THE MEDICAL COUNCIL ON ALCOHOL

MEDICAL STUDENTS' HANDBOOK: ALCOHOL & HEALTH (3rd Edition)

1. Facts about Alcohol Content of Drinks

The Unit System

The alcohol content of the various alcoholic beverages differs widely. Thus similar quantities of the various beverages can contain markedly different quantities of alcohol. The alcohol content of a given beverage is, however, easily calculated from its percentage alcohol content by volume (% ABV), which is clearly marked on the container, taking the specific gravity of alcohol into account, *viz.*

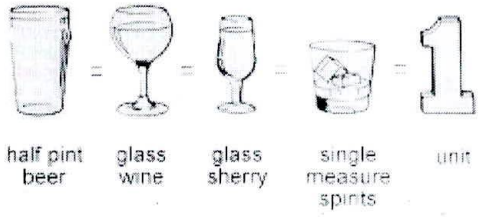
% ABV x 0.78 = g alcohol/100 ml

The absolute amount of alcohol in a given drink can then be calculated by reference to its volume (Table 1.1).

Table 1:1 Alcohol Concentrations in Various Beverages

Beverage Type	Alcohol by Volume (%) ABV	Alcohol Content (g/100ml)
Beers/lagers/stouts/ciders		
alcohol-free	<0.05	0.04
low alcohol	0.05-1.2	0.4-0.9
standard strength	3.0-4.0	2.3-3.1
premium srength	5.0-6.0	3.9-4.7
super strength	8.0-11.0	6.2-8.6
Alcopops	5.0-6.0	3.9-4.7
Wines	5.0-13.0	3.9-10.1
Fortified Wines		
sherry, vermouth, cinzano	14.0-20.0	10.9-15.9
Spirits		
light (gin, vodka, white rum)	37.5	29.3
dark (whisky, brandy, dark rum)	40.0	31.2
Liqueurs	14.0-40.0	10.9-31.2

In order to simplify the quantification and hence to facilitate assessment of alcohol intake, a system, based on defining quantities of beverages containing equivalent amounts of alcohol has been devised for use in Great Britain. A 'unit' of alcohol is the amount contained in 1/2 pint (284 ml) of beer, a single glass (125 ml) of table wine, a single glass (50 ml) of fortified wine, for example sherry, or a single measure (25 ml) of spirits; it approximates to 10 ml or 8 g of absolute alcohol.



Inaccuracies of the Unit System

This system is now used widely by the lay public, by 'alcohol agencies' and by physicians alike. As currently publicized, however, it is greatly over-simplified.

- the alcohol content of beers and lagers varies considerably (see Table 1.2) so that a pint of beer (568 ml) may contain from 2 to 5 units of alcohol depending on its strength
- second, beers and lagers, particularly for off-licence consumption, are sold in cans, in volumes varying from 330 to 440 or 500 ml, which bear little relationship to the pint measure
- there is no standardized measure for wine; a 'glass' may contain from 4 to 12 fluid ounces (114 to 342 ml) and so, depending on the alcohol content of the wine, from 0.6 to 4.5 units
- until recently the standard 'pub' measure of spirits varied from 1/6 to 1/4 gill (24 to 37 ml) by region; European Community directives have now ensured that the measure is standardized to 25 or 35 ml
- measures of drinks consumed at home differ from 'standard' measures; beer is consumed from bottles or cans in varying volumes, wine measures tend to be larger while measures of spirits tend to exceed optic measures by a factor of 2.5 to 3.0
- the unit system is essentially parochial and does not lend itself to international comparisons; thus, in Australia and New Zealand, a 'standard' drink contains 13 ml or 10 g of absolute alcohol while in the United States of America, a 'standard' drink contains 15 ml or 12 g of absolute alcohol.

Improving Accuracy

The accuracy of the 'unit' system can be improved by taking differences in beverage strengths and volumes into account. Thus, the exact number of units of alcohol in a given beverage volume can be calculated from the % ABV using the information that 10 ml of absolute alcohol is equivalent to 1 unit of alcohol. Thus the number of units of alcohol in a given volume of beverage equals:

$$\frac{\%\ \text{ABV} \times \text{volume (ml)}}{1000}$$

A half-litre can of 8% ABV lager contains 4 units of alcohol $\left(\frac{8 \times 500}{1000}\right)$; likewise, a 750 ml bottle of 13% ABV wine contains 9.8 units of alcohol $\left(\frac{13 \times 750}{1000}\right)$ (Table 1.3).

Newer Drinks

In recent years new ranges of fortified wines, such as MD 20/20 and Mad Dog, strong white ciders, such as Diamond White and Ice Dragon, fruit-flavoured lagers and ciders, such as Desperados and Maxblack and alcoholized soft drinks, the co-called 'Alcopops', such as Hooch alcoholic lemon, have been marketed. The fortified wines have sweet fruit flavours such as cherry, banana and strawberry and a % ABV of between 13 and 21%. The white ciders, which are filtered to remove colour and some flavours, have a % ABV of between 8 and 9%. The lagers and ciders which are additionally flavoured with citrus fruits or blackcurrant and the 'Alcopops' which are essentially soft drinks which have been 'fortified' with alcohol have a % ABV of between 5 to 6%. These drinks are attractively packaged, often in small volumes, which may nevertheless contain several units of alcohol. Their obvious appeal to young people has become a focus of public concern.

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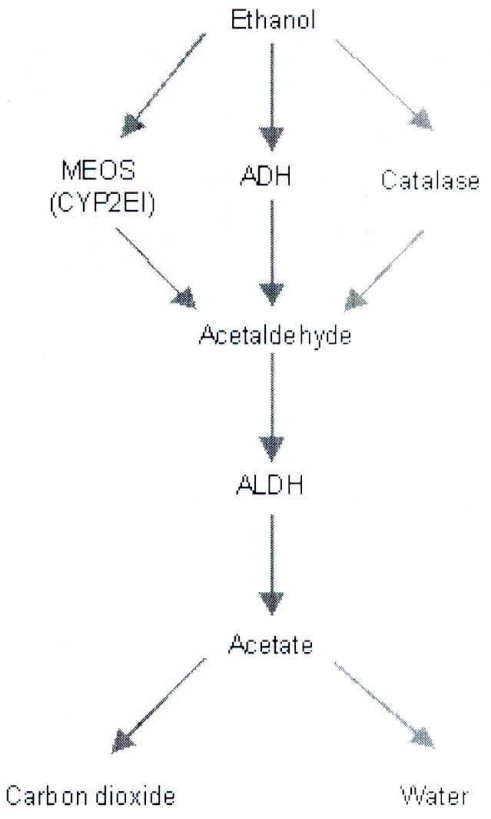
2. Alcohol Metabolism

Once ingested, ethanol is rapidly absorbed from the upper gastrointestinal tract. The majority is then oxidized, primarily in the liver; only 2 to 10% is eliminated in urine and breath. Hepatocytes contain three pathways for ethanol metabolism: the alcohol dehydrogenase (ADH) pathway in the cytosol; the microsomal ethanol oxidizing system (MEOS) located in the smooth endoplasmic reticulum and the catalase pathway located in peroxisomes (Figure 2:1).

Figure 2:1 The Metabolism of Ethanol



ADH – alcohol dehydrogenase
ALDH – acetaldehyde dehydrogenase
MEOS – microsomal ethanol oxidizing system
(CYP2E1 – cytochrome P450 isoform)

ADH, which exists in multiple molecular forms, catalyses the conversion of ethanol to acetaldehyde. An 'atypical' ADH has been

identified in between 5 to 20% of Europeans but in 90% of Mongoloid individuals. Although this isozyme shows a 7-fold increase in activity in vitro its presence is not accompanied by an acceleration of ethanol metabolism *in vivo*.

MEOS activity has now been attributed to CYP2E1, an isoform of cytochrome P450. Its role in ethanol metabolism in non-habitual drinkers is probably small, at least when circulating ethanol concentrations are low. Catalase does not appear to play a major role in ethanol oxidation, at least under physiological conditions.

Acetaldehyde dehydrogenase (ALDH)

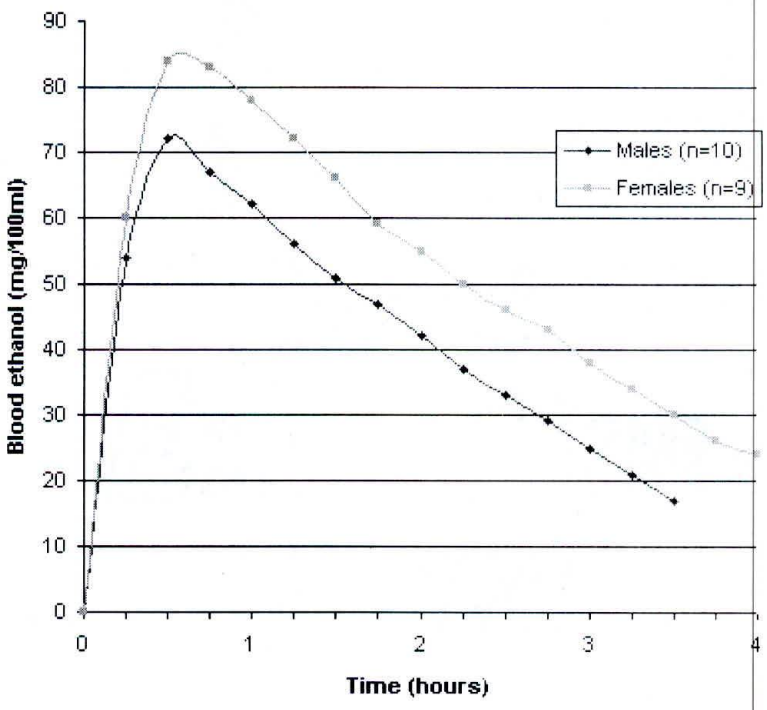
Acetaldehyde is oxidized to acetate by the activity of the enzyme acetaldehyde dehydrogenase (ALDH). Two major isoforms of ALDH have been identified which play a major role in hepatic acetaldehyde metabolism; of these the mitochondrial form (ALDH2) is the more important. The ALDH2 gene is of considerable interest because it occurs in two polymorphic forms; the 'wild' type gene encodes the active enzyme whereas the 'mutant' form encodes an inactive enzyme. The mutant allele is rarely observed in Caucasians but is found in some 40% of Orientals; it is inherited as an autosomal dominant. Individuals carrying the mutant allele have a markedly reduced capacity to metabolize acetaldehyde and the resultant increase in circulating acetaldehyde concentrations produces general vasodilatation with a striking facial flushing response. The acetate produced as a result of acetaldehyde oxidation is rapidly and safely metabolized to carbon dioxide and water.

Blood ethanol concentration

Peak blood ethanol concentrations are attained approximately one hour after ingestion. A number of factors influence the levels attained, including the speed at which the beverage was drunk, whether it was consumed together with food, the rate of gastric emptying and body habitus.

Women attain consistently higher blood ethanol concentrations than men following a standard oral dose of ethanol because their body water, and hence the compartment in which the ethanol distributes, is significantly smaller than in men (Figure 2.2).

Figure 2:2 Gender Differences in Ethanol Metabolism

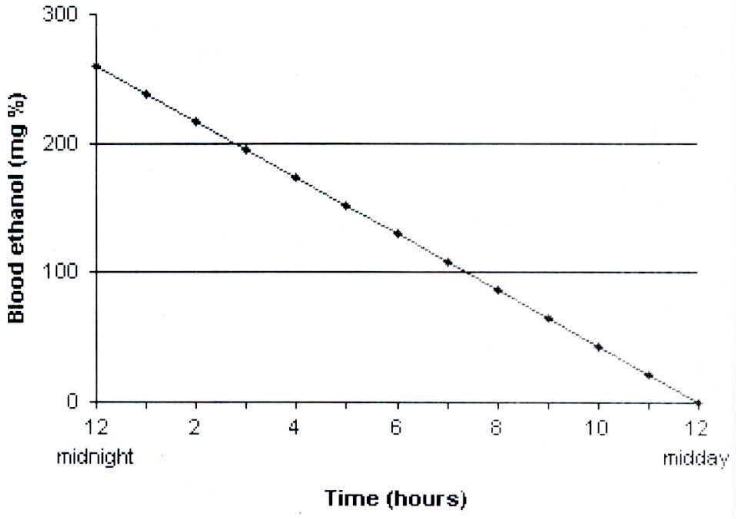


Blood ethanol concentrations following a standard dose of ethanol of 0.5g/kg body weight in healthy men and women

source: Marshall at al, Hepatology 1983; 3:701-706

Ethanol is eliminated from the body at a rate of 7 to 10 g (1 unit) an hour. Blood ethanol concentrations may, therefore, remain elevated for considerable periods following ingestion. Thus, if an individual imbibes 6 pints of premium strength beer (18 units) during an evening, then ethanol will still be detectable in their blood at 11.00 a.m. the following day (Figure 2:3).

Figure 2:3 Time Course of Ethanol Elimination



Ethanol elimination in a non-habitual drinker following ingestion of 150g in the four hours before midnight

The rate limiting factor in the metabolism of ethanol is the dissociation of the NADH-ADH enzyme complex. The ADH-mediated oxidation of ethanol results in transfer of hydrogen to the co-factor NAD converting it to its reduced form NADH. The rate of ethanol oxidation is, therefore, determined by the capacity of the liver to re-oxidize NADH. Chronic alcohol misuse is associated with an increase in the metabolic rate for ethanol as a result of induction of the MEOS system; under these circumstances this alternative pathway can account for up to 10% of ethanol oxidation.

The oxidation of ethanol generates an excess of hydrogen equivalents in the liver, primarily as NADH. If the ability of the hepatocyte to maintain redox homeostasis is overwhelmed, then a number of metabolic disturbances may arise including hypo- or hyperglycaemia, lactic acidosis, ketoacidosis, hyperuricaemia, abnormalities of hepatic lipid metabolism and alterations in the metabolism of galactose, corticosteroids, serotonin and other amines.

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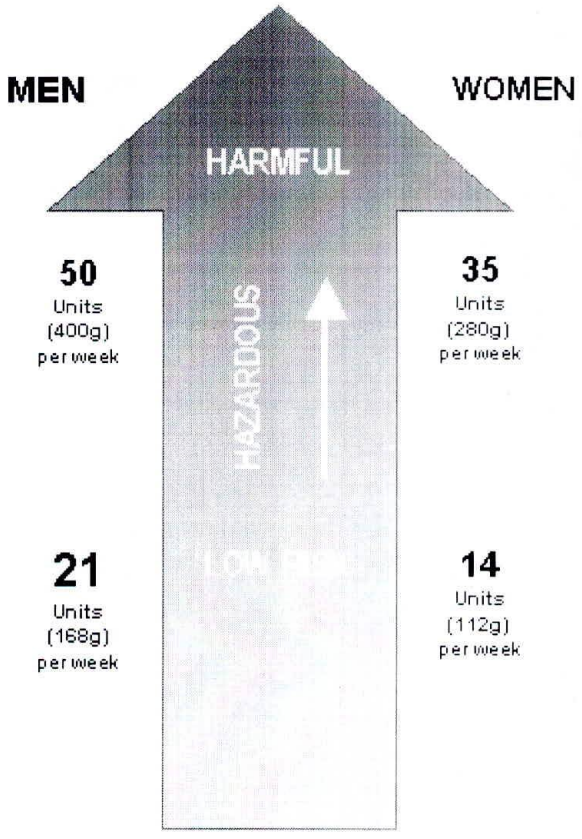
3. Predisposition to Harm

The aetiology of problem drinking can be usefully understood by employing the classical medical constructs of *agent* (alcohol), *host* (the drinker), and *environment*. Although the relationships within this pathogenic system are not fully understood, they do provide pointers to causation, early recognition and prevention of alcohol-related problems.

Alcohol, the Agent

Alcohol taken in any amount may be harmful if the time and situation are inappropriate, for example, when driving. Indeed, the risk of sustaining alcohol-related injuries begins to increase with blood ethanol concentrations as low as 20 mg/100 ml (4.3 mmol/l). It is impossible, therefore, to identify a level of alcohol consumption that can be described as 'safe'. In the 1980s, however, the Royal Colleges of Psychiatrists, Physicians and General Practitioners sought to define more clearly the relationship between levels of alcohol consumption and the development of alcohol-related physical harm, excluding injuries. The consensus opinion was that, in men, intakes of alcohol of 21 units a week or less and, in women, of 14 units a week or less are associated with a 'low risk'. Intakes of between 22 and 50 units a week in men and between 15 and 35 units a week in women, described as hazardous drinking, are associated with an 'intermediate risk', while intakes of >50 units a week in men and of >35 units a week in women, described as harmful drinking or alcohol misuse, are associated with a 'high risk' (Figure 3.1). The differences in threshold levels between men and women reflect the fact that blood ethanol concentrations in women, following a standard oral dose, are approximately one-third higher than in men. Intakes in pregnancy should be reduced to 1 to 2 units, once or twice a week.

Figure 3:1 Alcohol Consumption and the Risk of Physical Harm



Sources:
Royal College of Psychiatrists, 1986
Royal College of General Practitioners, 1986
Royal College of Physicians, 1987

Sensible drinking

In late 1995, the Government published a review of the scientific and medical evidence on the health effects of drinking alcohol. The report set benchmarks for sensible drinking, stating that regular consumption of 3 to 4 units of alcohol a day for men and 2 to 3 units a day for women will not accrue a significant health risk, whereas consistently drinking 4 or more units a day for men or 3 or more units a day for women would be associated with progressive risks to health. The review also recognised that alcohol conferred protection from coronary heart disease in middle-aged men taking 1 to 3 units a day and in post-menopausal women taking 1 to 2 units a day.

This report has been interpreted as 're-setting' the 'low risk' levels to 28 units a week for men (4 x 7) and 21 units a week for women (3 x 7) but these are also the levels at which health risk is said to increase. Many medical and alcohol agencies were unhappy with these recommendations although recognising the benefit of setting daily limits. In consequence, there does not appear to be any compelling reason, at present, to change the low-risk thresholds from those originally set by the three Royal Colleges.

The availability of the stronger beers and lagers has made it more

difficult for individuals to be sure how many units of alcohol they are consuming. However, the inclusion of % ABV on beverage labels may allow a more accurate assessment (Table 3:1).

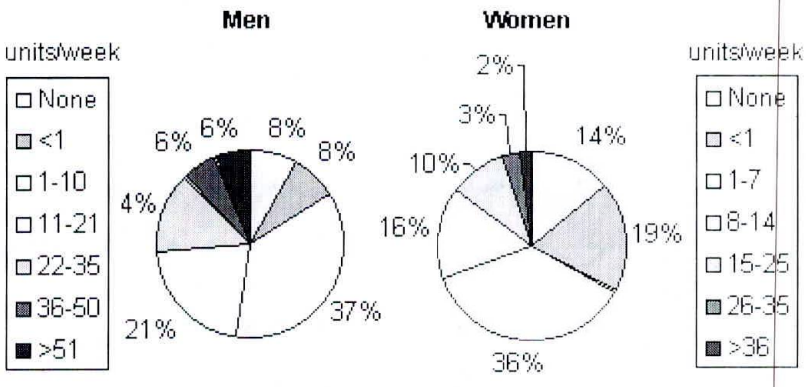
Table 3:1 Number of 440ml Cans of Beers Containing 14 and 21 Units of Alcohol

Beverage	ABV (%)	Number of 440ml Cans	
		14 Units	21 Units
Standard	3.6	9	14
Premium	5.0	6	9
Super	9.0	3.5	5

Alcohol consumption in Great Britain

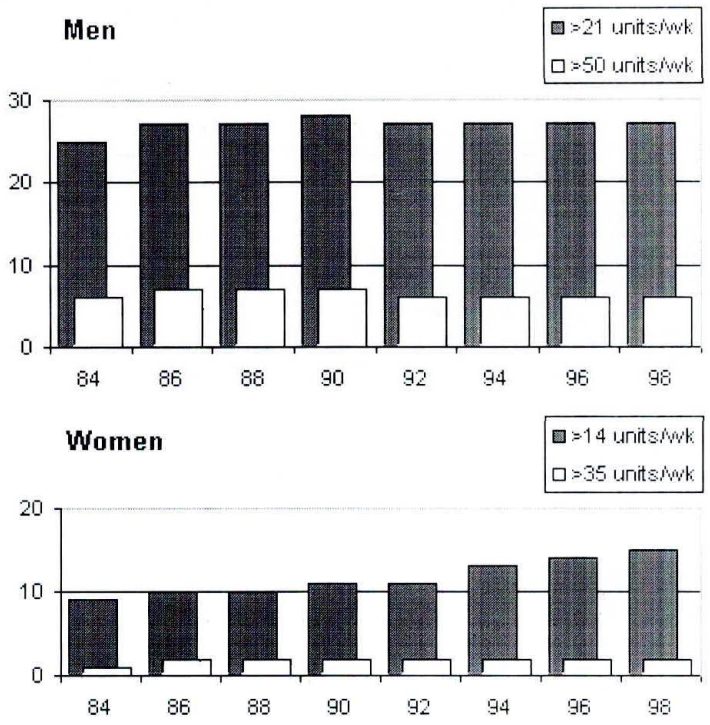
In 1998, the average weekly consumption of alcohol by men aged 16 years and over, in Great Britain, was 16.4 units, while women drank on average 6.4 units. Overall, 27% of men and 15% of women drank in excess of the recommended 'low risk' levels of 21 and 14 units a week, while 6% of men and 2% of women drank in excess of 50 and 35 units a week respectively (Figures 3.2 and 3.3)

Figure 3:2 Level of Alcohol Consumption in the Adult Population, Great Britain, 1998



Source: ONS - General Household Survey, 1998

Figure 3:3 Percentage of Adults Drinking Over Weekly Threshold Levels, Great Britain, 1998



Source: ONS - General Household Survey, 1998

The Host

Personality

There is no typical personality which predisposes to alcohol problems. Some problem drinkers undoubtedly have damaged personalities but it is difficult to know whether this is the consequence or cause of heavy drinking. Evidence suggests that younger male problem drinkers are more likely to have severe personality disturbances; they may drink excessively as a means of holding on to a precariously-held image of masculinity, and may have fathers who were themselves delinquent or problem drinkers. Individuals who are anxious, including those with phobic anxiety states, appear particularly vulnerable to alcohol misuse, and the association between depressive states, particularly in women, and alcohol dependence has long been recognized. Individuals with a psychopathic personality, characterized by impulsiveness, an inability to defer gratification and an inability to form close emotional ties, also appear to find alcohol rewarding and are immoderate in their drinking, as they are in many other aspects of their lives.

Thus, despite decades of research, no evidence has emerged to support the belief that there is a typical addictive personality. The characteristic features so frequently encountered in problem drinkers are more likely to be the consequences of years of excessive drinking rather than the cause. Certain traits, particularly associated with anti-social personality disorder, are however conspicuously common in the life histories of patients with alcohol problems.

Inheritable Factors

It is now generally accepted that 'alcoholism' runs in families. Indeed,

it has been estimated that one in three 'alcoholics' have at least one parent similarly afflicted. Those individuals with a positive family history, who themselves misuse alcohol, tend to drink earlier in life and to experience more alcohol-related problems than their counterparts without a family history. However, simply because a trait is familial does not mean that it is genetically inherited as environmental cues may be necessary for its expression.

Twin studies can be used to assess the relative strengths of the genetic and environmental components of phenotypic variance. Monozygotic twins (MZ: identical) are genetically identical whereas dizygotic twins (DZ: fraternal) share only half their genes. Thus, if a trait has a genetic component the concordance rates will be greater amongst MZ twins than DZ twins. In the majority of twin studies on alcohol-drinking behaviour and 'alcoholism' greater concordance has been observed in MZ twins. Hereditability estimates of about 0.3 to 0.6 for the amount and frequency of alcohol consumption have been obtained by most investigators where a factor of zero indicates no genetic influence and a factor of one indicates total genetic control.

The results of twin studies do not completely exclude environmental effects. Identical twins may, for example, have a higher frequency of social contact than fraternal twins but when controls are exercised for this variable the higher concordance observed for drinking behaviour in MZ twins remains.

Adoption studies can also be used to separate genetic and environmental factors in phenotype variance. Such studies have shown that the frequency of 'alcoholism' in later life is three to four times greater in adopted-away children who have at least one 'alcoholic' biological parent. Studies on adopted men suggest the existence of at least two different types of 'alcoholism' based on the clinical features of the parents.

Types of alcoholism

- Type I 'alcoholism' affects both men and women and is more common than Type II 'alcoholism'. It is 'milieu-limited' as its expression requires both a genetic predisposition and environmental provocation; if both these factors are present then the risk of 'alcoholism' is doubled. Type I alcohol abuse begins after the age of 25 years; it is generally classified as mild and legal problems are only infrequently encountered. It is associated with a history of mild alcohol misuse in either biological parent.

- Type II 'alcoholism' is male-limited. Environmental factors appear to play little role in its expression; genetically predisposed men have a nine-fold increase in their risk of developing 'alcoholism'. Type II alcohol misuse begins in adolescence; it is classified as serious and is associated with frequent encounters with the law. The personality of these individuals is characterized by impulsivity, excitability, brash and uninhibited behaviour, and disturbed social relations. It is associated with severe 'alcoholism' in the biological father.

Genetic studies in the future

Thus, twin, adoption, family hereditability and genetic transmission studies indicate that genetic factors play a role in the predisposition to 'alcoholism'. However, a number of important questions remain, *viz*: (i) what are the heritable traits that influence susceptibility to 'alcoholism'?; (ii) what are the genes that control the traits? and; (iii) could reliable trait markers be found that would be predictive of the development of 'alcoholism'?

Unlike disorders with simple Mendelian modes of inheritance, 'alcoholism' is likely to have a much more complex mode of transmission. Moreover, the ultimate phenotype might be influenced by environmental factors. This complexity, compounded by the likelihood that there is more than one genetic type of 'alcoholism' will make the task of identifying the genetic component extremely difficult. Nevertheless, this line of research is being actively pursued.

Genetic studies may, in addition, help to differentiate subtypes of problem drinkers who may respond differently to treatment and hence may have different outcomes. For example, some 'types' may respond better to specific drug treatments than others, perhaps reflecting differences in the neurochemical responses to alcohol misuse.

An ability to identify individuals genetically predisposed to alcohol problems raises the possibility of targeting educational and preventive approaches. The ethical dilemmas posed by such information require careful consideration.

The Environment

A variety of environmental factors impinge on the individual and influence their consumption of alcohol. These include the availability of alcoholic beverages and the prevailing climate of expectations, traditions and customs.

Culture

Alcohol is proscribed in certain cultures, for example Islam. Under these constraints, any drinking is in a sense deviant and there is some evidence that those who do drink in a predominantly abstinent culture are more likely to be disturbed and to drink abnormally. Some cultures, for example, the Irish, are intensely ambivalent about alcohol and combine a high level of traditional condemnation of drinking and a high prevalence of abstainers with an acceptance and even the promotion of widespread alcohol use.

Parental Influence

The double standard whereby parents and other authorities often endeavour to prohibit drinking amongst young people, while conveying by their actions that it is acceptable 'adult' behaviour, only serves to make alcohol seem more attractive to young people as a means of marking their own transition to adulthood.

Parents pass on their beliefs and attitudes to their children. These include their drinking habits and views about alcohol. Adolescents who grow up in a home where alcohol is assigned disproportionate significance are more likely to drink abnormally themselves.

Paradoxically this holds true both when the parents are strongly 'anti-drink' and where one or both parents have a drinking problem. It seems that in such homes drinking becomes part of the emotional currency of the family. One consequence of this, coupled perhaps with a degree of biological vulnerability, is that alcohol addiction is four times more common among the sons of problem drinkers than in the general population. The family doctor is obviously particularly well placed to try and prevent the tragedy of alcohol misuse passing from one generation to the next by educating those at risk and by early detection of alcohol problems should they arise.

Peer Group Influences

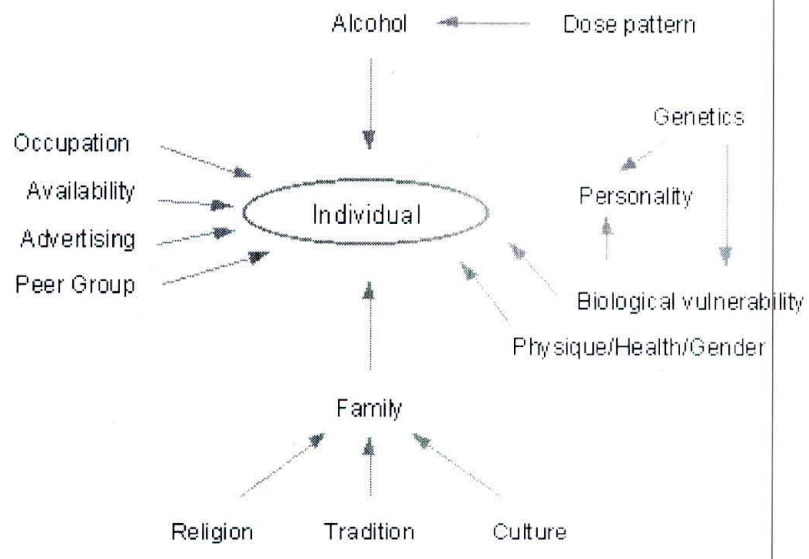
The peer group becomes increasingly important in adolescence and this can have a major effect on the pattern and quantity of alcohol consumed as well as the choice of beverage.

