Masters in Public Health

Alcohol Problems: A Health Promotion Approach

Module Guide

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School of Public Health
University of the Western Cape

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Module Registration Number: 880111
Value of module: 20 credits
Study time required: 200 notional learning hours

Pre-requisites:
Postgraduate Diploma in Public Health or equivalent;
Core modules for the Masters in Public Health

Study Materials for this module:
Module Guide & Module Readings

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The vision of the School of Public Health at the University of the Western Cape is to build the capacity of Public Health workers to transform the health sector from a predominantly curative, hospital-based service to a high quality, comprehensive, community-based, participatory and equitable system. The aim of this module is to enhance the measurement skills required to achieve these Public Health objectives.

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I MODULE INTRODUCTION

1 LETTER OF WELCOME

School of Public Health (SOPH)
University of the Western Cape
Private Bag X17
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South Africa

Dear colleague,

Welcome to the 'Alcohol Problems: A Health Promotion Approach' module. Since alcohol abuse can have negative consequences for individuals, families and the wider society, it constitutes an important public health issue. Unfortunately it is not as straightforward to deal with on a policy and educational level as other tobacco, because alcohol can be used with no harmful effect if used responsibly. In developing countries it is still a neglected problem in terms of prevention and rehabilitation, with few resources allocated to law enforcement, awareness raising, and training of service providers and policy makers.

We have purposely introduced the history of the use of alcohol in Southern Africa at the beginning of the module, as the history has important socio-political, economic and behavioural influences on current patterns of alcohol use.

The module will help you to develop an understanding of the various consequences of alcohol abuse and of the research processes used to measure this. The rest of the module will provide you with approaches to preventing alcohol problems, ranging from policy and environmental changes to educational and rehabilitation programmes. Some of the readings were chosen to illustrate the main concepts of the module using the following themes: youth, women, and foetal alcohol syndrome.

We hope that you will be equipped to assess alcohol problems in the communities in which you work and live, and have some realistic ideas on initiatives involving people in taking control of alcohol sales and consumption. This is normally demonstrated through the two assignments that are required to be done for this module.

We hope that you find the module interesting and that you will be an advocate for putting alcohol problems higher on the public health agenda locally and

nationally.

We would greatly value your feedback on how you found the experience of completing the Module. You can let off steam and reflect on what you have gained from this experience, while letting us know how we could have made the study experience easier and more useful for you. For your convenience, please use the Module Evaluation Form located on this site. We suggest you complete the Evaluation Form soon after you complete the module.

Sincerely

Kirstie Rendall-Mkosi
Module Convenor

2 INFORMATION ABOUT THIS MODULE

2.1 Module Aims and Rationale

This module is designed to address the following issues:

- The history of the use of alcohol, focusing on developing countries;
- How the burden of disease/injury and social problems relates to alcohol;
- The concepts of responsible drinking, risky drinking, and dependent drinking;
- The different approaches that can inform health promotion strategies to reduce alcohol related problems;
- Planning interventions on a policy, environmental and individual basis;
- Community based programme planning and development using the Ottawa Charter as a framework.

2.2 Module Outline

The module consists of four units, each of which is divided into three study sessions.

Study sessions vary in length, and may take between five and six hours to complete. The four units are as follows:

Unit 1 - Alcohol Origins and Use.

Unit 2 - Consequences and Approaches to Alcohol Problems.

Unit 3 - Policy and Environmental Interventions.

Unit 4 - Alcohol and the Individual.

2.3 Learning Outcomes

This module is intended to assist you in further developing the following skills and knowledge.

By the end of this unit, you are expected to be able to:
▪ Develop tools for planning, monitoring and evaluating alcohol interventions. ▪ Discuss the shifts in patterns of alcohol use in South Africa, in relation to socio-political and cultural factors. ▪ Contrast the benefits and harmful effects of alcohol, particularly in developing contexts.

- Identify and interrogate measures used in collecting alcohol related data and the factors which affect them.
- Use these measures critically to identify patterns of use.
- Explain and apply different explanations and theories of alcohol use, addiction and dependence, and how these theories influence prevention and treatment approaches.
- Describe and contrast the Harm Reduction and the traditional Preventive approaches to alcohol problems and their range of relevant strategies.
- Describe the range, requirements and uses of multifaceted integrated programmes in the control of alcohol problems.
- Show a critical understanding of the role of different agencies (such as government, media and community involvement) in alcohol intervention.
- Describe ways in which policy can be used to control the use, marketing, cost, availability and contents of alcohol.
- Describe and assess the concept and technique of the Brief Interventions strategy to alcohol intervention and assess the requirements for making the intervention succeed.

2.4 Texts and References

Parry, C.D.H., & Bennetts, A.L. (1998). *Alcohol Policy and Public Health in South Africa.* Cape Town: Oxford University Press

You will also be expected to pursue relevant current literature and additional resource material as required for your assignment tasks. The School of Public Health provides students with a Reader of just over 400 pages, which contains the required readings for the module, but not the readings listed under Further Readings at the end of each session. SOPH pays for copyright for these Readers per student and therefore cannot offer the Reader as an OER.

Relevant websites

The following websites may be helpful to you in the course of this module:

Web Address	Organisation / document
www.mrc.ac.za/adarg/adarg.htm	Alcohol and Drug Abuse Research Group – Medical Research Council. Can download recent publications.
http://wn.apc.org/sanca/	South African National Council on Alcohol and Drug Abuse. Resource centre in Milpark, Johannesburg.
www.CDA.gov.za	Central Drug Authority. Responsible for implementation of National Drug Master Plan.
www.niaaa.nih.gov/	National Institute on Alcohol Abuse and

	Alcoholism – part of the National Institutes of Health in the USA. Range of resources.
www.adca.org.au/	Alcohol and other Drugs Council of Australia – NGO representing alcohol and other drugs field.
www.alcohol.org.nz/	Alcohol Advisory Council of New Zealand
www.ccsa.ca	Canadian Centre on Substance Abuse
www.ias.org.uk	Institute of Alcohol Studies
www.cad.org.za	Christian Action for Dependents in South Africa
www.alcoholicsanonymous.org.za	Alcoholics Anonymous in South Africa
www.fasworld.com	National Organisation on FAS in Canada

2.5 Module Evaluation

When you come to end of the module, we would be grateful if you could provide us with feedback on how you found the experience – what was good about it, as well as things you would like to see changed. A link to the evaluation form is located on the webpage menu. This feedback will assist us in revising the module, planning future modules and providing students with appropriate support.

3 ASSESSMENT

3.1 Information about Assessment

There are TWO compulsory assignments in the module.

The modules are weighted as follows:
Assignment 1: 40%
Assignment 2: 60%

To pass the module:

- You are required to pass both assignments with a minimum of 50%.
- You must have a minimum aggregate of 50% or more for the module.
- If you get below 50% in Assignment 1, you may repeat it once only.
- If you do not pass it second time around, you cannot proceed to Assignment 2 and must repeat the module.
- If you do not achieve 50% in Assignment 2, you repeat the entire module the following year.

3.2 Assignments for *Alcohol Problems: A Health Promotion Approach*

ASSIGNMENT 1: A Comparison of Two Approaches to Alcohol Problems
(100 marks; length: 2 500 words) (40% of module result)

Compare "reduction in consumption" and "harm reduction" - the two main approaches to reducing alcohol related problems at a population level.

Discuss the theoretical origins and main principles of the two approaches. Describe a concrete example of each approach in action, from the literature.

Then, briefly describe a local setting where drinking takes place and argue for the use of either one of the two approaches in implementing one specific strategy, giving reasons for the choice.

Marking Criteria: Assignment 1	**Marks**
Assignment has a logical structure & is written in an academic style.	10
The approaches and their theoretical origins are clearly distinguished.	30
Appropriate examples are presented.	10
Reasons for choice of approach and strategy are convincingly argued.	30
Insight and creativity is evident.	10
Referencing and Reference List/Bibliography are presented in a recognised academic format.	10
Total	100

ASSIGNMENT 2: Plan an Intervention for Alcohol Problems
(100 marks; length: 2 500 words) (60% of module result)

Plan a range of appropriate interventions to reduce alcohol related harm for a specific target group or risky setting in the area where you live or work.

Address the following issues in the discussion of your plan:
a) The community group or setting.
b) Evidence of alcohol related problem/s in terms of patterns of alcohol use, the social dynamics involved, and the consequences of alcohol abuse.
c) Describe and justify key interventions at a policy, environmental and personal level that could realistically reduce the risks in this setting.

Marking Criteria: Assignment 2	**Marks**
Assignment has a logical structure & is written in an academic style.	10
Sound description and analysis of drinking patterns and consequences.	20
Scope, appropriateness to setting and creativity of interventions is evident.	30
Rationale for choices of interventions convincingly argued.	20
Appropriate structures and role players are included in the intervention strategies.	10
Referencing and Reference List/Bibliography are presented in a recognised academic format.	10
Total	**100**

UNIT 1

Introduction:
Alcohol Origins and Use

Introduction

Welcome to the first unit of this module, which has been designed to present a contextual background to the topic of alcohol problems in the Southern African context. The first unit focuses on the history of alcohol in this region, as well as patterns of consumption and abuse.

Remember that alcohol is no ordinary commodity: so before looking at the consequences of problematic uses of alcohol, you need to think and read about its use and meaning to different people. This will lay the foundation for understanding the difficulties and challenges of designing appropriate legislation for control of alcohol, and for shifting patterns of alcohol use in different communities.

There are three Study Sessions in this unit:

Study Session 1: Alcohol: Origins of Use, and Value as a Commodity.

Study Session 2: Patterns of Consumption.

Study Session 3: The Theories of Alcohol Use and Addiction.

In Session 1, we explore the history of alcohol use and production in colonial and post-colonial Southern Africa, the socio-political and cultural influences on the use of alcohol in developing countries, and the impact of industrialising alcohol production in these contexts.

Session 2 provides an overview of the concepts and measures used in researching alcohol problems, and stresses the importance of understanding social and cultural patterns of alcohol usage.

Session 3 focuses on the theories of alcohol use and health behaviour, and explores how one's model of understanding alcohol problems influences the intervention strategies one is likely to choose.

INTENDED LEARNING OUTCOMES OF UNIT 1

By the end of this unit, you should be able to:
▪ Discuss the origins and shifts in alcohol use in Southern Africa in relation to socio-political forces. ▪ Explain the production and consumption of alcohol as an economic activity. ▪ Identify and interrogate measures used in collecting alcohol related data. ▪ Identify the patterns of use and other critical factors which promote or limit the use of alcohol. ▪ Discuss cultural variables in the measurement of alcohol consumption. ▪ Explain and apply the different theories of addiction and dependence. ▪ Describe the influence of these theories on prevention and treatment approaches. ▪ Demonstrate insight into possible explanations for alcohol problems.

This unit is important in providing the essential conceptual tools you will need for addressing alcohol problems using a Health Promotion approach. Commit yourself to engaging with the tasks, as this is the best way to ensure that you have internalised new concepts and issues.

Unit 1 - Session 1

Alcohol: Origins of Use, & Value as a Commodity

Introduction

This session introduces you to the historical, political and socio-economic issues surrounding alcohol from the 1800s to the present. We ask you to consider how alcohol has been used in your own family and to engage in a quick survey of historical changes in the practices of alcohol production, control and usage in the colonial and post-colonial contexts.

We look in some detail at the economics of alcohol production in the developing country context, and who benefits from it, particularly in the Southern African context. This sets the scene for Sessions 2 and 3, where we consider how different communities use alcohol today, as well as the patterns of abuse which have developed from our socio-political past and persist in the present.

A good question to hold in mind while you study this session is:
What political and economic roles has alcohol played, then and now?

Contents

Timing of this session

This session requires you to complete three substantial readings totalling 64 pages and three tasks. It should take you about four hours to complete.

1 LEARNING OUTCOMES OF THIS SESSION

By the end of this session, you should be able to:
▪ Discuss shifts in alcohol use in Southern Africa in relation to socio-political forces. ▪ Explain the production and consumption of alcohol as an economic activity.

2 READINGS

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

Author/s	**Publication details**	**Page numbers in Reader**
Room, R., Jernigan, D., Carlini-Marlatt, B., Gureje, O., Makela, K., Marshall, M. Medina Mora, M., Monteiro, M., Parry, C., Patanen, J., Riley, L., Saxena, S.	(2002). Ch 2 - Drinking in Developing Societies: The Economic, Social and Cultural Context. In *Alcohol in Developing Societies: A Public Health Approach.* Helsinki: Finnish Foundation for Alcohol Studies in collaboration with the WHO: 21-36.	**339-348**
Ambler, C. & Crush, J.	(1992). Ch 1 - Alcohol in Southern African Labor History. In J. Crush & C. Ambler (eds). *Liquor and Labor in Southern Africa.* Pietermaritzburg: University of Natal Press: 1-35.	**1-18**
Jernigan, D. H.	(1999). Ch 9 - Country Profile on Alcohol in Zimbabwe. In L. Riley & M. Marshall (eds.). *Alcohol and Public Health in 8 Developing Countries.* Geneva: WHO: 157-175.	**167-178**

3 THE ORIGINS OF THE USE OF ALCOHOL

In order to understand the complexities of the meaning and use of alcohol in the world today, we need to trace its origin and the influences on its use. Alcohol is no ordinary commodity like milk or bread: because of its *psychoactive* properties, i.e. that it affects the brain and influences behaviour, it has been effectively used and abused across most societies in the world.

Before you start reading, it may be interesting to reflect on your own family's values and experience (historical and cultural) of alcohol by doing **Task 1**.

TASK 1 – Tracing alcohol use in your family

Think of your grandparents or what you know of your great grandparents in the late 1800s and early 1900s.

a) Do you know what norms and values surrounded the use of alcohol in their time?

b) Were norms (like age, gender, time and place of drinking) influenced by factors outside of their immediate community, or did they follow their traditions only?

c) What was the drink of choice? Who produced it and how was it distributed?

d) Now think of your current family and answer the same questions for the present situation, before moving on to question (e).

e) What main factors have resulted in changes in alcohol consumption compared to 100 years ago?

Now compare your conclusions on the factors that have influenced these changes with those identified by Room et al (2002). This historical survey identifies trends in alcohol use which have arisen from our colonial history. As you read, take note of the economic and social trends which are identified as significant areas to investigate in a Health Promotion approach to alcohol use.

READING: Room, R. et al. (2002). Ch 2 - Drinking in Developing Societies: The Economic, Social and Cultural Context. In *Alcohol in Developing Societies: A Public Health Approach.* Helsinki: Finnish Foundation for Alcohol Studies in collaboration with the WHO: 21-36. See pp339-348 in the Reader.

For those of you working in developing contexts, the reading suggests that the contextual aspects of alcohol usage need to be well understood, and sensitively handled in the post-colonial era.

Room et al emphasise the historical links between alcohol and political control of groups of people in colonial Southern Africa. “Alcoholic beverages were … commonly used as a colonizing force to attract, pay, entertain and control indigenous labourers” (Room et al, 2002: 24). However, it is also significant that historically, alcohol followed the same pattern of industrialisation as most other commodities and that colonies were “… turned into markets for alcoholic beverages …” (Room et al, 2002: 24).

In South Africa, home-brewed liquor from the rural areas was recognised as a popular beverage and commodity in the urban areas: it was therefore commercialised alongside the European-origin malt beer. Although this challenged the traditional role that women played in brewing the beer, it did not end their role in brewing and selling liquor in both rural and urban areas. In fact, many of the shebeens and taverns that serve as important places for socialising, are owned by women and enable their owners to make an income. Traditional home-brew is now often sold alongside commercially produced beer, wine and spirits. Another phenomenon which may arise from contextual factors is the emergence of different choices of drink being made by different classes of drinker. Working class people still tend to buy traditional and commercial beer, and sometimes cheap wine, while those aspiring to a middle class lifestyle choose only commercial liquor, particularly spirits.

The next reading by Ambler & Crush (1992) traces the use of alcohol in pre-colonial Africa and Europe, and describes the convergence of the two during the colonial era in the 19th and 20th centuries. The Temperance Movement which swept the world in the 1880s, during which authorities and temperance societies tried to ban the use of alcohol, also had some influence in Southern Africa.

Most striking again is the use of alcohol as a political tool of control by the white colonialists over the majority black population. The tension facing the authorities

between the potential profits in selling liquor and the need to be in control of people's behaviour and movements, is clearly described.

TASK 2 – Consider the impact of the control of alcohol on our society

As you read this chapter, take notes on the effect that past control of access and sale of liquor has had on Southern African societies today.

READING: Ambler, C. & Crush, J. (1992**).** Ch 1 - Alcohol in Southern African Labor History. In J. Crush & C. Ambler (eds). *Liquor and Labor in Southern Africa.* Pietermaritzburg: University of Natal Press: 4-35. See pp 1-18 in the Reader.

In Southern Africa today, it is clear that traditional norms on the use of alcohol have largely been eroded. This is identified as one of the many reasons for increased consumption of alcohol, especially in urban areas. In this regard, think of who produces and sells what alcohol, and the extent of economic gains: in other words, who benefits from the increased use of alcohol today?

Clearly liquor selling and use is an integral part of all communities in Southern Africa and needs to be accepted as such. Any attempt to regulate harmful consumption needs to take this history and economic reality into account. In relation to the economic aspect of the industry, we will discuss the current Liquor Act in South Africa in Unit 3, and the way in which it attempts to formalise the production and sale of liquor. In part, this Act attempts to increase the controls on liquor, while at the same time expanding its economic potential, by increasing the number of licensed sellers, and relaxing the times of operation.

