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WHO alcohol brief intervention training manual for primary care

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Abstract

Alcohol contributes significantly to the disease and mortality burden in the WHO European Region, and primary health care systems play an important role in reducing the impact of harmful alcohol use. Screening and brief interventions (SBIs) for alcohol are an evidence-informed approach to addressing the needs of the many patients presenting in primary care who may benefit from reducing their alcohol consumption. This manual provides information to plan training and support for primary care practitioners to confidently deliver SBI for alcohol problems to their patients. The manual outlines the background and evidence base for SBI, and gives practical advice on establishing an implementation programme as well as detailed educational materials to develop the knowledge and skills of participants in organized training sessions.

Keywords

Alcohol drinking – prevention and control
Alcoholism – rehabilitation
Manuals as topic

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Abbreviations

ABI	alcohol brief intervention
AUDIT	Alcohol Use Disorders Identification Test
AUDIT-C	Alcohol Use Disorders Identification Test – consumption
BA	brief advice
BLC	brief lifestyle counselling
BMI	brief motivational interviewing
CFIR	Consolidated Framework for Implementation Research
EBI	extended brief intervention
eSBI	electronic screening and brief intervention
HBCC	health behaviour change counselling
IBA	identification and brief advice
MI	motivational interviewing
OARS	open-ended questions, affirmations, reflections and summaries
SBI	screening and brief intervention
SBIRT	screening, brief intervention and referral to treatment

Foreword

The need to promote evidence-based interventions such as screening and brief interventions (SBIs) has never been greater; the European Region has the highest level of alcohol consumption among all WHO regions, and alcohol-related mortality has increased over the last 2 decades. Now is the time to ensure that all Member States have tools to address alcohol-related problems through their primary health care systems.

The European action plan to reduce the harmful use of alcohol 2012–2020 highlights the vital role of the primary health care system in reducing alcohol-related harm through the delivery of SBIs for alcohol. SBIs focus on identifying individuals who are drinking at levels that may have a negative impact on their health and delivering interventions to motivate and support them to reduce or stop drinking. Such interventions vary in length, content, deliverer and delivery style. These are not a substitute for, but a complement to, treatment services for alcohol dependence. Governments can support the success of SBI programmes by ensuring that primary care providers receive the necessary training, resources and structural support.

The manual has been developed to be used by Member States to expand and improve the training of health professionals on alcohol and SBI. Together with other supportive measures at the level of the health system, such training has the potential to reduce the gap between the number of people who would benefit from reducing their consumption, and the number who actually receive support or advice to do so.

The SBI model outlined in the training materials is based on international expert consensus, which was established during a series of discussions at the International Network for Brief Interventions on Alcohol and Other Drugs (INEBRIA). This training manual describes how to prepare for and set up training in SBI for health professionals in primary health care settings. Furthermore, the manual outlines in detail interactive activities and role plays that form part of the training, in order to develop providers' skills in addressing alcohol consumption with patients. The manual also includes a section on the evidence regarding the impacts of alcohol on individual health as well as the health care system and society at large. At a systemic level, the materials also include considerations for developing training for trainers.

Gauden Galea
Director, Division of Noncommunicable Diseases and Promoting Health through the Life-Course WHO Regional Office for Europe

How to use this manual

This manual has three main sections: introduction for trainers, training materials and post-training materials.

The introduction for trainers contains background information on what constitutes an alcohol brief intervention and evidence for efficacy, effectiveness and implementation, including information on how the routine delivery of such interventions can be used as an opportunity to build on current evidence. You can also find information to help you plan the implementation of an alcohol brief intervention and suggested outlines for the training for trainers and practitioners in such interventions using these materials.

The training materials are divided into eight units of activity (Table 1).

Table 1. Units of activity for training

Unit		Format	Time	Page number
1	Introduction, course overview and group agreement	Discussion	20 minutes	24
2	Attitudes to alcohol	Small group discussion	40 minutes	28
3	Alcohol impact, consumption and harms	Presentation and group quiz	40 minutes	36
4	ABIs: goals, skills and practice change	Discussion and small group work	40 minutes	46
5	Beginning a conversation about alcohol	Discussion and individual work	25 minutes	54
6	Screening and feedback using the Alcohol Use Disorders Identification Test (AUDIT)	Presentation and work in pairs	60 minutes	58
7	Brief intervention skills: evoking and planning	Presentation and work in pairs	45 minutes	69
8	Brief intervention practice session	Work in groups of three	75 minutes	78

The final section, post-training materials, includes pre- and post-training questionnaires for evaluation purposes, as well as a sheet to aid reflection by practitioners after the training course to manage their own learning in practice.

Introduction for trainers

What is an alcohol brief intervention?

> *"Brief interventions are those practices that aim to identify a real or potential alcohol problem and motivate an individual to do something about it." (1)*

Face-to-face alcohol brief interventions (ABIs) are heterogeneous interventions *(1–4)* that include "short conversations aiming in a non-confrontational way to motivate individuals to think about and/or plan a change in their drinking behaviour in order to reduce their consumption and/or their risk of harm" *(5)*. ABIs have historically included the use of a screening questionnaire to assess an individual's consumption level and risk of alcohol problems, and the provision of personalized feedback to those identified as being in need of support *(1)*.

Evidence supports the use of widespread screening for alcohol problems in primary care so as to identify people who may benefit from an intervention at the earliest opportunity. Some large-scale programmes (such as in Scotland, United Kingdom) have chosen to take a very broad targeted approach in primary care, in which practitioners were provided with a long list of potential presenting conditions and issues for which screening was recommended *(6)*. Although this approach potentially missed some patients, it was felt to make it easier for practitioners to feel comfortable raising the issue of alcohol and to take a patient-centred approach.

ABIs also include interventions delivered electronically, such as through mobile phone applications and websites. These interventions may be accessed independently by patients, accessed following a recommendation from a professional, used with guidance or together with advice from, for example, a primary care professional. There is evidence from several systematic reviews that electronically delivered interventions are also effective in reducing alcohol consumption by a small but significant amount. Digitally delivered screening and brief interventions may cost less to establish and implement per patient and have the potential to reach a wider population, but they might not be accessed by those less motivated to change. This training manual focuses on the delivery of face-to-face interventions *(7)*.

Brief interventions are known in research literature and practice by many different names and acronyms (Table 2). The most common terms in the international research literature are screening and brief intervention (SBI) and, in the United States of America, screening, brief intervention and referral to treatment (SBIRT). In the United Kingdom, identification and brief advice (IBA) is the most common term. There is little consensus about specific differences between the different terms, and the content or delivery of an intervention cannot necessarily be identified by the acronym by which it is described.

Table 2. Terms used for brief interventions

Abbreviation	Term
BI	brief intervention
SBI	screening and brief intervention
SBIRT	screening, brief intervention and referral to treatment
ABI	alcohol brief intervention
IBA	identification and brief advice
BMI	brief motivational interviewing
EBI	extended brief intervention
BA	brief advice
BLC	brief lifestyle counselling
HBCC	health behaviour change counselling
eSBI	electronic screening and brief intervention

The term brief intervention is, therefore, best seen as an umbrella term encompassing a wide range of interventions that fit within the broad definitions given above. Most types of brief intervention draw (or have drawn) to a greater or lesser extent on two key concepts: stages of change and motivational interviewing.

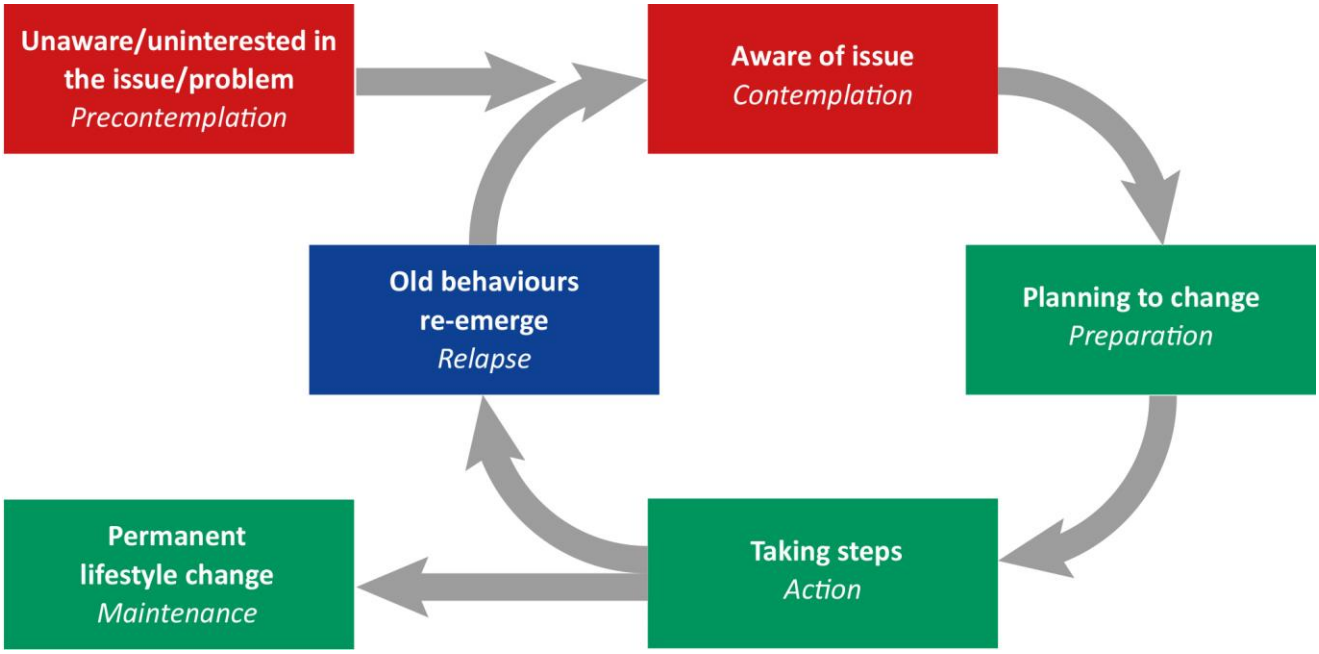
This manual uses the terms ABI, meaning an alcohol brief intervention which includes screening, and SBI, meaning screening and brief intervention.

Key concept 1. Stages of behaviour change

The stages of change or trans-theoretical model identifies five sequential and mutually exclusive stages associated with specific tasks that the individual must undertake to achieve intentional behaviour change (Fig. 1) *(8)*. The five stages are described as follows by Heather & Honekopp *(9)* in their discussion of the evidence on the stages of change model.

- In the *precontemplation stage*, the person is either unaware of a problem that needs to be addressed or aware of it but unwilling to change the problematic behaviour.
- This is followed by a *contemplation stage*, characterized by ambivalence regarding the problem behaviour and in which the advantages and disadvantages of the behaviour, and of changing it, are evaluated, leading in many cases to decision-making.
- In the *preparation stage*, a resolution to change is made, accompanied by a commitment to a plan of action.
- This plan is executed in the *action stage*, in which the individual engages in activities designed to bring change about and in coping with difficulties that arise.
- If successful action is sustained, the person moves to the *maintenance stage*, in which an effort is made to consolidate the changes that have been made.
- Once these changes have been integrated into the lifestyle, the individual exits from the stages of change. Relapse, however, is common, and it may take several journeys around the cycle of change, known as “recycling”, before change becomes permanent.

Fig. 1. The stages of change or trans-theoretical model of behaviour change



Source: based on Prochaska & DiClemente *(8)*.

While there have been several criticisms of the original and adapted versions of this model, notably the lack of evidence that designing interventions to match a specific stage of change is effective, the notion of differing stages of readiness to change is an intuitive and useful concept in practice. In particular, a strength of the model is that *behaviour change is viewed as a process rather than an event.* This is useful to practitioners thinking about helping different patients to set realistic goals. The model can also be used to make the case that it does not matter if someone is not interested in change at the time of the consultation, as that is a normal part of a cycle of change and does not mean that practitioners should not intervene.

Heather & Honekopp give the following explanation *(9)*.

> The idea of qualitatively different stages or phases is consistent with an ordinary language understanding of what happens when someone changes their behaviour over time. If someone is concerned, however inconsistently, about the harm his behaviour may be causing to himself, he is surely in a qualitatively different situation to someone who has no such concerns. Equally, someone who is taking action to eliminate or reduce that harm is surely in a qualitatively different place to someone who is worried about it but has not done anything to alleviate his concerns.

They further note that a main key strength of the model is the concept of contemplation, when an individual is ambivalent about change. This concept underpins an approach to individual behaviour change known as motivational interviewing, which is designed to reduce ambivalence and increase readiness to change. Motivational interviewing is also a key concept underpinning many brief interventions.

Key concept 2. Motivational interviewing

Put simply, motivational interviewing (MI) is a collaborative conversation style for strengthening a person's own motivation and commitment to change *(10)*. More technically, MI is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change in an atmosphere of acceptance and compassion *(10)*. Brief intervention and MI are not interchangeable terms. Some brief interventions involve the use of motivational interviewing delivered by fully trained counsellors, some draw heavily on the motivational interviewing style and others are only partly

influenced by some concepts and principles in MI.

Key concepts in MI that transfer over to brief interventions are an emphasis on patient autonomy and a patient-centred collaborative approach built on acceptance. The most recent version of MI developed by Miller & Rollnick *(10)*[1] builds on four processes:

- engaging (building a relationship, trust – listening throughout)
- focusing (jointly agreeing the focus for the conversation)
- evoking (listening actively to selectively increase ”change talk”)
- planning (jointly developing and agreeing a plan for change).

The model of brief intervention described in this manual draws on this latest version of MI, in particular in relation to the processes of evoking and planning. The focus is on engaging the patient throughout. While the topic of the conversation in this case is alcohol, the emphasis is on seeking permission from patients before discussing alcohol in any detail with them.

There is no minimum or sufficient “dose” of training to enable practitioners to reach a particular level of competence in MI, and most practitioners will require training, feedback on performance and coaching to become proficient. It is beyond the remit of these training materials to support such further coaching or to train practitioners to be competent in delivering MI. Those leading ABI initiatives are, however, encouraged to consider training as a process of building competence rather than a one-off event.

Although MI may be time-consuming to learn and use proficiently, some early outcome studies are encouraging in that they have found that reducing the frequency with which practitioners make unhelpful (confrontational or directive) responses to patients in a consultation may be at least as important to outcomes as learning to do MI well. A key focus for trainers delivering the materials in this manual is, therefore, to help practitioners to recognize when they are being directive or persuading or disagreeing with patients, rather than using active, empathic listening and using a guiding style.

Types of brief intervention

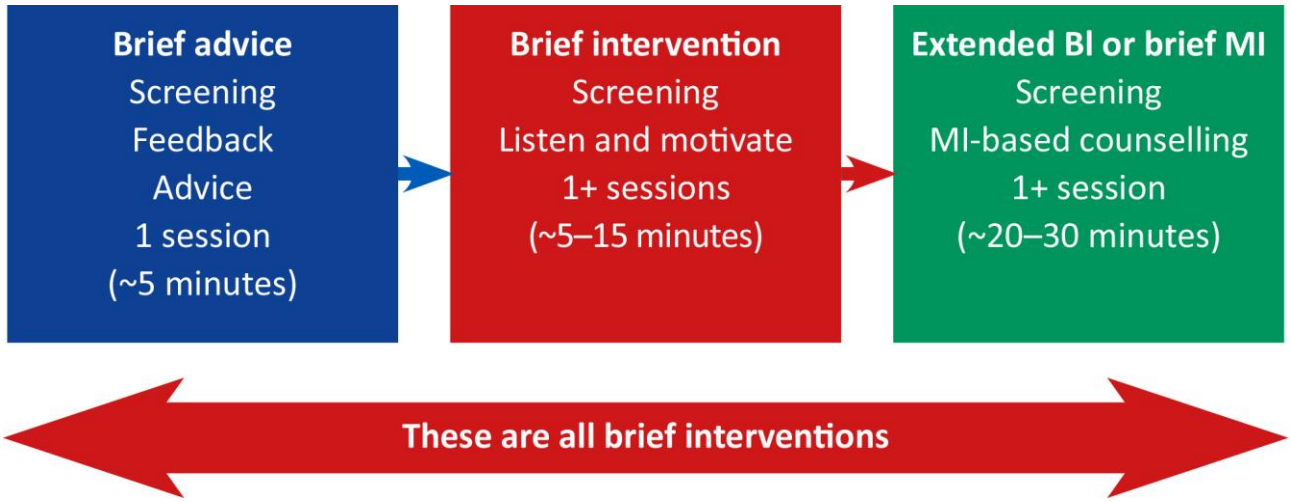
Brief interventions vary in several ways:

- length: from five minutes to several sessions of an hour or more
- tone: advice-giving versus guiding
- based (or not) on MI
- based (or not) on stages of change
- focused on different severities of alcohol problem (hazardous/harmful/dependent drinking).

While the length of brief interventions does not dictate the content or style, they are best viewed as a continuum (Fig. 2). Although they may be known under different names and acronyms, they are all brief interventions. The model of brief intervention taught in this training manual is described in full in Unit 4 and the accompanying handouts for that unit.

[1] The most recent (third) edition of *Motivational Interviewing* has been translated into several languages and is a recommended read for trainers delivering this course *(10)*.

Fig. 2. A continuum of brief interventions



Evidence for the efficacy and effectiveness of brief interventions

Several systematic reviews have found ABIs to have an effect on patients, primarily in reducing self-reported alcohol consumption *(11–13)*. A Cochrane Review from 2007, which is currently being updated, analysed the findings of 24 trials in primary care and five in accident and emergency settings. Having analysed all 29 trials together, the meta-analysis included over 7000 patients, mean age 43 years, average reported drinking 306 g (30 standard drinks) per week at entry, randomized to receive a brief intervention or to a control group *(11)*.

After one year, people who received the brief intervention reported drinking less alcohol than the control group by 38 g (four standard drinks) per week on average. The benefit was clearer for men than for women as only eight trials reported results by gender, of which only five included women. While brief single contact (one-off) interventions were found by the authors to be as effective as longer multisession interventions, only one trial of the 29 tested a five-minute intervention and the median duration was 25 minutes (neither figure includes the time for screening). The authors also concluded that there was no difference in the effect of the intervention in trials which were conducted in routine primary care practice (effectiveness studies), and those which were conducted under more ideal research conditions (efficacy studies) *(11)*. Subsequently there has been debate over the method used to classify studies in this way *(14)* and thus whether the evidence base for brief interventions can be applied to routine primary care practice *(15)*.

A more recent systematic review conducted by Jonas et al. for the US Preventive Services Taskforce included 23 trials in primary care *(13)*. It concluded that the best evidence was for brief (10–15 minute) multicontact interventions, such as two 15-minute sessions with a primary care doctor one month apart, each followed two weeks later by a five-minute telephone call with a nurse.

Jonas et al. found that single contact very brief interventions (up to five minutes) or brief interventions (up to 15 minutes) were less effective or ineffective *(13).*

In the Jonas et al. meta-analysis, which included 10 trials and 4332 patients, consumption in the intervention group decreased in comparison with control participants over 12 months by 50 g (five standard drinks), and 11–12% fewer adults in the intervention group reported drinking above limits or having heavy drinking episodes. There was insufficient evidence to judge the impact of the interventions on accidents, injuries or alcohol-related liver problems; although reporting was poor, there was little or no evidence of any harms arising from brief interventions *(13)*.

What works to get ABIs into routine practice?

Implementation can be defined as the process of putting to use or integrating evidence-based interventions in a setting *(16)*. Implementation science is a discipline in its own right and there are many models of the factors and activities that can influence whether or not an intervention is implemented *(16)*. One such model is the Consolidated Framework for Implementation Research (CFIR) which describes the factors influencing implementation in five categories or domains *(17)* which are helpful for considering the multiple levers which may be utilized to support the implementation of ABIs in any setting. These are:

- characteristics of the intervention (design of the ABI)
- outer setting (wider political, social, economic context)
- inner setting (structural, political and cultural contexts of the implementing organization)
- characteristics of individuals (targeted practitioners)
- process of implementation (actions and strategies to achieve implementation).

Each of these domains has multiple subdomains. Models such as the CFIR have seldom been applied to the implementation of ABIs. Williams et al. found, however, that an exceptionally high rate of screening in one ABI programme was associated with implementation strategies in the outer setting, inner setting and process of implementation domains of the CFIR *(18)*.

Nilsen et al. also reviewed implementation strategies for ABI utilized in published studies and identified four main strategies: written materials, telemarketing, training and support to practitioners. In general, implementation rates were found to have "increased with the intensity of the intervention effort, that is, the amount of training and/or support provided" *(19)*. In a qualitative review, Johnson et al. found that: "Adequate resources, training and identification of those at risk without stereotyping" were the main facilitators of implementation in primary care *(20)*.

A recent multicountry randomized-controlled trial of implementation strategies for ABI in primary care found that financial incentives in conjunction with training and support were effective in increasing reported screening rates in primary care, and were more effective than training and support alone, financial reimbursement alone, electronic SBIs, or treatment as usual *(21)*. Financial incentives were the most cost-effective of these implementation strategies *(22)*.

Unfortunately, it cannot always be assumed that increases in recorded screening or brief interventions following incentivization reflect a change in what happens with patients and what impact any such change may have on patient outcomes. Incentives may increase the incidence of screening or intervention, or may increase the likelihood that conversations that were happening anyway are recorded and reported for reimbursement *(23)*. Alternatively, such incentives, when coupled with training, may increase the formality of screening or quality of those conversations. However, without adequate knowledge about the components of brief interventions that are most likely to be effective, it is difficult to decide where exactly incentives should be directed *(23)*. While distortions such as misrepresentation and gaming are also recognized risks *(24)*, several recent studies in the United Kingdom have provided promising evidence that financial incentives may be effective in increasing actual screening rates in primary care *(25–28)*.

Finally, a qualitative study of a large national programme of ABI implementation in Scotland (United Kingdom) found that the leaders of the implementation process had not been trained in any implementation model or related science, leaving them to learn about effective implementation strategies the hard way through trial and error, when many issues could have been anticipated in advance *(29)*. These leaders identified five strategies that might be helpful for others planning the large-scale implementation of ABIs in any given setting. These were:

- setting a high-profile target for the number of ABIs delivered in a specific time period, with clarity about whose responsibility it was to implement the target;
- gaining support from senior staff from the outset;
- adapting the intervention, using a pragmatic and collaborative approach to fit current practice;
- establishing practical and robust recording, monitoring and reporting systems for delivery of the intervention prior to widespread implementation; and
- establishing close working relationships with frontline staff including flexible approaches to training and readily available support *(29)*.

Bridging the gap between evidence and practice

While legislative measures addressing the affordability, availability and marketing of alcohol may have a stronger evidence base, primary care professionals treat people every day who are suffering from conditions that may be caused or aggravated by alcohol consumption. There is ample evidence to suggest that opportunities to help are missed *(30–33)*, but much less to guide what form that help should take, and how best to incentivize or train practitioners to provide it *(4,33–36)*.

Further study, including analysis of recordings of consultations (obtained with permission), could enable basic assessments of quality to be carried out and contribute to a better understanding of the mechanisms through which such conversations may successfully support changes in patients' behaviour *(4,37)*. Further study of different types and models of training and support for practitioners is also needed to answer questions about the minimum levels of competence and skill required for ABIs to be effective *(36)*.

There are a number of key limitations to the evidence base for brief interventions in primary care, including the following.