Availability

If alcohol is readily to hand, it is more likely to be drunk. Cost is also very important. In relative terms alcohol has become cheaper in recent years. Thus, between 1950 and 1976 the length of time a manual worker needed to work to pay for a pint of beer fell by 48% from 23 to 12.5 minutes; the work time to pay for a bottle of whisky fell even further from 6.5 to 2.5 hours, a 68% reduction. The time needed to pay for a loaf of bread, on the other hand, increased by 22% during this period. Individuals with high disposable incomes and those who have easy access to alcohol, or whose drinking is subsidized, are more at risk of developing alcohol-related problems (Table 3:2).

The origins of a harmful drinking pattern are, therefore, multifactorial (Figure 3:4). The influences interact and may promote or diminish the likelihood of problem drinking.

Figure 3:4 Aetiological Factors in Problem Drinking



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4. Alcohol-Related Physical Harm

The possibility that acutely intoxicated individuals may suffer abdominal discomfort and may injure themselves, intentionally or otherwise, is generally recognized; less well-recognized is the fact that they may develop gastrointestinal bleeding, cardiac arrhythmias, cerebrovascular accidents and respiratory depression, all of which may prove fatal. Equally, while it is generally acknowledged that individuals who chronically misuse alcohol may develop, and indeed die from cirrhosis of the liver, the fact that they may develop damage to every organ system in the body and that they are just as likely, if not more likely, to die as a result of suicide or injury, is generally not appreciated. Thus, while both acute and chronic misuse of alcohol are associated with the development of physical disorders and harm (Table 4:1), the association between the two is often missed or ignored.

Table 4:1
Acute and Chronic Effects of Alcohol Misuse

Acute		
Acute Accidents and injury	Acute alcohol poisoning	Aspiration pneumonia
Oesophagitis	Mallory-Weiss syndrome	Gastritis
Pancreatitis	Cardiac arrhythmias	Cerebrovascular accidents
Neurapraxia	Myopathy/rhabdomyolysis	Hypoglycaemia
Chronic		
Accidents and injury	Hypertension	Peripheral neuropathy
Oesophagitis	Cardiomyopathy	Myopathy
Gastritis	Cerebrovascular accidents	Osteoporosis
Malabsorption	Coronary heart disease	Skin disorders
Pancreatitis	Brain damage:	Malignancies
Liver damage:	• dementia	Infertility

• fatty change • hepatitis • cirrhosis	• Wernicke-Korsakoff syndrome • cerebellar degeneration • Marchiafava-Bignami syndrome • central pontine myelinolysis	Foetal damage

These deleterious physical effects may be produced by alcohol *per se*, by its metabolites, or by the consequences of alcohol metabolism. However, an individual's susceptibility to develop alcohol-related physical harm varies considerably. Thus, for example, only between 20 to 30% of individuals who chronically misuse alcohol will eventually develop cirrhosis. The determinants of susceptibility have yet to be identified but genetic, constitutional and environmental factors are all likely to be important. Equally, habitual drinkers who have sustained alcohol-related harm may remain asymptomatic for long periods of time or else may present with florid symptoms and signs at an early stage.

Alcohol-related physical harm is entirely preventable. Thus, every effort should be made to identity individuals at risk at an early stage. Once harm has developed in an habitual drinker, it may still be reversed, to a large extent, by long-term abstinence from alcohol. Even individuals with established alcohol-related physical harm may benefit significantly, in terms of outcome, if they cease drinking alcohol completely.

General Features

Individuals who chronically misuse alcohol may develop a number of cutaneous, and other superficial signs, irrespective of whether they have sustained major alcohol-related organ damage (Table 4:2). The mechanisms by which these develop are unknown, but with the exception of Dupuytren's contractures, they may all regress, at least partly, following abstinence from alcohol.

Table 4:2 Cutaneous and Other Superficial Signs Suggestive of Alcohol Misuse

(Click the link for illustrations of each feature)

Spider Naevi

Telangiectasia

Facial Mooning

Parotid enlargement

Palmar erythema

Dupuytren's contracture

Gynaecomastia

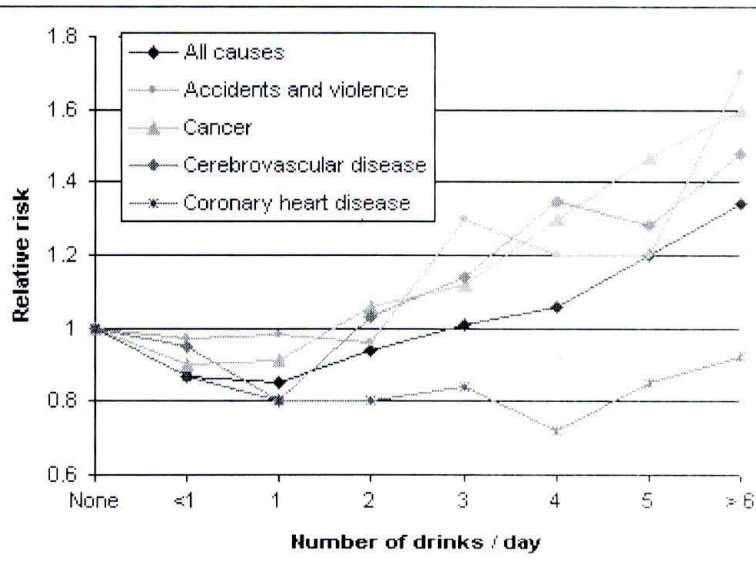
Some of these signs may occur in association with other disorders, for example, spider naevi and palmar erythema in non-alcoholic chronic liver disease and Dupuytren's contracture in individuals who sustain repeated, minor hand trauma, but the signs, in constellation, occur most frequently in association with chronic alcohol misuse and, as such, are extremely important diagnostic features. Clubbing of the fingers may also occur. This may occur in any cause of cirrhosis as well as in other non-hepatic conditions.

A number of laboratory test abnormalities may occur in chronic alcohol misusers including elevation of the serum aspartate aminotransferase (AST) and gamma glutamyl transpeptidase (GGT) activities and an increase in the erythrocyte mean corpuscular volume (MCV). These abnormalities arise as a result of alcohol abuse *per se* and do not necessarily reflect the presence of significant alcohol-related organ damage.

Accidents and Injury

Accidental injury constitutes the largest public health problem in the United Kingdom today for individuals aged 1 to 40 years, and accounts for more deaths in adolescents than all other causes. Alcohol is a major factor in road traffic and other transport accidents, industrial and domestic accidents and accidental drownings and fire injuries. Alcohol is also a major factor in parasuicide, suicide, violent assault and homicide. Alcohol-related accidents and injuries are associated with greater morbidity and mortality than all other alcohol-related disorders (Figure 4:1).

Figure 4:1
Alcohol Consumption and Relative Risk of Death



American Cancer Society prospective study of 276,802 men aged 40 to 59 years followed for 12 years.

Mortality ratios for the four most common causes of death from all causes adjusted for age and smoking habits. 1 drink = 12g of absolute alcohol (1.5 units)

Source: Boffeta and Garfinkle, Epidemiology 1990; 1:342-8

Gastrointestinal System

Oesophagus

Alcohol reduces the sphincter pressures at both ends of the oesophagus and impedes oesophageal peristalsis. In chronic alcohol misusers the resultant motor dysfunction may lead to the development of gastro-oesophageal reflux, oesophagitis, Barrett's oesophagus and distal mucosal ulceration. Vomiting occurs frequently and may result in a Mallory-Weiss tear in the mucosa of the cardio-oesophageal junction; this is associated with gastrointestinal bleeding, often profuse. There is a strong association between alcohol misuse and carcinoma of the oesophagus, particularly in heavy smokers.

Stomach

Acute alcohol misuse may result in the development of acute gastritis; individuals may complain of nausea, vomiting and epigastric pain but the symptoms settle quickly after 48 to 72 hours abstinence from alcohol. Sometimes after alcohol acute gastric erosions develop which may produce severe haemorrhage. Habitual drinking is associated with the development of chronic gastritis which may be asymptomatic or else accompanied by a number of non-specific digestive symptoms. Chronic alcohol misuse is not, however, associated with an increased prevalence of peptic ulceration; indeed, alcohol misusers tend to have a lower prevalence of infection with *Helicobacter pylori* than non-habitual drinkers; it has been suggested that alcohol might have an important anti-*Helicobacter pylori* effect.

Small Intestine

Both acute and chronic alcohol misuse are associated with the development of diarrhoea; this probably reflects changes in small intestinal permeability and motor activity. Habitual alcohol misuse is also associated with defective absorption of a number of nutrients including glucose, amino acids, vitamins and minerals.

Further information on alcohol and the gastrointestinal tract can be found in the MCA Newsletter 19 (5).

Pancreas

Click the links to view illustrations

Alcohol misuse may result in the development of chronic pancreatitis. Some individuals may develop this condition with alcohol intakes as low as 1 to 20 g/day (< 2 units); others may need to drink in excess of 200 g/day (25 units) before evidence of the disease develops, while some individuals never develop this condition no matter how much they drink or for how long. In susceptible individuals the longer the

duration of drinking the greater the risk.

Alcoholic pancreatitis is a disorder mainly of men in their 3rd to 5th decades. It may present as an acute episode of abdominal pain, nausea and vomiting and in severe cases can be accompanied by profound metabolic abnormalities and circulatory collapse which may be fatal.

These acute episodes may recur, often precipitated by an increase in alcohol intake. Complications such as pressure on the common bile duct, localized leakage of pancreatic fluid and pancreatic exocrine and endocrine insufficiency may develop resulting in jaundice, pseudocyst formation, malabsorption and diabetes. In some individuals, however, the clinical course is insidious with progression to pancreatic insufficiency without acute inflammatory episodes.

Withdrawal of alcohol at an early stage may arrest the process and, even when the condition is established, may reduce the number of inflammatory episodes and allow for better control of both the exocrine and endocrine insufficiency.

The diagnosis is made using pancreatic function tests and imaging. A straight X-ray of the abdomen may reveal pancreatic calcification and endoscopic retrograde cholangiopancreatography (ERCP) will show the typical picture of an irregular and attenuated ductal system. Management is directed at relief of the pain and correction of both the exocrine and endocrine insufficiency.

Liver

Click the links to view illustrations

Men drinking equal to or greater than 60 g (equal to or greater than 7.5 units) and women drinking equal to or greater than 40 g (equal to or greater than 5 units) of alcohol daily are at increased risk of developing alcohol-related liver disease. Alcohol produces a spectrum of liver injury but only a minority of individuals misusing alcohol, some 20 to 30%, develop cirrhosis; of these, approximately 15% will develop hepatocellular carcinoma as a terminal event; the factors which determine an individual's susceptibility to develop significant alcohol-related liver injury are unknown.

The majority of individuals misusing alcohol will develop fatty change in their liver; this is an adaptive lesion which arises because of changes in hepatic fat metabolism linked to the excess hydrogen ion generated during ethanol oxidation. This lesion is not in itself harmful and quickly reverses when alcohol is withdrawn. Individuals are usually asymptomatic and generally present incidentally.

Individuals who develop alcoholic hepatitis may remain asymptomatic and escape detection unless they present for other reasons. Alternatively they may present with clear evidence of chronic liver disease such as jaundice, hepatomegaly and fluid retention.

The outcome in individuals with alcoholic hepatitis is determined by their subsequent drinking behaviour, their gender and by the histological severity of their liver lesion. Thus, in men with mild to moderate alcoholic hepatitis, the liver injury is likely to resolve

completely with abstinence from alcohol, whereas in women, and in individuals of both sexes with severe disease, the liver lesion is likely to progress to cirrhosis, even if they abstain from alcohol long-term.

The mortality rate in individuals presenting with severe alcoholic hepatitis may be as high as 40%. Certain of these individuals might benefit, in terms of outcome, from a short course of corticosteroids.

Individuals who develop alcoholic cirrhosis may remain asymptomatic and come to attention only if inadvertently identified, for example, at an insurance medical examination. Alternatively, they may present with features of hepatocellular failure and portal hypertension such as jaundice, fluid retention, blood clotting abnormalities, hepatic encephalopathy and haemorrhage from oesophageal varices.

The outcome for patients with cirrhosis is determined largely by the degree of decompensation at presentation and by the subsequent drinking behaviour. Thus, a middle-aged man who is identified incidentally and who subsequently abstains from alcohol has a 60% chance of being alive in 10 years, whereas a similar individual who presents with variceal bleeding, who survives the initial presentation but who continues to drink is unlikely to survive a year. The presence of superimposed alcoholic hepatitis and the development of hepatocellular carcinoma significantly reduce survival.

The most important management aim is to ensure long-term abstinence from alcohol. Complications such as fluid retention and variceal bleeding are treated symptomatically. Orthotopic liver transplantation has a place in the management of patients with decompensated alcoholic cirrhosis who have failed to improve despite well-documented abstinence from alcohol and expert medical treatment for a period of at least 6 months. Survival rates are similar in these patients to those observed in patients transplanted for non-alcoholic disease. However, recidivism rates are still unacceptably high in some centres.

Further information on alcoholic liver disease will be found in the article by C Day in issue 21 of The MCA newsletter.

Cardiovascular System

Both acute and chronic alcohol misuse can affect the cardiovascular system.

Haemodynamic/Electrophysiological Effects

Acute alcohol ingestion may be associated with depression of left ventricular function and the development of ventricular premature beats even in individuals with 'healthy' hearts. These acute effects may be more pronounced and of greater clinical significance in individuals with pre-existing heart disease.

Further description of the effect of alcohol on the heart will be found in the article by Obel and Camm, MCA Newsletter *Alcoholis*, 1998 Volume 17 (3).

Blood Pressure

Alcohol consumption is associated with increases in both systolic and diastolic blood pressure which appear to be dose-related. Thus, systolic blood pressure is increased by, on average, 2.7 mmHg in individuals drinking 4 to 6 units of alcohol/day and by 4.6 mmHg in individuals drinking equal to or greater than 7 units/day. These increases in blood pressure reverse when alcohol is withdrawn, at least in a percentage of individuals.

Heart Muscle

Alcohol-related heart muscle disease or alcoholic cardiomyopathy develops in a proportion of individuals who have consumed in excess of 60 g (> 7.5 units) of alcohol/day for a minimum of 10 years. Individuals with this condition may be asymptomatic and remain undetected unless discovered incidentally; they may present with non-specific manifestations of heart disease such as fatigue, palpitations or breathlessness especially when the heart is stressed, or else may present with frank heart failure manifest as arrhythmias, raised central venous pressure, cardiomegaly, pulmonary and peripheral oedema.

The findings on ECG and chest X-ray are non-specific. The echocardiogram can, however, be used to identify and quantify chamber dilatation and ventricular function. Confirmation of the diagnosis is obtained from cardiac catheterization studies and histological examination of cardiac muscle biopsies.

The cardiac changes in individuals in whom the disorder is subclinical will reverse entirely with subsequent abstinence from alcohol. Death occurs within 2 to 4 years of the onset of cardiac failure in individuals who continue to drink; the course of the illness may, however, be terminated at any stage by the onset of ventricular arrhythmias particularly in association with an acute episode of drinking.

The most important management aim is to secure life-long abstinence from alcohol. Symptomatic individuals are managed with diuretics and with antiarrhythmic agents, as indicated. This form of low-output heart failure is quite distinct from the high-output heart failure observed, albeit rarely, in problem drinkers with thiamine deficiency; this so-called beri-beri heart disease responds well to the prompt administration of high doses of thiamine.

Coronary Heart Disease

Daily alcohol intakes of 1 to 3 units protect middle-aged men from coronary heart disease. Much less information is available in women, but daily intakes of 1 to 2 units may similarly protect those who are post-menopausal.

Cerebrovascular Disease

Both acute and chronic alcohol misuse increase the risk of stroke; acute alcohol misuse possibly increases the risk of strokes overall whereas chronic alcohol misuse more especially increases the risk of haemorrhagic stroke. Individuals who abuse alcohol are at increased risk of sustaining head injuries and hence of developing both subdural and extradural haematomas.

Nervous System

Alcohol misuse can have profound effects on both the central and peripheral nervous systems; the damage may be caused either directly, or indirectly as a consequence of thiamine deficiency.

Central Nervous System

Alcohol intoxication, alcohol withdrawal and fitting are described in Chapter 10. Chronic alcohol misuse is associated with the development of several organic brain syndromes. Although these are traditionally described, as here, as distinct entities their clinical presentation is often heterogeneous and as such they are best considered as a spectrum which includes minimal cognitive impairment, amnesia and dementia.

Alcoholic Dementia

Specific cognitive deficits are demonstrable in some problem drinkers which may or may not be accompanied by mild non-progressive impairment of intellectual capacity. Non-invasive neuroimaging shows evidence of cortical atrophy or shrinkage with reduction in the volume of the cerebral white matter. These changes in mental state and cerebral appearance reverse, to a variable degree, following prolonged abstinence from alcohol. The term 'alcoholic dementia' with its connotation of progression has been applied, somewhat unsatisfactorily, to this condition.

Wernicke-Korsakoff Syndrome

The Wernicke-Korsakoff syndrome develops in problem drinkers who are thiamine deficient. However, other as yet unidentified factors must be important in its genesis as thiamine deficiency, in this context, is not invariably associated with the development of this syndrome. ***Wernicke's encephalopathy*** comprises a triad of global confusion, eye signs and ataxia; the confusional state is accompanied by apathy, disorientation and disturbed memory, but drowsiness and stupor are uncommon. The ocular abnormalities include nystagmus, gaze palsies and ophthalmoplegia, while the ataxia predominantly affects the trunk and lower extremities. The clinical abnormalities may develop acutely or evolve over several days. The cerebral lesion is characterized by degenerative changes in the structures surrounding the third ventricle and aqueduct, particularly the mamillary bodies. ***Korsakoff's psychosis*** is an amnesic state in which there is profound impairment of both retrograde and anterograde memory but relative preservation of other intellectual abilities; confabulation may be a feature. The cerebral lesion is characterized by changes in the dorsomedial thalamus. Korsakoff's psychosis generally develops after an acute episode of Wernicke's encephalopathy. However, some patients develop a combined syndrome from the outset, with memory loss, eye signs and unsteadiness but without confusion; others do not develop either the eye signs or ataxia.

Treatment with high-dose parenteral thiamine should be instituted immediately the diagnosis is suspected and prophylactically in patients at risk (Table 4:3). The Wernicke's encephalopathy resolves rapidly but resolution of the Korsakoff's psychosis is less predictable; some residual memory deficit is observed in approximately 50% of

individuals.

Table 4:3
Treatment of the Wernicke-Korsakoff Syndrome

A presumptive diagnosis of the Wernicke-Korsakoff syndrome should be made in patients with a history of alcohol misuse and one or more of the following otherwise unexplained symptoms: ataxia, ophthalmoplegia, nystagmus, confusion, memory disturbance, comatosed/ unconscious, hypotension, hypothermia

↓

Give two pairs of IV high potency Pabrinex® t.d.s. for 2 days; dilute ampules 1 and 2 with 50 to 100 ml of normal saline or 5% glucose and infuse over 15 to 30 minutes

↙ ↘

No Response
Discontinue and reassess

Response
One pair of IM high potency Pabrinex® o.d. for 5 days or until no further improvement is observed. Use IV route in patients with liver disease and deranged blood clotting.

Recommendations of the Committee on Safety of Medicines

Severe allergic reactions may occur during or shortly after administration of IV Pabrinex®.

- Restrict use to patients in whom parental administration is essential
- Administer slowly over 10 minutes plus
- Facilities for treatment of anaphylaxis should be available

Treatment of Wernicke-Korsakoff Syndrome was further decsribed in the MCA Newsletter 19 (4)

Cerebellar Degeneration

A cerebellar syndrome characterized by varying degrees of ataxia, predominantly affecting the trunk and lower limbs, may be observed in problem drinkers; the upper limbs are little affected and dysarthria is not a feature. Non-invasive neuroimaging shows atrophy of the cerebellar cortex mainly in the anterior and superior vermis. The condition improves following prolonged abstinence from alcohol.

Marchiafava-Bignami Syndrome

This condition, which is characterized by demyelination of the corpus callosum, is rare. Affected individuals present with dementia, spasticity, dysarthria and an inability to walk; the clinical presentation may be acute, subacute or chronic. No treatment is available; patients may deteriorate very quickly, lapse into coma and die or else may survive, profoundly demented, for many years; occasional individuals who present acutely recover completely.

Central Pontine Myelinolysis

This rare demyelinating disorder of the cerebral white matter is often rapidly fatal. It manifests clinically as progressive quadriplegia, pseudobulbar palsy and paresis or paralysis of horizontal eye movements. Its exact aetiology is unknown although its development is often associated with rapid correction of hyponatraemia.

Peripheral Nervous System

Individuals who misuse alcohol may develop focal peripheral nerve lesions when heavily sleeping or stuporosed. These lesions develop as a result of nerve compression; 'Saturday night palsy' of the arm, which results from radial nerve compression, is the best example of this type of neurapraxia; recovery is inevitable.

Individuals chronically misusing alcohol may develop a symmetrical, bilateral, mixed sensory-motor, peripheral neuropathy, predominantly affecting the lower limbs, most likely associated with thiamine deficiency. Individuals may be asymptomatic or else present with numbness, pain and burning in the feet and hyperaesthesia; muscle weakness and diminished tendon reflexes may be observed. Abstinence from alcohol and supplementation with thiamine may result in improvement in the condition but this is often slow and incomplete.

Skeletal Muscle

Skeletal muscle damage may develop in association with both acute and chronic alcohol misuse; its prevalence is unknown as many individuals remain asymptomatic; for this reason its presence is often overlooked.

Acute Myopathy

Acute alcoholic myopathy develops in association with an episode of acute intoxication or binge drinking. The spectrum of the disorder is wide; some individuals may be asymptomatic and only detected because of elevation of their serum creatinine kinase activity, whilst others may develop an acute toxic rhabdomyolysis with myoglobinuria, acute tubular necrosis and fatal renal failure. The majority of individuals, however, present with some combination of: (i) myalgia or muscle pain, typically around the hip and shoulder girdles and in the calves; (ii) muscle swelling and; (iii) progressive weakness particularly in the legs and most noticeable on climbing stairs. Once alcohol is discontinued the symptoms resolve over days or weeks. Symptoms may recur after further episodes of heavy drinking.

Chronic Myopathy

This condition occurs in individuals with a long history of chronic alcohol misuse. It develops as a progressive and usually painless wasting and weakness of the proximal limb muscles. Patients tend to complain of difficulty climbing stairs, rising from a squatting position, opening windows and combing their hair; signs of a peripheral neuropathy may coexist. Abstinence from alcohol results in considerable improvement over a period of 2 to 12 months.

Bone

Chronic alcohol misuse is associated with an increased incidence of trauma and injury, particularly bone fractures. Indeed, the term 'Battered Alcoholic Syndrome' was coined to describe the presence, on radiological screening, of multiple bone fractures, at different stages of healing. Although repeated trauma is an important aetiological factor in fracture development, these individuals are particularly vulnerable to trauma because they have an increased prevalence of osteoporosis; they show a reduction in bone mass which is thought to reflect a direct effect of alcohol on bone remodelling and mineralization but other factors, such as nutritional deficiencies and cigarette smoking may also play a role. These effects of alcohol on bone metabolism are, at least in the early stages, reversible.

Skin

Alcohol misuse is associated with the development of a number of cutaneous abnormalities such as spider naevi and linear telangiectasia, and is specifically associated with the development of discoid eczema. Alcohol misuse can also precipitate the development of psoriasis in genetically predisposed individuals or else exacerbate existing lesions. In general the psoriatic lesions observed in alcohol misusers are more severe and more inflamed than in non-drinkers and occur in atypical flexural sites. Alcohol misuse is also associated with the development of seborrhoeic dermatitis and cutaneous bacterial and fungal infections. Abstinence from alcohol will help ameliorate these conditions and, where appropriate, render treatment more effective.

Malignancies

There is a strong association between chronic alcohol misuse and the development of cancer of the mouth, pharynx, larynx and oesophagus; smoking has an associated effect. Individuals with alcoholic cirrhosis are at risk of developing hepatocellular carcinoma but alcohol misuse *per se* is not a risk factor for the development of this tumour. Alcohol, if taken regularly, even in moderate amounts, is a risk factor for the development of breast cancer in women.

More information on alcohol and breast cancer will be found in the article by Kemm, MCA Newsletter *Alcoholis*, 1998 Volume 17 (3).

Fertility

Alcohol misuse may have significant effects on sexual function and reproductive capacity in both men and women. However, alcohol can have significant effects on fertility, if taken on a regular basis, even in moderate amounts. Thus, in susceptible men, alcohol intakes of 4 to 6 units/day can result in a significant reduction in the sperm count; in many such individuals abstinence from alcohol is associated with restoration of fertility. Women who drink alcohol in excess of 3 units/day may be subfertile; no information is available on the reversibility of this effect. Women who consume alcohol in excess of 1 unit/day during the first trimester of pregnancy double their risk of spontaneous abortion in the second trimester.

Foetal Damage

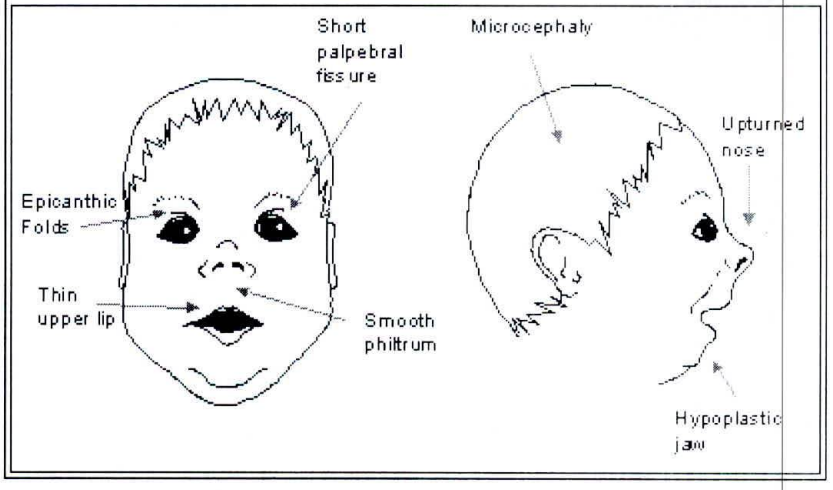
Regular consumption of alcohol, at any level, during pregnancy may potentially harm the foetus. The abnormalities observed range from growth retardation to development of the 'Fetal Alcohol Syndrome' (Table 4:4, Figure 4:2). The more severe forms of foetal damage are observed in women misusing alcohol but even these women may produce infants that are seemingly unharmed. However, over time, some apparently unaffected infants may develop both cognitive and behavioural abnormalities; they tend to perform poorly at school and up to two-thirds show hyperkinetic, emotional, eating and speech disorders. The most vulnerable period for the foetus is from 4 to 10 weeks gestation but alcohol-related damage may occur throughout the pregnancy. Thus, benefit to the infant can be obtained if alcohol is withdrawn at any stage of the pregnancy. It is recommended that women avoid alcohol during the first trimester and then limit their intake to 1 to 2 units once or twice a week for the remainder of their pregnancy.

Table 4:4 Fetal Alcohol Syndrome

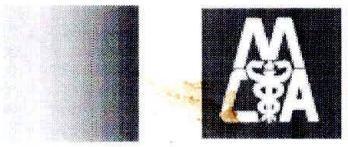
- Pre and post-natal growth retardation
- CNS abnormalities including microcephaly, mental retardation, irritability, hypotonia, inco-ordination, hyperactivity
- Craniofacial abnormalities including short palpebral fissures, ptosis, strabismus, epicanthic folds, mid-facial hypoplasia, smooth philtrum, short upturned nose, thin upper lip, lower jaw hypoplasia
- Associated abnormalities including congenital defects of eyes, ears, mouth,

cardiovascular system, genitourinary tract and skeleton and an increase in the incidence of birthmarks and hernias

Figure 4:2 Schematic Diagram of the Facial Features of the Fetal Alcohol Syndrome



We would like to thank Dr Ruth Mayall, Consultant Anaesthetist, North Manchester Healthcare NHS Trust, for her assistance in obtaining the medical illustrations included along with this chapter.



THE MEDICAL COUNCIL ON ALCOHOL

MEDICAL STUDENTS' HANDBOOK: ALCOHOL & HEALTH (3rd Edition)

10. Prevention

There is good evidence that, within any population, the level of alcohol consumption is closely linked to its availability and cost. Regular access to drinking and pressures to drink, for instance from advertising and other inducements, promote increased drinking. Efforts at ***primary prevention*** should, therefore, focus on reducing both average *per capita* consumption and the quantities consumed by individuals. The principal approaches adopted are: control of availability, public education about sensible use, decreasing the incentives to drink and providing alternatives.

Controls usually take the form either of taxation or legislation aimed at reducing availability, for example by restricting the time of sales, and the number and location of licensed premises. These measures are often unpopular politically but are probably the most potent ways of affecting the overall level of alcohol-related harm in the population. Surveys show that the public accepts the need to restrict access to alcohol and appreciate the harm associated with unfettered promotion.

Alcohol education

The effects of education and social controls on alcohol consumption is more difficult to assess. In general the effects of education campaigns have been disappointing in that while they may increase knowledge of the potential hazards of excess alcohol consumption they usually have little or no effect on drinking behaviour. Campaigns focused on increasing knowledge about alcohol, such as understanding the units system for measuring alcohol consumption and appreciating the patterns and levels of consumption which are likely to cause harm, are generally useful. Education focused specifically on certain behaviours such as drinking and driving, or minimising drinking during pregnancy, can be particularly effective.

