**UNIT**

# 4 Introduction: Alcohol and the Individual

## Introduction

Welcome to the final unit of this module. This module deals with alcohol problem interventions that focus on individuals. We have intentionally left individual level interventions to the last unit, because most people think that education, individual counselling or treatment are the only options. In order to tip the balance towards the idea of environmental change, the previous units concentrated on the broad level interventions that can be made to reduce alcohol problems.

There *is,* however, definitely a place for education and skills development to prevent alcohol misuse, and for counselling of individuals who are experiencing alcohol related problems. Formal treatment is also necessary for the few people who are addicted to alcohol.

Although much is published in developed countries about these topics, very little literature based on service delivery and research in Southern Africa is available or accessible.

**There are three Study Sessions in this unit:**

Study Session 1: Alcohol Education. Study Session 2: Early Intervention. Study Session 3: Rehabilitation.

In Session 1, we explore two aspects of awareness raising and skills development in relation to alcohol, particularly when it comes to young people. Preventive campaigns through schools and mass media are discussed, and the dearth of such programmes with regard to alcohol prevention in the developing world is highlighted.

Session 2 provides an introduction to the strategy of Brief Interventions, with some evidence and debate on the efficacy of the approach.

Session 3 focuses on rehabilitation issues, concentrating more on the accessibility of rehabilitation services than on the actual processes.

## INTENDED LEARNING OUTCOMES OF UNIT 4

**By the end of this unit, you should be able to:**

* Describe possible educational and skills development programmes commonly used to raise awareness of alcohol problems.
* Understand the role of mass media in raising awareness and promoting policies.
* Assess the application of some of the alcohol education interventions to a local target group.
* Explain the concept and technique of Brief Interventions.
* Identify key opportunities at a primary care level for alcohol screening, counseling (motivational interviewing) and referral.
* Describe the requirements for building staff capacity to carry out Brief Interventions.
* Discuss the potential for people to overcome alcohol dependency, and the factors that influence the ability to practice “normal drinking”.
* Understand the aspects of western rehabilitation services which need to change in order to improve access, appropriateness, affordability and availability.

We hope that you will find the unit helpful and that you will become an advocate for appropriate educational programmes and treatment services in the future. Hopefully the principles of brief interventions will enhance your ability to counsel people with alcohol problems, formally or informally.

# Unit 4 - Session 1 Alcohol Education

## Introduction

The development of Health Education materials and health talks are typical activities of health promoters and health workers, and can be termed *primary prevention*. In the past decade, it was realised that issuing materials or giving didactic talks may improve knowledge of substances such as alcohol, but it does little to enhance young people’s motivation and skills to control their own experimentation, or the habitual use of alcohol by adults. Nowadays these methods are regarded as too passive and often not in tune with the reality of the drinking context.

A number of strategies have been shown to be more effective: these include skills development and interactive methods for improving people’s awareness of the consequences of alcohol abuse, and how they can manage the *pull* factors towards drinking. In addition, multimedia campaigns and *edutainment* programmes, with messages about alcohol embedded in the overall portrayal of lifestyle, are becoming recognised as the most appropriate media for Health Education.

## Session contents

1. Learning outcomes of this session
2. Readings
3. Awareness and skills development
4. Mass media initiatives
5. Session summary
6. Further reading

## Timing of this session

This session requires you to read three short readings totalling 16 pages and complete two tasks. It should not take you more than an hour and a half.

## LEARNING OUTCOMES OF THIS SESSION

**By the end of this session, you should be able to:**

* + Describe possible educational and skills development programmes commonly used to raise awareness of alcohol problems.
  + Understand the role of mass media in raising awareness and promoting policies.
  + Assess the application of some of the alcohol education interventions to a local target group.