- Results of trials may be biased towards null findings, that is, they are more likely to find no or a reduced effect of brief intervention because the behaviour of control participants could have been affected by alcohol misuse assessments *(13,38).*
- Results of trials may be biased towards positive findings, that is, they are more likely to find a positive effect from a brief intervention because participants receiving one may be more likely to report a reduction in alcohol consumption afterwards even if they have not changed their behaviour, if they know that that is what is expected of them *(15)*. This hypothesis is supported by the lack of evidence in relation to actual health outcomes, as noted by Jonas et al. *(13)*.
- Little is known about which specific components of brief interventions are effective in motivating behaviour change in patients *(4,35)*, or which components are effective for different patients with different levels of drinking problems in different scenarios. A review by Gaume et al. found that the following elements were promising: personalized feedback, change planning exercises, advice, presentation of alternative options for change, moderation strategies, patient change talk, perceptions of norms and discrepancy between current behaviour and life goals, but that there was no clear and consistent evidence *(4)*.

These gaps in knowledge show the strong need for those considering implementing a programme of ABIs at national or regional level to commit resources to research and to build links with researchers who can navigate the complexities of the current evidence base.

The International Network on Brief Interventions for Alcohol and Other Drugs[2] is a network of researchers, practitioners and policymakers interested in this field which can provide useful guidance on these issues. Similarly, the International Confederation of Alcohol Tobacco and Other Drug Research Associations[3] may also be able to facilitate links with researchers.

[2] The International Network on Brief Interventions for Alcohol & Other Drugs [website]. Barcelona: Government of Catalonia, Health Department (secretariat); 2017 (www.inebria.net, accessed 3 July 2017).

[3] International Confederation of ATOD Research Associations [website]. Storrs (CT): University of Connecticut; 2017 (www.icara.uconn.edu, accessed 3 July 2017).

Continued learning about the best ways to support practitioners and their patients in reducing the risks of alcohol-related harms is vital to ensure the optimal use of time and resources in the health service. Although several unanswered questions have already been identified, this should not mean that practitioners do nothing while research continues. Those responsible for implementing programmes of ABIs and related training and support should consider ways in which their implementation programmes can be designed to contribute to the evidence base.

McCambridge & Saitz identify the following priority areas for research to improve the management of alcohol problems in the health system *(15)*. These provide several useful starting points.

- What does the general public understand about unhealthy alcohol use, and what are the implications for receptivity to interventions?
- What do clinicians see more broadly as their roles in relation to unhealthy alcohol use and prevention, and how can strategic health system-wide prevention be better designed?
- What knowledge and skills do clinicians need to prevent and treat the consequences of heavy alcohol use?
- How can the prevention and management of unhealthy alcohol use be delivered in the contexts of comorbidities, multiple risk behaviours and conditions and health inequities?
- How much treatment of more severe alcohol use disorders should be delivered in general practice, and what are the roles of specialist services?
- How far can the effectiveness of alcohol interventions be enhanced in comparison with existing care for patients, and with what cost-effectiveness and cost savings?

Where ABIs are already being implemented, research could also focus on the quality of such interventions. Submission of audiorecordings of consultations (subject to patient consent) could be mandated as part of training or financial incentive programmes to assess quality, map content to outcomes and support the development of practitioners' skills *(39,40).* Where electronic patient records are in place, clear and robust systems of recording and monitoring the delivery of brief interventions and patient outcomes could be designed in collaboration with researchers to facilitate future studies.

As a minimum, the collection of data on patients' demographics, the number of AUDIT screenings conducted, AUDIT scores, the number of AUDIT positive results, the number of brief interventions provided and the number of referrals made to other services or other action taken as a result will provide the necessary data to monitor the level of need and delivery rates effectively. Follow-up data on patient consumption levels and any clinical tests would also aid evaluation.

Where possible, it is important to avoid rolling out the same programme of implementation and training in all areas at the same time rather than planning smaller comparable pilots which allow learning about the merits of different approaches. Many training for trainers programmes are successful in training enthusiastic individuals to become trainers, but fail to achieve the system-wide change that enables those trainers to access frontline practitioners or to ensure that frontline practitioners actually change their practice.

Planning for ABI implementation

Consider all of the aspects highlighted in the implementation research reviewed above. Working through an evidence-based framework such as the CFIR at the start of the programme will probably increase your chances of success. Unlike the CFIR, the issues raised in this short introduction do not represent a comprehensive list of issues to consider but reflect the experiences of the authors and contributors to this manual.

Champions

It is important to identify enthusiastic and committed senior individuals (champions) as early as possible in the implementation programme and to engage them in it. Such champions could be identified through existing interested organizations, government bodies or professional groups. They can use their contacts in local systems and primary care networks to identify who can facilitate the system-level changes that will be needed to support the routine delivery of ABI following training.

Senior clinicians in local services or in professional or governmental organizations with a remit to support and develop skills of frontline practitioners are ideal champions (and potential trainers). To recruit such people, significant work may need to be done to make the case for SBIs at national level and among the leadership of professional groups. This is worth making time for at the start of the programme. Otherwise there is a risk that: (i) trainers are trained to deliver the programme but have few or no practitioners to whom they can deliver it and lose confidence over time; or (ii) that practitioners are trained to deliver ABIs but fail to do so in practice because of a lack of systemic support.

Services

In Unit 6 of the training course you are asked to provide practitioners with a local or national protocol or care pathway for the management of dependence in primary care. This should indicate which treatments are recommended, which care services should be in place, what specialist support and/or mutual aid and recovery services is/are available, and how primary care staff can help patients to find the right support to help them recover from alcohol dependence.

System-level planning

Systematic planning is needed for the delivery of SBIs within a system (a single practice or a national primary care service), including consideration of the following aspects.

- The *policy* should make clear how the ABI programme fits with wider policy action on alcohol such as controls on price, availability or marketing or other local initiatives. This helps all involved to see the programme as part of broader partnership work, and can serve to increase engagement and commitment.
- *Aligning SBIs with other healthy lifestyle interventions*, such as smoking and obesity interventions, may help to build support. Similarly, consideration should be given to how the programme fits with and can contribute to progress on other government, local health or other priorities (such as the reduction of crime, transport safety and child protection).
- The *design* of the content, duration and target group for the ABI programme is important. It needs to take careful and detailed account of current practice and systems regarding alcohol and any complementary or competing initiatives, as well as current evidence.

- It is important to have clear *systems for delivery* in place, with an understanding of specific responsibilities and the pathways for delivery of SBIs and referral on to more structured treatment, where this is available.
- An honest assessment of the *cost and resource* implications (including time) of ABI implementation should be presented together with evidence of benefits. Consideration should be given to where additional resources can be sourced (if possible). The evidence on the cost–effectiveness of ABI presented in previous sections should provide a case for funding.
- Consideration needs to be given to how staff will be able to find the time to attend *training courses* and whether their service or time will be reimbursed centrally.

Planning training for trainers

Responsibility for delivering the training for trainers programme

Training for trainers is probably best delivered by a pair or team of experienced trainers with an in-depth understanding of alcohol and SBIs, the ability to support others in learning how to manage the range of methods covered in the training manual, and confidence in leading discussions about challenges. Ideally, representatives of local specialist services and senior practitioners and officials in local health governance would also support the training for trainers programme.

Individuals to be recruited to attend the training for trainers programme and deliver future practitioner training

This training manual is not a substitute for training experience or qualifications. It will work best where trainers have a prior knowledge of delivering effective training and interactive learning. It is important to recruit a committed cohort of individuals who have the skills, remit and resources to train and preferably provide support to their colleagues or other professionals in ABIs. The following groups of professionals could be considered as potential trainers:

- general practitioners: particularly those with:
  - a training role in the primary care system
  - an alcohol specialty or interest, and/or
  - a health promotion or behaviour change specialty or interest;
- nurse specialists: particularly those with:
  - a training role in their profession, and/or
  - an alcohol specialty or interest;
- public health specialists: particularly those with:
  - a healthy lifestyles or behaviour change specialty or interest
  - an alcohol specialty or interest, and/or
  - training leadership or responsibility in prevention or primary care;
- other interested senior health professionals, such as those with an alcohol-related remit, such as liver specialists, maxillofacial surgeons, trauma clinicians or mental health consultants;
- training leaders or professionals in the health system, particularly those with responsibility for organizing or delivering training to health professionals in the primary care setting.

The initial invitation to the cohort being recruited will need to outline the requirements and expectations that being part of the training programme will involve. These include:

- acting as champions in recruiting colleagues and frontline health professionals to participate in the ABI training programme;
- attending the training for trainers course and participating in reading the materials allocated in advance of the course, where these are provided;
- committing to delivering SBI training within their system;
- completing evaluations as required;
- supporting and assisting with further monitoring and evaluation.

Suggested programme for training for trainers

The following suggested programme for the training for trainers course lasts for two days.

DAY 1	
8:30–9:00	*Registration of participants*
9:00–9:30	Official welcome and introductions
9:30–9:45	Background to the ABI programme *Senior organizer/champion*
9:45–10:15	Introductions to participants, expectations and the training for trainers
10:15–11:15	Introduction to ABI: key concepts, evidence and implementation Review introduction to training manual *Whole group discussion*
11:15–11:45	*Coffee break*
11:45–12:45	Attitudes to alcohol – participant activity (40 minutes) Trainers' debrief (20 minutes) *Small group activity and whole group discussion*
12:45–13:45	*Lunch break*
13:45–14:40	Alcohol impact, consumption measures and harms (40 minutes) Trainers' debrief (15 minutes) *Small group activity and whole group discussion*
14:40–15:30	ABIs: goals, skills, practice change *Discussion and small group work*
15:30–15:50	*Coffee break*
15:50–16:20	Trainers' debrief of previous session *Whole group discussion*
16:20–16:50	Getting started: beginning a conversation about alcohol Trainers' debrief *Individual and whole group activity and discussion*
16:50–17:00	*Round-up, end of day 1*
DAY 2	
9:00–9:15	Recap, questions, issues arising
9:15–10:15	Screening and feedback using the AUDIT *Presentation and paired role play activity*
10:15–10:45	Screening and feedback trainers' debrief *Whole group discussion*
10:45–11:15	*Coffee break*
11:15–12:30	Brief intervention core skills *Whole group discussion and paired activities, followed by coffee break* Trainers' debrief (15 minutes) *Whole group discussion*

12:30–13:15	Core skills – supporting dependent patients *Senior clinician with expertise in treatment of dependent patients in a primary care setting* *Small group activity*
13:15–14:15	*Lunch break*
14:15–15:15	Brief interventions in practice: role-play *Role-play in groups of three*
15:15–15:35	*Coffee break*
15:35–16:00	Role-play – practitioner debrief *Whole group discussion*
16:00–16:30	Managing the final role-play: preparing, organizing, observing and providing constructive feedback. Provision of any additional handouts on generic training skills, if these are used *Whole group discussion*
16:30–17:00	Recap, round-up, evaluation

Planning training sessions for practitioners

It can be useful to build the training course into existing training or professional development programmes and to obtain accreditation or endorsement from relevant professional and health care organizations, institutions or educational establishments. The following elements should be considered.

- The *target group* for this training manual is primary care professionals, primarily doctors and nurses working in frontline general practice/universal health care services.
- The *size of group* for each training course will be about 15 practitioners, although with a skilled and experienced trainer, support from additional facilitators and some adaptation, it could be delivered to much larger groups. The extent to which trainees will be able to benefit from individual feedback on their performance as they learn to deliver ABIs will diminish as the size of the group increases. This could be mitigated by planning careful feedback on practice following the course and/or providing further coaching for practitioners.
- The training is interactive in nature so the *venue* needs to be sufficiently large to accommodate participants working in small discussion groups, as well as allowing room for them to spread out and work in twos and threes without being too close to another group. PowerPoint and flipchart facilities will be needed (for both the training for trainers and practitioner courses).
- Some aspects for *evaluation* to consider are outlined below and sample training evaluation forms are included in the Post-training materials section of this manual. How will you evaluate the success of the training? There are various ways to assess this, some of which are more effective than others. Process evaluation can be undertaken easily, although outcomes can be more difficult to assess. End-of-course feedback sheets can be useful for gathering initial thoughts but will not be able to capture the true impact of the training on SBI skills and delivery. It is important to carry out follow-up evaluations with trainers to evaluate training activity resulting from the train-the-trainer programme as well as to explore with frontline practitioners whether and how they are implementing ABIs (as well as making use of monitoring data, as outlined above).

The flowchart in Handout 4.1 outlines the key stages of an ABI as taught in this training manual. Table 3 explains how the stages in the flowchart (see Fig. 2) are informed by the different training activities in this manual.

Table 3. How this training course covers the stages of a brief intervention

Flowchart stage	Training activity	Non-stage specific
1. Engage and introduce the issue	Unit 3. Alcohol impact, consumption and harms Unit 5. Beginning a conversation about alcohol	Unit 2. Attitudes to alcohol Unit 4. Brief intervention goals, skills and practice change Unit 8. Brief intervention practice session
2. Screening and feedback	Unit 3. Alcohol impact, consumption and harms Unit 6. Screening and feedback using AUDIT	
3. Listen and respond	Unit 7. Brief intervention core skills	
3a. Evoking 3b. Planning	Unit 6. Screening and feedback using AUDIT Unit 7. Brief intervention core skills	
Exit/signpost at any time		

Aim and objectives of the training course for practitioners

Aim

The aim of the training course for practitioners is to build on practitioners' existing skills so that they can competently, confidently and appropriately raise and respond to alcohol issues with their patients through SBIs.

Objectives

After this course, participants will:

1. have considered their own and others' attitudes to alcohol and how they might impact on providing ABIs in practice;

2. be able to outline the ways in which alcohol causes harm to the physical and mental health of the individual drinker, and to people and society beyond the individual;

3. be able to outline national and/or international drinking guidelines and estimate the number of standard drinks in various drinks containing alcohol;

4. understand the basic principles of discussing behaviour change with individuals in a motivational way and the different elements of SBIs;

5. have reflected on the challenges and opportunities presented by alcohol SBIs for themselves, their practice and organization, and their patients;

6. be aware of the various ways in which they could raise alcohol as an issue with individuals who may benefit from a brief intervention or other support with an alcohol problem;

7. be able to explore levels and patterns of alcohol consumption with their patients accurately, in an objective and nonjudgemental way, and give appropriate feedback using the Alcohol Use Disorders Identification Test – Consumption (AUDIT C) and the full AUDIT screening tool;

8. be aware of possible responses, services and sources of support for individuals across the spectrum of alcohol problems;

9. understand the core skills of a brief motivational intervention: engaging, evoking change talk; eliciting options for and planning change; and

10. have had an opportunity to observe, practise and get feedback on the delivery of SBIs.

Suggested programme for practitioner training

DAY 1	
8:30–9:00	*Registration of participants*
9:00–9:30	Official welcome and introductions Background to the ABI programme *Senior organizer/champion*
9:30–9:50	Unit 1. Introduction, course overview and group agreement *Discussion*
9:50–10:30	Unit 2. Attitudes to alcohol *Small group discussion*
10:30–11:00	*Coffee break*
11:00–11:40	Unit 3. Alcohol impact, consumption measures and harms *Presentation and group quiz*
11:40–12:20	Unit 4. ABIs: goals, skills and change in practice *Discussion and small group work*
12:20–12:45	Unit 5. Beginning a conversation about alcohol *Discussion and individual work*
12:45–13:45	*Lunch break*
13:45–14:45	Unit 6. Screening and feedback using AUDIT *Presentation and paired work*
14:45–15.30	Unit 7. Brief intervention core skills *Presentation and paired work*
15:30–15:50	*Coffee break*
15:50–17:05	Unit 8. Brief intervention practice session *Work in groups of three*
17:05–17:30	Round-up, evaluation, end of course

Training materials

The training materials for the training for trainers/practitioners course are listed in Table 4.

Table 4. Training materials for the training for trainers/practitioners course

Unit		Format	Time
1	Introduction, course overview and group agreement	Discussion	20 minutes
2	Attitudes to alcohol	Small group discussion	40 minutes
3	Alcohol impact, consumption and harms	Presentation and group quiz	40 minutes
4	ABIs: goals, skills and practice change	Discussion and small group work	40 minutes
5	Beginning a conversation about alcohol	Discussion and individual work	25 minutes
6	Screening and feedback using AUDIT	Presentation and work in pairs	60 minutes
7	Brief intervention skills: evoking and planning	Presentation and work in pairs	45 minutes
8	Brief intervention practice session	Work in groups of three	75 minutes

Unit 1. Introduction, course overview and group agreement (20 minutes)

Learning outcomes

By the end of Unit 1, participants will:

- be familiar with the overall aim and structure of this training course
- have introduced themselves and communicated their expectations of the course
- have agreed some ground rules to ensure a positive experience of the course.

What you need

- Course programme (to be prepared by trainer in advance).
- *Handout 1.1. Course aim and objectives* (one copy for each participant).
- *Handout 1.2. Suggested group rules.*
- Slides 2–8 from the PowerPoint presentation; projection facilities.
- Flipchart paper, marker pens.

Preparation

- Prepare the programme for your course in line with the available time and priorities.
- Revise the background and rationale for this training course referring to the Introduction for Trainers section of this manual.
- Adjust *Handout 1.1. Course aim and objectives* to reflect the length and focus of your course.
- Familiarize yourself with slides 2–8 and *Handout 1.2. Group agreement suggestions.*
- Write "Expectations" as the title on a sheet of flipchart paper.

Process

1. Welcome everyone and introduce yourself as the trainer and give a brief outline of the background to the training using any notes you have prepared (slide 3).

2. Ask all participants to introduce themselves to the group (slide 4) by giving:

   - their names
   - job titles and roles, where they work
   - their expectations for the training course.

3. Write the expectations on the flipchart as each person raises them. When everyone has finished, explain that you will refer to the expectations on the wall throughout the course, where relevant, and in particular at the end of the course when time will be spent reviewing whether the course has met people's expectations or not. If anyone raises a topic that will not be covered, explain this and attempt to direct the individual concerned to an appropriate source of training that might address the issue.

4. Give out *Handout 1.1. Course aim and objectives* and talk through the aims and objectives (slide 5) and the definition of a brief intervention (slides 6 and 7).

5. Explain any housekeeping issues, including:

   - location of the toilets
   - fire procedures, fire exits and arrangements in the event of emergency
   - switching off mobile phones
   - arrangements for tea/coffee and lunch breaks
   - smoking rules
   - any other pertinent housekeeping information.

6. Give each participant a copy of *Handout 1.2. Group agreement suggestions.* Point out that these are fairly obvious norms to which professionals would adhere anyway in conducting themselves, but that it is helpful to be clear about them from the start in the unlikely event of any difficult issues arising (slide 8).

7. Ask participants briefly if there is anything that they would like to add to the list. If so, make a note of the addition(s). Ask whether people are happy to agree these rules for the course.

Handout 1.1. Course aim and objectives

Aim

The aim of the course is to build on practitioners' existing skills so that they can competently, confidently and appropriately raise and respond to alcohol issues with their patients through SBIs.

Objectives

After this course, participants will:

1. have considered their own and others' attitudes to alcohol and how they might impact on providing ABIs in practice;

2. be able to outline the ways in which alcohol causes harm to the physical and mental health of the individual drinker, and to people and society beyond the individual;

3. be able to estimate the number of standard drinks in various drinks containing alcohol and to outline the risks of different levels of consumption;

4. understand the basic principles of discussing changes to behaviour with individuals in a motivational way and the different elements of SBIs;

5. have reflected on the challenges and opportunities presented by SBIs for themselves, their practice and organization, and their patients;

6. be aware of a variety of ways they could raise alcohol as an issue with individuals who may benefit from a brief intervention or other support with an alcohol problem;

7. be able to explore levels and patterns of alcohol consumption with their patients accurately, in an objective and nonjudgemental way, and give appropriate feedback, using the AUDIT-C and full AUDIT screening tools;

8. be aware of possible responses, services and sources of support for individuals across the spectrum of alcohol problems;

9. understand the core skills of a brief motivational intervention: engaging, evoking change talk; eliciting options for and planning change; and

10. have had an opportunity to observe, practise and get feedback on the delivery of SBIs.

Handout 1.2. Group agreement suggestions

- √ *Respect each other, even when we disagree.* We need to recognize diversity and our differences. Discussing alcohol use and alcohol problems can sometimes be sensitive and raise strong feelings and emotions. It is important to acknowledge and accept these differences and each other's right to express views and feelings, even if we do not always agree with them.

- √ *There should be no "put-downs" (snubbing or humiliating people).* If we do not agree with a view or an opinion we all have a right to challenge that view. We also have to respect people's right to express that view or opinion, even though we may not agree with them. We should, therefore, challenge the view or behaviour and not the person. We are also responsible for considering and managing the effect of our views and behaviour on others and on their feelings.

- √ *Listen to what other people say without interrupting them.* Everyone should be afforded the same opportunity to participate and to be listened to. People should be given the opportunity to speak and express their views and opinions without interruption. This course has been designed to ensure that people can participate equally.

- √ *Be on time.* As trainers we commit ourselves to finishing the day on time, and we expect that participants will also return from breaks on time.

- √ *Participate actively and constructively.* The more we put into training, the more we will get out of it. The training course is designed to be interactive with lots of opportunities for active participation and for sharing information and knowledge and learning from each other. We commit ourselves to giving our best to each unit and practice session to maximize our own learning and to give active and constructive feedback to others when it is called for.

- √ *Ask questions as needed.* We come to training from different starting points. It is the responsibility of each participant to make sure they understand by asking when things are not clear or if they want additional information.

- √ *Respect confidentiality.* It is important that people feel comfortable expressing their views and opinions in the knowledge that whatever is said is not repeated outside the course. Participants are not expected to share any personal information that they do not feel comfortable about, whether about their own behaviour or that of family or colleagues. Anything that is shared should remain confidential, including information or opinions about organizations or patients.

- √ *Enjoy the course.* We learn best when we are relaxed and enjoying ourselves. It is up to all the participants to ensure that the session is enjoyable by getting involved with the activities, giving their opinion and providing feedback where they can.

Unit 2. Attitudes to alcohol (40 minutes)

Learning outcomes

By the end of Unit 2, participants will have considered their own and others' attitudes toward alcohol and how they might impact on providing ABIs in practice.

What you need

- *Handout 2.1. Attitudes to alcohol – worksheet* (one copy for each participant).
- *Handout 2.2. Attitudes to alcohol – notes* (one copy for each participant).
- Slides 9–11.

Preparation

Consider your own feelings about the statements and read over *Handout 2.2. Attitudes to alcohol – notes*. Be prepared to provide this information to participants along with any additional information you have.

Process

1. Split participants into groups of three to five people.

2. Explain the following (slide 10).

   - Each group will be provided with a list of attitude statements about alcohol – examples of things people might say about various drinking behaviours, policies and risks.
   - Each group should discuss each statement in turn and decide whether they agree or disagree with the statement. They may choose "not sure" if they cannot agree or can see arguments for and against.
   - There are no right or wrong answers. It is the discussion that is important.
   - Each group should be prepared to report back on their decisions, particularly about statements that were controversial.

3. Provide each participant with a copy of *Handout 2.1. Attitudes to alcohol – worksheet*. If you are using the worksheet, explain that the group should complete ONE worksheet only as a group, rather than working as individuals. Ask each group to begin discussing a different statement, for example, group 1 starts on #1, group 2 on #4, group 3 on #7.

4. If a group quickly comes to a decision, ask them to imagine why others might have a different opinion and why. Remind the groups that the discussion is the most important part of the unit, not being the first to finish!

5. Listen in discreetly to the discussions so that you can pick on issues/myths arising when debriefing. After about 10–15 minutes (or whatever time you have allocated), close the discussion and move to the debrief below. If the groups finish more quickly, close the unit sooner.

Debrief

- With the whole group of participants listening, ask each group in turn to choose one statement which provoked a good discussion and to outline the issues raised and the reasons for their decision. Prompt as follows.