4 ALCOHOL AS A COMMODITY

The production and sale of alcohol is an important aspect of the economy in many countries, and developing countries are no different. However, owing to the transitional nature of their economies, much alcohol production and sale in developing countries takes place informally, making it difficult for the authorities to regulate and tax these transactions.

Some countries have state-run alcohol production, resulting in direct revenue to the government, such as the beer halls in Zimbabwe. Other countries have a few large commercial companies producing and selling liquor, which are directly taxed on their sales. These operate alongside and interact with many unregulated small outlets, such as in South Africa and Nigeria, where it is difficult

for the government to ensure that tax is paid.

The economics of alcohol production and marketing is critical to understand: **Task 3** offers you a chance to consider the issue in your local context before reading about it at national and global levels.

TASK 3 – The economic importance of alcohol in your area

Consider the town or city in which you live, and try to list all the different kinds of producers and sellers of liquor.

a) What proportion are informal sellers and what proportion are formal sellers?

b) Where do they get their stock? Is it brewed on site or is it bought from a wholesaler?

c) Do you know who owns the wholesaler and where the various liquors are produced? If not, try to find out.

d) What are the numbers of people benefiting from the production and sale of alcohol - ranging from the managing director and shareholders of the holding company, to the shebeen owner?

e) What is the geographical spread of liquor outlets? Are there more in working class areas than in middle class areas, or less?

f) What do you conclude about the importance of alcohol as a commodity in your area?

There is unfortunately a lack of research and ongoing surveillance data to confidently describe alcohol production, consumption and consequences in Southern African countries. This includes South Africa which is ranked as a middle-income country and therefore could be viewed as more able to monitor and control issues around alcohol. Understandably Zimbabwe, a low-income country with a legacy of political use of alcohol similar to South Africa, faces many more serious challenges than the control of alcohol.

The next reading by Jernigan (1999) highlights the dilemmas of Zimbabwe with regard to alcohol. Liberalisation of the market economy, under pressure from the International Monetary Fund (IMF) and World Bank, has resulted simultaneously in increased production and advertising of alcohol, and reduced controls on sales, especially in the rural areas. The article also describes the monopoly that exists on traditional and non-traditional alcoholic beverages and the relationship of these to the government of Zimbabwe, and to the South African monopolies.

READING: Jernigan, D.H. (1999). Ch 9 - Country Profile on Alcohol in Zimbabwe. In L. Riley & M. Marshall (eds.). Alcohol and Public Health in 8 Developing Countries. Geneva: WHO: 157-175. See pp167-178 in the Reader.

Jernigan applies his conclusions to developing countries in general, emphasising the need for "… monitoring, research and exchange of experience regarding alcohol policies in developing country contexts. … Without this [he concludes], there is a strong chance that, as in Zimbabwe, alcohol will be left to the market to regulate" (Jernigan, 1999: 171).

5 SESSION SUMMARY

In this session, you have considered contextual influences on alcohol production and consumption. Through the readings, you have hopefully gained some insight into the socio-political history of alcohol and the economics of production and consumption in Southern Africa. If you consider the numbers of people that benefit from alcohol production, it is clearly not to be ignored as a commodity in the market. However, bear in mind that we have not yet discussed alcohol in a balanced way, by looking at the negative consequences of the use of alcohol and the costs thereof.

In the next session, we introduce you to the concepts used for measuring consumption and the importance of understanding the patterns of use in a community. We also consider the consumers' perspective on when, how much, with whom, and where they choose to drink.

6 FURTHER READING

- Mager, A. (1999). The First Decade of "European Beer" in Apartheid South Africa: The State, the Brewers and the Drinking Public, 1962-72*. Journal of African History,* 40: 367-388.
- Haworth, A. & Acuda, S. W. (1998). Sub-Saharan Africa. In M. Grant (ed.). *Alcohol and Emerging Markets. Patterns, Problems and Responses.* USA. International Centre for Alcohol Policies: 19-56.
- Riley, L. & M Marshall. (1999). Country Profile on Alcohol in South Africa. In *Alcohol and Public Health in 8 Developing Countries*. Geneva: WHO: 135-156.

Unit 1 - Session 2

Patterns of Consumption

Introduction

In the first session, we introduced the socio-political and economic issues related to alcohol production and consumption. In this session, the focus is on consumption and patterns of usage.

As you well know, there is plenty of variation in the consumption of alcohol from one person to the next. How do we measure and monitor the use of alcohol by an individual, or in a group, a community or at a societal level? What methods and indicators can be used by health promoters to measure these different levels of consumption, and what are some of the factors that promote or limit alcohol use? Hopefully by the end of this session you will be clearer about these issues, and the dilemmas we face in measuring alcohol use. There are a lot of tasks in this session: try to engage with them, to ensure that you grasp the "essential tools" or concepts you need for working in this field.

Contents

Timing of this session

This session contains eight fairly short readings totalling 32 pages, and six tasks. It is a very important session, so you should work through it thoroughly. It could take you at least four hours to complete.

1 LEARNING OUTCOMES OF THIS SESSION

By the end of this session, you should be able to:
▪ Explain some of the key terms used to describe alcohol consumption and patterns of use. ▪ Identify and interrogate measures used in collecting alcohol related information. ▪ Discuss cultural variables in the measurement of alcohol consumption. ▪ Describe the patterns of use and other critical factors which promote or limit the use of alcohol.

2 READINGS

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

Author/s	**Publication details**	**Page numbers in Reader**
Roche, A. M. & Evans, K. R.	(1998). Ch 13 - The Implications of Drinking Patterns for Primary Prevention, Education, and Screening. In M. Grant & L. Litvak (eds). *Drinking Patterns and Their Consequences.* USA: International Centre for Alcohol Policies: 243-265.	**315-338**
Parry, C.D.H., Bhana, A., Myers, B., Plüddemann, Flisher, A.J., et al.	(2002). Alcohol Use in South Africa: Findings from the South African Community Epidemiology Network on Drug Use (SACENDU) Project. *Journal of Studies on Alcohol*, 63(4): 430-435.	**297-304**
Claasen, J. N.	(Sept. 1999). The Benefits of the CAGE as a Screening Tool for Alcoholism in a Closed Rural South African Community. *South African Medical Journal,* 89(9): 976-979.	**57-62**
Flisher, A. J. et al.	(2001). Substance Use by Students in South Africa, Tanzania and Zimbabwe. *African Journal of Drug & Alcohol Studies,* 1(2): 81-97.	**121-130**
London, L., Nell, V., Thompson, M-L. & Myers, J.E.	(1998). Health Status Among Farm Workers in the Western Cape – Collateral Evidence from a Study of Occupational Hazards. *South African Medical Journal,*	**187-194**

	88(9): 1096-1101.	
Croxford, J. & Viljoen, D.	(Sept. 1999). Alcohol Consumption by Pregnant Women in Western Cape. *South African Medical Journal,* 89: 962-965.	**63-68**
Bennett, L. A., Janca, A., Grant, B. F. & Sartorius, N.	(1993). Boundaries Between Normal and Pathological Drinking: A Cross-Cultural Comparison. *Alcohol Health & Research World,* 17(3): 190-195.	**39-46**
Heath, D. B.	(2000). *Drinking Occasions: Comparative Perspectives on Alcohol and Culture.* USA. International Centre for Alcohol Policies: 191-198.	**149-154**

3 CONCEPTS AND MEASURES OF CONSUMPTION

Measuring the consumption patterns of alcohol at community or countrywide level is not an easy exercise. As discussed in Session 1, the production and sale of alcohol ranges from regulated to unregulated, which makes measurement at the point of sale difficult. In addition, consumption patterns vary considerably from person to person, as a result of a myriad of influences.

The terminology used in measuring drinking includes the following concepts amongst others: *dependent drinkers*, *risky drinking, drinking patterns, regular* and *harmful use of alcohol, absolute* and *average alcohol content* and *drinking occasions.* We will discuss the use of these concepts in the course of this session.

At this point it may be useful to define what we mean by *dependent drinking* and *risky drinking*:

> "Alcohol dependence" refers to a user's experience of tolerance to alcohol, withdrawal symptoms such as an acute craving for alcohol and trembling, relief drinking to take away the withdrawal symptoms, loss of control, and/or compulsive drinking, which is a compelling need to consume alcohol." (American Psychiatric Association, 1994)
>
> *Risky drinking* refers to a drinking level that (at a particular time) that could lead to negative consequences., These are often dependent on the individual, his or her sex, alcohol tolerance and the environment.

Alcohol problems are usually discussed in terms of the quantities of alcohol used.

Setting aside cultural norms of what constitutes problem drinking at this point, we face the dilemma of how to measure it. This is a conceptual dilemma which must be resolved at the outset and we will now explore it further.

3.1 Two Models for Measuring Alcohol Usage

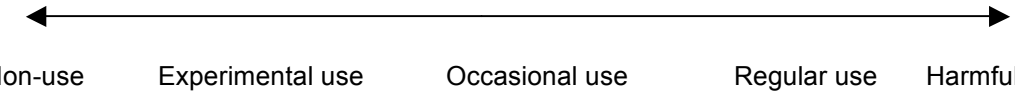
It has been found that the total per capita intake of alcohol, or even the weekly or monthly intake by an individual, is not a particularly useful measure in addressing alcohol problems. Can you think why?

Faced with an individual's total consumption or even their weekly or monthly intake, how can you know whether they are engaging in problem drinking? Do they drink most of their intake over one continuous occasion as in binge drinking, or do they drink a little each day? Total consumption is meaningless in this context. A more meaningful way to measure drinking is to focus on and measure *drinking occasions* or events when drinking takes place, rather than measuring total individual consumption.

Another way to measure alcohol intake is represented by Model A below. How useful do you think it would be to you in assessing problem drinking in a community? (Remember that the significance of a model is that it represents the way we understand something: it therefore influences the interventions we propose.) Model A is often used to elucidate drinking: it is a continuum stretching from *Non-use* to *Harmful use.* The scale implies little or no intake on the left and heavy usage on the right.

Model A

A Model of Alcohol Usage



(*The Public Health Bush Book*, 1999:1.53)

In this model, the continuum is based on the assumption that we can identify people's average consumption and locate them on the continuum. The model also implies that *Harmful use* is one stage more serious than *Regular use*, implying that only very frequent use or dependence are the problem areas.

TASK 1 – Analyse a model of alcohol consumption

Why do you think Model A is problematic as a tool for identifying risky drinking in a community?

FEEDBACK

This model is questionable, because it equates drinking at the *harmful* level, (i.e. drinking which could result in problems) with high consumption or *dependent drinking*. In fact many people who use alcohol occasionally or experimentally, do so in a harmful way, perhaps in a binge fashion. In addition, there are many more risky drinkers than dependent drinkers, and the dependent drinkers are more likely to practise harm minimisation strategies.
If this model were to be used in isolation to understand a situation of alcohol consumption, it is likely that interventions would target the *Regular users* in particular, to prevent them from reaching the *Harmful use* end of the continuum. This suggests that there would be little or no focus on the broad range of drinkers, nor on occasional or experimental binge drinkers, nor on the specific occasions of drinking. Such interventions would only target a small number of people rather than the occasions when people from across the spectrum indulge in risky drinking.

Thus far we have noted that neither total nor average consumption are particularly helpful in identifying problem or harmful drinking, which is what we are mainly interested in. This model is therefore not that helpful.

Model B

A more recent model discussed by Roche & Evans (1998) in the reading mentioned below advocates a shift away from a focus on average consumption, to a focus on *drinking patterns* and the risks involved in some of them. The concept of a *drinking pattern* implies describing the amount, regularity and context in which alcohol is used, while *drinking occasions* are those events during which alcohol is used "in one sitting". In using this model, our interventions would aim to reduce the potential harm of *drinking occasions,* regardless of the individual's average or total intake, and to promote the beneficial aspects of low levels of social drinking in a safe environment.

To assist you in reading the paper with focus, try Task 2. The paper covers more than we are presently addressing in this session, but you will also find it helpful when you start your first assignment; so remember to return to it.

Focus on the eight conceptual shifts that have influenced the way alcohol

problems are addressed, as well as on the discussion of "Contextual Issues". Take note of Table 13.1 on page 249, in which the authors describe three levels of perspective on alcohol problems: their model focuses on the *meso* or middle level perspective. This perspective implies that one should "[f]ocus on particular episodes of drinking in which individuals or community are harmed or placed at risk" (Roche & Evans, 1998: 249). The section on "The Continua of Risk" presents their model, which is seen as "alternative or complementary" to the traditional model (Roche & Evans, 1998: 254).

READING: Roche, A. M. & Evans, K. R. (1998). Ch 13 - The Implications of Drinking Patterns for Primary Prevention, Education, and Screening. In M. Grant & L. Litvak (eds). *Drinking Patterns and Their Consequences.* USA: International Centre for Alcohol Policies: 243-265. See pp 315-338 in the Reader.

Task 2 – Using a complementary model to measure alcohol problems

a) Summarise the conceptual shifts in describing alcohol problems which are covered in this paper: what does each imply about the data we collect to describe or measure alcohol problems?

b) What do you believe to be the value of the meso level perspective when dealing with alcohol related problems?

c) What sort of data must be collected in the "risk level" model presented by the authors?

FEEDBACK

Here is some selective feedback:

a) We have summarised the conceptual shift termed "Alcohol as an Exception to Population Health Control Concepts". Alcohol, because of its nature, (intoxicating, able to produce dependence in some individuals), does not fit the usual Public Health approach of advocating reduction at the population-wide level: instead of gathering data on average or total consumption, this shift implies that patterns of use and drinking occasions should be described.

b) The meso level perspective focuses on patterns of consumption and drinking occasions, thereby addressing the specific risks caused by this particular substance.

c) You will find these data listed at the bottom of page 254.

In order to describe patterns of alcohol use in a community or society, we need to pose a series of questions relating to the *when, where, who, how, what,* and *why* of alcohol use. The trends in alcohol use that shift over time can also be traced through answering these questions for different decades. Read the short chapter by Heath to understand the contribution of qualitative data in the understanding of alcohol patterns.

READING: Heath, D. B. (2000). *Drinking Occasions: Comparative Perspectives on Alcohol and Culture.* USA: International Centre for Alcohol Policies: 191-198. See pp 149-154 in the Reader.

The dilemma as to which model is more useful or whether they should be used in combination will be discussed again in Unit 2; but keep it in mind when reading about the measures currently being used to quantify alcohol use, and their consequences. The next important concept that we will discuss is the alcohol content in different drinks.

3.2 Alcohol Content and Risky Drinking

Absolute alcohol content (or pure alcohol) is a quantity measured as a percentage of a volume of an alcoholic beverage. Different countries use slightly different measures for a "standard drink". The amount of alcohol per standard drink (usually a commonly used size for serving each type of beverage) is calculated as a percentage, and as an absolute amount in grams (ranging between 6g and 16g of pure alcohol, but more usually around 11g or 12g). The range of different alcohol contents is detailed in the table below.

HOW MUCH ALCOHOL IS THERE IN ONE DRINK?

Drink	Average alcohol content (%volume)	Size of one drink (typical serving)	Absolute alcohol content (g)
Malt beer (lager)	5%	340ml	12
Sorghum beer	3%	500ml	12
Cider	6%	340 ml	16
Cooler / grape	5-10%	340ml	12
Wine	12%	120ml	11
Sherry	17%	50ml	7
Liqueur	30%	25ml	6
Brandy, whisky, gin, vodka, cane	43%	25ml	11

(Adapted from Parry & Bennetts, 1998: 129)

To quantify the amount of absolute alcohol taken by a person, the type of drink and the number of *standard drinks* needs to be recorded. A calculation can then be done to find the *absolute alcohol intake*, e.g. two glasses (120ml) of wine (11g) = 2 x 11g = 22g of alcohol.

When *blood alcohol concentration (*BAC) is measured, it is expressed in g/ml. The legal limit for driving in South Africa is 0.05g/100ml or 50mg/100ml. This is roughly the level after drinking two beers, or two glasses of wine, or a double tot

of spirits.

Risky drinking can be understood as: five (5) or more standard drinks for males on any one occasion, and three (3) or more standard drinks for females on any one occasion. However, depending on the safety of the environment and the tolerance of the individual, negative consequences could arise after even fewer drinks e.g. A man doing scuba diving could have impaired judgement after only two drinks, resulting in his drowning.

3.3 Sources of Data

It is necessary to use various sources of data when describing levels and patterns of consumption of alcohol. These sources may be based on routine data collection such as police statistics, occasional surveys, or health service records, treatment centres and mortuaries. Inevitably many of these sources measure the consequences of alcohol abuse and only indirectly, the amount of alcohol consumed, e.g. Measuring the blood alcohol level of bodies in a mortuary gives an indication of the level of alcohol use before death.

While it is possible to gather information on alcoholic beverage sales from the formal liquor companies and to calculate crude per capita alcohol use over a specific period of time, this does not, as we have seen, give sufficient information on the nature of drinking habits, nor on the consequences of harmful drinking.

To get a broader overview of the range of sources of data, read the article by Parry et al (2002) which presents the findings of a study of alcohol usage in South Africa over a four year period. Focus on the questions in **Task 3** as you read.

READING: Parry, C. D. H. et al. (2002). Alcohol Use in South Africa: Findings from the South African Community Epidemiology Network on Drug Use (SACENDU) Project. *Journal of Studies on Alcohol*, 63 (4): 430-435. See pp 297-304 in the Reader.

TASK 3 – Limitations in various methods of describing alcohol use.

