Alcohol and Primary Health Care:

Training Programme on Identification and Brief Interventions.

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FOREWORD AND GENERAL REMARKS

Notes for the trainer

This training manual is the result of a joint effort made by the scientists and professionals who have participated in the European PHEPA project.

Alcohol is a main health determinant throughout the world, and Primary Health Care (PHC) is in a pivotal position to prevent and minimize most of the harm done by alcohol. This manual aims to enhance the skills, knowledge, attitudes and motivation of PHC professionals facing the challenges posed by their patients who drink in a hazardous or harmful manner.

Alcohol related problems are often under diagnosed in PHC settings, and risky drinking is usually forgotten. General Practitioners (GPs) tend to concentrate on the most severe and visible alcohol related problems, while most of the preventive activities that should be routinely done with hazardous and harmful drinkers are often forgotten. Based on this assumption, this manual tries to present alcohol problems as a continuum ranging from hazardous drinking to severe dependence. Even though alcohol dependence is addressed in Session 5, the manual gives priority to the identification and brief intervention techniques that have proven cost-effective in PHC settings.

This training manual is one of the products of the PHEPA project (Primary Health care European Project on Alcohol) (http://www.phepa.net), which aims at the integration of health promotion interventions for hazardous and harmful alcohol consumption into primary health care professionals' daily clinical work. Europe is presently going through an important integration process that tends to harmonization, and this includes drinking patterns. PHEPA contributes to the harmonization of responses to alcohol related problems, taking into account the differences that make country based customisation of the training package a necessity. Those differences relate not only to beverage type and drinking patterns, but also to the organization of PHC and specialized addiction units. Thus, we strongly recommend that every trainer adapts the core contents of this training package to individual training styles, the differing needs of course participants and to country specificities.

WHO Collaborative Project on Identification and Management of Alcohol-related Problems in Primary Health Care (http://www.who-alcohol-phaseiv.net) has inspired relevant parts of this manual. In the frame of that study, the dissemination of identification and brief interventions is seen as a slow and sometimes difficult iterative process. Because of this, the philosophy behind the manual is that it is a better approach to target modest achievable goals than to aim at dramatic changes. If as a result of the training, PHC professionals start to revise their traditional misconceptions about alcohol, the trainer should be satisfied.

How to use this manual

The organization of this training manual is inspired by the WHO's Skills for Change Package (Mason & Hunt 1997).
For each of the six training sessions, the manual offers five different sections that allow the trainer to prepare them with different levels of training:

- The 'Objectives and Aims' summarizes the main goals to be reached during the session, and the materials (Overheads and Handouts) to be used.
- The 'Session Plan' guides the trainer on the different topics to be covered during the session, and the recommended duration of each topic. In each of the topics the trainer will find detailed information on how to develop it, and the materials to be used. Even though the schedule provided is not strict, the trainer should be aware of the wide range of issues to be covered and the limited amount of time usually available for training.
- The 'Background notes' offer detailed explanations and tips on how to conduct every one of the parts of each session.
- The 'Work Documents' provide detailed information on the topics to be learned in each session.
- The 'Overheads' offer visual aids for the explanations of each session.

Finally, even though this manual has been updated with the most recent available evidence, new data will be available continually in the literature. We encourage trainers to include in their sessions any new important findings. We recommend checking regularly the website of the Primary Health Care European Project on Alcohol (PHEPA) at *http://www.phepa.net* .

FIRST SESSION

Introduction and basic concepts

Objectives and Aims

Aim

To introduce ourselves and the programme. To raise interest in the alcohol topic.

Objectives

At the end of the session the trainees will know:

- The general course objectives
- How to identify their needs and interests in managing alcohol issues
- How to describe alcohol consumption in terms of standard drinks
- How to describe the type of intervention that is needed according to the drinking pattern

Material

Work documents:

1. Health and social costs
2. Standard drinks and drinking patterns

Overheads:

1. Training Programme
2. Contents of the Training Programme
3. Outline of the first session
4. WHO Collaborative Project on Identification and Management of Alcohol-related Problems in Primary Health Care (http://who-alcohol-phaseiv.net)
5. The PHEPA Project (http://www.phepa.net)
6. Alcohol as a risk factor for ill-health (I)
7. Alcohol as a risk factor for ill-health (II)
8. Attributable fractions in European men (%)
9. Risk of female breast cancer
10. Risk of coronary heart diseases
11. Benefit-cost analysis
12. Standard drinks
13. Drinking patterns
14. Risk levels and intervention criteria

Plan of the First Session: Introduction and basic concepts

Time	Methods
10 min	**1) Introduce yourself and the training programmme** State your name, profession and the health centre where you work. Briefly describe the outline of the sessions (Overheads 1, 2 and 3) and the way in which they will be presented. Explain that this course is part of the European PHEPA project and is associated with the WHO Collaborative Study on alcohol and PHC, and briefly explain its developments (Overheads 4 and 5). Distribute the material for the trainees and briefly describe it.
5 min	**2) Health and social costs - Explanation** Try to give a clear, summarised view of the costs and harms caused by alcohol consumption. You can consult Work Document 1 and use Overheads 6-11. If available add local and national data.
	3) Discussion on alcohol and Primary Health Care Under this heading, develop an open discussion on the three following aspects:
5 min	**1. Specific problems caused by alcohol in trainees' health centre**
5 min	**2. Responses already given to these problems**
5 min	**3. New initiatives that could be adopted and the necessary resources for responding to alcohol problems.**
	Write down all the ideas. For each of the aspects mentioned, ask the group to agree on the 5 most important ideas and write them on the paperboard or blackboard. It is essential to identify the relevant topics for the trainees.

Time	Methods
10 min	**4) Standard drinks and drinking patterns** You will have to agree the risk consumption levels and revise the 'standard drink' concept (Overhead 12). Work document 2 provides all the necessary information. Then explain briefly the concept of hazardous and hornful drinking as it is shown in Overhead 13.
10 min	**5) Risk levels and intervention criteria** Explain the different types of drinkers that we may come across, based on the WHO classification, and the type of intervention that we should use in each case. Overhead 14 will give you all the necessary information. Discuss the proposed forms of intervention with the group, as well as their suitability and viability in their case. Adapt to national standards if necessary.
5 min	**6) Summary** Briefly summarise the whole session, highlighting that alcohol does not only lead to costs, but also to a problem area that is sometimes difficult to cope with. Clarify that we will be talking about alcohol and health (and not just alcohol dependence). Emphasize that the course will help them by providing the appropriate skills and tools.

FIRST SESSION

Introduction and basic concepts

Background Notes

1) Introduce yourselves and the training programme

If training is delivered in a PHC Centre, the trainees already know one another and all that is necessary is to create a suitable rapport with the tutor. In case trainees don't know each other a short introduction will be necessary.

We can begin by introducing ourselves and asking the trainees to do the same. You can tell them that both tutors and trainees are called by their first name, as this degree of informality will help group discussion and to share difficulties that arise later on in the course.

It is important to explain that it is a participation-based course, relating to the trainees current knowledge and also adding additional content. The "basic rules" will be that the trainees help each other to learn things and share their ideas and knowledge.

A typical list of basic rules is as follows:

- Respect confidentiality during the exercises. Do not discuss the personal questions of others with anyone outside the course.
- Respect everyone's point of view, even if you do not agree.
- Arrive punctually and return promptly after breaks.
- Speak one at a time in group discussions and listen when others talk.
- Respect differences
- Ask if you have a query about anything.

It may be a good idea to remind the trainees that the course is not a series of individual seminars, but rather a complete course. Each session is related to the previous one and the subsequent ones. The trainees must make an effort to attend them all. Emphasize that the trainees are expected to actively participate in the exercises, since it is unlikely that they will try new strategies with patients if they have not done it previously in the sessions. Reassure them that anyone not willing to participate in the exercises will not have to do them.

Giving an overall view of the course. Placing it within the PHEPA project and the WHO Collaborative Study will help the trainees to appreciate its continuity.

2) Health and social costs - Explanation

A brief comment should be made in order to initially address the need to manage alcohol problems (WHO 2002a; Anderson et al 2005). You can use Work Document 1 and the Overheads (6-11) specified in the session plan. Give particular emphasis to the harms and disorders caused by consuming alcohol.

3) Discussion on alcohol and Primary Health Care

You should set aside approximately fifteen minutes to discuss the reality and the concern that alcohol consumption causes in the trainee's primary health care centre, so that you can adapt your intervention to the relevant needs and characteristics.

Organising a discussion will make easier to gather the maximum number of opinions, which you should note down on the paper board. At the end you can ask them to agree on the five most important ideas or that they propose a better definition of each of the questions raised.

From time to time it may be useful during the course to briefly summarise the points raised, in diagrammatic format. The trainees will then feel that we understand them and we are paying active attention to their comments (not just noting them down). It will also encourage the group to qualify or continue linking ideas.

At the end of this discussion trainees should have the feeling that the course will address their needs concerning the alcohol issue.

4) Standard drinks and drinking patterns

Explain the standard drink concept (overhead 12) according to the peculiarities of your country. Insist on the idea that we sacrifice accuracy for the benefit of simplicity.

Introduce the patterns of alcohol consumption (Work Document 2 and Overhead 13) and be sure that the trainees understand the difference between a hazardous drinker, a harmful drinker and someone who is dependent on alcohol (pay particular attention to this because generally the trainees tend to get confused and assume that hazardous and harmful drinkers and people who are dependent on alcohol are very similar).

It may be useful to mention that even the people who only drink on certain occasions can cause problems for themselves and others and, therefore, it is more appropriate to consider the promotion of health in a wider sense instead of only focusing on alcoholism problems.

5) Risk levels and intervention criteria

A brief explanation is necessary based on Overhead 14. Remember that in the next sessions you will introduce in detail the concepts, diagnosis and treatment criteria. Therefore, you should now just provide an overall view.

Bear in mind that this is only an introductory session in which we are trying to get to know one another, and in which we are trying to define the harm caused by alcohol consumption. The discussion at this point should be kept theoretical, since later on you will address the practical part when discussing the levels of implementation in the trainees' particular setting.

6) Summary

At this point, the tutor can refer once again to the session objectives and gradually summarise the fundamental ideas that have arisen. It is important to emphasize that the training programmme will deal with alcohol from a global point of view, introducing two complementary ideas: 1) the training programme tries to provide them with useful tools to address alcohol problems in their setting, and 2) the course is not focused on alcohol dependence, but in health promotion, and this cannot be achieved without also addressing the most severe cases.

SECOND SESSION

Early identification

Objectives and Aims

Aim

To provide the trainees with a framework for understanding the different types of problems associated with alcohol consumption and to give them identification tools.

Objectives

At the end of the session the trainees will be able to:

- Describe the problems associated with alcohol consumption
- Use the AUDIT and AUDIT-C. The SIAC (Systematic Interview on Alcohol Consumption) or any other validated quantity / frequency questionnaire to identify hazardous drinking can also be described.
- Differentiate between the different implementation levels of identification.

Material

Work documents:

3. Identification of hazardous and harmful alcohol use
4. Identification tools - Group exercise
5. Brief interventions effectiveness - Explanation

Overheads:

15. Outline of the second session
16 and 17. AUDIT questionnaire
18. AUDIT-C questionnaire
19. SIAC questionnaire
20. Implementation levels
21. Cost effectiveness (I)
22. Cost effectiveness (II)

Plan of the Second Session: Early identification

Time	Methods
5 min	**1) Introduction** Begin by summarizing the previous session and asking if there are any queries. In order to minimize resistance, explain that there are different options to choose when implementing early identification strategies. At the same time, show Overhead 15.
15 min	**2) Identification of hazardous and harmful alcohol use** Tell the trainees to consult Work Document 3. Explain how to prepare a register of consumption in standard drinks. Give the trainees the necessary instructions for using the AUDIT and the SIAC questionnaire, while showing Overheads 16-19. The SIAC can be replaced by any standard quantity/frequency questionnaire validated in your country. Add whatever is necessary, using Work Document 3.
10 min **10 min**	**3) Identification tools - Group exercise** Divide the trainees into three groups and explain that we are doing an identification exercise with a simulated interview in pairs. One group will use AUDIT, another will use Audit-C and the other will use the SIAC (or its equivalent in your country). When playing the role of a patient all the trainees should take the case in Work Document 4 as a model. When finished, note the AUDIT, AUDIT-C, and SIAC scores on the paperboard, and comment on the differences between the 3 methods, the questions, the applicability, etc. Pay particular attention to the time involved in each technique. Try to elicit feedback on positive aspects of the instruments. Ask the trainees to make a diagnosis and briefly discuss which form of intervention would be necessary, according to Overhead 14.

Time	Methods
10 min	**4) Implementation levels** During 5 minutes, propose a brief exchange of ideas on how selective the identification ought to be in the trainees' health centre and ask the trainees to specify each professional's role (doctor, nurse, etc.). Finally, use Overhead 20 to describe the three implementation levels for these forms of intervention.
5 min	**5) Brief interventions effectiveness - Explanation** Give a brief introduction, commenting on the key findings resulting from the research in this area. Use Work Document 5 and Overheads 21 and 22 for support. At the end of this session, provide trainees with additional references for further consultation.

SECOND SESSION

Early identification

Background Notes

1) Introduction

In order not to raise defensiveness, it is important to tell the audience in advance that identification tools can be used with different levels of intensity. Use Overhead 20 to explain this idea.

2) Identification of hazardous and harmful alcohol use

Here you must make sure that everyone understands how to use and correct the AUDIT (Bohn et al. 1995) and the AUDIT-C (Bush et al. 1998), as well as the standard drink equivalences of the most frequently consumed drinks. Quite often PHC professionals prefer quantity/frequency questionnaires. It also is becoming common that computerized medical records include a quantity/frequency measurement of alcohol consumption. Because of this, we suggest also offering the SIAC (Gual et al. 2001) or any similar tool currently used in your country as alternatives.
The trainees may find useful to have Work Document 3 to hand.

3) Identification tools - Group exercise

Group organization must be done quickly since there is not much time available. If you have more time, this exercise can be extended, and the group can even be divided into pairs so that they can conduct a simulated interview.

With this exercise (Work Document 4) you can check that the trainees have really understood the differences between the three drinking patterns and discuss the pros and cons of each screening method. Try to reinforce any positive feedback received from the audience in relation to the screening tools.

4) Implementation levels

Here you have to review the team's previous attitude to screening and explain the different implementation levels (Overhead 20). Clarify the fact that at the end of the course they can choose the level that best suits their needs.

5) Brief Interventions effectiveness – Explanation

The details given here will depend on the needs and interests of the group of trainees. It is also advisable to mention (or add to Work Document 5) all the local research projects of which the tutor has knowledge, or which have been published since this document was prepared. Depending on the audience, the trainer can consider placing this point before the previous one (point 4). Nevertheless, we recommend using scientific information to support the group proposals on implementation levels, rather than a way of directing them to higher levels of screening.

THIRD AND FOURTH SESSIONS

Brief Intervention I

Objectives and Aims

Aim

To give an overall view of how to conduct a brief intervention to reduce alcohol consumption based on the stages of change model, using a motivational approach.

Objectives

At the end of those two sessions the trainees will know:

- The stages and processes of change, according to the model of Prochaska & DiClemente
- How to establish a helping relationship.
- How the different intervention styles used by health care professionals can increase or reduce resistance in patients.
- The basic components of Brief Interventions.
- The differences between Minimal and Brief Interventions.
- How to deal with relapse.