In recent years, educational programmes have been devised to broaden information on all aspects of health, not just the effects of alcohol. These aim to inculcate individuals with a sense of responsibility for their own health and safety and that of the community. They are designed, for example, to assist individuals to decide whether to drink, under what circumstances, and in what quantities, clear in the knowledge of the consequences of their actions. It remains to be seen whether this new approach will be more effective in bringing about change. Peer group education seems more effective in influencing young people than outside experts lecturing on alcohol use.

Society imposes its own subtle controls on drinking behaviour which are difficult to identify and even more difficult to quantify. In recent

years, for example, attitudes to drinking and driving have changed dramatically and individuals who indulge in this sort of behaviour are now considered socially unacceptable. This change in attitude has occurred gradually over time and cannot be attributed to any specific event or series of events. Whether social attitudes to other aspects of excessive or irresponsible drinking will change over time, and influence behaviour, remains to be seen.

Advertising

Every year the 'drinks' industry spends vast amounts of money advertising and promoting their wares. In recent years, however, they have been involved with Government in establishing an ethical code of conduct in relation to advertising and sales promotion, and a number of voluntary 'watchdog' organizations are involved in monitoring performance to ensure conformity to the agreed regulations and codes.

Attempts have been made to ensure that advertising does not target teenagers and to enforce more effectively laws prohibiting sales to underage drinkers. From a public health and clinical perspective, it is noteworthy that the early onset of drinking correlates closely with smoking and other forms of drug misuse.

At a local level, many communities are now examining the part they can play in reducing the level of alcohol-related harm, for instance by encouraging alternatives such as non-alcoholic drinks and not linking social and sporting activities too closely with drinking. In some cities new bye-laws have been introduced creating zones in which public drinking is prohibited and attempts made to reduce the level of drinking at sporting events by banning alcohol sales before and during the game.

Efforts at ***secondary prevention*** are usually directed at high-risk groups and are aimed at early diagnosis and intervention. High-risk groups would include persons who consume amounts of alcohol known to be harmful and individuals who, for a variety of generic, social or constitutional reasons, appear to be either unduly susceptible or else are unduly exposed to the effects of alcohol, for example, women, the young, Asian Indians, the those in occupations which allow them free or easy access to alcohol. As the risk of developing alcohol-related physical harm increases significantly with daily intakes of alcohol in excess of 40 g (5 units) in women and 60 g (7.5 units) in men, large proportions of the adult population, in many countries, fall into these high-risk categories. Therefore the efforts of secondary prevention, in this context, largely overlap with those of primary prevention.

A number of campaigns have been undertaken, for example, National Drinkwise Days, designed to increase awareness among the public at large and among individuals in the high-risk groups, of the levels of alcohol consumption associated with the development of physical harm. These are repeated at intervals and certainly increase awareness and knowledge, but the effects on behaviour are less well documented. Health-care screening is becoming more popular in many countries and as these schemes address several aspects of health they tend to be more appealing and less threatening than schemes designed to screen selectively for excess alcohol consumption. All patients registered with a general

practitioner undergo regular health-care screening. Individuals who are found to be drinking in a hazardous or harmful way can be alerted and given simple advice about reducing intake either by the general practitioner or by a practice nurse. Many industrial companies operate an alcohol policy aimed at the early detection of alcohol-related problems and early and effective intervention aimed at preserving the work force. Other companies, while not operating an alcohol policy as such, arrange for middle and senior management to undergo comprehensive health screening medicals, usually on an annual basis, thereby providing opportunities for early detection of alcohol-related problems.

Tertiary prevention is, more or less, synonymous with treatment; it is aimed at ensuring future abstinence from alcohol and preventing the development of further social, emotional, psychological and physical harm.

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7. Brief Intervention

There is good evidence that many patients benefit from straightforward, focused advice about their drinking behaviour. Despite this, doctors seem reluctant to discuss drinking behaviour with their patients, even though in the majority there will be no particular cause for concern.

If the patient reports drinking at a hazardous or harmful level then the doctor is well-placed to offer timely advice about changing these habits to a less damaging level. The patient's current view of their own drinking and their attitude towards making change must be taken into account. This crucial stage is often best addressed by an approach known as motivational interviewing. This is a technique which assists the patient to arrive at their own decision about changing their habits. The clinician should always be positive about the changes envisaged, stressing the benefits and offering suggestions for strategies for change. Some patients seen in hospital and primary health care will respond well to simple advice and it is always worth using this as a first approach. Other patients will require more help in making a commitment to change.

It is important to remember that while it might be clear to everyone else concerned that the patient needs to change their drinking behaviour, they may not share this point of view. Often, patients will acquiesce to a doctor's opinion while not truly incorporating the advice they are given. The patient's own views of their drinking habits and problems must be elicited. They may be at a 'pre-contemplative' stage and may not have thought seriously about changing their drinking behaviour. In these circumstances the first task is to provide information and feedback about the risks associated with their current alcohol intake and to discuss any associated health problems which may have already arisen. At this stage it is helpful to make it clear that the onus lies with the patient to make the necessary change, and only when they are willing to accept this first step is it appropriate to give advice about strategies for cutting down and achieving a less harmful level of drinking. The essential components of motivational interviewing and brief interventions of this kind have been summarized with the acronym FRAMES (Table 7:1).

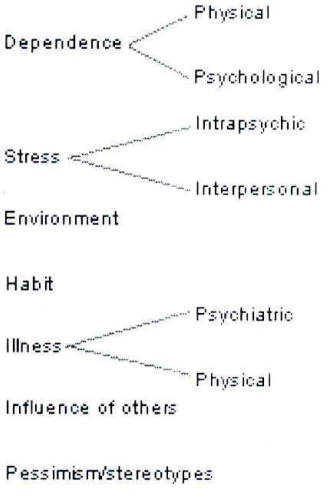
Table 7:1
The Essential Components of Motivational Interviewing and a Brief Intervention:
FRAMES

- **F**eedback about the risk of personal harm or impairment
- Stress personal **R**esponsibilty for making change
- **A**dvice to cut down or, if necessary, stop drinking
- Provide a **M**enu of alternative strategies for changing drinking patterns
- **E**mpathetic interviewing style
- **S**elf efficacy: an intuitive style which leaves the patient enhanced in feeling able to cope with the goals they have agreed

Source: Bien et al, Addiction 1993; 88; 315-36

Habits are difficult to change. Many problem drinkers will find that much of their life is dominated by the need to drink and many barriers to change (Table 7:2) will have to be confronted including:

Table 7:2 Barriers to Change



Dependence: May be physical or psychological; those physically dependent will have to be carefully withdrawn from alcohol (Chapter 9); those psychologically dependent will need to identify triggers to drinking and find new ways of dealing with craving and alternative ways of coping.

Stress: For some patients this is a major barrier to making change; they regularly use alcohol to deal with difficult situations in their lives. Counselling and other forms of psychological help may be necessary to overcome this problem.

The patients' **environment** can be a barrier to change; for example they may have a job where selling or entertaining brings them into regular contact with alcohol, or their social life may be constructed around drinking occasions.

Habit: Never underestimate the force of habits. The patient needs to identify occasions when they have been 'in the habit' of having a drink: for example at particular times of day, in particular company or situations. Keeping a regular diary (Figure 6:1) is often a good means of identifying these risky times. The patient and doctor can together agree a plan for dealing with these situations and then review how successfully they have been overcome.

Occasionally alcohol will have been used as a form of self-medication to cope with **psychiatric** or **physical illness**. In these circumstances, the underlying condition must be identified and treated along with the alcohol problem so that the patient gains confidence in coping with the symptoms without recourse to drinking.

The **influence of others** is a powerful factor for many. This may either be of a positive nature, supporting and encouraging the patient during times of potential relapse, or a negative influence by encouraging and cajoling them to drink, for example, by saying 'one won't do any harm', or repeatedly asking why they have given up drinking and become 'a killjoy'. It is often helpful to rehearse dealing with such pressure, either at individual interviews or as part of a social skill management group.

A final barrier to change is a sense of **hopelessness** or **pessimism**. The drinker may feel that it is impossible for them to change their drinking habits. Equally, the doctor may feel pessimistic about the likelihood of a given patient succeeding in attaining this goal or more broadly about their own ability to effect change in any of their patients. These feelings are often based on a few unrewarding experiences; it is easy to forget that the majority of problem drinkers respond well to help and advice.

Aim to enhance the patient's self esteem and sense of being able to cope before they leave the interview.

Set Goals: Goals should be specific, attainable, short-term, and preferably immediately rewarding. They should be defined and agreed by the patient.

Involve the family: Family distress is common and encouraging family members to join in the interview is a useful way of reinforcing the decisions made.

Often the patient will respond very well to the advice given and only brief follow-up will be necessary. If the interview has taken place in hospital, then the general practitioner should be told what advice has been given so that it can be followed up at a later stage.

In some circumstances the patient will be unable to make the anticipated changes and may need further help. This may be because some of the barriers to change have proved insurmountable in the first instance and will require more detailed attention. Patients who are physically dependent on alcohol may need help to withdraw

from alcohol before any changes are possible.

Abstinence or Controlled Drinking: To drink or not to drink is one of the earliest questions likely to be raised. Most patients will hope that they can regain controlled social drinking.

Abstinence from alcohol is the preferred aim in older individuals, those who have exhibited serious physical dependency on alcohol, those with significant alcohol-related physical injury and those who have previously failed to modify their drinking behaviour despite advice. If the family is very strongly against attempting controlled drinking, or if the environment is such that relapse seems extremely likely, then again abstinence is the preferred aim. For some patients, particularly those who are younger and those who have little evidence of physical harm, **controlled** or **modified** drinking may be appropriate.

Whichever goal is adopted initially, it may have to be modified by experience and events. It is often helpful to draw up a balance sheet to help the patient agree their goals and look at the problems which are likely to arise in making changes. Balance sheets and a diary for self-monitoring review are very helpful aids (Table 7:3). It is very important to encourage even modest but realistic gains in the early stages. Changing habits is never easy and even small gains should be applauded.

Table 7:3 Sample Balance Sheet of Drinking

	Likely consequences of drinking		
	Continuing	**Reducing**	**Stopping**
PROS of chosen course	Forget my worries (for a time) Keep my drinking friends	Be like others Not be a kill-joy at business lunches	Family want me to Doctor says it is the only way my liver will recover Save a lot of money
CONS of chosen course	Partner may leave Children very upset Lose my job Liver failure	Didn't work when I tried before Partner would'nt believe me Liver damage persists	Could I cope with business lunches? Feel uncomfortable with my friends

Further description of managing alcohol problems in general practice will be found in the article by Noble and McLean, MCA Newsletter *Alcoholis*, 1998 Volume 17 (4).

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Webmaster: Dr Guy Ratcliffe Website design: Karen Widdowson

Alcoholism Treatment HelpLine

1-800-527-5344

AMERICAN COUNCIL ON ALCOHOLISM

Frequently Asked Questions

Why do people drink alcoholic beverages (beer, distilled spirits, or wine)?

Positive reasons for drinking alcoholic beverages include:

Celebrating significant occasions with friends or loved ones.
Enhancing enjoyment of social activities and relaxation.
Complementing certain meals.
Participating in religious ceremonies.
Enjoying the taste as a beverage of choice.

Negative reasons for drinking alcoholic beverages include:

Escaping from tension or worries.
Blocking out painful feelings such as fear, loneliness, and self-doubt.
Attempting to relate better to people.
As a substitute for meaningful relationships with people.
Finding courage or strength to face certain situations.

What are symptoms of alcoholism?

Only a qualified professional can determine if an individual is alcoholic. Howe following warning signals may indicate the presence of alcohol-related problem these signals involve later stages of alcoholism and involve symptoms that may to time periods and drinking patterns.

Drinking increasing amounts of alcohol and becoming intoxicated often.
Being preoccupied with drinking, to the exclusion of other activities.
Making, but readily breaking, promises to quit or control drinking.
Experiencing "black outs", *i.e.*, unable to remember what he/she said or did

drinking.

Experiencing personality changes, *i.e.*, tense, irritable, denies or conceals dri
wide mood swings.
Making excuses for drinking.
Drinking alone, in the morning or before a party.
Refusing to admit to excessive drinking and becoming angry if someone mei
Having trouble on the job or at school, i.e., misses work or school, is frequer
has conflicts with coworkers or fellow students.
Changing jobs frequently and/or is usually demoted, rarely promoted.
Losing interest in personal appearance or hygiene.
Suffering from poor health, e.g., loss of appetite, respiratory infections, nerv
Having several arrests for drunken driving or other alcohol-related incidents.
Suffering from family, marital, academic, and/or economic hardships.
Spending a great deal of time overcoming hangovers.
In final stages, experiencing grave social, financial, and personal damage.

Is the person who regularly takes a cocktail before dinner an alcoholic?

Not necessarily. Drinking every day - in and of itself - does not indicate alcoho
people drink every day for a variety of reasons with no subsequent problems. T
ask is: "Do I need that drink?" If the answer is "No" and you can control the an
alcohol you drink, then more than likely you are not an alcoholic.

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About Alcoholism

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Chairman's Corner

Is there such a thing as a weekend alcoholic?

Yes. Alcoholism is a complex illness and involves symptoms that may be unrel
periods and drinking patterns. Not everyone exhibits the same symptoms.

What is social drinking? How much does a social drinker drink?

Social drinking is not based on - nor defined by - a certain number of drinks. W
an exact definition, social drinking usually takes place with two or more particij
satisfying to the drinker and participants, and does not impede the drinker's heal
interpersonal relations, or economic functioning.

A social drinker respects alcohol and its effect on the body, consumes alcohol a
family and social customs, and realizes that alcohol complements the pleasures
the social drinker, drinking is not an end in itself but an accompaniment to othe

What distinguishes a social drinker from an alcoholic?

Loss of control. A social drinker has control over when, where, and how much
drinks. An alcoholic has lost this ability and after beginning to drink, usually di
intoxication.

What type of person is an alcoholic?

There is no typical alcoholic. Anyone can abuse alcohol and become and alcoh
studies show an increasing number of alcoholic women, teenagers, and children
young as 10 years old. There is also a rising number of alcoholics among senio

is estimated that as many as one out of ten people over age 60 have alcohol-rela

What is denial?

Denial occurs when a person refuses to believe that alcohol-related symptoms a
excessive drinking. Denial is a major obstacle to alcoholic recovery.

What is the difference between denial and rationalization?

With denial, the alcoholic believes that drinking has nothing to do with his/her p
With rationalization, the alcoholic attempts to find logical reasons for drinking,
drinking to certain occasions - *e.g.*, "I'll drink because it's my birthday" or "I'll d
it'll help me unwind" - without the ability to control drinking during any of thes

Why do alcoholics refuse to recognize their problem with alcohol?

The effects of chronic intoxication interfere with thinking and impairs attitude,
personality. The alcoholic is incapable of recognizing the serious harm caused
repeated use of alcohol. Until drinking stops, the brain does not function norma
effects may last for weeks or months, but they are mostly reversible.

How can you help an alcoholic who does not want help?

First, learn as much about alcohol, alcohol abuse, and alcoholism so that you m
able to deal with the problems of alcoholism and some of your own feelings abo
problem. Next, talk to the person about their behavior changes that result from
firm, considerate, single-minded, and focus on the drinking behavior, not the re
drinking. Some alcoholics always find a reason to drink. Be specific: point out
drinking interfered with the person's life.

Offer hope. Alcoholism is a treatable illness. Between one-third to two-thirds o
who seek help actually recover from alcoholism when the first step is taken to s
consumption. Since many alcoholics lapse again into heavy drinking, patience
encouragement can help the alcoholic regain sobriety.

Finally, remember that the worst thing to do is to ignore the problem and hope t
away.

What is an intervention?

In the book *Intervention*, Vernon E. Johnson describes intervention as a "proces
the harmful, progressive, and destructive effects of chemical dependency are int
the chemically dependent person is helped to stop using mood-altering chemica
alcohol] and to develop new, healthier ways for coping with his or her needs an
The ultimate goal of an intervention is to get the alcoholic into a treatment prog

How does an intervention work?

Intervention occurs when the alcoholic person is in denial or does not seem to w
any help and loved ones, relatives, and even employers decide that it is time to

take action. They do this to help the alcoholic to recover a sober and healthy lif

Under the guidance of a professional, an intervention team forms, made up of tw
people who are concerned and close to the alcoholic and who have first-hand kn
the alcoholic's symptoms or behavior.

The team meets and, in an objective and caring way, the alcoholic is confronted
about his/her drinking. By using specific examples of the alcoholic's drinking b
team attacks the alcoholic's wall of defenses. the alcoholic meets head-on with t
the effects of alcoholism. This process causes discomfort and upset. The alcoh
out of denial and this may lead to agreement to seek help.

What attitude should I have toward a problem drinking spouse?

Don't blame yourself for your spouse's alcoholism. An alcoholic can be very cl shifting the responsibility for drinking to others and may use your feelings of ca feelings of guilt within you. You are not responsible for the illness that affects and you cannot control or change alcohol-related behavior. Seek professional h spouse, yourself, and other family members.

How do you handle children experimenting with alcohol if one or both parent recovering alcoholic?

One way to prevent alcohol abuse is to give children accurate information abou properties, and its effects on the body. If a child is well informed about the imp of alcohol and has a feeling of self-confidence, chances of abusing alcohol are g reduced. "Scare tactics" should not be used to change undesirable behavior. Cl expectations and rules are important and discipline should be consistent if rules Finally, seek professional help.

What if I'm the child of an alcoholic?

Just remember that you are not the cause of your parent's drinking; it is an illnes not responsible for their actions. It does not mean that you are a "bad" person a not feel guilty. If you are really upset about a parent's drinking, you should try professional help.

How does an alcoholic recover from alcoholism?

Alcoholism is a chronic progressive illness. While there is no medical cure for many alcoholics do "arrest" it; *i.e.*, stop its progress with medication and trainin

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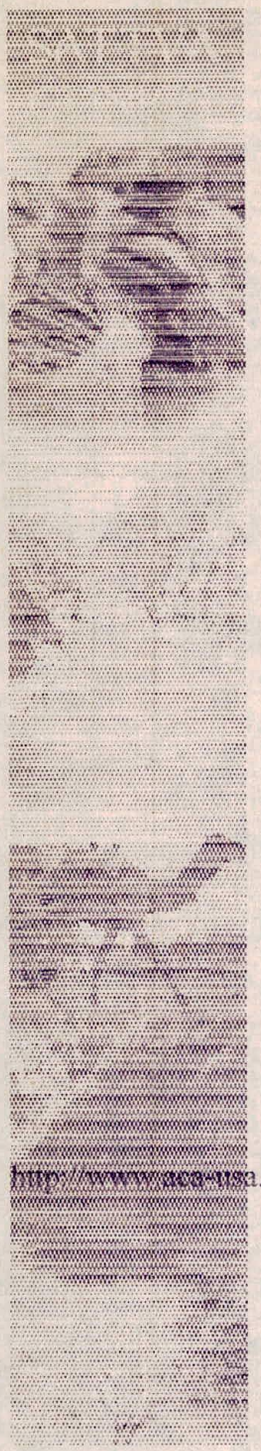

"There is the strange and constant fact that it is only after a pious journey to a di region, in a strange land, that the meaning of the inner voice can be revealed to to that strange and constant fact there is another: that the person who reveals th of our mysterious inner voyage to us must himself be stranger, of another faith a race"

Why India?

Global travelers, when they return home, often are confronted with a riddle: why is it that so many people in the wealthiest countries seem so stressed, worried, overweight, angry, spiritually bereft, and, - in a myriad of ways - unhappy?

Conversely, in a city like Bombay, where over 70% of people are what we would call homeless, amidst the most crowded conditions, seeming chaos, and unspeakable poverty, one can sense an incredible generosity of spirit and peace amidst outward turbulence and squalor. How is this? The answer is, of course, culture. We live in culture as a fish lives in water, so permeated by it that we hardly notice it.

You see, we create our culture, and are in turn created by it, unless we are able to receive a different perspective. There are many common-sense reasons why people in the west feel impoverished amidst relative gluttony, empty in the middle of opulence, and victimized despite being given unlimited opportunities.

Many Americans are fat, angry, depressed, dissatisfied, addicted to a variety of drugs or activities mainly because it is a tall order to make sensible choices in a culture where you are exposed to hundreds of advertisements every day, most of which follow the same formula: create dissatisfaction and therefore a need, then offer a material solution for a non-material need. More dissatisfaction follows.

But this much is clear: our culture in the west has reached the stage where the majority of

PRICE:
India provides the oppo
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strong cultural antecedi

lifestyle choices. Most people living in western culture have the means and the opportunity to live lifestyles which lead to vibrant health. Most people in the west have shelter, enough money to eat vegetables and fruits, time to meditate, and have access to free information about how to transform the quality of one's life beyond one's wildest dreams.

But most people do not. In fact, even children in America are becoming obese and depressed at increasing rates. Prescriptions to anti-depressants for children - unheard of ten years ago - are skyrocketing. While there are obvious reasons why Americans and their children live unhealthy lifestyles - essentially spending lots of time eating processed foods and/or ingesting drugs, immobile in front of an electronic screen - its also obvious that in order to change the quality of one's health and one's life that you have to change your lifestyle.

You know what you have to do: create your own regimen for exercise, healthy diet, sleep, and self-reflection, stick to it, and reap the rewards.

western and eastern tr

*** COMBINING TRADI TREATMENT WITH ALTERNATIVE CARE:** Meditation, acupunctur bodywork, and yoga ar utilized in selected hos American in treating ac disorders and other ailr proven results. Americ spend more money on health care treatments not covered by insuran they do on traditional h India has ancient tradit alternative health care aimed at preventive m optimum health, traditi steadily gaining accept American market.

Traditional Methods Used to Help Navajos Stop Drinking

by AP, The Associated Press

By Leslie Linthicum, Albuquerque Journal

Gallup, N.M. (AP) _ As fire smolders and sweet smoke hangs thick in the air, Harrison Jim shakes the rattle of the Native American Church while a couple dozen people sit shoulder-to-shoulder and sing peyote songs in the dark.

The world outside is cold and wet and fraught with dangers: beer, wine and hard liquor and fears that disappear only when they are drowned in drink.

Inside the drumming circle at the Na'Nizhoozhi Center, Jim offers blessings of cedar smoke to fortify the spirit and Navajo words to kindle memories of the past.

Recognizing that alcohol treatment programs that succeed in the white world often fail in Indian country, counselors here are looking to the past the songs and stories that have sustained Navajo people for centuries _ to help Navajos in their battles against alcohol today.

A 6-year-old program immerses Indian alcoholics in 24 days of corn pollen ceremonies, sweat lodges, drumming, talking circles and tutorials with medicine men in the snug confines of cedar-log hogans outside the Na'Nizhoozhi doors.

The program, known as Hinn'ah Bits'os (or Eagle Plume) Society, has shown remarkable results, with 40 percent of its 1,800 graduates sober two years later.

And it has won Jim, one of its founders, a three-year public health grant to take the concept nationwide.

Under a $75,000 grant from the Robert Wood Johnson Foundation, Jim will work with others in the field of substance abuse counseling to try to incorporate traditional elements into programs for Native American addicts.

Jim is a road man with the Native American Church, a Navajo healing practitioner and a recovering alcoholic. An eighth-grade dropout who had his first drink at age 7, he has studied modern, scientific approaches to treating alcoholism. But he has found the strongest medicine in Navajo spirituality.

"Our purpose is not to take people back to the old ways," said Jim. "Our job is to guide them back to the teachings of the Holy People. To say, 'This is who you are and this is where you come from so you can carry on in your life, in your job, with your family, with this strength to guide you.' "

The dozen people who took part in the residential program that ended last week included a silversmith, a sand painter, a heavy equipment operator, a fast food clerk and unemployed, chronic alcoholics, among others. Many were there by court order after too many arrests for drunken driving or public intoxication. Others were there by choice, trying to kick a habit that has cost them jobs and family relationships.

"Having that first drink, it's just like lighting a fire," said Norbert Peshlakai, a noted silversmith from Crystal, who has tried without success to stop drinking through Christian-based programs and through Alcoholics Anonymous.

"This is working," Peshlakai said. "It feels good to get back to the old ways."

Matthew Kelley, clinical director of Na'Nizhoozhi, said the center is the largest detoxification facility in the nation and, at $45 per day for each client, one of the cheapest.

While one or two dozen people are enrolled in the specialized Eagle Plume program at any time, the main business of the center is more basic to pull intoxicated people off the street and into a safe place for a few days while they get sober.

"This is a high-volume, low-cost program," said Kelley.

The center was built 10 years ago to address Gallup's notorious problem with wandering street drunks. Nearly 40,000 people a year were cycling through the Gallup jail on public intoxication arrests before Na'Nizhoozhi opened to replace it with a different approach.

In its first year it saw 24,000 admissions. That has been cut to about 17,000 clients today as some repeat offenders have graduated to sober lives.

Most of the center's clients are picked up on the streets or dropped off by relatives. They stay for two to five days before heading home nourished, rested and with encouragement to get help for alcoholism.

Most don't.

Sixty percent of the admissions each year involve the same 700 people a core group of chronic drinkers who sometimes spend 200 nights each year sobering up on a Na'Nizhoozhi cot.

About 95 percent of the clients are Native American mostly Navajo.

When the center replaced the drunk tank at the Gallup jail it began offering a standard 12-step Alcoholics Anonymous program.

Jim remembers leading Alcoholics Anonymous meetings and watching the disconnect.

"They wouldn't listen to it," Jim said. "They'd drift off. Some of them would fall asleep."

Drawing on brain wave research Kelley had done on the effects of drumming and other Native American traditions on relaxation among Navajos and on Jim's personal experience with getting sober through the old teachings, Jim and other counselors changed their meetings in 1996.

"We started talking about what our grandfathers and grandmothers used to talk about traditions, having self-respect and responsibility, teachings put forth by the Holy People," Jim said. "They started sitting up straight and listening because we were using our own language."

Counselors began introducing themselves by using their clan identifications and talking about the kinship system that ties all Navajos together. Instead of calling the people receiving treatment "clients," they called them "relatives." They built a traditional healing center on a patch of land next to the center that includes four hogans and four sweat lodges and found room inside the center for a dormitory for the "relatives" enrolled in the program.

It was a gamble on a developing approach to the treatment of alcoholism among American Indians known as the "red road to recovery."

And it worked.

Six years into the program, four out of 10 people who go through the Eagle Plume program have quit drinking entirely and maintained their sobriety for two years. Seven out of 10 have shown significant improvements. That compares with less than a 30 percent sobriety rate for those who follow AA programs through the center.

The wind blows cold outside, but the big metal drum inside the hogan is burning warm with cedar logs.

The 12 members of the Eagle Plume Society sit in a circle, talking about their lives and learning the history of the hogan, the eight-sided traditional Navajo dwelling.

Russell Kaye, a sand painter from the Navajo community of PiÒon, reflects on his life and his days in the program.

"Somewhere along the way," says Kaye, "I have made some mistakes. I am learning ways to bring myself back into harmony."

He hopes to go home sober, stay sober and begin filling orders for artwork that have been piling up.

Jerome Curley, from the Navajo community of Wheatfields, speaks for the group.

"We want to change, to be better men, to be the men we should be," Curley says.

Jim uses the example of the warrior twins of the Navajo creation story and their encounters with monsters to teach the importance of maintaining a "warrior mentality" when "relatives" leave the center and return to their lives in modern times.

"Our people are still going through these hardships," Jim says, "but the monsters are different now."

The fire sits in the middle of the one-room log building and visibly glows from the east-facing door.

"Wherever you go," Jim says, "it guides you home."

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[We welcome your comments and suggestions...]

Why Do We Do What We Do? The Diffusion of Alcoholism Treatment Methods into Practice

Heidi Erickson Pritchard, M.S., and William R. Miller, Ph.D.
Center on Alcoholism, Substance Abuse, and Addictions (CASAA), The University of New Mexico, USA

ABSTRACT

How do clinicians come to adopt the particular treatment methods that they use? A survey of 70 alcoholism professionals found little relationship between methods of practice and years of education. Instead endorsement of a traditional disease model of alcoholism predicted several aspects of practice behavior, including the use of a larger number of different treatment methods, inclusion of the family in treatment, and recommendation of twelve-step programs. Practitioners reported learning new treatment approaches primarily through informal methods, and through workshops and seminars. Endorsement of a traditional disease model was associated with using less evidence-based treatment methods. The continuing gap between science and practice in the addiction field may be related not to amount of education, but rather to values and models acquired during professional training that deem scientific evidence to be irrelevant to practice.

IDENTIFYING THE SAMPLE

- Surveyed all substance abuse treatment programs in the Albuquerque metropolitan area
- Contacted 31 program directors
- Each nominated 2-3 clinicians to interview
- Of 72 nominated, 70 (97%) participated

THE INTERVIEWED SAMPLE (N = 70)

50% women — 18.4 years of education
23% minorities — 14.8 years of counseling experience
77% working in outpatient-only settings
64% masters degree, 20% doctoral degree

METHODS

- Administered a qualitative interview to identify what new alcoholism treatment methods clinicians had learned since their initial training, and how they had learned them
- Administered the Understanding of Alcoholism Scale (Moyers & Miller, 1993) to assess clinicians' endorsement of disease and psychosocial models
- Two raters developed qualitative categories of methods of diffusion, then used these to classify all narratives. Inter-rater agreement = 92.5%, with discrepancies decided by a third rater

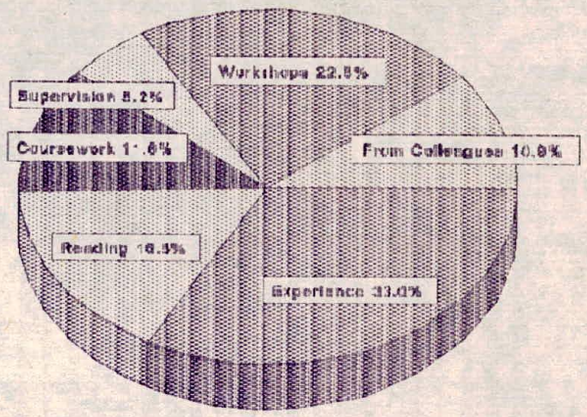
NEW TREATMENT METHODS LEARNED

of 47 methods grouped by 11 *a priori* categories

% of total	Newly acquired method	% claiming to have learned it anew
18%	"Alternative" therapies	70%
18%	Coping skill training	70%
18%	Other cognitive-behavioral	69%
11%	Brief interventions	43%
9%	Traditional/standard methods	36%
7%	Use of medications	27%
6%	Marital/family therapies	21%
5%	Psychotherapies	17%
4%	Spiritual approaches	16%
3%	Self-help approaches	13%
0%	Aversion therapies	0%

On average, clinicians claimed to be currently using 32 (69%) of the 47 different therapeutic methods in treating their clients for alcoholism

HOW DID THEY LEARN?