- Ask why it was contentious.
- Refer to the points highlighted in *Handout 2.2. Attitudes to alcohol – notes*.
- Mention any interesting points that you may have overheard while you were circulating during the discussion.
- If groups easily came to a conclusion about a statement, ask whether they think that anyone might hold the opposite view and give examples if none are forthcoming.
- Ask the other groups what they think.

- Debrief as many statements as possible in the time available. Explain that everyone will receive a handout with notes for all statements.
- Highlight the language that has been used in the statements to describe ways of drinking alcohol, such as excessive drinking, drinking heavily, drinking too much or alcohol problems. Point out that many of these terms are subjective. Explain that the risks of drinking at different levels will be covered later in the course.
- Close Unit 2 by asking:
  - how the participants felt about this unit
  - whether they felt that attitudes are important
  - how they thought that attitudes might affect their work.
- Distribute *Handout 2.2. Attitudes to alcohol – notes* to each participant.

Key points (slide 11)

- Our attitudes to alcohol, alcohol risks and to different levels of consumption or different drinkers affect how and when we deliver brief interventions.
- Brief interventions can help individuals to make informed choices about their drinking but are not a substitute for population-based policies (price, availability, marketing).
- Empathy with patients who drink alcohol is a central tenet of successful brief intervention delivery.

Handout 2.1. Attitudes to alcohol – worksheet

Together as a group, discuss and consider whether you mostly agree or disagree with each statement, and make a group decision on each one. You can choose Not sure if there is no consensus or you can see many reasons for and against.

Statement	Agree	Not sure	Disagree
You have to die of something, so you should enjoy life and not worry too much about lifestyle advice.			
Health advice changes so often that there is no point in trying to follow it.			
It is easy to spot someone who drinks too much alcohol.			
Alcohol problems affect children and young people in ways that smoking does not.			
Drinking to excess is embedded in our culture and is here to stay.			
It is rude not to join in if you are offered an (alcoholic) drink in company with others.			
All the fuss about alcohol is missing the point – drugs cause more problems.			
Standard drink measurements are too complicated for the general public to understand.			
Alcohol relaxes you when you are stressed.			
Men and women drink differently, think about alcohol differently, and are judged differently for it.			
People who drink heavily are not going to change after a short conversation; they will need intensive specialist treatment.			
Advising someone to cut down drinking when it is their main pleasure in life is unfair.			

Handout 2.2. Attitudes to alcohol – notes

1. *You have to die of something so you should enjoy life and not worry too much about lifestyle advice.*
   - Everyone has different values about lifestyle, health and risk, but many people make these choices without full knowledge of the implications of choices. ABIs are about supporting people in thinking about how their drinking fits with their values and goals, in both the short and the longer term, and helping them to make the choices that they feel are right for them.
   - As pointed out by Dr Peter Tate, patients are people and they are all different so their choices may not be yours. Thus it is important that health professionals who themselves subscribe to this view do not assume that their patients agree *(41)*. While it is not helpful to stereotype individuals, it can be useful to reflect on certain extreme types of patient who, for example:
     - want to make their own decisions and believe they have the power to change their health (internal controllers);
     - want to be told what to do and can be fatalistic (external controllers);
     - believe you are in charge and do not want to be involved (powerful others).
   - Gattellari et al. found that whatever the stated preferences of patients prior to a consultation, satisfaction with the consultation and the amount of information and emotional support received was significantly greater in those who reported a shared role in decision-making about cancer care *(42)*.

2. *Health advice changes so often that there is no point in trying to follow it.*
   - Some countries set national drinking guidelines to help inform the public about the risks from alcohol, and to enable them to make more informed choices about whether to drink alcohol and how much to consume.
   - The exact point at which a national guideline is set depends how it was developed – if there was a scientific process involved and on a number of choices within that process: whether absolute or relative risk is considered, whether purported health benefits of alcohol are taken into account, and the extent to which acute or chronic harms are factored in. Those factors often explain why guidelines differ from country to country.
   - In most cases, health advice (such as drinking guidelines) is not generally just made up by governments or health bodies. Rather, as new research is published, the advice may change to reflect increased knowledge and understanding of the harmful effects associated with particular forms of behaviour. This has recently happened with alcohol guidelines in the United Kingdom as a clearer understanding of the links between drinking and cancer has emerged *(43)*. It would be wrong of governments not to update advice periodically to acknowledge new evidence.
   - One reason why people feel that health advice changes so often is that individual studies are often misrepresented in the media, possibly to make exciting headlines.
   - The risks associated with alcohol are significant and real, with many public health professionals putting them second only to smoking in the long term. The latest evidence suggests simply that the more alcohol consumed, the greater the risk of harm (this will be discussed further in Unit 3).

3. *It is easy to spot someone who drinks too much.*
   - "Too much" is a subjective judgement: what a doctor judges to be too much may be just right from a patient's perspective. Using judgmental language may induce defensiveness in patients rather than encouraging them to be open. Rather than describing a high drinking level as too much, it would be better to let patients know the risks associated with that level of consumption and ask them what they think.
   - Many people who drink at a level that is putting their future or current health at risk show no outward signs. In fact, regular drinking may be risky to long-term health without causing drunkenness or

hangovers. Practitioners should not make assumptions about the people for whom brief interventions may be relevant without speaking to them first.

- In addition, heavy episodic drinking (drinking heavily on a single occasion) is a risk factor for road traffic accidents, injuries, violence, fires, drowning and other violent episodes.
- Practitioners should not assume that certain groups (different genders, ethnic or religious minorities or age groups) are more or less likely to drink at a risky level. People's alcohol consumption cannot be judged based on their appearance, their background, their lifestyle or any other stereotype. There is some evidence that health professionals feel more reluctant to deliver ABIs to patients who are of a similar age and/or the same gender as them *(44),* which introduces an unhelpful bias into what should be a routine aspect of primary care.

4. *Alcohol problems affect children and young people in ways that smoking does not.*
   - Alcohol consumption causes death and disability relatively early in life. In the group aged 20–39 years, approximately 25% of the total deaths are attributable to alcohol *(45)*. In contrast, smoking tends to kill people when they are older.
   - Alcohol is associated with violence, accidents, assaults and suicide in a way that smoking is not.
   - Children living with parents or family members with alcohol problems may experience harm due to alcohol taking the form of emotional or physical neglect, material hardship and stigma. At the extreme, they may be exposed to interpersonal violence in the home *(46)*.

5. *Drinking to excess is embedded in our culture and is here to stay.*
   - Few countries in the world are populated by people with a single alcohol culture. It is important to recognize that drinking excessively is not normal among many people in each country, and that there are many religious and ethnic subcultures in which alcohol consumption may be moderate or actively discouraged.
   - Across the population of a country as a whole, alcohol consumption tends to follow a pattern in which there are some people who do not drink at all, many who drink at lower levels, and a smaller group who drink a large proportion of the alcohol consumed. WHO's *Global status report on alcohol and health 2014* provided figures for each country *(47)*.
   - Alcohol consumption is not static over time but changes enormously in times of conflict or recession and can be affected by government policy (in particular, price, availability and marketing controls can reduce consumption). The patterns and locations of drinking also change over time, as do preferences for different types of alcoholic drink. There are also cohort effects that change overall consumption levels in a country as heavy or light drinking generations age through the population and die off.
   - There is no doubt that alcohol plays a central role in the life of some communities and is central to the social life of many people. In many countries, consumption by women has increased due to a variety of factors. In others, home drinking has increased as wine drinking has become more popular. Drinking by young people is falling in many countries in the world.

6. *It is rude not to join in if you are offered an (alcoholic) drink in company with others.*
   - In some groups, cultures or settings, it might be viewed as rude not to join in and people can feel uncomfortable about declining a drink, particularly if they do not have what is perceived as an acceptable reason not to join in. It may be more acceptable for people to use excuses for not drinking such as the need to drive, illness or current medication rather than to say that they are cutting down on alcohol for whatever reason.
   - It is perhaps even more difficult for individuals simply to say that they do not want to drink any more because they feel that they have had enough after one or two drinks. Some people may also find it

uncomfortable to be sober in the company of drinkers. It is important to try to identify the different pressures that may make it difficult for individuals to cut down and to help them develop coping strategies that address particular high-risk situations. While peer pressure is seen as an issue for young people, too often adults also feel unable to make their own choices about drinking.

- People who wish to cut down, but not stop, drinking alcohol may appreciate strategies that will work without radical changes to their lifestyle. This may include changing the type or size of drink chosen as well as avoiding situations where they are likely to drink more than they wish to.

7. *All the fuss about alcohol is missing the point – illicit drugs still cause more problems.*
   - The use of some illicit drugs may carry a more immediate risk of overdose or infection for individual users. In many countries, however, the overall costs of alcohol problems to society far outweigh those of the problems resulting from illegal drugs, due to the number of people who drink alcohol. Alcohol consumption accounts for a greater burden of ill health and premature death than common conditions such as asthma and diabetes combined *(48)*.
   - Some people would argue that many of the problems (for example, relating to health and crime) associated with illegal drugs such as heroin arise directly from their legal status (which places manufacture and distribution in the hands of criminals) rather than from the drug itself – noting that heroin (diamorphine) can be safely prescribed for severe pain. The law on intoxicating substances is neither consistent nor necessarily logical, but it is unlikely to change drastically in the near future.
   - The media portrayal of drug use tends to focus on its more extreme newsworthy elements rather than the experience of the large number of people who have used illicit drugs with little harm.
   - There are interesting developments in relation to the legalization of medical and recreational marijuana/ cannabis, particularly in the United States of America. Many people are concerned that lessons learned from experiences with alcohol about the importance of controlling advertising, price and availability will not inform these changes *(49)*.

8. *Standard drinks are too complicated for the general public to understand.*
   - It is important that people can measure their drinking so that they can work out (approximately) when they will be sober, whether they are drinking over the sensible drinking limits and if so by how much. Although it is true that standard drink measurements can be difficult to grasp at first, they are the best way to standardize information about the actual alcohol content in a given drink.
   - Standard drinks may seem even less relevant to people who drink at home or from a large shared bottle of, for example, wine or spirits, but they can still be aware of the number of standard drinks in a whole bottle. In this case, particular care is needed to work out what volume of the drink is being poured, so that the number of standard drinks can be calculated.
   - People can be taught the standard drinks in their preferred drink, and interactive resources such as apps or measuring glasses can help people to understand standard drinks better. Some alcoholic drinks also have the number of standard drinks indicated on the label.

9. *Alcohol is a relaxing reward after a stressful day.*
   - In many countries, drinkers describe looking forward to a drink of wine or beer after a busy day at work, and in some cases that drink can have almost a mythical quality of stress release. Much of the effect of that first drink is about expectation and learned behaviour: it is a signal that the working day is over and that it is time to relax. In fact, people often describe feeling relaxed as soon as they have opened the bottle, never mind before drinking it and giving it time to affect their brain. In many respects this is a new phenomenon, partly driven by internationalism and partly by marketing as the wine market expands globally and the beer industry is increasingly owned by a very few giant multinational corporations. How did people in the past relax after work? What was their signal? Can

that be recaptured? Would a non-alcoholic drink such as tea or juice do the same job, if we could believe it would?

- Pharmacologically, alcohol is a depressant drug which can have a calming effect, and drinking may seem to provide short-term relief from stress. However, drinking alcohol does nothing to remove the source of stress, and some people find that getting drunk can appear to magnify their problems. If drinking is how people attempt to deal with stress, other coping strategies are not likely to be developed.
- Regular drinking to relieve stress can lead to additional problems. It can cause hangovers, disrupt sleep, affect relationships and sometimes lead to financial difficulties. All of these effects can make the feelings of stress, anxiety or depression even worse. The more often this happens, the greater the risk that an individual will come to rely on alcohol and develop dependence.
- Symptoms of depression, anxiety and insomnia can often be helped if people cut down on their alcohol consumption instead of using it as a self-medication.

10. *Men and women drink and think about alcohol differently, and are judged differently for it.*
    - There is persistent and strong evidence from multiple countries worldwide that men and women relate to, perceive and use alcohol differently *(50,51)*.
    - "Nearly everywhere that epidemiological or ethnographic research has been carried out, historically and cross-culturally, men have consumed more alcohol than women" *(52,* p. 153*)*.
    - Women are more likely to abstain. Men are more likely to drink heavily and develop alcohol problems *(51,53)*.
    - Women are more likely to suffer violence from their intimate partners. Men are more likely to engage in drink–driving *(54)*.
    - Men are more likely to experience short-term harm from assaults and violence.
    - In many cultures, there is a level of stigma associated with female drinking, particularly heavier drinking, which may not exist or may be lower for drinking by men. This sometimes translates into policy, where media campaigns and messages may blame the victim of a sexual assault for being drunk rather than the perpetrator for committing the assault.
    - Throughout history, women have been judged negatively for drinking alcohol. In some cases this has led to a kind of moral panic over drinking by women even though men are still more likely to drink and more likely to develop problems with alcohol.

11. *People who drink heavily are not going to change after a short conversation; they will need intensive specialist treatment.*
    - Brief interventions are about giving people an opportunity to learn and think about the potential risks of their drinking and to decide what they want to do. There is evidence from multiple trials and systematic reviews that ABIs in primary care result in a small average reduction in self-reported alcohol consumption for periods lasting up to a year *(12–14)*.
    - As well as people whose drinking is risky, screening will identify people with some features of alcohol dependence such as an inability to control drinking once they have started or drinking to relieve withdrawal after a period of heavy drinking. These features can vary in frequency and severity. Alcohol dependence is a continuum with shades of grey, not a black and white diagnosis. Studies of alcohol dependence show a range of outcomes from no change to partial remission to abstinence *(55)*.
    - While many people with dependence recover or improve with the assistance of specialist services, many make progress without intensive treatment *(56,57)*. Together with influences such as changing family circumstances and finding employment, expressions of concern and support from a primary

care practitioner can be important in helping people make changes.

- For some patients, the adoption of a chronic disease model whereby the practitioner expects to provide support over a long-term treatment process with periods of remission and relapse may be useful in cases of heavy drinking with features of dependence. While there is limited outcome research on this, any reduction in lifetime alcohol consumption will reduce the risks of alcohol-related harm. Many effective psychological and pharmacological treatments for alcohol dependence can be delivered in primary care *(58)*.
- Some patients will not make progress with only primary care support so it is important that specialist services are available and accessible.
- There will be times in primary care, when a "teachable moment" exists, where a person is presenting with issues and problems that may be alcohol-related *(59)*. This can be a turning point in the patient's life, even when there is a serious alcohol problem.
- There is some evidence from randomized controlled trials that simply going through a screening process for alcohol problems may result in some people reducing their drinking *(38,60)*.
- While individual interventions can be effective, it is important to remember that legislative measures such as price rises (through taxation or other controls), restrictions on the availability of alcohol (by, for example, minimum age, limited location or time of purchase) and other controls on marketing (such as banning sports sponsorship) are considered more effective at reducing alcohol consumption and harms at a population level *(54,61)*.

12. *Advising someone to cut down drinking when it is their only pleasure in life is unfair.*
    - All people are entitled to make informed choices. A brief intervention is not so much about advising someone to cut down but presenting that as an option and helping them to work out if they wish to choose to cut down. The practitioner might focus on helping the patient to identify the benefits, as they see them, of cutting down rather than giving advice.
    - Empowering people to develop alternative coping strategies and interests is important. It is particularly important to consider drinking among certain groups, such as those with mental health problems, where reliance on alcohol may be more common.
    - Alcohol can make symptoms worse, decrease the efficacy of medication and increase the chances of dying prematurely, particularly if it is allied to medication, smoking, poor diet, little exercise and increased vulnerability.
    - It may be, therefore, that alcohol is someone's only pleasure in life because drinking is preventing him or her enjoying or accessing other, richer, pleasures. Only the patient can make that judgement.

Unit 3. Impact, consumption and harms of alcohol (40 minutes)

Learning outcomes

By the end of Unit 3, participants will:

- be able to outline the ways in which alcohol causes harm to the physical and mental health of the individual drinker, and to people and society beyond the individual;
- be able to estimate the number of standard drinks in various drinks containing alcohol and to outline the risks of different levels of consumption.

What you need

- *Handout 3.1. Impact of alcohol* (one copy for each participant).
- *Handout 3.2. Standard drinks and drinking levels – quiz* (one copy for each participant).
- *Handout 3.3. Standard drinks and drinking levels –answers to quiz* (one copy for each participant).
- Slides 12–16.

Preparation

- Read through the handouts and slides until you feel comfortable enough to discuss them with your participants.

Process

1. Discuss the impact of alcohol making reference to *Handout 3.1. Impact of alcohol* and displaying slides 13 and 14. Ask participants to read through the handout and invite discussion.

    - What did participants find interesting?
    - Was anything surprising?
    - What are the implications of the harms described?

2. Give out *Handout 3.2. Standard drinks and drinking levels – quiz* and ask participants to complete one quiz per group, relying on their own knowledge rather than using aids such as smartphones or calculators (slide 15). (NB. Different countries use different measures and sizes of standard drinks. This manual uses the WHO measure, which is 10 g of pure alcohol.)

3. Explain that they have no more than 10–15 minutes to complete the quiz and that an answer sheet will be provided on completion.

4. Ask each group in turn for their answers to the quiz questions and explore understanding across the groups before explaining the correct answers using *Handout 3.3. Standard drinks and drinking levels – answers to quiz.*

5. Give all participants a copy of *Handout 3.3. Standard drinks and drinking levels – answers to quiz.*

Debrief (20 minutes)

- Obtain feedback from the quiz by focusing on the following questions.
  - Did anyone find any of the answers surprising?
  - Is everyone clear about how to calculate the number of standard drinks in an alcoholic drink using the formula provided?
  - What level of drinking should health professionals seek to address?
- Check for and address any final questions arising.

Key points (slide 16)

- Even relatively low levels of regular alcohol consumption increase the risk of a range of diseases, especially cancers. Higher levels of consumption, even on single occasions, raise the risks of injuries and accidents.
- For people whose drinking places them at risk, any reduction in alcohol consumption will lower that risk. Brief interventions can motivate people to cut down by giving them a more informed choice.
- While brief interventions have mainly been aimed at hazardous and harmful drinkers, the same motivational techniques can be used to support dependent drinkers to seek help.

Supporting notes for trainers

- Some may be surprised at the low levels of drinking that lead to increased risk of harm. They may feel it is unrealistic to expect risky drinkers to drink at a low risk level. Brief interventions aim to let patients decide that for themselves.
- It is inevitable that some practitioners will realize that their own drinking is risky. This may make them uncomfortable or defensive. That is all right, and that discomfort will be discussed in Unit 4.

Handout 3.1. Impact of alcohol[4]

Key facts

- Alcohol impacts on people and societies in many ways through ill health, violence, injuries, social harms and inequalities both to drinkers and those around them.
- Worldwide, 3.3 million deaths every year result from the harmful use of alcohol, representing 5.9% of all deaths.
- The harmful use of alcohol is a causal factor in more than 200 disease and injury conditions.
- Overall, 5.1% of the global burden of disease and injury is attributable to alcohol, as measured in disability-adjusted life years.
- Alcohol consumption causes death and disability relatively early in life. In the group aged 20–39 years, approximately 25% of the total deaths are attributable to alcohol.
- There is a causal relationship between the harmful use of alcohol and a range of mental and behavioural disorders, other noncommunicable conditions and injuries.
- Recently, causal relationships have been established between harmful drinking and the incidence of infectious diseases such as tuberculosis as well as the course of HIV/AIDS.
- Beyond health consequences, the harmful use of alcohol brings significant social and economic losses to individuals and society at large.

Alcohol is a psychoactive substance with dependence-producing properties that has been widely used in many cultures for centuries. The harmful use of alcohol causes a large disease, social and economic burden in societies.

The impact of alcohol consumption on chronic and acute health outcomes in populations is largely determined by two separate but related dimensions of drinking:

- the total volume of alcohol consumed, and
- the pattern of drinking.

The context of drinking plays an important role in the occurrence of alcohol-related harms, particularly those associated with the effects on health of alcohol intoxication and, on rare occasions, the quality of the alcohol consumed.

WHO European Region

Alcohol has a long history of consumption in Europe, with both positive and negative aspects.

- The WHO European Region has the highest per capita alcohol consumption among WHO regions.
- Consumption levels and historical trends vary widely across the countries in the Region.
- The alcoholic beverage industry and trade is economically active in Europe, including many key employers and brands or drinks with cultural symbolism and tourism value.

Ill health

Alcohol consumption is a causal factor in more than 200 disease and injury conditions. Drinking alcohol is associated with a risk of developing health problems such as mental and behavioural disorders, including

[4] The statistics in this handout are taken from the *Global status report on alcohol and health 2014 (47)*, unless otherwise stated.

alcohol dependence, major noncommunicable diseases such as liver cirrhosis, seven types of cancer and cardiovascular diseases as well as injuries. Specifically, there is a dose–response relationship between alcohol consumption and the risk of liver, breast, oesophageal, mouth, throat, colon and rectal cancers. Frequent drinking in younger adults is the biggest risk factor for early onset dementia.

While very small amounts of alcohol (one standard drink per day) may reduce the risks of death from ischaemic heart disease and stroke, the evidence is highly contested *(62)*. Even at this level people would be at higher risk of death from hypertension, haemorrhagic stroke and cardiac arrhythmias, as well as cancer and cirrhosis *(63)*.

Alcohol consumption can have an impact not only on the incidence of diseases, injuries and other health conditions, but also on the course of disorders and their outcomes in individuals.

Heavy drinkers are more likely to suffer from depression, and anxiety can be exacerbated by alcohol consumption *(64)*. The latest evidence suggests a link between harmful drinking and the incidence of infectious diseases such as tuberculosis as well as the progression of HIV/AIDS *(65–69)*.

Violence and injuries

A significant proportion of the burden of disease attributable to alcohol consumption arises from unintentional and intentional injuries, including those due to road traffic crashes, violence and suicides. Fatal alcohol-related injuries tend to occur in relatively younger age groups.

- Alcohol-related violent injuries represent a significant proportion of violence-related injury.
- Alcohol is recognized as a trigger and risk factor in cases of domestic and sexual violence.
- Alcohol is a major contributor to traffic accidents and related fatalities.
- Self-directed violence is facilitated and contributed to by problematic alcohol use.

Social harms

The harmful use of alcohol can also result in harm to other people, such as children, other family members, friends, co-workers and strangers. Moreover, the harmful use of alcohol results in a significant health, social and economic burden on society at large *(70,71)*.

- Problematic alcohol use can have a significant impact on families, leading to family break-ups and, in some cases, a long-lasting negative impact on children in families with an alcohol-dependent parent.
- Alcohol consumption decreases workplace productivity and constitutes a workplace health and safety issue. Heavier alcohol consumption is a risk factor for unemployment.
- Problematic alcohol use can create or add to financial hardship, both through the diversion of money into buying alcohol and through a lower income due to decreased productivity or unemployment *(70,71)*.