## READINGS

You will be referred to the following readings in the course of this session.

|  |  |  |
| --- | --- | --- |
| **Author/s** | **Reference details** | **Page nos in Reader** |
| Botvin, G. J. &  Kantor, L. W. | (2000). Preventing Alcohol and Tobacco Use Through Life Skills Training. *Alcohol Research and Health,* 24 (4): 250-257. | **47-56** |
| WHO. | (2002). *Prevention of Psychoactive Substance Use. A Selected Review of What*  *Works in the Area of Prevention*. Geneva:  WHO, Dept of Mental Health and Substance Dependence: 22-28. | **464-474** |
| Soul City. | (Undated). *Alcohol and You.* (33 page booklet  linked to radio and TV production). Johannesburg: Jacana Education: 16-21. | **399-408** |

## AWARENESS AND SKILLS DEVELOPMENT

Health Education message development is generally based on an understanding of the beliefs, attitudes and values of people regarding a specific behaviour, as well as the environmental and interpersonal factors influencing the individual’s decision-making. You could refer back to the different theories of health behaviour in your *Health Promotion II* module: decide which are suitable to explain alcohol use, and which could assist us to plan education that enables people to take control over the factors influencing their alcohol use or abstinence. You could also refer to Morojele’s use of the Theory of Planned Behaviour in Adolescent Alcohol Misuse (1997)*,* in Unit 1. In addition, in the Botvin reading below, there is a diagram illustrating the factors that commonly play a role in decision making and behaviour by youth.

Various programmes are run with youth as part of the school curriculum, or within environments like youth clubs, in areas where capacity and resources are to be found. Although the contents, methods and leadership may vary, all of the programmes aim to inform youth of drug and alcohol dangers and consequences; many also try to equip them with enough insight and skills to make responsible decisions about using any substances.

The article by Botvin & Kantor (2000) describes a prevention programme which targeted younger students on the understanding that use of substances increases with age. We need, however, to bear in mind that the type of programme described in this article is based in the United States, where many years of research and programme development has taken place. While there are some innovative programmes in Southern Africa, these are few and far between. This is partly due to the capacity and resources required to offer these programmes, but it is also because alcohol is not yet recognised as a significant Public Health issue in Southern Africa.

As you read the article, consider whether any aspects of the programme would be applicable in your context.

**READING**

Botvin, G. J. & Kantor, L. W. (2000). Preventing Alcohol and Tobacco Use Through Life Skills Training. *Alcohol Research and Health,* 24 (4): 250-257. See pp 47-56 in the Reader.

The Health Promoting Schools initiative that is taking root in Southern Africa is a good vehicle through which alcohol and drug awareness at schools can be promoted. A strength of the Health Promoting Schools philosophy is that it involves all stakeholders related to the school – learners, teachers, parents and the broader community – and aims to increase Health Promotion at the level of environmental as well as curriculum interventions.

A large scale systematic review of prevention strategies for substance abuse was recently released by WHO. They have divided these strategies into regulation of availability, mass media, community based programmes and school based programmes. The authors were not convinced that the school based interventions they had literature on demonstrated a positive outcome, but did say:

“In particular, [this suggests] encouraging programme planners to adopt a formative phase of development that involves talking to young people and testing the intervention out with young people; providing interventions at relevant periods in young people’s development; interventions that are interactive and based on skill development; interventions that have a goal that is relevant and inclusive of all young people; appropriate teacher training for interactive delivery of the intervention; making effective programmes widely available and

adopting marketing strategies that increase their exposure.” (WHO, 2002: 56)

**TASK 1 – Assess awareness-building initiatives**

1. Identify the alcohol issues in your local community with regard to youth.
2. Investigate what kind of awareness and skills building programmes are available to the youth in school and/or through clubs or other groupings such as the church.
3. If there are some interventions, what is your judgment of the design of these programmes, and their effectiveness in building awareness and/or skills?

Building awareness of the risks of alcohol and skills to manage experimentation with alcohol form important aspects of prevention, particularly amongst young people.

## MASS MEDIA INITIATIVES

We have already looked at the role of the media in marketing alcohol and suggested that some control needs to be exerted in this area. Conversely, however, the media and multimedia *edutainment* programmes can serve to integrate various positive health messages with appealing images or dramas. Some of the messages being conveyed are intended to influence people’s behaviour, while others aim to promote understanding of new policies. We include a section of a WHO review of “what works in the area of prevention” which is relevant to the issue of using mass media. You could refer to the whole document if you want more detail. It can also be ordered from WHO on CD.

The authors of this reading emphasise that the use of media is most effective when it is part of a “health advocacy” approach, and where the overall purpose is to provide a more supportive environment for healthy behaviour.