PREDICTORS OF PRACTICE BEHAVIOR

Only clinicians' strength of belief in the disease model of alcoholism (not years of education or experience) predicted practice behavior. Clinicians more strongly endorsing the disease model were also more likely to:

- use a larger number of different treatment methods
- emphasize AA and abstinence
- involve the family in treatment
- be more directive in counseling style
- use methods with less scientific evidence of efficacy (from Miller et al., 1995)

Miller, W. R., Andrews, N. R., Wilbourne, P., & Bennett, M. E. (1998). A wealth of alternatives: Effective treatments for alcohol problems. In W. R. Miller & N. Heather (Eds.) *Treating addictive behaviors* (2nd ed.), 203-215. New York: Plenum Press.

Moyers, T. B., & Miller, W. R. (1993). Therapists' conceptualizations of alcoholism: Measurement and implications for treatment decisions. *Psychology of Addictive Behaviors, 7*, 238-245.

This research was supported in part by grants T32-AA07468 and K05-AA00113 from NIAAA.

Learning Theory for the Teaching of Stress Management

1. Identify the needs of the audience (individual or group).
2. Establish appropriate goals and specific learning objectives for specific training sessions.
3. Select appropriate content to match goals, learning objectives and time available.
4. Select appropriate teaching/learning strategies based on age, educational level, occupation, interest of participants, group size, length of training and training intervals, facilities and environment.
5. Sequence instructional strategies appropriately.
6. Explain the importance of establishing set, internal transition and pacing.
7. Provide opportunities for appropriate practice by participants.
8. Explain the importance of modeling.
9. Demonstrate good presentation skills.
10. Analyze group dynamics in simulated situations and identify strategies for handling specific situation, i.e. slow learners and resistant group members.
11. Evaluate understanding and skills acquisition.

12. Provide appropriate reinforcement and feedback.

13. Establish appropriate levels of mastery.

14. Select appropriate equipment, audio-visuals, instructional materials and facilities.

15. Evaluate training and modify it based on evaluation.

16. Establish a method for follow-up to evaluate effectiveness of the program for future development.

17. Explain the role of behavior modification strategies in promoting life-style change.

18. Apply motivational theory in designing instructional strategies for use with specific types of groups or individuals.

19. Discuss the importance of feedback and reinforcement in learning stress management coping skills.

20. Identify how part/whole learning is important in teaching relaxation skills.

21. Explain the need for proper timing and progression in teaching intervention strategies.

22. Explain state-dependent learning.

THE HINDU

Group Publications

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Online edition of India's National Newspaper
Tuesday, Dec 18, 2001

Southern States

`Alcohol abuse a serious problem in State'

By R. Vijaya Kumar

BANGALORE, DEC. 17. The final report of the Task Force on Health and Family Welfare, chaired by Dr. H. Sudarshan, has urged the State Government to take ``responsible action'' towards prevention and control of alcohol abuse.

In an elaborate analysis of the increasing problem in Karnataka, the task force has termed alcohol abuse as a major public health problem and a socio-economic issue. The task force has suggested various measures to reduce the problem.

Imparting training to all medical officers, especially at the primary healthcare level on screening patients for alcohol-related problems, and early detection and intervention for health-related problems are some of the suggestions.

According to the report, training should include sensitisation on the association of alcohol use with domestic violence, and sexually-transmitted diseases, including HIV/AIDS.

Though Article 47 of the Constitution states that ``The State shall regard the raising of the level of nutrition and the standard of living of its people as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption, except for medicinal purposes, of intoxicating drinks and drugs which are injurious to health,'' the State governments have abdicated their responsibility. The reasons cited are loss of revenue, cost of policing, corruption of enforcement machinery, illicit distillation, hooch-related deaths and, above all, lack of political will.

According to the report, the alcohol industry contributes a major part of the revenue of the States. In 1997 it was estimated to be about Rs. 17,000 crore in the form of taxes and levies. The rate of liquor consumption in the country is growing at a steady 15 per cent annually.

In Karnataka, though accurate figures are not available, the sale and consumption of alcohol and alcoholic beverages is on the increase. What is worrying is that it is spreading among

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sale and consumption of alcohol and alcoholic beverages is on the increase. What is worrying is that it is spreading among the youth, including high-school students.

According to the report, alcohol consumption results in a large number of problems, adversely affecting almost every organ in the body. While gastritis is an early symptom which brings the patient to the doctor, it can lead to hepatitis and cirrhosis. There is also an increased risk of cerebral haemorrhage.

According to the task force, while alcohol consumption is an accepted social and traditional norm in many developed countries, it used to be predominant among males and rarely among women in India. But this pattern of drinking has rapidly changed.

``Social drinking'' is considered to be synonymous with ``moderate drinking''. While this is so in the traditional ``wet'' or alcohol-using culture, it is not so in a ``dry'' country like India. Now social drinking has come to mean drinking to intoxication.

In Karnataka, while about one-third of the adult male population uses alcohol, one out of two people who drink develop significant problems related to drinking. It has also been found that alcohol dependence is a recurrent and relapsing illness which affects one in four drinkers in Karnataka.

The task force report has said that alcoholism is a disease which needs intense medical and psycho-social interventions for the alcoholic and his family.

The report has further said that as a public health issue, the medical, social and economic costs borne by the larger population (not just the alcoholic) as a result of alcoholism are immeasurably greater.

It has also said the lax implementation of regulations and laws is leading to increased production and wide availability of alcohol. This stems from the perceived loss of income to the Government from reduced production and sale of alcohol, and is compounded by pressure from the liquor lobby. Unfortunately, this does not take into account the spending on health and the economic loss due to alcohol-related ill health.

Quoting a 10-year study conducted by NIMHANS in Karnataka between 1988 and 1999, the report has said that Karnataka's installed capacity for beverage alcohol is one of highest in the country. Production has gone up by 150 per cent, and per capita consumption by 114 per cent (which means that the average consumption by an average drinker has gone up from nine bottles of whisky per year to 20 bottles).

Other findings of the NIMHANS study are: people are beginning to drink at an earlier age (average age dropped from 25 to 23 years), and in larger quantities; more than 50

beginning to drink at an earlier age (average age dropped from 25 to 23 years), and in larger quantities; more than 50 per cent of all drinkers have a problem drinking pattern, and associated morbidity; early alcohol-related health problems are under-recognised by the primary healthcare physician; heavy drinkers far outweigh chronic alcoholics in numbers and account for substantially more medical, social and economic problems; the problem is larger and more serious in rural areas; and the Karnataka Government's alcohol-related health expenditure and losses due to alcohol-related industrial accidents was Rs. 975 crore, more than the earnings from excise on beverage alcohol.

The task force has suggested some measures to reduce the problem. They are: reduce the supply by increasing the taxes; increase the minimum age for legal purchase of alcohol; reduce the number of alcohol outlets; restrict the hours of sale of liquor; and restrict sales on certain days.

Alcohol use and abuse is associated with violence, especially against women and children. It is important to actively look for history of violence in drinkers. Alcohol abuse has a definite association with serious risk behaviour such as unsafe sex which will lead to sexually-transmitted diseases, the report has said.

THE HINDU

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Online edition of India's National Newspaper
Monday, Aug 05, 2002

Metro Plus Hyderabad

Published on Mondays, Tuesdays, Wednesdays & Thursdays

When images sink in

The recent ban on the surrogate advertisements promoting liquor on television has opened a fresh round of debate among the talking heads. SYEDA FARIDA reports.

DRINK DEEP: Packaged water, apple juice anyone? - Photo: P.V. Sivakumar

HAVE YOU watched this image on television lately? Darts fly and voila, it hits the bull's eye! It is the slick duel at the darting board commercial of Haywards 5000. Was it about a darting kit? Or how about this? A cool dude going high at a glass of sparkling drink -the line says Aristocrat Apple Juice, one of the bolder commercials to hit the tele tube today. Advertisement as a popular medium of paid communication has drawn public ire time and again for moving away from truth andthe consumers `right to know' to providing false images. Enter the new concept of surrogate advertisement -- the advertisement of the items on the negative list, those that have downbeat social favour, such as tobacco and liquor. The masked creatives leave it to the consumer to read between the lines.

For instance, the Haywards 5000 darting kit, *Mera* No 1 Mc Dowell's packaged drinking water, ditto for the Kingfisher `king of good times' beer going the packaged water way, theWills Lifestyle, ITC-GTDs'(Greeting Cards Division) Expression Greetings cards and the Red

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& White Bravery Awards from the tobacco wing.

Brand managers call it leveraging on the existing equity of the brand, agencies define it as an exercise in brand recall of products on the negative list, while the government comes down heavily on the intriguing concept of surrogate advertising. With the anti-tobacco lobby going strong worldwide, every country has a negative list of products. One of the popular examples of surrogate advertisement from Sweden with a ban on liquor advertising has been the usage of black and white terriers for the Scottish whisky.

A parliamentary consultative committee on surrogate advertisement, headed by Additional Secretary Anil Baijal, was set up recently to deliberate on the determination of advertisements that would fall under the surrogate bracket. The committee observed that Mc Dowells and Gilbeys Green Label were the cases of surrogate advertisement since there was clear recall of the actual product, which is liquor in each case following which the I&B ministry sent show cause notices to television channels quoting the Cable Television Networks Rules Act 2001 according to which `no broadcaster is permitted to show advertisement which promotes directly or indirectly the promotion of alcohol, liquor or other intoxicants...' (Rule 7(2) of the Cable Television Networks Rules Act) and calling for a ban on such commercials. And this fresh ban on the airing of the surrogate advertisement Aristocrat Apple juice and the likes on the Indian airwaves - STAR, Sony and Zee TV networks has got the talking heads get into the debate over society versus financial figures.

Celebrity endorsements, with Shatrughan Sinha for the Bagpiper soda to the leading stars such as Akshay Kumar for the Red & White Bravery Awards, events -- Baccardi Blast which has been a pilgrimage with the hip youth, Kingfisher - Saurav and Jadeja at the popular jig for a mineral water, the famous Charminar Challenge and the other sports promotions -- Gold Flake Open and Royal Challenge, music -- Charms Spirit of Freedom Concerts and fashion -- the designer collection at the Wills Lifestyle chain of stores, the face of surrogate advertising has been ever improvising while the story boards have been reworked and gone creative.

"Event marketing has benefited sports, fashion and music. For instance music got quite a patronage with the Charms Spirit of Freedom Concerts featuring Indian classical music to the Western bands such as Rock Machine. The companies have an advertising budget maximum of which is spent on television. And when television does not carry them where do you spend that to get the visibility?" asks Satish Kocharekar, director, Livewires Advertising Pvt Ltd.

One essential function that surrogate advertising does is that of brand recall and not necessarily an exercise in increasing sales. Commodities such as tobacco and cigarettes are habit-forming with a high degree of brand loyalty and rely on word-of-mouth product information. Thus, a strong convincing logic is needed to convert the consumer to the brand over a sustained period of time, consequently the strong ad appeal. "They drink the image," says Chandrasekhar, an advertisement consultant. While it is easy for the teenagers to switch brands, the consistency and brand loyalty comes at 26-30 years, he observes.

"A brand is a sum total of the product, with the imagery and feeling. The change in maturity may lead for instance a shift from the front line

Navy Cut to chief executive India Kings imagery," says Sandeep Nath, director Livewires Advertising Pvt Ltd. On one hand is the drive to break the brand loyalty and on the other the competition from the house of the global liquor majors and smuggled cigarettes, and the ban on advertisement.

"Consumers should be given a choice. In the absence of this there will be bootlegging and adulterated products lining up on the shelves," says Chandrasekhar.

Observers believe that when the license to set up the industry, manufacture and sale is given, it would be suicidal for the authorities to take a high moral ground and stop the advertisement. The tobacco and liquor industry provide a major chunk to the exchequer in the form of the Central and State excise and under other tax heads. "There is an ethical question. The government is keen that surrogate advertising does not advertise liquor; to that extent the surrogate advertising is wrong. But manufacturers have every right to sell the product," says Vishwa Mohan, vice president RK Swamy BBDO.

The industry on its own has demonstrated the maturity and sense of responsibility to promote instruments of advocacy of restraint and moderation in consumption of alcoholic products. "Society for Alcohol Related Social Policy Initiative (SASPI) is a self-evident initiative in this direction. Mc Dowell's and Seagram's have undertaken campaigns for responsible drinking," says Vijay K. Rekhi, president UB Group Spirits Division.

Some of the reasons for the ban on the advertising of the products have been to shield the young and impressionable minds from consumption. The Tóbacco Institute of India (TII) is of the opinion that the freedom of commercial expression should be permitted since tobacco is a legal product and that consumption should be an informed personal choice for adults only.

"Rather than an outright ban on advertising, the government should endorse the code in operation which specify the timings when the ad should be aired," says Vijay Rekhi.

Yet another reason why liquor ads in particular face flak has been the frames being used in the commercial. `What have women got to do with the darting kit," says a consumer. Further, can anyone go on a high on an apple juice?

"You don't want to induce children to smoke and thus remove the sports sponsorship as in the case of cricket. Fair enough. But then one tends to question the censorship for other advertisements shown on the television," says Santha John, director Mindset EYW Advertising Pvt Ltd.

As regard to the debate, the liquor product has shown negative growth rates plunging to a current 2.5 million cases from a 3.7 million cases in 2000 while there has been a de-growth in cigarette volumes with the restriction on smoking in public places ever since the Tobacco Products (Prohibition of Advertisement and Regulation) Bill 2001 called for a ban on smoking in public places, and on surrogate advertising with a total ban on sponsoring of sports and cultural events by cigarette and other tobacco product companies. As a thought forward, the companies have put their eggs in different baskets `cashing in on their expertise' in

hospitality, lifestyle and more.

As of now, the ban applies to the liquor segment. It is yet to be seen how soon the axe falls on the tobacco surrogates - lifestyle, retail and the works. And it would not be long when the companies producing sports kits, darting boards, sparkling water, ice cubes and greeting cards would also be known for the liquor and cigarettes they make.

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Parenting — the right strokes

Parenting is a happy experience. But for parents these days, it is fraught with travails and tensions, what with the rapid transition from a traditional culture to a more western one. KAUSALYA SANTHANAM writes...

"IT IS the duty of the old to feel anxious about the young. And the duty of the young is to scorn the anxiety of the old," says the elderly librarian at Oxford in "The Golden Compass", the first of Philip Pullman's fascinating trilogy. A family friend, the father of two teenage daughters, quoted these lines with delight when we met him some months ago.

Parenting, as is pointed out incessantly and rather intimidatingly, these days, is not an easy road. It has always been an endless one as the

anxious years continue; one is never free of the tension and travails that being a parent means. Balanced of course by the unequalled joy that it brings. Infancy, childhood, the difficult teens, the uncertain twenties... it goes on. The turbulent relationship continues with the squabbles and the serious differences between two generations that can make the `gap' seem a chasm at times and a mere hairline crack at others.

For the urban parents of today, the rapid transition from a traditional culture to a strong western influence has brought in problems that their parents did not face. Apart from the strong consumer lifestyle in a globalised economy, the differences in attitudes and outlook between them and Generation Next embrace such a diversity of topics that walls can come up as quickly, even before you can say `Berlin' and then take as many years to demolish. Teen years begin to assume the proportions of a lifetime of pitched battles with the "You can'ts" and the "I won'ts" filling the air with the frequency of rapid fire shots. The parents-as-ogres and children-as-monsters phase seems to go on forever. Till suddenly one day, if you are fortunate, the miracle happens — it's not just truce but ceasefire and before you know it, you are friends!

Chennai, a conservative society which is registering changes at an astonishing frequency, has parents grappling with the morphing scenario — pubs, discos, the more liberal interaction between the sexes, dating. The academic scene too is fraught with tension for the parent as everyone around you seems to have a wizard for a child who can notch up scores with magical prowess minus the Potterian wand. The urge to have one of these models of academic excellence as your very own to flaunt makes the 1960s or even the 1970s parent take on Dinosaurian hues.

With achievement becoming the buzzword, parents are keen to nurture individualism and enterprise. But when the young who have the West for their model, turn to western ways, the dilemma sets in as the balance begins to totter and parents watch with panic the loss of `traditional values' — respect for elders, the scoffing of traditional clothes and the ever growing appetite for Western food as the colas and the burgers take over. Many parents are worried about behavioural problems.

"My children behave perfectly at school. But the same is lacking at home. There is a lack of respect for their grandparents," worries Priya, a mother of two. "I never indulge them but they simply cannot take rebukes. My ten-year-old takes on much more than she can handle — debates, girl guides, cycling, games — and then passes on all the tensions to me. She neglects her food and then has no energy to carry on with these activities. My children are least health conscious and live on junk food. When we were young, we did not demand variety on the menu all the time. Certain things we did not like, certain things we learnt to like. They don't allow this to happen," she frets.

"When I was a girl, I had just four sets of clothes and was quite happy. Looks were not a matter of concern while at school. But, my daughter is worried that she is not fair enough and slim enough to qualify for the now accepted norms of beauty though I think she is quite pretty," says Shaila, mother of a 14-year-old while Priya is afraid that all this attention on looks is taking her daughter's attention away from her lessons. The beauty contests and the cosmetic industries advertising

blitz have made a difference to how girls view themselves and the time spent on appearance is inordinate, they both feel.

Communication is a major problem area. "My daughter has told my husband, `whatever be the problem, don't talk to me in the early morning before I go to school, when I come back from school or at night.' Where does that leave us?" asks Shaila with a helpless smile. "You don't understand the tensions we face," is a charge that parents face all the time. Selfishness, a materialistic attitude, lack of sensitivity, not enough giving and sharing on the part of the young are other areas of anxiety. More serious are the reckless driving, addiction to alcohol and experimentation with drugs, for parents of boys. The pub culture that has begun making its presence in the city has parents fearing "we are going the `Bangalore way'." "Parents in Chennai are finding it quite difficult to deal with the changing scene," says Dr. Vijay Nagaswami, psychotherapist and relationships consultant. "Parents have always found their role tough but now they are talking more openly about the problems they face. Workshops are now being held in the city for parents, such as the one organised by the voluntary organisation Nalanda Way recently, on how to deal with a changing world."

The key to good parenting is to bond and spend time with the child from the infant stage and later share your thoughts with him/her and become a trusted friend even in the pre-adolescent stage. The focus, he says should be to share and not find out. "We place too much of a premium on education and not vocation. If a child wants to be a DJ, he should have the freedom to become one. These are legitimate career options, not just engineering or medicine. Unfortunately, we don't follow the West in the right areas such as freedom of choice and dignity of jobs."

The therapist says he comes across more single parents now than before. But Chennai, `the reluctant metro', has still not become impersonal; it offers more back-ups and family support for single parents than perhaps any other metro. Adolescent sexuality is not a new phenomenon, says the specialist. It's just that now it's much more open. "When kids are pushed on all sides, they are on the look out for an escape, a completely different lifestyle which makes them experiment with sexuality as well." As for the pubs here, "they are very different from those in the West," he points out. Many youngsters go there to be seen more than anything else. Alcohol is a different matter altogether as some youngsters may get hooked on to it. But for most, pub and disco hopping is just a phase in their lives and if they are focussed on a career, they will not spend too much time on it. It is only when children don't have a trusting relationship with their parents they will keep their world away from them.

"We have to give our children basic values which are never outmoded such as pursuit of excellence, honesty, integrity and the need to be forgiving and caring. Then things will work out well."

Sociologist Prema Rajagopalan feels that parents have to modify their approach to parenting. "Seventy per cent of the parenting problems are caused by the parents — they are driven by external pressures and don't know what they want." There are changes internally within the family structure such as the break up of the joint family and there are external pressures such as globalisation. "We are not going either the Indian way or the Western way. We give our children freedom but expect something in return. And Indian society has not got out of

kinship ties. We are constantly worried about what our relatives, friends and acquaintances will say to what our children wear and whom they are out with. Parents have to make their choices. Every family has its rules and you should instil these in children. If you reason with the young, they understand. You have to be firm. One of my colleagues cut off the cable TV connection when his child spent too much time in front of the set."

She feels many of the problems are caused because parents act according to convenience — allowing their children freedom when it suits them and restricting at other times. Thrusting your ambitions on the children and fulfilling your unrealised dreams through them is very unfair. In the joint family system, the child received a lot of love and less attention, now the child gets a lot of attention and less love as parents don't accept the child for what he/she is but try to groom the child according to what they want. Building up trust and giving freedom with responsibility will work fine, she feels.

"The youngster is stuck between the authority of parents and teachers on the one hand and peer pressure on the other," says psychiatrist Dr. N. Rangarajan. "During adolescence, the child is trying to find his own identity. If authority is too demanding and the peer group is accepting, he settles in. The parent, however, wants an extension of himself and his beliefs are driven by society. He wants his identity to be defined by the fact that his son is in the IIT or in the U.S. If the child can't measure up, he begins to feel inferior and a sort of ganglord supremacy sometimes sets in and this can result in delinquency. Disrespect for the grandparents can arise from the fact that they are often more conservative than the parent and the youngster is rude in order to reduce interaction with them."

There is, however, nothing like total freedom for anyone, he underlines, and a child is answerable to his parents. The level of freedom can be reached through an interactive process between parent and offspring. One can't blame parents alone if something goes awry. Parents, teachers and children are all involved in the process of a child's development and growth of personality.

Parents are of different kinds — the autocratic, the overindulgent, the neglectful and the democratic one. The last, of course, is the best, says counsellor and special educator, Usha Ramakrishnan. He/she lays down laws, has certain controls, explains them and lets the child develop his own personality. The ineffective parent is one who does not carry out the threats and the child does not take him seriously and so continues in the same vein. Each child has a different emotional intelligence level and should be handled accordingly. Some youngsters are naturally good at taking care of themselves and handling others while others just can't. "We give children negative strokes and we tell them what not to do. Every parent thinks what he/she does is best; we don't sit back and think. When children receive emotional warmth, they get strength and are able to take stress. The emotional warmth begins with touch and bonding at which Indians are very poor."

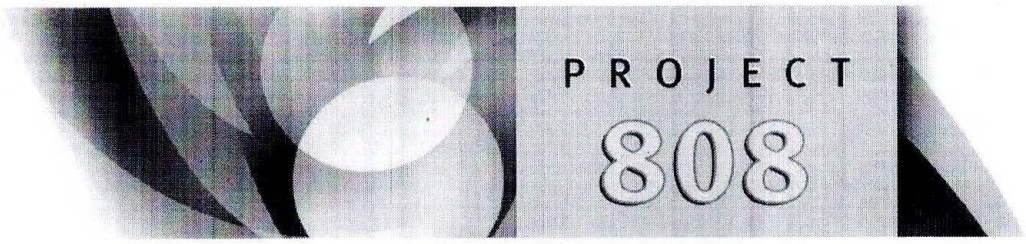
The first few years are critical and one can't correct mistakes in parenting later, is what all the experts stress time and again. Just as it is important to embrace your children tightly when they are young, it is also very important to know when to let go when your grasp is suffocating, says Dr. Nagaswami.

Many parents tend to cling on and this can sour a relationship. When the child is ready to fly, parents who are not obsessed with fears of the empty nest, help him replicate the happy home he has left behind and use their parenting as a model for his own.

The network

THE NETWORK for Information in Parenting (NIP) was created in Tamil Nadu in 1999 by the Bala Mandir Research Foundation, which is NIP's Secretariat, as a response to the growing concern for the need to address early childhood care and development through effective parenting at home and through institutions.

The NIP is an organisation of like-minded individuals and institutions committed to parenting and creating the right environment for the development of children in the rural and urban areas and to promote child-rearing practices with special focus on children below six years. "The major intent is to demystify parenting. The activities inspired by the Hincks Dellchrist Children's Centre in Canada in the U.S. were conducted with the help of the UNICEF. The Tamil Nadu Government had been very helpful and the programme has proved useful. We are now involved in 30,000 anganwadis," says Maya Gaitonde, who represents the Secretariat. "We are also working with schools. The Learning Through Play Material is available in Tamil, Kannada, Hindi, Bengali and Telugu, and is unique as it uses simple pictures to communicate. Contact address: Bala Mandir Research Foundation, 126, G.N.Chetty Road, T.Nagar, ph:28214252.



Preface

The use and abuse of alcohol, cannabis, opium and other drugs has a relatively long history in India. In the last two decades, with the introduction of heroin, the problem has acquired new and alarming dimensions. Today, India is not only an acknowledged transit country but also has a significant drug consumer population. It is clear that India faces a serious problem of drug abuse, and remedial measures are urgently required.

Drug abuse ravages society in innumerable ways. It affects people in their most productive age groups. It imposes an unimaginable burden on families and often destroys them. It has a serious impact on public health. Drug abuse is a recognised risk factor in the spread of HIV/AIDS. There is a well-established relationship between drugs and crime.

Problems in the community are often reflected at the workplace. Workplaces can be seriously impacted by substance (alcohol and drug) abuse, through accidents, absenteeism, workplace violence and health related problems. Preventive measures against substance abuse and planned assistance for troubled employees not only keep such problems in check, but in the long run also improve productivity.

Responses to drug demand reduction need to take into account factors initiating and maintaining drug abuse. Problems relating to substance abuse may arise as a consequence of personal, family or social factors, or from certain work situations. As it is often a combination of these factors, multiple approaches to prevention, assistance, treatment and rehabilitation are required.

India has been cognisant of the growing problem of substance use and several agencies, both governmental and non-governmental are engaged in prevention and treatment activities. Encouraged by the sub-regional experience on community drug rehabilitation garnered between 1990 and 1992, a new project, AD/IND/94/808 titled **"Developing Community Drug Rehabilitation and Workplace Prevention Programmes"** was developed. This project was financed by the United Nations Drug Control Programme (UNDCP), with funds provided by the European Commission (EC), with the International Labour Organization (ILO) as the executing agency and the Ministry of Social Justice and Empowerment (MSJE) as the implementing agency. The project was based on the ILO Reference Model, which was used and adapted in the earlier projects.

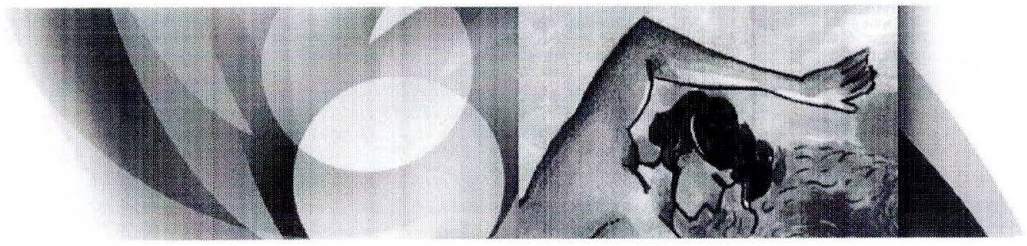
The 808 Project titled "Developing Community Drug Rehabilitation and Workplace Prevention Programmes" focused on training and manpower development, development of community based rehabilitation programmes with a focus on Whole Person Recovery, and workplace prevention programmes. The project demonstrated the flexibility and adaptability of the ILO model of community-based rehabilitation in different regions and cultural settings within India. Human resource development formed the backbone of this project.

The project provided a good example of partnership between the non-governmental organisations (NGOs), governmental and international agencies. It also created another form of partnership, which facilitates interaction and collaboration between employers and workers, between enterprises and NGOs offering drug demand reduction services as well as between respective organisations and the community, in addressing issues related to substance abuse. The Association of Resource Managers against Alcohol and Drug Abuse (ARMADA) was a result of such a partnership, and will attempt to continue the successful collaboration built up during the project.

The project has made a significant impact both at regional and national levels. The gains achieved in this project need to be maintained and strengthened in order to achieve its long-term objective – the reduction of substance abuse and its adverse consequences through effective community and workplace initiatives in a coherent national strategy to combat substance abuse related problems in India .

This monograph presents two key experiences. The experiences of drug treatment and rehabilitation centres throughout the country in implementing community based drug rehabilitation, and that of workplace prevention programmes implemented in diverse work settings. Both these projects were based on the ILO model for community based drug rehabilitation and workplace prevention. It emphasises the need for development of integrated services for persons with addiction, a shift in focus to prevention, and for the development of effective partnerships to deal with the complex problems caused by drug and alcohol abuse in society.