Material

Paperboard and pen or blackboard and chalk

Work documents

6. Stages of Change Model
7. Processes of change
8. Stages of change group exercise: questions for discussion
9. Stages of change group exercise: responses
10. Communication style for a helping relationship
11. Opening strategies
12. Basic components of Brief Interventions
13. Relapse prevention: helping people to recycle

Overheads:

23. Outline of the third session
24. Stages of Change Model
25. Stages of change and therapist aims
26. Processes of change
27. Minimal versus Brief Interventions
28. Minimal interventions
29. Communication Model
30. Outline of the fourth session
31. Opening strategies
32. Basic components of Brief Interventions
33. What precipitates relapse?
34. Helping people to recycle

Plan of the Third Session: Brief Intervention I

Time	Methods
3 min	**1) Introduction to session 3** Summarize the previous sessions and present the contents of session 3 using Overhead 23. Emphasize that sessions 3 and 4 will deal with brief advice.
10 min	**2) Stages of Change Model - Explanation** Explain the stages of change, based on Work Document 6 and using Overhead 24. Emphasize the basic characteristics of each stage and the objectives that we, as therapists, have to set (Overhead 25). Ask the trainees to discuss the clinical importance of identifying the stages of change.
10 min	**3) Processes of Change - Explanation** Describe and explain what helps people to move forward through the stages of change based on the information contained in Overhead 26 and Work Document 7.
7 min	**4) Stages of change group exercise: questions for discussion and responses** Ask the group to try and reach an agreement in the exercise in Work Document 8. If the group of trainees is very large, you can divide them into smaller groups of 4-6 people. Ask them to check the responses using Work Document 9.
3 min	**5) Types of interventions** Using Overhead 27 highlight the similarities and differences between minimal and brief interventions.
5 min	**6) Minimal Interventions** With the help of Overhead 28 explain the basic components of a minimal intervention and insist on the friendly, directive and non confrontational style needed. Show how to start a minimal intervention based on the results of the identification exercise.

Time	Methods
8 min	**7) Minimal Interventions - Exercise** Invite trainees to perform a practical exercise in pairs. One of them takes on the role of the patient described in Work Document 4. The intervention begins by presenting the Audit score to the patient. Pay special attention to the length of the exercise. You should stick firmly to 3 minutes for each intervention. After 3 minutes, change roles. Avoid a general discussion and refer participants to the discussion that will be held after the Brief Intervention exercise.
10 min	**8) Communication style for a helping relationship- Explanation and exercise** Using the Gordon Model (Overhead 29) and the Work Document 10 explain the communication style that is needed to establish a helping relationship. Then divide the trainees into pairs and propose an exercise for practising different listening levels: · The speaker talks about something he feels two ways about (ambivalent) and the listener: · listens attentively (1 minute) · gives him/her advice instead of listening (1 minute) · Speaker and listener change roles and repeat the exercise Elicit and comment on how the trainees felt in each role.
3 min	**9) Summary of session 3** Give a brief summary, focusing on the importance of identifying the patient's stage of change and matching the intervention to the patient's initial stage. Emphasise that, in this way, the patient is more likely to be motivated rather than reluctant to change.

Plan of the Fourth Session: Brief Intervention II

Time	Methods
3 min	**10) Introduction to session 4** Summarize the previous session and present this second part using Overhead 30
7 min	**11) Opening strategies** Explain the basic opening strategies that help in establishing a good therapeutic rapport. Explain their importance and emphasize the need for an integrated use of the 4 strategies: open-ended questions, affirming, reflective listening and summarizing. Use Overhead 31 and the Work Document 11 for support.
14 min	**12) Basic components of Brief Interventions - Explanation** Introduce the basic components and style of brief interventions. Use Overhead 32 and Work Documents 12 for support. Begin the session by discussing with the trainees the meaning and the importance of the three concepts which define the style and spirit of brief interventions: · Communicate Empathy · Instil self-efficacy · Emphasize patient's responsibility Remember how this style recalls the elements previously introduced and then introduce and discuss the basic components of brief interventions: · Provide feedback · Give advice with permission · Assess readiness to change · Negotiate goals and strategies · Monitor progress

Time	Methods
20 min	**13) Pairs Exercise** Invite trainees to perform a practical brief intervention exercise in pairs. One of them takes on the role of the patient described in Work Document 4. The intervention begins with feedback. After 7 minutes, the pairs change roles. Pay particular attention to keeping to time. Hold a group discussion for 5 minutes on how this experience went. Compare it to the previous Minimal Intervention exercise. Discuss when it is more appropriate or suitable to use each of those interventions.
5 min	**14) Relapse Prevention: helping people to recycle** Work with Work Document 13 and Overheads 24, 33 and 34. Relate back to stages and processes of change.
8 min	**15) Pairs Exercise** Invite trainees to think of a situation in their own lives when they tried to change their behaviour and relapsed. How did they feel? Pair students up to discuss how they felt (3 minutes. each way). One trainee listens and reflects while the partner describes his/her experience.
3 min	**16) Summary** Highlight the key points and summarize the session, linking it to the previous session. It is very important that both sessions are presented as parts of a whole.

THIRD AND FOURTH SESSION

Brief Intervention I and II

Background Notes

1) Introduction to session 3

A brief summary of the previous session on early identification should lead you to introduce Brief and Minimal Interventions as the core element of the course. Be sure you emphasize enough that, even though we will also discuss how to treat dependence, learning how to implement brief interventions with at risk drinkers is the primary aim of the course.

2) Stages of Change Model - Explanation

This initial explanation (Prochaska & DiClemente 1986) has to be simple (Overheads 24,25 and Word Document 6). The subsequent explanation of these processes details the model's complexities. Before you start this part, check with the audience how familiar they are with the model. If it has already been explained in other continuing medical education courses, you can go through it briefly, and even substitute the group exercise with a general discussion on the usefulness of the model.

3) Processes of change - Explanation

Base this explanation on Work Document 7 and Overhead 16. Processes of change (Prochaska & DiClemente 1986) are coping activities or strategies used by people in their attempts to change. Each change process is a broad category of coping activities which encompasses multiple techniques, methods and interventions. There are two types of processes: the cognitive (involves changes in the way people think and feel) and the behavioural (involves changes in their behaviour).

4) Stages of change group exercise: questions for discussion and responses

Before starting, tell the trainees to read the heading. This exercise can also be performed after explaining the change processes and will help the trainees to clarify and consolidate what they have learnt from the explanation and apply it to real life situations.

There is practically no time to discuss the "correct replies" to each question. The best way to make the most of the discussion time is to check that the trainees understand which process is being discussed and how it relates to the stages of change. Emphasize the idea that boundaries between different stages are not always clear, and that in case of doubt using the least advanced stage should be the rule. Use Word Documents 8 and 9.

5) Types of interventions

It is important here to emphasize that both Minimal and Brief Interventions build on the patients' abilities to change habits. Emphasize also the fact that Minimal Interventions are suitable for opportunistic actions, while Brief Interventions are more time consuming and need to be scheduled in advance. Highlight the idea that Minimal Interventions focus on advice while Brief Interventions focus on patients' motivation. Use Overhead 27.

6) Minimal Interventions

With the help of Overhead 28 present the core components of Minimal Interventions (Whitlock et al. 2004). It is essential here to insist on the need to always ask for permission prior to giving advice. If trainees ask questions on the need to ask for permission, they should be answered briefly, and referred to the next session where the need to ask for permission will be handled in the frame of Brief Interventions.

7) Minimal Intervention - Exercise

Time constraints are to be taken into account continuously in this part. The exercise should be conducted starting with a statement like: 'In the AUDIT questionnaire you just filled in you have obtained a score of 12.' Followed by a statement like: 'Would you like to know what those results mean? Or 'May I explain to you what those results could mean for your well-being?' or any similar sentence. Again, in order to keep on the scheduled time, it is important to refer the group to the next session for a group discussion on the exercise that will take place after the Brief Intervention exercise, where both exercises will be discussed together.

8) Communication style for a helping relationship- Explanation and exercise

Active listening is a set of techniques that the health care professional can use to establish a good helping relationship. In this part, emphasis should be placed in the use of both open-ended questions and reflective listening. After a brief reminder of what open-ended questions are, use the Gordon's (1970) model (Overhead 29) to emphasize the idea that reflective listening is a way of guessing what the patient really means to say (use Work Document 10).

Generally, people find it difficult to follow the task set in the listening exercise; the tutor may have to walk between the groups reminding them what they have to do. The fact that someone "does not listen" is particularly traumatic for both parties. In this exercise, the time has to be accurately controlled; the trainees' comments regarding this were as follows: "one of the interesting aspects is that, subjectively, a minute is two or three times longer when nobody listens to you".

To help the trainees to understand, at the end of the exercise, you can ask:

- What did you feel when the others didn't listen to you or only half listened?
- What are the characteristics of poor listening or half listening?
- What are the characteristics of good listening?

9) Summary of session 3

To summarise, once again it is necessary to highlight the importance of listening and establishing a good helping relationship, and also introduce the idea that users who are not very inclined to changing their habits become reluctant when they are addressed too directly.

10) Introduction to session 4

Pay special attention to reminding trainees that sessions 3 and 4 are part of a whole, and that the basic concepts introduced in the previous session will also be dealt with in this one (Overhead 30).

11) Opening Strategies

Here it is important to present reflective listening, open-ended questions, summaries and affirmation as the basic opening strategies. Special attention must be placed to transmit the idea that all those skills must be used together. Overhead 31 and Work Document 11 may be useful in this sense. Try to keep the idea simple for the trainees: if change talk appears, keep on track; if resistances appear, change strategy. Since there's not much time available, don't go into detail on how to deal with resistances or how to promote change talk. For those interested, refer to the book from Miller and Rollnick (2002).

12) Basic components of brief intervention – Explanation

It is essential to make a clear distinction between spirit and contents of brief interventions (AlcoholCME 2004). It can be useful to compare it with the music and the lyrics of a song. Then, it is necessary to go in detail through every one of the concepts presented in Overhead 32 and Work Document 12. Remember this is a core issue in the whole training, and it is essential that you focus on it as much as needed.

13) Pairs Exercise

It is very important to make trainees completely aware of how the style proposed here is coherent with the stages of change model and the opening strategies previously explained. At the end of this exercise trainees should be able to integrate in their practice the skills practiced in sessions 3 and 4: stages of change, opening strategies and brief interventions.
A group discussion should follow the exercise. Time constraints should be discussed. The trainer should take the opportunity to notice that time needed gets shorter as trainees get more experienced (examples like 'How was it the first time you drove a car, went skiing, rode a bike, etc' might help).

14) Relapse Prevention: helping people to recycle

In this part of the session, trainers should have two priorities: first, to be sure that everybody understands that relapse is not only normal in addictions, but a natural part of the processes of change and second, that trainees should relate to their own relapse experiences, in order to help them change their attitudes towards 'relapsers' (Marlatt & Gordon 1985).
Special attention should be devoted to the differentiation of lapse and relapse. The importance of early intervention in the case of relapses should be emphasized. Also, trainees should be faced with the fact that a good therapeutic relationship may help the patient to seek help sooner. Finally, the importance of supportive non-judgmental attitudes with patients in relapse should be emphasized.

15) Pairs Exercise

As stated above, this exercise is devoted to help trainees to relate it to their own relapses. The aim is to make them aware of how 'normal' relapse is in the process of change. Relapse must also be presented as a chance to learn. The need for a supportive attitude must be discussed.

16) Summary

The summary must include the contents of sessions 2, 3 and 4, explaining brief interventions as a unitary process that starts with the detection of hazardous drinking, continues with the identification of the stage of change where the patient is, and ends with the delivery of the essential components of a brief intervention in a motivational style. The idea of process should be emphasized, and the privileged position of PHC professionals should be outlined. As an example, it can be useful to remind trainees that monitoring progress and relapse prevention are two key strategies they can use in their daily practice.

Special Remark

These sessions have very tight schedules. It is important to go through all the contents of the sessions. Whenever possible, it is advisable to split each in two and to allow more time for practical exercises.

FIFTH SESSION

Alcohol dependence

Objectives and Aims

Aim

To offer trainees a clear guideline and sufficient resources to intervene in cases of alcohol dependence.

Objectives

At the end of the session, trainees will know:

- How to diagnose alcohol dependence
- How to discriminate which cases are to be referred and which are to be treated in the health centre.
- How to establish suitable guidelines for detoxification and rehabilitation.

Material

Paperboard and pen or blackboard and chalk

Work documents

14. Alcohol dependence diagnostic criteria
15. Pharmacological treatment of alcohol dependence

Overheads:

35. Outline of the fifth session
36. Diagnostic criteria
37. Treatment in Primary Health Care settings
38. When to refer to specialised treatment
39. Detoxification criteria
40. Conditions needed for outpatient detoxification
41. Contraindications for outpatient detoxification
42. Outpatient detoxification tapering doses
43. Rehabilitation treatment
44. Shared treatment criteria

Plan of the Fifht Session: Alcohol dependence

Time	Methods
5 min	**1) Brainstorming** Use Overhead 35 to introduce the session. Ask the trainees to explain what alcohol dependence means to them, and the criteria defining it. Make it clear that they have to mention any ideas that come into their head, and note them down on the paperboard. Remember that the ideas are not to be discussed at this point.
10 min	**2) Diagnostic criteria – Explanation** Use and explain the ICD-10 criteria, using Overhead 36 for support. Avoid confusing the trainees with other criteria (if they ask about DSM-IV, just make a short reference). You can use Work Document 14.
10 min	**3) Criteria for treatment in Primary Health Care Settings** Start with a group discussion on 'Which patients should be referred and which should be treated at a PHC level'. Draw up a list. Explain the proposed criteria using Overheads 37 and 38 for support, and discuss them with the trainees.
20 min	Detoxification and rehabilitation guidelines: explain the treatment and indications based on Overheads 39-43, and Work Document 15. Clarify any doubts that may arise.
10 min	**4) Shared treatment criteria** Explain the criteria used for shared treatment cases, using Overhead 44 for support, and discuss them with the trainees. Insist on the idea of flexibility and coordination.

FIFTH SESSION

Alcohol dependence

Background Notes

1) Brainstorming

The aim of this activity is to get an idea of the level of the trainees' previous knowledge of alcohol dependence, so that you can adapt your explanation and avoid explaining things that trainees already know or, vice versa, skipping topics which are in fact unknown to them.

It can also help the trainees to get an idea of what they actually know and do not know. It is also a good opportunity to reframe the classical prejudices against people with alcohol dependence, who are often seen as weak and vicious people.

2) Diagnostic criteria – Explanation

This involves giving a simple explanation, based on Work Document 14 and using Overhead 36. It will be helpful to mention that the criteria defining alcohol dependence (WHO 2003) are qualitative and not quantitative. Remind them here that when we defined hazardous drinking the criteria were mostly quantitative.

Even though DSM and ICD criteria can be used, by focusing just in one of the two classifications, we will be less likely to confuse the trainees. Since this training programme is part of an European Project and is inspired by previous WHO training packages, we suggest ICD-10 criteria as a first choice.

3) Criteria for treatment in Primary Health Care Settings

Start this section with a group discussion on which patients should be referred to the specialised centres and which ones should be treated in PHC settings. You should expect a lively discussion here. Pay attention to the schedule, since a lot of time may go by. Once the main topics have been raised, use Overheads 37 and 38 and try to reach consensus on the criteria presented there (Servei Català de la Salut 1996; Scottish Intercollegiate Guidelines Network 2003).

Keep in mind that those topics will be discussed again in the sixth session, in the frame of the local particularities that apply to your country or region.

