refused to amalgamate. The MCA decided, with British Brewer's support, to stuggle on. Action on Alcohol Abuse (Triple A) and Alcohol Concern remained as major watchdogs but only the latter has any government funding and Triple A may fade out through lack of resources.

John Wakeham MP, Leader of the House of Commons, chairs a Ministerial Group on Alcohol Misuse involving 11 different Government departments. Unfortunately, this Group has been described as "nothing but a wastepaper basket into which all effective action gets dumped before it can be implemented.[10]" The Licensing Hours have escaped this treatment, but it looks as if Lady Masham's recommendations for Young People and Alcohol[11] and the North Report on drink-driving[12] have not been so fortunate—with luck they are only gathering dust on the desk and not yet in the wastepaper basket.

However despondency is not universal. The World Health Organization has funded several international projects of which Ritson *et al.*[13] have given us an excellent review. These suggest early intervention stategies in primary care, the use of screening and offering brief advice as the way forward.

In addition, 3 Medical Royal Colleges have published substantial reports on the misuse of alcohol[14–16] and that of the RCGPs has emphasized the role which the community and primary care can play.

Attention to prevention has thus led to attention to the community and primary care.

Models for Community Services

At present no effective, integrated prevention and treatment programmes exist in the community and for this there are several reasons.

Firstly—The 'in-phrase' nowadays is interdisciplinary teamwork—in alcoholism as many other subjects. But, just as placing a wedding ring on one's spouse's finger doesn't make a marriage work, placing members of different disciplines together doesn't make a team. Effective teamwork takes commitment, tolerance and time to mature and this integration has often not been allowed for in many proposed schemes. Unfortunately, wishing it does not make it come true.

Secondly—The community has many dedicated workers, beavering away in their own little corners, each seeing different aspects of alcohol's many faceted character in their own special—yet different—ways. To take only three examples: Probation

Officers when drinkers brush with the Law; Social Workers when drink threatens family and marriage; Factory Doctors when alcohol causes mistakes at the workbench. Rarely will the three meet. This is generally thought to be a fault which needs correcting.[17] It may or may not be so. Why does everyone have to meet, relate, discuss? There is a need for many different agencies to deal with the many faceted aspects of alcohol abuse, but, provided all know their respective roles and the referral system is good, face to face meetings need not be too frequent.

But the real problem is that most of these dedicated workers can only deal with customers who are either motivated to go to them or obliged to for legal or other reasons. By their very nature, they are not in a position to give individual preventive care.

Thirdly—There are the clients themselves. All the dedication in the world can be set at nought by the well known, notorious vacillations, the caprices, of the clients or patients. The Salford CAT report,[7] for example, noted that half the new clients failed their appointments.

Fourthly—The doctors. Why do doctors hate dealing with alcoholism? This is an intriguing subject. Search of the literature fails to provide an answer to or an explanation of the complex and ambiguous views taken by the medical profession towards patients who may drink too much. There is no doubting that these views exist. An attitude survey in the *BMJ*[18] revealed alcoholism at the bottom of the pile—the least favoured subject with which to deal as seen by senior and junior medical staff alike. The thought of alcohol and alcohol related problems induces iatrogenic myopia. Several medical papers[19–22] have commented on the drinking problems lying unrecognized in orthopaedic and other hospital beds, whilst casualty and psychiatric departments are likely to yield a rich, yet largely untapped, harvest.

Where to Go

As every good clinician knows diagnosis preceeds treatment, therefore the problem requires definition before discussing methods of improvement. It can be gauged, from a variety of sources, there are between 1 to 1.5 million adults in U.K. at the present time with drinking problems of some kind or another. Only a minority of these are likely to come into contact with any advisory or therapeutic organization. There is the hidden iceberg based on the following estimates per annum:–

About *25,000* new clients are seen by various voluntary organizations. Culled from the annual reports of 30 local alcohol councils (Pollak).

About *25,000* clients are seen by AA and other specialist organizations, e.g. Alcohol Concern, Drink Watchers. Accept, etc.