As you read the article by Parry et al (2002), try to answer this question:
To what extent is SACENDU able to provide an accurate picture of alcohol consumption and its effects in South Africa?

Use these sub-questions to do your analysis:

a) Identify all the studies and sources referred to in this paper, the methods used and the populations which fall into the samples.

b) Which sources have inherent biases in them, and which are less biased?

c) Are there other sources or methods which you think could provide better information on which to base policies and interventions?

FEEDBACK

Check your responses to questions (a) and (b) here.

a) The main sources of information referred to in this paper are:

1. The South African Demographic and Household Survey.
2. An epidemiological study on foetal alcohol syndrome (FAS).
3. A study of the drinking habits of a group of people in jail.
4. AOD (Alcohol and other drugs) treatment centres' profile of their patients.
5. National Violence and Injury Surveillance study.
6. Survey of high school students' drinking habits.
7. Study of the blood alcohol content in a sample of people arrested.

b) **Limitations and possible biases in the studies:**

A major issue in any behaviour-related study is the use of *self reported* information. Drinking alcohol is a behaviour that is likely to be under reported, owing to the stigma of drinking too much, or not being in control of one's behaviour. It is also difficult to quantify alcohol intake because of: differing alcohol content in different beverages (ranging from 3% to 49%), styles of drinking (e.g. passing a vessel around), and the sizes of glasses or other vessels used. The studies where blood alcohol level is measured, or a breathalyser is used, give a more accurate picture of the person's current alcohol intake but cannot be used to describe the pattern of drinking of the individual.

The majority of the studies focus on the major cities and therefore exclude most of the rural population. In some provinces, the rural population is higher than the urban, and therefore a significant section of the population is not reflected in the studies, e.g. in the Eastern Cape and Limpopo Provinces.

Another issue is whether the data on treatment in a particular year is representative of a population. Although treatment centres report various trends in the types of drugs used, ages of patients, etc, one needs to consider critically what part of the population gets admitted to treatment centres, or uses an outpatient facility. Poorer people, women with dependents and people in outlying areas are likely to experience problems in accessing these services. So again, the trends should be viewed with caution as they do not represent all those *who may need* treatment, but only *those who have accessed* treatment.

What did you conclude about the SACENDU initiative?
In the absence of data that is collected in a systematic and standardised way, and bearing in mind the limitations of each of the data sources contributed at SACENDU meetings, the information can be used to understand only *some* trends, and inform policy on *some specific problems*.

3.4 Screening for Alcohol Problems and Alcohol Dependence

By now you will have realised that a person can have problems as a result of using alcohol without necessarily being dependent on it (or being classified as an "alcoholic").

The CAGE screening tool (which stands for **C**utting down, **A**nnoyance at criticism, **G**uilty feelings and use of **E**ye-openers) is commonly used in the screening of people to detect possible alcohol problems or dependence. As can be seen in the article by Claasen (1999), the tool can also be used as part of a survey to gather information at the level of alcohol problems in a particular community.

READING: Claasen, J. N. (Sept. 1999). The Benefits of the CAGE as a Screening Tool for Alcoholism in a Closed Rural South African Community. *South African Medical Journal,* 89 (9): 976-979. See pp 57-62 in the Reader.

When combined with a few other questions, the CAGE screening tool can provide a clearer picture of the place, time, amount, alcohol of choice and company in which people drink. These patterns, as well as the extent of problematic drinking, could be established through this sort of cross sectional survey, bearing in mind the difficulty of getting honest answers from people.

Other commonly used screening tools are the MAST (Michigan Alcoholism Screening Test) and the AUDIT (Alcohol Use Disorders Identification Test). Both of these use responses to a number of questions related to a person's drinking patterns. The scoring is designed to give the clinician or researcher a sense of the level of use of alcohol in terms of potential harm to the individual or others

around them. The MAST is more useful in identifying dependent drinkers while the AUDIT is used for categorising levels of problem drinking.

4 IDENTIFYING PATTERNS OF DRINKING

A critical part of understanding alcohol use is analysing data based on specific groups of people who live, work or naturally congregate together. Most such studies, focusing on individual beliefs and behaviour regarding alcohol, engage specific age groups or those in particular settings, and involve the surveillance of alcohol patterns and consequences.

In this section, we will explore two studies, one of which focuses on drinking patterns within a particular age cohort (Flisher et al, 2001), while the other (London et al, 2001) concentrates on a particular setting, a fruit farm in the Western Cape.

If the young people in the Flisher study and the farm workers in the London study had only been asked about their average weekly consumption, it is likely that no problematic drinking would have been identified. It is the binge nature of drinking practised by both these groups that results in high levels of risky drinking. It is therefore necessary to collect information that describes *how much is drunk in one occasion* and *how frequent these occasions are*. The *factors encouraging more risky drinking* are also of interest if meaningful preventive interventions are to be made.

4.1 Measuring Usage by Age Group

In developing countries, we are particularly concerned about the beliefs and behaviours of young people regarding alcohol. The factors influencing the experimentation and regular use of alcohol amongst youth are complex and need to be examined from various angles.

The paper by Flisher et al (2001) demonstrates how classroom based surveys can be used to gauge the knowledge, beliefs and practices of school-going youth. If repeated every few years, the trends of *age of first use of substances*, frequency, amount consumed and gender differences can then contribute to the design of educational and life skills programmes. Appropriate policies around access to and control of the amount of alcohol consumed, and the enforcement thereof, could also be made more realistic.

Factors such as access to money, religious norms and the stage of societal development are all used to explain the differences between the rates of use of substances in the three cities in Flisher et al's paper, i.e. Cape Town, Harare, and Dar es Salaam, and the difference of use between the sexes. It must be noted, however, that since the studies for each city were not identical, and the

analysis for this paper is based on extrapolation, the results are difficult to generalise beyond these particular cities or urban areas.

READING: Flisher, A. J. et al. (2001). Substance Use by Students in South Africa, Tanzania and Zimbabwe. *African Journal of Drug & Alcohol Studies,* 1 (2): 81-97. See pp 121-130 in the Reader.

TASK 4 – Measures of alcohol consumption

After reading this paper on substance use by students, answer the following questions:

a) What are the main measures of substance use in the questionnaires?

b) What do the different time periods imply?

c) What are the main conclusions of the study and how would this inform prevention programmes in those places?

4.2 Measuring Usage in Relation to Setting

Another important way to conduct research on people who drink is through a focus on the occupational setting. This article by London et al (2001) describes a study assessing the occupational hazards for a group of male fruit farm workers in the Western Cape. Alcohol consumption was found to be an important co-factor in poor nutrition, rate of head injuries and exposure to pesticides. Focus on **Task 5** while you read it.

READING: London, L., Nell, V., Thompson, M-L & Myers, J.E. (1998). Health Status Among Farm Workers in the Western Cape – Collateral Evidence from a Study of Occupational Hazards. *South African Medical Journal,* 88 (9): 1096-1101. See pp 187-194 in the Reader.

TASK 5 – Assessing further measures of alcohol consumption

While reading this paper, which includes a focus on alcohol use by male farm workers, answer the following questions:

a) What are the main measures of alcohol use in the study?

b) Are the data collection tools more reliable than the questionnaires used in the previous study? Why?

c) What does the information about the length of time spent working in the agricultural setting tell us?

d) What role could the patterns revealed in this study play in guiding a Health Promotion intervention in this context?

4.3 Measuring Drinking Patterns with Surveys & Self-reported Habits

The article by Croxford & Viljoen introduces you to a survey method of assessing drinking patterns, based entirely on self-reported data; it also introduces the phenomenon of foetal alcohol syndrome (FAS).

READING: Croxford, J. & Viljoen, D. (Sept. 1999). Alcohol Consumption by Pregnant Women in Western Cape. *South African Medical Journal,* 89: 962-965. See pp 63-68 in the Reader.

The study reported in the article aimed to assess alcohol use by pregnant women in three under-resourced areas of the Western Cape – two of them small towns and one within the Cape Metropole. The sample of 636 women was drawn from 17 antenatal clinics across the three areas, and each woman was interviewed once only. In this study, the collection of demographic information was important in order to establish whether, amongst these pregnant women, there are subgroups (for example based on age, socio-economics or geographical location) that drink more heavily than others.

The results provide a useful description of women attending clinics in predominantly *coloured* areas. The dominant characteristics of the group were: between 20 - 30 years of age; single (57%); Christian (72.8%); with formal education between 8-10 years. As high as 42.8% admitted to varying degrees of alcohol ingestion during pregnancy with beer being the drink of choice (91.5%); the drinking pattern was of a “binge” nature. Smoking was reported by 45.6% altogether, and 29.6% admitted to smoking and drinking. This left only 41.2 % of women using neither alcohol nor cigarettes.

This is important data on which to base interventions to reduce drinking in pregnancy, and can also serve as a baseline to compare to after a few years. It is also alarming to realise from the data that up to 9.5% of the women were at risk of having a child with FAS or a milder version thereof (ARND – alcohol related neurological defects).

Even though honesty is an issue when it comes to self-reported data relating to alcohol use and smoking, the authors report that it seemed not to be a concern in this study.

5 NORMS FOR DRINKING

One of the issues that every researcher should be aware of when measuring alcohol consumption is the concept of what is regarded as *normal drinking in a particular community*. The relationship between alcohol and culture, and specifically what is viewed as *normal* and *not-normal* drinking, differs widely in different areas of the world. It is also important to recognise that people are strongly influenced by such norms, e.g*. We keep spirits for special occasions like dances, and people get very drunk.*

The reading by Bennett et al (1993) provides an insight into "how people from different cultures differentiate between normal and pathological drinking" (Bennett, 1993: 190), which is in itself a major influence on drinking patterns.

READING: Bennett, L. A., Janca, A., Grant, B. F. & Sartorius, N. (1993). Boundaries Between Normal and Pathological Drinking: A Cross-Cultural Comparison. *Alcohol Health & Research World,* 17 (3): 190-195. See pp 39-46 in the reader.

The paper also summarises what we covered in our discussion of patterns of consumption. Although there are no simple explanations or descriptions of drinking patterns for any community, the author gives some means to answering the *when, where, who, how, what* and *why* of alcohol use. As you read it, try to answer the questions in Task 6.

TASK 6 – The effects of alcohol: descriptors used in your community.

After reading this paper, consider the following questions:

a) What are the main questions that have been asked in this paper on the effects of alcohol?

b) Apply the same questions to members of your own community and write down your responses in a similar way to the results in tables 2 and 3.

c) Which community in the study is most similar to your community and why do you think this is so?

d) What are some of the factors which influence drinking patterns?

FEEDBACK

When doing a situational analysis in order to plan any intervention related to alcohol problems, it is essential to have a sense of the prevailing norms around drinking alcohol. If people in the community do not view risky drinking in the same way as you do, you will have difficulty involving them in any prevention or harm reduction programme. Any interventions need to bear in mind the status of the drinkers as well as the facilitating and inhibiting factors in relation to *who drinks where* and *how much* on any occasion.

6 SESSION SUMMARY

In this session, we have looked at a range of data sources and methods for measuring and describing alcohol use, through a number of studies. Hopefully you have recognised that there are limitations in all the sources of data, but that together they can provide quantitative and qualitative information to understand the alcohol problems and possible prevention possibilities.

Hopefully you are convinced that it does not help to just monitor the average consumption of a population as this tells us nothing about the *where, when, how much* and *why* of individual and group drinking habits. In this regard, remember that more harm is caused by drinkers who occasionally become intoxicated (risky drinkers) than dependent drinkers.

You may have concluded that both quantitative measurements and qualitative descriptions are necessary in order to have a full picture of alcohol use patterns in any community or target age group. You will possibly also have noted that

some methods are more accurate than others, but that they may carry the disadvantage of cost or skill required to use them, e.g. Gamma-glutamyltransferase (GGT) tests.

You have also started to apply some research questions to your own community and should have begun to build a picture of their patterns of alcohol consumption. In addition, you should be able to identify the economic forces that operate in that context, from the information in the previous session.

In the final session of Unit 1, we introduce you to the debates around alcoholism and the effect that different models of understanding people with alcohol problems has on our prevention and treatment approaches.

7 REFERENCES AND FURTHER READING

- American Psychiatric Association. (1994). *Diagnostic and statistical manual mental disorders*, fourth edition. Washington, DC: American Psychiatric Association.
- *The Public Health Bush Book: A Resource for Working in Community Settings in the Northern Territory.* (1999). Darwin: Northern Territory Health Services.
- Parry, D. H. C. & Bennetts, A. L. (1998). *Alcohol Policy and Public Health in South Africa*. Cape Town: Oxford University Press.
- WHO. (1999). *Global Status Report on Alcohol.* Geneva: Substance Abuse Department, Social Change & Mental Health, WHO.

Unit 1 - Session 3

Theories of Alcohol Use and Addiction

Introduction

Although most of this module focuses on moderate alcohol use consumed in a risky pattern, it is also important to discuss consumption which occurs as a result of a dependency relationship between an individual and alcohol.

Much of the emphasis in the past was on “the alcoholic”, while little emphasis was placed on other consumers. Before you read any further, choose the description of alcoholism which you believe to be correct:

A person who is addicted to alcohol (an alcoholic):
- has a disease called “alcoholism” or
- has developed a habit that cannot be controlled.

This question remains debatable, so read the interesting articles that follow and then reflect on your own understanding of alcohol addiction.

While we are focusing on individual alcohol use, we will also apply two of the well-established theories of Health Behaviour, in order to understand the interrelationship of various factors in the decision to drink and the level of drinking.

Contents

Timing of this session

In this session there is only one task, and the task requires you to start addressing issues in your local context. There are also four fairly long readings totalling 63 pages. Allow at least four hours to complete the session.

1 LEARNING OUTCOMES OF THIS SESSION

By the end of this session, you should be able to:
▪ Explain and apply the different theories of addiction and dependence, i.e. the medical, psychological and sociocultural theories. ▪ Describe how these theories influence prevention and treatment approaches. ▪ Apply selected theories of Health Behaviour to alcohol use. ▪ Demonstrate insight into possible explanations for alcohol problems.

2 READINGS

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

Author/s	**Publication details**	**Page numbers in the Reader**
Fingarette, H.	(1988). Ch 3 - What Causes Alcoholism? In *Heavy Drinking: The Myth of Alcoholism as a Disease.* Berkeley, California: University of California Press: 48-69.	**95-108**
Edwards, G., Marshall, E. J. & Cook, C. C. H.	(1997). Ch 11 - Drinking Problems and the Life Course. In *Treatment of Drinking Problems: A Guide for the Helping Professions.* Cambridge, UK: Cambridge University Press: 175-185.	**79-86**
Tones, B. K. & Tilford, S.	(2001). Ch 2 - Selecting Indicators of Success: The Importance of Theories of Change. In *Health Promotion: Effectiveness, Efficiency and Equity.* Cheltenham, UK: Nelson Thornes: 74-93.	**437-446**
Morojele, N.	(1997). Ch 12 - Adolescent Alcohol Misuse. In C. de la Rey, N. Duncan & T.Shefer & A. van Niekerk (eds).	**257-270**

	Contemporary Issues in Human Development. A South African Focus. Johannesburg: International Thomson: 207-232.	

3 MODELS FOR UNDERSTANDING ALCOHOL PROBLEMS

Many academic modules on substance abuse would begin with the theory of alcohol consumption and alcoholism as it applies to individuals. In this module we have purposely covered the *environmental approach* (meaning socio-political, cultural and economic issues) to addressing alcohol problems first. The reasons for this will become clearer as we proceed through the units. However, the main reason is that we are taking a Health Promotion approach, focusing on alcohol use and problems from a risky drinking/harm reduction perspective and balancing the environmental variables with individual factors.

It is, however, necessary to understand the theories which are applied to alcohol problems: this will enable you to choose which model you personally accept as the most useful explanation for alcohol dependence, and to identify the most likely set of factors influencing this behaviour.

Read the chapter by Fingarette (1988) in which the author questions the various explanations of alcoholism; then review your answer to the question we asked when we began this session.

READING: Fingarette, H. (1988). Ch 3 - What Causes Alcoholism? In *Heavy Drinking: The Myth of Alcoholism as a Disease.* Berkeley, California: University of California Press: 48-69. See pp 95-108 in the Reader.

Whether you believe in the concept of *an alcoholic,* and that it is a disease with genetic influence and physiological explanations, will directly influence your approach to prevention and treatment. Many treatment programmes, including the Alcoholics Anonymous organisation, base their approach on the premise that if a person has had the problem of alcohol dependence, they will remain an "alcoholic in recovery" forever. This is what we call the Disease Model: it tends to focus on the individual and that "pathology" to the exclusion of the culture and context in which the person drinks.

An alternative perspective is to view alcohol consumption on a continuum, where anyone may drink at a light, moderate or heavy level, occasionally or regularly. Authors such as Fingarette prefer to explain drinking patterns from a social and cultural perspective and reject the notion of a univalent disease. For them there is no single causal explanation. This is called the Sociocultural Model and

suggests that heavy drinkers, whose drinking is causing problems, need to be individually understood and not automatically classified as “mentally ill” with alcoholism.

A combination of the psychological hypothesis and the sociocultural explanation is most likely to lead to a treatment approach that balances the necessity for individual counseling with making changes in the norms the people under treatment accept and the context of their drinking.

The DSM IV Criteria for making a diagnosis of alcohol dependence are stated in the reading by Morojele (1997: 213). This classification system for mental health problems attempts to aid clinicians and researchers to diagnose problems in a standardised way. But as Morojele suggests in the article you will read later in this session, the classification system is not always applicable to adolescents. It may also not be applicable to those of other ages in populations outside of Western developed countries. As you read about the DSM IV Criteria, consider the example of an unemployed man with no pattern of daily activities: he probably does not drive and does not own anything substantial. Most of the criteria are not applicable to him, despite the fact that he spends a lot of time drinking every day, and is at risk of developing long-term health problems.