Explain the detoxification process using Overheads 39-42 and Work Document 15 for support. Keep it as simple as possible, and emphasize that these are simple techniques that can be used safely in PHC by trained physicians. Emphasize that treatment goes far beyond detoxification, which should be seen as a starting point.

Highlight the importance of establishing a strong therapeutic alliance and conducting regular follow-up visits during the rehabilitation process. In this phase it is important to encourage the trainees to depend less on the apparently instantaneous responses obtained with medication, and to be more aware of the importance of human support and action. The way in which this is explained and emphasised may vary according to local preferences regarding the use of medication. At this point, it is important not to present anticraving (acamprosate, naltrexone, etc) and aversive drugs (disulfiram, etc) as magic pills. It is essential to transmit the idea that these drugs are useful tools that can be used during the rehabilitation process (Overhead 43), but the key element is always the therapeutic alliance that supports the patients' commitment to solve his/her drinking problem.

4) Shared treatment criteria

Based on the criteria established in this session (Overheads 38 and 44), a short discussion should be conducted in order to identify which patients are more suitable for shared treatment. Remember that the main aim of these sessions is to promote detection of hazardous drinkers by PHC professionals. They are not expected to actually treat people with severe alcohol dependence, and to offer referral is a way of reducing PHC professionals' reluctance to deal with hazardous drinkers.

It may well be that you are a bit short of time. In this case, it is advisable to include this part of the session in the sixth session.

SIXTH SESSION

Implementation of the EIBI Alcohol Programme

Objectives and Aims

Aim

To reach a consensus with the PHC professionals on how the Early Identification and Brief Intervention (EIBI) alcohol programme can be implemented in their own PHC Centre

Objectives

At the end of the session a consensus should be reached on the following issues:

· Level of implementation of EIBI techniques that can be adopted in the trainee's PHC Centre

· Referral criteria, including clear guidelines on when, how and to whom to refer difficult patients

· Level of training and support needed to continue EIBI activities

· Detailed agreement on which patients should receive shared care treatment and how to coordinate it.

Material

Paperboard and pen or blackboard and chalk

Work documents

16. Evaluation Form

Transparencies:

2. Contents of the Training Programme
20. Implementation levels

Since this session is to be tailored to each country's needs and specificities, the trainers are expected to choose any additional local materials that they think might be helpful.

Plan of the sixth Session: Implementation of the EIBI Alcohol Program

Time	Methods
10 min	**1) Introduction** Summarize very briefly the contents of the previous 5 sessions. Emphasize that in PHC settings priority should be given to EIBI activities. You may use Overhead 2.
10 min	**2) Group discussion** Start a discussion on the pros and cons of dealing with alcohol in PHC. Be neutral and try to be sure that every opinion is reflected in a list that everybody can see. The aim is not to discuss here, but to acknowledge all the pros and cons.
20 min	**3) Work in small groups** Divide the trainees into small groups of 3-4 people. Based on the previous list and using Overhead 20, ask them to reach a consensus in each group on the following topics: · What implementation level would be feasible in their PHC Centre · What level of support would they need from specialised centres · What are the immediate steps they think should be taken
10 min	**4) Plenary** Go through the previous 3 points and try to reach a general commitment based on the lowest levels of agreement. Keep in mind that it is better to achieve a low level of implementation with high commitment than vice versa.

Time	Methods
10 min	**5) Evaluation and closure** Remind the trainees very briefly of the general contents of the training programme, of the agreements reached, and of the next steps to be taken. Briefly discuss any comments that may arise and end the session by thanking the trainees for their interest. Emphasize the importance of completing the evaluation form (Work Document 16) before leaving the room. Allow 5 minutes for this task.

SIXTH SESSION

Implementation of the EIBI Alcohol Programme

Background Notes

1) Introduction

An overview of the contents of the whole programme should be given here. The aim is to present alcohol as a complex and important phenomenon, emphasizing two basic ideas: a) PHC professionals are in a pivotal position for early identification of hazardous drinkers; and b) when they screen hazardous drinking more severe problems will arise, and they have now the tools to decide if those patients need to be referred to a specialised centre. At this stage it is important to be clear and simple with your message: 'Screen alcohol consumption, advise hazardous drinkers, identify alcohol problems and refer patients you cannot treat.'

2) Group discussion

The aim of this group discussion is to mobilize the trainees. Be neutral. The alcohol issue must be presented as a very complex one, ranging from anecdotal problems to very severe diseases. Try to promote a lively discussion centred on the professionals. The issue is not to raise awareness on the importance of alcohol, but to promote real debates on the 'pros and cons' for the professionals in dealing with alcohol problems in PHC settings. So, issues like ethics, practical consequences of dealing and not dealing with alcohol, etc. must be discussed. Some of the topics the trainer may raise are the following:

- What are the ethical implications of using/not using EIBI in your clinical practice?
- What are the main obstacles in the trainee's Centre to promoting the dissemination of EIBI?
- What are the best opportunities to conduct EIBI in the trainee's Centre?

The discussion should be stopped before it diminishes, so that participants are still wanting to talk. All the main topics raised should be listed and visible, and this should be used as an introduction to the next part of the session.

3) Work in small groups

Divide the audience into small groups (3 to 5 persons maximum). It is essential here to have small groups, since larger groups tend to have more difficulties in reaching agreements. Ask them to reach a consensus on the topics raised in the group discussion. From this consensus they should derive an answer to the 3 questions raised:

- Which implementation level would be feasible in their PHC Centre?
- Which level of support would they need from specialised centres?
- What are the immediate steps they think should be taken?

You can ask them to write down these 3 questions and to provide their answers later. In this part you should encourage trainees to be very precise, practical and realistic, so that they deal with real conditions and talk about feasible actions. Practical things like: when and where to meet, where to phone, etc. are very relevant here. Emphasize the importance of paying attention to the next steps that they think should be taken immediately.

4) Plenary

Here all small groups should present their written opinions to the three previous questions. They should be asked to present their conclusions very briefly. The work of the trainer here is to point out the commonalities, and to highlight the lowest levels of agreement reached. These lowest levels of agreement should be presented as the minimum standards they have agreed on. Trainers should give priority to commitment, which means that a consensus on the desired levels of implementation of EIBI should be reached on the basis of the perceived commitment of the trainees. A low level of implementation accepted with high commitment should be preferred to more ambitious goals that may produce resistance in some trainees.

5) Evaluation and closure

This is particularly important, since the lasting impression of the training will be coloured by what happens in the last minutes. It is essential to control the timing, so that you are sure you can devote at least 10 minutes to the final part of the session. You can organize its contents in a flexible way, but the basic components of the closure should be:

- To thank all participants for their attendance and participation
- To show how interesting it has been for you to work with them
- A very brief summary of the general contents of the training programme
- Ask for short comments from the participants
- Detailed relation of the agreements reached
- Summarize the next steps to be taken

This part of the session should be conducted lively, in a way that you avoid situations where people start to leave the session one by one. Also, pay particular attention to obtain the evaluation forms of all participants. You can avoid losing the evaluations of those who may leave early by saying at the beginning of the session that even those who are in a hurry should fill in the forms before they leave.

Alcohol and Primary Health Care:

Training Programme on Identification and Brief Interventions.

WORK DOCUMENTS

WORK DOCUMENT 1

Health and social costs – Explanation

The Europe Union is the region of the world with the highest proportion of drinkers and with the highest levels of alcohol consumption per population. Alcohol is the third most important risk factor for ill-health and premature death after smoking and raised blood pressure, being more important than high cholesterol levels and overweight. Apart from being a drug of dependence and besides the 60 or so different types of disease and injury it causes, alcohol is responsible for widespread social, mental and emotional harms, including crime and family violence, leading to enormous costs to society. Alcohol not only harms the user, but those surrounding the user, including the unborn child, children, family members, and the sufferers of crime, violence and drink driving accidents.

Alcohol increases the risk of a wide range of social harms in a dose dependent manner, with no evidence for a threshold effect. For the individual drinker, the higher the alcohol consumption, the greater the risk. Harms done by someone else's drinking range from social nuisances such as being kept awake at night through more serious consequences such as marital harm, child abuse, crime, violence and ultimately, homicide. Generally the more serious the crime or injury, the more likely alcohol is to be involved. Harm to others is a powerful reason to intervene for hazardous and harmful alcohol consumption.

Alcohol is a cause of injuries, mental and behavioural disorders, gastrointestinal conditions, cancers, cardiovascular diseases, immunological disorders, skeletal diseases, reproductive disorders and pre-natal harm. Alcohol increases the risk of these diseases and injuries in a dose dependent manner, with no evidence for a threshold effect. The higher the alcohol consumption, the greater is the risk.

A small dose of alcohol consumption reduces the risk of heart disease, although the exact size of the reduction in risk and the level of alcohol consumption at which the greatest reduction occurs are still debated. Better quality studies and those that account for

possible influencing factors find less of a risk and at a lower level of alcohol consumption. Most of the reduction in risk can be achieved by an average of 10g of alcohol every other day. Beyond 20g of alcohol a day the risk of coronary heart disease increases. It appears to be alcohol that reduces the risk of heart disease rather than any specific beverage type. Drinking larger amounts of alcohol on one occasion increase the risk of cardiac arrhythmias and sudden coronary death.

The risk of death from alcohol is a balance between the risk of diseases and injuries that alcohol increases and the risk of heart disease that in small amounts alcohol decreases. The level of alcohol consumption with the lowest risk of death is zero or near zero for women under the age of 65, and less than 5g of alcohol a day for women aged 65 years or older. For men, the level of alcohol consumption with the lowest risk of death is zero under 35 years of age, about 5g a day in middle age, and less than 10g a day when aged 65 years or older.

There are health benefits from reducing or stopping alcohol consumption. All acute risks can be completely reversed if alcohol is removed. Even amongst chronic diseases, such as liver cirrhosis and depression, reducing or stopping alcohol consumption are associated with rapid improvements in health.

Thus, as alcohol is implicated in a very wide variety of physical and mental health problems in a dose dependent manner, there is an opportunity for primary health care providers to identify those adult patients with hazardous and harmful alcohol consumption. Further, since primary health care involves the treatment of many common physical and mental conditions, their causes in the use of alcohol need to be addressed and managed. It is of particular importance to reduce the risk of harm to others.

WORK DOCUMENT 2

Standard drinks and drinking patterns

Standard drinks

Primary health care providers can describe the alcohol consumption of their patients either in terms of grams of alcohol consumed or in terms of standard drinks, where one standard drink in Europe commonly contains about 10g of absolute alcohol.

At a scientific level, reports of quantities of alcohol consumed should be expressed in grams of absolute alcohol, in order to facilitate international comparability.

The term standard drink is used to simplify the measurement of alcohol consumption. Although some inaccuracy must be expected, its level of accuracy is good enough to recommend it as a method of recording alcohol consumption in a variety of settings like primary health care, accident and emergency departments and hospital in-patients.

Even though using the term standard drink has advantages, there are also difficulties:

- The alcohol contents of drinks ranges enormously, from 1% to over 45%, which may easily lead to miscalculations;
- The same kind of drink may be placed in many different types of containers, with different amounts of alcohol;
- The same type of drink may differ in alcohol concentration, depending on where and how it is produced;
- Standard drinks vary from country to country; and
- In most countries the alcohol content of a standard drink has been reached through consensus, without previous scientific research.

The World Health Organization (Babor & Higgins - Biddle 2001) described a standard drink that contains about 13g of alcohol. This content of a standard drink is close to the US standards, but in Europe most of the countries use a standard drink of 10g of alcohol. The use of standard drinks simplifies the assessment of alcohol

consumption, and makes easier its systematic use in primary health care settings. However, since there are country differences, the alcohol content of standard drinks should be defined in each country according to scientific research, and not only through consensus.

One standard drink in Europe commonly contains about 10 g of alcohol. For example:

- 250 ml of beer at 5% strength
- 125 ml of wine at 12% strength
- 70 ml of fortified wine (e.g. sherry) at 18% strength
- 50 ml of a liqueur of aperitif at 25% strength
- 25 ml of spirits at 40% strength

Drinking patterns

Hazardous alcohol consumption is a level of consumption or pattern of drinking that is likely to result in harm should present drinking habits persist; a working definition of the World Health Organization describes it as more than 20g of alcohol per day for women and more than 40g of alcohol a day for men.

Harmful drinking is defined as 'a pattern of drinking that causes damage to health, either physical or mental'. Heavy episodic drinking (sometimes called binge drinking), which can be particularly damaging to some forms of ill-health, can be defined as a consumption of at least 60g of alcohol on one drinking occasion.

Alcohol dependence is a cluster of physiological, behavioural, and cognitive phenomena in which the use of alcohol takes on a much higher priority for a given individual than other behaviours that once had greater value.

Risk levels and intervention criteria

Risk level	Criteria	Intervention	Role of PHC
Low	<280 g/w men <140 g/w women AUDIT-C <5 men AUDIT-C <4 women AUDIT <8	Primary prevention	Health education, advocacy, role model
Hazardous*	280-349 g/w men 140-209 g/w women AUDIT-C ≥ 5 men AUDIT-C ≥ 4 women AUDIT 8-15	Simple advice	Identification, assessment, brief advice
Harmful	≥350 g/w men ≥210 g/w women* Presence of harm AUDIT 16-19	Simple advice plus brief counselling and continued monitoring	Identification, assessment, brief advice, follow-up
High (alcohol dependence)	ICD-10 criteria AUDIT≥20	Specialized treatment	Identification, assessment, referral, follow-up

** Any consumption by pregnant women, children under 16 years of age and people who are ill or receiving treatment or who perform activities where they are advised not to consume alcohol.*

WORK DOCUMENT 3

Identification of hazardous and harmful alcohol use

Here we have two elements to consider. The first is gathering sufficient information on the user's alcohol-related habits, in order to decide whether their treatment concerns us or not. The second element is helping the user to consider whether this situation presents a problem for him/her and if he/she wants to modify their consumption of alcohol.

Hazardous and harmful alcohol use can be identified either by measuring alcohol use, or by using a screening instrument specifically designed for the purpose. Alcohol use can be measured using quantity frequency questions or daily estimation methods. These questions and methods can be completed orally, with written questionnaires or with computers. Screening instruments include the World Health Organization's Alcohol Use Disorders Identification test (AUDIT) and the CAGE instrument. AUDIT was specifically designed to identify hazardous and harmful alcohol use in primary care settings.

Alcohol Use Disorders Identification test (AUDIT)

The AUDIT questionnaire was developed by the World Health Organization to detect at-risk, harmful, or heavy drinking. It includes ten questions covering the three domains of hazardous alcohol use, alcohol dependence and harmful alcohol use. The AUDIT is easy to score. Each of the questions has a set of responses to choose from, and each response has a score ranging from 0 to 4. All the response scores are added to provide a total score.

Users normally respond better to AUDIT when:

- the person conducting the interview is friendly and not threatening.
- the aim of the question is clearly related to diagnosing the user's state of health
- the user does not consume alcohol or drugs whilst the selection is made
- the information is considered to be confidential
- the questions are easy to understand

The best way to present the AUDIT questions is to give the user a general idea of the questionnaire content, specify the aim and also the need to give exact replies, which will also help to clarify what he/she means by alcoholic drinks, tell him/her how much alcohol is consumed by the group to which they belong and make sure you mention those drinks which not everyone considers to be alcoholic, for example, cider or low alcoholic beer.

The questions must be asked in order and as they are written. Write the responses accurately, but also watch out for additional information that the user gives about their drinking habits and their thoughts and feelings regarding this habit. This information will be valuable when working together to interpret the results of the AUDIT and deciding whether they are significant and important for the user.