About *50,000* more patients are seen in hospitals and Alcohol Treatment Units.[23]

Thus a total of only about *100,000* per annum are receiving help or advice.

Whilst all these bodies obviously require further funding and more personnel, even given such resources they are unlikely to more than double this total. So between 900,000 to 1.4 million vulnerable people remain untouched. It would appear therefore that what is required is a resource which has access to the drinking population at risk but based upon an existing personal relationship.

Community Agents in Personal Relationship with Large Numbers of Adults

These include the following:–

1. *The Churches*

Since there is no sign of a religious revival, their influence must remain, at best, minimal.

2. *The Workplace*

Some large companies are tackling alcohol problems but the U.K. might well emulate the States where nearly every company has an active programme. If companies are to have private health schemes for their employees it must be ensured that the prevention of hazardous drinking is included in these schemes.

3. *Family, Relatives and Friends*

In theory, these should be the most important preventive and therapeutic influence on the majority. But the conspiracy of silence is pervasive. How to break this down has not yet been satisfactorily tackled.

4. *The Media*

So far, health programmes on the Media are, at best, equivocal and overshadowed by invidious advertisements; whilst it seems than no man, in soap opera or otherwise, can be a hero nowadays without pouring himself a glass of what is definitely not lemonade.

5. *Community and Family Doctors*

The *4,000* Community doctors work mostly with babies and children. Although prevention is in their remit, they have not so far been engaged in serious, wide scale anti-drinking campaigns. There is no real

reason why this could not be encouraged, but they would be left with one serious disadvantage—they do not have an entree to people's homes nor a personal relationship with their so-called clients.
Family Doctors There are approx. 30,000 Family Doctors in the U.K. General practice has both disadvantages and advantages for undertaking this work and we will discuss this further below.

Disadvantages
The day-to-day workload is already heavy without any additional tasks. Some patients may deliberately avoid discussing what they might see as their 'weaknesses' with their family doctor. As Thom's paper[24] has shown, many GPs are not motivated to involve themselves in drinking patients whom they consider frustrating, depressing and unrewarding.

Advantages
However, on the more positive side, there is now ample research evidence (Babor *et al.*[13]; Anderson[25]; Wallace *et al.*[26]) to suggest that early recognition and a brief patient–doctor intervention at primary care level might be a promising line of approach. Family practice has a captive clientele. Most patients stay registered with their family doctors for years—sometimes all their lives. And, trite as it may sound, there is a special relationship between doctor and patient. One must feel rather differently towards a doctor one has known and seen many times, often at times of stress, than towards a stranger. At his or her best, the family doctor therefore has acceptability as a counsellor. Perhaps the most important feature is that the GP has obvious possibilities for opportunistic screening whilst seeing patients for problems other than drink. There is a built-in monitoring system—70% of the practice population in one year, rising to 100% in 5 years, will consult their doctor.

Put in a more general context, the time is right to introduce preventive health care in family practices as the public is becoming more interested in healthy living, whilst the GP's role has changed to include more psychiatric, social and preventive medicine. As the Primary Care Teams grow more time becomes available for screening and counselling.

The report of the RCGPs,[14] which is called *Alcohol—a Balanced View*, suggests that GPs should establish a drink register of all their patients. One of many other suggestions is the use of an alcohol card, placed inside the medical record envelope which would provide valuable information of drinking habits together with any abnormalities, investigation results and disposal of any problems uncovered. Unfortunately, it is the author's opinion that the initial completion of such a card would take a minimum of half an hour or, with two consulting sessions daily of 15 patients each, 15 hours/day. The RCGP report is, therefore an ideal rather than a practical proposition.

My Work with Alcoholics
In the 1960's I was interested in the 'hard liners' many of whom were Skid Row alcoholics.[27]

Subsequently, in the 1970's, I began to study alcohol problems in my own practice. Patients came under suspicion if they exhibited some or any of pre-agreed diagnostic pointers of alcohol misuse. These patients then had a detailed drinking history taken. An examination and investigations followed to estimate the degree and type of damage. Those who were identified as heavy drinkers were treated. Where possible, family support was enlisted. The patients were kept under regular review.