READING: Edwards, G., Marshall, E. J. & Cook, C. C. H. (1997). Ch 11 - Drinking Problems and the Life Course. In *Treatment of Drinking Problems: A Guide for the Helping Professions.* Cambridge, UK: Cambridge University Press: 175-185. See pp 79-86 in the Reader.

Despite there being little consensus between various follow-up studies of people with alcohol dependence, Edwards proposes some factors which could be used to indicate potential for recovery in the long term: these include baseline characteristics, acceptance of a treatment goal, treatment and AA support and natural processes of recovery. Rather than supporting any intensive treatment, Edwards proposes that “… it is the nudging of the person towards a more constructive way of seeing things, the encouragement of self-actualisation and the enhancement of self-efficacy, help with choice of appropriate goal, and the alliance between therapeutic intervention and natural processes of change, that research suggests are in the long-term the most potent contributions which treatment can make to recovery” (Edwards, 1997: 182). We will revisit this approach in Unit 4, when we discuss the role of service providers in carrying out “Brief Interventions” with people with alcohol problems.

4 THEORIES OF HEALTH BEHAVIOUR

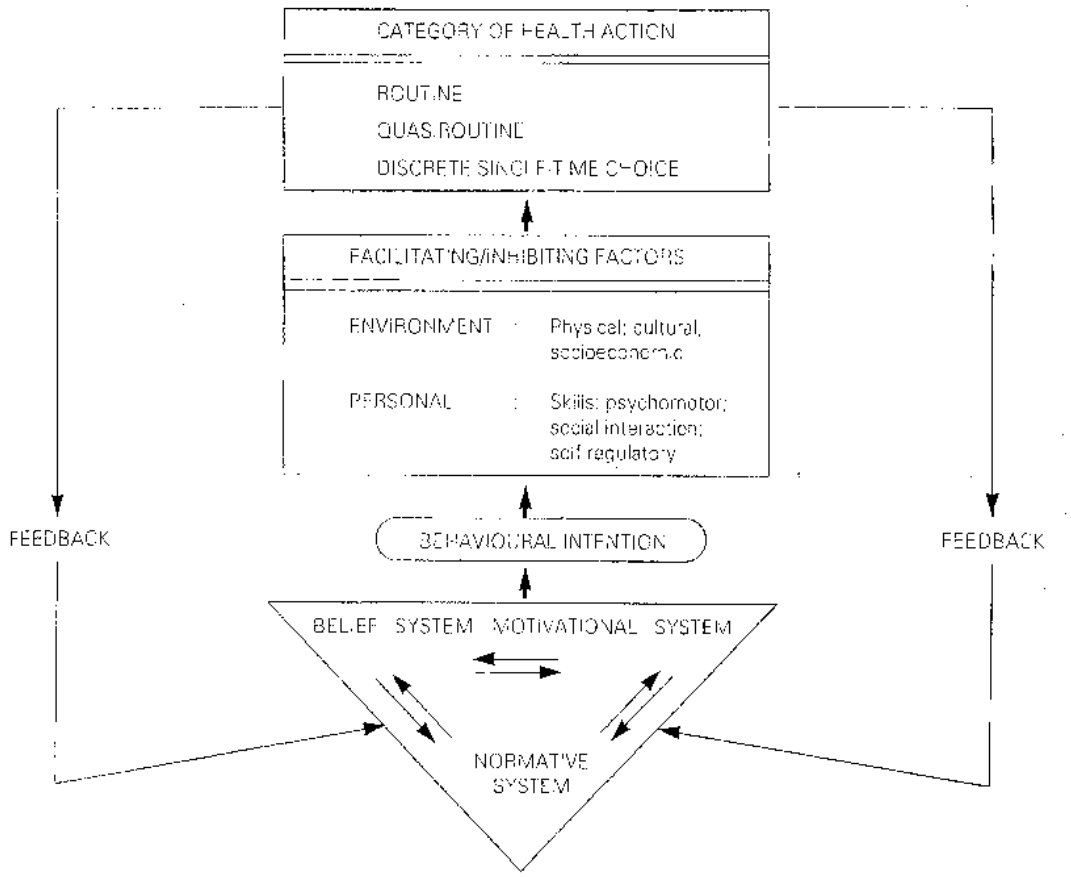
Whether your interest in alcohol and health is at the individual level or the broader population level, it is necessary to be able to describe the factors that promote and inhibit alcohol use at the individual level. Since alcohol use can vary so much from one person to the next, one needs to be able to describe these individuals as part of a sub-group, and have an understanding of what the critical factors are that influence their drinking pattern, in order to plan appropriate interventions.

An important stage in the development of a Health Promotion response to alcohol related problems is to have a theory through which to understand the underlying factors or determinants. Various health behaviour models were dealt with in the *Health Promotion II* module and will not be revised here. However, I have found the Health Action Model proposed by Tones and Tilford to be useful when describing the factors influencing alcohol use, and understanding possible points for intervention.

This chapter by Tones and Tilford (2001) was also included in the *Health Promotion II* module, so you may recognise it. Although it is quite densely written, and is not specific to alcohol issues, the references to drug use can be applied equally well to alcohol use. After looking at the diagram on page 78, focus your reading on the "Theory at a micro level" on pages 84-93, and the critique thereof on page 77 under "Gaining insights into client characteristics".

READING: Tones, B. K. & Tilford, S. (2001). Ch 2 - Selecting Indicators of Success: The Importance of Theories of Change. In *Health Promotion: Effectiveness, Efficiency and Equity.* Cheltenham, UK: Nelson Thornes: 74-93. See pp 437-446 in the Reader.

Below is another version of the Health Action Model (HAM) which was presented at a short course at UWC by Sylvia Tilford in 2002.



The health action model: an overview.

Tilford, S. (2002). Health Action Model. Slide from School of Public Health *Winter School,* UWC.

The next reading has been included because Morojele (1997) gives some explanation and theoretical argument for substance use by adolescents, and its potential harmful consequences. In addition to reading the content of what she writes, take note that this paper provides an example of how to apply theory to a particular group. You could use it as a model when you conduct your own research.

Morojele's focus on adolescents is also important in that the population pyramid in developing countries indicates that a third or more of the population is under 15 years old. It is partly for this reason that we have included in this unit the survey of student substance use in Session 2 as well as the reading by Morojele. While the article by Flisher et al (2001) gave some self-reported rates of use of various substances, Morojele's chapter goes further towards theorising in relation to the determinants of substance usage. Focus your reading primarily on pages 215-224 and consider whether you are convinced by his theoretical application and proposed intervention strategies.

READING: Morojele, N. (1997). Ch 12 - Adolescent Alcohol Misuse. In C. de la Rey, N. Duncan & T.Shefer & A. van Niekerk (eds). *Contemporary Issues in Human Development. A South African Focus.* Johannesburg: International Thomson: 207-232. See pp 257-270 in the Reader.

TASK 1 – Apply the Health Action Model to a familiar group.

Select a specific group within your community for consideration, e.g. young men, adult farm workers, pregnant women or teachers.

a) Refer to the Health Action Model diagram and attempt to explain the factors that influence the drinking of alcohol among your chosen group. Insert key words that describe your target group under each of the main sections of the diagram provided.

FEEDBACK

Your work on this task could be used in your second assignment, so check the assignment requirements and file your work on this task for future use.

5 SESSION SUMMARY

In this session we have considered different arguments relating to ways of understanding alcohol problems, and emphasised the influence that this understanding has on your intervention strategy. We have also introduced several theories of Health Behaviour which can be applied to the study of alcohol problems, and you applied one of them to members of a familiar community of drinkers.

This concludes the first unit of this module, which has hopefully given you a foundation in three important areas in the study of alcohol problems:

- Contextual aspects of alcohol usage.
- Useful measures and data in researching alcohol usage.
- Key theories of alcohol usage and Health Behaviour and their influence on intervention strategies.

In the second unit, we focus on the harm and benefits of alcohol use and consider various Health Promotion approaches to alcohol problems.

6 FURTHER READING

- Edwards, G., Marshall, E. J. & Cook, C. C. H. (1997). Ch 1 - Causes of Drinking Problems. *Treatment of Drinking Problems: A Guide for the Helping Professions.* Cambridge, UK: Cambridge University Press.

UNIT 2 Introduction

Consequences and Approaches to Alcohol Problems

Introduction

Welcome to Unit 2, in which we focus on some of the consequences of alcohol problems and explore different approaches, strategies, levels and sites of intervention, and the importance of using integrated strategies.

There are three Study Sessions in this unit:

Study Session 1: The Consequences of Alcohol Use.

Study Session 2: Approaches to Alcohol Problems.

Study Session 3: Types and Levels of Intervention.

In Session 1, we explore the benefits and consequences of alcohol and risky drinking on the individual, and on particular social groups as well as at a broad social and economic level.

Session 2 provides an introduction to the conceptual shift which has taken place from the so-called Preventive to the Harm Reduction or Harm Minimisation Approach.

Session 3 focuses on the possible levels and types of intervention within a strategy to address alcohol-related problems.

By the end of the unit you should be in a position to tackle your first assignment.

INTENDED LEARNING OUTCOMES OF UNIT 2

By the end of this unit, you should be able to:
▪ Explain why the harm related to alcohol outweighs the benefit, particularly in developing contexts. ▪ Discuss the range of social and health problems caused directly or indirectly by alcohol use. ▪ Identify specific high risk contexts, groups or behaviours linked with alcohol usage. ▪ Contrast the Harm Reduction approach with the traditional Preventive approach. ▪ Give a rationale for the Harm Reduction approach. ▪ List a range of strategies applicable to the two approaches and apply these to a specific population or setting. ▪ Summarise a range of policies that can increase control over alcohol and promote safer usage. ▪ Identify strategies and interventions at different levels of implementation, e.g. the meso level. ▪ Discuss the roles that different agencies can play in interventions, and the value of integrating strategies.

We hope that you will find the unit stimulating and challenging and that it will enable you to recognise the important shift in perspective that has taken place in this field.

Unit 2 - Session 1
The Consequences of Alcohol Use

Introduction

In Unit 1, we considered alcohol use in the social context, particularly in the developing country context. We also introduced the concept of patterns of usage as well as ways of measuring alcohol consumption, and we explored some of the theories of use and addiction. As we embark on Unit 2, we are preparing to explore approaches to addressing alcohol problems. It is therefore important to consider some of the consequences of alcohol use. This will hopefully also reinforce your understanding of why it is important to address alcohol use in its contextual setting, and to identify patterns of usage.

Session contents

Timing of this session

This session includes four readings amounting to about 30 pages. From the May (1995) reading, you need read only the feedback for **Task 3**, which is in one of the tables in the reading (you will be referred to it at the appropriate point). There are three tasks; the session should take you three to four hours to complete.

1 LEARNING OUTCOMES OF THIS SESSION

By the end of this session, you should be able to:
▪ Explain why the harm related to alcohol outweighs the benefit, especially in developing contexts. ▪ Discuss the range of problems caused directly or indirectly by alcohol use. ▪ Identify specific high risk contexts, groups or behaviours linked with alcohol usage.

2 READINGS

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

Author/s	**Reference details**	**Page nos in Reader**
Gureje, O.	(Aug, 2000). The Health Claims of Alcohol: Contextual Considerations for Africa and the Developing World. *Proceedings of the Global Alcohol Policy Advocacy Conference.* Syracuse, New York: The Globe, Special Edition: 33-35.	**145-148**
Parry, C. D. H. & Bennetts, A. L.	(1998). Ch 3 - The Consequences of Alcohol Misuse. *Alcohol Policy and Public Health in South Africa.* Cape Town: Oxford University Press: 57-76.	**271-282**
May, P. A., Brooke, L., Gossage, J. P., Croxford, J., Adnams, C., Jones, K. L., Robinson, L. & Viljoen, D.	(2000). Epidemiology of Fetal Alcohol Syndrome in a South African Community in the Western Cape Province. *American Journal of Public Health,* 90 (12): 1905-1912.	**223-232**
May, P. A.	(1995). A Multiple-level Comprehensive Approach to the Prevention of Fetal Alcohol Syndrome (FAS) and Other Alcohol-Related Birth Defects (ARBD). *International Journal of the Addictions,* 30 (12): 1549-1599.	**195-222**

3 THE BENEFITS AND RISKS OF ALCOHOL USE

Although there is research to support the theory that alcohol has some physical health benefits, this can only be said to be true when alcohol is taken in low quantities by people over 40 years of age who have a predisposition to ischaemic heart disease (ISD).
As Dr Gureje from Nigeria explains in the first reading (2000), the risky effects of alcohol use in developing countries far exceed the positive effect on ISD. He points out the main issues in a risk-benefit analysis:

- There are low rates of ischaemic heart disease in developing countries; therefore there would be a minimal overall reduction effect if low level drinking in older people was promoted.
- The population distribution and health status is such that the main focus should be on young people and basic survival needs.
- The drinking pattern in developing countries is generally different to that in developed countries, with more binge drinking; in addition, the environment in which people drink is more hazardous.

We should not forget that alcohol can be used safely, and *is* used safely by many people. It plays a significant role in celebrations (champagne at various events), some churches (for communion), as well as in social gatherings. At social gatherings, it helps people relax, and as long as people drink in moderation, the risk of negative behaviour is low.

Read the paper by Gureje (2000) and do **Task 1** in which you are asked to decide whether the "contextual considerations" raised by the author apply to the context in which you work.

READING: Gureje, O. (Aug, 2000). The Health Claims of Alcohol: Contextual Considerations for Africa and the Developing World. Towards A Global Alcohol Policy. *Proceedings of the Global Alcohol Policy Advocacy Conference.* Syracuse, New York: The Globe, Special Edition: 33-35. See pages 145-148 in the Reader.

TASK 1 – The impact of alcohol consumption on a local community

Read article by Gureje. As you read, note the positive and negative impacts of alcohol consumption which he discusses.

Record the negative impacts, you will use them in Task 2.

a) To what extent do the negative impacts apply to the community with which you work?

b) Do you agree with Gureje that "…drinking holds no overall benefit for Africans today"? (2000: 35).

FEEDBACK

Lack of data may make it difficult to decide whether the so-called health claims of alcohol are valid in your context; however, it is likely that many of the consequences noted by Gureje apply to your context. In the next section, we explore the issue of the harmful consequences of alcohol.

4 HARMFUL CONSEQUENCES

Many of the harmful consequences of alcohol use have already been mentioned in some of the readings. You will have noted that some of these consequences are direct, and impact on the individual, their family or others involved with the individual, through violence or accidents. Others are indirect, resulting in an economic burden on society through high health service costs or trauma response, and lost productivity.

Many of the negative consequences of alcohol abuse are associated with specific groups (age or gender based drinking) while others are associated with the context of drinking, e.g. work-based drinking resulting in occupational injuries; drinking while engaging in water sports resulting in drowning, etc.

You could revisit a couple of readings from Unit 1 to reinforce the linkage between *who* drinks, *where*, *how much,* and the negative consequences that can follow. There is a useful summary of the consequences of alcohol abuse for youth in the chapter by Morojele (2000: 214); and the SACENDU paper by Parry et al (2002: 430 & 431) addresses consequences for adults generally.

4.1 Categories of Harm

It is useful to group the consequences of alcohol abuse into: medical consequences, e.g. chronic conditions, injuries and accidents; effects on the

family; economic, workforce and social issues, as well as criminal activities. Obviously, any individual could cause and suffer consequences in more than one area, but when planning interventions on a population wide basis, it is important to respond to the kind of data presented by Parry & Bennetts (1998), which enables you to target areas where problem drinking exercises greatest impact or damage. As you read this chapter, take notes on the range of consequences of problem-drinking, particularly for women, using the suggested template in **Task 2**, which follows.

READING: Parry, C. D. H. & Bennetts, A. L. (1998). Ch 3 - The Consequences of Alcohol Misuse. *Alcohol Policy and Public Health in South Africa.* Cape Town: Oxford University Press: 57-76. See pages 271-282 in the Reader.

TASK 2 – Identify the consequences of problem drinking and consider their application to a familiar context

Take notes from the article under the section headings, and then consider whether these consequences apply to the group or setting in which you plan to focus your assignment and/or work. Take particular note of consequences for women and children, as well as any which are particular to your context.

Negative consequence	Summary of key points in reading	Application to your assignment / work context
Individual (chronic and injury) • •		
Individual (social, economic) • •		
Family and public • •		
Economic & social Development • •		
Business & work-force • •		
Criminal justice system • •		
Other • •		

FEEDBACK

You may find the summary table you have created a useful reference when you plan an intervention for Assignment 2. Take note that you have been considering the consequences of drinking at a social and an economic level, as well as at an individual medical level; remember that economic consequences are also conceptualised in terms of family income, losses to private companies and impact on the national budget in terms of health costs.

4.2 Fetal Alcohol Syndrome

One of the serious consequences of problem drinking is Fetal Alcohol Syndrome (FAS). This affects up to 5% of people in towns and districts in the Western and Northern Cape and in other pockets of Southern Africa. A child born with FAS is permanently affected, and will have lower intellectual functioning than other children; they will display behavioural problems, and be of smaller stature.

An epidemiological study undertaken in 1999 in the Western Cape confirms the seriousness of this preventable, yet long term problem: it is a case-control study and is described in the paper by May et al (2000). Information gathered in this study provides a starting point for planning FAS prevention programmes and for identifying women at high risk. Read the article using **Task 3** to focus your reading.