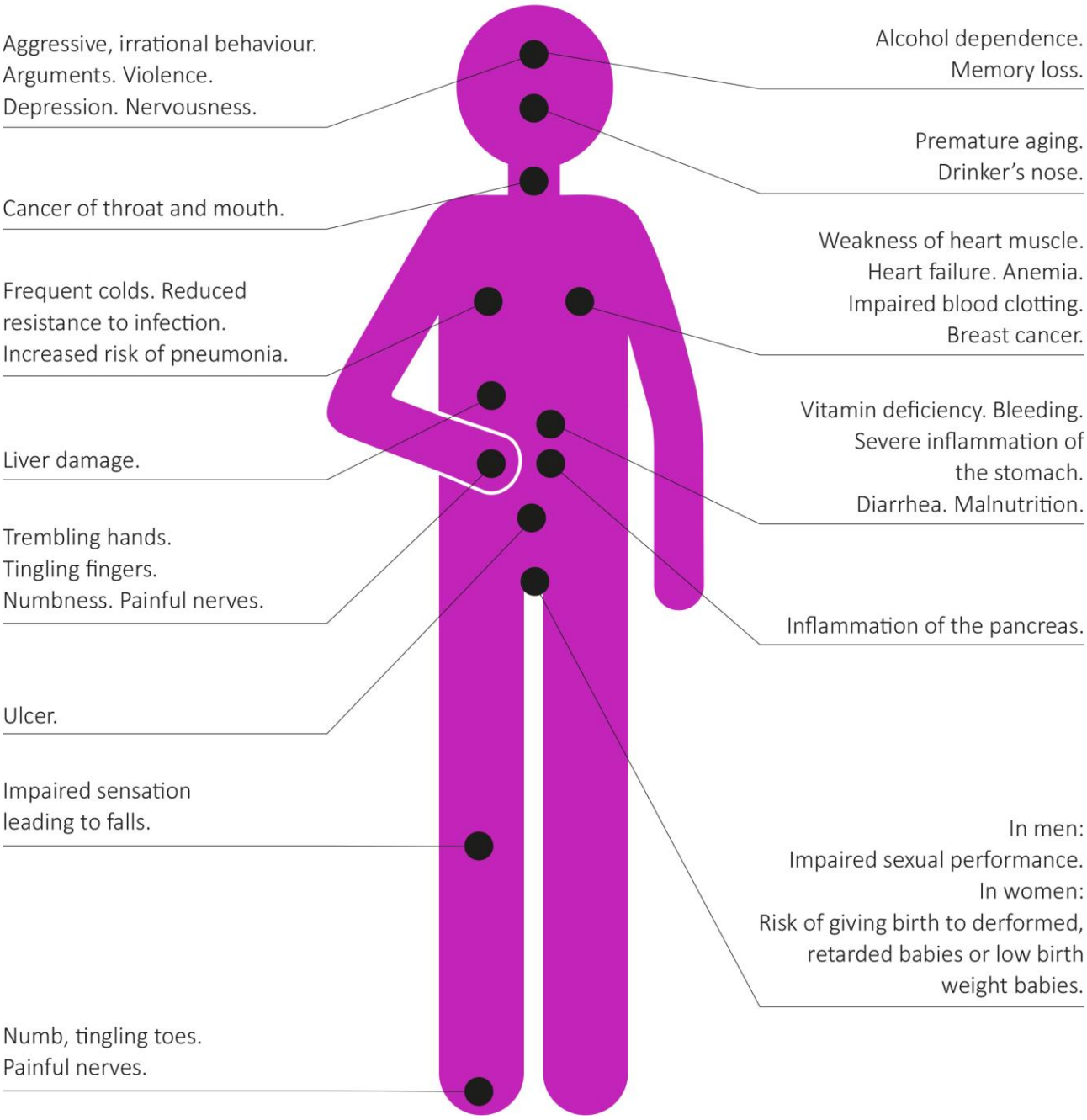
Gender

There are gender differences in alcohol-related mortality and morbidity as well as in the levels and patterns of alcohol consumption.

- There is persistent and strong evidence from multiple countries worldwide that men and women relate to, perceive and use alcohol differently *(50,51)*.

- In most countries of the world, and in different time periods, men have been found to consume more alcohol than women *(52,* p. 153).
- Women are more likely to abstain. Men are more likely to drink heavily and develop alcohol problems *(51,53)*.
- Total alcohol per capita consumption in 2010 among drinkers worldwide was on average 21.2 litres for males and 8.9 litres of pure alcohol for females.
- The percentage of alcohol-attributable deaths among men amounts to 7.6% of all global deaths compared to 4.0% of all deaths among women.
- Women are more likely to suffer violence from their intimate partners. Men are more likely to engage in drink–driving *(54)*.
- In some countries, the level of alcohol consumption by women has approached that of men, though significant differences remain in drinking choices, motivations and risks.
- Alcohol consumption by an expectant mother may cause fetal alcohol syndrome and preterm birth complications.

Fig. 3 Effects of high-risk drinking



Source: Babor et al *(72)*.

Handout 3.2. Standard drinks and drinking levels – quiz

(NB. Different countries use different measures and sizes of standard drinks. This manual uses the WHO measure, which is 10 g of pure alcohol.)

1. Match the following drinks with the correct number of standard drinks.

Quantity and kind of alcoholic drink	Standard drinks
A 500 ml glass or bottle of lager (4%)	1.1
A 50 ml glass of aperitif (17%)	1.6
A 175 ml glass of wine (14%)	1.6
A 250 ml glass of strong beer (8%)	7.2
A 70 cl bottle of vodka (40%)	2
A 750 ml bottle of wine (12%)	0.7
A 275 ml bottle of alcopop or other ready-to-drink alcoholic beverage (5%)	22.4

2. What effect does alcohol consumption have on the risk of dying from the following illnesses?

Complete the following table. The first one is completed for you as an illustration. The relative risk figures given in the example mean that men drinking 100 g of alcohol (10 standard drinks) per week are 1.5 times more likely to die of liver cirrhosis than men who do not drink alcohol. Women drinking 100 g of alcohol per week are 1.6 times more likely to die of liver cirrhosis than women who do not drink alcohol.

Drinking level	Disease	Gender	What is the relative risk of mortality? Insert your estimate here
100 g per week	Liver cirrhosis	Males	1.5
		Females	1.6
	Oesophageal cancer	Males	
		Females	
	Breast cancer	Females	
200 g per week	Liver cirrhosis	Males	
		Females	
	Cancer of the rectum/colon	Males	
		Females	
	Hypertension	Males	
		Females	
300 g per week	Liver cirrhosis	Males	
		Females	
	Epilepsy	Males	
		Females	
	Haemorrhagic/non-ischaemic stroke	Males	
		Females	

Handout 3.3. Standard drinks and drinking levels – answers to quiz

1. Match the following drinks with the correct number of standard drinks

Quantity and kind of alcoholic drink	Standard drinks
A 500 ml glass or bottle of lager (4%)	1.6
A 50 ml glass of aperitif (17%)	0.7
A 175 ml glass of wine (14%)	2
A 250 ml glass of strong beer (8%)	1.6
A 70 cl bottle of vodka (40%)	22.4
A 750 ml bottle of wine (12%)	7.2
A 275 ml bottle of alcopop or other ready-to-drink alcoholic beverage (5%)	1.1

You can work out the number of standard drinks in any given drink using the following formula:

Number of standard drinks = volume (ml) x alcohol by volume (%) x 8 /10 000

2. What effect does alcohol consumption have on the risk of dying from the following illnesses?

Complete the following table. The first one is completed for you as an illustration. The relative risk figures given in the example mean that men drinking 100 g of alcohol (10 standard drinks) per week are 1.5 times more likely to die of liver cirrhosis than men who do not drink alcohol. Women drinking 100 g of alcohol per week are 1.6 times more likely to die of liver cirrhosis than women who do not drink alcohol.

Drinking level	Disease	Gender	Relative risk of mortality: answers
100 g per week = 10 standard drinks	Liver cirrhosis	Males	1.5
		Females	1.6
	Oesophageal cancer	Males	1.65
		Females	1.65
	Breast cancer	Females	1.17
200 g per week = 20 standard drinks	Liver cirrhosis	Males	2.23
		Females	2.55
	Cancer of the rectum/colon	Males	1.2
		Females	1.2
	Hypertension	Males	1.3
		Females	1.3

Drinking level	Disease	Gender	Relative risk of mortality: answers
300 g per week = 30 standard drinks	Liver cirrhosis	Males	3.33
		Females	4.05
	Epilepsy	Males	1.7
		Females	1.7
	Haemorrhagic/non-ischaemic stroke	Males	1.35
		Females	1.67
	Mouth cancer (lip, oral cavity, pharynx)	Males	2.68
		Females	2.68

Drinking levels, harms and related terminology

Continuum of risk

The relative risk estimates above illustrate clearly that the risks of alcohol are dose-dependent and exist on a clear continuum. Many countries around the world use information about risk to set drinking guidelines for adults and sometimes other groups in the population to enable them to make informed choices about how much to drink. These guidelines vary, but it is clear that if someone is drinking above about one standard drink per day, any reduction in alcohol consumption will reduce most of the short- and long-term risks associated with alcohol. Conversely any increase in consumption will increase risk.

There are also many circumstances when no alcohol should be consumed: during pregnancy, when driving, by children (there is no agreed age at which small amounts are acceptable), while performing certain occupations or operating machinery, by people with certain medical conditions or medications, and before or during certain sports such as swimming or skiing.

Terminology

Different language and terms are used to describe levels and patterns of drinking. You should be aware of and consider the impact of using particular terminology when discussing alcohol and drinking patterns.

Hazardous drinking is a level of alcohol consumption or a pattern of drinking that increases the risk of harm if current drinking habits persist. In some circumstances, any consumption could be hazardous (see above). Evidence continues to emerge but it is clear that any consumption increases the risk of cancer, and that the risks of drinking are likely to outweigh any benefits (if they exist) at above one standard drink per day.

Harmful drinking is a pattern of drinking that causes damage to health (either physical or mental, although sometimes social consequences are included). In contrast to hazardous drinking, the implication of harmful drinking is that the drinkers will already have experienced harm of some kind, with or without their knowledge. There is no definite level of consumption at which health is certain to have been damaged.

Binge or heavy episodic drinking can be defined as drinking an excessive amount on any one occasion, leading to drunkenness or loss of control. Colloquially, the term is now used to describe heavy drinking in one day or evening. A drinking binge is a term used to describe a bout of heavy drinking, typically over several days, often with intervening periods of abstinence.

Alcohol dependence can be defined as 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 previously had greater value. Someone who is alcohol-dependent may persist in drinking, despite the harmful consequences. ABIs may not be sufficient for individuals who are dependent on alcohol, particularly if they are severely dependent. However, a brief intervention will not harm the individual and the overall approach can help to identify people that may benefit from other kinds of support and encourage them to consider it. (See also Unit 6.)

Alcohol problems/problem drinking. These terms may refer to a whole spectrum of harm (actual or potential) to work, relationships, social position and physical or mental health. The amounts of alcohol involved will vary from one individual to another and over time.

WHO has a helpful lexicon of terms used in relation to substance misuse, including alcohol *(73)*.

Unit 4. ABIs: goals, skills and practice change (40 minutes)

Learning outcomes

By the end of Unit 4, participants will:

- have been introduced to the basic principles of discussing behaviour change with individuals in a motivational way and the elements of an ABI;
- have reflected on the challenges and opportunities presented by alcohol SBIs for themselves, their practice and organization, and their patients.

Part A. Discussion (20 minutes)

What you need

- *Handout 4.1. What is an alcohol brief intervention?* (one copy for each participant). This should be provided as reading for participants prior to the course and discussed in this unit.
- Slides 18 and 19.

Preparation

- Familiarize yourself with *Handout 4.1*.

Process

1. Refer to *Handout 4.1.* Ask whether participants managed to read through the handout in preparation for today's training course.

2. Briefly talk through each of the key steps and approaches detailed in the flowchart and *Handout 4.1* (slides 18 and 19).

3. As you do so, note that each of these will be dealt with in turn in more detail later and that the course will end with a practice session involving delivery of the full process.

4. The flowchart is designed to act as a quick memory aid for putting brief interventions into practice.

Part B. Group activity (20 minutes)

What you need

- Flipchart stand, paper and markers
- Sticky-note pads and pens
- *Handout 4.2. Overcoming challenges* (one copy for each participant)
- Slides 20 and 21

Preparation

- Read Handout 4.2 and ensure that you are comfortable with explaining it to participants.
- Display PowerPoint slide 20 (or write): 'What challenges and opportunities might primary care practitioners perceive about delivering ABIs?'

- Prepare a sheet of flipchart paper as shown.

CHALLENGES	
Can I do this?	*Should I do this?*
How can I do this?	*What's the point?*
OPPORTUNITIES	
Benefits to patients	*Benefits to practice or organization*

Process

1. Split the participants into small groups and give each group a number of sticky note pads and some markers.

2. Display the question *'What challenges and opportunities might primary care practitioners perceive about delivering alcohol brief intervention?'* as prepared (slide 20). Prompt the group: challenges can be very broad; opportunities might include benefits for patients, benefits for practitioners' practice or ways it complements their existing work.

3. Ask the participants to answer the question, writing **one** issue on each sticky note.

4. Collect the answers as people write them down and place the sticky notes in one of the four quarters of the grid on the prepared flipchart paper as appropriate, or invite participants to come forward and place their own sticky notes.

5. Explain that the issues which have been highlighted are very similar to those that have been identified in research into practitioners' feelings about taking on this role.

6. Start the feedback when participants have exhausted ideas and all the notes have been placed.

Debrief

Use *Handout 4.2.Overcoming challenges*

- Display the flipchart page with the four quarters (now with all the sticky notes attached) so that all participants can see clearly and briefly explain each heading.
- Start with the *challenges*. Explain that you have sorted the challenges into two sections and explain

what they mean. Go through the sticky notes. Ask the participants to explain what they have written if it is unclear and discuss the issues that arise.

- Move onto the *opportunities*. Acknowledge that at this early point in training it is positive that people are already starting to identify so many opportunities for both their patients and services. Discuss some of the sticky notes.
- Acknowledge participants' *concerns*, bearing in mind that training cannot resolve all of the issues.
- Participating health professionals may wish to take back some of their concerns to senior colleagues or local or national health officials. It may be necessary to access further information or develop protocols in relation to certain issues that have been highlighted. For example:
  - confidentiality and information-sharing protocols;
  - referral arrangements;
  - contact time;
  - appropriate support and supervision/opportunities for reflective practice;
  - scoping to explore if and how current assessment processes could be changed to support the identification of patients who may benefit from brief intervention delivery – this may entail the use of different screening tools or questions by different teams and the replacement of current tools;
  - consideration of how a minimum level of recording and monitoring can be built into participants' current procedures, using existing electronic systems (where available).
- Ensure that the most common concerns have been discussed and that the participants know where particular concerns will be covered in the remainder of the course.
- The information provided in *Handout 4.2. Overcoming challenges* about managing dependence in primary care repeats that provided earlier in *Handout 2.2. Attitudes to Alcohol* as regards attitude statement 11. If you did not discuss it fully at that stage, you should take the opportunity to return to it here and address it fully as a common concern for primary care practitioners. The response to patients who are drinking more heavily who may have alcohol dependence is also discussed in Unit 6. Screening and Feedback.
- Return briefly to the *opportunities*. Emphasize that as well as the challenges discussed, there are clearly benefits not only for patients but also for health professionals and services. The rest of the training course will be concerned with equipping people with the necessary knowledge, skills and confidence to be able to deliver an ABI and to support individuals in realizing some of the benefits highlighted.
- Remind participants that just as patients can make an informed choice about changing their levels of alcohol use, health professionals need to consider the potential value of discussing alcohol with individual patients and decide whether or not to incorporate this into their practice. Encourage reflection on this over the rest of the day.
- Finish by handing out a copy of *Handout 4.2. Overcoming challenges* to all of the participants.

Key points (slide 21)

- It is normal for health professionals to have some concerns about discussing alcohol with patients, although their concerns are often unfounded.
- Experience suggests that patients are more receptive to discussing these issues than professionals imagine they are.
- It is normal to feel awkward when learning a new skill, but with good training and a willingness to have a go, professionals can quickly become confident about raising and discussing the subject of alcohol if they choose to do so.

Handout 4.1. What is an alcohol brief intervention?

Definition

Brief interventions are short, empathetic and structured conversations with patients that seek in a non-confrontational way to motivate and support them to think about and/or plan a change in their drinking behaviour.

Underpinning style and principles

Critically, brief interventions are based on an empathetic, respectful, positive relationship with the patient and they are non-confrontational. The idea is to work with the person's own ideas, concerns and motivations, not to shock or confront them or assume you know best. Practitioners should be aiming for conversations that mimic "dancing, not wrestling". The goal is to collaborate and work with people (dance) and not to try to persuade them to make a change or to do something that they do not want to do (wrestle).

A central aspect is the use of active listening skills, including **o**pen-ended questions, **a**ffirmations, **r**eflections and **s**ummaries (OARS). These skills are used to create a supportive and friendly atmosphere in which individuals feel comfortable enough to explore and discuss their drinking.

- Open-ended questions are questions that invite people to think before they answer and to provide descriptive rather than yes/no answers, thus allowing them to talk about issues from their own point of view.
- Affirmations are statements of appreciation and understanding that provide positive reinforcement and are particularly helpful for people with low self-esteem.
- Reflections are statements that attempt to guess at the meaning of what has just been said by the patient and that allow the practitioner to check his or her understanding and invite the patient to expand further.
- Summaries are attempts to combine key points of what patients have said, to pull together the whole picture to show that the practitioner has been listening and to help them both to clarify their thoughts.

Brief interventions encourage individuals to take *personal responsibility* for their decisions. It is essential that practitioners do not try to push people in a particular direction, as this is likely to meet with resistance. Practitioners should adopt a guiding rather than directive stance and emphasize patients' freedom to make their own choices, challenge patients' statements that imply that they have no choice, and encourage individuals to think about what they want for themselves.

Goals: the intended outcomes of an ABI

The outcome of an alcohol brief intervention could be:

- the patient thinks about changing his/her drinking behaviour;
- the patient plans to change his/her drinking behaviour;
- the patient successfully reduces or stops his/her drinking, and therefore risk of illness, accidents and other harms to him/herself and others.

The goal for a brief intervention with an individual with more severe problems may be for him/her to think about or plan change or to access further support to address his/her drinking behaviour.

For some people, getting them to think about what they are doing could be a success – they may not be

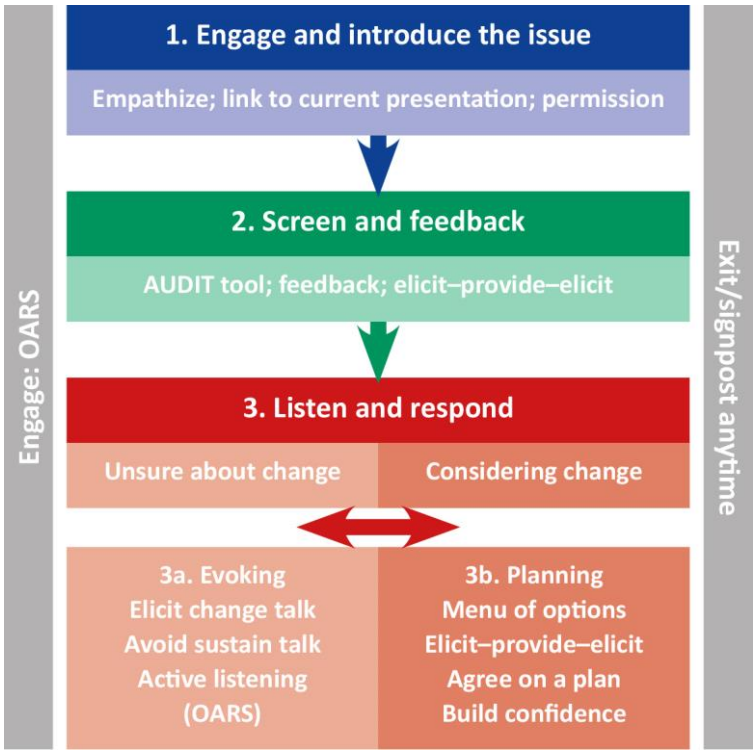
interested in planning a change yet. Others may be willing to make plans, or may already be trying. Crucially, practitioners cannot actually control what patients do, but they can try to ensure that they leave the brief conversation with something to think about or something to do!

Stages of a brief intervention in primary care

A brief intervention for alcohol use may comprise one or more face-to-face consultations or electronic interventions with the aim of assisting an individual to reduce or abstain from drinking alcohol. If available and necessary, a brief intervention may be delivered over several sessions (for example, 5–30 minutes) to help the individual to develop the skills and resources to change, or followed up to assess if further treatment is required.

Throughout the SBI, practitioners should engage patients by following an empathetic, person-centred and strengths-based approach, in which individuals find their own strength and motivation to take responsibility to change their drinking behaviour. "Eliciting" is the skilled use of active listening to draw out from someone what they know, think, feel or value. It is used repeatedly in brief interventions.

Fig. 4. Stages of a brief intervention in primary care



Delivering brief interventions on alcohol

1. To get started, the practitioner will *introduce the issue* of alcohol use in the context of the individual's health or well-being, including the reason that brought him/her to the current visit, while seeking to *engage* the patient from the beginning.

2. With permission, a self-report *screening* tool or question is used to explore the patient's current drinking, in order to identify people who might benefit from a brief intervention, those who do not need one, and those who might benefit from a more intensive intervention.

   Following screening, the practitioner: provides *feedback* on the screening result; *elicits* the patient's views; provides *information* on what it means for the individual (in particular relating to the presenting

issue); and *elicits* the patient's reaction to his/her alcohol use and the information provided. Open questions, including about the patient's values and goals, are helpful at this stage.

3. The practitioner listens actively and empathetically, without judgement, and considers the patient's readiness to reduce his/her alcohol consumption. The approaches taken next may vary depending on how receptive the patient is to change.

    a. Where the patient is *unsure about changing* his/her drinking the practitioner uses open questions and reflections to *evoke* "change talk" (the patient's reasons to change or benefits of change) and actively avoids persuasion, advice without permission, argument or unhelpful questions that generate "sustain talk" (the patient's reasons not to change or barriers to change).

    OR

    b. Where patients are *willing to consider or want to change*, the practitioner uses the *planning* approach to *elicit* from the patient, or provides with the permission of the patient, a menu of alternative self-help or treatment options and listens actively to *elicit* the patient's preferences, support the patient to set goals, agree a plan and make a commitment to change. The practitioner builds the patient's confidence to successfully *change* his/her behaviour and navigate any difficult situations.

At any time, the practitioner closes the consultation by summarizing the discussion and any plans made and ensuring that the patient understands what will happen next.

Brief interventions may be supported by written or electronic resources, and by the use of specific scaling techniques such as the "importance ruler", which will be discussed later.

There is good evidence from studies of motivational interviewing that the likelihood of a patient changing behaviour is predicted by the ratio of change talk to sustain talk in the conversation. This is discussed further in Unit 7.

More change talk and less sustain talk = increased chance of change

Handout 4.2. Overcoming challenges

Practitioners may have concerns about or face barriers to the delivery of ABIs. Research suggests that these barriers and concerns fall into four main categories, as follows (adapted from *74,75*).

Can I do this? (Role adequacy)

"I don't know enough about alcohol"

You do not need to be an expert on alcohol to deliver an ABI. In fact, successful delivery of an ABI depends upon a collaborative approach with your patient and is, therefore, at odds with the idea of the practitioner as an expert. Individuals are best placed to know their own lives and concerns and to decide what is best for them.

A good training course should provide you with all of the knowledge and skills that you need to enable you to deliver an ABI effectively. This training course will build your confidence by developing your knowledge and skills first in each of the different approaches of a brief intervention, and then by putting it all together (a skills-based unit designed to allow you to practise all the different approaches of a brief intervention together).

How can I do this? (Role support)

"I don't have the time to talk to everyone about their drinking – the time I spend with individuals is limited"

You may feel that you do not have sufficient support professionally or practically to enable you to deliver brief interventions. The commonest concern relates to time, but you may also be worried that advice and assistance may not be available when necessary.