A paper, published in 1978[28] demonstrated how, in this way, in a practice of approximately 9,000 patients, 69 heavy drinkers were identified, 30 of whom were alcohol dependent. All were treated within the practice. Ten of these patients died—seven from cirrhosis and three committed suicide.

I am satisfied that such patients can be identified and treated in general practice, but the time and motivation involved cannot recommend it for general use in family practice (although I continue to use it).

This led me to think that quicker and simpler methods of secondary prevention would be more practical in general practice. So I embarked upon the *Green Form Scheme*—so called because the forms were a vivid green to distinguish them from the normal record card which is Government beige (both fit into the record envelope). This was an opportunistic screening device, the form being completed at the end of a normal consultation. It recorded basic demographic data and weekly alcohol consumption in units and included short advice on the need to reduce intake where indicated. A stopwatch was used to measure the extra time needed for completion of the form. Two hundred consecutive adult patients formed the study. The average time was 2 min 6 seconds. Thus, at 15 patients/session and two sessions daily, this amounts to 5 hours extra consulting time per week. I

do not believe this is any more acceptable to the average busy GP than is the RCGP's scheme.

The Yellow Dot Scheme

I then developed the *Yellow Dot Scheme*. A round, yellow label of 2.5 cm diameter is fixed on the front of each patient's Record Envelope. At the end of each consultation the patient is asked if he or she drinks alcohol, if so, whether during the week or weekends or both, and whether regularly or only occasionally. He is asked how much and what kind of alcohol he drinks and where he usually consumes it.

The replies are immediately translated into units/week and this is written onto the yellow dot, together with the date. The yellow dot label has eight letters (R—regular; O—occasionally; W—weekends; P—pub; H—home; B—beer; S—spirits; W—wine) printed on it and a line is put through the appropriate letters.

Figure 1 shows the completed Yellow Dot label of a patient who drinks 36 units of **B**eer, in the **P**ub, both **R**-egularly and at **W**-eekends.

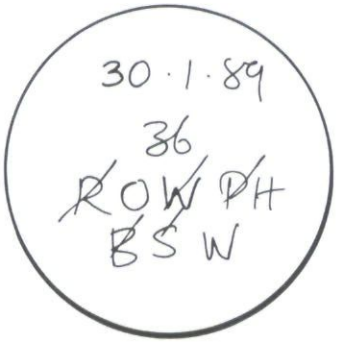

Figure 1. *Yellow Dot Scheme. A very simple way of recording a patient's alcohol consumption.*

Four hundred and fifty-eight patients who consulted over 60 consecutive surgeries make up the pilot project. However, 58 of these were already known as alcoholics at some time in the past, and were excluded from the study. Thus the total sample is 400 adult patients, when adult is defined as 16 years or older.

Results

Each patient took a mean of 30 seconds, with a range of 10 seconds for a total abstainer to 2 min for a heavy drinker or slow historian (using stopwatch). This added $7\frac{1}{2}$ min per consulting session or 15 min a day.

Figure 2 shows the total number of patients seen in each age group and their distribution by drinking categories.

In the original 458, 51% were males and 49% females, but, because the 58 alcoholics were predominantly male, 54% of the final 400 are female and 46% male.

The 129 non-drinkers and 210 low risk drinkers were considered to be the 'normals'; they make up 32 and 52% of the 400 total. Many more women (64%) than men (36%) were non-drinkers whilst the sex ratio for low-risk drinkers was almost equal (48% male, 52% female). Thus 339—or 84% of the total sample—were, by these criteria, at no risk.

Thirty one patients (8%) were intermediate risk drinkers, 48% being male and 52% female. 8% of the total sample (30 patients) were high risk drinkers. The sex ratio is four to one—being 24 males and six females. (See Fig. 3).