The grid can help to obtain the score and decide upon which form of intervention to adopt. Count the numbers underneath the response (for example, if the user responds "monthly or less" to the first question add a point to the score). A total score of 8 or above suggests that potential problems could exist and that it is better to talk about the situation and investigate the drink aspect further.

A high score for items 7-10 suggests "harmful" alcohol consumption, i.e., not only does it increase the risk of future problems, but the user already has problems. A high score for items 4-6 suggests the beginning of dependency. The scores can be used as the basis for considering different aspects of treatment following the initial assessment. In some cases, the most appropriate course of action may be to refer the user to a specialist.

AUDIT-C

There are shortened versions of the Audit with a similar accuracy, which are preferred by many PHC professionals: AUDIT-C, Fast Alcohol Screening Test (FAST) (Health Development Agency and University of Wales College of Medicine 2002). and Five shot questionnaire (Seppä et al. 1998). The AUDIT-C includes just the first 3 questions of Audit, while the FAST is a two steps questionnaire based on questions 3, 8, 5 and 10 of the Audit and the Five Shot Questionnaire combines 2 questions from AUDIT with 3 from CAGE.

SIAC (Systematic Inventory of Alcohol Consumption) [i]

The AUDIT questionnaire has proved to be effective in identifying hazardous drinkers, and it has been translated into many languages. Nevertheless, some professionals are reluctant to use it and seem prefer using direct questions.

In order to standardize direct questions, the SIAC questionnaire was developed in Spain. It includes 3 questions on quantity and frequency for ascertaining alcohol consumption.

The questionnaire must be completed according to the following instructions:

· In question 1, the user must specify the number of units consumed every day that alcohol is consumed (for example, if the patient says that he/she has 2 beers, 2 glasses of wine and a glass of brandy, the consumed standard drinks would be 2+2+2=6). The obtained result in standard drinks should be entered in the corresponding row (working days or holidays) and in the "quantity" column.

· In question 2, the user must specify the number of days that alcohol is consumed, and write it in the corresponding row (working days or holidays) and in the "days" column.

· If the response to question 3 is no, the corresponding boxes can be filled in directly. If the response is yes, the user will have to repeat questions 1 and 2 and write the responses in the corresponding row (working days and holidays) in order to complete the questionnaire.

· In order to obtain information on the weekly amounts drunk, the number of days that alcohol is consumed is multiplied by the amounts consumed, and the sum of the working days and holidays will give the weekly total expressed in standard drinks. Remember that risk consumption is set at 280 grams per week for men and 140 for women (28 and 14 standard drinks, respectively).

[i] *Subject to national adaptations*

Blood tests

Biochemical tests for alcohol use disorders such as liver enzymes [e.g. serum γ-glutamyl transferase (GGT) and the aminotransferases], carbohydrate deficient transferrin (CDT) and mean corpuscular volume (MCV) are not useful for screening because elevated results have poor sensitivity, identifying only a small proportion of patients with hazardous or harmful alcohol consumption.

If the AUDIT score gives a high result, it is recommended to undertake a general analysis, as well as an analysis of liver function using the above tests, because the results can complement the information obtained in the interview and help to identify existing damage. Abnormal results of blood tests due to a high alcohol consumption could be an important factor in helping the user to take a decision.

The user's perspective

To address the intervention properly it is important to take into account the user's responses to the pros and cons of drinking. The advantages and disadvantages of drinking can be related to social, financial, employment, psychological or legal aspects as well as health aspects.

People drink in order to obtain certain advantages and it becomes a problem when:

a) Alcohol does not obtain the advantages that the person sought initially; for example, "I drink to cheer myself up, but the sedative effects make me feel worse", or "I drink to give myself confidence and impress important people, but I drink too much and then I act stupidly".

b)The use of alcohol can bring short term advantage, it can also lead to longer term adverse consequences, for example, " I drink so that I can sleep at night, but I wake up with a hangover every morning", or "I drink to be sociable with my friends, but I can see that I'm damaging my liver".

A holistic view of the situation helps self-reassessment, and a shared understanding of its complexity could tip the balance in favour of change by the user.

WORK DOCUMENT 4

Identification tools – Group Exercise [ii]

Hypothetical setting

A 45-year old man makes an appointment following a company medical check-up. He is married and has 2 adolescent children. He is a manager in a textile firm.

He usually drinks a glass of wine when eating. Many nights when he leaves the factory, he has a couple of beers with his colleagues, and on Saturday night he drinks even more when he goes out with his friends, about 6 or 7 beers. His wife complains that he doesn't help enough with the housework; she expects him to help her in the evenings but for her part it seems that when he gets home he just sits down in front of the television and relaxes with a brandy. Three months ago the company doctor warned him that his blood pressure was high and told him to reduce his alcohol intake. This concerned him slightly, since he has a family history of embolism and cardiac problems. Nevertheless, he thinks that if there is a tendency in his family to have high blood pressure, there is probably little he can do to prevent it. Alcohol helps him to relax and he thinks it reduces his stress, although once, he thinks that when he had drunk too much he became irritable and violent with his wife.

As for his doctor, he has known him for a long time and trusts him and, therefore, thinks he is reasonably honest. He has answered the AUDIT and obtained a score of 12.

[ii] *Subject to national adaptations*

WORK DOCUMENT 5

Brief Interventions effectiveness - Explanation

Brief interventions are effective in primary health care settings in reducing hazardous and harmful alcohol consumption. Eight patients need to be advised for one patient to benefit. This compares favourably with brief advice from a general practitioner to cigarette smokers, where about 20 patients need to be offered advice to quit for one to benefit; the ratio improves to about 10 with the addition of pharmacotherapy. There is little evidence for a dose response effect and it does not seem that extended interventions are any more effective than brief interventions. The effectiveness is certainly maintained for up to one year and maybe be maintained for up to four years.

Brief interventions are effective in primary health care settings in reducing alcohol related problems amongst persons with harmful alcohol consumption, but without alcohol dependence. Eight patients need to be advised for one patient to benefit. Brief interventions are also effective in reducing mortality. 282 patients need to receive advice to prevent one death within one year.

Brief interventions appear to be to equally effective for men and women, and for young and old. They appear to be more effective for less serious problems. The evidence to date suggests that interventions during pregnancy are ineffective.

WORK DOCUMENT 6

Stages of Change Model

There are many studies which demonstrate that an intended change of addictive behaviours can occur both with and without expert assistance. Prochaska & DiClemente (1986) have studied how people intentionally change their behaviour with and without psychotherapy and have described that individuals modifying behaviours move through a series of stages from precontemplation to maintenance. In each stage the individual experiences different sensations and thoughts, and he/she will find that different activities help him/her to progress. This model is nearly always described diagrammatically as a circle or as a spiral. Before entering the circle of change, the person is said to be in the **precontemplation** stage. Precontemplation is the stage at which there is no intention to change behaviour in the foreseeable future. Many individuals in this stage are unaware or under aware of their problems. Sometimes they do not know that their use of alcohol causes them problems or puts them at risk. Other times, though, they are fully aware of the risks that this behaviour causes them but, on the other hand, they do not want to change owing to other very important reasons. Families, friends, however, are often well aware that the precontemplators have problems and often pressure them to look for help and as long as the pressure is on they even demonstrate change. Once the pressure is off, however, they often quickly return to their old ways.

The awareness or concern over behaviour-related risks and problems cause the person to move onto the **contemplation** stage**.** In this stage, people are aware that a problem exists and are seriously thinking about overcoming it but have not yet made a commitment to take action. On the one hand, they are aware that they have to change, but they are still tied to the problematic behaviour. They are still not ready for change, and can remain stuck in this stage for long periods. The stage is marked by ambivalence and the weighing of the pros and cons of the problem. Contemplators appear to struggle with their positive evaluations of the addictive behaviour and the amount of effort, energy and loss it will cost to overcome the problem and they are seriously committed to changing their behaviour in the next six months.

The people in the **preparation** stage are those who plan to change their habits soon. They are intending to take action in the next month and have failed in the past year. They report some small behavioural changes but they have not yet reached a criterion for effective action, such as abstinence. They start telling others that they are trying to change their habits and make clear plans on how to achieve this.

In the **action** stage, people modify their behaviour, experiences, or environment in order to overcome their problems. The modifications made are visible and receive the greatest external recognition. Modification of the target behaviour to an acceptable criterion and significant overt efforts to change are the hallmarks of action. In this stage people usually have contact with professionals or with self-help groups to help them.

This active period is followed by a **maintenance** period in which people work to prevent relapse and consolidate the gains attained during the previous stage. The change of behaviour is continuous and several temporary changes can be part of it. If the consolidation does not occur, the person **relapses** and from there he/she regresses to an earlier stage. Stabilizing behaviour change and avoiding relapse are the hallmarks of maintenance.

Most people trying to change addictions do not successfully maintain their gains at their first attempt. Relapse and recycling through the stages occur quite frequently as individuals attempt to cease addictive behaviours and linear progression is a possible but relatively rare phenomenon. The spiral pattern illustrates better how people move through the stages.

Some people pass from one stage to another very quickly or skip one stage. However, if they go through the contemplation or preparation stages too quickly there is a high risk that they will have a relapse, since the decision to change their habits and the plan for supporting this decision are not yet strong enough.

The model is transtheoretical, i.e., it describes the stages people go through regardless of how the problems themselves are explained, or whether the person has access to professional help or not and, if they do, regardless of what theory and techniques the therapist uses.

WORK DOCUMENT 7

Processes of change

To understand the behavioural change we also need to know how the people shift from one stage to another. The following are 10 coping strategies that people use to move forward through the stages of change:

- Consciousness raising
- Social liberation
- Dramatic relief
- Environmental reevaluation
- Self reevaluation
- Self liberation - Commitment
- Reinforcement management - Reward
- Counterconditioning
- Stimulus/Environment control
- Helping relationships

Successful changers use the processes of change that are most appropriate to each stage of change. The cognitive change processes help people to move through the early stages and the behavioural change processes help to move through the later

Consciousness raising

It means knowing more about themselves or the nature of their problem. This awareness can be achieved by reading information on health care matters or by being aware of their own behaviour models, through knowledge of themselves or through responses from others. People usually become more aware in the *precontemplation* and *contemplation* stages.

Social liberation

This is an external force which occurs regardless of changes in the environment. These changes are noticeable in a different way, according to the stage of change in progress. For example, if there is a "No Smoking" sign on public transport (bus, train, etc), those who are in the *precontemplation* stage may be more aware of the importance smoking has for them and how difficult it is to travel home from work, tired and tense, without smoking a cigarette.

This may lead them to consider their dependency on this habit. However, those who find themselves in the same position and in the *maintenance* stage and can cope with the situation, overcome a high risk factor that day.

Dramatic relief

This is rather the concept of catharsis, a great emotive experience caused by a fact associated with the problem. It can occur as a result of a tragedy in someone's life (it is often said that illnesses and the death of acquaintances or parents lead people from the precontemplation to the contemplation stage). Also films and theatre shows can stimulate emotions. This method is usually useful in the *contemplation* and *preparation* stages.

Environmental reevaluation

This occurs when a person assesses how his problem behavior affects others and society in general. This usually helps moving from precontemplation to contemplation.

Self reevaluation

This occurs when a person thinks about how they perceive themselves, about their values and objectives, and how to adapt their "problematic" behaviour and its consequences. Using this method often implies weighing up the pros and cons of the behaviour and the change. This method is usually used in the *contemplation* and *preparation* stages.

Self liberation – Commitment

This occurs when a person embraces and reinforces his decision to change. Commitment is important in the *preparation, action* and *maintenance* stages. It occurs when the person accepts responsibility for choosing to make the changes and take the appropriate action. If a private commitment is made public, this creates social pressure when coping with the change. For this reason, self-help groups usually encourage that people make their commitments public.

Counterconditioning

This is a question of substituting unhealthy behaviours for more healthy ones. It is primarily associated with forms of behaviour where people are trying to give up a habit (for example, smoking, drinking and eating in excess). Finding alternative activities (listening to music, doing physical exercise or relaxation techniques) are ways of compensating our necessary emotional needs. Any activity that distracts us from thinking about the problem or the anxiety it produces, changes our behaviour.

Stimulus/Environment control

Controlling the environment is useful in the *action* and *maintenance* stages, so as to reduce temptation and so that the healthy habits are easier to adopt than less healthy habits. For example, a person who wants to change their eating and drinking habits can restrict the types of food and drink they have at home. Others write reminder notes and leave them in strategic places around the home or place of work.

Reinforcement management - Reward

People reward themselves in different ways; some use approval from friends, colleagues and family; others buy presents with the money that they have saved by giving up smoking or drinking. In the *action* phase rewards are very important for the intrinsic benefits involved in realising that the change is obvious. Sometimes people who give up smoking, drinking or start doing physical exercise, feel worse at the beginning. It is not until several weeks or months later that the habit changes begin to bring their reward.

Helping relationship

Everybody can provide a helping relationship - the health care professional, a person in the self-help group, a member of the family, a friend, a priest, a colleague. The helping relationship is an important process. It is probably the people who want to change their habits who seek this type of support when they are in the *action* and *maintenance* stages. It is probable that the health care

professionals want to provide this helping relationship to those who are in the precontemplation and contemplation stages, and also to those who are preparing to make the change. People need different types of help in the different stages and this help needs to be associated with other methods they are using (for example, a person who listens and asks the corresponding questions in the self-reassessment method or another who give rewards).

Summary

Particular processes are often used in different stages of change, as described below.

Precontemplation	Contemplation	Preparation	Action	Maintenance
Consciousness raising				
Social liberation				
Dramatic relief				
Environmental reevaluation				
	Self reevaluation			
		Commitment		
		Reinforcement management		
		Counterconditioning		
		Stimulus/environment control		
		Helping relationship		

WORK DOCUMENT 8

Stages of change group exercise: questions for discussion

Consider the 10 actions listed below and, in each one, circle one or more responses to indicate for which stage or stages this action could be useful (circle as many as you want). Try to reach an agreement with your group and if you do not agree, discuss the matter.

1) Keep a diary to note down eating, drinking or smoking patterns

precontemplation contemplation preparation action maintenance

2) Attend alcoholics anonymous meetings:

precontemplation contemplation preparation action maintenance

3) Tell friends and family that you have decided to be more physically active:

precontemplation contemplation preparation action maintenance

4) Receive medical test results that indicate that your lifestyle is beginning to harm your health:

precontemplation contemplation preparation action maintenance

5) Weigh up the pros and cons of smoking:

precontemplation contemplation preparation action maintenance

6) Watch a film on television about somebody with an unhealthy lifestyle who dies of a cardiac illness:

precontemplation contemplation preparation action maintenance

7) Read an article on healthy nutrition and eating:

precontemplation contemplation preparation action maintenance

8) Make your office, bedroom or car a non smoking area and put up a no smoking sign:

precontemplation contemplation preparation action maintenance

9) Buy yourself a present for eating healthily for a month:

precontemplation contemplation preparation action maintenance

10) Learn relaxation techniques:

precontemplation contemplation preparation action maintenance

WORK DOCUMENT 9

Stages of change group exercise: responses

Each activity considered in this exercise could trigger one or more change processes and, therefore, prove more useful in some stages as opposed to others. Below, you will find examples of how individuals could respond to these activities:

1) Keep a diary to note down eating, drinking or smoking patterns

This activity could make the individual aware of the behaviour pattern and its implications and consequences. If used in this way, it is more helpful in the *precontemplation* and *contemplation* stages. Some people keep a diary to note down the efforts they make to change. If these efforts are at least partially successful, the diary can be used as reward in the action stage.