Some key ingredients for a successful mass media campaign are highlighted: having a well defined target group; the undertaking of formative research to understand the target audience and pre-testing campaign materials; in addition, using messages that build on an audience’s current knowledge and which satisfy pre-existing needs and motives is beneficial; addressing knowledge and beliefs which impede adoption of the desired behaviour is also important, as is a long term commitment to the campaign (WHO, 2002).

**READING**

WHO. (2002). *Prevention of Psychoactive Substance Use. A Selected Review of What Works in the Area of Prevention*. Geneva: WHO, Dept of Mental Health and Substance Dependence: 22- 28. See pp 464-474 in the Reader.

You may be familiar with some Southern African examples of educational media. Soul City, for example, is a South African health and development organisation based in Johannesburg, which has had a lot of success in using an edutainment approach. Over approximately the past 10 years, Soul City has produced a TV drama series on various determinants of health, and the prevention and treatment of common conditions. The main characters depicted are also used in radio dramas and print media that accompany the TV series. Soul City has become a well recognised “brand” of edutainment and is being translated for use in many different countries.

The *Alcohol and You* booklet (see Reader) is one example of the print media produced by Soul City. These can be ordered in bulk and used in various settings such as clinics, social development offices and schools. The sensible drinking message is made relevant and realistic to the local context and the typical drinks available.

**READING**

Soul City. (Undated). *Alcohol and You.* (33 page booklet linked to radio and TV production). Johannesburg. Jacana Education: 16-21. See pp 399-408 in the Reader.

**TASK 2 – Identify mass media strategies relevant to alcohol prevention**

Are there any other examples which you have encountered of edutainment or mass media carrying a strong preventive health message? Would any of these strategies work for alcohol problems in your area?

Try using the WHO criteria summarised above to evaluate educational media.

## SESSION SUMMARY

This session provided a brief overview of educational strategies being used to raise awareness of alcohol problems and to shift behaviour towards *sensible*, or low risk use of alcohol. However, in the face of the continuous pressure being applied by companies marketing alcohol, educational programmes have to work hard at countering the image of alcohol portrayed in the media. It has therefore been suggested that education and skills building, through organisations like schools and the mass media, have a role to play in enabling people, especially youth, to make responsible decisions about using alcohol.

## FURTHER READING

* WHO. (2002). *Prevention of Psychoactive Substance Use. A Selected Review of What Works in the Area of Prevention*. Geneva: WHO, Dept of Mental Health and Substance Dependence: 56-57.
* U.S. Dept of Health and Human Services. (June 2000). Ch 5 - Prenatal Exposure to Alcohol. In: *Special Report to US Congress on Alcohol and Health.* Rockville: National Institute on Alcohol Abuse and Alcoholism: 323- 338.

# Unit 4 - Session 2 Early Intervention

## Introduction

In this session, we explore the Brief Intervention approach which is a strategy for early intervention in cases of individual alcohol use. Early intervention aims to identify health problems before any permanent damage is done. Using prevention terminology, it is referred to as *secondary prevention*. Although most of what is written about early identification of alcohol problems comes from the health sector, the principles should be applied across all service sectors, i.e. welfare, education, safety and security.

Brief Interventions are promoted as a set of quick, yet effective steps, to ensure that alcohol related problems are identified, that counseling is offered, and follow-up is planned. The integration of Brief Interventions into the health services does, however, require some “reorientation of the health services”. This is in line with one of the action areas of the Ottawa Charter. It is also important to recognise that any intervention is only as good as the personnel offering it, as well as the enabling quality of the environment in which the behavioural change needs to take place.

## Session contents

1. Learning outcomes of this session
2. Readings
3. Brief Interventions
4. Capacity for Brief Interventions
5. Session summary
6. References and further reading

## Timing of this session

This session contains three readings totalling 33 pages, one of which is a handbook, and there are two tasks. It should not take you more than two hours to complete.

## LEARNING OUTCOMES OF THIS SESSION

**By the end of this session, you should be able to:**

* + Explain the concept and technique of Brief Interventions.
  + Identify key opportunities at a primary care level for alcohol screening, counseling (motivational interviewing) and referral.
  + Describe the requirements for building staff capacity to carry out Brief

Interventions.