- A brief intervention can take as little *time* as two to three minutes or up to 10–15 minutes. Even raising the issue, exploring consumption, assessing risk and giving personalized feedback on the risks of drinking could be enough to motivate people to take action to find out more, change their behaviour or come back later for further discussion and/or advice, and is therefore worthwhile.
- It is important to find out about local services to which you can direct and refer individuals for further *help*, and to engage with management to support your practice.
- It is wise to consider the limits to *confidentiality* in your work setting. What laws, policies or procedures apply to disclosures that might occur?
- Keeping patients *healthy* may reduce your workload in the longer term.

What's the point? (Motivation)

"Problem drinkers are never going to change. Nothing I try will make a difference."

The evidence indicates that ABIs work for enough people to make their delivery cost- and time-effective.

- Unlike smoking or other unhealthy habits, many people drink at a level which they have no idea is an increasing or higher risk. With adequate information, research indicates that some individuals do want to make changes. Others, perhaps a larger group, may initially be unmotivated or lack confidence to make changes, but techniques such as ABIs can help to build their motivation and confidence to change. Finally, some groups do want to cut down but are unsure where to start and how to set about making changes to their drinking. Again, ABIs include strategies and techniques to help these people.

- Of course, ABIs do not work for everyone, but they appear to compare favourably with other interventions where many more people have to be treated for one to benefit. You may not see that patient again or find out whether he/she has benefited, but you should not let this deter you from giving patients the opportunity to make more informed choices for themselves about their drinking.

Should I do this? (Role legitimacy)

"I'm worried that my patients will be offended"

The evidence suggests that people are *not offended* by professionals asking them about their drinking habits. When asking someone about their drinking, you are not suggesting that they are dependent or an "alcoholic", but just checking to see whether a reduction in alcohol consumption would lower their risk of health and social problems or injuries. It all depends on how the issue is raised. Later in this course we shall look at the wording which you could comfortably use to raise the issue without causing any offence.

"Dealing with problem drinkers is a specialist role"

Very few people who are drinking more than the recommended limits are or ever will be in contact with specialist alcohol services. As alcohol has such wide-ranging effects on so many different aspects of life, tackling alcohol-related harm is *everybody's business*, across all health and social care fields. Remember that you do not need to be an expert on alcohol and /or brief interventions to be able to help your patients.

- As well as people whose drinking is risky, screening will identify people with some features of alcohol dependence such as an inability to control their drinking once they have started, or drinking to relieve withdrawal after a period of heavy drinking. These features can be of variable frequency and severity. Alcohol dependence is a continuum with shades of grey, not a black and white diagnosis. Studies of alcohol dependence show a range of outcomes from no change to partial remission to abstinence *(55)*.
- While many people with dependence recover or improve with the assistance of specialist services, many make progress without intensive treatment *(56,57)*. Together with influences such as changing family circumstances and finding employment, expressions of concern and support from a primary care practitioner can be important in helping people make changes.
- While there is limited outcome research on this, for some patients the adoption of a chronic disease model, where the practitioner expects to provide support over a long-term treatment process with periods of remission and relapse, may be useful in heavy drinking with features of dependence. Any reduction in lifetime alcohol consumption will reduce the risks of alcohol-related harm. Many effective psychological and pharmacological treatments for alcohol dependence can be delivered in primary care *(58)*.
- Some patients will not make progress with primary care support and it is important that specialist services are available and accessible.
- There will be times in primary care, when a "teachable moment" exists, where a person is presenting with issues and problems that may be alcohol-related *(59)*. This can be a turning point in the patient's life, even where there is a serious alcohol problem.

"I drink a fair bit myself, and I do not want to be a hypocrite"

Like any other group in society, practitioners may also drink at hazardous levels, but at least they can make an informed choice.

- It is not necessary, for example, to be the healthiest of eaters to be able to give advice and/or information on healthy eating to individuals. The purpose of an ABI is to enable people to make an informed choice about what is right for them, and your own drinking habits should not affect what you do for them as a practitioner.
- It is essential to realize that the purpose of raising the issue of alcohol in an ABI is to give individuals an opportunity to discuss their drinking, if they are willing to do so. Practitioners should not try to discuss alcohol if patients do not agree.

Unit 5. Beginning a conversation about alcohol (25 minutes)

Learning outcomes

By the end of Unit 5, participants will be aware of a variety of ways they could raise alcohol as an issue with individuals who may benefit from a brief intervention.

What you need

- *Handout 5.1. Beginning the conversation* (one copy for each participant).
- Slides 22–26.

Preparation

- Familiarize yourself with *Handout 5.1. Beginning the conversation.*

Process

1. Introduce Unit 5 by explaining that before practitioners can start to support people in relation to changing their alcohol use, they firstly need to raise the issue of alcohol and engage them in a conversation about their drinking without making them defensive.

2. Brainstorm**:** ask participants when the issue of alcohol could come up with patients in their practice. Draw out the answers and highlight those that are examples of opportunistic, patient-led and planned ways that alcohol might arise as an issue (slide 23).

3. Explain the three broad ways in which alcohol can arise as an issue (slide 24).

   - *Opportunistic (practitioner-led)* is when an opportunity arises to discuss alcohol in response to an issue, symptom or event. An issue or problem that could relate to alcohol use, or be affected by alcohol, may provide an opportunity to start a discussion about alcohol in a way that is relevant to the patient's concerns.
   - *Patient-led* is when a patient brings up the topic of alcohol or is looking for information on alcohol. This provides an automatic way in.
   - *Planned (practitioner-led)* is when a practitioner systematically raises the topic of alcohol with all patients, or all patients in a specific group, as part of a routine assessment or initiative.

4. Ask each participant to think of one of these situations and to write down one example of the *exact words* they could comfortably use to raise the topic of alcohol with a patient (slide 25).

Debrief

- If there is time, ask for some examples of the situation chosen and the wording the participant has written down. Ensure that a verbatim example (that is, the exact words, not a description) is given in each case.
- Use the examples given in *Handout 5.1. Beginning the conversation* to discuss whether the wording suggested would be in keeping with the principles discussed: empathetic, nonjudgemental and patient-centred. Invite participants to improve their suggestions, if they can.

- Give out copies of *Handout 5.1. Beginning the conversation*. Ask participants to read through and closely examine the language and phrases suggested. Discuss if the participants notice anything that the phrases have in common, or ways in which they demonstrate the brief intervention techniques discussed earlier, for example:

  - generic (not personalized) non-threatening/nonjudgemental statements such as "We find that many people ...";
  - making the link between alcohol and the patient's presenting issue;
  - *demonstrating* empathy;
  - *open questions* – exploring;
  - *reflections* demonstrating active listening;
  - *emphasizing personal responsibility;*
  - asking *permission;*
  - highlighting that the phrases often share a similar structure (see *Handout 4.1,* Fig. 4. Stages of a brief intervention in primary care (empathize, link to current presentation, permission)), but note that practitioners can follow this structure using their own words; while there is a rhythm and pattern to the suggested phrases, practitioners must make them their own.

- Ask participants whether they would feel comfortable using these or similar phrases?

  - Highlight the importance of tone of voice. When a professional feels uncomfortable with a topic, this can make a patient feel uncomfortable; for example, if the voice and approach sounds judgemental "So you get drunk a lot do you?" or a tone is used that is overly sensitive and quiet, as though the question being asked is very serious and in some way shameful.
  - Experience/evidence suggests that a matter of fact tone is best.

Key points (slide 26)

- It is valuable for practitioners to become comfortable with a repertoire of phrases they can use to begin a conversation about alcohol.
- A matter of fact tone can help practitioners to make patients feel more comfortable when the issue of alcohol is raised.

Handout 5.1. Beginning the conversation

Opportunistic (practitioner-led) Chance opportunities to discuss alcohol in response to an issue, symptom or event. When a patient presents with an issue/problem that could relate to alcohol use, this may provide a way to start discussing alcohol.	*Practitioner links the presenting issue (social/medical/other) to alcohol* • Another aspect that can affect your condition is lifestyle, including drinking alcohol. Do you enjoy a drink? Could we talk about that a little? • Some people with similar symptoms find that these issues can be affected by their alcohol use, without them realizing. … Can I ask you, do you drink alcohol? • Some people find that alcohol helps them to ... (relax when they're stressed; sleep when they have problems with sleeping, escape from their worries). How have you been coping? • It is surprising how even small amounts of alcohol can affect the symptoms you describe or the reason for your visit. By exploring your alcohol use we would be in a better position to know if this was a factor for you. Would that be okay? Can I ask you what you would usually drink in a week? • We find that for many people who …. (get into fights/arguments, fall and injure themselves, can't sleep), alcohol can be a factor. Do you think your attendance here today is connected to alcohol in any way? • We'll come back to treatment options in a moment, but one thing that might help us to get to the bottom of this is alcohol. Do you drink at all? • I'm wondering if there are any other factors that might be affecting you at the moment. Something that we haven't picked up yet is alcohol. What do you know about how alcohol can affect this?
Patient-led Patient brings up the topic of alcohol/is looking for information on alcohol. This provides an automatic way in.	*Patient mentions alcohol* • It sounds as if you've been worrying about your drinking. Would you like to talk about that? • You've mentioned that you've stopped drinking just now. Is there a particular reason for that? • You mentioned that you were very drunk on Friday so are not clear how (an incident/injury) happened. Did you drink more than usual? • Actually, I've got some information here about alcohol that I can give you to take away with you. Is drinking something that you're concerned about just now? • You mentioned that your wife has been telling you to cut back on your drinking. She obviously cares about you. What about you, do you think you should cut down?

Planned (practitioner-led) Practitioner systematically raises the topic with all (or a specific group) of patients as part of a routine assessment or programme.	*Practitioner mentions alcohol to all patients/all those in a particular group* • We ask everyone who registers as a new patient some general lifestyle questions, and next on the list is alcohol. Would it be okay if I ask you about that? • We find that people who are in your situation … (homeless, carers, involved in offending, bereaved, traumatized, have family members who drink) can sometimes end up drinking more than they might want to. Is that something that you can relate to at all? • We are taking part in a new programme/campaign, and we're talking to everyone we see about their alcohol use. Would you mind if I ask you a few questions about this? • We find that many of the people who visit the practice for … (disease/ condition) find their symptoms improve if they cut down on their alcohol consumption. So now we ask everyone here for … (disease/ condition) about that. Do you drink alcohol at all? Would you mind if I ask you a few questions?

Unit 6. Screening and feedback using AUDIT (60 minutes)

Learning outcomes

By the end of Unit 6, participants will:

- be able to explore levels and patterns of alcohol consumption with their patients accurately, in an objective and nonjudgemental way, and give appropriate feedback using the AUDIT C and full AUDIT screening tool;
- be aware of possible responses, services and sources of support available for individuals across the spectrum of alcohol problems.

What you need

- Slides 27–43. Prepare handouts of these slides to give out at the END of this unit.
- *Handout 6.1. AUDIT-C/AUDIT alcohol screening tool* (one copy for each participant, plus more copies for Unit 8).
- *Handout 6.2. AUDIT-C/AUDIT screening practitioner unit* (one copy for each participant).
- *Handout 6.3. Screening case studies patient – information* (enough sets of cut-up cards for half the participants) or your own case studies prepared to suit the needs of the participants.
- *Handout 6.4. Screening case studies – answers* (one copy for each participant) or your own case study answers with the screening results for your case studies.
- *Handout 6.5. Responding to dependence* (one copy for each participant).
- Local or national protocols or care pathways for management of alcohol dependence in primary care.

Preparation

- Read through the presentation notes and the relevant information sheets until you feel comfortable enough to present and discuss them with your participants.
- Ensure that you have information on local services to which patients who would like additional support with their drinking can be referred. If there are local care pathways, referral criteria or protocols, you should be ready to provide that information to each participant. It may also be valuable to have a representative of those services available for this part of the course.
- Please bear in mind that during this unit, the conversation can be dominated by consideration of patients with severe drinking problems. For doctors learning to deliver brief interventions, it is important that they practise such conversations with drinkers who do not have dependence or severe problems, where the discussion is likely to be less challenging.

Process

1. Give out *Handout 6.1. AUDIT-C/AUDIT alcohol screening tool* and then talk through slides 27–40, addressing any questions asked either along the way or at the end, depending on your preference (15 minutes).

2. Explain that now everyone will have the opportunity to practise screening and feedback in pairs using brief case studies (slide 41). Emphasize that:

   - screening is not an exact science so it is not necessary to work out the exact number of standard drinks being consumed, but you should be aware that one alcoholic drink is often about two standard drinks; if the score is just below a particular category, you can let the patient know that;
   - this may feel awkward at first, but it is a chance to try it out and make mistakes and to be able to reflect and learn from the experience; no- one will be asked to demonstrate in front of the group.

3. Ask participants to form pairs and make sure they understand that you will then explain what they are to do next before asking them to get started.

4. Once in pairs, give the participants the materials they will need:

   - give each participant a copy of *Handout 6.2. AUDIT-C/AUDIT screening practitioner unit*;
   - give one participant from each pair a copy of Case Study A, and the other partner a copy of Case Study B from *Handout 6.3. Screening case studies – patient information*;
   - explain how the unit will work (as on slide 41) and give the instruction to start.

5. Circulate as the role play continues among the participants to help them out, to keep people on track in terms of time as necessary, and to ensure that the participants are practising only screening and feedback, and then swapping over, not moving on to deliver a full brief intervention.

Debrief

- When the time is up, stop the role play and ask the participants to stop playing their characters.
- Gather group feedback on the questions by asking the participants to report back first as practitioners on what they felt went well and then on what did not go so well. Repeat this from the perspective of the patient.
- Give out a copy of *Handout 6.4. Screening case studies – answers* to each participant.
- Go through the screening results for each of the scenarios as set out on the answer sheet and address any questions that arise.
- Give each participant a copy of the slides for this unit.
- Discuss slide 42 and *Handout 6.5. Responding to dependence* and provide information on local or national protocols for management of alcohol problems in primary care, where these are available. Provide information on local services and discuss how they can be accessed.

Key points (slide 43)

- The purpose of screening is to guide patients and practitioners on what to do next. It may be sufficient to get a general idea of what people are drinking and the problems or risks it is causing them without having to get a complete list of everything they drink.
- The exact score on the screening tools is for guidance. Scores just below the cut-offs may also merit intervention, especially in women, younger or older people and certain ethnic groups.
- Practitioners should avoid getting caught up in calculating exact numbers of standard drinks when completing the AUDIT and focus instead on building awareness about the continuum of risk from alcohol and identifying what matters to the patient.

- In practice:
  - if most of the patients that you screen have very high AUDIT scores, it is worth considering whether you are targeting people with more obvious signs of drinking or possible dependence (and probably missing people who could benefit but do not show any outward signs – usually a far larger group of patients);

  - if this happens, you may wish to reconsider the situations in which you are asking about alcohol (Unit 5), especially when you are first delivering SBIs, to give you a chance to become comfortable with discussing alcohol generally before focusing on patients with longer-term or more complex problems.

Handout 6.1. AUDIT-C/AUDIT tool

Drink	Standard drinks	Drink	Standard drinks
750 ml bottle of 14% wine	8.3	500 ml of 4.5% beer	1.8
175 ml glass of 14% wine	2	330 ml of 5% beer or other	1.3
700 ml bottle of 40% spirits	22	30 ml of 42% spirits	1

AUDIT C	**Scoring system**					**Score**
	0	**1**	**2**	**3**	**4**	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2–4 times per month	2–3 times per week	4+ times per week	
2. How many standard drinks (10 g) of alcohol do you drink on a typical day when you are drinking?	1–2	3–4	5–6	7–9	10+	
3. How often have you had 6 or more standard drinks (60 g of alcohol) on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
TOTAL AUDIT-C SCORE						

Score = 0–4	Advise that current drinking is low risk. Affirm ("That's great!"). Continue normal consultation.
Score = 5–12	Ask the 7 remaining AUDIT questions. If no previous dependence or signs of dependence and score is 5–7, go directly to Feedback.

Remaining 7 AUDIT questions (***continued overleaf)***	**Scoring system**					**Score**
	0	**1**	**2**	**3**	**4**	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Full AUDIT (continued)	0	1	2	3	4	Score
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
Total AUDIT-C score from overleaf:				**Total 7 question AUDIT score:**		
Total 10 question AUDIT score:						

AUDIT Score	Risk category	Action
0–7	Low risk	Advise that current drinking is low risk. Affirm ("That's great!"). If no other concerns, continue normal consultation.
8–15	Hazardous/risky	Give feedback and continue with brief intervention.
16–19	Harmful drinking Possible alcohol dependence	Give feedback and offer options for support including brief intervention and other support or services.
20+	Probable dependence	Give feedback and assessment *or* offer options for assessment and treatment by a specialist service.

Provide feedback: elicit – provide – elicit

Describe the result clearly, factually and without judgement. "From what you've told me, on the quiz here, you've scored X, which means that your drinking may cause you health problems in the future *or* may be harming your health." [Feedback]

Elicit "What do you know about the risks of alcohol?" [Open question]

Provide "This means that the amount you're drinking is putting you at risk of or going to lead to you [developing or worsening an illness/symptoms *or* getting injured]. You can reduce this risk/improve your [health/ symptoms/condition] by cutting down what you drink or stopping drinking. But only you can decide if that is something you want to do." [Personal responsibility]

Elicit "What do you think?"/"This has come as a surprise to you."/"How does that sound?" [Open question or reflection]

Handout 6.2. AUDIT-C/AUDIT screening practitioner unit

Drink	Standard drinks	Drink	Standard drinks
750 ml bottle of 14% wine	8.3	500 ml of 4.5% beer	1.8
175 ml glass of 14% wine	2	330 ml of 5% beer or other	1.3
700 ml bottle of 40% spirits	22	30 ml of 42% spirits	1

Case study A Jon is 57 years old, lives with his wife and daughter and works as a car salesman. He has come to the surgery with persistent indigestion.

Case study B Natalia is 34 years old, lives with her young son and works in a shop. She has come to the surgery with a very sore throat and feeling run down.

AUDIT C	**Scoring system**					**Score**
	0	**1**	**2**	**3**	**4**	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2–4 times per month	2–3 times per week	4+ times per week	
2. How many standard drinks of alcohol do you drink on a typical day when you are drinking?	1–2	3–4	5–6	7–9	10+	
3. How often have you had 6 or more standard drinks on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
TOTAL AUDIT-C SCORE						
Score = 0–4	Advise that current drinking is low risk. Affirm ("That's great!"). Continue normal consultation.					
Score = 5–12	Ask the 7 remaining AUDIT questions. If no previous dependence or signs of dependence, and score is 5–7, go directly to Feedback.					

Remaining 7 AUDIT questions ***(continued overleaf)***	**Scoring system**					**Score**
	0	**1**	**2**	**3**	**4**	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Full AUDIT (continued)	0	1	2	3	4	Score
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
Total AUDIT-C score from overleaf:			**Total 7 question AUDIT score:**			
Total 10 question AUDIT score:						

AUDIT score	Risk category	Action
0–7	Low risk	Advise that current drinking is low risk. Affirm ("That's great!"). If no other concerns, continue normal consultation.
8–15	Hazardous/risky	Give feedback and continue with brief intervention.
16–19	Harmful drinking Possible alcohol dependence	Give feedback and offer options for support including brief intervention and other support or services.
20+	Probable dependence	Give feedback and assessment *or* offer options for assessment and treatment by a specialist service.

Provide feedback: elicit – provide – elicit

Describe the result clearly, factually and without judgement. "From what you've told me, on the quiz here, you've scored X, which means that your drinking may cause you health problems in the future *or* may be harming your health." [Feedback]

Elicit "What do you know about the risks of alcohol?" [Open question]

Provide "This means that the amount you're drinking is putting you at risk of or going to lead to you [developing or worsening an illness/symptoms *or* getting injured]. You can reduce this risk/improve your [health/ symptoms/condition] by cutting down what you drink or stopping drinking. But only you can decide if that is something you want to do." [Personal responsibility]

Elicit "What do you think?"/"This has come as a surprise to you."/"How does that sound?" [Open question or reflection]

Handout 6.3. Screening case studies – patient information

Screening case study A: Jon

Profile

Jon is 57 years old, lives with his wife and daughter and works as a car salesman. He has come to the surgery with persistent indigestion.

Information for AUDIT-C screening

- He does not drink at all from Sunday to Wednesday.
- On Thursday and Friday he goes to the pub after work in the evening and has 2–3 large beers and 1–2 whiskies.
- He shares a bottle or two of wine with his wife over the weekend evenings.

Other details if asked (AUDIT remainder questions)

- A few weekends ago he fell asleep on the sofa drunk after returning from the pub and having a few glasses of whisky. He was smoking at the time at the time and burnt a large hole in the sofa and a small hole in his hand.

Screening case study B: Natalia

Profile

Natalia is 26 years old, lives with her young son and works in a shop. She has come to the surgery with a very sore throat and feeling run down.

Information for AUDIT-C screening

- Drinks 1–2 glasses of wine most evenings at home.
- When out on a Friday or Saturday, she drinks 6–7 vodkas with cola and some bottles of premixed spirits or shots if she goes clubbing (which she does about once a month).
- Most weeks she only goes out on one night, when her mother looks after her son.
- She does not usually drink on Sundays.

Other details if asked (AUDIT remainder questions)

- She has had a couple of occasions in the last year where she cannot remember what happened on a Saturday.
- Last year in January, she fell on a night out, badly spraining her ankle. At that time the nurse at the hospital asked her how much she drank and advised her to go easy.

Handout 6.4. Screening case studies – answers

Screening case study A: Jon

AUDIT-C
Question 1. Answer 3 times a week. *Score 3*
Question 2. Jon does not really have a typical day, so just choose his most common pattern. On Thursdays and Fridays he has: large beers ~2 SDs x 2–3; whiskies ~ 1 SD x 1–2 = between 5 and 8 SDs. Score as for 7–9: *Score 3*
Question 3. Jon also drinks a bottle of wine (7–8 SD) over the weekend evenings, so it is safe to guess that he is drinking more than 6 SDs on 2–3 evenings most weeks (but still not daily or almost daily). Weekly = *Score 3*

Total score AUDIT-C = ~9
Jon is AUDIT-C-positive

AUDIT remainder questions
Questions 4–8. Nothing to report. *Score 0*
Question 9. Been injured in the last year. *Score 4*
Question 10. Nothing to report. *Score 0*

Total score = 13

Jon is AUDIT- positive with few signs of dependence so is a good candidate for a brief intervention. Feedback should make links between alcohol and indigestion.

Screening case study B: Natalia

AUDIT-C
Question 1. Natalia drinks every day except Sunday = 4+ times a week. *Score 4*
Question 2. On a typical day she is drinking 1-2 glasses of wine = 3 to 4 SDs = *Score 1*
Question 3. On a weekend night out, at least 6-7 vodkas = ~6-7 SDs. Weekly = *Score 3*

Total score AUDIT-C = 8
Natalia is AUDIT-C-positive

AUDIT remainder questions
Questions 4–7. Nothing to report. *Score 0*
Question 8. Been unable to remember in the last year. *Score 1*
Question 9. Been injured but not in the last year. *Score 2*
Question 10. Been advised but not in the last year. *Score 2*

Total score = 13

Natalia is AUDIT-positive with few signs of dependence so is a good candidate for a brief intervention. Feedback should make links between alcohol and feeling run down and the reduced resistance to infection.

Handout 6.5. Responding to dependence

Avoid assumptions about what works

It should not be assumed that if someone is showing signs of dependence they can only be helped through specialist treatment or mutual aid (such as Alcoholics Anonymous) or any other specific method. Individuals with dependence often recover without any external help, and many can also be helped in primary care.