2) Attend alcoholic anonymous meetings

This activity can satisfy a large number of functions. Generally, it forms part of the *commitment* process towards a new lifestyle, provides *rewards* and also new *helping relationships* and, therefore, it can be important in the *preparation, action* and *maintenance* stages.

3) Tell friends and family that you have decided to be more physically active

This is another expression of *commitment* which can be the forerunner to the *helping relationship* and help in the form of *rewards* or the *control of the environment*. This activity is useful for the *preparation, action* and *maintenance* stages.

4) Receive medical test results that indicate that your lifestyle is beginning to damage your health

This activity can lead to the *consciousness raising (awareness)* and *dramatic relief*, therefore, it will have a greater impact on the *precontemplation, contemplation* and *preparation* stages.

5) Weigh up the pros and cons of smoking

This activity will lead to *self-reevaluation* and it will be more useful in the *contemplation* and *preparation* stages.

6) Watch a film on television about somebody with an unhealthy lifestyle who dies of a cardiac illness

This activity can lead to *dramatic relief* or to *consciousness raising (awareness)* therefore, it will be useful in the *precontemplation* and *contemplation* stages.

7) Read an article on healthy nutrition and eating

This activity can lead to consciousness raising (*awareness)* and, therefore, it can be useful in the *precontemplation* and *contemplation* stages. The information in the article can be used for *counterconditioning,* i.e., for imagining new healthy eating patterns to replace less healthy eating patterns. If used in this way, it will be useful in the *action* and *maintenance* stages.

8) Make your office, bedroom or car a non smoking area and put up a no smoking sign

This activity can strengthen the *commitment* and be used as a way to *control the environment*; therefore, it is more likely that it will be used in the *preparation, action* and *maintenance* stages.

9) Buy yourself a present for eating healthily for a month

As a reward, this activity will be useful in the *action* and *maintenance* stages.

10) Learn relaxation techniques

This activity can be used as a substitute or alternative for the problematic behaviour. It is especially helpful during the *action* and *maintenance* stages.

A person's stage of change provides proscriptive as well as prescriptive information on treatment choice. Action-oriented therapies may be quite effective with individuals who are in the preparation or action stages. The same programs may be ineffective with individuals in precontemplation and contemplation stages. Matching treatments and activities to stages will be very important. It is unlikely that a person in the precontemplation phase chooses to join a self-help group or put up a no smoking sign in their office. On the other hand, it is unlikely that someone in the maintenance stage spends their time reading basic health care information on a particular subject.

WORK DOCUMENT 10

Communication style for a helping relationship

One of the key factors in people changing their habits is that they are involved in "helping relationships", someone who takes care of them, understands them and is committed to helping them. This is particularly valuable when passing from the *precontemplation* to the *contemplation* stage, and also to the *maintenance* stage. The helping relationship can be provided by a therapist, a friend, a partner or a member of the family.

For therapists, who tend to have a limited time for each patient visit, an important way of establishing a helping relationship is by listening attentively and actively to what the users tell them about themselves and their problems. This has two functions: first of all, it makes it easier for them to perfectly understand the person and their problem, which leads them to take care of the matter and commit themselves. Secondly, they have to demonstrate this understanding, care and commitment to the user. The fact that someone listens to you is in itself therapeutic for the person who is talking, and for the person who is listening, it is also a way of gathering information.

You will find below a list of different types of behaviour that help active listening and establishing a helping relationship and others which do not.

Types of behaviour that favour listening	Types of behaviour that do not favour listening
Looking the other person in the eyes	Fidgeting
Shaking your head appropriately	Not looking at the user
Smiling, facial expressions and hand gestures, etc.	Fiddling with clothes, pens, etc.
Adopting a relaxed body position	Physical barriers
Allowing for silences	Looking at the clock/watch
Observing the user's body language	Looking bored, impatient, hostile

Using a clear voice	Being too fatherly
Repeating key words	Acting condescendingly
Asking open questions	Not valuing certain aspects
Checking/clarifying	Drawing conclusions
Reflecting on what has been said	Judging
Summarising	Talking too much
Concentrating on what is being said	Too many silences
Structuring what has been said	Interrupting
Avoiding physical barriers	Ordering
	Advising

It is difficult to maintain active listening. Some of the obstacles you may come across are as follows:

Listening "off and on"

Many of us think about 4 times faster than most people speak, therefore, the person who listens has three quarters of a minute for thinking during every minute that he/she is listening. Sometimes we use this extra thinking time to think about something else, instead of listening to what the other person is telling us.

Listening with "ears open - mind shut"

Sometimes we quickly decide that what the other person is talking about is boring, illogical and not true. We often draw the conclusion that we can predict what will come next and we conclude that there is no reason to listen, because we will not hear anything new if we do.

Listening "with a vacant look"

Sometimes we look pointedly at a person and it almost looks as if we are listening even though our minds may be thinking about

other things and we are miles away. We start to concentrate moreon our own comforting thoughts and our facial expression becomes vacant and often, you can tell from our face that we are not interested

Listening to things "that are too deep for me"

When we listen to ideas that are too complex and complicated, there is a danger that we switch off.

Listening to "arguments which go beyond our way of thinking"

We do not like it when people alter our ideas, prejudices and points of view, and neither do we like it when they question us about our opinions and views. Consequently, when the speaker says something that clashes with our beliefs, thoughts and convictions, unconsciously we stop listening or, even, become defensive and plan a counterattack.

Being the "focal point" instead of "the central speaker"

Sometimes we concentrate on the problem and not the person. The details and the facts of an incident are more important than what the people tell us about themselves.

Listening to "the facts"

Often, when listening, we try to remember the facts and repeat them to ourselves again and again so as to remember them. If we do this, the speaker may have moved on to give new facts which we do not hear.

Listening "with a pen"

By trying to write down everything the person says we may lose some information because the speaker talks quicker than we can write. In this situation, it is also harder to maintain visual contact.

WORK DOCUMENT 11

Opening strategies

When people consider making changes they weigh up the pros and cons involved. The person feels motivated when he/she realises the disadvantages of their current behaviour and the advantages and benefits that he/she hopes to achieve by changing their behaviour.

However, people are often divided between wanting to continue their current behaviour and, at the same time, wanting to change it. This "ambivalence" poses a source of conflict for the person, and when they talk to someone about changing their habits (a health care professional, a member of the family or a friend) this conflict is alleviated. Sometimes people who want to help are tempted to take part in the conflict, for example, highlighting the disadvantages of the person's current behaviour and/or the advantages of changing it, with the result that the user adopts the contrary position and it becomes an external conflict, i.e., between the user and the person helping them.

Unfortunately, the consequences of this dialogue are that the users find themselves telling the people helping them all the reasons why changing their habits is not a good idea, and why their current behaviour is not really a major problem, which may increase the user's conviction in their current behaviour. If the dialogue becomes heated and the user and helper confront one another, the user will become even more reluctant to change their habits.

"The motivational interview" (Miller & Rollnick 2002) is a way of making the user aware of this conflict and their ambivalence and making it easier for them to view it as clearly as possible and decide that it has to be resolved. Below you will find a list of principles of the motivational interview which may prove useful when using brief interventions with users who are reluctant to change their habits.

The initial contact with patients sets the tone of the whole encounter, and it is essential to promote a friendly atmosphere in order to keep resistances as low as possible. From a motivational approach, some useful opening strategies have been described under the acronym of OARS:

- Open ended questions
- Affirming
- Reflective listening
- Summaries

O - Open ended questions

Open questions invite patients to talk about their problems from their own point of view. This not only minimizes resistances but also provides useful information about patients' priorities and intrinsic motivations. Usually GPs are afraid that open ended questions may be time consuming. Research has shown that the average time used by patients in PHC settings to answer an open question is 92 seconds (Langewitz et al. 2002).
Open questions allow the patient to present different topics or perspectives. This offers the practitioner the possibility to select which of the options posed by the patient he reacts to.

A - Affirming

Patients with alcohol problems tend to have a low self esteem. Showing a supportive attitude and explicitly recognizing their effort and progress, helps to increase their self-efficacy and promotes readiness to change. Affirming can be achieved through statements of appreciation and understanding. It is essential that the therapist picks up those topics where he can honestly express a positive reinforcement.

R - Reflective listening

The core element of motivational interviewing is reflective listening. It can be defined as an effort to guess what the patient really means when he speaks (see overhead 29). It takes the form of a statement, not a question that turns down at the end, inviting the patient to elaborate on it. Reflective listening statements can range from very superficial (repetition of a few relevant words), to quite deep (reflection of feelings). Simple reflections should be used in the beginning, while deeper reflections should be used only in advanced phases. It is important to note that, in order not to raise defensiveness, words must be chosen carefully (ie: "you're concerned" is better than "you're worried").

Reflective listening is a gentle and powerful tool that allows the therapist to be directive: choosing which part he/she reflects allows him/her to decide in which direction the interview continues. Anyhow, it is very important not to forget that reflective listening is a guess. Therapists must be much focussed in patients reactions to that guess and, if wrong, change direction.

S - Summaries

Summaries can be used in order to put together topics previously discussed. They help to keep track and avoid dispersion. When patients listen to their own words from the therapist's mouth they not only realize that the practitioner is really listening, but also their motivation to change increases. Summaries are, in fact, long reflections. They must be used not as closing sentences, but as statements that invite to explore what comes next.

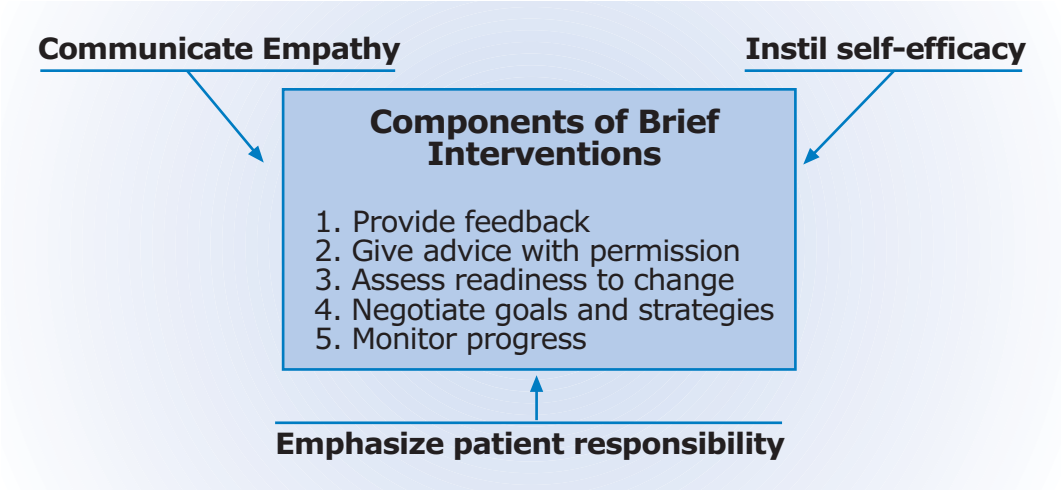
In brief

All the opening strategies are to be used together, in order to create a friendly atmosphere where the patient feels safe enough to explore in depth the user's ambivalence. The main aim of the practitioner when the interview starts must be to create this safe atmosphere, even if this implies that the topics discussed are not exactly those in the GP's agenda.

WORK DOCUMENT 12

Basic components of Brief Interventions [iii]

When delivering brief interventions special attention should be paid to both contents and spirit. Spirit is very important since brief interventions are designed to trigger internal cues, and this can only be reached through an approach that increases the patient's motivation.



Style and spirit of the Brief Interventions

The brief interventions style is based on motivational interviewing, and has been summarized in three ideas:

- Communicate Empathy
- Instil self-efficacy
- Emphasize patient responsibility

Communicate empathy

Empathy is one of the key characteristics of a successful therapist. It implies respect, supportiveness, warmth, sympathetic understanding and commitment. It has been described by Miller & Rollick as 'a specifiable and learnable skill for understanding another's meaning through the use of reflective listening.

[iii] *This information was provided by Clinical Tools, Inc., and is copyrighted by Clinical Tools, Inc*

It requires sharp attention to each new client statement, and a continual generation of hypotheses as to the underlying meaning.Your best guess as to meaning is then reflected back to the client, often adding to the content of what was overtly said. The client responds and the whole process starts over again'.

It is important to emphasize that empathy is a learnable skill, since a lot of people tend to think of empathy as a natural ability that someone has or has not, and therefore they do not feel like making efforts to improve their empathic skills. Empathy implies learning to focus on the person, not in the disease.

Instil self-efficacy

Brief interventions bring about changes because they set in motion internal mechanisms of the patient which he or she does not fully trust. Helping the patient to believe in his or her ability to change is a way of increasing the probability that the change will take place. To this end it is often useful to look for those episodes in the patient's recent or past history in which this ability has been in evidence, for example, changes that were successfully made in other areas (weight loss, physical exercise, etc.) In particularly despairing patients it can also be useful to value the personal effort represented in their attending the consultation and talking about their problems.

In general, affirming is a good strategy to promote self-efficacy.

Emphasize patient responsibility

Patients are always dealing with a lot of ambivalence when they address their alcohol consumption. Because of this, if the practitioner pushes in one direction (reduce or abstain from alcohol) the patient is likely to take the opposite side (increasing resistance). To avoid this trap, practitioners should stay 'neutral', and emphasize that the patients' freedom to choose will be respected, and that it is his/her responsibility to make the choice. This attitude of respect and neutrality allows the patient to contact with his internal ambivalence. In fact, the therapeutic strategy lies in avoiding external confrontation (telling the patient what he/she should do), in order to enhance internal confrontation, which is a much powerful change agent.

Contents of Brief Interventions

Since time is a main constraint in the delivery of brief interventions, it is essential to use properly its main components:

- Provide feedback
- Give advice with permission
- Assess readiness to change
- Negotiate goals and strategies
- Monitor progress

Provide feedback

To be successful, brief interventions must be personalized. In PHC settings a natural way of personalizing brief intervention is delivering feedback through the results of the assessment conducted. Feedback must be given in a non judgmental way avoiding any criticism, and trying to be as clear as possible about the actual harm and the present risks to the patient's health. It is important that feedback also includes the abilities and strengths of the patient to overcome his/her problem.

Give advice with permission

As pointed out by Miller & Rollnick (2002), 'Well-timed and tempered advice to change can make a difference. In fact, brief advice has shown to be effective in changing the patient's use of alcohol and tobacco. To be effective, advice would be given just when it is needed. If it is given too soon, it will probably increase patient's resistances. On the other hand, if we wait to long the patient might feel a bit confused. The best way to deliver a 'well-timed' advice is to ask the patient permission before we start. Some examples would be:

- 'Would you like me to give you some more information on this topic?'
- 'Do you want me to tell you what I think about it?'
- 'May I give you an overview of what we've been talking so far?'

Those introductory statements work as door openers, and keep resistance low. If the patient answers 'No thank you', it is very important not to give advice at this moment. An answer like 'That's ok, if later on you want this information don't hesitate to ask me'.

Assess readiness to change

The stages of change have been described in detail in session 3. It is very important that the practitioner identifies the stage of change the patient is at concerning a particular issue. In fact, the intervention must be tailored to the patient's stage of change, and the therapist should fix his/her objectives according to this, never expecting him to jump from precontemplation to action. It may well be that the same patient is at different stages for different problems (i.e., precontemplator concerning alcohol and contemplator concerning overweight). Sometimes the therapist may not be sure of the stage the patient is in. In such cases it is advisable to treat the patient as if he/she were at the least advanced stage, since this strategy minimizes resistance.