The intermediate and high risk patients make up the positive pickups which the Yellow Dot Scheme identified and are 16% of the total. This compares well with other screening schemes in general practice—for example cervical smears. (0.02%).[29]

The Yellow Dot Scheme revealed other interesting features. For example, in *every* case of high risk drinkers, alcohol was either responsible for or associated with their problem, diagnosis or treatment. The 24 males were suffering from one or more of the following: hypertension, coronary heart disease, gastro-intestinal disorders, diabetes, gout, and obesity. The six females presented with gastro-intestinal disorder, hypertension, obesity, brain damage, psychosis or skin disorder. Each case of high risk drinkers thus signalled the importance of alcohol in medical practice as illustrated by the following case histories.

Some Case Histories

A 52-year-old woman complaining of longstanding acne and rosacea had found specialist treatment ineffective. Her alcohol consumption was 40+ units. She was a barmaid accepting complimentary drinks. It could be explained to her that alcohol dilated the skin vessels in her face and was a strong contributory factor in her skin disease.

A 28-year-old draughtsman, not seen since childhood, was complaining of intermittent episodes of severe upper abdominal pain and vomiting. His weekly alcohol intake came to 100 units/week. A

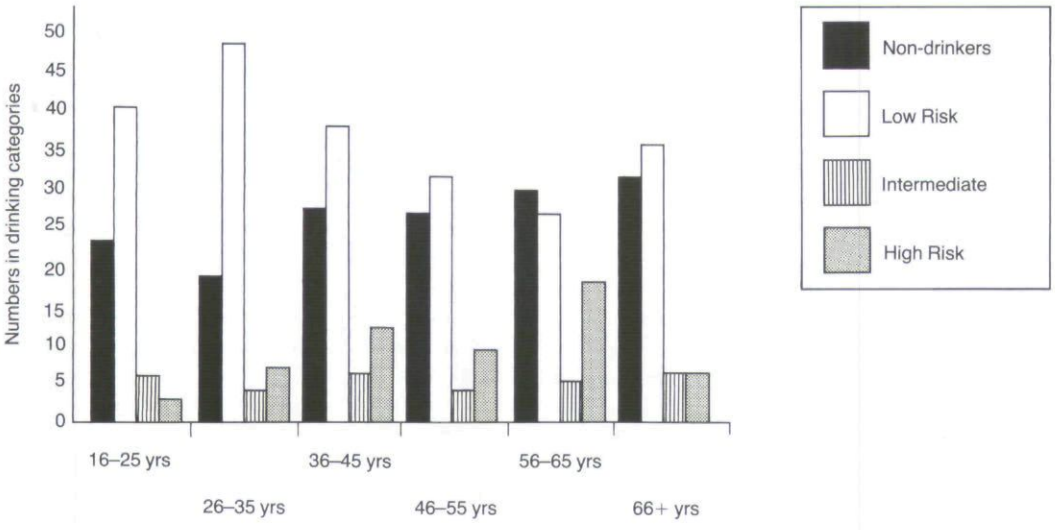

Figure 2. *Results of yellow dot scheme.*

Non-drinkers. Did not drink.
Low risk drinkers. 1–29 units/week men. 1–19 units per week women.
Intermediate risk drinkers. 30–39 units/week men. 20/29 units/week women.
High risk drinkers. 40+ units/week men. 30+ units/week women.

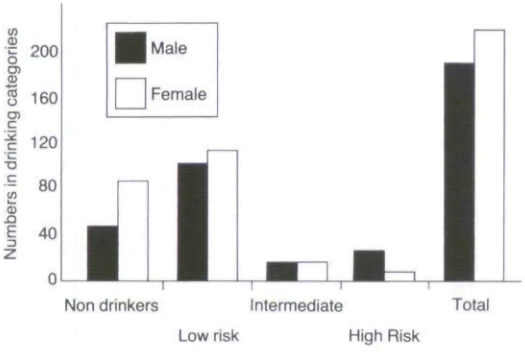

Figure 3. *Numbers in drinking categories.*

barium meal and other investigations were negative but his GT and cholesterol were raised. Remaining teetotal for a fortnight abolished his symptoms and he remains under observation.

A 69-year-old retired architect with late onset of diabetes and hypertension was imbibing over 50 units/week. His attention was drawn to the fact that the control of his diabetes and hypertension were adversely affected by alcohol and he has since restricted his consumption significantly.