Avoid assumptions about treatment goals

It should also not be assumed that abstinence is the only suitable goal for people with dependence. For many people with mild to moderate dependence, controlled drinking may be an appropriate and achievable goal. Although research evidence can provide relevant information, the selection of drinking goal is essentially a clinical decision depending on the unique characteristics, circumstances and preferences of the individual patient *(76)*.

For most patients who are not physically dependent on alcohol, primary care doctors are well placed to help them to access self-help material, to provide support and monitor progress. The techniques covered in Unit 7 will also be helpful to practitioners for keeping patients motivated over time.

Physical dependence and detoxification

If a patient drinks every day, and has a history of fits if they stop drinking, it is important that they do not stop without support. Patients with a history of drinking will usually be aware of what happens if they stop and it may help to ask them "How did you handle this last time?" A short course of benzodiazepines may be indicated. It is important to consider what support patients have available once they become alcohol-free as frequent detoxes are associated with negative outcomes. In many countries, patients have the option of staying at home to go through detox, for example with daily visits from a nurse. In others, residential detox will be the norm.

In moderate to severe dependence, medication for prevention of relapse may also be considered.

Defining dependence

The AUDIT score is only one indicator of dependence; various other definitions exist. The International Classification of Diseases, 10th Revision *(77)* states that:

> … 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 year:
>
> a. a strong desire or sense of compulsion to take the substance;
>
> b. difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use;
>
> c. a physiological withdrawal state when substance use has ceased or been reduced, as evidenced by: the characteristic withdrawal syndrome for the substance; or use of the same (or a closely related) substance with the intention of relieving or avoiding withdrawal symptoms;
>
> d. evidence of tolerance, such that increased doses of the psychoactive substances are required in order to achieve effects originally produced by lower doses (clear examples of this are found in alcohol- and opiate-dependent individuals who may take daily doses sufficient to incapacitate or kill nontolerant users);
>
> e. progressive neglect of alternative pleasures or interests because of psychoactive substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects;
>
> f. persisting with substance use despite clear evidence of overtly harmful consequences, such as harm to the liver through excessive drinking, depressive mood states consequent to periods of heavy substance use, or drug-related impairment of

cognitive functioning; efforts should be made to determine that the user was actually, or could be expected to be, aware of the nature and extent of the harm.

Narrowing of the personal repertoire of patterns of psychoactive substance use has also been described as a characteristic feature (e.g. a tendency to drink alcoholic drinks in the same way on weekdays and weekends, regardless of social constraints that determine appropriate drinking behaviour).

Unit 7. Brief intervention core skills
(45 minutes)

Learning outcomes

By the end of Unit 7, participants will understand the core skills of a brief motivational intervention: 3a evoking: evoking change talk by active listening; 3b planning: eliciting and agreeing options for change; building confidence.

What you need

- Slides 44–61.
- *Handout 7.1A. Evoking change talk using open questions – basic* and/or *Handout 7.1B. Evoking change talk using reflections – advanced.*
- *Handout 7.2A. Planning for change – basic* and/or *Handout 7.2B. Planning for change – advanced, using rulers*

Preparation

- Prepare a handout from slides 44–61 to give out at the end of this unit.

Process

1. Recap what has been covered to date, show slide 45. Refer to *Handout 4.1. What is an alcohol brief intervention?* Point out that the participants have already had an opportunity to consider step one (Engage and Introduce the Issue) and Step 2 (Screening and Feedback). In the practice sessions in this unit, the practitioner should assume that the issue of alcohol consumption has already been raised and screening completed. Only the microskill of open questions (and reflections, if covering the more advanced option) will be practised.

2. Use the PowerPoint presentation to introduce the key concepts (slides 46–48).

3. Show slide 49, and ask participants to count how many instances of change talk and how many of sustain talk they can find in the passage. Discuss what participants recognized using slide 50.

4. Talk through the importance of generating change talk and how it can be directly influenced by a practitioner's behaviour (slide 51).

5. Two versions of *Handout 7.1* are provided: basic and advanced versions. For most practitioners who are new to these skills and who are attending a training course of one day or less, the basic version, which covers open questions, will be most appropriate. If practitioners are more experienced, keen or there is more time, the advanced version and task could be covered. There is no harm in practitioners taking away the advanced instructions even if they do not have time to practise them in training.

6. Distribute *Handout 7.1A. Evoking change talk using open questions – basic*, which provides examples of open questions designed to lead to change talk. This task is focused on helping practitioners to use open rather than closed questions, specifically open questions that will lead the patient to more change talk. Use slide 52 to explain the task and let participants start. Debrief the task using the handout and questions provided.

7. Distribute *Handout 7.1B. Evoking change talk using reflections – advanced*, which provides examples of helpful and unhelpful reflections. This task is focused on helping practitioners to use reflections of patient change talk so as to encourage more patient change talk. Use slide 53 to explain the task and let participants start. Debrief the task using the handout and questions provided. If you are not covering this option – skip this slide.

8. Two versions of *Handout 7.2. Planning for change* are provided. As before, for most practitioners who are new to these skills and who are attending a training course of one day or less, the basic version, which covers open questions, will be most appropriate. If practitioners are more experienced, keen or there is more time, the advanced version could be discussed.

9. Talk through slides 54–58 (and 59 if covering the advanced skills, otherwise skip this slide) and explain that participants will have the opportunity to practise using these skills when they practise a full brief intervention in Unit 8. Give out *Handout 7.2A* and/or *7.2B Planning for change*, highlighting any additional points missed during your slides.

Overall debrief

- Discuss examples of good practice and suggested areas of improvement generated from your own notes when circulating around the pairs (without identifying specific individuals).
- Remind the participants of the key principles of motivational interviewing that apply to these brief intervention approaches, namely that the individual is the expert on what changes are right for him/her. This means that as professionals we have to hold back from giving advice and ensure that patients feel in control of the changes being discussed. In some cases this could mean accepting that the person does not (yet) want to change his/her current drinking behaviour
- Reflect back to the continuum of risk and emphasize that even small reductions in alcohol consumption, or sometimes even just spreading consumption across several days instead of only one day, will reduce the risks associated with drinking even if the person is still drinking more than the recommended limits. These small changes can have a positive benefit for the individual, and if many people make small changes, the benefits will also become apparent in society as a whole.
- Distribute a handout of the slides for this unit to participants.

Key points (slides 60, 61)

- The techniques discussed in Unit 7 are the core microskills of a motivational approach and can be learned with practice (slide 60).
- It is normal for practitioners to experience a steep (and perhaps uncomfortable) learning curve as they try to put these techniques into practice, but they should not feel discouraged (slide 61).
    - There is good evidence to suggest that a significant proportion of the benefit of motivational interviewing may come from practitioners *stopping* doing unhelpful things, even if they have not mastered all the skills.
    - This points to the need at the least to avoid telling patients what to do, avoid persuasion and spend more time listening.

Handout 7.1A. Evoking change talk using open questions – basic

Basic level: questions for change talk

Desire ✔ How would you like things to change? ✔ What do you hope you can change? ✔ Tell me what you do not like about how things are now. ✔ What would you like to be different?	*Reasons* ✔ What concerns you? ✔ Why would you want to cut down? ✔ What might be the benefits of drinking less? ✔ What are the reasons to change as you see them?
Looking forward ✔ How would you like your life to be in a year? ✔ What do you hope for over the next five years? ✔ In what way do you want to feel better?	*Looking back* ✔ Can you remember a time before you were drinking like you've described? What was different? ✔ How did you cope before?
Querying extremes: no change ✔ What most concerns you about your drinking in the long run?	*Querying extremes: change* ✔ If you cut down today, how would you hope to feel different?
Whenever you hear change talk, you can ask open questions that encourage elaboration. ✔ In what way? ✔ Tell me more? ✔ What else?	
Avoid questions that will lead to sustain talk. X Why do you drink in the way you've described? X What's stopping you from cutting down? X What worries you about drinking less?	

TIP! When asking questions, remember the points about tone of voice from Unit 5. At all times you are trying to communicate empathy, acceptance and respect for the other person and avoiding judgement.

Using open questions – practice activity

In pairs, one person is Julia, the other person is the practitioner. Both should read through this page first and start when instructed to do so.

Julia is 34, she lives with her husband and two school-aged children and she has presented with anxiety. She reported drinking a couple of glasses of wine about three nights a week with her husband and a big night out two or three times a month when she has more than six drinks. She reported no other problems, except missing the children's activities one Saturday morning. Julia enjoys drinking and feels that she might both miss it and miss out on her chance to have fun outside of being a mother if she has to stop drinking.

Screening has already been completed. Her AUDIT score was nine and the feedback conversation went as follows.

Practitioner: *Result*. From what you've told me, on the quiz here, you have scored nine, which means that your drinking may cause you health problems in the future and it could be affecting your anxiety.

Elicit. What do you know about the risks of alcohol?

Julia: I don't think I drink very much. Is it really true that is risky?

Practitioner: *Provide*. It is risky in that it can increase your chances of future problems like cancer and high blood pressure. But for you just now, it may be affecting your anxiety. We know that when people cut down on drinking, their symptoms often improve. Also, many people don't realize that alcohol affects your sleep, so you might sleep better and be less anxious if you cut down or stopped drinking. But only you can decide if that is something you want to do.

Julia: Uh. I didn't know that. (slight groan)

Practitioner: *Elicit*. This has come as a surprise to you?

Julia: Yes, I didn't know that alcohol could make you anxious. I've been using it to relax, to be honest.

In this task, you should start by role-playing the feedback conversation above, and then the practitioner should continue by asking open questions of Julia (your own or those on *Handout 7.1*) to generate more change talk and see how the conversation progresses. Julia should respond naturally to each question asked as she feels appropriate.

When the conversation stops, discuss how it went.

- How did the practitioner feel about asking open questions (and avoiding closed ones or giving advice)?
- How different was this from a usual consultation?
- Did the open questions lead to change talk or sustain talk or both?

(Swap roles if time allows)

Handout 7.1B. Evoking change talk using reflections – advanced

Intermediate/advanced: reflections for change talk

Reflections are statements that attempt to guess at the meaning of what has just been said by the patient that allow the practitioner to check his/her understanding and invite the patient to expand further.

Good reflective listening statements should constitute a substantial proportion of your responses to the patient at the beginning of the discussion. *Once you have asked an open question, respond to the person's answers with a reflection* designed to clarify your understanding and convey this to the patient *(10)*. Questioning is easier to do than reflecting, but you risk falling into the question-answer trap, asking a series of questions rather than listening and reflecting the patient's statements back to him/her. This can make the patient defensive.

Reflections are not questions, and the only difference in many languages is the inflection of the tone of voice at the end of the sentence that can turn a reflection into a question. Try saying the following sentences out loud.

- You don't think this is a problem
- You don't think this is a problem?
- You want to be around for your grandchildren.
- You want to be around for your grandchildren?

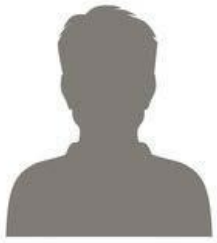
After gaining feedback from screening, in the evoking stage, reflections hone in on change talk and highlight it to evoke more change talk. This also requires the skill to ignore sustain talk. Reflections can vary in depth from simple repetition to paraphrasing to complex reflections that "continue the paragraph". Some examples are given below, including some marked as X that focus on sustain talk and will probably lead to more sustain talk and should, therefore, be avoided.

Patient says	Simple reflections	Complex reflections (all good to use)
I don't drink more than anyone else I know. I don't see it as a problem.	✔ Nothing serious from your perspective.*	You're surprised that I'm sitting here telling you about risky drinking.
I've always been a drinker. I enjoy socializing with folks and that's important as I think about retiring.	✔ You're thinking about retirement. X You enjoy the social aspect of drinking.	You're hoping for a long and happy retirement.
My wife would like me to drink less and lose weight. I know she cares, but it annoys me.	✔ She cares about your health.	You can see the benefits for yourself.
Actually, it's been a really tough week. I'm fed up with everything.	✔ You're feeling down.	Something has to change.
When I'm out drinking with friends, it's not easy to be the one asking for a soft drink.	X You feel a social pressure to drink.	That's a puzzle for you, how you can cut down while still enjoying your nights out.
I'm not sure I really believe this, to be honest. Everything is bad for you these days.	X You're sceptical about whether you're really at risk.	It's a bit of a shock to hear how it might affect you personally.

* This is a reflection of sustain talk, but it is also an amplified reflection which invites the patient to disagree, so may also result in change talk.

Using reflections – practice activity

In pairs, one person is Jon, the other is the practitioner. Both should read through this page first and start when instructed to do so.



Jon is 57, lives with his wife and daughter and works as a car salesman. He has come to the surgery with persistent indigestion. He does not drink from Sunday to Wednesday. He goes to the pub after work in the evening on Thursdays and Fridays and has two to three large beers and one to two whiskies. He shares a bottle or two of wine with his wife over the weekend evenings. A few weekends ago he fell asleep on the sofa drunk after returning from the pub and having a few small glasses of whisky. He was smoking at the time and burnt a large hole in the sofa and a small hole in his hand. Jon is conscious of getting older and knows that he should focus on his health so that he does not die as young as his father did. His daughter will be leaving home soon so he is thinking about how to fill his time when she moves out. He thinks his friends from the pub will be a good source of support to him when he retires.

Screening has already been completed. His AUDIT-C score was nine and the feedback conversation went as follows.

Practitioner From what you told me, we can see that your score on the short quiz was nine, which means that your drinking is at a level that increases your risk of health problems in the future. It is also likely to be making your indigestion worse. *[Elicit]* I'm wondering what you already know about the risks of drinking?

Jon Well, I have noticed that the indigestion is worse when I've been drinking, but what other health problems are you talking about? I'm not an alcoholic.

Practitioner *Provide.* You are right, you're not an alcoholic, that is clear from what you've told me. What your level of drinking can mean is a bigger chance of future problems like cancer and high blood pressure. If we don't get your indigestion under control you run the risk of a stomach ulcer. We often find with indigestion, that when the alcohol goes down, the symptoms improve. Of course, any change would need to be your decision. *[Elicit]* What do you think?

Jon My dad had high blood pressure and he died young, as you know, so I obviously don't want to go down that path. But my nights in the pub are the best part of my week.

In this task, you should start by role-playing the feedback conversation above, and then the practitioner should continue using mostly *reflections of change talk*. Open questions can also be used but should be followed by two or three reflections. Use complex reflections if you can. Jon should respond naturally.

When the conversation stops, discuss how it went.

- How did the practitioner find thinking of reflections? Did he/she manage any complex ones?
- How did it feel to Jon?
- Did the reflections lead to change talk or sustain talk or both? Why?

(Swap roles if time allows)

Handout 7.2A. Planning for change – basic

Planning

If a patient is not ambivalent and recognizes a need to change or wants to change his/her drinking, it may be counterproductive to explore his/her reasoning and motivation further using evoking.

- Instead, use open questions to *elicit* ideas about how he/she might change.
- If necessary, and with permission, *provide* a menu of options for change.
- *Elicit* his/her thoughts and feelings about the options.

Elicit: open questions for planning

- If you really decided to do it, how could you change your drinking?
- In what ways could you drink less?
- What ideas do you have about how you might cut down?
- What seems the most do-able option for you?

Provide options with permission

There are many ways in which people can reduce their consumption that are not always obvious to them, and making them aware of the options may make change more achievable to them. If they are unsure, you could offer to help. It may be useful to revisit their knowledge of standard drinks and the alcohol content of different drinks. Small changes in people's choice or size of drink can make big changes in their overall consumption and risk to health. Possible changes fall into three main categories as described here.

Drink on fewer occasions, for example, find alternative activities.	On each occasion drink fewer alcoholic drinks, have a soft drink or drink more slowly.	Drink less alcohol in each drink, for example, switch drinks to a lower strength or a different kind of drink with less alcohol in it.

Elicit what the patient thinks about these options

- What would work for you?
- How would these fit with what is important to you?
- Where would you like to start?

Make a plan

If the patient is interested in one of the options discussed, make a plan. Agree on goals, plans, timescales and follow-up for change. Elicit a commitment from the patient.

Goals could be ways to cut down, how patients will avoid certain situations, take up new activities or even keep themselves safer while drinking. Some people may welcome a discussion of how they will keep an eye on how they are getting on. This could include using a drinks diary or writing their goals down.

- From what we've discussed, what do you think you will do over the next X weeks?
- How will you reach that target?

Example of a planning conversation

Elicit "What ideas do you have about how you could cut down?

- What else? What would work best for you?"
- (If no/few ideas – get permission). "If you like I can tell you about some of the ways others have found useful, and you can let me know if they would work for you?"

Provide information about available options: "One option is to have more days where you don't drink at all, perhaps by finding other things to do on those evenings. Another option is to have fewer drinks when you are drinking, or smaller ones, or you could swap drinks for ones with lower alcohol (for example, …). And of course you could stop drinking altogether. I can tell you more about any of these if you wish, but first I want to hear what you think you might be able to do. You'll know best what would work with your life."

Elicit "What do you think?"

Example of a planning conversation for dependent drinkers

Elicit "What do you know about the support available to help people cut down or stop drinking?"

(If no/few ideas – get permission): "If you like I can tell you about some of the options to see if they might interest you. Would that be okay?"

Provide information about available options: "Yes, Alcoholics Anonymous is one option. There are also treatment services, or I can provide you with some materials to help you cut down by yourself and we could discuss this again in a few weeks? Or you could do nothing and carry on with the risks/ symptoms as they develop. I can give you more information, but it's your decision."

Elicit "What do you think?"

Advise that it is dangerous for a severely physically dependent patient to suddenly stop drinking.

Building confidence

If patients want to change but are not sure that they will manage it, or if they are worried about how they will keep to their plans in certain situations, it is useful to spend a little time building their confidence and planning ahead to help them manage and maintain change. The following can be helpful questions at this stage.

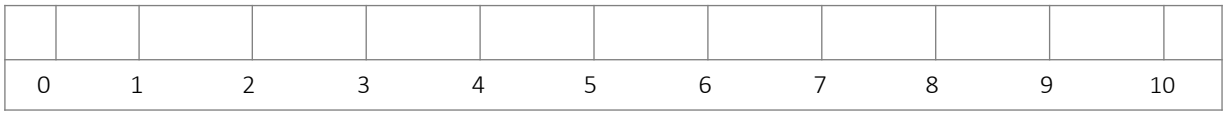
- *Past successes.* What else have you changed in your life? What worked then?
- *Role models.* Who else do you know who have changed their lifestyles? How did they manage?
- *Supporters*. Who will support you? Who else cares about your health? How can you draw on their support?

If patients discuss specific situations in which they might find it hard to stick to their plans, you could explore those, again using reflections of change talk. This time you are looking for change talk about how to cope. They should plan strategies for those situations. If they do not manage to stick to the plan, they should not be disheartened: that is a normal part of the process towards a permanent lifestyle change.

Handout 7.2B. Planning for change – advanced, using rulers

Using ruler or scaling techniques

The ruler can be used to ask about a patient's confidence in changing when *planning* change, or about the importance of change when *evoking* change talk.



1. If you think of a scale 0–10, where 0 is not at all confident and 10 is completely confident, how confident (sure) would you say you are about your ability to change your alcohol use?

   OR

   If you think of a scale of 0–10, where 0 is not at all important, and 10 is the most important thing for you right now, how important is it to you to reduce your risk from drinking?

2. If not at 0, affirm ("that's great!"), why here and not lower? If at 0, thank them for honesty.

3. Ask "where would you like to be?"

4. Ask what would need to happen to get to a higher point? Set steps/goals? Explore values. Use your open questions then reflect change talk.

Unit 8. Brief interventions – practice session (75 minutes)

Learning outcomes

By the end of Unit 8, participants will have had an opportunity to practise delivering a complete brief intervention.

What you need

- *Handout 8.1. Practice session instructions* (one copy for each participant).
- *Handout 8.2. Practice session observation sheet* (at least one copy for each participant).
- Case studies (one copy of each case study per threesome).
- *Handout 8.3. Case study feedback notes* (one copy for each participant).
- Participants will have the opportunity to choose what materials they wish to have to hand for practising a complete ABI. They may wish to use some of the following materials which they should have already received.
    - *Handout 4.1. What is an alcohol brief intervention?*
    - *Handout 6.1. AUDIT-C/AUDIT tool* (one extra copy for each participant)
    - *Handouts 7.1. Questioning for change talk*
    - *Handout 7.2. Reflections for change talk*
    - *Handouts 7.3. Planning for change.*
- Slides 62–76 from the PowerPoint file.

Preparation

Read over the instructions for Unit 8 and slides 62–76 to ensure that you can clearly picture what is supposed to happen at each stage and round.

Process

1. Explain that the purpose of Unit 8 is for the participants to have the opportunity to practise delivering an ABI from start to finish.

2. Distribute *Handout 8.1. Practice session instructions* and give participants time to read it through. Give out a copy of *Handout 6.1. AUDIT-C/AUDIT tool* to each participant.

3. Using slides 62–76, set up and guide participants through this practice unit. Explain that participants will work in threes and there will be (time allowing) three rounds of the practice. This will allow each person in the threesome to have a turn playing the part of practitioner (delivering an ABI), patient and observer.

    - For example, in round one, one person will play the part of the patient (Peter), another the practitioner and another the observer.
    - In round two, the person who was Peter will become the observer, the practitioner will play the part of a new patient (Alex) and the observer from round 1 will be the practitioner.
    - In round three: participants will swap roles again (if time allows) to consider the case of Veronica
    - Only the person playing the part of the patient in each round will have the case study handout

with the information about that patient, to help them with the role play.

4. Additional notes.

   - When playing the part of the patient, read through the character you will be playing to familiarize yourself with their details. Be prepared to introduce their character by describing the setting and context, personal information and scenario to the practitioner before starting the brief intervention/role-play proper.
   - When playing the part of the observer, the key elements of an ABI that you should be looking for are outlined in *Handout 8.2. Practice session observation sheet*.
   - When playing the part of the practitioner you may want to revisit *Handout 4.1. What is an alcohol brief intervention?* and *Handout 4.2. Beginning the conversation.* For screening, you could complete *Handout 6.1. AUDIT-C/AUDIT tool.* It may also be useful to have to hand *Handouts 7.1. Evoking change talk* and *7.2. Planning for change (basic or advanced, as appropriate).*

5. Ensure that participants are listening, then highlight the following key information.

   - A maximum of 15 minutes will be allowed for each round, including five minutes for debriefing after each round referring to the debrief questions.
   - Each patient will be debriefed with the whole group before moving onto the next round.
   - Patients should share some basic information (name, age, context) with the practitioner before the brief intervention starts proper, but not any information relating to alcohol use: it is the practitioner's role to ask about this and work out consumption.
   - The patient should be as natural as possible and not to make it too difficult for the practitioner. It is not the aim to catch the practitioner out.
   - Do a final check that everyone has everything that they need and that everyone is clear about what they are being asked to do.

6. Listen in discreetly to the threesomes' practice sessions and write on a flipchart (facing it away from the group while they practise) examples of good/bad practice. Be prepared to feed this back in the debrief.

7. Stop the groups after each 15 minute round for five minutes of whole-group debriefing, working through each case study one at a time using *Handout 8.3. Case study feedback – notes* and the appropriate slide. Use your notes from listening in to discuss key points for success in future.

Overall debrief

- As time allows, consider the following discussion questions (slide 74).

  - Were the case studies realistic?
  - What changes (if any) will you make to your practice after learning about brief interventions?
  - Have any other issues or questions arisen as a result of the practice?