Negotiate goals and strategies

The practitioner must be fully aware that changing habits is a slow and difficult process. So, brief interventions must be planned as actions that increase the likelihood that hazardous drinking patterns slowly diminish. With this long term strategy, intermediate goals can be fixed, taking into consideration not only the clinical status of the patient, but also his/her readiness to change his/her drinking behaviour. It's always preferable to set modest achievable goals that enhance patient's self efficacy and increase the probability that they return to the follow up appointments, rather than fixing ambitious goals difficult to accomplish.

Both, goals and strategies to reach them must be discussed with patients. Negotiation with patients has many advantages:

- Gives information on the acceptability of goals from the patient's point of view
- Shows very clearly which are the patient's values and priorities
- Enhances patient's commitment to attain the negotiated goals
- Provides useful information on the patient's abilities and strengths

It is important to explain to patients that negotiation must take place within two limits: the patient's freedom and the therapist's good clinical practice. This means that agreements cannot be taken against good clinical practice or against the patient's will. This may seem paradoxical, since what the health care professional wants is to promote the change, on the other hand, what he/she can do is make it easier for the user to view their resistance and the obstacles for change as objectively as possible, without being tied to them by having to defend them in a discussion with the health care professional who does not seem to appreciate the importance they have for the user.

Monitor progress

Change is a continuing slow process. Therefore, instead of planning intensive short term interventions it is more reasonable to plan brief interventions that spread over the long run. PHC settings are ideal for this strategy, since patients keep in contact with their GP for a variety of reasons and this gives the chance to keep alcohol on the agenda. On the other hand, when patients change their drinking pattern, monitoring their progress allows the practitioner to give positive feedback in both objective and subjective changes that the patient may be experiencing.

When delivering brief interventions, patients may respond with resistance or with interest. It is very important for the clinician to be sensitive to the patient's reaction, since this must lead him/her to different answers. Below we describe the basic attitudes to react to both a resistant and a committed patient.

1) Continue with the resistance to changing their habits

If the users in the precontemplation and contemplation stages are inclined to be reluctant to change their habits and the likelihood of confrontation tends to increase this reluctance, other strategies have to be used.

When describing such strategies, Miller and Rollnick (2002) draw a similarity with martial arts in which, instead of blocking or countering an attack, the martial artist "rolls" with it thus rendering it harmless.

The above is transferred to the consulting room in the following way: if the health care professional starts to talk about changing habits and the user shows resistance, instead of introducing the argument about replacement, the health care professional has to accept and recognise the resistance, and use reflexive listening techniques. Once the resistance has been accepted, the user leaves this particular point and is free to move on to consider other aspects of the problem.

In fact, this approach can help to encourage the user to study their resistance to change a little bit so that both the user and the health care professional understand it more. This may seem paradoxical, since what the health care professional wants is to promote the change, on the other hand, what he/she can do is make it easier for the user to view their resistance and the obstacles for change as objectively as possible, without being tied to them by having to defend them in a discussion with the health care professional who does not seem to appreciate the importance they have for the user.

The resistance can also "be left to one side", according to another combat strategy. If the user shows resistance with respect to a particular set of questions, the health care professional can lead the discussion to another subject or focus on the same subject from a different angle. The aim is to continue a constructive and collaborative discussion, as long as possible, without reaching an obstacle in this subject. Meanwhile, the user continues to talk and examine his/her feelings and thoughts, which helps the contemplation process.

2) Extract change-talk

When patients react positively, there are ways in which we can promote their commitment to change, stimulating them to formulate `self motivating statements (change talk)
If someone listens to us when we express an opinion aloud, we usually strengthen our conviction to that opinion. Therefore, if we want to encourage and facilitate the change, it is a great help if we direct the consulting session in such a way that the user feels encouraged to mention the reasons he/she sees for changing their habits.

Below, are some examples of these self-motivating phrases:

"I'm aware that, if I smoke, I'm setting a bad example for my children."

"If I were more physically active, it would help with the stress at work"

"My father died of a heart attack and I don't want that to happen to me.I know that if I change my lifestyle I could reduce the risk"

"I don't like being fat, I don't feel attractive and I get tired easily".

The self-motivating phrases can be obtained by asking questions such as:

"You've told me some of the things you like about tobacco. Are you worried about any aspect of this habit?"

"Have you considered changing some of your lifestyle habits?"

"Do you think that you would gain some advantages if you change your habits?"

Change talk can be expressed in different ways: expressions of interest, concern, etc. But the most powerful self motivational statements are those which express commitment.

WORK DOCUMENT 13

Relapse prevention: helping people to recycle

Relapse prevention: helping people to recycle

Maintenance is a stage of active and continuing change. New coping strategies are learned in order to avoid relapse and to establish a new healthier lifestyle. Only about 20 percent of people permanently change long-standing problems at the first attempt. Most people revert, at least temporarily, to the problem behaviour, before trying again.

The most detailed work on relapse and how to help people to recycle has been done by Alan Marlatt. Marlatt & Gordon's (1985) work has been later reviewed and developed by others (Society for the Study of Addiction 1996) and provides a useful framework for clinical work.

What Precipitates Relapse?

Relapse is usually a way of:

- Coping with emotional distress (i.e. to feel better when they feel bad).
- Enhancing positive emotional states (i.e. to feel even better when they feel good).
- Giving in to temptations or urges.
- Responding to social pressure.

Avoiding Relapse

People need the skills to cope with these situations and to feel confident that they can do it. Each time someone successfully avoids a potential relapse their confidence will be increased, making it more likely they will use the strategy successfully next time. People can prepare themselves against such high risk situations when they are in the maintenance stage.

Looking ahead over future weeks they can list situations in which they can foresee wanting to return to the problem behaviour.

They can then be helped to develop appropriate coping strategies; counterconditioning, environment control and using their helping relationships:

- Assertiveness skills to cope with social pressure,
- Anxiety management or anger management to cope with those negative emotional states,
- Support networks to cope with other emotional distresses,
- Mood changing strategies to help distract themselves from urges or cravings,
- Changes in routine to avoid situations where temptation is great.

"Slips" and Relapses

Often people set themselves on a path of strict adherence to a new lifestyle (no smoking, healthy eating, vigorous exercise etc) and then slip from this path on occasion. Many people give up as soon as they slip, believing that they have failed and a complete relapse is inevitable. They then feel guilty and blame themselves. They lose confidence in their coping strategies and it becomes harder for them to get back on the path to a healthy lifestyle. Every relapse begins with a slip but not every slip needs to become a relapse. People can learn to manage their slips and to get straight back on course as quickly as possible. It is possible to smoke one cigarette without becoming a smoker again.

Helping People to "Recycle"

Slips and relapses can teach us a lot about our habits and attempts to change. However, we need first to acknowledge that our first response may be disappointment, anger or frustration.

Having acknowledged these feelings identifying what triggered a slip or a complete relapse can help to clarify what situations are "high risk" and what sort of coping strategies need to be developed. and how skills are developing.

It can be helpful to explore:

- Did the person have enough good counterconditioning techniques? Do more need to be developed?

- Was there enough support available? Can the existing helping relationships be strengthened or more support engaged?

- Has this experience showed up a need for professional, specialist help with the problem?

- Or, was the person truly ready and committed to change or was the attempt premature? Is it a good idea to try again yet or is more contemplation and preparation needed?

Similarly people can learn from successful attempts to avoid slips in high risk situation. These can show which coping strategies work and how skills are developing. This in turn builds confidence.

WORK DOCUMENT 14

Alcohol dependence diagnostic criteria

It is very likely that when screening alcohol consumption, we find not only people whose level of consumption is a risk, but also people who have already started to experience problems with alcohol or who have very high consumption levels. In order to diagnose the alcohol dependence syndrome, traditionally two international diagnostic classifications are used: the Diagnosis and Statistics Manual of Mental Disorders (DSM-IV) and the International Classification of Diseases (ICD-10).

ICD-10 criteria

A definite diagnosis of dependence should usually be made only if three or more of the following have been present together at some time during the previous 12 months:

- A strong desire or sense of compulsion to take alcohol.
- Difficulty in controlling drinking in terms of its onset, termination or level of use.
- A physiological withdrawal state when drinking has ceased or been reduced (eg tremor, sweating, rapid heart rate, anxiety, insomnia, or less commonly seizures, disorientation or hallucinations) or drinking to relieve or avoid withdrawal symptoms.
- Evidence of tolerance, such that increased doses of alcohol are required in order to achieve effects originally produced by lower doses.
- Progressive neglect of alternative pleasures or interests because of drinking and increased amount of time necessary to obtain or take alcohol or to recover from its effects (salience of drinking).
- Persisting with alcohol use despite awareness of overtly harmful consequences, such as harm to the liver, depressive mood states consequent to periods of heavy drinking, or alcohol-related impairment of cognitive functioning.

Patients with hazardous and harmful alcohol consumption and those with a clinical suspicion of harmful alcohol consumption or alcohol dependence can benefit from further assessment. A first line tool is the World Health Organization's ten item Alcohol Use Disorders Identification Test. AUDIT scores of 20 or more are indicative of

alcohol dependence and patients may require referral to a specialist for diagnostic evaluation and treatment. Alcohol dependence can be measured with alcohol dependence module of the World Health Organization's Composite International Diagnostic Interview (CIDI-SF 12 Month) (WHO 2002b). This contains seven questions to measure alcohol dependence, with a positive answer to four or more being diagnostic.

Composite International Diagnostic Interview (CIDI-SF 12 Month) for measuring alcohol dependence.

1 In the past 12 months, was there ever a time when your drinking or being hung over interfered with your work at school, or a job, or at home?
1 Yes
2 No

1.1 If yes, How often in the past year?
1 Once or Twice
2 Between 3 and 5 times
3 Between 6 and 10 times
4 Between 11 and 20 times
5 More than 20 times

2 During the past 12 months, were you ever under the influence of alcohol in a situation where you could get hurt — like when driving a car or boat, using knives or guns or machinery, or anything else?
1 Yes
2 No

3 During the past 12 months, did you have any emotional or psychological problems from using alcohol — such as feeling uninterested in things, feeling depressed, suspicious of people, paranoid, or having strange ideas?
1 Yes
2 No

4 During the past 12 months, did you have such a strong desire or urge to drink that you could not keep from drinking?
1 Yes
2 No

5 During the past 12 months, did you have a period of a month or more when you spent a great deal of time drinking or getting over the effects of alcohol?
1 Yes
2 No

6 During the past 12 months, did you ever have more to drink than you intended to, or did you drink much longer than you intended to?

1 Yes
2 No

6.1 If yes, How often in the past year?
1 Once or Twice
2 Between 3 and 5 times
3 Between 6 and 10 times
4 Between 11 and 20 times
5 More than 20 times

7 During the past 12 months, was there ever a time when you had to drink much more than you used to to get the same effect you wanted?
1 Yes
2 No

Elevated levels of serum GGT and the aminotransferases, CDT and MCV are often due to alcohol. Since these tests are performed routinely as part of a biochemical test battery, the presence of an elevated level should alert the clinician to a possible diagnosis of harmful alcohol consumption and alcohol dependence.

WORK DOCUMENT 15

Pharmacological treatment of alcohol dependence

Managing withdrawal symptoms

People who are physically dependent upon alcohol are likely to experience withdrawal symptoms 6 to 24 hours after the last drink is consumed. Diazepam is recommended as the first-line treatment for withdrawal because of its relatively long half-life and evidence for effectiveness. The standard therapeutic regimen involves regular doses of diazepam over two to six days, not continuing past day six, to avoid the risk of dependence.

The following table indicates the recommended doses of diazepam.

	Diazepam (5 mg cps)	
Day	**Low**	**High**
1	**1-1-1**	**4-4-4**
2	**1-0-1**	**4-3-4**
3	**0-0-1**	**3-3-4**
4	**stop**	**3-3-3**
5		**3-2-3**
6		**2-2-3**
7		**2-1-3**
8		**1-1-3**
9		**1-1-2**
10		**1-1-1**
11		**1-0-1**
12		**0-0-1**
13		**stop**

If the patient suffers from one or more of the following symptoms it will be recommended to use the diazepam doses to prevent the withdrawal syndrome:

- Previous delirium tremens or seizures
- Morning withdrawal signs
- Drinking first thing in the morning
- Patient willing to take medication
- Actual withdrawal signs
- Severe physical condition

The contraindications for outpatient detoxification are:

- Confusion or hallucinations.
- History of previously complicated withdrawal.
- Epilepsy or history of fits.
- Poor nutritional state.
- Severe vomiting or diarrhoea.
- Risk of suicide.
- Severe dependence coupled with unwillingness to be seen daily.
- Failure of home-assisted withdrawal.
- Uncontrollable withdrawal symptoms.
- Acute physical or psychiatric illness.
- Polysubstance use.
- Home environment unsupportive of abstinence.

In the event that the patient needs detoxification, we must evaluate whether it is recommendable to refer the patient to a specialised centre, or whether he/she can be managed by primary health care. A patient should be referred to a hospital or emergency centre, if the following conditions are apparent:

- Previous unsuccessful treatment attempts
- Severe complications:
    - Risk of withdrawal symptoms from moderate to severe.
    - Serious medical illness
    - Family unable to provide support.
    - Psychiatric co morbidity.
    - Regular use of other addictive substances.
- Treatment cannot be managed by the PHC team.

If we opt for out-patient detoxification within the primary health care framework, the following conditions must be present:

- Daily alcohol consumption below 25 standard drinks/day.
- No severe medical or psychiatric complications.
- Patients commitment to:
    - Alcohol abstinence during the detoxification.
    - Staying at home
    - Avoidance of risky activities.
- One relative without addictive problems must be responsible to control the medication and supervise the treatment.
- No availability of alcoholic beverages at home during the detoxification.
- Daily contact with GP or nurse (in person or by phone)

Managing alcohol dependence

Some people with alcohol dependence get better by themselves, and not everyone with alcohol dependence requires specialist treatment, although many do. Specialist treatments include behavioural approaches and pharmacotherapy. Social skills training, the community reinforcement approach, and behavioural marital therapy are among the most effective approaches, particularly when they emphasize the person's ability to stop or reduce drinking through learning self management skills, when they motivate enhancement, and when they strengthen the person's support system. Acamprosate, the opiate antagonist naltrexone and disulfiram are also effective.

Acamprosate modulates the NMDA-glutamate system and it has proved to be effective in increasing abstinence rates at 6 and 12 months follow-up in detoxified, alcohol dependent patients. Its effect persists once the treatment finishes. The dose is 2g daily, administered either as 2 tablets every 8 hours or, 3 tablets every 12 hours.

Naltrexone is an opiate antagonist which has proved to be effective in reducing the relapse rate in alcohol dependent patients when given for 3 months. Its effect wears off once the medication is stopped. It is administered in one dosage of 50 mg daily, in one single tablet.

Disulfiram acts by inhibiting the metabolism of alcohol dehydrogenase. Although the clinical studies on its efficacy give contradictory results, it appears to be useful in patients who find it difficult to maintain their decision to abstain from drinking alcohol. The recommended dosage is 250 mg per day in one single dosage. Calcic cyanamide produces similar effects to disulfiram, with the disadvantage that its average active life is very short and it must be administered twice daily.

While acamprosate and naltrexone cause a reduction in the desire to drink (anticraving substances), the effect of disulfiram and calcium cyanamide is base on their dissuasive reaction that is experienced by patients who drink alcohol after taking the medication (antidipsotropic substances).