Ministry of Social Justice and Empowerment
Government of India
UNDCP Regional Office for South Asia
International Labour Organization
European Commission



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Section1

Introduction

Alcohol and drug related problems are not new in India. Over the years, however, the abuse of synthetic and semi-synthetic opiates and and psychotropic substances has replaced traditional use patterns. While alcohol is still the most widely used intoxicant in the country, heroin, cannabis, volatile solvents and pharmaceutical preparations like buprenorphine, codeine containing cough syrups and benzodiazepines are some of the other most commonly abused drugs. The South Asia Drug Demand Reduction Report (2000) represents the first major attempt to document the problem and responses to substance use (drugs and alcohol) in the region. The report acknowledges the serious resource scarcity for drug demand reduction activities and the need for Non-Governmental Organisation (NGO) involvement and external assistance for developing sustainable programmes in this area.

In India, demand reduction activities have evolved over the years. The initial interventions in the 1950's and 1960's consisted predominantly of treatment of medical complications. The 1970's and 1980's saw the development of more intensive treatment services, initially hospital based, and the emergence of the non-governmental treatment sector. In the 1990's, there emerged multiple treatment approaches to address these complex problems.

Earlier Initiatives

The Ministry of Social Justice and Empowerment (MSJE) earlier known as the Ministry of Welfare, has been sponsoring NGOs working in the area of drug rehabilitation since the mid-1980s. The focus of these MSJE funded interventions was predominantly on counselling and medical treatment of severe addictions. They focused largely on clients during their stay in the rehabilitation centres. The follow-up was poor, and focus on important aspects such as social re-integration, occupational stability, and maintenance of recovery received scant attention. Recovery was thus incomplete and relapse rates were high. The need to develop a comprehensive programme to deal more effectively with addiction related problems, the need to reach the community rather than wait for the addicts to reach the treatment centres, and to improve the quality of recovery was felt.

Intersectoral Partnerships to Tackle Drug and Alcohol Problems–Pilot Projects

The Ministry of Social Justice and Empowerment has long perceived the need for a coherent national strategy to deal with substance abuse. While several agencies (both in government and in the voluntary sector) dealing with welfare, health, education, labour have long been cognisant of the problems related to substance use, it is inter-sectoral partnerships between organisations that have led to a forward movement in the area of treatment and rehabilitation.

Two demonstration projects carried out between 1989 and 1992 involved such inter-sectoral collaboration between the International Labour Organization (ILO), the European Commission (EC), the MSJE and four Delhi based NGOs. The first project titled 'Prevention and Assistance Programmes for Workers with Drug and Alcohol Related Problems' focused on group training and the development of drug rehabilitation and reintegration services through a community-oriented approach. Emphasis was laid on recovering addicts being gainfully employed. This was done by introducing income generating activities that were supported by a revolving loan scheme. Outputs from this project included:

- Formulation of training curricula on addiction rehabilitation
- Training of NGO staff
- Production of a trainer's manual and practitioner's handbook on addiction rehabilitation
- Video presentation of the demonstration project to other NGOs
- Experience with rehabilitation of 1000 recovering addicts

The second project "Asian Regional Programmes for Community Drug Rehabilitation" addressed workers with drug and alcohol related problems in India, Philippines, Sri Lanka and Thailand. In India, this project was implemented by the Ministry of Labour in collaboration with employers' and workers' organisations and a number of enterprises. Six enterprises implemented prevention and assistance programmes. Over 8000 workers were reached and 400 staff members trained to assist in various aspects of workplace

initiatives to prevent and reduce drug problems. Information material was disseminated to these enterprises.

Project 808: Community Based Rehabilitation and Workplace Prevention Programme

The project '808' titled "Developing Community Drug Rehabilitation and Workplace Prevention Programmes" was the joint initiative of the ILO, United Nations Drug Control Programme (UNDCP), MSJE and the EC. It was conceived of in 1994 to last for three years, but was extended by a further two years, until December 1999, because of the overwhelming response to it.

The immediate objectives of the project were:

- To establish the capacity at the national level to mobilise community participation in developing drug rehabilitation services and workplace prevention and assistance programmes throughout India
- To introduce to, and train, key drug rehabilitation professionals and paraprofessionals in a wider spectrum of rehabilitation approaches and techniques
- To introduce, and train professionals (including NGO representatives) in developing prevention and assistance measures at the workplace as well as supportive action in the community.

Phase 1. Community Rehabilitation

This involved strengthening selected NGOs in various components of addiction rehabilitation under the ILO Reference Model (discussed in Section 2) with a focus on Whole Person Recovery (WPR). WPR seeks to make a person 'drug free, crime free and gainfully employed'. This phase included a rapid situation assessment of substance abuse problems in the identified community, the rehabilitation of identified substance abusers in that community, with an emphasis on vocational rehabilitation and aftercare. A major component included developing income generating activities and supported employment, as well as training of recovering drug users in developing effective work habits.

Phase 2. Workplace Prevention Programme (WPP)

Workplaces mirror the community, and the well being of the community and workplaces are inextricably linked. Therefore, it is imperative that initiatives to rehabilitate and prevent addiction be a joint venture between the community and the workplace.

The existing situation

At the time of initiating the ILO Workplace Prevention Programme, few companies had programmes to deal with alcohol and drug problems. Even those that existed were initiated mainly on a felt need, and focused almost entirely on employees with a serious problem of addiction. Relapse rates were high, leading to a pessimistic and rather negative attitude towards such programmes.

The objectives of the ILO model of Workplace Prevention used in Project 808 were to:

- Create and maintain a drug free environment at the workplace
- Generate an open atmosphere where substance users are able to come forward and seek assistance without risk of recrimination or personal consequences
- Lay down systems and procedures for identification, motivation and referral to treatment, of persons with substance use related problems.

The Results

The project successfully developed and established 18 community based drug rehabilitation programmes in nine cities/towns across India, where it replaced the 'medical' model with the 'community model'. The emphasis was on involving the family and community leaders in treatment. Focus was also on the inclusion of vocational rehabilitation and income-generating activities in rehabilitation, with the emphasis on Whole Person Recovery.

Coverage of the Community Based Drug Rehabilitation and Workplace Prevention Programmes:

- 18 community based drug rehabilitation programmes in nine cities/towns covering 25,000 drug users
- 411 participants trained over 12 training workshops
- 12 enterprises and 110,664 employees covered
- 1420 managers, supervisors, worker's representatives and NGO staff trained in local workshops

Twelve workplace prevention programmes were initiated in 8 cities through a partnership between selected NGOs and enterprises. Treatment and care was extended to employees with drug and alcohol problems. The main emphasis was on prevention of drug and alcohol problems at the workplace.

Several NGO staff and enterprise personnel were trained in both rehabilitation and prevention to create a large pool of resource persons. This was done through seminars, workshops, fellowships and study tours.

Attempt of this Monograph

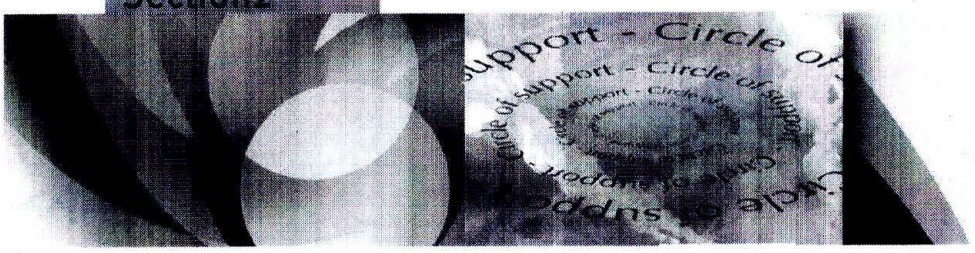
There is growing work on the extent, patterns and problems associated with drug and alcohol use in India. However, the documentation of efforts to handle such problems in a comprehensive manner is completely lacking. This monograph attempts to capture the results of such interventions across the county. It is not just a report on Project 808. It is an attempt to capture the spirit of the community and workplace programmes and the need for partnerships to address the complex problems of drugs and alcohol in our society. The monograph goes beyond numbers. It provides real life examples of who benefited and how. It narrates the success stories of enterprises that initiated the workplace programme. It describes programme formulation

and the process of setting up of comprehensive community based interventions and workplace programmes. The monograph has been based largely on the reports provided by the participating organisations, project documents, evaluation reports (appendixed as source documents) and site visits by the content providers.

Several lessons learnt from the experiences gained during this project and the limitations of some of the efforts are also shared. These rich experiences provide valuable insights for treatment providers, policy makers, administrators, trainers and researchers working towards reducing drug and alcohol related problems in the community and at the workplace.

The project "Developing Community Drug Rehabilitation and Workplace Prevention Programmes" is referred to as the Project 808, CBDR (Community Based Drug Rehabilitation) project and WPP (Workplace Prevention Programme), or simply the Project in different sections of the monograph. The term "substance" refers to both drugs and alcohol. In many of the case illustrations provided, names have been changed to protect confidentiality. A list of the main abbreviations used in this monograph is provided at the end.

Section2



The International Labour Organization Reference Model

The ILO Reference Model forms the basis for both the Community and Workplace initiatives. Some of the key concepts of the model are discussed in this section.

Addiction Rehabilitation

The United Nations (in the resource book on *Measures to Reduce Illicit Demand for Drugs*) defines Rehabilitation as "the process of helping individuals to establish a state where they are physically, psychologically, and socially capable of coping with the situations encountered, thus enabling them to take advantage of the same opportunities that are available to other people in the same age group in the society". The crucial goal of rehabilitation is re-entry, readjustment and independent functioning of the recovered substance user into society. Rehabilitation as defined by the ILO relies on the "combined and co-ordinated use of educational, social and vocational measures for training or retraining the individual to the highest level of functional ability".

Whole Person Recovery

The aim of a comprehensive treatment programme is not just to get the addicted individual off alcohol or drugs. It focuses on making the person 'drug free, crime free and gainfully employed'. The key elements of WPR include:

- Commitment to a drug and alcohol free life
- Adaptation to work and responsibility
- Social re-integration
- Personal growth and self acceptance
- Acceptance of higher values

For people striving to WPR, four factors, popularly known as the Four Keys to Change are necessary. These are:

- Practical guidance on what needs to be done
- Caring encouragement for one's efforts - a powerful "fuel" for motivating recovery
- Successful role models who have achieved the goal
- A peer learning group working together towards that goal

Self-Help

For WPR to occur, the commitment of the addicted individual to change is crucial. The power of self-help (the ideathat by helping another, we help ourselves) in recovery is well recognised. One of the best recognised self-help organisations is the Alcoholics Anonymous (AA), which was initiated in the USA in the 1930's. Several other forms of self-help groups, either led by peers (ex-users), or professionally led peer groups have served as powerful vehicles for recovery.

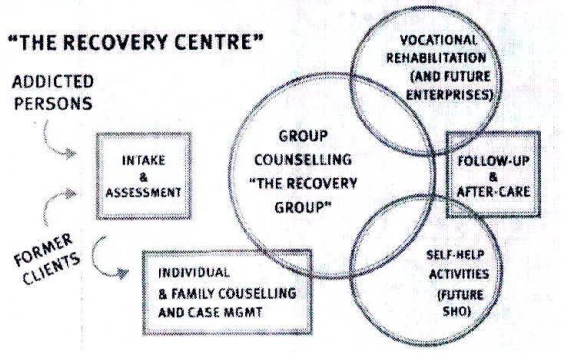
After-care

It has been well established that for recovery from addiction to be complete and the chances of relapse to be minimised, providing continuous care for the recovering person beyond institutional services is crucial. This includes fostering social re-integration, helping families support the recovering person, and ensuring the ex-user's adaptation to employment.

Partnerships

For effective treatment, rehabilitation and aftercare, there needs to be networking between different individuals, agencies and community organisations. Families of substance users, ex-users, non-governmental agencies, detoxification and treatment centres, hospitals, legal and enforcement personnel all play an important part in recovery.

THE REFERENCE MODEL PROGRAMME DESIGN



Work and Recovery

Productive work is an essential part of recovery. Addicted individuals often need help to keep or get jobs, to adapt to work more easily, to handle the demands and responsibilities of work, to get along comfortably with fellow-workers, to be accepted as trustworthy, and to be able to accept direction and authority without resentment. This is what is called Work Conditioning.

Vocational Rehabilitation refers to training/retraining the recovering addict for suitable and viable employment, selective placement, on-the-job assistance and follow-up, sensitising key employers and workers' groups to addiction as a safety and health problem, and forging relationships with community groups that have a business and employment orientation.

Where "open employment" (conventional work for an employer) is not a viable option, alternatives such as self-employment, supported work, apprenticeship, and co-operatives may be more suitable for addicted persons in recovery.

Whatever the nature of employment, work-conditioning increases the likelihood of successful vocational rehabilitation.

Developing SMART Objectives

All organisations desire to improve programme effectiveness and achieve successful results. It is important to develop SMART objectives for this. SMART objectives are:
Specific in defining programme objectives
Measurable outcomes
Attainable goals which are
Relevant and are
Time-bound.

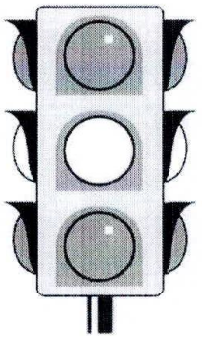
The International Labour Organization Code of Practice

The ILO Code of Practice on the management of alcohol and drug related problems at the workplace was evolved in 1995. The key points in this code of practice include the following:

- Alcohol and drug policies and programmes should promote the prevention, reduction and management of alcohol and drug related problems in the workplace
- Such problems should be considered health problems and dealt with in a non-discriminatory manner
- Assessment of the problem and evolution of a policy and programme to address issues related to alcohol and drugs needs to be a joint initiative of employers and workers
- The policy should be clear and unambiguous and apply to the entire workforce
- Job situations that contribute to alcohol and drug related problems need to be identified and appropriate preventive or remedial action taken
- Information, education and training programmes concerning alcohol and drugs should be integrated where feasible into broad-based health and safety programmes
- Principles of confidentiality and non-discrimination should be ensured to protect workers who seek assistance for such problems
- While it must be recognised that the employer has authority to discipline workers for employment-related misconduct associated with alcohol and drugs, counselling, treatment and rehabilitation should be preferred to disciplinary action

Recognising and Helping with Problems Before Addiction Sets In – The Traffic Lights Model

While addiction is a chronic and potentially relapsing condition which requires intensive treatment, it is increasingly recognised that risky (e.g. drunken driving, intravenous drug use) and regular patterns of drug and alcohol use are associated with major public health, social and workplace problems. In the context of workplace prevention of substance use, the ILO uses the traffic light analogy to categorise levels of drinking and drug use. Using this analogy, persons can be categorised under three zones: the green, amber and red.



The "traffic light" representation of the drug and alcohol problem at the workplace is simple and attractive. Persons with an addiction to substances or serious problems associated with it are categorised as being in the "red" zone, those at risk to develop problems related to use are in the "amber" zone, and those with no problems are in the "green zone". The philosophy of the ILO approach is to keep the 'greens green', shift the amber to the green and the red to green or amber. The ILO model thus shifts the focus from the red zone to green and amber zone interventions. It seeks to develop a comprehensive approach to the problem at the workplace. It speaks a language comfortable to employees and management, fosters collaborations with other agencies, focuses on policy development and guidelines as a key activity, and allows flexibility in approaches. These strengths help companies to readily accept the model.

Workplace Programmes Towards Prevention - A Paradigm Shift

Traditional workplace substance abuse programmes focused almost exclusively on providing assistance to a few workers in the red zone. A shift to a prevention programme expands the focus to the entire workforce, with an emphasis on workers in the green and amber zones. It also focuses on "life-style" changes by developing lifestyles that promote healthy living, and replace substance use with healthy alternatives.

Management Led Programmes

Substance abuse prevention programmes should be the responsibility of the management, with the focus on performance, which is a management issue. A comprehensive workplace programme on substance abuse should be integrated into management strategies, such as occupational safety and heath, to ensure long term sustainability.

Workplace Policy

For a successful programme, a written policy setting out the objectives and goals of the programme, its structure and elements, coverage, roles and responsibilities should be formulated. Guidelines must be available for training, counselling, assistance and treatment referral, testing, and consequences of policy violation.

Total Staff Involvement

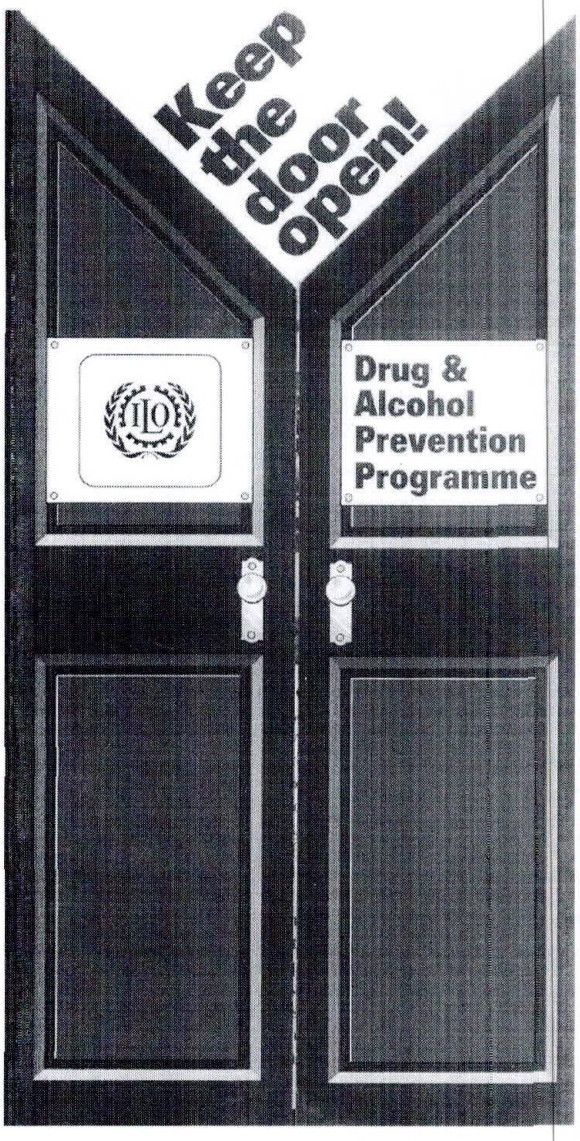
At all levels of programme planning, policy formulation and programme implementation, involvement of both management and employee representatives is vital for programme sustainability. Various levels of staff need to be sensitised and trained in the programme's objectives.

Going Beyond the Workplace

A successful workplace prevention programme ensures the involvement and well being of the worker beyond the factory gates, both at home and in the community. It also involves actively developing community and family linkages.

Ensuring Programme Sustainability

The support of the top management, availability of resources for the programme, regular programme evaluation, and integration



of the programme into ongoing programmes of health, welfare, occupational safety, security or human resources can strengthen programme sustainability. Networking with local and regional agencies for support to the programme, and networking across enterprises to share expertise and resources are other strategies to ensure sustainability.

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COMMUNITY DEVELOPMENT FOR HARM REDUCTION FROM DEPENDENCY TO ENPOWERME

TAPPING THE SOCIAL CAPITAL WITHIN USER NETWORKS

The field of harm reduction has generated considerable interest as a public health res aimed at reducing and containing the negative impacts of continued substance use. One p reason for the surge in interest in harm reduction was the emergence of the HIV/AIDS epi and its linkage to injecting drug use. Practitioners in the field are recognising the limitati specific strategies such as drug - substitution and needle exchange programmes. Ther need, therefore, to broaden the scope of current harm reduction strategies by incorporating systemic factors, which directly or indirectly affect the quality of life of user groups.

We need to move away from reductionist paradigms to adopting multi-causal inter ecological models, which recognise that substance use has a reciprocal relationship betwe individual and his or her social environment. Harm reduction strategies ought to be di towards strengthening the adaptive capacities of the users and their networks; enhanci supportive qualities of their social environment; and improving the relationship between the components.

The Role of Social Capital in Community Development: One way of addressing the neglected area of marginalisation of substance users, is through the deployment of partici community development methods, which have the potential of tapping the social capital o networks and enhancing their ownership in programme planning and implementation. capital is the basic fabric or the essential ingredient of communities, and is a prerequis community development processes.

Within the context of the developing world a multitude of socio-economic and health r problems impinge on marginalized population, and the depleted stocks of social capital a these groups have contributed to their relative poverty, and consequently their social excl The stigmatisation of the drug problem along with the mental health consequence of prol substance use often results in depleting the already scare resource of social capital with group of heterogeneous dependent users. How then do we, as harm reductionist interv reconstruct social capital amongst deprived networks of substance users?

Biography: I have been working in the area of substance use since 1984 in New Del Mumbai, India. My focus has been on developing an integrated community based progr which is accessible to both substance users and marginalized people. Set up an governmental agency in 1987 called Mukti Sadan Foundation which has its base in two biggest slum communities of Asia, Jogeshwari and Dharavi. Felt the need to include eco rehabilitation programme such as an engineering and fabrication factory for user marginalized youth in collaboration with UNESCO and DOH, Germany in 1999. Currentl holding the position of Executive Director of Mukti Sadan Foundation.

Professionally I am a trained Medical and Psychiatric Social Worker. I received my M Degree and my M.Phil degree in Social Work from the Tata Institute of Social Sciences, M Currently I am in the process of completing my Doctoral Programme from the Tata Instit Social Sciences. My area of interest has been the role of social systems in process of ad

and recovery from substance use. Developing qualitative research methods in understandin seeking behaviour of substance users and network analysis has been another area of inter me.

Currently I am working as the National Coordinator for the UNDCP for a study on drug amongst women in India. This has been a major area of interest since 1991 when I worke the Commonwealth Secretariat, UK, to undertake the first study on women substance us India. The second area of interest has been the development of community based approac demand reduction and harm reduction. I have worked with the WHO, UN/ESCAP an European Union to develop this approach for Mumbai since 1988 as temporary adviso consultant.

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The Use of Acupuncture in Drug Addiction Treatment
- by Judd R. Spray and Sharon M. Jones

Alternative medicine in the United States is a billion-dollar industry. A 1993 study published i New England Journal of Medicine found that the American public spent almost as much pocket money on alternative medicine in 1990 ($10.3 billion) as they did on hospitaliz ($12.8 billion). In fact, the study estimated that people made more visits to unconventional th providers (425 million) than they did to primary care physicians (388 million) Viewed skepticism by some, and virtually unknown to many, alternative medical techniques de serious attention

Acupuncture, now one of the most popular forms of alternative medicine, was virtually unkno the United States until recently. In 1971, James Reston, one of the New York Times' respected journalists, was traveling in China when he was stricken with acute appendiciti subsequent article on the use of acupuncture as an anesthetic turned his misfortune int spark of much Western interest in acupuncture and other Chinese medicines.

Serious medical research and experimentation with the healing powers of acupuncture has the discovery of a highly promising weapon in the fight against chemical dependency. T there is a consensus in the medical community that more reliable scientific data on the s need to be collected, anecdotal evidence and clinical success stories strongly sugges acupuncture can alleviate many of the serious symptoms of withdrawal, thus facili detoxification and encouraging acute addicts to continue treatment.

Recent enthusiasm for acupuncture treatment has encouraged some detoxification clini incorporate it into their programs. Court systems in several major cities have created courts," in which a program of intensive counseling and treatment, sometimes incl acupuncture, is substituted for traditional prosecution. The need for more effective approac dealing with repeat drug offenders, combined with the relatively low cost of maintaining clie drug court programs, makes some law enforcement officials hopeful that acupuncture will effective part of the solution for addicts who find the lure of substance abuse more powerfu the threat of incarceration.

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Cyber Lectures

MEDICAL ACUPUNCTURE

DR VINAY VARMA

ACUPUNCTURE IN MODERN MEDICINE Acupuncture is an important prestigious heritage of Chinese people. Traditional Chinese medicine which includes acupuncture has been largely integrated with Western medicine in China. Patients entering hospitals and clinics may opt, if they wish, for the whole spectrum of antibiotics or other modern drugs, OR they may prefer to take the door that leads to the traditional Acupuncture department. Western or Chinese, who do we discuss medicines in such isolated and culturally relative terms, while disciplines like mathematics and physics know no such boundaries. Since traditional & Western medicines have the same object to cure and help suffering humanity. They should not have to compete but rather compete but rather complement each other for the ultimate good of the patient. For the patient whose only wish is to get well as quickly as possible, without any harmful effects, this is all that matters for the patient.

Considerable controversy has surrounded Acupuncture, on the one hand extravagant claims have been made for its efficacy while, on the other hand, it has been criticized for its lack of Scientific standing. There are fake training centers, fake acupuncturists. Unfortunately, every profession has its incompetents, quacks & confidence tricksters. Acupuncture practitioners may have more than their fair share of these because there is no agreed standard of training which must be reached before one may practice acupuncture.

So what is a Scientific method ? At the close of the last century, T. H. Huxlay defined science as "organized common sense " and the method of organization came to be known as " Scientific method " The scientific method consist of observations inference and experiment, followed by the formulation of hypothesis, theories and laws which in turn are subject to verification or otherwise by further experiments. Acupuncture was born from keen observations of clinical facts. Aldous Huxley states that a needle stuck into one's foot should improve the headache or functioning of one's liver is obviously incredible, it can not be believed because, in terms of currently accepted

physiological theory it makes no sense. Within our system of explanation there is no reason why the needle prick should be followed by an improvement of headache or liver function. Therefore, we say it can't happen. The only trouble with this argument is that, as a matter of empirical fact, it does happen, inserted at precisely the right point, the needle in the foot regularly affects the function of liver, or improves the headache. What should we do about events which by all the rules, ought not to occur, but which nevertheless occur ? Two course are open to us, we can either shut our eyes with the hope that, if we don't look at them, they will go away and leave us in peace or alternatively we can accept them – accept them for time being as inexplicable anomalies and confirm, that is what I have done.

It is believed that acupuncture developed in both India and China, independently of each other. If we go back to the Indian medical classics, known as Vedas, said to have been written about 7000 years ago, we find "needle therapy" mentioned there. The oldest known Chinese book on acupuncture, Nei Ching, did not appear before fourth century before Christ and historical data indicate that the Nei Ching was probably written around the second or Third century B. C. One volume of the Vedas, known as Suchi Veda, translated as the "art of piercing with a needle," was written approximately 3,000 years ago and deals entirely with acupuncture, and described 180 points known as "MARMA", which are said to heal or kill. The whole knowledge of Shalya Chikitsa or acupuncture is arranged in an orderly manner in eight volumes of the famous ancient CLASSIC SUSHRUTA SANHITA. Nevertheless, one cannot argue the fact that the

acupuncture was more developed by the Chinese than the Indians, and presented to the World in a more complete fashion. So, WHAT IS ACUPUNCTURE ? The word Acupuncture is derived from Latin. In Latin, acus = needle, pungra = to prick, to prick a needle for treatment is acupuncture. The combination of acupuncture and moxibustion is known in Chinese as Chen Chiu [needle & heat therapy.] Acupuncture treatment is usually carried out by inserting very fine needles at acupuncture points. Acupuncture point means a specific spot on the body surface where needling is done to get particular therapeutic response. The practice of cauterizing a part of the ear or body with a hot metal probe is very common in rural India and many Asian countries even today, is nothing but rudimentary form of acupuncture. The Eskimos of instance, are still using sharpened stones for treating their illnesses. The Bantus of South Africa scratch certain areas of their skin to ally the symptoms of many illnesses, while in Brazil there is a tribe whose method of treating illnesses is to shoot tiny arrows from a blow pipe on to a specific areas on the surface. Karate, the martial art of unarmed combat from Japan is yet another variation of acupuncture. Moxibustion represents a special form of point stimulation and involves burning pieces of drug plants generally the moxa leaf, either on needle so as to conduct heat into the body, or in some cases actually on the surface of the skin directly or indirectly by using some kind of barriers like ginger of garlic slices.

MECHANISMS OF ACUPUNCTURE Acupuncture is not a drug, it is a complete science OR healing system by it self, having several effects to regulate the function of the human body and to increase its resistance by enhancing the immune system and the anti-inflammatory, analgesic, anti-spastic, anti-shock and anti-paralytic abilities of the body. So, Acupuncture effects can not be explained by single theory. Nor is acupuncture simply a trigger for releasing endorphins to create a temporary anesthetic effect by blocking nerves that transmit pain message, as currently maintained in medical circles. It is far more than that. Originally, the theory of Acupuncture is based upon an ancient Chinese concept of (w) holism. This concept views human beings not only in relation to our own integral totality of body mind, and spirit, but also as microcosmic expressions of a universe whose characteristics are inherent in every organism & in every process. Health is viewed as the maintenance of harmony between ourselves and this universe while illness in an expression of disharmony. The most fundamental biologic expression of the relative balance or imbalance of that primordial energy which the Chinese called Qi (pronounced Chi). A free and balanced flow of Qi in the body expresses harmony and health while a blockage of this energy indicates illness. Qi travels along certain pathways called meridians. There are TWELVE PAIRED & TWO UNPAIRED meridians, named pertaining to particular organ. Acupuncture points and meridians have been demonstrated in 1933 by a special technique called by Kirlian Photography (Kirlian & Kirlian of USSR and it was confirmed that acupuncture points have low electrical resistance than surrounding skin surface. Gunn & associates have correlated the acupuncture points with points of accepted anatomical structures. Most of acupuncture points correspond to motor points of muscles.

YIN & YANG THEORY, THEORY OF FIVE ELEMENTS, ORGAN CLOCK and many more traditional theories not only explain Chinese Philosophy but dictates the rules to practice the art of acupuncture. These theories are difficulty to digest by others who are trained in so called Modern Medicine. But some of these are getting proved to very close to Modern Medicine, for example ORGAN CLOCK & CIRCADIAN RHYTHM .