READING: May, P. A., Brooke, L., Gossage, J. P., Croxford, J., Adnams, C., Jones, K. L., Robinson, L. & Viljoen, D. (2000). Epidemiology of Fetal Alcohol Syndrome in a South African Community in the Western Cape Province. *American Journal of Public Health,* 90 (12): 1905-1912. See pages 223-232 in the Reader.

TASK 3 - List risk factors for FAS

Read the article by May et al and establish a list of the factors that put some women at higher risk than others, for producing a FAS baby.

For feedback, you will find most of the key factors listed in the table on page 1562 of the reading by May, P. A. (1995) below. You will read this paper in full in the next Unit.

READING: May, P. A. (1995). A Multiple-level Comprehensive Approach to the Prevention of Fetal Alcohol Syndrome (FAS) and Other Alcohol-Related Birth Defects (ARBD). *International Journal of the Addictions,* 30 (12): 1549-1599. See pages 195-222 in the Reader.

5 SESSION SUMMARY

In this session, you have explored the benefits in contrast to the harmful consequences of drinking. We have focused on a broad range of consequences of problem drinking, noting the particularly serious impact on women, especially pregnant women.

The session also aimed to provide you with data similar to that which you may need when planning interventions. Such data would enable you to understand

more fully the seriousness of the problem within a particular context, and to guide your strategy for intervention. In Session 2, we consider the Preventive and Harm Reduction/Minimisation approaches used to intervene in alcohol-related problems. In the session, we provide a rationale for the latter approach.

6 FURTHER READING

- WHO. (2002). *A Summary of Alcohol in Developing Societies: A Public Health Approach.* Management of Substance Abuse Dependence, Non-Communicable Diseases. Geneva: WHO.

Unit 2 - Session 2
Approaches to Alcohol Problems

Introduction

This session focuses on the traditional Preventive approach to alcohol problems and on what is known as a Harm Reduction or Minimisation model, tracing the shift in perspective in recent years. This change is largely contingent on a shift in the way we understand alcohol consumption, and refers to a number of the issues discussed in Unit 1 Session 2 - Patterns of Consumption. The importance of understanding risky drinking in terms of drinking patterns and drinking occasions is again raised, suggesting forms of intervention designed to reduce harm rather than to prevent drinking. This session provides opportunities to do much of the groundwork for your first assignment.

Session contents

Timing of this session

In this session, you are expected to read three texts amounting to about 40 pages, and to undertake three tasks. The tasks constitute useful preparation for both your assignments. You should already be fairly conversant with the contents of one of the readings. This session could take you up to four hours to complete.

1 LEARNING OUTCOMES OF THIS SESSION

By the end of this session, you should be able to:
▪ Compare the Harm Reduction approach with the traditional Preventive approach. ▪ Give a rationale for the Harm Reduction approach. ▪ List a range of strategies applicable to the two approaches and apply these to a specific population or setting.

2 READINGS

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

Author/s	**Reference details**	**Page nos in Reader**
Parry, C. D. H. & Bennetts, A. L.	(1998). Ch 5 - Reducing Per Capita Consumption and High-Risk Behaviours. *Alcohol Policy and Public Health in South Africa.* Cape Town: Oxford University Press: 103-127.	**283-296**
Grant, M. & Single, E.	(1998). Ch 15 - Shifting the Paradigm: Reducing Harm and Promoting Beneficial Patterns. In M. Grant & L. Litvak (eds). *Drinking Patterns and Their Consequences.* USA: International Centre for Alcohol Policies: 287-294.	**131-140**
Roche, A. M. & Evans, K. R.	(1998). Ch 13 - The Implications of Drinking Patterns for Primary Prevention, Education, and Screening. In M. Grant & L. Litvak (eds). *Drinking Patterns and Their Consequences.* USA: International Centre for Alcohol Policies: 243-265.	**315-338**

3 THE PREVENTIVE APPROACH

The traditional Preventive approach to alcohol problems is concerned with levels of consumption and addresses alcohol problems at primary, secondary and

tertiary levels.

- The primary level would include all the general *educational strategies* aimed at preventing problems from occurring and encouraging people to consume low levels of alcohol, or to abstain completely. Primary prevention may be supported by various policies that restrict access to alcohol.
- The secondary level is aimed at the *early detection* of problematic alcohol use by individuals, and the use of *counselling* to reduce alcohol usage. The legislation designed to catch drunk drivers is a secpndary level intervention and could be seen as a punitive approach to reducing consumption by individuals with occasional or established alcohol abuse.
- Tertiary prevention identifies people who have *serious ongoing problems* with alcohol and applies a *treatment and rehabilitative* approach.

If you refer to the table on pages 106-107 of the next reading by Parry & Bennetts (1998), you will see a wide range of possible legislative, structural, and educative strategies, most of them aiming to reduce overall consumption; in addition there are early intervention strategies at an individual level. Many of these strategies are in place in South Africa, but have had limited success in reducing the consequences of alcohol use. This is mainly because many people do not take the risks seriously and much risky drinking occurs where legislation cannot be enforced, such as in people's homes and in unlicensed premises. In addition, it would require huge resources to implement and enforce these legislative measures.

Read this chapter, and identify what strategies Parry and Bennetts suggest within legislation, structural changes, education, and early intervention.

READING: Parry, C. D. H. & Bennetts, A. L. (1998). Ch 5 - Reducing Per Capita Consumption and High-Risk Behaviours. *Alcohol Policy and Public Health in South Africa.* Cape Town: Oxford University Press: 103-127. See pages 283-296 in the Reader.

Although Parry and Bennetts briefly state that: " … the two approaches or pillars of reducing per capita consumption and high-risk behaviours (harm reduction) are in the end complimentary" (Parry & Bennetts, 1998:107), the strategies they list are mostly focused on reducing consumption (the Preventive approach) through population-based control measures. This approach appears to be predominantly based on research and policies from other countries in the early 1990s, and there is no mention of Harm Reduction strategies. There is also very little targeting of high risk groups. You will learn about the Harm Reduction approach in the next section and will be able to compare the strategies suggested by the Harm Reduction proponents with the ones suggested in the reading by Parry & Bennetts.

4 THE HARM REDUCTION APPROACH

While some aspects of the traditional Prevention approach continue to be important, there is growing support for a Harm Reduction approach. This approach refers to policies and programs that focus on reducing the adverse consequences of drinking rather than restricting access to alcohol..
The Harm Reduction approach, also known as Harm Minimisation approach, relies on identifying risky drinking groups and patterns of drinking, and attempts to mitigate the harm caused by these groups or individuals. The outcomes of this approach are measured in terms of reduced *harm*, and not reduced *consumption*.

For those who believe that all alcohol use can lead to harm, and that abstention should be the ultimate goal, a mind-shift towards accepting that people *will continue to use alcohol*, is necessary. In addition, one needs to accept that many people will use high levels of alcohol at times, but that the risks of harm can be reduced.

Read the chapter by Grant and Single (1998), and identify the Harm Reduction strategies that they propose.

READING: Grant, M. & Single, E. (1998). Ch 15 - Shifting the Paradigm: Reducing Harm and Promoting Beneficial Patterns. In M. Grant & L. Litvak. *Drinking Patterns and Their Consequences.* USA: International Centre for Alcohol Policies: 287-294. See pages 131-140 in the Reader.

TASK 1 – Identify harm reduction interventions

As you read Grant and Single's chapter, identify the Harm Reduction strategies being proposed and consider whether they would be appropriate or possible in a setting with which you are familiar.

FEEDBACK
Some of the interventions suggested by Grant and Single (1998) are:
- Education on harmful consequences of alcohol.
- Responsible hospitality programmes.
- Measures to encourage quality control of alcoholic beverages.
- Measures designed to ameliorate adverse consequences of intoxication.
- Early identification and simple interventions.
- Controlled drinking programmes as a treatment alternative.

Essentially, Grant and Single are promoting *Sensible Drinking* guidelines which go far beyond how many drinks are consumed. They focus, in their words, on "… the reduction of harmful consequences of reckless drinking rather than on monitoring individual levels of consumption to avoid dependence" (1998: 297).

You have already read much of the chapter by Roche and Evans (1998) in Unit 1. The authors explore the need for a shift in mind-set from the traditional Preventive approach (calling it a shift in "gaze" or perspective). They suggest that those who address alcohol problems need to focus half way between the population and the individual level at what they term "the meso level": this would involve data collection on drinking occasions where harm is caused; identifying potentially harmful patterns of drinking; and intervention which focusses on minimising harmful episodes and ensuring environments that facilitate low-risk drinking. While you revisit this chapter, try Task 2. Note that issues of screening will be dealt with in Unit 4.

READING: Roche, A. M. & Evans, K. R. (1998). Ch 13 - The Implications of Drinking Patterns for Primary Prevention, Education, and Screening. In M. Grant & L. Litvak (eds). *Drinking Patterns and Their Consequences.* USA: International Centre for Alcohol Policies: 243-265. See pages 315-338 in the Reader.

TASK 2 – Identifying the points in an argument

As you read the chapter by Roche and Evans, identify the key points in their argument in favour of the Harm Reduction approach. Take notes as a series of steps (in the argument) that build upwards to this conclusion. Note the page number where you found each point in the argument.

FEEDBACK

STEPS IN THE ARGUMENT IN FAVOUR OF A HARM REDUCTION APPROACH

STEP I

Mean levels of drinking and single distribution theory of alcohol consumption have been abandoned. (p244)

Overall levels of consumption are no longer used to predict risky drinking. (p245)
…and so on.

From the reading by Grant and Single (1998), you identified a set of Harm Reduction intervention strategies. Roche and Evans (1998) add the following proposed strategies:

- Appropriate control over access to the product.
- Increased knowledge among consumers and health professionals of the risks associated with inappropriate use of the product.
- Minimisation of the risk of harms associated with consumption on particular occasions and under particular circumstances.

TASK 3 – Select appropriate intervention approaches

Return to your analysis of a target group in your community. Consider which strategies from the Prevention approach and which from the Harm Reduction approach could usefully apply to this group in order to reduce alcohol related problems.

Justify your choices in terms of the drinking patterns you have identified and the potential for these strategies to be realistically implemented in this community.

There is no feedback to this task, but you will find that your work will be helpful in preparation for your second assignment; so file it safely.

5 SESSION SUMMARY

In this session you have been introduced to the debate concerning the two key approaches to dealing with alcohol problems – the Preventive approach which aims to reduce overall consumption, and the Harm Reduction approach, which aims to reduce harmful consequences of consumption at any level. The authors who have promoted a "shift in our gaze" provide some interesting food for thought, and encourage us to consider a less punitive, less "legislative" approach to alcohol control. Instead, they favour an emphasis on drinking occasions, and strategies to make the environment less risky, regardless of the level of consumption. Both approaches incorporate environmental as well as individual changes to reduce the consequences of alcohol use, but they offer very different approaches to consumption.

In the third session of this unit, we take up the issue of intervention in more detail.

Unit 2 - Session 3
Types and Levels of Intervention

Introduction

Based on what you have covered in Unit 1 and the first two sessions of Unit 2, you now have some of the necessary insights and skills to investigate and describe patterns of alcohol consumption, and to access data to understand the consequences of alcohol use. You have also been introduced to examples of interventions that are particular to reducing consumption and to minimising potential harm. We shall now focus on planning interventions, and locating them at a particular level of society.

In this session, we invite you to consider a broad range of possible interventions and the different levels at which intervention is possible, i.e. from government policy to individual counselling. We also encourage you to consider the importance of an integrated strategy in addressing alcohol-related problems.

Session contents

Timing of this session

This session requires you study two readings amounting to about 20 pages and to do two tasks related to those readings; it should take you about two hours to complete, after which you should be ready to draft your first assignment.

1 LEARNING OUTCOMES OF THIS SESSION

By the end of this session, you should be able to:
▪ Summarise a range of policies that can increase control over alcohol, and promote safer usage. ▪ Identify strategies and interventions at different levels of implementation, e.g. the meso level. ▪ Discuss the roles that different agencies can play in interventions, and the value of integrating strategies.

2 READINGS

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

Author/s	**Reference details**	**Page nos in Reader**
Room, R., Jernigan, D., Carline-Marlatt, B., Gureje, O., Makela, K., et al.	(2002). Ch 9 - Building an Effective Response to Alcohol Problems. In *Alcohol in Developing Societies: A Public Health Approach.* Helsinki: Finnish Foundation for Alcohol Studies in collaboration with the WHO: 217-228.	385-398
Tenth Special Report to the United States Congress on Alcohol and Health.	(2000). Latest Approaches to Preventing Alcohol Abuse and Alcoholism. *Alcohol Research & Health*, 24 (1): 42-51.	409-420

3 POLICIES FOR DIFFERENT LEVELS OF INTERVENTION

Across the world, policies have been made and programmes implemented by both governments and civil society bodies in response to alcohol problems. Part of the transition from developing to developed country status seems to bring with it wider use of alcohol and more alcohol related problems. In addition, the resources to implement policies and programmes that limit these problems are

seldom available (Room et al, 2002: 217). To develop and carry out any strategy, many different sectors are involved, not just health nor just economic affairs.

Ideally, consistent messages should be developed and co-ordinated with implementation of educational endeavours and policy formulation. To achieve this, we need to have an understanding of the spheres of influence exercised by different levels of government and civil society groupings.

Broadly, national level government can develop policy guidelines, and can assist with supporting more regional and local initiatives. Where possible, however, policies and programmes should be adapted to suit the local culture, norms and values.

In the reading below by Room et al (2002), you will find a useful summary of the current situation regarding alcohol drinking patterns and problems, and the economic dynamics involved in most developing countries. Concentrate on the section that focuses on policy formulation, and the different levels at which policies are applied.

TASK 1 – Identify different levels of intervention

As you read Room et al (2002), summarise the information in the following way:

Draw a table in which you list examples of: policies around services, taxing, alcohol availability, harm reduction and the collection of data. Group these according to the level(s) that would be most appropriate for the policy to be developed and implemented: international; national; provincial and local level.

READING: Room, R. et al. (2002). Ch 9 - Building an Effective Response to Alcohol Problems. Alcohol in Developing Societies: A Public Health Approach. In *Alcohol in Developing Societies: A Public Health Approach.* Helsinki: Finnish Foundation for Alcohol Studies in collaboration with the WHO: 217-228. See pages 385-398 in the Reader.

4 INTEGRATED STRATEGIES

In the previous section, we identified the levels at which responsibility could be taken for various policies and strategies to reduce alcohol related problems. In this section, we look at examples of particular alcohol related problems e.g. driving under the influence (DUI), and learn about the necessity for designing a

range of integrated policies and programmes to deal with the same particular problem.

A tension always exists between factors that facilitate alcohol use, and deterrent moves on alcohol use. On the one hand, there are the economic benefits of selling alcohol plus people's desire to use alcohol. On the other, there is the need to protect individuals and the broader society from the potential harms arising from alcohol use. Control measures need to be multi-dimensional and well coordinated, so that both these factors are taken into account. Essentially, from a Health Promotion perspective, we aim to reduce the factors promoting harmful use of alcohol, and to maximise the factors that provide limits, without unduly affecting individual rights and the economy. These strategies need to be integrated across different sectors in order to achieve the intended reduction of harm.

The next reading, the Tenth Special Report to the United States Congress on Alcohol and Health (2000), looks at a particular problem, i.e. drunk driving. This reading illustrates why it is necessary to have a variety of strategies, or an integrated strategy focusing on the same problem. In this instance, a mix of strategies, consisting of education, restrictions on driving, and improvements to car safety mechanisms, have all contributed to a reduction in road fatalities resulting from drunk driving in the USA. Unfortunately, however, many of the strategies are more difficult to implement in developing countries.

If you are interested in youth and alcohol problems, the community based interventions mentioned in this reading will also be useful. The effects of on children and youth of advertising alcohol, is mentioned and will be covered in more depth in the next unit. Take a look at **Task 2** before you start reading.

READING: Tenth Special Report to the United States Congress on Alcohol and Health. (2000). Latest Approaches to Preventing Alcohol Abuse and Alcoholism. *Alcohol Research & Health*, 24 (1): 42-51. See pages 409-420 in the Reader.

TASK 2 – Identify the barriers to integrated strategies

After reading the article, identify the actual strategies used in the USA to reduce drunk driving and note the effects thereof. Consider each of these strategies and debate how feasible it would be to implement each in your home province, region

This sort of exercise could be undertaken in relation to any specific drinking problem or pattern.

5 SESSION SUMMARY

By this stage, you will be aware of the range of strategies that may be needed to tackle alcohol-related problems, the importance of an integrated strategy and of possibility that the responsibility for some parts of these strategies could be placed at various levels of government or civil society. You have probably also recognised that any particular problem is best addressed using a variety of methods that aim for changes in individual awareness and behaviour, as well as environmental changes.

This is the end of Unit 2: at this point you should be ready to tackle your first assignment provided that you have worked consistently through the units so far. Unit 3 tackles the broad level environmental and policy interventions in more detail, while in Unit 4, we return to strategies for intervention aimed at the individual.

6 FURTHER READING

- Republic of South Africa. (March 1999). *National Drug Master Plan.* Drug Advisory Board. Pretoria: Government Printers.

UNIT 3 Introduction

Policy and Environmental Interventions

Introduction

Welcome to Unit 3. This unit focuses on intervention strategies for alcohol problems targeted at a broad or environmental level. Broad, environmental approaches are the essence of the role of the Health Promoter or Public Health practitioner and have great potential for a broad range impact at national, regional or community level, particularly since alcohol problems derive from a reciprocally broad range of determinants.