Methods that lack effectiveness include those designed to educate, confront, shock or foster insight regarding the nature and causes of alcohol dependence, as well as mandatory attendance to Alcoholics Anonymous. There is little evidence to suggest that the overall outcomes of treatment can be improved when patients are matched to different types of treatment.

The best model for the relationship between primary care and specialist services is not clear, although it seems that integrated primary care and specialist treatment gives a better outcome than when the two services are separated. Follow-up may reduce the risk of relapse, so it is important for primary health care providers to maintain contact over the long term with patients treated for alcohol dependence who are no longer in contact with specialist services.

WORK DOCUMENT 16
EVALUATION FORM

Please tick the box that best describes how you feel about each objective.

At the end of the course how far do you feel able to:

	Not at all	*Not much*	*To some extent*	*A lot*
• Measure alcohol consumption in standard drinks per week	☐	☐	☐	☐
• Identify hazardous drinkers according to their weekly alcohol intake	☐	☐	☐	☐
• Identify hazardous drinkers using the AUDIT	☐	☐	☐	☐
• Identify hazardous drinkers using the AUDIT-C	☐	☐	☐	☐
• Describe Prochaska and DiClemente's model of the stages of change	☐	☐	☐	☐
• Describe the basic components of a brief intervention	☐	☐	☐	☐
• Provide brief advice to a hazardous drinkers taking into account his/her stage of change	☐	☐	☐	☐
• Describe typical ways patients show their resistance to health promotion behaviours	☐	☐	☐	☐

	Not at all	*Not much*	*To some extent*	*A lot*
• Respond to a client's resistance in a way that does not provoke further argument	☐	☐	☐	☐
• Exchange information in a client-centred way	☐	☐	☐	☐
• List problems related to regular heavy drinking and intoxication	☐	☐	☐	☐
• Describe the ICD criteria for alcohol dependence	☐	☐	☐	☐
• Describe the basic criteria to refer a patient to a specialized alcohol clinic	☐	☐	☐	☐
• Prescribe a home detoxification for a patient drinking 150 g/day.	☐	☐	☐	☐

Please comment or make suggestions on the following:

The pace of the course

The methods used

The course materials (handouts and visual aids)

Thanks for your collaboration.

Alcohol and Primary Health Care:

Training Programme on Identification and Brief Interventions

OVERHEADS

Alcohol and Primary Health Care:

Training Programme on Identification and Brief Interventions

OVERHEADS

Contents of the Training Programme

- **Session 1:** Introduction and basic concepts
- **Session 2:** Early identification
- **Session 3:** Brief intervention I
- **Session 4:** Brief intervention II
- **Session 5:** Alcohol dependence
- **Session 6:** Implementation of EIBI alcohol programme

2

First Session:

Introduction and basic concepts

- Introduction
- Health and social costs
- Alcohol and primary health care
- Standard drinks
- Drinking patterns
- Risk levels
- Intervention criteria

3

WHO Collaborative Project on Identification and Management of Alcohol-related problems in Primary Health Care

- **PHASE I (1983-1989)**
  Development of the AUDIT screening tool
- **PHASE II (1985-1992)**
  RCT on the effectiveness of brief interventions
- **PHASE III (1992-1998)**
  Marketing and training & support strategies to implement early alcohol interventions in PHC
- **PHASE IV (1998-2004)**
  Dissemination and wide implementation of early alcohol interventions in PHC

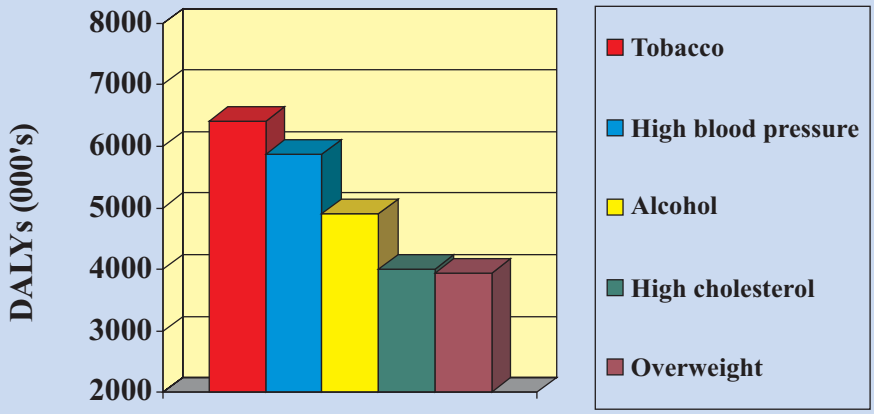
4

The PHEPA Project

- **Aim:** to integrate health promotion interventions for hazardous and harmful alcohol consumption into PHC professionals' daily clinical work.
- **Activities :**
  - ✓ European recommendations and clinical guidelines for health care purchasers and providers
  - ✓ European training program for PHC professionals
  - ✓ Comprehensive Internet site database on good practice

5

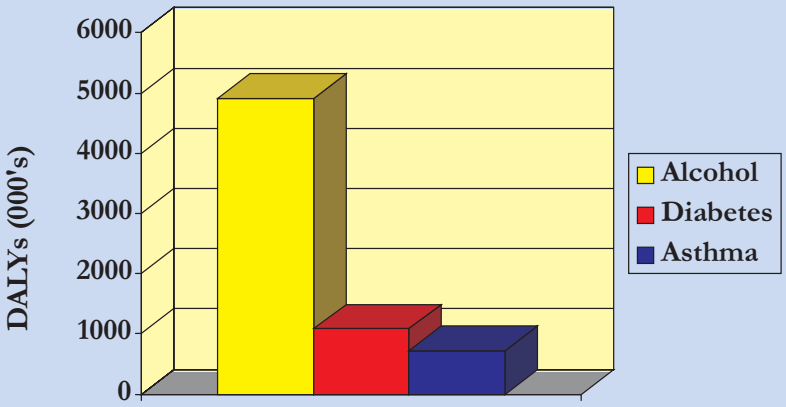
The top 5 risk factors for ill health and premature death, Europe



Source: World Health Organization (2002a).
*A disability adjusted life year (DALY) is a measure of one year's premature death or ill-health adjusted for the severity of ill-health

6

Alcohol is more important as a cause of ill-health and premature death than diabetes or asthma



Source: World Health Organization (2002a).
*A disability adjusted life year (DALY) is a measure of one year's premature death or ill-health adjusted for the severity of ill-health

7

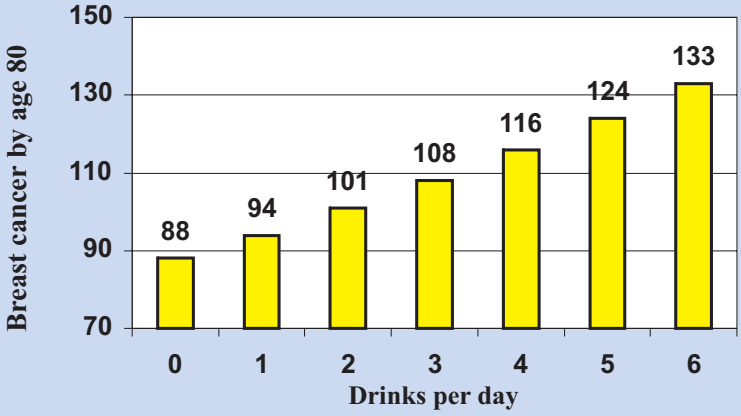
Attributable fractions in European men (%)

• Cirrhosis of the liver	63
• Haemorrhagic stroke	26
• Mouth and oropharynx cancers	41
• Oesophagus cancer	46
• Other cancers	11
• Homicide	41
• Other Intentional injuries	32
• Motor vehicle accidents	45
• Other unintentional injuries	32

Source: World Health Organization (2002a).

8

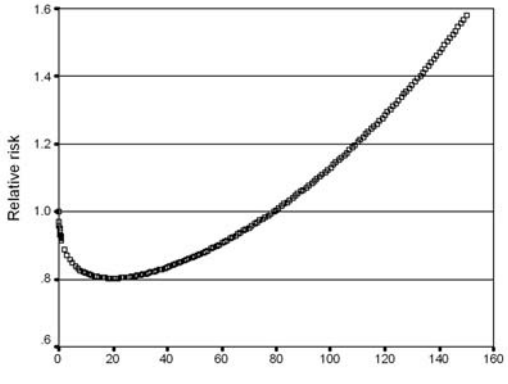
Risk of female breast cancer



Source: Collaborative Group on Hormonal Factors in Breast Cancer (2002). Cumulative incidence of breast cancer per 1000 women by aged 80 years in relation to number of alcoholic drinks per day

9

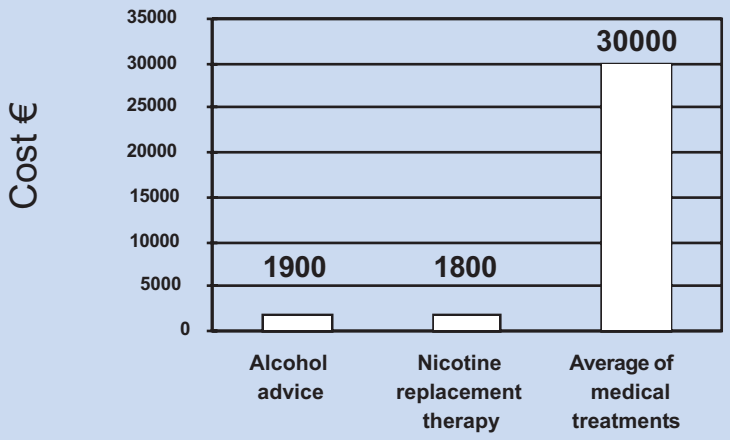
Risk of coronary heart disease



Source: Corrao et al. (2000).

10

Cost per year of ill-health or premature death prevented



11

Standard Drinks*

- One standard drink commonly contains about 10 g of alcohol. For example:
  - ✓ 250 ml of beer at 5% strength
  - ✓ 125 ml of wine at 12% strength
  - ✓ 70 ml of fortified wine (e.g. sherry) at 18% strength
  - ✓ 50 ml of a liqueur of aperitif at 25% strength
  - ✓ 25 ml of spirits at 40% strength

*Every country must adapt this overhead

12

Drinking Patterns

- **HAZARDOUS DRINKING**: a level of alcohol consumption or pattern of drinking that is likely to result in harm should present drinking habits persist.
- **HARMFUL DRINKING**: a pattern of drinking that causes damage to health, either physical or mental . In contrast with risky drinking, the diagnosis of harmful drinking requires that damage has been caused to the user.
- **ALCOHOL DEPENDENCE**: a cluster of physiological, behavioural, and cognitive phenomena in which the use of alcohol takes on a much higher priority for a given individual than other behaviours that once had greater value. A central characteristic is the desire to drink alcohol. Return to drinking after a period of abstinence is often associated with rapid reappearance of the features of the syndrome.

13

Risk levels and intervention criteria

Risk level	Criteria	Intervention	Role of PHC
Low	<280g/w men <168g/w women* AUDIT-C<5 men AUDIT-C<4 women AUDIT<8	Primary prevention	Health education, advocacy, role model
Hazardous*	280-349 g/w men 140-209 g/w women AUDIT-C ≥ 5 men AUDIT-C ≥ 4 women AUDIT 8-15	Simple advice	Identification, assessment, brief advice
Harmful	≥350g/w men ≥210 g/w women Presence of harm AUDIT 16-19	Simple advice plus brief counselling and continued monitoring	Identification, assessment, brief advice, follow-up
High (alcohol dependence)	ICD-10 criteria AUDIT ≥ 20	Specialized treatment	Identification, assessment, referral, follow-up

*Any consumption in pregnant women, and people younger than 16 years or with illnes or treatments that advise against alcohol consumption
Source: Anderson P (1996).

14

Second session: Early identification

- Identification of hazardous and harmful use:
  - ✓ AUDIT
  - ✓ AUDIT-C
- Implementation levels
- Brief interventions effectiveness

15

The Alcohol Use Disorders Identification Test (AUDIT)-1

1. How often do you have a drink containing alcohol?

never (0 points)	less than monthly (1 point)	Monthly (2 points)	weekly (3 points)	daily or almost daily (4 points)

2. How many standard drinks containing alcohol do you have on a typical day drinking?

1 or 2 (0 points)	3 or 4 (1 point)	5 or 6 (2 points)	7 or 9 (3 points)	10 or more (4 points)

3. How often do you have six or more drinks on one occasion?

never (0 points)	less than monthly (1 point)	Monthly (2 points)	weekly (3 points)	daily or almost daily (4 points)

4. How often during the last year have you found that you were not able to stop drinking once you had started?

never (0 points)	less than monthly (1 point)	Monthly (2 points)	weekly (3 points)	daily or almost daily (4 points)

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

never (0 points)	less than monthly (1 point)	Monthly (2 points)	weekly (3 points)	daily or almost daily (4 points)

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The AUDIT-2

6. How often during the last year have you needed a drink in the morning to get yourself going after a heavy drinking session?

never (0 points) | less than monthly (1 point) | Monthly (2 points) | weekly (3 points) | daily or almost daily (4 points)

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

never (0 points) | less than monthly (1 point) | Monthly (2 points) | weekly (3 points) | daily or almost daily (4 points)

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

never (0 points) | less than monthly (1 point) | Monthly (2 points) | weekly (3 points) | daily or almost daily (4 points)

9. Have you or someone else been injured as a result of your drinking?

No (0 points) | yes, but not in the last year (2 points) | yes, during the last year (4 points)

10. Has a relative, friend, doctor or health worker been concerned about your drinking or suggested you cut down?

No (0 points) | yes, but not in the last year (2 points) | yes, during the last year (4 points)

Reproduced with permission from the World Health Organization

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The AUDIT-C

1. How often do you have a drink containing alcohol?

Never (0 points) | monthly or less than monthly (1 point) | 2-4 times/month (2 points) | 2-3 times/week (3 points) | 4 or more times a week (4 points)

2. How many standard drinks containing alcohol do you have on a typical day drinking?

1 or 2 (0 points) | 3 or 4 (1 point) | 5 or 6 (2 points) | 7 or 9 (3 points) | 10 or more (4 points)

3. How often do you have six or more drinks on one occasion?

Never (0 points) | less than monthly (1 point) | monthly (2 points) | weekly (3 points) | daily or almost daily (4 points)

18

SIAC (Systematic Inventory of Alcohol Consumption)

- If you ever drink alcoholic beverages (wine, beer, etc), how many drinks you have in a day? (expressed in Standard Drinks (SD))
- How often? (number of days in a week)
- On weekends (or workdays) do your drinking habits change?
- Registration sheet (on SD):

	quantity	days	total
Workday drinking			
Weekend drinking			

1 SD = 10 g.

Risky Drinking: > 28 SD/per week among men
> 14 SD/ per week among women

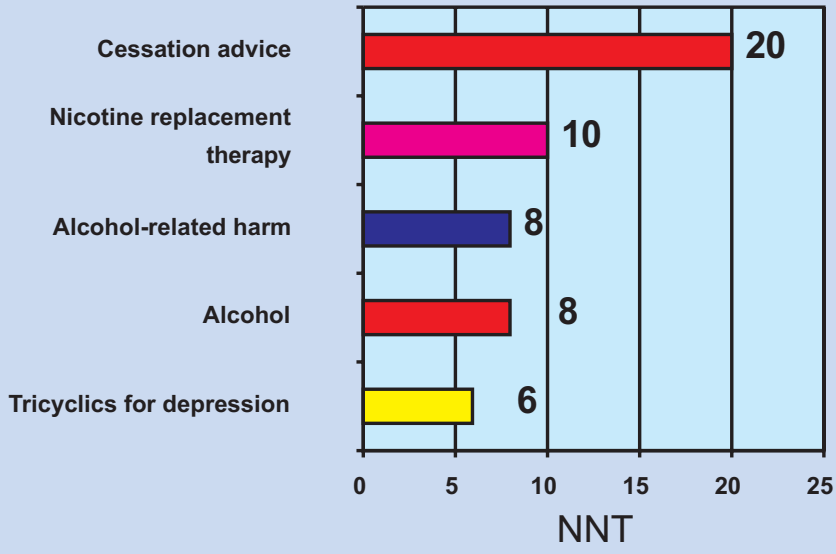
19

Implementation levels

- **Low:** Identification of hazardous drinking in special populations (ie: pregnant women, children of alcohol dependents, etc.)
- **Standard:** Identification of hazardous drinking in groups with known high levels of consumption (ie: men between 20-50 years of age, etc.)
- **Maximum:** Systematic identification and brief advice of the whole population