Research based on Modern Medicine started in & outside China, only after Mr. Nixon's visit to China 1971. Recent research for a mechanism of acupuncture has primarily focused on analgesic effect of Acupuncture. Analgesic effects of acupuncture may be explained by GATE CONTROL THEORY OF RONALD MELZACK and P D WALL, LONDON (1965). This theory believes that all pain impulses are controlled, modulated and modified by means of a functional gate which is located in the substantia gelatinosa of the spinal cord, and at higher levels. Normally pain impulses are conducted by small diameter fibres (delta & C fibres) at the speed of 1-2 m/ sec, inhibit substantia gelatinosa cells in turn reduces its inhibition over firing of T cells to higher levels and thus pain impulses are allowed to pass and pain is felt. Non-noxious impulses of acupuncture conducted by large diameter fibres (a beta fibres) at the speed of 120 m/ sec. activates substantia gelatinosa which in turn inhibits, firing of T cells and thus no impulses are allowed to pass and thus gate is closed and pain is not experienced even though pain impulses can travel up to the level of spinal cord. This theory fails to explain analgesic effect above spinal cord level and modified theories like "Two Gate Theory" and "Four Gate Theory" have been but forward.

Dr. Bruce Pomeranz, Prof. Of Neurobiology of Toronto University and his co-worker suggest that the naturally occurring endorphin play a prominent part. Acupuncture analgesia can be explained to a large extent as being due to the release of a hormone called "Endorphine" during Acupuncture needling.

Endorphine is a naturally occurring neuropeptide having a chain of 31 amino-acids and like morphine and other opiates it has a propensity of binding on to the opiate receptors of pain cells in the brain. The present evidence suggest that, acupuncture stimulation results in a message to the brain causing release of Endorphine from the pituitary gland and mid brain raphe system Experimentally it has shown that ablation of the pituitary gland & likewise injection of Nalorphine which is a morphine antagonist annuls acupuncture analgesia. Endorphine takes some time to get release from the pituitary and this may be the reason for there being an induction period which has to elapse before an operation can commence under acupuncture analgesia. Chemical Or Humoral mechanisms are also involved in Acupuncture. For instance, if rabbit is acupunctured its pain threshold is found to rise, & if the blood from this animal is then circulated into a non-acupunctured rabbit, the pain threshold of the second animal also raises, like wise perfusion of spinal fluid from Acupunctured to non-acupunctured animal results in a similar effect showing that chemical transmitters are definitely involved in the mechanism of acupuncture. Many acupuncture points have specific effects on insertion of needles. For instance 1. ZUSANLI (St. 36) needling at this point, Phagocytosis of staphylococcus Aureus by the leucocytes increases by one to two times even in case of healthy persons. Rise in the phagocytic index from 1.74 to 3.97 and rise in the Phagocytic power from 48.2 to 71.5% have been registered on the second day after acupuncture. 2. A two to eight fold increase in antibody titre, rise in gamma-globulin a specific immunoglobulins after needling at Quchi (L. I. 11.) and Sanyinjiao (Sp. 6) have been reported.

The last of the theories on acupuncture is that of Bio-electrical phenomenon. This theory suggests that Western medicine deals with body chemistry , the principles of working in acupuncture have to do with body physics. In 1973 at Yale University School of Medicine Burr and Associated confirmed that all living things have electrodynamics fields which can be mapped out with fine voltmeters. These fields vary with physical and mental conditions and thus may be used in diagnosing and treating a variety of disorders.,

CLASSIFICATION: Acupuncture may be classified as 1) Symptomatic acupuncture 2) Classical or Traditional acupuncture 3) Acupuncture Anesthesia. It may be further sub divided into (a) Body Acupuncture (b) Ear Acupuncture (c) Scalp Acupuncture

Symptomatic acupuncture is mainly practiced by BARE FOOT DOCTORS as first line symptomatic treatment for non specific short lived illness in rural setup. Classical Acupuncture is based on (W) Holistic Approach. Total person is evaluated before treatment, regardless of the particular treatment. Acupuncture does not treat named disease but rather the cause of the disease because symptoms are just signals of a problem in the body. Although acupuncture's effects are not permanent in treatments for analgesia and some pain disorders but they are long lasting. They are permanent when treating disorders from deafness to sterility. Acupuncture Anesthesia is one of the most impressive developments of Chinese medicines. It was in 1958, that the foundations of Modern Acupuncture Anesthesia were laid by first operation under acupuncture anesthesia at Shanghai and it was a tonsillectomy. The term 'acupuncture' anesthesia 'is really a misnomer. Although pain impulses are cut off by raising the pain threshold, other sensations like temperature, balance and vibration sense are found to remain intact. Hence it would be more accurate to use the term 'Acupuncture Analgesia' Advantages: 1) It is absolutely safe, non-toxic and free from adverse effects like over dosage, side-effects of drugs and hypersensitivity reaction. 2) There are no major disturbance of physiological functions under acupuncture anesthesia. 3) Hemorrhage too is very much less, and blood transfusion is less often needed. 4) Post – operative complications are much less as compared with general anesthesia. 5) Analgesia continues for several hours after the operation and consequently post-operative pain is very much reduced. 6) Post-operative nausea, vomiting and respiratory complications are absent. 7) Dehydration, electrolyte imbalance and post-operative debility are circumvented because the patient can eat or drink immediately after and even during surgery. 8) Acupuncture anesthesia is simple safe effective and economical. Like any other innovative procedure acupuncture anesthesia too has certain limitations and unsolved problems. While pain threshold is greatly elevated, it may not be always one hundred percent complete, and some patients may still experience varying degrees of pain during certain stages of an operation. In abdominal operations, difficulty is sometimes encountered owing to inadequate muscular relaxation and discomfort from traction on the viscera. So, in recent years ACUPUNCTURE ASSISTED ANESTHESIA is preferred in western countries. Acupuncture anesthesia (analgesia) has been tried in over 100 different types of operations in over 2 million cases with success rate of about 90% in China. Generally, it is thought to be more effective in head, neck and chest surgery. In India too, few major surgical operation are performed under acupuncture analgesia and results are encouraging. Medical acupuncture is relatively recent terminology i.e. acupuncture approach most commonly integrated by physicians into conventional medical practice

INDICATIONS: Theoretically it is possible to help or cure by acupuncture any disease that can be affected by a physiological process. So, acupuncture can be used in many conditions. The W. H. O. at the Interregional Seminar, Beijing 1979, drew up the following provisional list of disorders that lend themselves to acupuncture treatment. The list is based on clinical experience { and not necessarily based on controlled clinical research }. Upper Respiratory Tract: Acute sinusitis Acute rhinitis Common cold Acute tonsillitis Respiratory System: Acute bronchitis Bronchial asthma (most effective in children and in patients without complication disease) Disorders of the Eye: Acute conjunctivitis Central retinitis Myopia (in children) Cataract (without complications) Disorders of the mouth: Toothache, post-extraction pain Gingivitis Acute and chronic pharyngitis Gastro intestinal Disorders: Spasm of the oesophagus and cardia Hiccough Gastroptosis Acute and chronic gastritis Gastric hyperacidity Chronic duodenal ulcer (pain relief) Acute and chronic colitis Acute bacilliary dysentery Constipation Diarrhoea Paralytic ileus Neurological & Musculo-skeletal Disorders: Headache and migraine Trigeminal neuralgia Facial palsy (within three to six months) Meniers's disease Neurogenic bladder dysfunction Nocturnal enuresis Interconstal neuralgia Cervicobrachial syndrome Frozen shoulder, tennis elbow Sciatica, Low-back pain Osteo-arthritis

The only criticism is that this list was drawn up by a panel of Western qualified clinicians. It would have been more gracious of the W. H. O to have allowed and have this list of disorder set out in their traditional equivalents as well, in listing these disorders. This list has many drawbacks and is not acceptable to all. In ancient times, even disease like tuberculosis, malaria etc had been treated by acupuncture. But now it is proved that in these disease acupuncture cannot play the key role and effective medicines have been found. One should remember that acupuncture is neither panacea for the disease not it is alternative to modern medicine. There is nothing like alternative medicine. However a cure depends upon how well the cause of the disease is understood and in consequences to what extent it can be eliminated and Acupuncture should be used were it can give better & long lasting results compare to modern medicine. One should know the limitations of Acupuncture first. Acupuncture will never replace conventional medical treatment. As we learn more about it, the possibilities of using acupuncture alongside 'orthodox' medicine will increase. Acupuncture should be practiced as a BRANCH OF MEDICINE Acupuncture is highly effective in management of musculoskeletal & neuropathic pains by virtue of its well know analgesic effects, cervical spondylosis low back ache, sciatica, arthritis, trigeminal neuralgia, migraine, pain of secondary cancer (course of cancer cannot be influenced by acupuncture at present) or any acute or chronic painful condition. Results are long lasting without side effects which is the main advantage over modern medicine in case of chronic pains. All most all non-progressive paralytic conditions respond well to acupuncture treatment. Acupuncture " HASTENS" the speed of natural recovery and should be combined with rehabilitation & physiotherapy techniques to improve quality of life. Respiratory ailments potentially accessible to acupuncture intervention include allergic rhinitis, sinusitis, and bronchitis. Gastrointestinal ailments include gastritis, irritable bowel syndrome, hepatitis, and hemorrhoids. Gynecological problems include dysmenorrhea and infertility. Genitourinary problems include irritable bladder, prostatitis, male infertility, and some forms of impotence. In ophthalmology so called incurable eye conditions like optic atrophy retinitis pigmentosa, high myopia, skin disorders vitiligo, psoriasis etc. Acupuncture, particularly when applied to the external ear, has proven valuable for managing substance abuse problems and reducing prescriptions for narcotic analgesics. One of the most socially visible for acupuncture, this application has gained the respect of rehabilitation programs internationally. For mental and emotional disturbances, acupuncture can be useful as a transient aid in early and acute emotional states such as anxiety, excitability, worry, early stages of depression, and fearful states In malignancies, acupuncture can be considered as an additional therapy to combat the secondary effects of conventional therapy, and as an adjunct in pain management. Off late, acupuncture is indicated by N I H, USA to alleviate side effects of anti malignancy drugs like resistant nausea & vomiting. In recent years, people with HIV have been using acupuncture to enhance the immune system and reduce pain, to manage HIV-related disorders and symptoms and the side effects of anti-retroviral therapy , to help in the process of recovery from drug and alcohol addiction, and to cope with stress and emotional disorders.

COMPLICATIONS: Complications of acupuncture (acupuncture accidents) can occur from improper technique, lack of skill, or failure to observe certain guidelines and are very much PREVENTABLE 1. PAIN on insertion of the needle may be because of a) Bad acupuncturist b) Bad needle c) Bad posture d) Bad patient 2. BLEEDING sometimes occurs on withdrawal of the needle. This may be considered a benign complication 3. FAINTING – uncommon as with any injection 4. THE FORGOTTEN NEEDLE – therapist may forget to remove the needle after treatment 5. BENT, BROKEN OR STUCK NEEDLE 6. INFECTION – if needles are not sterilized properly. PERSONAL SET of needles are used to take away the fear of AIDS/ HEPATITIS B 7. INJURY TO INTERNAL ORGANS OR VITAL STRUCTURES 8. OVER CORRECTION OF CERTAIN PHYSIOLOGICAL PARAMETERS, especially if the patient is also on drug therapy or

associated with hypertension / diabetes 9. COMPLICATION FROM ELECTRO – ACUPUNCTURE 10. ADDICTION TO ACUPUNCTURE 11. ABORTION certain points in first trimester may induce abortion

RECENT DEVELOPMENTS Electro – Acupuncture, Transcutaneous Electrical Nerve Stimulation (T E N S) Sono – Acupuncture, Laser Acupuncture And Homeo – Acupuncture

THE W. H. O. VIEW POINT OF ACUPUNCTURE v Acupuncture should be integrated with western medicine and included in the medical curricula v Acupuncture analgesia is a "VALUABLE ADDITION" to the therapeutic armory of the QUALIFIED ANESTHETIST. A western – trained physician may require no more than THREE MONTHS TRAINING to learn the technique in theory and practice v Special programs might be organized to reverse the unfavorable at attitudes of medical professionals and to educate the general public about the safety of the procedure, its indications and its limitations

ACUPUNCTURE AS TODAY In CHINA, 800 DISEASES are being treated with ACUPUNCTURE THERAPY and at least in 140 countries in the world. Many prestigious hospitals, universities, and medical schools around the world have now established departments for acupuncture research, therapy and analgesia. The Karolinska Institute, Stockholm, Sweden for instance, the Ivory tower which awards Nobel Prizes annually in Western medicine and allied science, has established a Pain Clinic with Acupuncture since 1982. SRI LANKA – Best training Centre outside China having separate Minister for Traditional Medicines & Acupuncture. US Government – opened the office of Alternative Medicine at the National Institute of Health and found Acupuncture can help relieve the nausea caused by chemotherapy in addition to analgesia. The FDA approved Acupuncture needles for use by licensed practitioners in 1996 BMJ 2000;321:11 (1 July) issue news is that Acupuncture wins BMA approval and according to Mark Silvert, BMJ, Acupuncture should become more widely available on the NHS and family doctors should be trained in some of its techniques, a BMA inquiry has concluded. The therapy has proved effective in treating back and dental pain, nausea and vomiting, and migraine, the BMA's Board of Science and Education has found after a two year study

ACUPUNCTURE IN INDIA v There is mushrooming of fake acupuncturist because of lack of proper institutions v Dr. B. K. Basu Memorial Research & Training Institute , Calcutta Recognized By W. B. Govt – 1996 v Three Govt. Clinics in Calcutta: ONE MONTH TRAINING: Medical Officers of Bankura, Hoogly & Nadia Dist. v Dr. Kotnis Acupuncture Medical College, LUDHIANA, Punjab v P. G. I. Chandigarh, few Hospitals in Delhi, Nanavati Hospital, Bombay Port Trust Hospital, G. T. Hospital & Others at Mumbai, have Acupuncture Department v S. D. M College Of Naturopathy & Yogic Science – Ujre, Acupuncture for B. N. Y. S Degree – Mangalore University. (Rajeev Gandhi University) v Many qualified Doctors are taking up Acupuncture

CONCLUSION: Evidence-based acupuncture is a simple method for no-drug pain control and should be taught in medical schools and made available to all physicians. (Evidence-based medicine (EBM) is the use of the best current evidence in making decisions about the care of individual patients) Acupuncture is one of the best of modality for treating the sick, It works, it is great, if it does not work, patient still can get his surgery done or medical line of treatment as many be the indication. The safety of a technique must be judged on its results in the hands of competent practitioner who use it properly. If this criterion is accepted, acupuncture per se must be seen as a very safe therapeutic system, whose complication are very rare and are easily avoided or rectified. It is does no good, at least it does no harm either. In conclusion it is clear that research on acupuncture will not be only significant for the health and welfare of the people but also important for the progress of medical science. As we learn more about it, the possibilities of using acupuncture alongside 'orthodox' medicine will increase When acupuncture is combined with modern medicine, the patient benefits. Combining Western medicine and Acupuncture is what DR VINAY VARMA is practicing to bring smile by relieving pains and thus ADDING LIFE TO YEARS.

TIPS: Where to go for Acupuncture Acupuncture should be practiced as a BRANCH OF MEDICINE; so go to a practitioner who is fully qualified to treat western medical conditions, as well as being fully trained in acupuncture.

For LIVE DEMONSTRATION, Or Further Details, please feel free to contact DR VINAY VARMA, Anand Polio & Pain Relief Centre, Eureka Colony, Op: SBI Zonal Office Sholapur Road, Keshwapur, HUBLI – 580023. Phone: 283977

If you want to know more about this topic, please click here

What is Rehabilitation Treatment or "rehab?"

Rehabilitation programs traditionally have the following basic elements:

Initial Evaluation
Abstinence
Learning about addiction
Group counseling
AA or other 12 step participation
Individual counseling
A family program

What will "Rehab" accomplish?

Abstinence:
In many cases it seems that as long as the substance is in the blood stream, thinking remains distorted. Often during the first days or weeks of total abstinence, we see a gradual clearing of thinking processes. This is a complex psychological and biological phenomenon, and is one of the elements that inpatient programs are able to provide by making sure the patient is fully detoxified and remains abstinent during his or her stay.

Removal Of Denial:
In some cases, when someone other than the patient, such as a parent, employer, or other authority, is convinced there is a problem, but the addict is not yet sure, voluntary attendance at a rehab program will provide enough clarification to remove this basic denial. Even those who are convinced they have a problem with substances usually don't admit to themselves or others the full extent of the addiction. Rehab uses group process to identify and help the individual to let go of these expectable forms of denial.

Removal Of Isolation:
As addictions progress, relationships deteriorate in quality. However, the bonds between fellow recovering people are widely recognized as one of the few forces powerful enough to keep recovery on track. The rehab experience, whether it is inpatient or outpatient involves in-depth sharing in a group setting. This kind of sharing creates strong interpersonal bonds among group members. These bonds help to form a support system that will be powerful enough to sustain the individual during the first months of abstinence.

"Basic Training:"
Basic training is a good way to think of the experience of rehab. Soldiers need a rapid course to give them the basic knowledge and skills they will need to fight in a war. Some kinds of learning need to be practiced so well that you can do them without thinking. In addition to the learning, trainees become physically fit, and perhaps most important, form emotional bonds that help keep up morale when the going is hard.

e.g. - Assertive Training
- Life skills training

How To Choose The Right Program

Inpatient or Outpatient?

The goals of rehabilitation can often be accomplished without necessarily "going away" to an inpatient setting. Structured outpatient treatment programs include education, group bonding, work on more subtle forms of denial, and support in maintaining abstinence. However, since the decision to go to treatment must be made for each session over a period of weeks or months, there must be a greater degree of self-motivation.

Who needs inpatient treatment?

The simplest criteria for making this decision are as follows:
Outpatient treatment requires:

1. Willingness and ability to attend sessions dilligently and regularly.
2. The ability to abstain from all mood altering substances for 48 hours at a time with support.

Those who cannot meet these criteria will probably need to be referred to an inpatient rehabilitation program.

What if the addicted person doesn't believe he or she has a problem?

External motivation is OK. Many poeple start recovery because of a push from someone else. All rehab programs are voluntary. (Historically, Rockefeller programs, which were involuntary, were not a success.) Therefore, the patient must still give his or her consent to treatment. This level of acceptance is good enough for the beginning of recovery.
For adolescents, we feel that the basic training, even if the patient clearly wants to return to drug use as soon as possible following treatment, is still worth a great deal. The education and the experience of what recovery is like may not be utilized immediately, but are likely to be valuable in the future.

What if the addicted person has been in treatment before?

It is good to get evaluation and advice about this from a professional familiar with recovery. Sometimes the individual is at a new stage of recovery, and the experience will be entirely different than before. At other times, it may be repetitious. Some programs have a specialized "relapse" track, which may be more relevant.
When we evaluate patients who have relapsed, we look at three areas:

1. Was there ever a full recovery program in place?
2. Is there a source of enabling that is preventing recovery from working?
3. Is there an internal "Stuck Point," (See Terrance Gorsky's writings) that stops the recovery process at a certain spot?

What if the problem has significant psychiatric aspects?

This is a hard question to address in general. Evaluation by a professional who specializes in substance abuse as well as mental health is particularly important. Many mental health specialists are well trained at recognizing symptoms of psychiatric problems, but may not be as knowledgable about how emotional symptoms interact with addiction. Addiction specialists may not be as sensitive to emotional problems and diagnoses. Let's take anxiety for example:

Anxiety can be a result of addiction.
Anxiety can be an accompaniment of addiction.
Anxiety can be a contributor to addiction.

If you think the person you are concerned about could be "dual diagnosis," put your energy into getting the best possible initial evaluation and treatment recommendation.
Where addiction and other psychiatric problems coexist, the options are either to focus on the addiction first, or both problems at once. It is almost never optimal to focus on emotional problems before focusing on an active addiction.

What kind of programs are available?

Freestanding Inpatient Rehabilitation
These programs live by their ability to create a life-changing experience. Many of them do amazing work in the short time they have.

Hospital Based Rehabilitation Unit
The quality depends on the particular unit and hospital. Some insurance policies may only reimburse for a unit that is part of a general hospital. Hospital based rehab units may be more able to work with patients who have complicating psychiatric or physical illness.

Hospital Detoxification Unit
Withdrawal from alcohol and sedative medication is the most dangerous, though opiate withdrawal is extremely intense. Freestanding rehab programs may do detoxification, but the hospital may have more medical backup for complicated or difficult cases. Increasingly, detoxification is being done on an outpatient basis.
Watch out for the problem of the patient who finishes the detoxification feeling better than in years, and is suddenly no longer motivated for treatment. Before entering a unit that does detoxification only, be sure that a very strong route has been established for follow up rehabilitation, either inpatient or outpatient.

Long Term Residential Program
Following rehabilitation, many individuals lack the impulse control and sober habits to successfully maintain a recovery in their community. This is especially true of young people, who have maturational work to do as well as recovery.
For these individuals, long term residential treatment may make the difference between success and failure. Professional staff in rehab programs will help evaluate the need and feasibility of long term residential treatment.
Staff in rehab programs are also a good source of up to date knowledge about the quality and services of long term residential programs.

Therapeutic Community
The term "rehab" usually refers more to programs that are associated with an AA or 12 step tradition. Therapeutic Communities have their origins with Synanon and such programs oriented primarily for heroin abusers. Nowadays, many are much stronger supporters of total abstinence and the 12 step principles. They may encourage and require residential stays of up to 2 years. When the addiction is serious enough to warrant such a long length of stay, these programs may offer an approach that is uniquely effective.

Should you focus on programs exclusively for a special population?

Special programs for special populations have advantages and disadvantages. Addicted people have a tendency to think that they are "different" from everyone else. That is part of the isolation. If they find themselves in a program that is specialized for just the group they identify with, that "uniqueness" defense may melt away. On the other hand, feeling like a special member of a special group may acutally strengthen the sense of being different, and with it a need to pick and choose among recovery tools and supports. Picking and choosing is not good for early recovery.
Criterion: If membership in a special group is likely to be a real barrier to mainstream treatment, then do try to find a special program of high quality. Otherwise, a mainstream program with people of roughly similar background may be more helpful.

Matching the program to the person

A major part of recovery is "identifying" with other recovering people. Extreme cultural/educational differences may be an impediment to seeing the commonality of addictions. In general, some diversity is useful. It is often surprising who an individual most identifies with, on the other hand,

adding culture shock to the stress of rehabilitaiton is not therapeutic in itself.

Local vs. Long Distance:

Many insurance companies emphasize local treatment. One advantage is that family members can more easily participate in the family program. On the other hand, the cost of airfare is a small fraction of the total outlay, and the program's ability to provide just the services you need may justify travel. Especially for young people, being away from familiar "people, places and things," may be an advantage. Rehab programs away from home may also have ties with long term residential programs in their locale.

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Glossary of Terms

Abstinence:
The act of refraining from the use of the substance or substances on which a person has become dependent.

Addiction:
The physical and psychological craving for a substance that develops into a dependency and continues even though it is causing the addicted person physical, psychological and social harm. The disease of addiction is chronic and progressive, and the craving may apply to behaviors as well as substances.

ACOA:
Adult Children of Alcoholics. A self-help organization for individuals who have suffered and suffer as the result of the alcholism of one or both parents.

Al-Anon:
A self-help organization for individuals whose lives are affected by the addiction of a family member.

Alcoholic:
Someone who as the result of their alcohol consumption, either excessive or habitual, suffers or has suffered physical, psychological, emotional, social or occupational harm.

AA:
Alcoholics Anonymous. A voluntary, anonymous self-help organization of individuals who have recognized their chemical dependence and are committed to living a life of abstinence. Abstinence is achieved by a 12-Step Program and members of AA support each other by sharing their own struggles, experiences and hopes.

Alcoholism:
A disease characterized by excessive and habitual drinking of alcoholic beverages, that causes the alcoholic, physical, psychological, and social harm.

Antabuse (disulfiram):
A drug which alters the way in which the body breaks down alcohol. Someone who is taking antabuse and consuming alcohol will have a violent physical reaction to the alcohol. nausea, vomiting and rapid changes in blood pressure occur. Antabuse is sometimes prescribed as a part of treatment after detoxification is complete to reduce the possibility of relapse.

Chemical Dependency:
A general term to describe a physical or psychological reliance on drugs.

Co-Dependency:
The condition in which people allow the behavior or sickness of another to affect them to the extent that they lose their own sense of identity and their own life becomes unmanageable. Co-dependency is characterized by trying to control the behavior of another and having unrealistic expectations about the power of that control.

Detoxification:
The process of withdrawing a person from any addictive substance. Detoxification occurs naturally when the addict cannot get his or her drug, and under these circumstances. The detoxification process can be both uncomfortable and dangerous, but under hospital supervision, detoxifcation is controlled and safe. Detoxifcation precedes rehabiltation treatment.

Dual Diagnosis:
The presence of a substance abuse or chemical dependency diagnosis with a coexisting psychiatric disorder.

What is meant by Enabling : in addiction field?
Any behavior or aciton that assists the addict in the continuation of their addiction. Enabling is either intentional or unintentional, and is usually done out of love and misguided concern. Enabling allows the addict to continue their destructive behavior.

FA:
Families Anonymous. A self-help organization for families whose lives have been affected by the addiction of a family member.

Halfway House:
A residence for those who have completed treatment at a rehabilitation facility but are not yet ready to return to their community. They need daily support to assist them in the restructuring of their lives. Often, this includes assistance in getting a job and gradually living more independently.

Intervention:
When people whose lives are affected by the addict, confront him or her with their feelings about the addict's behavior and how it has affected them. An intervention is an attempt to get the addict to accept help and go into treatment. The participants in the intervention make all the arrangements for treatment, transportation to, etc.

Long Term Residential Treatment:
A treatment program for those who having completed a rehabilitation program are still not ready to return to their communities and maintain a recovery. Similar to a halfway house program, long term residential treatment offers the support and sturcture often needed to control the impulse to relapse. Programs usually run between 3 and 6 months.

Methodone:
A drug used with heroin addicts as a substitute for heroin. Methodone is used both during detoxifcation to ease the discomfort, and it is used in maintenance programs. In maintenance, it is administered orally under controlled conditions, and is usually accompanied by some form of rehab program. Like heroin, methodone is addictive.

MICA:
Mentally Ill Chemical Abuser. MICA refers to programs for those who are dually diagnosed.

Narcotics Anonymous:
A self-help organization of individuals who have recognized their dependency on drugs and are committed to living a life of abstinence.

Recovery:
The change of attitudes and behaviors that brings about a life free of chemicals. Recovery is in terms of a process not a single event. It is ongoing, and one refers to being "in recovery." Recovery embraces the idea that one lives life positively one day at a time.

Relapse:
To repeat the addictive behavior for which an individual has received treatment.

Sobriety:
A life free of chemicals or chemical dependency.

Tolerance:
The need to take increasingly large amounts of chemicals in order to achieve the desired effects; the same effects previously achieved by smaller amounts.

Twelve Step Programs:
The 12 Steps are the philosophical basis of Alcoholics Anonymous and all Anonymous

self-help groups. They are the means by which one can get into recovery and achieve a sober life. The first step is to acknowledge one's powerlessness over the substance and that one's life has become unmanageable.

Withdrawal:

The symptoms experienced by substance abusers when they stop using the drug upon which they have become dependent. These symptoms are usually unpleasant and uncomfortable; they may include, nausea, insomnia, anxiety, weakness, trembling, sweating, dizziness, convulsions, and dementia.

 How to cut down on your drinking

If you are drinking too much, you can improve your life and health by cutting down. How do you know if you drink too much? Read these questions and answer 'yes' or 'no':

Do you drink alone when you feel angry or sad?
Does your drinking ever make you late for work?
Does your drinking worry your family?
Do you ever drink after telling yourself you won't?
Do you ever forget what you did while you were drinking?
Do you ever get headaches or have a hang-over after you have been drinking?

If you answered 'yes' to any of these questions, you may have a drinking problem. Check with your doctor to be sure. Your doctor will be able to tell you whether you should cut down or abstain. If you are alcoholic or have other medical problems, you should not just cut down on your drinking — you should stop drinking completely. Your doctor will advise you about what is right for you.

If your doctor tells you to cut down on your drinking, these steps can help you. You might find that some strategies are more useful than others. Remember you can have the support of your family and/or friends to overcome your alcohol problem.

1. Write your reasons for changing

Why do you want to drink less? There are many reasons why you may want to cut down or stop drinking. First think carefully about your reasons for wanting to change. Then have a look at the list below and mark those that apply to you. If you have other reasons write them and discuss them with your doctor and/or counsellor.

you will feel better
you will have more energy
you will lose excess weight
you will sleep better
you will save money
you won't have any hangovers
you will work better
your performance at work will improve
your health will improve
your family life will improve
your memory will improve
there will be less conflict at home
you won't be thinking about your next drink all the time
you will prevent serious health problems

2. Set a drinking goal

Choose a limit for how much you will drink. You may choose to cut down or not to drink at all. Talk to you doctor about what is right for you.

Here are some suggestions about setting goals:

if you are trying to stop drinking altogether, it is important to set a definite 'quit date'
if you are trying to reduce your drinking, it will help if you plan on which days you will drink alcohol and how many drinks you will have on each of these days. Make sure that you have at least two alcohol-free days in a week
it also helps to record the number of drinks that you have each day. Keeping a record will remind you to cut down and it will help you to keep track of whether you are following your goals

Now - write your drinking goal on a piece of paper. Put it where you can see it, such as on your refrigerator or bathroom mirror. Your paper might look like this:

DRINKING GOAL

I will start on this day .....
I will not drink more than .....drinks in one day
I will not drink more than .....drinks in one week
OR

I will stop drinking alcohol.