Key points

- It is normal for practitioners to feel awkward when first practising brief interventions. This course includes a lot of information and it may be difficult to put it all into practice at once. It is possible to work towards full brief interventions in stages, by changing small aspects of your practice and reflecting on how you discuss behaviour change with patients over time (slides 75 and 76).
- Thank the participants for their participation and give any instructions for evaluation as needed (slide 77).

Handout 8.1. Practice session – instructions

You will work in groups of three: patient, practitioner and observer.

Patient instructions

- You will be the patient for this practice session in which the practitioner will try to screen the patient and deliver a BI from beginning to end.
- Before you begin:
  - read over the information provided about the patient;
  - tell the practitioner and observer who you are and why you have come to the practice, as outlined in the first box on the case study.
- Try to be as realistic as you can. Respond to the questions asked but do not give too much information freely.
- The information is there to help you, but you are encouraged to make it your own. Depending on the questions from the practitioner you may need to improvise some answers.

Practitioner instructions

- You will be delivering an SBI from beginning to end in this practice session.
- *Before* you begin:
  - you will be given some basic information about the patient's character, including personal information and the reason for attending;
  - you will need *Handout 6.1. AUDIT-C/AUDIT tool*;
  - consider what other materials you would like to have in front of you to help with the practice, for example:
  - *Handout 4.1. What is an alcohol brief intervention?* Brief intervention flowchart diagram
  - *Handout 5.1. Beginning the conversation*
  - *Handout 7.1. Increasing change talk* (basic or advanced as appropriate)
  - *Handout 7.2. Planning for change* (basic or advanced as appropriate).
- You should start the practice session using one of the approaches to beginning the conversation discussed in Unit 5.
- Then screen the patient using AUDIT-C or AUDIT, and deliver a brief intervention using open questions, reflections and, if appropriate, planning for change.

Observer instructions

- *Before* starting the role play, ensure that the patient tells you and the practitioner the basic personal information and why he or she is attending.
- You are responsible for keeping time and should allow no more than 10 minutes in total for each practice, followed by five minutes discussion in your threesome about how it went.
- You will observe the practice session and take note of what was done well and what could be improved using *Handout 8.2. Practice session observation sheet.*
- Focus on writing down verbatim examples of phrases/questions you noticed to help feedback.

Handout 8.2. Practice session observation sheet

Stages of a brief intervention	**Notes on what went well/not so well** Write examples of the words used for good phrases or missed opportunities to enable you to report back
1. *Beginning the conversation* ☐ Nonjudgemental and linking to the presenting issues.	
2. *Screening and feedback* ☐ Was screening accurately done? ☐ Collaboration with patient? ☐ Feedback using elicit – provide – elicit? ☐ Not making decision for patient (you must/should/need).	
3a. *Evoking* ☐ Open questions for change talk. *Write example.* ☐ Reflections for change talk? *Write example* (advanced only) ☐ Less/little focus on sustain talk. ☐ Summaries. ☐ Personal responsibility. ☐ Correct use of importance ruler?	
3b. *Planning* ☐ Elicit options for change from the patient. *Write example.* ☐ Provide options with permission. ☐ Elicit patient reactions. ☐ Explore commitment to the plan. ☐ Build confidence using past successes, role models or supports. ☐ Correct use of confidence ruler (advanced only)	
4. *Close the discussion* – ensure the patient knows that he/she can return at any time.	

Handout 8.3. Sample reflective practice recording sheet

Reflective practice recording sheet				
Way in		**Patient-led**	**Planned** (practitioner-led)	**Opportunistic** (practitioner-led)
Develop rapport and empathy?		☐	Nonjudgmental approach?	☐
Screening		AUDIT-C score ____	AUDIT score _____	Other approach?
Readiness to change?		**Ready to change**		**Not ready to change**
Approaches		Your approach		Next time?
Using open questions for change talk	☐			
Using simple and complex reflections	☐			
Active listening (OARS)	☐			
Eliciting menu of options/ planning	☐			
Building confidence	☐			
Signposted or referred to:				
What went well?				
What did not go well?				
Learning points?				

Case Study 1. Peter	
Introduction: share with practitioner and observer	Peter is 43, married, no children. He has a senior post in an office and is increasingly overweight. Peter is discussing with the doctor how stressed he has been recently, and also mentions that he wants to lose some weight.
Background information for patient	You drink to relax. Your job is stressful and drinking helps you switch off from work before going home in the evening. Your wife also does not get home until late, so there is no point in going home early. At the weekends you really enjoy the time spent with your wife. You sometimes go out together for a meal with wine but mostly just share a bottle with a takeaway meal. It is a chance to catch up about your weeks and offload a bit.
Drinking, if asked Remaining 7 AUDIT questions (if required)	• Vague at first, only give specifics if asked: a couple of beers in the pub after work, on your way home. • Exact drinking if asked: a couple of beers (0.5 litres each) most weekdays after work, along with several beers (0.5 litres each) and more wine at the weekends. At weekends you maybe share two (standard 750 ml) bottles of wine with your wife. Q4: You have never been unable to stop drinking. Q5: You always go to work. Your wife moans when the place is a mess on a Sunday morning or you fall asleep on the sofa as soon as you get home but you don't think that's very fair because she's never there anyway. Q6: You have never needed an "eye-opener". Q7: You have got carried away, been indiscreet once or twice. Q8: Once or twice things have been a bit sketchy. Q9: You have never been injured or injured anyone. Q10: Your sisters have noticed your weight but no-one has said anything about the drinking. You think most people you know drink about the same (or more) as you do.
Further information/ feelings about situation	• You would think about cutting down if your job was less stressful and if your wife was around more. Maybe you could do more together. • You would like to lose some weight but you are just sitting around all day in the office. You do not think the drinking is that bad for you. You do not fancy those lighter beers – they are just bad value.
Willingness to change	• If the practitioner helps you to see the downside to your drinking, you are willing to consider changes but you would not want to give up. One option could be to switch from large beers to a small whisky in the pub; you did not realize that would be a lot less alcohol in each drink. You are willing to try that for a couple of weeks. • You have never discussed it with your wife, but if the practitioner asks you and is supportive, you might decide to speak to her and see if she is willing to help. You are not too happy about how much you have both started to drink; you think it has been a habit that has been slowly creeping up.

Case Study 2. Alex	
Introduction: share with practitioner and observer	Alex is 52 years old, married with two adult sons, works in a warehouse. Last year he had a stent inserted (coronary angioplasty), is doing very well and is attending for a routine follow-up appointment.
Background information for patient	You have just started working for a new distribution company in their warehouse. You mainly work night shifts (12:00–08:00) at the weekends (Friday and Saturday) and one or two other nights a week, depending on your rota. You would like to work more hours overall and less at the weekends.
Drinking if asked Remaining 7 AUDIT questions (if required)	• Sunday–Friday: most nights of the week you would normally drink three cans of lager (normal strength, 0.5 litres) in the house while relaxing and watching TV. You also drink a few glasses of spirits (whisky or vodka) most evenings (but not Fridays as you have to work), getting through a bottle every couple of weeks. • Saturday: you catch up with friends about 20:00 and have three or four large beers (0.5 litres) before leaving the pub around 23:00 to walk to work at midnight. Q3: You like a good drink at Christmas and when a wedding comes around. Q4: You can always stop drinking. Q5: It has never been a problem getting to work. Q6: You never drink in the morning. Q7: You do not do stupid things or feel guilty. Q8: You were unable to remember after a big night like weddings or Christmas parties. Q9: You fell and cut your head when drunk in your early 20s. Q10: Nobody ever said drinking is a problem.
Further information/ feelings about situation	• Saturdays has always been your big night out. You used to drink with friends after watching the football but have had to cut your sessions short since your work changed to the weekends. • You are bored during the week now that you are only doing weekend work and since you are not getting up in the morning, you may as well have a drink. That said, you are not sleeping very well anyway, but at least a few drinks help you drift off. • You know you cannot drink as much as you used to do on Saturdays because you have to work, but you do not think a couple of pints are a problem. You do not really want to give up Saturday drinking completely. You used to really drink a lot more so are a bit defensive at the idea that even what you drink now could be problematic.
Willingness to change	• You have never heard of standard drinks or that alcohol can raise blood pressure. You gave up smoking years ago so it was a bit of a shock to hear that you needed a stent. You want to be around for your grandchildren. • You are concerned about your heart and want to be healthy, but you don't think there's anything wrong with what you drink. You admit that the cans during the week have just become a habit and you probably would not really miss them if you cut down. You are not interested in 'that rubbish low alcohol beer' but you could just have fewer cans or a night off every so often. • You had no idea that alcohol affected your sleep and admit that you might have more energy in the daytime if cutting down helped you sleep better.

Case Study 3. Veronica	
Introduction: share with practitioner and observer	Veronica is 69 years old, living alone, children grown up and living abroad. Her husband (Jim) passed away about 12 months ago after they had been married for over 40 years. She has come to the practice for a check-up after a recent fall. It is noted in the emergency department discharge letter that Veronica disclosed that she had had a few drinks when she fell.
Drinking if asked	• You drink a glass of red wine every afternoon Monday to Friday at home. • On a Friday night you drink a glass of wine and two or three gin and tonics. • You have also started having the odd gin and tonic on a Saturday evening. • You do not drink at all on a Sunday. Exact drinking if asked. • You do not really know what size of glass of wine you drink, but you get through about two bottles a week. You do not measure the gin, sometimes it's stronger than others.
Remaining 7 AUDIT questions (if required)	Q4: You have never been unable to stop. Q5: You have never failed to do what was normally expected of you. Q6: You have never needed a drink in the morning. Q7: You felt guilt/remorse when you thought it might be linked to your fall. Q8: You can always remember what you have done. Q9: You think the fall was linked to the drinking. Q10: No-one has ever suggested you cut down except in the Accident and Emergency Department.
Further information/ feelings about situation	• The fall did shake you up a bit. It has made you think about getting older and you are worried about losing your independence if you have a bad fall. • You used to enjoy sharing the odd bottle of wine with your husband, but since he died you do not have anyone to share it with. • You get a bit lonely during the week, although you have a few local friends who pop into the house about once a week to check that you are okay (and you might have a few gin and tonics together).
Willingness to change	• You do not know much about standard drinks but have seen something on the bottle label. You have never really heard about the health risks of alcohol: you have to die of something. But you don't want to fall again. • You have never really thought about your drinking before and would be surprised to hear that it is risky. • You are willing to listen to the expert doctor, but you would not like it if he/she suggests that you are drinking too much. It is your life, after all. If they emphasize that it is your choice, you'd be willing to talk about ways to cut down.

Brief intervention case studies – trainer's notes. 1: Peter

Peter drinks a couple of large beers (0.5 litre size each) most weekdays after work plus several beers and more wine at the weekends. At weekends he maybe shares two bottles of wine with his wife.

Weekday total: ~28 SDs — 5 (nights) x 2 (large beers 500 ml) x 1.6 (SDs in each glass) = 3.2 SDs per day = 16 SDs

Weekend total: ~13 SDs — 3–4 beers (0.5 litre cans) = ~4.8–6.4 SDs
2 bottles of wine shared with wife = 1 bottle for Peter = 7 SDs

Total per week: ~27.8–29.4 SDs

AUDIT-C: Peter	**Scoring system**					**Score**
	0	**1**	**2**	**3**	**4**	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2–4 times per month	2–3 times per week	**4+ times per week**	
2. How many standard drinks of alcohol do you drink on a typical day when you are drinking?	1–2	**3–4**	5–6	7–9	10+	
3. How often have you had 6 or more standard drinks on a single occasion in the last year?	Never	Less than monthly	Monthly	**Weekly**	Daily or almost daily	
					TOTAL AUDIT-C SCORE: 8	
Score = 5+	Score is 8 , so should ask the remaining AUDIT questions.					

Remaining 7 AUDIT questions	Scoring system					Score
	0	1	2	3	4	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	**Never**	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected from you because of your drinking?	**Never**	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	**Never**	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	**Less than monthly**	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	**Less than monthly**	Monthly	Weekly	Daily or almost daily	
9. Have you or somebody else been injured as a result of your drinking?	**No**		Yes, but not in the last year		Yes, during the last year	
10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	**No**		Yes, but not in the last year		Yes, during the last year	
Total AUDIT-C score: 8			**Total 7 question score: 2**			
Total score for full 10 question AUDIT: 10 **Proceed with brief intervention**						

Motivating Peter

It seems as if Peter has not really thought about his drinking before or the contribution the alcohol might be making to his weight or stress. The practitioner would be expected to elicit his knowledge about calories in alcohol and about alcohol and anxiety, build his awareness and then explore whether he would consider making changes. Peter offers a lot of change talk for the practitioner to reflect including:

- stress
- weight
- irritation from wife
- indiscretions
- desire to spend more time with wife.

Brief intervention case studies – trainer's notes. 2: Alex

Alex drinks three cans of lager (normal strength, 0.5 litres) and a few glasses of spirits (whisky or vodka) most evenings, getting through a bottle every couple of weeks. On Saturdays he drinks three or four large beers (0.5 litres).

Sunday–Friday total: ~41 SDs	6 (nights) x 3 (500 ml cans of 4% lager) x 1.6 (SDs in each can) = 4.8 SDs per day = 28.8 SDs per week 1 bottle of spirits per fortnight (23.7SDs) = 2.4 SDs per night = 11.9 SDs per week Total per day (Sunday–Thursday) = 7.2 SDs
Saturday total: ~4.8–6.4 SDs	Saturday: 3–4 (500 ml cans of 4% beer) x 1.6 (SDs in each beer) = 4.8–6.4 SDs
Total per week:	28.8 + 11.9 + 4.8/6.4 = 45.5–47.1 SDs

AUDIT-C: Alex	**Scoring system**					**Score**
	0	**1**	**2**	**3**	**4**	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2–4 times per month	2–3 times per week	**4+ times per week**	
2. How many standard drinks of alcohol do you drink on a typical day when you are drinking?	1–2	3–4	5–6	**7–9**	10+	
3. How often have you had 6 or more standard drinks on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	**Daily or almost daily**	
TOTAL AUDIT-C SCORE: 11						
Score = 5+	Score is 11, so should ask the remaining AUDIT questions.					

Remaining 7 AUDIT questions	Scoring system					Score
	0	1	2	3	4	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	**Never**	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected from you because of your drinking?	**Never**	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	**Never**	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	**Never**	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	**Less than monthly**	Monthly	Weekly	Daily or almost daily	
9. Have you or somebody else been injured as a result of your drinking?	**No**		Yes, but not in the last year		Yes, during the last year	
10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	**No**		Yes, but not in the last year		Yes, during the last year	
Total AUDIT-C score: 11			**Total 7 question score: 1**			
Total 10 question AUDIT score: 12 **Proceed with brief intervention**						

Motivating Alex

Alex used to drink much more alcohol than he does now, and he managed to cut down by himself. He is concerned about his health but does not want to give up drinking completely. The practitioner would be expected to elicit his knowledge about links between alcohol and high blood pressure or other health risks. Alex should have offered change talk for the practitioner to reflect on:

- wanting to avoid needing another procedure or stent
- drinking having just become a habit
- desire to be around for his grandchildren
- wanting to sleep better and do more with his days.

Brief intervention case studies – trainer's notes. 3: Veronica

Veronica drinks a glass of red wine every afternoon Monday to Friday, plus two or three gin and tonics on a Friday and the odd gin and tonic on a Saturday evening.

Weekly total: ~22.6 SDs

Wine: 5 (afternoons) x 1 (glass of wine) – but 2 bottles per week (16.6 SDs) = 3.3 SDs per day Monday–Friday.
Friday and Saturday: ~4 (gins) x 1.5 SDs (estimate) = 6 SDs per week
[Friday wine and gin total = ~6.3 SDs]

Total per week: ~23 SDs

AUDIT-C: Veronica	**Scoring system**					**Score**
	0	**1**	**2**	**3**	**4**	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2–4 times per month	2–3 times per week	**4+ times per week**	
2. How many standard drinks of alcohol do you drink on a typical day when you are drinking?	1–2	**3–4**	5–6	7–9	10+	
3. How often have you had 6 or more standard drinks on a single occasion in the last year?	Never	Less than monthly	Monthly	**Weekly**	Daily or almost daily	
					TOTAL AUDIT-C SCORE: 8	
Score = 5+	Score is 8, so should ask the remaining AUDIT questions.					

Remaining 7 AUDIT questions	Scoring system					Score
	0	1	2	3	4	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	**Never**	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected from you because of your drinking?	**Never**	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	**Never**	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	**Less than monthly**	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	**Never**	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		**Yes, during the last year**	
10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		**Yes, during the last year**	
Total AUDIT-C score from overleaf: 8			**Total 7 question score: 9**			

Total 10 question AUDIT score: 17
Proceed with brief intervention

Despite her high score, examination of the domains generating the score suggest that it is unlikely that Veronica is dependent on alcohol as she does not score highly on domains 4, 5 and 6 which relate to dependence symptoms.

She has recently suffered alcohol-related harm through her fall which is reflected in her higher score for the harmful drinking domain (questions 7–10).

Motivating Veronica

Veronica feels that while she has always enjoyed a drink, she has never over-indulged. It will be important not to make her feel judged and to focus on what matters to her. She has not really thought about how much she is drinking and is surprised to hear about the risks. While Veronica does not want to give up drinking, she is motivated to avoid falling again. The practitioner would be expected to elicit her knowledge about the links between alcohol and falls and how interested she is in taking action. The key thing here is to help Veronica think

of ways to continue to socialize and enjoy life without taking risks she would rather avoid. Veronica offers some change talk for the practitioner to reflect including:

- not wanting to fall again
- wanting to keep her independence.

Veronica is probably ready to make small changes, if they seem manageable without impinging too much on her life.

Post-training materials

Evaluation and monitoring

Considering evaluation and ongoing monitoring

The design of this manual and associated training activities and approaches has been based on an evidence-informed approach. This approach has ensured that:

- all learning activities have clearly defined and specific learning objectives that reflect available evidence;
- the design of pre- and post-test questionnaires relates closely to the learning outcomes and competencies that the training course sets out to develop among practitioners; and
- learning approaches incorporate elements of observation and facilitated self-reflection (particularly through skills practice and development).

The following are key questions for trainers when considering review and evaluation.

- How will you evaluate the immediate impact and ongoing impact of training on practitioners' knowledge, skills and attitudes?
- How will you monitor their style and the approaches used in training?
- How will you monitor and assess any needs for ongoing learning and support in relation to ABI delivery in practice?

Some potential methods are:

- facilitated self-reflection, where an external appraiser supports and guides the process of self-assessment;
- peer observation, which is similar to the above but guided by a colleague: this can be useful for evaluating knowledge, understanding, attitudes and skills in practice, and observations should be incorporated with feedback;
- self-review using observation sheets such as the one in *Handout 8.1* straight after a brief intervention or while reviewing an audio-recording to reflect on your own practice.

Encouraging reflective practice

A useful approach for supporting the effective implementation of ABIs is to encourage reflective practice. This can also be used to monitor and assess the continuing impact of training. It involves participants thinking back on a specific interaction with a patient and considering how they managed to implement each of the different aspects of the ABI approach, that is, raising issues such as alcohol and screening.

Reflective practice can be incorporated into an overall evaluation plan by making time for discussion of ABI delivery and implementation in team meetings. This could be an opportunity for staff to share their reflections recorded on the *Reflective practice recording sheet* and to discuss any continuing support needs.

ABI follow-up clinic

If you are training a wider groups of practitioners (with whom you may not have regular contact), a useful approach to support the delivery, and to review and monitor the implementation, of ABIs is to hold an ABI

follow-up clinic. This involves allocating time (approximately one hour) at an agreed date following the training course (ideally one to three months or six months) to provide support to the practitioners who attended the course. The approaches used can include:

- being available at a set time for trained participants to telephone or drop in to discuss any questions/ issues that have arisen while they were trying to implement ABIs in practice;
- pro-actively following up a selection of participants by telephone to explore:
  - whether they have implemented ABIs in their practice;
  - if yes, to discuss and learn about examples of good practice;
  - if no, to discuss what has prevented them from doing so/what barriers they have experienced; and
  - what (if any) needs they have for continuing support.

The above approaches should be seen as opportunities to reinforce the important principles of ABI delivery and/or to remind practitioners about specific challenges or opportunities that were raised as part of the training. This could include:

- who ABIs are appropriate for;
- the best approaches for raising the issue of alcohol, for example, opportunistic or planned.

Sample pre-course questionnaire

1. Which service do you work for?.....

2. What is your job title/position?.....

3. How long have you been in this post?.....

4. Previous training in alcohol issues *(please circle* **all** *that apply)*:

This is the first time I have attended a training course in alcohol issues	A
I received training in alcohol issues during my professional training/qualification	B
I have completed a formal training course (> 1 day in duration) or have a qualification related to alcohol/drugs/addiction	C
I have received training in relation to changing health behaviour	D
I have received training in alcohol and brief interventions	E

If you circled any of B–E at Q4 above, please give details of the course/s attended.

.....

.....

5. How important do you think it is for health professionals to be able to address patients' drinking behaviour (please circle one option)

Very important	1
Quite important	2
Neither important nor not important	3
Not very important	4
Not at all important	5

6. Knowledge of alcohol-related issues

Please indicate how knowledgeable you feel about the following by assigning a score from 1–4 according to the following scale:

1 = I do not know much about this
2 = I understand a little about this
3 = I understand this well
4 = I understand this very well

	1	2	3	4
The health effects of alcohol				
Standard drinks of alcohol and the alcohol content of common drinks				
Brief interventions as a means of preventing/reducing alcohol problems				
Motivational interviewing techniques				
The AUDIT screening test				
Services for referral of people affected by alcohol problems/ dependency				

7. Dealing with alcohol-related situations

Please indicate how you feel in managing the situations below by assigning a score from 1–4 according to the following scale.

1 = I would not be confident about managing this situation and would not know what to do/say.
2 = I think I could manage this situation but would be a little unsure of what to do/say.
3 = I think I would manage this situation well and I would have a good idea of what to do/say.
4 = I am sure I would manage this situation well – I feel confident about what to do/say and I know who to refer to and where to get appropriate support or advice

	1	2	3	4
Explain what alcohol is and the impact it has on individuals and wider society				
In terms of standard drinks, explain the alcohol content of common drinks and risks to health from different levels of consumption				
Raise the issue of alcohol in an appropriate way				
Encourage patients to take personal responsibility for their drinking/ behaviour				
Use the AUDIT screening test to explore current alcohol use				
Be able to give structured feedback to patients on the results of screening using the elicit – provide – elicit technique				
Be able to use open questions to elicit change talk from patients				
Be able to use reflections to elicit change talk from patients				
Be able to support patients to plan behaviour change and build their confidence				
Be able to deliver alcohol SBIs in routine practice				

Thank you for taking the time to fill in this questionnaire

Sample post-course questionnaire

1. Knowledge of alcohol-related issues

Please indicate how knowledgeable you feel about the following by assigning a score from 1–4 according to the following scale:

1 = I do not know much about this
2 = I understand a little about this
3 = I understand this well
4 = I understand this very well

	1	2	3	4
The health effects of alcohol				
Standard drinks of alcohol and the alcohol content of common drinks				
Brief interventions as a means of preventing/reducing alcohol problems				
Motivational interviewing techniques				
The AUDIT screening test				
Services for referral of people affected by alcohol problems/ dependency				

2. Dealing with alcohol-related situations

Please indicate how you feel in managing the situations below by assigning a score from 1–4 according to the following scale.