Although Session 1 focuses on policies and Session 2 on environmental changes, this is really an artificial separation, since many environmental changes depend on legislation to drive them.

By now, you will be aware that the argument for broad impact strategies also arises out of the understanding that some of the highest levels of harm are caused not necessarily by individual dependent drinkers, but also by moderate drinkers who engage intermittently in high risk drinking practices. In addition, an environmental approach takes account of the diversity of societies, and places potential safety nets at different levels for reducing the harm caused by alcohol.

Within this Unit, you will also be reminded of key steps in the planning and implementation of programmes. Session 1 incorporates community mobilisation processes, Session 2 includes collection of relevant data on which to base a prevention programme, and Session 3 includes monitoring and evaluation activities.

There are three Study Sessions in this unit:

Study Session 1: Control through Policy.
Study Session 2: Environmental Changes.
Study Session 3: Multifaceted Integrated Programmes.

In Session 1, we focus on alcohol legislation and its enforcement. In dealing with

this, we consider a range of interventions intended to control or limit the coercive marketing and consumption of alcohol.

Session 2 provides an overview of a range of environmental strategies for harm reduction and the introduction of alternative activities that can serve to reduce drinking. Based on these examples, you will consider what would work in your context.

Session 3 explores the value of multifaceted programmes for addressing alcohol problems and links this approach to the Health Promotion principles of the Ottawa Charter. You will again consider the value of this approach to your own potential target group.

INTENDED LEARNING OUTCOMES OF UNIT 3

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

- Describe and assess different countries' policy interventions to control alcohol marketing, cost, availability and contents.
- Discuss different approaches to taxing alcohol sales.
- Analyse ways in which alcohol is made attractive to different target groups.
- Demonstrate insight into the process of community involvement in interventions.
- Assess international examples of environmental adaptations to reduce alcohol intake and alcohol-related harm in local settings.
- Discuss the role of a variety of media in supporting the communication of alcohol-related policy and environmental changes.
- Discuss the rationale for a multifaceted approach to alcohol problems.
- Apply the Ottawa Charter framework to alcohol interventions.
- Assess the viability of the multifaceted approach to specific contexts of alcohol use.
- Develop tools for planning, monitoring and evaluating alcohol interventions.

Unit 3 provides substantial preparation for your second assignment: while you work through it, start gathering background information about your target group and their context, e.g. drinking patterns. This will enable you to engage more critically and effectively with tasks in the sessions. Many of them refer you to a range of intervention strategies discussed in the literature and ask you to consider their applicability in your situation. We hope that you will find some fresh and challenging ideas in Unit 3 for addressing alcohol problems in your own context, as well as an effective way of monitoring and evaluating the impact of your programme.

Unit 3 - Session 1
Control through Policy

Introduction

One of the key action areas in promoting health is the development of health promoting policies. We have seen in Session 1 of Unit 2 that there are many situations in which alcohol abuse can result in harm to the drinker and to others. How to control alcohol use without totally prohibiting it is one of the dilemmas faced by governments in trying to limit harm. A balance needs to be struck between developing and enforcing regulations, and maintaining a free market and freedom of lifestyle.

In this session you will familiarise yourself with different approaches to alcohol legislation and control, and analyse the impact of coercive advertising of alcohol, particularly on young people. You will also consider ways of limiting this impact and educating drinkers.

Session contents

Timing of this session

This session contains six readings totalling 93 pages of reading, and four tasks. You will need to put aside at least six hours to complete this session.

1 LEARNING OUTCOMES OF THIS SESSION

By the end of this session, you should be able to:
▪ Describe and assess different countries' policy interventions to control alcohol marketing, cost, availability and contents. ▪ Discuss different approaches to taxing alcohol sales. ▪ Analyse ways in which alcohol is made attractive to different target groups. ▪ Demonstrate insight into the process of community involvement in interventions.

2 READINGS

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

Author/s	**Reference details**	**Page nos in Reader**
Parry, C. D. H. & Bennetts, A. L.	(1998). Ch 5 - Reducing per Capita Consumption and High-Risk Behaviours. In *Alcohol Policy and Public Health in South Africa.* Cape Town: Oxford University Press: 103-127.	**283-296**
Room, R. et al.	(2002). Ch 8 - Targeting Environmental Change to Reduce Alcohol-Related Problems. In *Alcohol in Developing Societies: A Public Health Approach.* Helsinki: Finnish Foundation for Alcohol Studies in collaboration with the WHO: 181-215.	**349-384**
Parry, C. D. H., Myers, B. & Thiede, M.	(June 2003). The Case for an Increased Tax on Alcohol in South Africa. *The South African Journal of Economics,* 71(2): 265-281.	**305-314**
Jackson, M. C., Hastings, G., Wheeler, C., Eadie, D. & Mackintosh, A. M.	(2000). Marketing Alcohol to Young People: Implications for Industry Regulation and Research Policy. *Addiction* 95*,* Supplement 4: S597-S608.	**155-166**
Webster-Harrison, P. J., Barton, A. G., Sanders, H. P., Anderson, S. D. &	(2002). Short Report - Alcohol Awareness and Unit Labelling. *Journal of Public Health Medicine,* 24(4): 332-333.	**463-466**

Dobbs, F.		
Treno, J. A. & Holder, H. D.	(1997). Community Mobilization: Evaluation of an Environmental Approach to Local Action. *Addiction* 92, Supplement 2: S173-S187.	**447-462**

3 LEGISLATION AND ENFORCEMENT

All governments face the responsibility of developing policies that act to control alcohol use in the interests of public safety and health. At the same time, they face the challenge of ensuring that such policies can be enforced, and are not too elaborate. Political, economic, religious and cultural factors can all affect the extent to which a government attempts to regulate the use of alcohol.

You have already come across some international examples of policies related to controlling access to alcohol and punishing of DUI offenders in the Session 3 of the previous unit (Room et al, 2002; and the Tenth Special Report, 2000).

In the reading that follows, Parry and Bennetts (1998) provide a useful overview of the most common legislative measures relating to alcohol use in South Africa. These measures include reducing drunk driving, generating revenue through taxes on alcohol, requiring liquor outlets to be licensed and to adhere to certain hours of operation, and restricting the advertising of alcohol. Take a look at page 106 of the reading which summarises the legislative measures that could be strengthened in South Africa. Developing a broad knowledge of the kinds of legislation used in other countries and the impact thereof is an important step to contributing to such policies in your own context. Use Task 1 to engage analytically with the reading.

READING: Parry, C. D. H. & Bennetts, A. L. (1998). Ch 5 - Reducing per Capita Consumption and High-Risk Behaviours. In *Alcohol Policy and Public Health in South Africa.* Cape Town: Oxford University Press: 103-127. See pp 283-296 in the Reader.

TASK 1 – Analyse alcohol legislation strategies

Select two different legislative strategies described in the chapter by Parry and Bennetts. Decide whether these strategies aim to reduce consumption or reduce harm. Analyse whether you think cultural, religious, political or economic factors have informed these policies. Consider what resources it would take to enforce these strategies, and what limitations may be encountered. Consider the sorts of reactions enforcement is likely to draw from alcohol users. Then assess the potential effectiveness of these legislative strategies.

The National Drug Master Plan was prepared by the Drug Advisory Board, at the request of the then Minister for Welfare and Population Development, and published in February 1999. This document is informed by the United Nations Drug Control Programme (UNDCP) and is 'the single document adopted by the government outlining all national concerns in drug control'. Although much of the Plan focuses on illegal drugs, the problem of alcohol abuse is included within the scope of the focus areas:

- Crime
- Youth
- Community health and welfare
- Research and information dissemination
- International involvement

The implementation is being facilitated and monitored by the Central Drug Authority (CDA), based in Pretoria. The implementation of the Plan is to be through provincial forums and drug action committees.

The CDA was brought about through the 'Prevention and Treatment of Drug Dependency Act, 1999', which is an amendment of the Act 20 of 1992. The CDA has representatives from most government departments and other national bodies. See website: **www.CDA.gov.za**

The next reading by Room et al (2002) provides some interesting case studies to illustrate some of the main strategies used in regulating alcohol sales and consumption. The authors describe a range of interventions, some of which fall into the "harm reduction" category, and provide evidence of their effectiveness. At this stage, refer only to the specific page numbers listed below, and then read from page 192 - 210. Choose one of the case studies and redo Task 1 with this example.

READING:

Room, R. et al. (2002). Ch 8 - Targeting Environmental Change to Reduce Alcohol-Related Problems. In *Alcohol in Developing Societies: A Public Health Approach.* Helsinki: Finnish Foundation for Alcohol Studies in collaboration with the WHO. Focus on the boxed case studies on the following pages:

Page 188: Minimising intoxication at soccer matches in the Netherlands
Page 190-1: Legislating against selling alcohol along state highways in Brazil
Page 198-9: Prohibition of alcoholic beverages from 1996-8 in Haryana state, India
Page 200: Prohibition of importation of alcoholic beverages in Barrow, Alaska
Page 205-207: Grog-free days in Tennant Creek, Australia
Page 208: Alcohol rationing in Greenland in the 1970s
Page 211-213: The women's lobby for prohibition in Moen, Chuuk, Micronesia
Page 213-215: The women's lobby for prohibition of alcohol in Andra Pradesh, India in the 1990s.

3.1 Government Taxation of Alcohol Consumption

Decisions on the level of excise duty (tax) imposed on liquor products are not straightforward. While it can be demonstrated that alcohol abuse is a cause of many social and health problems, the liquor industry has significant economic power and influence.

In general, governments would want to generate a pool of revenue from alcohol taxes to support the services required to deal with the problems it causes. However, if the taxes are set at too high a level, illegal brewing and cross border smuggling is likely to increase. In turn, reduced overall consumption and increased production costs could jeopardise employment in the industry.

In general, liquor products are taxed according to the absolute alcohol content. This is a strategy which has been successfully used in Australia, where lighter beer was promoted by reducing the tax on the product.

Read this article by Parry et al (2003) arguing for an increased tax on alcohol in South Africa. If you live elsewhere than South Africa, see if you can find out the most recent tax levels on alcohol in your country, and whether the rationale to increase tax in real terms has been implemented in your context.

READING: Parry, C. D. H., Myers, B. & Thiede, M. (June 2003). The Case for an Increased Tax on Alcohol in South Africa. *The South African Journal of Economics,* 71 (2): 265-281. See pp 305-314 in the Reader.

In the next section, we consider the role of the media in spreading promotional or educative messages, and the control of alcohol marketing strategies, particularly amongst young people.

4 MARKETING ALCOHOL

Promoting products in a free market economy is a well established practice, and sophisticated communication methods are used to appeal to diverse needs in different segments of the potential market. In the process of marketing, liquor can be portrayed in a variety of ways and through different media including radio, television, or printed media such as magazines, newspapers, billboards, branded clothes and other products. Such messages could be educative, for example a health discussion on how to drink sensibly, or they may promote the use of alcohol, as do advertisements of different liquor brands. Norms and values about the use of liquor can also be conveyed unintentionally by *movies* and television dramas, through their portrayal of drinking and the associated image of those who drink.

It is because of the powerful impact of marketing that many governments have introduced strict policies to limit the promotion of tobacco and alcohol products. In South Africa, much effort was made by the Health Promotion Directorate in the National Health Department to ensure that the Tobacco Control Policy included a ban on advertising and sports sponsorships, the introduction of packet labeling with health warnings, and the restriction of smoking in public buildings and workplaces. Work is currently being done to promulgate appropriate legislation to further control alcohol availability and marketing, but the issues are unfortunately not as clear-cut as they are with tobacco.

One segment of the market which is particularly susceptible to advertising is the youth. The next reading by Jackson et al (2000) provides a detailed analysis of the marketing of liquor to young people, and makes recommendations about a range of ways in which the production, marketing and availability could be controlled. According to this article there have recently been four major changes in the United Kingdom which impact on the drinking habits of young people:

1. The development of new designer drinks such as “alcopops”, white ciders and alcoholic energy drinks.
2. An increase in the strength of alcohol products, in direct competition with the illicit psychoactive substances market.
3. The use of sophisticated advertising and branding techniques, in keeping with emerging youth culture.
4. The opening of new drinking outlets such as café bars and theme pubs to attract younger drinkers.

Before you read the article, take a look at **Task 2**.

READING: Jackson, M. C., Hastings, G., Wheeler, C., Eadie, D. & Mackintosh, A. M. (2000). Marketing Alcohol to Young People: Implications for Industry Regulation and Research Policy. *Addiction* 95*,* Supplement 4: S597-S608. See pp 155-166 in the Reader.

TASK 2 - What influences the drinking habits of youth in your area?

Using the four trends listed above for the United Kingdom to guide you, gather relevant information on the marketing and promotion of alcohol to youth in your local area. Based on the information you gathered, answer the following questions:

b) What are young people drinking when they get together?
c) What is the alcohol content of these drinks?
d) In what way does current alcohol advertising appeal to young people?
e) Which of the new venues where alcohol is sold, e.g. restaurants, pubs or cafes, seem to appeal to young people?

Based on your findings, answer this question: *Is there enough evidence to say that in your area there is a similar trend to that in the UK?*

4.1 Labeling of alcohol products

Labeling is one of the ways to advertise and promote a product. The packaging of any product serves both to appeal to the potential buyer, as well as to provide information on its contents and possible harmful effects. Liquor producers are only required to reveal the percentage of alcohol content on the package, but nothing else. There remains a potential to have laws that require standard drinks to include warnings and information on labels.

Read the requirements of **Task 3**, then read the article by Webster-Harrison et al (2002).

READING: Webster-Harrison, P. J., Barton, A. G., Sanders, H. P., Anderson, S. D. & Dobbs, F. (2002). Short Report - Alcohol Awareness and Unit Labeling. *Journal of Public Health Medicine,* 24(4): 332-333. See pp 463-466 in the Reader.

TASK 3 – Analyse marketing of alcohol to the youth in your area and make recommendations for its regulation

Spend some time in the next few days purposefully collecting liquor advertisements from magazines and newspapers, and noting down those you see on the television. Review all the examples you have collected, and analyse their appeal in terms of the youth market segment, the type of liquor, and the key message being promoted. An example of a key message is, for example, *If you have this drink you will be part of the trendy set.*

Revisit the five recommendations on alcohol regulation made by Jackson et al (2000) on pages S606-7, and decide which are relevant in your province or area in relation to the youth.

Control of marketing and labeling is one strategy to increase legislative control of alcohol, particularly in relation to groups like youth which are vulnerable to peer and image pressure. In the next section, we discuss the importance of community mobilisation and promotion of ownership in any broad intervention to control alcohol use or reduce harm caused by risky drinking.

5 COMMUNITY MOBILISATION

It would not be possible to implement many of the strategies and policies described in this session at a local level without the participation of community based organisations.

The next reading by Treno and Holder (1997) emphasises the importance of community mobilisation in the process of implementing policies and environmental changes. The authors use the concept *community mobilisation* to refer to "… the efforts to involve community members in activities ranging from defining needs for prevention … to obtaining community support for a pre-designed prevention program" (Treno & Holder, 1997: S173).

This is a rather dense article; to begin to process it read the abstract carefully and then focus mainly on the figure and the tables: this will give you a sense of what the "Community Trials Project" in the USA was all about. The purpose of the paper is to be found on page S175, in the right column, second paragraph. Take note of the challenges of bottom-up and top-down approaches to community mobilisation (under *Strengths and limits in both approaches*). Below is a brief introduction to the paper. Read it and then try **Task 4** as you read the paper.

READING: Treno, J. A. & Holder, H. D. (1997). Community Mobilization: Evaluation of an Environmental Approach to Local Action. *Addiction* 92, Supplement 2: S173-S187. See pp 447-462 in the Reader.

The programme described by Treno and Holder involved three comparable communities - Southern California, Northern California and South Carolina. The main interventions were:

- The Drink/drive reduction
- Responsible beverage service (RBS)
- Controls of access to alcohol
- Youth prevention

In this context, the environmental approach refers to "… implementing policies to reduce alcohol-related trauma" (Treno & Holder, 1997: S173).

A phased approach was undertaken comprising:

1. Project design: an ideal set of interventions was developed including objectives and activities.
2. Staff development: local indigenous workers were appointed and trained.
3. Coalition development: community organisations were involved.
4. Task force development: focused action groups were formed from the coalition and staff.
5. Intervention: implementation was achieved through leader support and community awareness.
6. Evaluation: the evaluation of the programme focused on the extent to which policies were adopted and implemented in the main areas of intervention.

TASK 4 – Plan community mobilisation strategies for an intervention

a) Borrowing from the conceptual model used in the paper by Treno and Holder (1997) and taking the particularities of your own target group, identify which strategies could be used to mobilise community involvement in an environmental intervention in your context. Specify what organisations you would involve and why they would be critical to the success of a programme.

b) What is the importance of community involvement in alcohol-related interventions?

FEEDBACK

a)

Deciding on community mobilisation strategies cannot easily be done

before your programme development process has begun. Below is an example of community mobilisation strategies from my experience. You could look back at Treno & Holder, pages S174 - S175, and the diagram on page S177, to assess to what extent the Sensible Drinking Project in Cape Town, described below, matches that of the Community Trials Project in the reading.

CASE STUDY – THE SENSIBLE DRINKING PROJECT, CAPE TOWN, PART 1

How did the Sensible Drinking Project start?
This project started in Manenberg and Guguletu, in Cape Town in 2000. Research done by the Medical Research Council (MRC) had shown the strong association between alcohol and trauma at the GF Jooste Hospital, which serves these two communities. The Regional Medical Officer decided that a community based project was needed to try to reduce the amount of alcohol use that was leading to this harm.