3. Keep a 'diary' of your drinking

To help you reach your goal, keep a "diary" of your drinking. For example, write down every time you have a drink for one week. Try to keep your diary for 3 or 4 weeks. This will show you how much you drink and when. You may be surprised. How different is your goal from the amount you drink now? Use the "drinking diary" below to write down when you drink.

Week:

Number of drinks
Type of drinks
Place consumed

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Sunday

Now you know why you want to drink less and you have a goal. There are many ways you can help yourself cut down. Try these tips.

4. Tips for cutting down

Watch it at home
Keep a small amount or no alcohol at home. Don't keep temptations around.

Change the way you drink

quench your thirst with non-alcoholic drinks before having an alcoholic drink
avoid salty snacks when you are drinking
eat before drinking; It will make you feel more full and then you will drink less
have one or more non-alcoholic drinks before each alcoholic drink
try to take small sips of your drink, avoid gulping, drink slowly
dilute your drinks, e.g. add soda to wine and mixers to spirits
take a break of one hour between drinks.

Take a break from alcohol
Pick a day or two each week when you will not drink at all. Then, try to stop drinking for one week. Think about how you feel physically and emotionally on these days. When you succeed and feel better, you may find it easier to cut down for good.

Learn how to say NO
You do not have to drink when other people drink. You do not have to take a drink that is given to you. Practice ways ot say no politely. For example, you can tell people you feel better when you drink less. Stay away from people who give you a hard time about not drinking.

Stay active
What would you like to do instead of drinking? Use the time and money spent on drinking to do something fun with your family or friends. Go out to eat, see a film, or play sports or a game.

Get support
Cutting down on your drinking may be difficult at times. Ask your family and friends for support to help you reach your goal. Talk to your doctor if you are having trouble cutting down. Get the help you need to reach your goal.

Watch out for temptations
Watch out for people, places or times that make you drink, even if you do not want to. Stay away from people who drink a lot or bars where you used to go. Plan ahead of time what you will do to avoid drinking when you are tempted. Do not drink when you are angry or upset or have a bad day. Section 5 below "Dealing with difficult times" will help you with this.

5. Dealing with difficult times

Changing habits like drinking can be difficult. There will be times when you may drink more than what you have planned or there might be times when it is very difficult not to drink or limit your drinking.

Can you think of any difficult times when you had problems in controlling your drinking?

Where were you?
Who were you with?
What were you doing?
What were you feeling?

Now look at the list below. Mark the situations or feelings that tend to make you drink more. If you have other similar situations, write them below. Then discuss your list with your physician, counsellor, family member or a close friend.

when I go to a party

when I go to dinner

when I go to the pub

meeting people in social situations

when I am with friends who drink

when I am on my own

when I am feeling in a low mood

when I am feeling anxious
when I am feeling angry

when I am feeling stressed

when I want to relax

when I have had a difficult day

when I have had an argument

when I am in a celebrating mood

when I invite friends over

Now you have the list of the most difficult times for you to resist drinking. If it is at all possible1 avoiding difficult situations will be very useful. Your initial strategy should be to reduce the temptation to drink.

However, in the long term, avoiding difficult situations may not be practical so it is also important to work out strategies to cope with difficult situations. Take a look at some of the strategies below and mark those that would be useful to you:

If you have the habit of going to pubs after work or have the habit of meeting your friends there try to organise a different social activity, e.g. going to see a film, or going to a gym or a park
If you drink mainly at night try to keep yourself busy, go to places where you cannot drink, e.g., movies
If you drink when you are with friends who drink heavily try to avoid contact with these friends
If you drink when you are alone reduce the amount of time that you spend alone, e.g. join a club or a support group or increase time doing activities with family members
If you drink when you are bored try to plan enjoyable activities, e.g. shows, movies, exercise, hobbies etc.
If you drink when you are stressed learn relaxation techniques or engage in relaxing activities, e.g. gardening
If you drink when you feel depressed or if you think that drinking calms your anxiety you must consult your doctor about it

Make a list of your most difficult times and write below a few strategies to help you In each of these situations

Difficult times Strategies
eg, Friday night after work
eg invite a non drinking friend to go and see a movie

6. Important things to remember

Keep your drinking at a level which is within the safe limits
Remember to have two alcohol-free days a week
Be realistic; you may want to plan your drinks for social occasions
Remember not to drink more than your limit.

7. A word about set backs

Most people do not cut down or give up drinking all at once. There may be times when you will find it difficult to stick to your goals. You might find that you had a few more drinks than you had planned to drink.

Do not get discouraged — do not think of yourself as a failure. Learn from each occasion. Keep on trying

Remember:

do not give in because you have had a bad experience
take one day at a time and gradually it will get easier
you need your family and friends to support you
every time you stop yourself from doing something as a habit you are one step closer to breaking the habit
the craving for alcohol will go if you mentally occupy yourself with something else
you should consult your physician and/or counsellor concerning your difficulties
Do not give up.

If you cannot achieve your goals it is important that you ask yourself 'why not?' or 'what went wrong?'. That might help you plan different strategies in the future. Use the diary on the next page to help you identify factors that are connected to your desire to drink and which need to be dealt with in order to help you to reach your goals.

8. About detoxification

If you are physically dependent on alcohol, the first part of treatment is called detoxification. Detoxification refers to a period of time when you stop taking alcohol. As a result your body has to re-adjust to a normal state without alcohol and you are likely to experience symptoms of alcohol withdrawal. The most common symptoms include nausea, shaking, sweating, irregular heart beat, anxiety and fatigue. These symptoms gradually improve over 3 to 5 days. People who have been drinking very heavily for a long time may experience more serious symptoms such as fits, confusion about the day, time or where they are. They may experience hallucinations, that is, seeing or hearing things that do not exist. For most people who are moderately dependent upon alcohol, it is safe to withdraw from alcohol as an out patient or at home, under the supervision of a doctor. Others need to be in a hospital setting. Discuss which is best for you with your doctor. Medication can help to reduce unpleasant symptoms of withdrawal during the withdrawal phase, though if you experience only mild withdrawal symptoms, you may need only support, lots of fluids and nutrition. There is no medication that will cure an alcohol problem.

When withdrawal is finished, you will need to use the non-drug strategies described in this leaflet. Self help groups such as Alcoholics Anonymous are also helpful for many people.

Understanding your drinking - diary

This diary will help you identify factors that are connected to your desire to drink and which need to be dealt with in order to help you to reach your goals. If you have slipped back, it will help you answer the question "why" and "'what went wrong?" That might help you plan different strategies in the future.

Day, date, times

Where, with, when, what

Thoughts before drinking/drug taking
What did you do?
Behaviours, feelings, consequences
What did you drink/take?
Number of standard drinks or drugs

Further sources of help for alcohol problems

Self Help Groups:

Al – Anon Family Groups UK and Eire
61 Great Dover Street, London SE1 4YF
020 7403 0888 24-hour helpline
Understanding and support for families and friends of alcoholics whether still drinking or not.
Alateen for young people aged 12–20 affected by others' drinking.
Alcoholics Anoymous
PO Box 1, Stonebow House, General Service Office, Stonebow, York YO1 7NJ.
01904 644026 Administration
Helplines:
020 7352 3001/7833 0022 (London);
0141 226 2214 (Scotland);
01907 6255574 (Mid Wales);
01685 875070 (South Wales);
01639 644871 (Swansea)
Helpline and support groups for men and women trying to achieve and maintain sobriety and help other alcoholics to get sober.
Drinkline
UK helpline: 0800 9178282 (Mon to Fri 11 am–11 pm)
Asian Line
0990 133 480 (Mon 1–8pm) Hindi, Urdu, Gujerati and Pujabi
Confidential alcohol counselling and information service
Northern Ireland Community Addiction Service

40 Elmwood Avenue, Belfast BT9 6AZ, Northern Ireland.
Tel: 01232 664 434
Scottish Council on Alcohol
2nd Floor, 166 Buchanan Street, Glasgow G1 2NH, Scotland
Tel: 0141 333 9677

Suggested Reading

Free information pack: Think About Drink, Health Education Authority Customer Services, Marston Book Services, PO Box 269, Abingdon OX14 4YN
The Family Partners Pack, Alcohol Concern, 1996
Drinking Problems: Information and Advice for the Individual, Family and Friends. Chick J and Chick J, Optima 1992

[1] Adapted, with permission, from World Health Organiazation, 1998, Mental Disorders in Primary Care: a WHO Education Package and Andrews G and Jenkins R, eds, 1999, Management of Mental Disorders (UK Edition) World Health Organization Collaborating Centre for Mental Health and Substance Abuse

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Guide developed by the WHO Collaborating Centre for Research and Training for Mental Health, Institute of Psychiatry, Kings College London.

Treatment

What is the Issue?

The provision of treatment options for those who develop problems associated with the misuse of alcohol, including alcohol dependence, or "alcoholism", is an issue of concern to health care systems. Central to this issue is how to enable individuals with problems of alcohol abuse and dependence to resume normal function. As defined by the ICD-10 classification system, the alcohol dependence syndrome is characterized by craving for alcohol, difficulty in controlling the compulsion to drink, withdrawal, tolerance to increasingly high doses of alcohol, neglect of other areas of life, once important, and persistent consumption despite clear evidence of harm (WHO 1992).

A number of approaches to the treatment and management of alcohol problems exist, each with its proponents and evidence to support its effectiveness.

What is the Debate?

Historically, the debate over which treatment options are most effective stems from the existing and often opposing views regarding the underlying causes of alcohol problems. One school of thought favors the "disease model" (Jellinek), while others favor a view of alcohol use, abuse and dependence as part of the same continuum. As a result, the long-term treatment goals of "disease model" approaches is complete abstinence, while other approaches allow for a return to moderate drinking.

Proponents of the "disease model" have argued for treatment with an emphasis on abstinence, based largely on the tenets of Alcoholics Anonymous and similar self-help groups. This model has tended to support the notion that there is something unique in the physiological, psychological and spiritual makeup of alcohol-dependent individuals, and that in order for them to lead "normal" lives, complete abstention from alcohol is the only road to recovery.

The "disease model" with its emphasis on extended residential treatment and long-term affiliation to self-help groups has been challenged by those who view alcohol use, misuse and dependence as part of a reversible sliding scale. The emphasis here is on early identification of potential problems and assisting individuals to change the patterns of their drinking in order to reduce undesired negative consequences. Inherent in this approach is the notion that it is possible for individuals to learn to drink responsibly, especially if they are diagnosed early, but even after they have met the criteria for dependence. The focus of the treatment modalities offered within this model tends to be community based and non-residential in nature.

What are the Approaches?

Treatment of alcohol related problems and dependence covers a broad range of interventions focusing on physiological approaches, psychological interventions, or on modifications of behavior or milieu. They generally involve three stages, addressed differently within each approach: detoxification to minimize withdrawal, rehabilitation or follow-up, and maintenance. Different approaches to treatment can be used individually or in conjunction with each other, depending on the needs of the patient and on what seems most appropriate under the circumstances.

In practice, treatment of alcohol problems and dependence ranges from brief counseling to

prolonged treatment or life-long affiliation with self-help groups. The important first step, however, consists of screening to assess the severity of the problem and to be able to diagnose dependence, if appropriate. A range of standardized assessment tests is available, some of which can be applied specifically to populations of adults or youth. Others, such as the AUDIT (Babor et al., 1992), are applicable across cultures.

For some individuals with alcohol abuse problems, brief intervention, followed by counseling, has proven effective (Chick et al., 1985; WHO Brief Intervention Study Group, 1996) in modifying behavior.

Group therapy and self-help groups are among the most prominent approaches to treatment. These include Alcoholics Anonymous, popular mainly in North America and Northern Europe in which the focus is on the individual and on achieving complete abstinence as the only effective solution. In contrast, the "club" system, popular in parts of Central and Southern Europe, focuses on the community, engaging the individualís family and social network in the recovery process (Hudolin, 1984). A third self-help approach is "controlled drinking", in which the view of use, abuse and dependence on a continuum prevails, and where the ultimate goal can be resumed moderate drinking (Davies, 1962; Kishline, 1994). The appeal of these approaches depends largely on the view of problem drinking in different cultures and the relationship of the individual and the community within the different traditions.

Pharmacotherapy offers another treatment option with the goal of assisting individuals to manage alcohol problems. Among the more commonly used drugs are disulfiram (or Antabuse), as well as and acamprosate and naltrexone, both effective in preventing relapse (Kranzler, 2000). Pharmacotherapy is often used in conjunction with counseling approaches (Barber & O'Brien, 1999).

Other therapies include: aversion therapy; behavioral therapy emphasizing coping and problem-solving skills, stress management, and social skills training; alcohol education; and family therapy. Often, these approaches are used in combination with each other. Pharmacotherapy, for example, may be coupled with behavior modification approaches.

Which of these treatment approaches is most effective is a question open to debate. Much depends on the circumstances surrounding the individual and the nature of his/her problems with alcohol. Some have argued that while less dependent drinkers may achieve "controlled drinking" and moderation, abstinence is more suited to high dependence drinkers (Sobell and Sobell, 1995).

Research carried out mainly in the United States into the potential value of matching patients to particular treatment modalities according to a set of criteria has failed to show any specific advantage for one treatment type over another (Project MATCH, 1997). In-patient treatment for alcohol dependence has been shown to be effective; however the benefit of this approach over less intensive treatment such as outpatient or day treatment is not apparent.

Is there a Consensus?

There appears to be mounting consensus that no single approach to the management of drinking problems or alcohol dependence holds the key to success. There is clear evidence to support the hypothesis that the capacity of the professionals delivering treatment is a considerable factor in determining successful outcomes.

There is a growing consensus in favor of evidence-based practice in relation to the management of alcohol problems. The introduction of harm minimization approaches to the management of drinking problems has gained significant currency in Europe, Canada and Australasia (Plant et al. 1997; Grant & Litvak, 1998). The United States, Asia and Central Europe continue to have a strong commitment both from funders and treatment providers to traditional abstinence only approaches.

Suggested Readings

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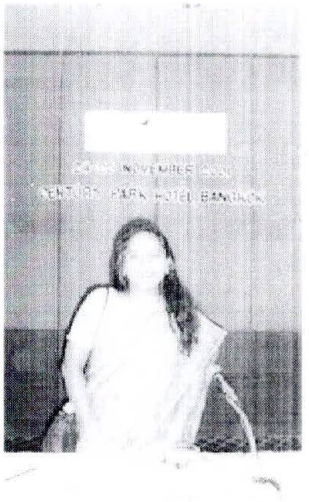
THE GLOBE *Magazine*

Alcohol in India

Monica Arora, Programme Manager of HRIDAY/SHAN



Prohibition is incorporated in the Constitution of India among the directive principles of state policy. Article 47 says: "The state shall regard the raising of the level of nutrition and standard of living of its people as among its primary duties and in particular, the state shall endeavour to bring about prohibition of the use except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health."

During the pre-independence period, Mahatma Gandhi himself issued several strong statements against the sale and consumption of alcohol.

The Alcohol Situation in India
Alcohol is one of the commonly consumed intoxicating substances in India. It has traditionally been drunk in tribal societies, although it has won increasing social acceptance among other groups, urban males being the prime example. It is easily available and widely used, especially at festivals such as Deepawali and Holi. At the moment the use of alcohol is infrequent among women who also tend to resist the habit among male family members.

Between 15 and 20 per cent of Indian people consume alcohol and, over the past twenty years, the number of drinkers has increased from one in 300 to one in 20. According to The Hindustan Times, it is estimated that of these 5 per cent can be classed as alcoholics or alcohol dependent. This translates into about five million people addicted to alcohol.

Of what is actually consumed, the Intake of Indian Made Foreign Liquor (IMFL) is growing at the considerable rate of 15 per cent a year. Again, The Hindustan Times says that 65 per cent of the Indian liquor market is controlled by whiskey manufacturers. The state of Kerala stands first in per capita consumption of liquor at 8.3 litres, followed by Punjab 7.9 litres.

Alcohol Situation in India among youth
Today in India, the tendency to alcohol consumption has percolated down to the youth. The media has played a leading role in encouraging the use of alcohol among young people by such means as the portrayal of drinking in congenial social settings, by associating the habit with glamour and celebrity status, and by direct and indirect advertising.

Over the years, the age at which youngsters begin to consume liquor has come down in Kerala. In 1986 the age was 19, by 1990 it had dropped to 17, and by 1994 the age was 14.

Indian liquor brands
The varieties of alcohol manufactured for consumption in India are:

- Beer
- Country Liquor
- Indian Made Foreign Liquor (IMFL)
- Wines

Indian liquor brands have registered significant growth in recent years - some of the top Indian alcohol brands showing an increase of as much as 50 per cent in sales (1993-97). United Breweries registered an increase of nearly 20 per cent in sale in the year 1998-99.

Taxes on alcohol
Alcohol is a significant contributor to government revenues in many states. In most states this accounts for over 10 per cent of total state tax revenues, whilst in the Punjab this accounts for over one third.

Policy measures in India
Alcohol policy is under the legislative power of individual states.
Prohibition, enshrined as an aspiration in the Constitution, was introduced and then withdrawn in Haryana and Andhra Pradesh in the midi-1990s), although it continues in Gujarat, with partial restrictions in other states - Delhi, for example, has dry days. There was an earlier failure of Prohibition in Tamil Nadu.

Increasing taxes as a means of reducing alcohol consumption is problematic as it has been shown to be unresponsive to price change. Tax increases will further add to economic hardship for consumers and have little or no impact on the reduction in other negative impacts. There would, however, be an increase in corruption, crime, and the production and consumption of illegal liquor.

An important aspect of policy is to delay initiation among youth. One way of doing this is to enforce age limits. The legal minimum age to purchase liquor ranges from 18 years in some state to 25 years in others. Delhi has minimum age limit of 25 years. So far, the efficiency of enforcement has not been studied. It has, however, been shown that an increase in the age of legal drinking from 18 years to 21 years achieves nearly 60 per cent of the effect of prohibition on alcohol consumption.

Legislation: alcohol advertisement
The Cable Television Network (Regulation) Amendment Bill, in force September 8, 2000, completely prohibits cigarette and alcohol advertisements. The government controlled channel, Doordarshan, does not broadcast such advertisements but satellite channels however are replete with them.

Efforts to counteract the problem
Ministry of Social Justice and Empowerment has been active in this field. In 1985-86 it urged the establishment of a reduction programme. The ministry co-operates with media and youth organisations and collaborates with the Ministry of Health and Family Welfare and with NGOs involved in the problem. The Ministry of Social Justice and Empowerment, in partnership with the United Nations International Drug Control Programme (UNDCP) and the International Labour Organisation (ILO), has launched three major initiatives for alcohol and drug demand reduction.

Non-Governmental efforts have been led by the Indian Health Organisation (IHO), Youth for Christ India (YFC), Health Related Information Dissemination Amongst Youth (HRIDAY), and the Student Health Action Network (SHAN).

THE GLOBE *Magazine*

BMJ 1998;316:1394 (2 May)

Views and reviews

Personal views

The politics of alcoholism in India

At a recent meeting in Goa organised by the National Commission for Women, its chairwoman, the vibrant and outspoken Ms Mohini Giri, exhorted the women of Goa to join hands with millions of women in other Indian states to demand that prohibition be implemented to reduce the appalling damage resulting from alcohol misuse by men.

The use of prohibition in India has a long history. Gujarat, the home state of Mahatma Gandhi, declared prohibition soon after the British left and has stuck to this policy ever since. More recently, however, prohibition became a major vote winner in the states of Andhra Pradesh and Haryana. Alcohol misuse has become such an enormous problem that it is now the main issue on which elections are being fought and won.

Alcohol misuse is one of the main killers of young men in India today. But its real impact is on the social and family dynamics that underlie our communities. Domestic violence and an exacerbation of poverty have made alcohol misuse the single most important problem for women in India. A recent study in Goa showed that women attending primary care clinics were more likely to cite a drinking relative as a key problem in their homes. They were also more likely to cite problems with making ends meet and to suffer from a depressive or anxiety disorder.

What has changed over the past 20 years is that these women are now an increasingly potent electoral force. Women's organisations have successfully mobilised millions of women and struck a sensitive chord in identifying alcoholism in their families as being a potentially preventable cause of poverty and abuse. Rather deviously, women have been identified by opportunistic politicians as a vote bank: political parties have thrown all the benefit of hindsight to the wind and made prohibition their prime election promise. The result was that the Telegu Desam party won a famous electoral victory, winning 224 out of 294 seats in Andhra Pradesh. Subsequently, the party which put prohibition at the top of its agenda won the elections in Haryana with a large majority.

But has prohibition made any difference to the real problem—that is, drinking by men? If Gujarat is anything to go by prohibition is a complete failure. Not only is alcohol readily available to the rich, but the poor have to resort to illegal brews, with a consequent rise in criminal activity and deaths from methanol poisoning. Prohibition has introduced massive problems for the government treasuries and caused further hardships for the poor by increasing unemployment. In Andhra Pradesh alcohol

breweries were shut with the loss of hundreds of legitimate jobs; the state was virtually bankrupted. The government attempted to counter the budgetary deficit by raising taxes and the cost of subsidised rice, the staple food of millions of Indians. Despite this, the deficit continued to spiral out of control reaching a third of the annual budget outlay. Finally, the Reserve Bank of India threatened to withdraw the overdraft facility to the state. The government then relented and introduced the AP Prohibition Act 1997, which effectively removed prohibition in favour of a more regulated alcohol retailing system.

"There has been no mention of any public health initiatives"

An amazing feature of all this grassroots democracy is that there has been no mention of any public health initiatives to tackle alcohol misuse. Primary preventive strategies would enable the reduction of problem drinking in an entire population. Such strategies could include the strict enforcement of laws on licensing and on drinking and driving, and the provision of peer education on drinking behaviour in colleges and schools. Secondary prevention would enable the reduction of the effects of problem drinking once it had been detected in an individual. How often does a woman who has been battered by her alcoholic husband receive counselling or a health worker visit her home to counsel the husband? How often does a man who has been in hospital for a bleeding gastric ulcer or after a drinking and driving accident receive information on the nearest Alcoholics Anonymous meeting place? Counsellors could work with other organisations, such as Alcoholics Anonymous and the Indian Psychiatric Association, in a united campaign to help families affected by problem drinking.

The policy of prohibition is at odds with an essential ingredient of any community health programme—namely, its participatory approach. By identifying drinking in men as the problem, the current approach alienates and excludes them from participating in finding a solution. Bar owners and alcohol manufacturers, usually men, see their livelihood destroyed and, instead of empathising with women on this sensitive issue, they feel threatened.

The current drive by the National Commission for Women is an admirable example of women uniting in an effort to make their lives better by forcing the government to act. But in their vociferous support for prohibition women's groups should remember that it will always be the poor who will suffer the most from prohibition. A community based, participatory public health model to tackle alcohol misuse is the only way to reduce the negative impact of problem drinking while safeguarding the economic benefits of alcohol, avoiding punishing the majority who drink sensibly, and preventing deaths and crime which result from the illegal bootlegging industry.

Vikram Patel.

secretary, Sangath Society for Child Development and Family Guidance,Goa, India

Rapid Responses:

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A Tipsy Liquor Policy

H B Soumya

"And when I'm dead, don't bury me at all,

Just pickle my bones in alcohol,

An amphora of wine at my head and feet,

And then I'm sure my bones will keep"

These lines are from *Goscinny and Uderzo's Asterix and Caesar's Gift.* Tremensdelirious sings these lines on being served with the alcohol of his choice. But what about Delhi? Are all concerned parties happy with the government's excise policy?

Licensing procedure

The Delhi government issues manufacturers an L-1/L-1A license every year on the fulfillment of some criteria. An L-1 is issued to an Indian made Foreign Liquor (IMFL), which is given an approval certificate on meeting a minimum sales figure target, which applies to all of India except Delhi. It is also required to undergo quality checks. An L-1A license is issued to country liquor manufacturers who have to undergo quality checks that are carried out by the government laboratories. IMFL brands are sold by government retail outlets, which have L-2 licenses, like the Delhi Tourism and Transport Development Corporation (DTTDC), the Delhi State Industrial Development Corporation (DSIDC), the Delhi State Civil Supply Corporation (DSCSC), and the DCCWS (expansion unknown) which run various outlets. While country liquor is sold in Government shops that are issued L-10 licenses sell. These shops also sell cheap IMFL, priced below Rs. 90.

applicant in view of the provision of rule 7 of Delhi Intoxicants license and sale rule, 1976
- Documentary evidence to prove that the alcohol is manufactured from natural alcohol (double distilled) Extra natural alcohol

The IMFL or the beer brand proposed to be sold by the applicant of the L-1 license should be owned by the distillery and in respect of the IMFL brands, excluding wine, the applicant should be in possession of trade mark certificate in respect to these brands. **However if the brand has been sold in Delhi before 1993-94 the TMC is not required. For the approval of rum and whiskey brands, the brand must have sold a minimum quantity in the all India market excluding Delhi as indicated in the terms and conditions.**

Once the license is approved, the applicant has to submit the following:

- Registration of brands
- Approval of bonded warehouse
- Approval of label
- Fixation of ex-distillery prices

Distilleries and breweries also have a bone of contention with the liquor policy of the government. According to the Constitution of India, under *Article 47,* it is the

"Duty of the state to raise the level of nutrition and the standard of living and to improve public health--the state shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and in particular, the state shall endeavour to bring about prohibition of the consumption except for medical purposes of intoxicating drinks and drugs which are injurious to health."

However experience of prohibition in other countries has shown that

The L-1 licences are given to a company, society, or manufacturing firm: partnership or proprietorship firm provided the applicant owns a distillery. The applications for this are invited through advertisements in leading newspapers. The prime job of L-1 license holders is to supply liquor to other license holders.

A number of certificates need to be submitted along with an L-1 license application. These are listed below:

- Solvency certificate from SMD
- Income tax clearance certificate
- No dues certificate from collector (excise)
- No dues certificate from sales tax officer
- Declaration of distillery on affidavit regarding sale and minimum ex-distillery prices and distance of distillery from Delhi
- CA certificate for sale and minimum ex-distillery prices
- Certificate from Excise authority regarding sale figures
- Registered partnership deed/memorandum and article of association
- Duly audited annual account and balance sheet of distillery
- Attested copy of the license for establishment of distillery/winery/bottling unit/brewery
- Power of attorney
- Attested photocopies of export passes/EVCs verifying the sale figures of the whisky and rum brand for which distillery has applied
- Trade Mark Certificate (TMC)
- Usership agreement under Trade & merchandise Marks Act, 1958
- Certificate from a government authorised laboratory or other reputed private institution regarding quality of brand.
- An affidavit stating that there is nothing adverse or against the

the prohibition would be counter productive. Therefore, the Delhi government grants a privilege to the distilleries with regulations, without granting any right to trade in liquor.

L-2 licenses are given to only select undertakings of the Delhi government namely DTTDC, DSIDC, DSCSC, and DCCWS. The proposal for opening a vend has to come from these corporations. Individuals wanting to rent out their premises for such a vend have to approach these institutions, which after looking at the suitability of the premises approach the relevant offices for the grant of the license. The premise is required meet the following specifications:

- The premise should be a *pucca* building with a minimum floor area of 400 sqft and located in a commercial area
- The area MLA should give his positive opinion on the matter.
- The Collector of excise, the DEO, and the representative of the corporations and the area SMD have to inspect the premises.
- The shop shall not be within 75m of the following

  - Industrial estate or any construction site

- Major educational institution

- Religious place

- Hospitals and nursing homes with more than twenty five beds

- Colonies of labourers and harijans

The permission of the area's MLA is a must. If approval is not given, then a retail outlet cannot be opened. For instance, in Vasant Kunj, there is not a single alcohol retail outlet, due to the negative opinion of the MLA of the area.

If all these qualifications are met by the proposed premise, then the license is given and the concerned party is required to deposit an amount of Rs. 60,000 as the license fees. IMFL/beer brands are sold

by these vends at rates fixed by the excise commissioner. In the year 1999-2000, there were 224 L-2 license holders.

L-3, L-5 licenses are given to hotels, which are approved by the Department of Tourism and are categorised as Budget hotels. The approval of the department of tourism is necessary for the grant of an L-3 license. This license is for the sale of liquor to its residents.

These hotels can also apply for an L-5 license for serving of liquor in exclusive bars and in the restaurant in the hotel premises. The following need to be submitted with the application of an L-5 license:

- Documentary proof regarding legal status of the hotel
- Whether the hotel is in legal possession of the plot.
- Completion certificate in respect of the hotel building.
- Trade license from the Local authority (MCD/NDMC)
- Lodging house license from the local authority
- Certificate of registration of eating house license issued by the DCP
- Documentary proof regarding applicant being an income tax assessee and sales tax assessee.
- A layout plan of the hotel, site plan of the license outlet and the liquor stores.

The application is to be submitted to the Commissioner of Excise. After scrutiny of the documents, the premises are inspected by the excise officer as under the excise rules, particularly rule 11 of the Delhi Intoxicants License and Sales Rule, 1976. The premises should not be within 75m of any of the institutions as were listed in the case of L-2 licenses.

Once the hotel has been found to be suitable, the views of the public/residents are invited on the proposal giving 7 days time to file objections before the licensing authority. If no objection is received then the authorities proceed with the approval for grant of

license. An L-5 license is given only with an L-3 license and the same requirements apply to an L-5 license. The total number of L-3/L-5 licenses given in 1999-2000 was 42.

An L-4 license is given to an independent restaurant approved by the Department of Tourism. Applications are submitted to the Commissioner of excise with the relevant documents. The restaurant should be located in a commercial area with adequate parking space. The requirements of rule 11 of Delhi Intoxicants License & Sales Rules 1976 have to be met by the restaurant. The requirements and procedure are the same as in the case of L-3 and L-5 licenses. The total number of L-4 licenses given in 1999-2000 was 81.