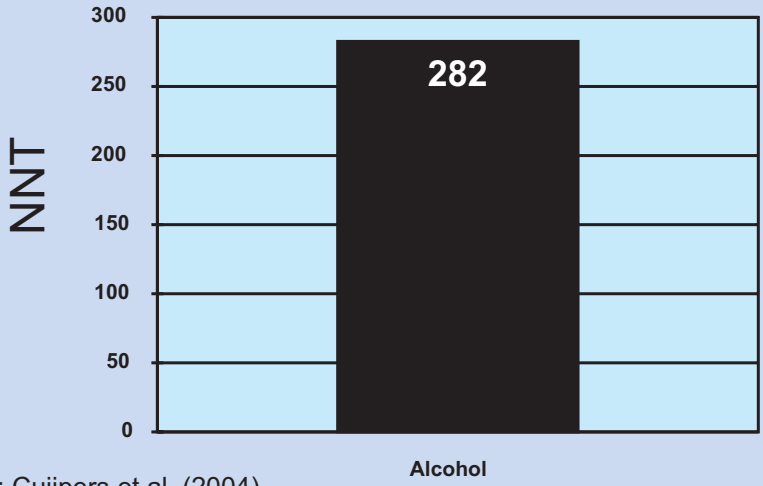
20

Numbers needed to treat (NNT) for one person to benefit



21

Numbers needed to treat to save one death in one year



Source: Cuijpers et al. (2004).

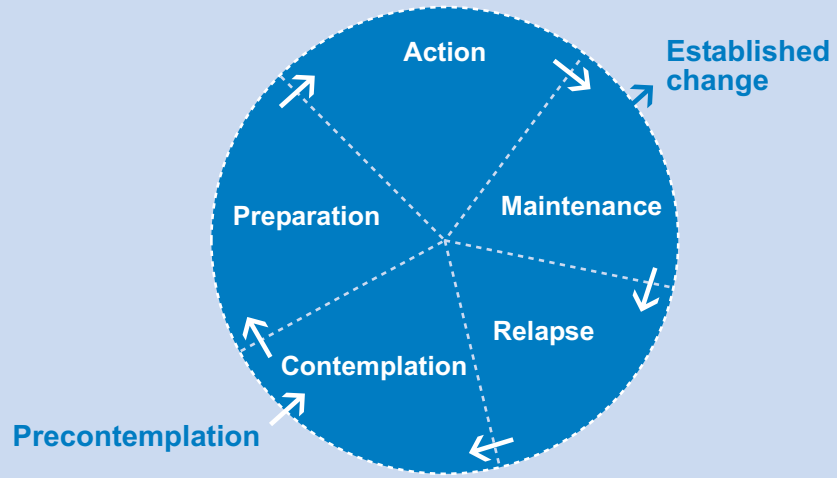
22

Third session: Brief intervention I

- Stages of Change Model
- Processes of change
- Minimal interventions
- Communication style for a helping relationship

23

Stages of Change Model



* Adapted from Prochaska & DiClemente (1986)

24

Stages of change and therapist aims

Stage	Basic element	Therapist objective
Precontemplation	Unawareness	Raise awareness
Contemplation	Ambivalence	Explore concerns. Develop internal discrepancies
Preparation	Ambivalence	Offer neutral information & advice. Provide choices
Action	Commitment	Enhance commitment & self-efficacy
Maintenance	Stability	Support
Relapse	Despair	Avoid criticism, increase self-esteem, renew commitment

25

Processes of change

In moving forward through the stages of change people use 10 main processes to help themselves:

Precontemplation	Contemplation	Preparation	Action	Maintenance
Consciousness raising				
Social liberation				
Dramatic relief				
Environmental reevaluation				
	Self reevaluation			
	Self liberation-Commitment			
		Reinforcement management		
		Counterconditioning		
		Stimulus/environtment control		
		Helping relationship		

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Minimal versus Brief Interventions

MINIMAL	BRIEF
➢Opportunistic ➢Based on advice ➢With or without formal follow up ➢Up to 10 minutes ➢With self help materials	➢Usually scheduled ➢Based on motivation ➢With formal follow up ➢Up to 30 minutes ➢With self help materials

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Minimal Interventions
(The 5 A's method*)

➢**Ask/Assess:** whether the person drinks and the factors that might affect choice of behaviour change, goals and methods.

➢**Advise:** Give clear, specific, and personalized advice for behaviour change, including information about personal health harms and benefits.

➢**Agree:** select treatment goals and methods based on the person's readiness to change drinking behaviour

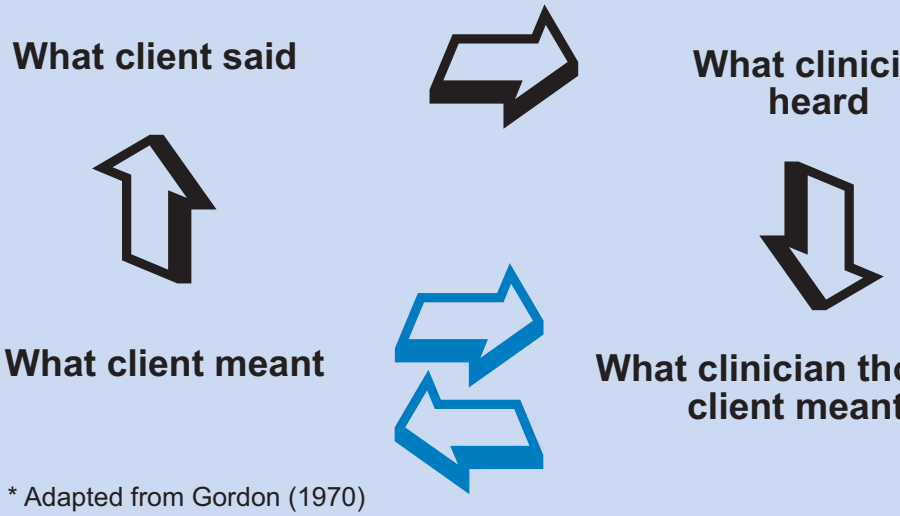
➢**Assist:** aid the drinker in achieving agreed-upon goals by helping them acquire the knowledge, attitudes, skills, confidence, and social and environmental supports for behaviour change

➢**Arrange:** Schedule follow-up contacts to provide support

* Adapted from Whitlock et al. (2004)

28

Communic ation Model
from Thomas Gordon



* Adapted from Gordon (1970)

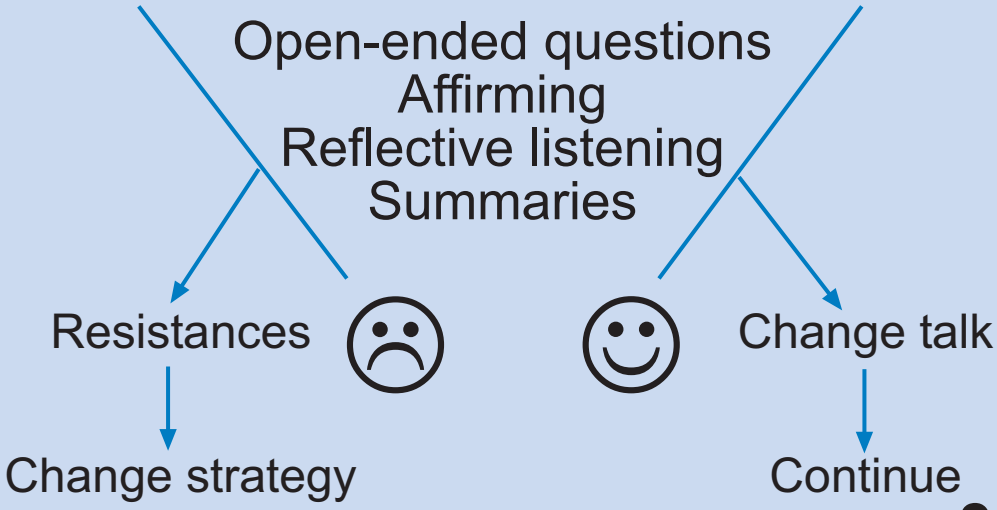
29

Fourth session: Brief Intervention II

- Opening strategies
- Basic components of brief interventions:
  - ✓ Style
  - ✓ Contents
- Relapse Prevention: helping people to recycle

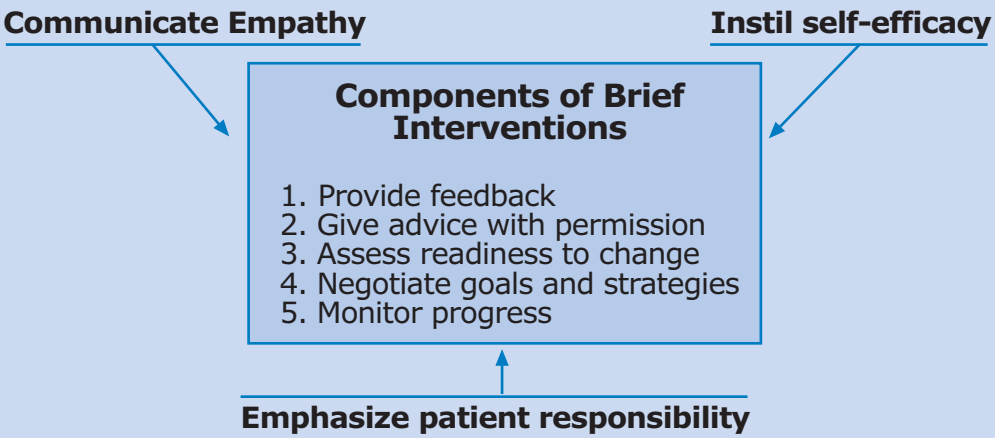
30

Opening strategies



31

Basic Components of Brief Interventions



* Adapted from AlcoholCME (2004)

32

What precipitates relapse?

- Emotional distress
- Wish to enhance positive emotional states
- Temptations or urges to drink
- Social pressure

33

Helping people to recycle

- ✓ Acknowledge the feelings.
- ✓ Check: lapse or relapse?
- ✓ Identify high risk situations.
- ✓ Identify better coping strategies.
- ✓ Check need for specialist help.
- ✓ Check readiness to change.

34

Fifth session: Alcohol dependence

- Diagnostic criteria
- Treatment in PHC settings
  - ✓ Treatment Criteria
  - ✓ Detoxification and rehabilitation protocols
- Referral to specialized centres
- Shared treatment

35

ICD-10 diagnostic criteria for alcohol dependence

A definite diagnosis of dependence should usually be made only if three or more of the following have been present together at some time during the previous 12 months:

- A strong desire or sense of compulsion to take alcohol.
- Difficulty in controlling drinking in terms of its onset, termination or level of use.
- A physiological withdrawal state when drinking has ceased or been reduced (ie: tremor, sweating, rapid heart rate, anxiety, insomnia, or less commonly, seizures, disorientation or hallucinations) or drinking to relieve or avoid withdrawal symptoms.
- Evidence of tolerance, such that increased doses of alcohol are required in order to achieve effects originally produced by lower doses.
- Progressive neglect of alternative pleasures or interests because of drinking and increased amount of time necessary to obtain or take alcohol or to recover from its effects (salience of drinking).
- Persisting with alcohol use despite awareness of overtly harmful consequences, such as harm to the liver, depressive mood states consequent to periods of heavy drinking, or alcohol-related impairment of cognitive functioning.

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Treatment in PHC settings

- Risky drinkers
- Harmful drinkers
- Alcohol dependents if:
  - ✓ Patient accepts to abstain even if he/she thinks he/she is not dependent on alcohol
  - ✓ Patient refuses to be referred to a specialized centre
  - ✓ Patient has no severe psychiatric, social or medical complications

Source: Servei Català de la Salut (1996)

37

When to refer to specialized treatment

- Previous unsuccessful treatment attempts
- Severe complications:
  - ✓ Risk of withdrawal symptoms from moderate to severe.
  - ✓ Serious medical illness.
  - ✓ Family unable to provide support.
  - ✓ Psychiatric comorbidity.
  - ✓ Regular use of other addictive substances.
- Treatment cannot be managed by the PHC team.

38

Detoxification Criteria

- Previous DT or seizures
- Morning withdrawal signs
- Drinking first thing in the morning
- Patient willing to take medication
- Actual withdrawal signs
- Severe physical condition

39

Conditions needed for outpatient detoxification

- Daily alcohol consumption below 25 standard drinks/day.
- No severe medical or psychiatric complications
- Patients commitment to:
  - ✓ Alcohol abstinence during the detoxification.
  - ✓ Staying at home
  - ✓ Avoidance of risky activities.
- One relative without addictive problems must be responsible to control the medication and supervise the treatment.
- No availability of alcoholic beverages at home during the detoxification.
- Daily contact with GP or nurse (in person or by phone)

40

Contraindications for outpatient detoxification

- Confusion or hallucinations.
- History of previously complicated withdrawal.
- Epilepsy or history of fits.
- Poor nutritional state.
- Severe vomiting or diarrhoea.
- Risk of suicide.
- Severe dependence coupled with unwillingness to be seen daily.
- Failure of home-assisted withdrawal.
- Uncontrollable withdrawal symptoms.
- Acute physical or psychiatric illness.
- Polysubstance misuse.
- Home environment unsupportive of abstinence

Source: Scottish Intercollegiate Guidelines Network. The management of harmful drinking and alcohol dependence in primary care. A national clinical guideline. Draft 2.11, 2003.

41

Outpatient Detoxification tapering doses

	Diazepam, 5 mg cps.	
Dosage	Low	High
1	1-1-1	4-4-4
2	1-0-1	4-3-4
3	0-0-1	3-3-4
4	STOP	3-3-3
5		3-2-3
6		2-2-3
7		2-1-3
8		1-1-3
9		1-1-2
10		1-1-1
11		1-0-1
12		0-0-1
13		STOP

42

Rehabilitation treatment

- **Psychosocial approach**
  - ✓ Brief Advice and follow up
  - ✓ Group therapy
  - ✓ Familiar support
- ***Anticraving drugs***
  - ✓ Acamprosate 2 g/day
  - ✓ Naltrexone 50 mg/day
- **Antidypsotropic drugs**
  - ✓ Disulfiram 250 mg/day
  - ✓ Calcium carbimide 36-75mg/day

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Shared treatment criteria

- Stable abstinent patients in psychosocial treatment at the specialised Center
- Patient who wants to start treatment but refuses to go to the specialised Center
- Uncomplicated cases who can undergo home detoxification
- Patients with other chronic diseases which need to be monitored at the PHC Center

44

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