A 78-year-old retired butler had been treated for hypertension by another of the practice partners. I had not seen him for some years when he had a sudden attack of acute gout. The Yellow Dot Scheme revealed that he regularly consumed over 60 units/week. I defined to him that both his gout and hypertension were related to his alcohol intake. He subsequently reduced consumption and the control of his BP is more satisfactory and there has been no further attack of gout since.

Opportunistic screening by itself has rewards. A 30-year-old West Indian—last seen as a baby with a nappy rash—came to ask for his passport application to be signed. Before leaving, he, too, completed the Yellow Dot and was found out to be a longstanding hard drug and alcohol addict of high tolerance. He has not been seen since. He may be in prison but I am waiting for him.

Another example of opportunistic screening concerns a very anxious young man who consulted about a dogbite on his finger. He was very much more concerned about the miniscule dogbite than the 96 units/week of alcohol consumed. I hope I was able to shift his area of concern, but his problem would certainly not have come to light without the Yellow Dot.

The concern in designing the Yellow Dot Scheme was to find a practical, quick method; acceptable to the patient; easy to record and review; yet enabling advice on cutting down, or abstaining where necessary, to be given. These objectives appear to have

been achieved and the pick up rate is very satisfactory. However, this is a pilot project and needs validation and repeating by others before putting into more general use.

Although the more obvious advantage of the Yellow Dot Scheme might seem to be it's scope for opportunistic screening, in fact, the chance of relating alcohol intake to the medical problem with which the patient is presenting, is of very much more practical importance. The problem is made immediately personal to the patient. This could help the patient's motivation towards a more sensible way of drinking and also demonstrates to the doctor the importance of alcohol in medicine. A further point is the Yellow Dot's record is there next time the patient consults.

The Strategic Role of the GP

It is tempting to reflect that if the country's 30,000 GPs persuaded only TEN of their patients to keep their drinking to moderate levels, 300,000 people would drink less. More important, these 300,000 would be exactly those who would not approach their problem voluntarily and have their attention drawn to the relationship of alcohol to their own problem of—for example—overweight, gastric ulcers, etc. It is this captive population which only a GP can significantly influence. Unfortunately, at present, most GPs have not convinced themselves of the common connection between medical problems and alcohol consumption.

We have got our educational priorities wide of the mark. A GP with an average sized list will have **15–20** diabetic patients[30] yet will have **100** high risk drinkers, many with alcohol-related medical problems.[31]

Medical Education on Substance Abuse

In educational terms this is a history of missed opportunities beginning at undergraduate level. As a tutor in general practice I have repeatedly noticed how interested medical students are in the problem drinkers of the practice, Skid Row alcoholics in particular. Yet Glass[33] informs us that medical students are only taught approximately one minute per week on this subject during their whole curriculum. A questionnaire sent to 40 training centres reveals that even student nurses and health visitors receive between 3 and 10 hours teaching per annum.

On entering general practice, young doctors spend 3 years in compulsory traineeship—why has it never been thought to give teaching on alcohol and drugs an official place in these schemes? There are Fellowships in general practice and a wide choice of diplomas in many medical subjects, so why not a Fellowship or Diploma in Substance Abuse, specifically tied to community care, and meriting financial benefit, rather as the DRCOG does, for example? The cost would be negligible compared to the six billion profit which the government makes on alcoholic drinks.

The older practitioners have also to be considered since most have been trained in curative, clinical medicine in which undifferentiated, psycho-social medicine played little part. But it seems likely that GPs will respond positively once alcohol problems are seen as an integral part of every day clinical practice and as health care and secondary prevention becomes accepted by the public. With increasing skills will come increasing interest leading to increasing satisfaction with the work.

We must not wait for Cassio's lament:—

> "Oh, God, that men should put an enemy in their mouth to steal away their brains. That we should with joy, pleasance, revel and applause, transform ourselves into beasts",[33] but rather agree with Iago—"Come, come, good wine is a good familiar creature, if it be well used."[33]

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