A Task Team consisting of representatives from the Department of Health, Unicity Officials, UWC School of Public Health, Cape Town Drug Counselling Centre, SANCA, Arrive Alive, MRC and others came together to plan harm reduction interventions in the GF Jooste Hospital's main drainage areas of Guguletu and Manenberg.

A workshop was held in each community involving faith based organisations, schools, crèches, relevant NGO's, mass media and community safety and security representatives, e.g. police. The participants supported the idea of promoting a responsible attitude towards alcohol usage and a stakeholder's group (the SDP Committee), consisting of interested community members, was formed in each area.

It was decided to appoint a person from each community to co-ordinate the various community interventions in shebeens, clinics, sports clubs, schools and in the broader community. Adverts for the position were displayed at libraries, multi-purpose centres and other public places. Applicants were short-listed, interviewed and eventually one coordinator from each catchment area was appointed. They attended a short course in developing community based alcohol prevention programmes at the UWC Winter School, as well as the Brief Interventions Training offered by the Cape Town Drug Counselling Centre.

Launch of Project
The Sensible Drinking Project was officially launched on 5 June 2002 at GF Jooste Hospital. The programme included presentations from the Director of the Unicity Health Services, UWC Public Health, the MRC and Dr Keith Cloete, coordinator of the project. Song items were delivered by Sinethemba and Manenberg Schools. Media liaison resulted in interviews on eight radio stations, and the community and regional newspapers carried articles.

Lessons Learnt
1. Spend time in selling the idea to all levels within a community, i.e. from councillors, to teachers, health forums and members of the community. This process could take many months, but is essential to removing obstacles later.

2. Choose a coordinator from the community to ensure that the project has a driver who understands local conditions.
3. Ensure that the coordinator has his/her own motor vehicle.
4. Provide adequate orientation and training to enable the coordinator to carry out the variety of tasks necessary to achieve the project goals.
5. Compile operational plans with each coordinator, so that they are clear as to what is expected of them, and the activities on which they should report.

Consider which of these strategies may be relevant to the community you work in, and do not forget the issue of community mobilisation when you come to design interventions both for your second assignment and in the future.

6 SESSION SUMMARY

In this session, you have analysed policy interventions which have been used to control alcohol marketing and availability, as well as the necessity of mobilising communities as part of the development and implementation of policies. You have also considered the ways in which alcohol is marketed to young people and made recommendations on how this could be controlled. Hopefully you have broadened your view of the range of policy-level interventions that are possible, and analysed some of the challenges that face governments in relation to reducing alcohol consumption and the harm caused by it. You were also asked to consider a model of community mobilisation in relation to your target group. Your notes on how some of these issues relate to drinking amongst young people in your own area may be useful in completing your second assignment.

In the next session, we build on the range of possible alcohol related interventions by considering broad environmental changes that can be made in the drinking context.

7 FURTHER READING

- Dept of Welfare, South Africa. (1999). *National Drug Master Plan*, RSA, 1999 - 2004.
- 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.
- Parry, C. D. H. (2000). Ch 23 - Alcohol and Other Drug Abuse. *South African Health Review 2000.* Durban: Health Systems Trust. [Online], Available: http://www.hst\sahr\2000\chapter23.htm/ 11pages. [2001-7-18]

Unit 3 - Session 2
Environmental Changes

Introduction

As you by now know, a Health Problem approach to drinking would prioritise broad strategies which could be used to steer people away from excessive drinking, or to mitigate the harm caused by it. In this session we explore environmental strategies for harm reduction and providing alternative activities in order to reduce drinking. You will consider whether such strategies could be applied in your local context.

Crucial to environmental interventions is the concept of *drinking patterns*, which was discussed in Unit 2 Session 2: so you may want to refresh your memory on this issue as you work through this session.
This session has relevance to your second assignment, which involves designing appropriate interventions to address alcohol problems. You may find that the international examples of environmental interventions stimulate new ideas for your setting; remember also the importance of community mobilisation as discussed in Session 1. This may be crucial to making your programme successful. Most importantly, you will be able to consider what baseline information you may need in order to evaluate any environmental programme that you may plan.

Session contents

Timing of this session

This session includes two readings, constituting 15 pages. There are two tasks which form useful preparation for your second assignment. Allow at least two hours for the session.

1 LEARNING OUTCOMES OF THIS SESSION

By the end of this session, you should be able to:
▪ Assess international examples of environmental adaptations to reduce alcohol intake and alcohol-related harm in local settings. ▪ Discuss the role of a variety of media in supporting the communication of alcohol-related policy and environmental changes.

2 READINGS

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

Reading	**Publication details**	**Page nos in reader**
Room, R. et al.	(2002). Ch 8 - Targeting Environmental Change to Reduce Alcohol-Related Problems. In *Alcohol in Developing Societies: A Public Health Approach.* Helsinki: Finnish Foundation for Alcohol Studies in collaboration with the WHO: 181-192.	**349-384**
Soul City.	(Undated). *Alcohol and You*. Johannesburg: Jacana Education: 16-21.	**399-408**

3 ALTERNATIVES TO DRINKING

It has often been asserted that people drink too much alcohol when they are unemployed or when they do not undertake any stimulating activities in their free time; however, probably as many people drink in a risky way although they are employed and alternatives to drinking are plentiful. Providing activities to replace drinking is a fairly common strategy, but its success is questionable and difficult to measure.

In areas of Southern Africa such as on farms where the dop-system operated, or on the mines where there are numerous shebeens, a general shift in culture would be required as well as alternative activities, to reduce the time people spend drinking.

In the previous session, you explored some of the case studies in Room et al's

Chapter 8 (2002). Now read the first part of the chapter in full (pages 181-185) after reading through the requirements of **Task 1**. This task provides good preparation for your second assignment.

READING: Room, R. et al. (2002). Ch 8 - Targeting Environmental Change to Reduce Alcohol-Related Problems. In *Alcohol in Developing Societies: A Public Health Approach.* Helsinki: Finnish Foundation for Alcohol Studies in collaboration with the WHO: 181-185. See pp 385-398 in the Reader.

TASK 1 – Assess alternative activity strategies and develop baseline information for evaluation

In this task, you are asked to consider whether alternative activities to drinking would have any impact on the community that you have described in previous tasks. Review your description and then:

b) List those alternative activity strategies mentioned by Room et al which would potentially work in your target group. Critically assess the strategies in terms of the context and available resources.

c) Before intervening with alternative activities, you would need baseline information on current patterns of drinking and harm, in order to measure any change that may be due to the alternative activities. How would you develop your baseline information? Refer back to Unit 1 Session 2 where some methods of measuring alcohol consumption and patterns are discussed.

FEEDBACK

As feedback, we have included another piece of the case study introduced in Session 1 of this unit, as an exemplar of baseline information to make monitoring and evaluation possible.

CASE STUDY – THE SENSIBLE DRINKING PROJECT, CAPE TOWN, PART 2

Alcohol availability and drinking habits in Nyanga and Manenberg
A study by the Medical Research Council (MRC) in 2001 in two Cape Town hospitals assessed the association between alcohol and trauma. The study showed that 50% of patients being treated in the trauma units for injuries had alcohol on their breath when and more than 30% of these had possible chronic alcohol problems. Injuries were due to violence (63%), traffic accidents (22%) and other accidents (15%). More cases were male than female, and the average age was 30 years old.

In late 2000, a researcher from the UWC School of Public Health was asked by the Sensible Drinking Project (SDP) Task Team to collect some qualitative data on the

drinking patterns in the target communities of the SDP. Over a two week period, Kirstie Rendall-Mkosi planned the study, recruited and trained two temporary fieldworkers (one Xhosa and one Afrikaans speaking) to collect the data through about 25 interviews. Ferdinand Bomvana, of the Metro Health Dept, collected data from interviews with youth. A presentation of the information gathered was made to the Task Team and to a community meeting in Manenberg, to highlight the nature of alcohol use in the area.

The main questions asked in interviews with alcohol sellers, drinkers, and to women in the community were:

What are the main drinks consumed in this area?
When do people drink and how much?
Is food eaten while drinking alcohol?
How available is alcohol – where and at what times?
Is there a difference between men and women's drinking habits?
What are the main reasons for drinking?
What factors influence drinking habits and the liquor trade?
What are the things that encourage more drinking and less drinking (the facilitators and deterrents)?
What happens when people have drunk too much?
What are some of the controls used by alcohol sellers?

Similarities were found between Nyanga and Manenberg, but also some differences. In both areas, people said drinking mainly happens on weekends, but in the late afternoons and evenings during the week too. Unemployed people can be drinking at any time, while employed people drink mainly on weekends. Alcohol can be bought 24 hours a day from some outlets, and the sellers range from informal (selling a few bottles from the back door) to formal licensed taverns. The habit of drinking until very drunk is common, and generally people drink without eating at the same time.

The reasons given for drinking alcohol were both positive and negative: for enjoyment and relaxation; to socialise and network; to celebrate special occasions; to escape from household problems; to counter boredom; and to make it easier to talk about problems.

There is some difference in what is used and by whom in the two communities: in Manenberg, people drink beer and wine mostly, and spirits are reserved for special occasions, while in Nyanga, mainly beer, brandy and umqombothi are used. In Manenberg, it is acceptable for both men and women to drink alcohol, whereas in Nyanga it is less accepted for women to drink. In both areas, drinking among young people is becoming more common.

The factors which promote alcohol use range from its economic profitability, which results in many outlets, to the need for people to relax and socialise. Some sellers allow alcohol to be bought on credit.

The factors which influence people to reduce intake or abstain are based on cultural and religious norms, expectations that families need to be cared for with available money, the increasing cost of alcohol, and the action taken by some sellers to limit drunkenness.

Drinking too much is said to cause fights between friends as well as strangers, to make people too brave and argumentative, to put them in danger of pedestrian accidents, and also results in domestic violence.

4 HARM REDUCTION

Interesting strategies are being implemented across the world to reduce the harmful effects from people drinking. Remember these strategies do not necessarily aim to reduce overall consumption of alcohol, but to put strategies in place to protect drinkers and others from possible harm. These strategies could take the form of boosting the nutritional status of drinkers, containing intoxicated people in overnight shelters or providing lifts home, and equipping servers of alcohol with skills to deal appropriately with the behavioural problems of drinkers.

READING: Room, R. et al. (2002). Ch 8 - Targeting Environmental Change to Reduce Alcohol-related Problems. In *Alcohol in Developing Societies: A Public Health Approach.* Helsinki: Finnish Foundation for Alcohol Studies in collaboration with the WHO: 186-192. See pp 349-384 in the Reader**.**

TASK 2 – Reducing harm or increasing the appeal of shebeens?

In trying to make shebeens safer places for drinking, some projects have promoted the idea of having games such as pool available in the shebeen. In addition, it has been suggested that food should be sold on site and water should be made freely available.

The problem is that those who advocate these alternatives could be accused of making shebeens more attractive, and in this way increasing the amount of time and money people spend there.

What is your opinion and how would you respond to people who question this "sensible drinking" strategy or harm reduction approach?

5 HEALTH PROMOTION USING THE MEDIA

The influence that visual and auditory images and messages have on people can be considered part of the environmental factors which influence attitudes, values and habits concerning alcohol. In the same way as the media is used to promote the sale of alcohol by producers, there is the possibility of using it to promote responsible drinking, and even to shift the norms of acceptable drinking towards more cautious drinking or none at all. While the media can have limited impact in achieving behaviour change, it can:

- Provide knowledge, and increase awareness of a health problem and its solutions;
- Contribute to changes in knowledge, attitudes and behaviour;
- Demonstrate skills;
- Role model positive health behaviours;
- Link people to resources;
- Set an agenda and bring issues to centre stage in public;
- Contribute to the creation of a social climate that supports both individual and collective action;
- Generate public support for healthy public policy initiatives.

(Coulson et al, 1998:117)

Although we do not have sufficient space to go into any detail on developing effective media here, it is worth at least considering the range of media one can use, and the fact that media can sometimes be used in combination:

- Posters and pamphlets
- Newspapers and magazines
- Newsletters and journals
- Drama, puppets and live media
- Radio and community radio
- Murals in public places, billboards and media on commuter vehicles
- Videos
- Television
- Personal media such as stickers and t-shirts.

Some educational strategies utilise mass media in an attempt to counter or balance the messages being promoted by companies marketing alcohol. Sometimes liquor companies will even sponsor the “sensible drinking” message, to demonstrate that they recognise that alcohol can cause problems.

READING: Soul City. (Undated). *Alcohol and You*. Johannesburg: Jacana Education: 16-21. See pp 399-408 in the Reader.

Take a look at the extract in the Reader from a booklet produced by Soul City on alcohol use. This series of booklets is distributed occasionally in the *Sunday Times* newspaper nationally in South Africa, and at petrol stations and other public outlets. This issue coincided with the Soul City TV show which dealt with alcohol problems, amongst other issues, at the time. Copies of the booklet can still be ordered from Viva Books in Johannesburg.

6 SESSION SUMMARY

In this session, you have touched on a number of aspects of environmental interventions including examples of such interventions, and the issue of using media to support healthy environmental changes and harm reduction strategies. You considered and assessed the application of environmental interventions similar to those described by Room et al (1992) in your own context. In the course of this session an important programme development issue was raised, namely developing a baseline understanding of drinking patterns in your target group, in order to plan and evaluate environmental interventions. In the final session of this unit, we explore the potential of multifaceted programme interventions.

7 REFERENCES

- Coulson, N., Goldstein, S. & Ntuli, A. (1998). *Promoting Health in South Africa: An Action Manual.* Sandton: Heinemann.

Unit 3 - Session 3
Multifaceted Integrated Programmes

Introduction

This session explores the value of multifaceted programmes in addressing alcohol problems, using the example of the Living with Alcohol Programme from the Northern Territory, Australia. This programme uses a multifaceted approach which follows the Health Promotion philosophy formalised in the Ottawa Charter. This provides a useful point to reflect on the importance of those principles in planning programmes to address alcohol problems.

In the second paper that you will read, May (1995) makes the point that it is the multiple influences on drinking behaviour that indicate the need for a broadly targeted response; he puts forward a wide ranging intervention proposal arguing that, "[E]mbracing a narrow paradigm such as the disease model of alcoholism will not be productive for either a full understanding of many behaviours (Illich, 1976) or for a truly successful prevention effort" (May, 1995: 1557).

In the course of the session, you are invited to familiarise yourself with multifaceted programmes and to consider the viability of such interventions in your own context. Programme monitoring and evaluation is covered briefly through the example of the Sensible Drinking Project programme matrix.

Session contents

Timing of this session

This session contains 76 pages of reading in four readings. You have, however, been provided with a summary of Crundall's interventions, and pointers for

reducing the time you take to read the article by May (1995). You are also asked to refer to a reading by Croxford & Viljoen, which you studied in Unit 1. There are three tasks in this session and if you do the reading selectively, it is estimated that it could take you about four hours to complete.

1 LEARNING OUTCOMES OF THIS SESSION

By the end of this session, you should be able to:
▪ Discuss the rationale for a multifaceted approach to alcohol problems. ▪ Assess the viability of the multifaceted approach to specific contexts of alcohol use. ▪ Apply the Ottawa Charter framework to alcohol interventions. ▪ Develop tools for planning, monitoring and evaluating alcohol interventions.

2 READINGS

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

Reading	**Publication details**	**Page nos in reader**
Crundall, I.	(Undated). *The Northern Territory Living with Alcohol Program: Climbing Through a Window of Opportunity.* Australia: 98-105.	**69-78**
May, P. A.	(1995). A Multiple-level Comprehensive Approach to the Prevention of Fetal Alcohol Syndrome (FAS) and Other Alcohol-related Birth Defects (ARBD). *International Journal of Addiction,* 30: 1549-1602.	**195-222**
Medical Research Council (MRC).	(Oct 2000). Stop the DOP ... and more. *MRC News*, 31(5): 7-8.	**233-236**
Territory Health Services.	(1999). The Public Health Bush Book. Darwin, Australia: Government Printer of the Northern Territory for Territory Health Services: 4.42 - 4.56.	**421-436**

3 PROGRAMMES FOR WHOLE POPULATIONS

Since a number of factors influence people's drinking behaviour as well as the environment in which they drink, it is logical that any programme aiming to change drinking behaviours or reduce the potential harm from drinking, should have multiple targets and a variety of components. Evaluations of many health promotion programmes relating to health behaviours, such as smoking, have shown that a multifaceted approach is the most successful (Community Intervention Trial for Smoking Cessation, COMMIT Research Group, 1995). The Living With Alcohol (LWA) programme in the Northern Territory of Australia is a well known programme designed to reduce alcohol related harm. Legislative, educational and treatment components or services were developed to tackle well established patterns of drinking, and to reduce the harm it causes. This inevitably involved a number of government departments (justice, education, health social welfare etc) as well as agencies from different sectors.

In the first reading, Ian Crundall describes the implementation of this multifaceted programme, discussing its guiding principles and the impact it had. You will note that a careful balance was maintained between bureaucratic top-down interventions such as drink-driving legislation, and community oriented approaches such as community action plans. Below is a summary of the components of this programme. Study the summarising diagram below and familiarise yourself with the requirements of **Task 1**, before reading the paper.

TASK 1 – Consider the Living With Alcohol (LWA) programme in terms of the Ottawa Charter

Revise your understanding of the action areas of the Ottawa Charter, i.e.