## READINGS

You will be referred to the following readings in the course of this session.

|  |  |  |
| --- | --- | --- |
| **Author/s** | **Reference details** | **Page nos in Reader** |
| Fleming, M. &  Manwell, L. B. | (1999). Brief Intervention in Primary Care  Settings: A Primary Treatment Method for At- risk, Problem, and Dependent Drinkers. *Alcohol Research and Health,* 23 (2): 128-  137. | **109-120** |
| Living with Alcohol. | (1998). *Living with Alcohol: A Handbook for Community Health Teams.* Northern Territory,  Australia: Territory Health Services: 6-13. | **129-186** |
| Andersen, P. | (1996). *Alcohol and Primary Health Care.*  Geneva: WHO: 39-56. | **19-30** |

## BRIEF INTERVENTIONS

There is unfortunately a general trend for service providers to approach alcohol related social and medical problems in a way that tries to deal with the symptoms of the problem, instead of its root cause. For example, an injured pedestrian presenting at a trauma unit will have the wound cleaned, stitched and bandaged, receive pain killers and be sent home. Seldom will a history of the event be taken to clarify the underlying cause of injury (which could be intoxication). Similarly, behavioural problems such as domestic violence, absenteeism from work and neglect of family responsibilities will not necessarily be investigated for their root cause. In communities with recognised problems of alcohol abuse amongst adults, service providers often

accept that alcohol is potentially the underlying problem, but they seldom have the confidence or will to deal directly with it.

The following reading by Fleming and Manwell (1999) introduces the rationale behind Brief Interventions and describes the basic steps in the technique. Although the literature often refers to “the physician” as the provider, Brief Interventions can be undertaken by any health and social service provider. Note that Brief Interventions have “… proved to be effective” (Fleming & Manwell, 1999: 129) and go beyond counselling, to include the assessment, counselling, referral to support services or specialist services, and a follow-up plan. The article outlines the essential elements or steps in the process, presents evidence of the results of its use in primary care settings, and places the approach in context with regard to alcohol problems and other intervention approaches. Acquaint yourself with Task 1 before you start reading.

**READING**

Fleming, M. & Manwell, L. B. (1999). Brief Intervention in Primary Care Settings: A Primary Treatment Method for At-risk, Problem, and Dependent Drinkers. *Alcohol Research and Health,* 23 (2): 128-137. See pp 109-120 in the Reader.

**TASK 1 – Try out a simulated Brief Intervention**

1. Ask a colleague or friend to role play a Brief Intervention with you, using the Five Essential Steps on page 130 of the reading by Fleming and Manwell (1999). The most important part of this process will be to discuss with your colleague or friend how they *felt* during the process and how you came across when asking the questions. Were you sufficiently respectful, were you empathetic but firm? This will give you some insights into the experience of an individual who is at the receiving end of a Brief Intervention.
2. What factors might influence the way the client received the message of the Brief Intervention?

Many authors, in discussing Brief Interventions, also refer to a Behaviour Change Model – the Stages of Change Model developed by Jim Prochaska and Carlo Di Clemente. The point they make is that the impact of the counselling message may differ according to the client’s level of realisation or recognition of the problem, and their level of motivation to change. Take a look at the diagram below (Rollnick et al, 1999: 19) which is adapted from Prochaska and Di Clemente and identifies six stages of readiness to change.

**SIX STAGES OF READINESS TO CHANGE**

Contemplation

Determination

Precontemplation

Action

Relapse

Maintenance

Permanent Exit

In the context of Brief Interventions, the actual counselling part is referred to as *motivational interviewing*. There are many booklets and charts available to assist service providers to use this theory to be more effective in their counselling. Study the example of an alcohol intervention booklet from Australia developed by a group called Living with Alcohol (1998), and decide to what extent it could be used in your own context. The booklet presents a range of helpful questions to prompt you to prepare yourself to conduct an alcohol intervention.

**READING**

Living with Alcohol. (1998). *Living with Alcohol: A Handbook for Community Health Teams.* Northern Territory, Australia: Territory Health Services: 6-13. See pp 179- 186 in the Reader.