1 = I would not be confident about managing this situation and would not know what to do/say.
2 = I think I could manage this situation but would be a little unsure of what to do/say.
3 = I think I would manage this situation well and I would have a good idea of what to do/say.
4 = I am sure I would manage this situation well – I feel confident about what to do/say and I know who to refer to and where to get appropriate support or advice

	1	2	3	4
Explain what alcohol is and the impact it has on individuals and wider society				
In terms of standard drinks, explain the alcohol content of common drinks and risks to health from different levels of consumption				
Raise the issue of alcohol in an appropriate way				
Encourage patients to take personal responsibility for their drinking/behaviour				
Use the AUDIT screening test to explore current alcohol use				
Be able to give structured feedback to patients on the results of screening using the elicit – provide – elicit technique				
Be able to use open questions to elicit change talk from patients				
Be able to use reflections to elicit change talk from patients				
Be able to support patients to plan behaviour change and build their confidence				
Be able to deliver alcohol SBIs in routine practice				

3. On a scale of 1–5 how useful did you find this training course?

1 = Very useful 2 = Useful 3 = Okay 4 = Not very useful 5 = Not useful

Reasons for your choice (*please indicate the most and least useful aspects of the course*):

.....

.....

4. Any other comments?

.....

.....

Thank you for taking the time to fill in this questionnaire

References

1. Babor TF, Higgins-Biddle JC. Brief intervention for hazardous and harmful drinking. A manual for use in primary care. Geneva: World Health Organization; 2001 (http://www.who.int/substance_abuse/publications/audit_sbi/en/, accessed 11 July 2017).

2. Heather N. Interpreting the evidence on brief interventions for excessive drinkers: the need for caution. Alcohol Alcohol. 1995;30(3):287–96 (https://www.academic.oup.com/alcalc/article-abstract/30/3/287/212291/INTERPRETING-THE-EVIDENCE-ON-BRIEF-INTERVENTIONS, accessed 11 July 2017).

3. McCambridge J, Cunningham JA. The early history of ideas on brief interventions for alcohol. Addiction. 2014;109(4):538–46 (https://www.readbyqxmd.com/read/24354855/the-early-history-of-ideas-on-brief-interventions-for-alcohol, accessed 11 July 2017).

4. Gaume J, McCambridge J, Bertholet N, Daeppen JB. Mechanisms of action of brief alcohol interventions remain largely unknown – a narrative review. Front Psychiatry. 2014;5:108 (https://www.ncbi.nlm.nih.gov/pubmed/25206342, accessed 3 July 2017).

5. HEAT (H4): Alcohol brief interventions – national guidance on data reporting 2008–9. Edinburgh: Scottish Government Health Department; 2008.

6. The management of harmful drinking and alcohol dependence in primary care. Edinburgh: Scottish Intercollegiate Guidelines Network; 2003 (http://lx.iriss.org.uk/sites/default/files/resources/sign74.pdf, accessed 11 July 2017).

7. Sundström C, Blankers M, Khadjesari Z. Computer-based interventions for problematic alcohol use: a review of systematic reviews. Int J Behav Med. 2016 (http://www.ncbi.nlm.nih.gov/pubmed/27757844, accessed 11 July 2017). doi:10.1007/s12529-016-9601-8.

8. Prochaska JO, DiClemente CC. Stages and processes of self-change of smoking: toward an integrative model of change. J Consult Clin Psychol. 1983;51(3):390–5.

9. Heather N, Hönekopp J. Readiness to change and the transtheoretical model as applied to addictive disorders. In: Martin LR, DiMatteo MR (editors). The Oxford handbook of health communication, behavior change and treatment adherence. Oxford: Oxford University Press; 2013 (http://www.oxfordhandbooks. com/view/10.1093/oxfordhb/9780199795833.001.0001/oxfordhb-9780199795833, accessed 29 June 2017).

10. Miller WR, Rollnick S. Motivational Interviewing, 3rd ed. Helping people change. New York (NY): Guilford Press; 2012.

11. Kaner EFS, Beyer F, Dickinson HO, Pienaar E, Campbell F, Schlesinger C et al. Effectiveness of brief alcohol interventions in primary care populations. Cochrane Database Syst Rev. 2007;(2):CD004148 (https:// www.ncbi.nlm.nih.gov/pubmed/17443541, accessed 11 July 2017).

12. O'Donnell A, Anderson P, Newbury-Birch D, Schulte B, Schmidt C, Reimer J et al. The impact of brief alcohol interventions in primary healthcare: a systematic review of reviews. Alcohol Alcohol.

2014;49(1):66–78 (http://alcalc.oxfordjournals.org/content/49/1/66.short, accessed 11 July 2017).

13. Jonas DE, Garbutt JC, Amick HR, Brown JM, Brownley KA, Council CL et al. Behavioral counseling after screening for alcohol misuse in primary care: a systematic review and meta-analysis for the U.S. Preventive Services Task Force. Ann Intern Med. 2012;157(9):645–54 (http://www.ncbi.nlm.nih.gov/pubmed/23007881, accessed 11 July 2017).

14. Heather N. The efficacy-effectiveness distinction in trials of ABI. Addict Sci Clin Pract. 2014;9(1):13 (https:// www.researchgate.net/publication/264830925_The_efficacy-effectiveness_distinction_in_trials_of_ alcohol_brief_intervention, accessed 11 July 2017).

15. McCambridge J, Saitz R. Rethinking brief interventions for alcohol in general practice. BMJ. 2017;356(116) (http://www.bmj.com/content/356/bmj.j116, accessed 11 July 2017).

16. Tabak RG, Khoong EC, Chambers DA, Brownson RC. Bridging research and practice: models for dissemination and implementation research. Am J Prev Med. 2012;43(3):337–50 (http://www.ncbi.nlm.nih.gov/pubmed/22898128, accessed 11 July 2017).

17. Damschroder L, Hagedorn H. A guiding framework and approach for implementation research in substance use disorders treatment. Psychol Addict Behav. 2011;25(2):194–205 (https://www.researchgate.net/publication/50890423_A_Guiding_Framework_and_Approach_for_Implementation_Research_in_Substance_Use_Disorders_Treatment, accessed 11 July 2017).

18. Williams EC, Johnson ML, Lapham GT, Caldeiro RM, Chew L, Fletcher GS et al. Strategies to implement alcohol screening and brief intervention in primary care settings: a structured literature review. Psychol Addict Behav. 2011;25(2):206–14 (http://www.ncbi.nlm.nih.gov/pubmed/21517141, accessed 211 July 2017).

19. Nilsen P, Aalto M, Bendtsen P, Seppä K. Effectiveness of strategies to implement brief alcohol intervention in primary healthcare. A systematic review. Scand J Prim Health Care 2006;24(1):5–15 (http://www.ncbi. nlm.nih.gov/pubmed/16464809, accessed 11 July 2017).

20. Johnson M, Jackson R, Guillaume L, Meier P, Goyder E. Barriers and facilitators to implementing screening and brief intervention for alcohol misuse: a systematic review of qualitative evidence. J Public Health (Oxf). 2011;33(3):412–21 (http://www.ncbi.nlm.nih.gov/pubmed/21169370, accessed 11 July 2017).

21. Anderson P, Bendtsen P, Spak F, Reynolds J, Drummond C, Segura L et al. Improving the delivery of brief interventions for heavy drinking in primary health care: outcome results of the ODHIN five country cluster randomized factorial trial. Addiction. 2016;111(11):1935–45 (http://doi.wiley.com/10.1111/add.13476, accessed 11 July 2017).

22. Angus C, Scafato E, Ghirini S, Torbica A, Ferre F, Struzzo P et al. Cost-effectiveness of a programme of SBIs for alcohol in primary care in Italy. BMC Fam Pract. 2014;15(1):26. (http://bmcfampract.biomedcentral. com/articles/10.1186/1471-2296-15-26, accessed 11 July 2017).

23. Fitzgerald N. Commentary on Anderson et al. (2016): The question is not just whether to incentivize and train practitioners on alcohol screening and brief advice, but how? Addiction. 2016;111(11):1946–7 (http://doi.wiley.com/10.1111/add.13513, accessed 11 July 2017).

24. Smith P. On the unintended consequences of publishing performance data in the public sector. Int J Public Adm. 1995;18(2–3):277–310 (http://www.tandfonline.com/doi/abs/10.1080/01900699508525011, accessed 11 July 2017).

25. O'Donnell A, Haighton C, Chappel D, Shevills C, Kaner E. Impact of financial incentives on alcohol intervention delivery in primary care: a mixed-methods study. BMC Fam Pract. 2016;17(1):165 (http:// bmcfampract.biomedcentral.com/articles/10.1186/s12875-016-0561-5, accessed 11 July 2017).

26. Khadjesari Z, Hardoon SL, Petersen I, Hamilton FL, Nazareth I. Impact of financial incentives on alcohol consumption recording in primary health care among adults with schizophrenia and other psychoses: a cross-sectional and retrospective cohort study. Alcohol Alcohol. 2016;52(2):197–205 (https://www. researchgate.net/publication/309187665_Impact_of_Financial_Incentives_on_Alcohol_Consumption_ Recording_in_Primary_Health_Care_Among_Adults_with_Schizophrenia_and_Other_Psychoses_A_ Cross-Sectional_and_Retrospective_Cohort_Study, accessed 11 July 2017).

27. Hamilton FL, Laverty AA, Gluvajic D, Huckvale K, Car J, Majeed A et al. Effect of financial incentives on delivery of alcohol screening and brief intervention (ASBI) in primary care: longitudinal study. J Public Health (Oxf). 2014;36(3):450–9 (http://www.ncbi.nlm.nih.gov/pubmed/24375203, accessed 11 July 2017).

28. Schölin L, O'Donnell A, Fitzgerald N. financial incentives for alcohol brief interventions in primary care in Scotland. Edinburgh: Scottish Health Action on Alcohol Problems (SHAAP); 2017 (http://www.shaap.org. uk/images/remuneration-report-web.pdf, accessed 11 July 2017).

29. Fitzgerald N, Platt L, Heywood S, McCambridge J. Large-scale implementation of ABIs in new settings in Scotland: a qualitative interview study of a national programme. BMC Public Health. 2015;15(1):289 (http://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-015-1527-6, accessed 11 July 2017).

30. Wilson GB, Lock CA, Heather N, Cassidy P, Christie MM, Kaner EFS. Intervention against excessive alcohol consumption in primary health care: a survey of GPs' attitudes and practices in England 10 years on. Alcohol Alcohol. 2011;46(5):570–7 (https://www.ncbi.nlm.nih.gov/pubmed/21690169, accessed 11 July 2017).

31. Town M, Naimi TS, Mokdad AH, Brewer RD. Health care access among U.S. adults who drink alcohol excessively: missed opportunities for prevention. Prev Chronic Dis. 2006;3(2) (https://www.ncbi.nlm.nih. gov/pubmed/16539794, accessed 11 July 2017).

32. Brown J, West R, Angus C, Beard E, Brennan A, Drummond C et al. Comparison of brief interventions in primary care on smoking and excessive alcohol consumption: a population survey in England. Br J Gen Pract. 2015;66(642):e1–9 (https://www.ncbi.nlm.nih.gov/pubmed/26719481, accessed 11 July 2017).

33. Fitzgerald N, Molloy H, MacDonald F, McCambridge J. ABIs practice following training for multidisciplinary health and social care teams: a qualitative interview study. Drug Alcohol Rev. 2015;34(2):185–93 (http:// www.ncbi.nlm.nih.gov/pubmed/25196713, accessed 11 July 2017).

34. McCambridge J. Brief intervention content matters. Drug Alcohol Rev. 2013;32(4):339–41 (https://www. ncbi.nlm.nih.gov/pmc/articles/PMC3746115/, accessed 12 July 2017).

35. Bertholet N, Palfai T, Gaume J, Daeppen J-B, Saitz R. Do brief alcohol motivational interventions work

like we think they do? Alcohol Clin Exp Res. 2014;38(3):853–9 (http://www.ncbi.nlm.nih.gov/pubmed/24125097, accessed 12 July 2017).

36. Fitzgerald N, Angus K, Bauld L. Reported training in ABI trials: a systematic narrative synthesis [Conference abstract]. Addiction Science and Clinical Practice. 2016;11(Suppl 1): A28 (https://ascpjournal. biomedcentral.com/articles/10.1186/s13722-016-0062-9, accessed 12 July 2017).

37. McCambridge J. Brief intervention content matters. Drug Alcohol Rev. 2013;32(4):339–41 (http:// onlinelibrary.wiley.com/doi/10.1111/dar.12044/full, accessed 12 July 2017).

38. McCambridge J, Bendtsen M, Karlsson N, White IR, Nilsen P, Bendtsen P. Alcohol assessment and feedback by email for university students: main findings from a randomised controlled trial. Br J Psychiatry. 2013;203(5):334–40 (http://www.ncbi.nlm.nih.gov/pubmed/24072758, accessed 12 July 2017).

39. Moyers TB, Martin T, Manuel JK, Hendrickson SML, Miller WR. Assessing competence in the use of motivational interviewing. J Subst Abuse Treat. 2005;28(1):19–26 (https://www.ncbi.nlm.nih.gov/ pubmed/15723728, accessed 12 July 2017).

40. Moyers TB, Martin T, Manuel JK, Miller WR, Ernst D. Revised Global Scales: Motivational Interviewing Treatment Integrity (MITI 3.1.1). Albuquerque (NM): University of New Mexico, Center on Alcoholism, Substance Abuse and Addictions; 2010 (https://casaa.unm.edu/download/miti3_1.pdf, accessed 12 July 2017).

41. Tate P, Tate L. The doctor's communication handbook. New York (NY): CRC Press; 2014.

42. Gattellari M, Butow PN, Tattersall MH. Sharing decisions in cancer care. Soc Sci Med. 2001;52(12):1865– 78 (https://www.ncbi.nlm.nih.gov/pubmed/11352412, accessed 12 July 2017).

43. GOV.UK. Consultation outcome. Health risks from alcohol: new guidelines [website]. London: Department of Health; 2016 (https://www.gov.uk/government/consultations/health-risks-from-alcohol-new-guidelines, accessed 6 July 2017).

44. Kaner E, Heather N, Brodie J, Lock C, McAvoy B. Patient and practitioner characteristics predict brief alcohol intervention in primary care. Br J Gen Pract. 2001;51(471):822–7 (http://www.pubmedcentral. nih.gov/articlerender.fcgi?artid=1314128&tool=pmcentrez&rendertype=abstract, accessed 26 August 2017).

45. Alcohol fact sheet [website]. Geneva: World Health Organization; 2015 (http://www.who.int/mediacentre/ factsheets/fs349/en/, accessed 6 July 2017).

46. Adamson J, Templeton L. Silent voices supporting children and young people affected by parental alcohol misuse. London: Children's Commissioner; 2012 (http://dera.ioe.ac.uk/15497/1/FINAL_OCC_Report_ Silent_Voices_Parental_Alcohol_Misuse_FULL_REPORT_11_Sept_2012%5B1%5D.pdf, accessed 26 August 2017).

47. Global status report on alcohol and health 2014. Geneva: World Health Organization; 2014 (http://www. who.int/substance_abuse/publications/global_alcohol_report/en/, accessed 6 July 2017).

48. Nutt DJ, King LA, Phillips LD. Drug harms in the UK: a multicriteria decision analysis. Lancet. 2010;376(9752):1558–65 (http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)61462-6/fulltext, accessed 2 September 2017).

49. Rehm J, Crépault J-F, Fischer B. The devil is in the details! On regulating cannabis use in Canada based on public health criteria. "Comment on Legalizing and Regulating Marijuana in Canada: Review of Potential Economic, Social, and Health Impacts". Int J Health Policy Manag. 2017;6(3):173–6 (http://www.ijhpm. com/article_3263.html, accessed 12 July 2017).

50. McCartney G, Mahmood L, Leyland AH, Batty GD, Hunt K. Contribution of smoking-related and alcohol-related deaths to the gender gap in mortality: evidence from 30 European countries. Tob Control. 2011;20(2):166–8 (http://tobaccocontrol.bmj.com/content/20/2/166, accessed 12 July 2017).

51. Erol A, Karpyak VM. Sex and gender-related differences in alcohol use and its consequences: Contemporary knowledge and future research considerations. Drug Alcohol Depend. 2015;156:1–13 (http://linkinghub. elsevier.com/retrieve/pii/S0376871615016166, accessed 29 June 2017).

52. Wilsnack RW, Wilsnack SC. Gender and alcohol: consumption and consequences. In: Boyle P, Boffetta P, Lowenfels AB, Burns H, Brawley O, Zatonski W et al. Alcohol science, policy, and public health. Oxford: Oxford University Press; 2013:153–60 (http://www.oxfordscholarship.com/view/10.1093/acprof:oso/9780199655786.001.0001/acprof-9780199655786, accessed 12 July 2017).

53. Emslie C, Lewars H, Batty GD, Hunt K. Are there gender differences in levels of heavy, binge and problem drinking? Evidence from three generations in the west of Scotland. Public Health. 2009;123(1):12–4 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2637302/, accessed 12 July 2017).

54. Babor TF, Caetano R, Casswell S, Edwards G, Giesbrecht N, Graham K et al. Alcohol: no ordinary commodity: research and public policy. 2nd ed. Oxford: Oxford University Press; 2010 (http://www.oxfordscholarship. com/view/10.1093/acprof:oso/9780199551149.001.0001/acprof-9780199551149, accessed 12 July 2017).

55. De Bruijn C, Van Den Brink W, De Graaf R, Vollebergh WAM. The three year course of alcohol use disorders in the general population: DSM-IV, ICD-10 and the Craving Withdrawal Model. Addiction. 2006;101(3):385– 92 (http://onlinelibrary.wiley.com/doi/10.1111/j.1360-0443.2006.01327.x/abstract, accessed 12 July 2017).

56. Klingemann H, Sobell MB, Sobell LC. Continuities and changes in self-change research. Addiction. 2009;105(9):1510–8 (http://doi.wiley.com/10.1111/j.1360-0443.2009.02770.x, accessed 12 July 2017).

57. Dawson DA, Grant BF, Stinson FS, Chou PS. Maturing out of alcohol dependence: the impact of transitional life events. J Stud Alcohol. 2006;67(2):195–203 (https://www.ncbi.nlm.nih.gov/pubmed/16568565, accessed 12 July 2017).

58. Rehm J, Anderson P, Manthey J, Shield KD, Struzzo P, Wojnar M et al. Alcohol use disorders in primary health care: what do we know and where do we go? Alcohol Alcohol. 2015;51(4):422–7 (https://www.ncbi.nlm.nih.gov/pubmed/26574600, accessed 12 July 2017).

59. Williams S, Brown A, Patton R, Crawford MJ, Touquet R. The half-life of the "teachable moment" for alcohol misusing patients in the emergency department. Drug Alcohol Depend. 2005;77(2):205–8 (http:// www.ncbi.nlm.nih.gov/pubmed/15664722, accessed 12 July 2017).

60. McCambridge J, Kypri K. Can simply answering research questions change behaviour? Systematic review and meta analyses of brief alcohol intervention trials. PLoS One. 2011;6(10):e23748 (http://journals.plos. org/plosone/article?id=10.1371/journal.pone.0023748, accessed 29 June 2017).

61. Martineau F, Tyner E, Lorenc T, Petticrew M, Lock K. Population-level interventions to reduce alcohol-related harm: an overview of systematic reviews. Prev Med. 2013;57(4):278–96 (http://www.ncbi.nlm. nih.gov/pubmed/23811528, accessed 12 July 2017).

62. Chikritzhs T, Stockwell T, Naimi T, Andreasson S, Dangardt F, Liang W. Has the leaning tower of presumed health benefits from "moderate" alcohol use finally collapsed? Addiction. 2015;110(5):726–7 (http://doi. wiley.com/10.1111/add.12828, accessed 31 August 2017).

63. CMO's alcohol guidelines document set. London: Department of Health; 2016 (https://www.gov.uk/ government/uploads/system/uploads/attachment_data/file/490560/List__of_documents_acc.pdf, accessed 31 August 2017).

64. Cornah D. Cheers! Understanding the relationship between alcohol and mental health. Vol. 33. London: Mental Health Foundation; 2006 (https://www.mentalhealth.org.uk/file/1250/download?token=3pcj8xzE, accessed 31 August 2017)

65. Lönnroth K, Williams BG, Stadlin S, Jaramillo E, Dye C. Alcohol use as a risk factor for tuberculosis – a systematic review. BMC Public Health. 2008;8(1):289 (http://www.ncbi.nlm.nih.gov/pubmed/18702821, accessed 31 August 2017).

66. Rehm J, Baliunas D, Borges GLG, Graham K, Irving H, Kehoe T et al. The relation between different dimensions of alcohol consumption and burden of disease: an overview. Addiction. 2010;105(5):817–43 (http://www.ncbi.nlm.nih.gov/pubmed/20331573, accessed 31 August 2017).

67. Rehm J, Samokhvalov AV, Neuman MG, Room R, Parry C, Lönnroth K et al. The association between alcohol use, alcohol use disorders and tuberculosis (TB). A systematic review. BMC Public Health. 2009;9(1):450 (http://www.ncbi.nlm.nih.gov/pubmed/19961618, accessed 31 August 2017).

68. Raviglione M, Poznyak V. Targeting harmful use of alcohol for prevention and treatment of tuberculosis: a call for action. Eur Respir J. 2017;50(1) (http://erj.ersjournals.com/content/50/1/1700946.long, accessed 31 August 2017).

69. Baum MK, Rafie C, Lai S, Sales S, Page JB, Campa A. Alcohol use accelerates HIV disease progression. AIDS Res Hum Retroviruses. 2010;26(5):511–8 (http://www.liebertonline.com/doi/abs/10.1089/ aid.2009.0211, accessed 31 August 2017).

70. Room R, Ferris J, Laslett A-M, Livingston M, Mugavin J, Wilkinson C. The drinker's effect on the social environment: a conceptual framework for studying alcohol's harm to others. Int J Environ Res Public Health. 2010;7(4):1855–71 (http://www.mdpi.com/1660-4601/7/4/1855/htm, accessed 31 August 2017).

71. Gell L, Ally A, Buykx P, Hope A, Meier P. Alcohol's harm to others. London: Institute for Alcohol Studies; 2015 (http://www.ias.org.uk/uploads/pdf/IAS reports/rp18072015.pdf, accessed 31 August 2017).

72. Babor TF, Higgins-Biddle JC, Saunders JB, Monteiro MG. The Alcohol Use Disorders Identification Test Guidelines for Use in Primary Care. Second edition. Geneva: World Health Organization; 2001 (http:// www.talkingalcohol.com/files/pdfs/WHO_audit.pdf, accessed 31 August 2017).

73. Lexicon of alcohol and drug terms. Geneva: World Health Organization; 1994 (http://apps.who.int/iris/bitstream/10665/39461/1/9241544686_eng.pdf, accessed 31 August 2017).

74. Shaw S, Cartwright A., Spratley T, Harwin J. Responding to drinking problems. London: Croom Helm; 1978.

75. Deehan A, Taylor C, Strang J. The general practitioner, the drug misuser, and the alcohol misuser: major differences in general practitioner activity, therapeutic commitment, and "shared care" proposals.Br J Gen Pract. 1997;47(424):705–9 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1409931/, accessed 29 June 2017).

76. Raistrick D, Heather N, Godfrey C. Review of the effectiveness of treatment for alcohol problems. London: National Treatment Agency for Substance Misuse; 2006 (http://www.nta.nhs.uk/uploads/nta_review_of_the_effectiveness_of_treatment_for_alcohol_problems_fullreport_2006_alcohol2.pdf, accessed 31 August 2017).

77. International classification of diseases and related health problems, 10th revision [website]. Geneva: World Health Organization; 2010 (http://apps.who.int/classifications/icd10/browse/2010/en, accessed 26 August 2017).

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