- Healthy public policy
- Supporting community action
- Developing personal skills
- Reorienting the health services
- Creating supportive environments

a) To what extent do you think the LWA programme uses the Ottawa Charter as a framework?

b) Brainstorm ideas for a programme for your own context which fulfil each of the five principles of the Ottawa Charter. Put down at least three ideas for each.

READING: Crundall, I. (Undated). *The Northern Territory Living with Alcohol Program: Climbing Through a Window of Opportunity.* Australia*:* 98-105. See pp 69-78 in the Reader.

SUMMARY OF THE ACTIVITIES OF THE LIVING WITH ALCOHOL (LWA) PROGRAMME, NORTHERN TERRITORY, AUSTRALIA

COMMUNITY ACTION PROGRAMME

Facilitators:

* Information on safe alcohol consumption and developing supportive environments for informed choices, e.g. story board.
* Feedback from community for development of community action plan (targeting *drinkers*, *non-drinkers* and *learners*).

FAMILY VIOLENCE STRATEGY

* Arrest (where enough evidence);
* Prosecution;
* Perpetrator programmes;
* Services for victims;
* Community based development of culturally appropriate education & schemes, e.g. night patrols; safe homes.

EDUCATION

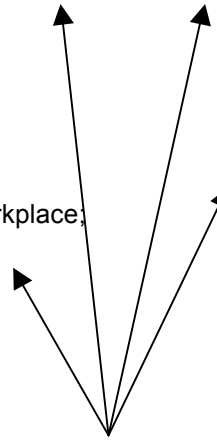
"*Drink Sense"*

* Media campaigns using slogans;
* NGO funding for awareness work;
* Selection of priority areas: youth; workplace; liquor industry.

LEGISLATION

* *Liquor Act*: increased penality for selling to underage or intoxicated;
* M*otor Vehicles Act:* increased penalties for drink driving;
* Tax: reduced tax on light beers,

  increased tax on high % alcohol.



LIVING WITH ALCOHOL PROGRAM (LWA)

Northern Territory, Australia

Targets: Reduce alcohol related road fatalities and accidents by half;

Reduce apparent consumption of alcohol by 40%.

DRINK – DRIVING

* Increased penalties;
* Alcohol training programme;
* "Sober driver's pubs";
* Breathalysers in pubs;
* "Home safely" campaigns in schools;
* Media campaign to promote responsible drinking guidelines.

TRAINING & PROFESSIONAL DEV

* Service providers receive training;
* Hospitality personnel trained in responsible serving of alcohol;
* Certificate in PHC & subs abuse;
* Alcohol handbook & resource kit.

TREATMENT & REHABILITATION

* Health services and NGOs provide counselling; day care and residential programmes.

Research, Monitoring and Evaluation was undertaken throughout all strategies.

FEEDBACK

Although the authors do not mention Health Promotion theory as such, the components of the LWA seem to correspond closely with the action areas of the Ottawa Charter.

- Healthy Public Policy: Various laws were promulgated to control drunk driving, reduce sales of liquor to underage children, and increase tax on higher alcohol content liquor. There was also local policy to increase arrest and conviction of perpetrators of family violence.

- Supporting community action: A localised community action plan was developed.

- Developing personal skills: Various media and educational programmes were developed to raise awareness of the problems and increase knowledge to facilitate behaviour change, e.g., Drink Sense campaign, and interventions with perpetrators of family violence.

- Reorienting health services: Training and resources were made available for health service workers, and there was a shift in treatment to an outpatient model.

- Creating supportive environments: Hospitality server training was provided, community based family violence strategies were developed and breathalysers were made available in pubs.

It can also be seen that any one campaign or component, such as the drink-driving one, has many elements, and each of these could be categorised under different action areas of the Ottawa Charter framework. Depending on which aspect of alcohol related harm is being addressed, so the weighting of policy, skills training and environmental changes will be different.

4 PROGRAMMES TARGETING SPECIFIC RISKS

According to Naidoo & Wills (1998), there are three main ways of using targeting in the design of Health Promotion programmes. These include targeting: risk contexts, at-risk groups and risky behaviours. There is, however, a dilemma in using targeting. Although targeting may ensure better use of resources if directed at the people or situations where the problem most often occurs, this approach can lead to *victim blaming* or *culture blaming*. For example, the cause of the problem may arise from the socio-economic context that people find themselves

in, or the inequities between groups; in this case, no amount of focus on the target group will improve the situation. Some health determinants require a more universal approach so as not to label and stigmatise people, but rather to deal with the causes on a broader basis.

In keeping with our themes of youth, women and settings, we will use the paper by May (1995) to apply the Preventive Model in reducing the prevalence of Fetal Alcohol Syndrome (FAS) and Alcohol-related Birth Defects (ARBD). While some of the interventions are aimed at pregnant women who drink, there are many that are directed more broadly at the population or aimed at changing the environment.

> **READING:** May, P. A. (1995). A Multiple-level Comprehensive Approach to the Prevention of Fetal Alcohol Syndrome (FAS) and Other Alcohol-related Birth Defects (ARBD). *International Journal of Addiction,* 30: 1549-1602. See pp 195-222 in the Reader.

This is a long paper, so unless you are very interested in the detail of the interventions required for reducing the risk of FAS, I suggest that you focus on **Figures 1** and **4,** and **Tables 4, 5,** and **6**. Together, these figures and tables will provide you with a summary of the levels of risk related to alcohol consumption, the targeting of prevention activities related to this risk, and the variety of activities required.

In the prevention of FAS, it is problematic to apply a Harm Minimisation Approach, since there is no way to protect the fetus from alcohol. The transmission of alcohol to the fetus is so fast and direct that the ideal remains that no alcohol should reach the fetus at any time during the nine months *in utero*. If one has to accept that a woman cannot stop drinking during pregnancy, the only opportunity to reduce harm is to alter the contents of the liquor, and the frequency and amount consumed.

TASK 2 – Assess the potential of an intervention programme and consider viable alternatives

In an earlier reading discussed in Unit 1 (Croxford, J. & Viljoen, D. (1999). Alcohol Consumption by Pregnant Women in Western Cape. *South African Medical Journal,* 89: 962-965), you were given some insight into the main risk factors and drinking patterns resulting in FAS in a Western Cape town. Many of them concur with Table 2 in the reading by May (1995).

a) *Bearing these factors in mind, and anything else you may know about the living conditions and level of service provision for women in the rural Western Cape of South Africa, assess the viability of the interventions proposed by May (1995). In other words, identify the activities that could be realistically implemented in such a context, and those that are unlikely to work. Most importantly, say why you say so. Think of the issues of culture, norms and conditions, as well as resource constraints and competing programmes.*

b) Can you think of any existing, universally available health and development programmes or services on which some of the FAS prevention activities could piggy-back?

FEEDBACK

In question (a) you were asked to choose an example that would work and one that would not work and to say why. While I support all the elements listed in the primary, secondary and tertiary prevention plans outlined by May, there are some that could easily be applied in the areas of Southern Africa where maternal drinking is a problem, but some would be impossible mainly due to resource constraints.

The DOPSTOP Association (meaning '*stop alcohol'*) which is based in Stellenbosch in the Western Cape is an example of an organisation working mainly on a primary prevention basis. We have included a short article by the Medical Research Council about its activities which you will find in the Reader.

READING: Medical Research Council (MRC). (Oct 2000). Stop the DOP ... and more. *MRC News*, 31(5): 7-8. See pp 238 - 236 in the Reader.

Although the changes in drinking culture and policies related to access to alcohol take a long time to have the desired effect, they are possible to achieve.

However, the aspects of May's proposed plan that are least likely to ever be

realised are the secondary and tertiary levels of treatment for women. Since so many women are potentially damaging their children, it is not feasible to offer intensive rehabilitation for every woman who binge drinks on the weekend. A different model of long term community based treatment and support for changing drinking patterns will have to be developed.

b) The kinds of programmes which could serve to piggy back FAS prevention activities are as follows: There are fairly wide spread antenatal clinics that could take on a more active role in the screening and counseling of women who drink. If they coordinated their work better with family planning services, they may succeed in lowering the rate of unplanned pregnancies amongst women, especially those who drink. Another programme which is being rapidly expanded, and where funds are being directed, is the prevention and care for HIV/AIDS. The link between alcohol problems and HIV could be highlighted and more screening and counseling related to alcohol use could be incorporated into HIV testing, support and care initiatives.

5 PROGRAMME MONITORING AND EVALUATION

It is difficult to cover all the intricacies of programme monitoring and evaluation briefly. We have therefore chosen to refer you to the reading below, by the Territory Health Services, which you may recognise from the *Health Promotion II* module, as well as some examples that appear in readings in this module.

Many policy and environmental interventions take years to effect the desired reduction of alcohol related harm, and it is difficult to isolate the effects of specific interventions, when there may be many other influences at the same time. However, one can monitor the achievement *process* and *impact* objectives in the shorter term, and make adjustments, to ensure that the anticipated longer term *outcome* is more likely to occur.

READING: Territory Health Services. (1999). *The Public Health Bush Book*. Darwin, Australia: Government Printer of the Northern Territory for Territory Health Services: 4.42 - 4.56. See pp 421-436 in the Reader.

If you refer back to the reading by Treno & Holder (1997) and look at page S177, the authors discuss the data used for evaluating their community mobilisation model.

In addition, in the paper by May (1995) which you read earlier, you will find a brief, but useful section on programme evaluation at the end of page 1587.

Here is another section of the case study on Sensible Drinking which you have studied in this unit: take a look at Task 3 before studying the evaluation matrix

used by the Sensible Drinking Project (SDP).

In the first setting the Health Promoting Schools approach was advocated since this is well known and quite widely used in the Western Cape. It places emphasis on the whole school system, and involves all role players in taking responsibility for developing a healthy learning environment and curriculum.

CASE STUDY – THE SENSIBLE DRINKING PROJECT, CAPE TOWN, PART 3				
MONITORING AND EVALUATION SDP PROJECT WORKSHOP				
Objectives	**Activities**	**Indicator**	**Measures**	**Time frame**
Setting: Sinethemba High School and Silver Stream School				
Develop capacity in school to deal with alcohol using HPS Approach. Increased level of understanding of consequences, risks and associations with alcohol.	Initiation of HPS focusing on alcohol. Training of teachers and learners. Selection and training of peer leaders. Class sessions by Coordinator and SANCA.	Commitment and process planned. Number trained. Number of active leaders. Number of learners involved. Reduction in drinking behaviour and attitude towards alcohol.	Training report. Training report and feedback from Coordinator. Baseline questionnaire compared with 6 months later. Number of incidents of drunkenness at school functions. Focus groups of learners and teachers to assess effectiveness of programme.	Jan – July Feb - August
Setting: Clinics, Day Hospitals (Health Centres) and GF Jooste Hospital				
Improvement in identification, counseling and referral of people with alcohol problems. Advocate for more resources and better networking in the area related to alcohol rehabilitation.	Further training of health workers on 3 day course. Introduction of case and referral form. Audit of resources. Meeting with role-players and decide what to lobby for.	Number trained. Positive attitude development in staff. Number of clients identified and referred successfully. Agreement on increased resources from authorities and NGOs.	Baseline knowledge of CAGE, counseling and resources. Training report. Feedback from supervisors. Analysis of forms. Documentation of meetings.	Feb – Nov March – Nov

	Compile document and present to relevant funders and authorities.			
Objectives	**Activities**	**Indicator**	**Measures**	**Time frame**
Setting: Shebeens in Nyanga and Manenberg				
Establish commitment of owners to implement various controls. To increase food intake while people drink. To increase other activities on premises e.g. pool, cards.	Establish a group of potentially committed owners (code of conduct). Agree on controls and developments to be tried. Promote specific food to be sold on premises. Monitor the drinking levels, food intake and drunk incidents. Introduce games and competitions.	Active groups established. Plan of action designed by participants. Food intake to drink ratio. Drunken incidents. Number of premises with games. Number of patrons involved in games.	Minutes of meetings. Monitoring forms analysed monthly. Try breathalyser.	Feb – March April – Nov April – Nov

Using this planning, monitoring and evaluation matrix as a model, develop one for your own planned interventions.

TASK 3 – Plan your interventions and establish monitoring and evaluation tools

Draw a table similar to the one above, and map out the strategies, activities and indicators that you are considering for your assignment. You may realise that many interventions are quite difficult to monitor. However, explaining your activities and what evidence there is of their implementation is essential for managing, as well as evaluating a project over time.

6 SESSION SUMMARY

In this session you have read three papers which focus on a multifaceted approach to addressing alcohol related problems. On the basis of these papers, one may conclude that no matter what the scale of such programmes, they require a multisectoral approach and components that use different approaches and strategies.

The process of establishing these types of programmes is as important as the actual policies, educational messages or changes that are carried out. Participation by the relevant stakeholders and beneficiaries from the outset is more likely to result in an understanding of the problems, as well as commitment to the planning and implementation of the strategies and activities.

This is the end of Unit 3. In Unit 4, we address individual strategies.

7 REFERENCES AND FURTHER READING

- Naidoo, J. & Wills, J. (1998). Ch 5 - Targeting Health Promotion. In *Practising Health Promotion: Dilemmas and Challenges.* London: Bailliere Tindall: 92-111.

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

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.

1 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.

2 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**

3 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

a) Identify the alcohol issues in your local community with regard to youth.

b) 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.

c) If there are some interventions, what is your judgment of the design of these

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

4 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.

5 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.

6 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

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.

1 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.

2 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**

3 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.

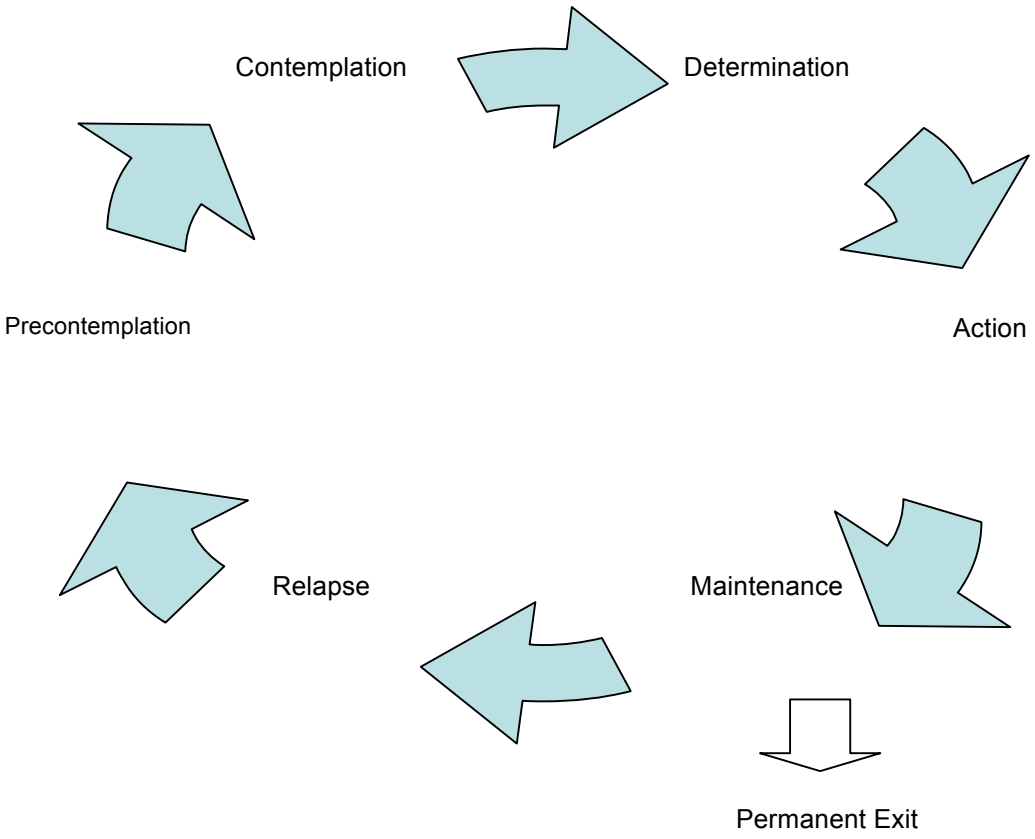
TASK 1 – Try out a simulated Brief Intervention

a) 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.

b) 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



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.

4 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:

a) When going for a consultation, is your use of alcohol discussed, no matter what the presenting problem is?

b) 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?

c) Do you think your provider knows about the techniques of Brief Interventions?

d) 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?

5 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.

6 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

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.

2 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**

3 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.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. 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.
12. 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.

4 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.

a) 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.

b) 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

a) 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?

b) 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?

5 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!

6 REFERENCES AND FURTHER READING

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- 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.

ALCOHOL PROBLEMS: A HEALTH PROMOTION APPROACH

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ALCOHOL PROBLEMS: A HEALTH PROMOTING APPROACH:
EVALUATION QUESTIONS
SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF THE WESTERN CAPE

Please give us some feedback on this module. Thank you.

1. In general, how do you feel about the module?
2. Did any aspects of the module challenge you to think more deeply about a health promoting approach to alcohol problems?
3. Are there any sections of the module which could be better explained? Be as specific as possible.
4. Were there any sections or sessions that you felt were unnecessary?
5. Were there any topics that you felt should have been included in the module?
6. Are there any improvements you could suggest to the assignment?
7. Are there any interesting readings which you feel should be added to the module?
8. Do you have any intention to use or adapt any part of the module?

Date:
Place:
Do you play a role in the field of Public Health? If so what?
Your name: [optional]:

Please paste your response into an email to: Ms L Alexander, SOPH, UWC
lalexander@uwc.ac.za