## CAPACITY FOR BRIEF INTERVENTIONS

As with so many interventions at a primary care level, there are inevitably problems with the capacity and facilities to render these effectively. The consumers also have perceptions and expectations as to what treatment they should receive when attending a primary level facility. Unfortunately, Brief Interventions fall easily into the category of “non-essential” services, and may be seen as requiring too much time per consultation.

The following reading offers insight into some of the barriers to implementing Brief Interventions, and draws attention to the capacity building strategies necessary to equip providers to be effective.

**READING**

Andersen, P. (1996). *Alcohol and Primary Health Care.* Geneva: WHO: 39-56. See pp 19-30 in the Reader.

**TASK 2 – Consider the use of Brief Interventions**

Consider your local primary level health service provider, whether public or private, and answer the following questions:

1. When going for a consultation, is your use of alcohol discussed, no matter what the presenting problem is?
2. If you told your health professional that you were drinking excessively, what would his or her approach be and what sort of advice would you expect?
3. Do you think your provider knows about the techniques of Brief Interventions?
4. If you were a health manager in the area where you live, what strategies would you use to ensure that all public and private health services implement brief interventions for alcohol related problems?

We have already noted that alcohol is not widely recognised as a significant Public Health issue in Southern Africa, a factor which is likely to influence the allocation of resources for capacity building, as well as the importance accorded to alcohol counseling programmes in health facilities. Think back to the economics of alcohol production, and the cultures which surround drinking in your own context. Are these potential factors for under-valuing alcohol problems in the field of Public Health?

## SESSION SUMMARY

There is a lot of work to be done within the primary level of health and social service provision to increase screening and counseling for alcohol related problems. If more practitioners were to be equipped with Brief Intervention skills, there would hopefully be fewer people requiring rehabilitation for alcohol dependence, less violence, fewer accidents and chronic health problems.

The concept of a Brief Intervention can be applied to many health related problems such as diet, exercise and smoking: this health promoting approach could therefore be used to impact on a range of conditions. In the final session of this unit, we discuss rehabilitation.

## REFERENCES AND FURTHER READING

* Rollnick, S., Mason, P., Butler, C. (1999). *Health Behaviour Change: A Guide for Practitioners.* Philadelphia: Churchill Livingstone.

# Unit 4 - Session 3 Rehabilitation

## Introduction

As alcohol abuse becomes more recognised as a health and lifestyle problem, there need to be support services to match the demand. The first two readings in this session contextualise alcohol dependency in the life course and describe the recovery from alcohol dependency as an individual process, the outcome of which is difficult to predict. One of the support organisations dealt with in some detail is Alcoholics Anonymous (AA).

In this session, we focus mainly on the western medical model rehabilitation services and examine their levels of suitability for the population, using the example of the Gauteng Province in South Africa. The appropriateness of rehabilitation services is taken further by exploring the “fit” of traditional western rehabilitation programmes for women with alcohol problems.

## Session contents

1. Learning outcomes of this session
2. Readings
3. Treatment for alcohol dependence
4. Accessibility and appropriateness of treatment
5. Session summary
6. References and further reading

## Timing of this session

This session includes four readings totalling 42 pages. In addition, there are two tasks. It should take you about three hours to complete.

## 1 LEARNING OUTCOMES OF THIS SESSION

**By the end of this session, you should be able to:**

* Discuss the potential for people to overcome alcohol dependency, and the factors that influence the ability to practice “normal drinking”.
* Understand the aspects of western rehabilitation services which need to change in order to improve access, appropriateness, affordability and availability.

## 20 READINGS

You will be referred to the following readings in the course of this session.

|  |  |  |
| --- | --- | --- |
| **Author/s** | **Reference details** | **Page nos in Reader** |
| Edwards, G.,  Marshall, E. J. & Cook, C. C. H. | (1997). Ch 11 - Drinking Problems and the Life Course. *Treatment of Drinking Problems:*  *A Guide for the Helping Professions.* Cambridge: Cambridge University Press: 175- 185. | **79-86** |
| Edwards, G.,  Marshall, E. J. & Cook, C. C. H. | (1997). Ch 18 - Working Towards Normal Drinking. *Treatment of Drinking Problems: A Guide for the Helping Professions.* 3rd Edition. Cambridge: Cambridge University Press: 305-  309. | **87-92** |
| Beckman, L. J. | (1994*).* Treatment Needs of Women with  Alcohol Problems: Theory, Methods and Empirical Findings. *Alcohol Health and Research World,* 18(3): 206-211. | **32-38** |
| Myers, B. | (2004) *Audit of specialist substances abuse*  *treatment facilities in Gauteng: Monitoring substance abuse treatment service delivery.* Cape Town: Medical Research Council, Alcohol and Drug Research Group: 7-17 & 95  - 101 | **237-256** |

## TREATMENT FOR ALCOHOL DEPENDENCE

Whatever one’s view of alcohol dependence - the extent to which it is seen as a disease which is genetically linked, or socially acquired - there are people in all societies who become addicted to alcohol, suffering reduced daily functioning and long term health problems. For this reason, *tertiary* or

specialised facilities are necessary, as are community based support groups to assist people to gain and maintain control over their addiction for as long as possible.

The treatment of alcohol dependence typically can include: short term medical intervention and management of detoxification over a few days, followed by residential care of varying duration, or outpatient treatment. We are not going to discuss the actual rehabilitation programmes typically used in Southern Africa. It suffices to say that most established and registered rehabilitation centres use the same approaches and methods as in western countries. However, the majority of the population either does not have access to these centres, and or makes use of a different approach, based on traditional medicine or spiritual healing, directed by their religious affiliation. Little is written about the conceptualisation of and approach to alcohol addiction in traditional African groupings.

The next readings by Edwards, Marshall & Cook (1997) explore alcohol dependence and the factors that may indicate the potential for successful rehabilitation in different individuals. The point is also made that dealing with alcohol dependence is a long term process and not just a once off rehabilitation event.

Some people are also more likely to be able to be “normal drinkers” than others. The factors influencing this are covered in Chapter 18.

**READINGS**

Edwards, G., Marshall, E. J. & Cook, C. C. H. (1997). Ch 11 - Drinking Problems and the Life Course. *Treatment of Drinking Problems: A Guide for the Helping Professions.* 3rd Edition. Cambridge: Cambridge University Press: 175-185. See pp

79-86 in the Reader.

Edwards, G., Marshall, E. J. & Cook, C. C. H. (1997). Ch 18 - Working Towards Normal Drinking. *Treatment of Drinking Problems: A Guide for the Helping Professions.* 3rd Edition. Cambridge: Cambridge University Press: 305-309. See pp 87-92 in the Reader.

Alcoholics Anonymous (AA) is a well established voluntary network of groups of people who meet regularly to support each other to maintain their sobriety. Although some people do not identify with the religiously based *12 Steps* that form the basis of the AA philosophy, there is research evidence to indicate that it assists many people with strengthening their commitment to sobriety. It also provides an alternative social setting to the drinking environment, and a *buddy system* of support. The organisation originates in the USA and has spread across the globe. It seems that in Southern Africa, there are branches in some of the urban areas (Parry & Bennetts, 1998:173).

These are the AA’s “12 steps”:

1. We admit we were powerless over alcohol – that our lives had become unmanageable.
2. Came to believe that a power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understand Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so

would injure them or others.

1. Continued to take personal inventory and when we were wrong promptly admitted it.
2. Sought through prayer and meditation to improve our conscious contact with God as we understand him, praying only for knowledge of His will for us and

the power to carry that out.

1. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our

affairs.

## ACCESSIBILITY AND APPROPRIATENESS OF TREATMENT

There is little research or follow-up done on people who have attended formal rehabilitation, and even less research on people who have alcohol dependency, but succeed in gaining control over it through religious conversion or personal will power. We can therefore only assume that there is some value in these formalised treatment programmes, based on established western medical model approach, which are offered in Southern Africa.

From a Public Health point of view it is important that rehabilitation services are, like any other health service, **a**vailable, **a**ccessible, **a**ffordable, and **a**ppropriate. Unfortunately, alcohol rehabilitation services fall short in all these respects. There is currently an audit process underway in South Africa using these four criteria, and so far, Cape Town and Gauteng have been covered. The results indicate much room for improvement in all four of these measures. Gauteng and Cape Town probably have the most resources and best developed services in Southern Africa, so if the rehabilitation services in these areas are found to be inadequate, those in other areas are likely to be almost non-existent.

**READING**

Myers, B. (2004). *Audit of Specialist Substances Abuse Treatment Facilities in Gauteng: Monitoring Substance Abuse Treatment Service Delivery.* Cape Town: Medical Research Council, Alcohol and Drug Abuse Research Group: 7-17 & 95-

101. See pp 237-256 in the Reader.

**TASK 1 – Accessibility and appropriateness of rehabilitation services**

Find out about the alcohol rehabilitation services nearest to your community – inpatient and outpatient.

* 1. Try to establish what the criteria are for admission into these programmes, and if there are any barriers in terms of cost, language or diagnosis.
  2. Are they accessible and appropriate for anyone in the catchment area who may require the services? If they are not, why is this?

To return to our theme of understanding alcohol use by women, the next article by Beckman (1994) questions the applicability of the well established in-patient treatment model, and proposes “women-oriented alcoholism treatment”. Such treatment requires health practitioners to rethink their attitudes and practices, taking account of women’s preferred styles of interaction and of the particular experiences of alcoholic women, such as physical and sexual abuse or reproductive health problems.

**READING**

Beckman, L. J. (1994*).* Treatment Needs of Women with Alcohol Problems: Theory, Methods and Empirical Findings. *Alcohol Health and Research World,* 18(3): 206-211. See pp 31-38 in the Reader.

**TASK 2 – Women’s roles and needs with regard to alcohol**

1. After reading the article about women oriented alcohol treatment, think about the gender roles that women in your culture play on a daily basis. How is “alcoholism” in women viewed in your community?
2. Could a *women only* treatment programme that takes women’s roles and needs into account be acceptable and successful if offered in your area? Why or why not?

## SESSION SUMMARY

In this session we have concentrated more on the issues of accessibility of rehabilitation services than on the nature of the services per se. We have also emphasised the point that some people with alcohol dependency will have to try to abstain from ever using alcohol, while others may be able to learn to be “normal drinkers”.

It should be part of any advocacy work around alcohol problems to lobby for appropriate rehabilitation and counseling services for *all* people in a given population who may *need* the service. This is a challenge when we plan for the diversity one finds in Southern Africa in terms of belief systems, religion, language and gender. At present, by screening people for alcohol problems, we may be raising false hopes that they can be helped to overcome their alcohol problems, since there is such low capacity in the health and welfare services.

This is the end of the module: we hope that it has been interesting, and stimulated you to continue to work in this field or to add your capacity to building this field. We would be most grateful if you would give us some feedback by filling in the evaluation form over the page, and sending it back with your assignment. Good luck with your endeavours in the area of alcohol problems!

## REFERENCES AND FURTHER READING

* Parry, C.D.H. & Bennetts A. (1998) *Alcohol Policy and Public Health in South Africa.* Cape Town: Oxford University.
* Morgenstern, J., Labouvie, E., McCrady, B. S., Kahler, C. W. & Frey, R. M. (1997). Affiliation with Alcoholics Anonymous after Treatment: A Study of its Therapeutic Effects and Mechanisms of Action. *Journal of Consulting and Clinical Psychology,* 65 (5): 768-777.
* Myers, B. & Parry, C. (2003). *Report on Audit of Substance Abuse Treatment Facilities in Cape Town - 2002.* Cape Town: Alcohol & Drug Abuse Research Group, Medical Research Council.

**EVALUATION FORM FOR *ALCOHOL PROBLEMS: A HEALTH PROMOTION APPROACH***

*Please would you be so kind as to fill in the form below giving us your comments on the module. Please send it back to The Student Administrator with your assignment. Thank you.*

1. In general, how do you feel about the module?
2. What aspects of the module challenged you to think more deeply about alcohol problems?
3. Were there any sessions or readings which you found difficult?
4. Are there any sections of the module which could be better explained? Be as specific as possible.
5. Was the timing suggested useful or accurate?
6. Could the structure of the sessions or the reader be changed in any way to make them more user friendly?
7. Do you think the module will have relevance in your workplace? Please explain how.
8. Are there any improvements you could suggest to the assignments?

Thank you very much.