L-19 licenses are given for the service of liquor in a club registered under the Societies Act 1860.The applicant is required to submit on the letterhead of the club an application along with the following documents:

- Registration certificate in respect of the club
- Documentary proof in support of legal possession of the plot of the club.
- No objection certificate from the area DCP
- List of members of the club
- List of office bearers of the club
- Registration passed by the management Committee to start the bar facility in the club and also to meet the liability thereof.

Rest of the procedure with regard to the grant of license is the same as indicated in respect of L-3/L-5 license.

Liquor, being an excisable article, can not be stored beyond a certain limit. A consumer is allowed to store a maximum of 20 litres. For higher possession, an application to the department and the payment of Rs. 2000 would get the applicant an L-49 license. The applicant has to be an income tax assessee to be eligible for the permit. The total

number of L-49 licenses given in 1999-2000 was 258.

Status of alcohol industry in India

The alcohol industry is very important for the government. It generates an estimated Rs. 16,000 crore per annum in spite of the fact that the per capita consumption of liquor in India is the lowest in the world. The total liquor industry is worth Rs. 2,000 crore. IMFL accounts for only a third of the total liquor consumption in India. Most IMFLs are cheap and are priced below Rs. 200 per bottle. Alcohol sales proceeds account for 45% of the total revenue collection in the country. Whiskey accounts for 60% of the liquor sales while rum; brandy and vodka account for 17%, 18% and 6% respectively. MNC's share is only 10% and they have been successful only in the premium and super premium ranges.

Post WTO the government may have opened India to foreign distilleries, but the duty has been increased from 222% to 464-706%. This is due to the fact that there is a 100% customs duty, 150% contravening duty, local taxes, distributor's margin, retailer's margin and publicity charges. The cost is finally borne by the consumer. Though the government claims that this is being done to protect the domestic liquor industry, the domestic industry accounts for 99% of the market share. This protectionist policy could prove to be counterproductive and lead to smuggling. As of now, only 45% of the sales are through legal channels and only 25% of this is duty paid for.

Within India itself, the policy of alcohol retail differs from state to state. While some states like Maharashtra, Uttar Pradesh, and Tamil Nadu have a liberal policy, some states like Haryana and Andhra Pradesh have had very bitter experiences in trying to make these states dry and have eventually had to withdraw the policy.

Method of ordering

The L-2 licensed authorities on the basis of the price of the alcohol place the orders for IMFL. For liquor priced below Rs. 90, the order is equally distributed among all those manufacturers who have been licensed in this category. For the alcohol priced between Rs. 91 and Rs. 205, the order is distributed among the L-1 holders in this category depending on the production capacity of the brewery. For the premium brands (above Rs. 205) the orders are placed by the individual vends themselves. Any stock of liquor lying unsold in a branch of an outlet is transferred to another shop of the same chain. When stocks pile up, a committee is appointed to look into the disposal of the stock of liquor. On a visit to a shop run by the DSIDC in Saket on July 1, 2001, about 15 whiskey, 14 rum brands and 15 beer brands in the under Rs. 90 category, and about 30 brands of alcohol (whiskey, gin, vodka, rum) in the Rs. 91- Rs. 205 category were displayed on their board of products with their prices. However, there was no beer available in this shop and only about 5 rum brands were stocked in the shop.

The **sales figures** of alcohol over the various years for entire Delhi is given below:

Year	Sale of beer in bottles	Sale of IMFL	Sale of country liquor
1994-95	18,797	29,784,767	15,304,848
1995-96	26,753,113	31,100,383	17,813584
Year	**Sale of beer in bottles**	**Sale of IMFL**	**Sale of country liquor**
1996-97	28,852,880	39,999,614	27,470,904

1998-99	3,657,063	47,567,740	31,920,975
1999-00	32,111,134	44,707,386	33,513,108

Source: delhigovt.nic.in website

(The sale of liquor did not have any units)

The **revenue growth** of the excise department is tabulated below:

Year	Revenue (Rs. crore)
1994-95	308.45
1995-96	335.75
1996-97	446.10
1997-98	545.00
Year	**Revenue (Rs. crore)**
1998-99	526.50
1999-00	566.00

Source: delhigovt.nic.in website

In 1996-97, till October, the total revenue collected by the Delhi government was Rs. 1429 crore. The excise contribution was Rs. 347.87 crore (24.34%). The cost of collection incurred by the department was 0.4 crore (2% of the revenue). (All these figures are according to the report on the *delhigovt.nic.in website.)*

As can be seen from the sales figures, there is a lot of fluctuation in the quantities sold every year. When asked about this, the relevant authorities refused to comment.

Area of objection

The Delhi government is the sole buyer and seller of alcohol in Delhi. There was Rs. 4 crore worth of liquor of inferior quality lying in the government retail outlets, according to a report in the *Times of India* dated May 29, 2001. What is meant by inferior quality liquor is something no one knows. On asking, the concerned officials in the DTTDC head office in Lakshmi Nagar said that the liquor was just unsold stock.

The government's excise policy is subject to a lot of sudden changes. The manufacturers sometimes just need to get their L-1 licenses renewed and at times they need to apply afresh, like in the year 2001. In 1993, the L-1 license holders were allowed to set up 5 'dedicated' shops in Delhi in which they could sell their approved brands in addition to having them sold in the government retail shops. The policy was withdrawn in an ad-hoc manner in 1994. On being questioned about the effects of this policy, an official in one of the country's leading breweries said that the introduction of this policy had led to an increase in their revenue by almost 30% which they have lost out on since the policy got crushed. Recently, the government's policy to open up 45 private liquor shops was quashed by the cabinet, because it meant that the MLA's power in the issue of a no-objection certificate for the setting up of a retail outlet would be questioned. Had this policy been implemented, the government

would have earned Rs. 7.5 lakhs on each vend as license fees annually.

So, are all the concerned parties satisfied? Apparently not. Customers often complain that they buy the alcohol that is made available to them and that the brand of their choice is difficult to get. Sometimes the scarcity is real, at other times it may be a case of "brand pushing". (The market rate for brand pushing starts at Rs. 30 per case.) Brand pushing depends on which company is willing to pay more commission to the man who is at the outlet of the government liquor vend. For example, a cheap whiskey may carry a commission of Rs. 30 per case while a premium brand may carry Rs. 60 per case. Though some officials of certain firms admitted to the practice of brand pushing, the DSIDC officials vehemently denied this practice.) Lines are long, stocks inadequate, and the service leaves a lot to be desired. More vends; particularly private ones would be welcome by the customers. The manufacturers would definitely welcome a change in the excise policy, not just in terms of licensing but also in terms of retail. It would mean a cleaner and clearer system and would eliminate the monopolistic and monopsonistic power of the government (the cost of which in 2001 was Rs. 4 crore of unsold liquor lying in government retail outlets) by bringing in efficiency through competition. The government would definitely not be worse off with the introduction of private stores. In fact, more revenue, in the form of license fees as well as in the form of taxes that would accrue to the government from these vends. The net alcohol consumption would also not increase. There would be just a change in the buying pattern of the people. Instead of stocking liquor as people do now, the same alcohol would be bought over a period of time in smaller amounts. Studies conducted by the Fraser Institute of Canada in Alberta, a place where alcohol is sold privately, have shown that privatization of liquor retail has not lead to an increase in consumption or any increase in crime.

The only party that would be worse off would be the people who

have made this policy--namely the people who are benefiting from the current policy. Whatever benefits they are accruing now would decrease, perhaps even be eliminated. But it would mean a big step towards consumer satisfaction. In any case, don't we all believe in the greatest good of the greatest number?

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About Distillery Industry of India

The use of alcohol as drink is an age-old story in India and it appears that the technique for fermentation and distillation was available even in the Vedic times. It was then called " Somarasa" and was used not only for its invigorating effect but also in worship. To date, not only has the consumption of alcohol been continued but it is an integral part of the Ayurvedic system of medicine.

The First distillery in the country was set up at Crwnpore(Kanpur) in 1805 by Carew & Co. Ltd., for manufacture of Rum for the army. The technique of fermentation, distillation and blending of alcoholic beverages was developed in our country on the lines of practices adopted overseas particularly in Europe.

The distillery industry today consists broadly of two parts, one potable liquor and the industrial alcohol. The potable distillery producing Indian Made Foreign Liquor and Country Liquor has a steady but limited demand with a growth rate of about 8 per cent per annum. The industrial alcohol industry, on the other hand, is showing a declining trend because of high price of Molasses which is invariantly used as substrate for production of alcohol. The alcohol produced is now being utilized in the ratio of approximately 52 per cent for potable and the balance 48 percent for industrial use. Over the years the potable liquor industry has shown remarkable results in the production of quality spirits.

The utilization of Ethyl alcohol or Ethanol, now popularly known as alcohol, for industrial use is a recent phenomenon and its importance came into being towards the end of the second world war. With protection being granted to the sugar Industry in 1932, a large number of sugar factories were established in

the country, particularly in Maharashtra and Uttar Pradesh where irrigation facilities existed for cultivation of sugarcane. This increase resulted in accumulation of molasses, which resultantly, caused unmanageable environmental problems. At that time the demand for molasses was almost insignificant and the sugar mills had to incur some expenditure on removal of this by product i.e. molasses. For resolving these problems a joint committee of U.P. and Bihar was constituted to explore the possibilities of developing alcohol based industries for the purpose of utilization of molasses. The Committee in its report recommended the establishment of distilleris for production of alcohol, utilizing molasses as substrate. They also recommended that alcohol produced by the distilleries should be admixed with petrol, to supplement motor fuel. The production of alcohol did not only help in solving the problems of disposal of molasses but it also filled up the gap in the demand and supply of motor spirit. As a substantial quantity of alcohol after meeting its requirement for manufacture of gasohol alcohol was diverted for production of alcohol based chemicals in different parts of the country. The utilization of alcohol for this purpose progressed steadily and a substantial quantity of alcohol produced in the country is now being utilized for manufacture of solvents and intermediates. Till a few years back a little more then 50 % alcohol produced in the country was being utilized for production of alcohol based chemical but after the decontrol of molasses in the year 1993 the utilization of alcohol for production of chemical, dye-stuff, synthetic rubber, polymers and plastics etc. has received a setback.

Manufacture of alcohol

In this country the bulk of alcohol is being produced from sugar cane molasses. Molasses is a thick viscous bye-product of the sugar industry which is acidic in nature, rich in salts, dark brown in colour and it also

contains sugar which could not be crystallized. For manufacturing alcohol, the Molasses is diluted with water into a solution containing 15-16 % of sugars. This solution is then inoculated with yeast strain and is allowed to ferment at room temperature. The fermented wash is distilled in a series of distillation columns to obtain alcohol of adequate/ requisite strength and quality/ specification. This alcohol is used for various purposes including potable and industrial. For manufacture of alcoholic beverages, the alcohol is, if required, matured and blended with malt alcohol (for manufacture of whisky) and diluted to requisite strength to obtain the desired type of liquor/ Indian Made Foreign Liquor (IMFL). This is bottled in bottles of various sizes for the convenience of consumers.

The production of alcohol has been acknowledged since the earliest recorded history and at least since ancient Egyptian records of 2000 BC. The modern sciences of microbiology, enzymology and biochemistry certainly belong to the twentieth century and these sciences have added flesh to the empirical knowledge of distillers in the previous millennia.

Today we have 295 distilleries, which are scattered throughout the country which have an installed capacity for production of 3198 million litres of alcohol. The requirement of alcohol in country for all purposes however stands at about 1200 to 1300 million litter of alcohol in a year. Which works out about 40 percent licensed capacity. The bulk of capacity thus remain dormant which can be advantagely utilize for production of anhydrous alcohol for being used as oxygenate/ fuel. The utilization of ethanol as oxygenate is the prime need of the country because the enormous increase in the population of motor vehicles after emphasize has been major cause of air pollution in particularly in metropolises and big cities. As the air pollution disposing a serious threat to the health of community it is absolutely necessary to devise way and means of

curbing pollution. Cheapest and best way to alternative this objective is to utilize ethanol as oxygenates in admixture with Petrol/ Diesel. The implementation of this program has been delayed rather inordinately and it should therefore be implemented as promptly as possible.

Alcohol is a member of a class of organic compounds containing carbon, hydrogen and oxygen, considered as hydroxyl derivatives of hydrocarbons, produced by the replacement of one or more hydrogen atoms by one or more hydroxyl (-OH) GROUPS.

Icoholism is a chronic, often progressive disease characterized by excessive and repetitive consumption of alcohol despite repeated alcohol related problems such as health, social or economic functioning of the individual. Alcoholism constitutes of symptoms such as

- A strong compulsion to drink. This is called craving.
- Alcohol is often taken in larger amounts or over a longer period of time than the person intended
- When alcohol use is stopped after a period of heavy drinking, there is development of characteristic withdrawal symptoms such as nausea, sweating, shakiness and anxiety.
- There is development of tolerance i.e. there is a need for increased amounts of alcohol in order to achieve a desired effect.

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Predisposing Risk Factors

Following risk factors may lead an individual to alcoholism.
1) Age - Men usually develop alcoholism in the third or fourth decade. It develops later in women.

2) Sex - Alcoholism is more common in males than females.

3) Socio-economic status - Alcoholism is more prevalent in lower socio-economic groups and less educated class of people.

4) Family history of alcoholism - Children of alcoholics are about four times more likely to become alcoholics than children of non-alcoholics. Genetic factors partially explain this pattern.

5) A person's environment such as the influence of friends, stress levels and the ease of obtaining alcohol may also influence drinking and the development of alcoholism.

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Prevalence

About 1% to 10% of the world's population aged 15 years and over are estimated to consume alcohol at that level, depending on the country of residence.

Surveys conducted in USA on drinking practices reveal that 70% of adults drink alcoholic beverages at least occasionally and about 12% are heavy drinkers. In USA, the ratio of male to female drinkers is approximately 3:1.

In India, studies carried out in northern states and in West Bengal show that the prevalence of alcohol addiction is 10 to 19 per thousand. The prevalence rate of alcoholism is comparatively low in the southern states of India. In India, it has been estimated that 40-50% of all males drink alcohol as compared to less than 1% of female adults.

In North America and countries in northern Europe, alcohol is frequently taken in concentrated forms to help in socializing. Alcohol dependence in these countries is usually characterized by heavy consumption of strong spirits, a tendency to periodic drinking and by overt drunkenness. In some countries, alcohol is consumed as wine, usually with meals. Here the alcohol dependence is characterized by a relatively continuous intake of alcohol and little overt drunkenness. Beer is also used in a similar way.

and little overt drunkenness. Beer is also used in a similar way.

TOP

Clinical Features

Alcohol does not require digestion and is quickly absorbed into the body. The affects of alcohol are seen about 10 minutes after consumption and peak at 40-60 minutes after consumption. The effects of alcohol depend on how much is taken, the expectations of the drinker and the circumstances at the time. Eating can slow down the effects of alcohol. The age, size and sex and how quickly people drink makes a difference. The effects appear early in those who are mentally or physically fatigued, in epileptics, in persons with head injury, and in those who have taken barbiturates or other CNS depressants. Regular drinkers develop a tolerance to alcohol and a reduced sensitivity to it i.e. there is a need for increased amounts of alcohol in order to achieve a desired effect. In addition, some physiological adaptation occurs so that the alcoholic appears less intoxicated and less impaired in performance at a given concentration of blood alcohol than is a non alcoholic.

Alcohol produces three stages -
1) Stage of excitement
2) Stage of incoordination
3) Stage of narcosis.

The symptoms are due to the depressant action of alcohol on the central nervous system.

1) Stage of excitement:
Small amounts of alcohol produce a sense of well being and pleasure resulting from inhibition of higher centres. People may become more sociable, active, self confident and talkative. The drinker converses well, laughs and smiles more readily or becomes angry more easily. It relaxes the control of emotions. There is lack of normal restraint and the drinker may behave in an obscene manner or talk in a vulgar manner. This is called flippant stage.

The face appears to be flushed and the conjunctivae are injected. The pupils are dilated and they sluggishly react to light. The pulse is fast and the breath smells of alcohol. Some people may retain mental clarity. In this stage the blood alcohol concentration is between 0.05 to 0.1 per cent (50-100 mg%).

2) Stage of incoordination:
The concentration of alcohol in blood in this stage ranges from 0.1 to 0.3 percent (100-300 mg%). This is the stage where offences are most committed. There is incoordination of thought, speech and action. This stage is sometimes called the stage of confusion because the person is confused due to incoordination of thought. The speech is slurred and incoherent and there is difficulty in pronouncing consonants. This is due to incoordination of speech. There is also incoordination of muscles which leads to staggering gait. There is also impairment of skilled movements and the reaction time is increased. A person driving a vehicle may commit an accident. A person is not fit to drive a motor vehicle with a blood concentration of 0.1 per cent or 100 mg% and above. The statutory limit for a charge of drunken driving in UK is 80 mg%.

The eyes appear suffused and the pupils usually dilated. Pupils sluggishly react to light. There is blurred vision and the person may also experience double vision. There is dryness of mouth and furred tongue. The breath smells strongly of alcohol. Nausea and vomiting are commonly present. Vomiting may be dangerous but it may also have. Some sobering effect as it may relieve the stomach of some alcohol. The person is untidy in his appearance and may suffer from hiccups. Depending upon the inherent emotions, the individual may become morose, gay or irritable. On drinking heavily, deep depression can be released with disastrous results. Under the effect of alcohol, the person may plunge into sexual excesses.

disastrous results. Under the effect of alcohol, the person may plunge into sexual excesses. It is said that alcohol kindles the desire but takes away the performance.

Various other accidents are also associated with intoxication including traffic accidents, falls, burns, drowning and work related accidents.

3) Stage of narcosis:
In this stage the blood alcohol level is 0.3 percent (300 mg%) or above. This is also known as the stage of coma as the patient passes into deep sleep and responds only to strong stimuli. Mouth and the tongue are frequently dry. The tongue may be furred. There may be excessive salivation. The temperature is low and the pulse is rapid. Pupils may be contracted. Nystagmus may be present. On stimulating the person by pinching his neck or face, the contracted pupils may dilate initially and slowly return to their original size. This is known as Macewan's sign. It is helpful in differentiating alcoholic coma from other comatose conditions.

There is slow, stertorous respiration and the skin is cold and clammy. The pulse is very feeble. If this stage lasts for more than twelve hours, paralysis of heart and respiratory centre may occur or pulmonary edema may occur resulting in death.

In this stage, Saturday night paralysis occurs. It is so called as it is seen in workers who receive their salary at weekends and go on drinking. While drunk, they may assume an abnormal posture, which may result in pressure on radial nerve and lead to its paralysis.

The common effect of heavy drinking is 'hangover'. In this, the person experiences headache, nausea, irritability, stomach upset, thirst and tiredness about 8 to 12 hours after drinking. Headache is due to cerebral edema. Blackouts may be experienced by some wherein they do not remember all that happened during a heavy drinking episode.

Alcoholism is characterized by psychic dependence on alcohol in all degrees. In milder degrees, alcohol may be desired if not present at meals or social functions. At moderate degrees, the individual is compelled to drink in order to work or participate socially. He may use all means to get his supply of alcohol. In cases of strong dependence, the individual drinks alcohol far exceeding the cultural norms and also drinks in unacceptable situations. He is so obsessed that he may use unfair means to maintain the supply of alcohol to the extent of drinking unusual or poisonous mixtures. Tolerance to alcohol may develop. This is the development of body or tissue resistance to the effects of alcohol so that larger doses are required to produce the original effect. There may be some cross-tolerance between alcohol and barbiturates, which is mutual but incomplete.

Another characteristic feature of alcoholism is its physical dependence. If the body develops dependence to alcohol, a sudden cessation of alcohol intake is likely to produce withdrawal symptoms. Withdrawal symptoms are manifested by tremors, sweating, nausea, severe anxiety, inability to sleep, irritability, increase in the pulse rate, rise in temperature, hyper-reflexia and postural hypotension. In severe cases there may be hallucinations, convulsions and delirium. The intensity varies with the duration and the amount of alcohol taken. If the symptoms are severe and proper medical management is not given, the condition could be fatal.

Various complications can arise due to alcoholism. These are:

(1) Intoxication:

The effect of alcohol is dose-dependent and results in progressive depression of the reticular activating system of the brain. This is followed by the general depression of the central nervous system function leading to coma and eventual death through respiratory arrest. A blood alcohol concentration of 0.1% is considered conclusive of intoxication.

(2) Alcoholic amnesia:

Alcoholic amnesia or blackout is a short term memory loss occurring during period of acute intoxication with a rising blood alcohol level. The loss of memory is in the short-term range, beyond the immediate 3 to 5 minutes. Remote memory that is the events prior to the onset of the rising blood level remains intact.

(3) Withdrawal:

If the body develops dependence to alcohol a sudden cessation of alcohol intake is likely to produce withdrawal symptoms. The earlier and most common features of alcohol withdrawal are anxiety, anorexia, insomnia and tremor. The patient appears hyper-alert and has jerky movements, irritability and a tendency to be easily started. Delirium tremens is most severe withdrawal state. It is characterized by marked tremor, anxiety, insomnia, anorexia, paranoia and disorientation. The person may attempt self-harm during outburst of irrational behavior. The state of delirium tremens peaks after about 3 days of abstinence but can also occur several days thereafter. The delirious state persists 2 to 3 days and rarely longer and often ends abruptly. Convulsive seizures of grand mal type may occur during the withdrawal from alcohol. The seizures tend to occur during the first later, especially if other depressant drugs have been used chronically.

(4) Malnutrition:

Many alcoholics show signs of malnutrition. There is replacement of normal caloric intake by alcohol. Also the available funds are used to purchase alcohol rather than food. Nutrient depletion resulting from chronic alcohol ingestion may gradually lead to damage of various body tissues. The central nervous system and the liver appear to be affected most significantly. Their dysfunction may further degrade nutritional wellbeing. The effects on other body tissues are also related to malnutrition such as on endocrine, cardiovascular, hematological and immune system. The alcoholics derive a major portion of caloric intake from alcohol. These are termed as empty calories as the alcoholic beverages do not contain significant amount of important nutrients like protein, vitamins and minerals. Over the period of months, depletion of nutritional stores is inevitable and there is deterioration of nutritional status.

In alcoholic patients, there are frequent abnormalities in digestive and absorptive abilities. Maldigestion and malabsorption may seriously compromise utilization of ingested food and degrade further the already poor nutritional status of the affected patient. The impaired digestion and absorption is due to the damaging effect of alcohol on the stomach and small intestines and subsequently on the liver and pancreas.

(5) Disorders of the gastrointestinal system:

Alcoholics show great frequency of symptoms such as abdominal pain, erratic bowel functions, nausea and vomiting, gastrointestinal hemorrhage and jaundice.

The alcoholic is susceptible to developing esophagitis that is inflammation of the esophageal mucosa. This is due to increased acid production by the stomach and frequent vomiting. There is also regurgitation of stomach contents into the esophagus.

Excessive alcohol ingestion leads to inflammation of the pancreas. This condition is termed as pancreatitis. When there is a single episode, which is reversible, it is termed as acute pancreatitis. Acute pancreatitis is manifested by upper abdominal pain, nausea and vomiting, ileus, decreased plasma volume, low blood pressure and serum electrolyte

vomiting, ileus, decreased plasma volume, low blood pressure and serum electrolyte disturbances. When there are repeated bouts of pancreatitis resulting in chronic irreversible scarring of the gland it is called 'chronic pancreatitis'. It is manifested by longstanding pain, fat malabsorption leading to weight loss, malnutrition, and foul-smelling bulky stools often with diarrhoea. It may also lead to endocrine insufficiency that is diabetes mellitus.

(6) Disorders of the liver:
The most common development in alcoholic liver is increased fat in the liver parenchyma - the so called alcoholic fatty liver. In some patients, continued heavy drinking may lead to necrosis of the liver cells and inflammation. This is termed as alcoholic hepatitis. This condition is characterized by enlargement of the liver, jaundice, abdominal pain and fever. It may lead to more fulminant form, advancing to death or cirrhosis of the liver. Alcoholic cirrhosis of the liver is the final part of the spectrum of alcoholic liver disease. In this condition there is fibrosis associated with disruption of normal liver lobules and formation of nodules.

(7) Neurological disorder in alcoholism:
Excessive use of alcohol may lead to acute and chronic brain and peripheral nerve dysfunction. Both the acute and chronic stages show alteration in memory, impairment of intellectual functions such as calculation, comprehension and new learning as well as impaired judgement and lability or shallowness of affect.

Secondary alcohol related effects may lead to organic brain damage. Blood alcohol levels may be high enough to induce coma with hypoventilation may cause hypoxia sufficient to produce organic damage. Vomiting during alcoholic stupor may lead to aspiration of gastric contents. Head injury associated with alcohol related trauma. Due to alcoholic hypoglycemia there may be serious and sometimes fatal damage to the central nervous system. Condition caused by acute niacin deficiency such as dementia, dermatitis and diarrhoea may develop rapidly.

Peripheral neuropathy is also frequently reported in the alcoholics. The onset of symptoms is slow over weeks or months. Involvement is usually bilateral and symmetrical. The first symptom may be pain in the calf muscles or feet or there may be associated burning, tingling in the lower extremities. Later, these symptoms may occur in the hands and arms. As the process continues, muscle weakness and wasting also occur. There may be foot drop gait. Later the legs may become completely paralysed. There is numbness of stocking or glove type.

Abstinence from alcohol and nutritional supplements may show improvement in some patients though in advanced cases there may be some degree of permanent disability.

(8) Alcoholic amblyopia:
This is a rare type of eye disorder. In the past it was referred as tobacco alcohol amblyopia as it was encountered in alcoholics who are usually also heavy smokers and are malnourished. The condition is characterized by painless, bilateral blurring of vision with reduced visual acuity and scotomas.

(9) Sleep disturbances:
Sleep disturbances including frequent awakening, restless sleep, insomnia and might terrors are the most common complaints of the alcoholics. There is marked insomnia when there is abrupt withdrawal from alcohol.

(10) Hematological disorders:
Anemia is the most common abnormality amongst the blood disorders due to alcoholism. White blood cell and platelet production and function are also affected. Basically there is defect in cell proliferation, cell maturation and cell survival.

(11) Disorders of the heart:

(11) Disorders of the heart:
Due to excessive ingestion of alcohol, a number of factors indirectly produce effects on the heart. These factors are decreased potassium levels, decreased magnesium levels, altered fluid balance, increase in blood lipid levels, alcohol withdrawal reactions, beri-beri heart disease and beer drinkers heart.

Drinking large amounts of alcohol often leads to lowered levels of serum potassium which is particularly true in those people who drink heavily and neglect food. Alcohol selectively increases the urinary excretion of magnesium and lead to lower magnesium levels. Severe alcohol withdrawal symptoms seen in alcoholics such as withdrawal seizures, nausea and vomiting and delirium tremens may place a stress on patient's cardiovascular system and lead to heart failure.

(12) Effects of alcohol on skeletal muscles:
Heavy alcohol ingestion has an adverse effect on the skeletal muscles and the heart muscles. It leads to acute alcoholic myopathy, chronic alcoholic myopathy and subclinical alcoholic myopathy.

Acute alcoholic myopathy is characterized by muscle pain, tenderness and swelling. The proximal muscles of the extremities, the pelvic and shoulder girdle and the muscles of the thoracic cage are the most common sites of involvement.

Chronic alcoholic myopathy is characterized by muscle wasting and weakness of the same muscle groups as acute alcoholic myopathy.

Subclinical myopathy may be defined as acute myopathy in which patients are seen in with acute intoxication or withdrawal but symptoms related to skeletal muscles are absent or obscured by the presenting symptom.

Treatment in all forms of alcoholic myopathy consists of abstinence from alcohol and return to a nutritious diet rich in vitamins.

ALERT alcohol ALE

Industry Targets the Young

"Scandal as drink bosses target our children" was the headline in the Daily Expres article was inspired by the recent Eurocare publication, "Marketing Alcohol to You People", an eye-catching brochure which brings together examples of advertisem from all over the world. The text shows how the drink industry cynically sets out t persuade the young to consume alcohol by making it appear glamourous, fashion and amusing. The advertisements associate alcohol with sporting and sexual pro Heroes of the football field play with the logo of a particular beer emblazoned acr chests. Beautiful young women imply a willingness to surrender to the man who s particular kind of booze. Perhaps most notoriously, there is the Carlsberg baby – of a few months who, in the colours of Liverpool FC, is already a living advertisem Carlsberg lager.

It was this last image which caught the attention of Gro Harlem Brundtland, the Director G the World Health Organisation, at the recent ministerial meeting in Stockholm on Young Pe Alcohol. Holding up the brochure, she said that this was evidence of what governments con about the well-being of youth were up against.

Besides the Daily Express, other major national newspapers took up the story, as did televi radio. The industry was perhaps unprepared and could only come up with the comment tha "Marketing Alcohol to Young People" was "inaccurate and misleading" though the various spokesmen could hardly deny that the advertisements were genuine and spoke for themsel "Self-regulation is working," said the industry's Portman Group and it is true that a numbe complains have been upheld but these have been against such flagrant violations that they hardly be ignored without the system being totally discredited.

Those working with the problem would say that what is much more insidious is the relentle pressure exerted by the kind of advertising strategies highlighted in "Marketing Alcohol to People".

The fact is that problems arising from alcohol use among the young are rising, particularly United Kingdom, and there is a vast consequent cost to the NHS – besides the terrible pers price many families have to pay. At least the Portman Group is happy with how things are the self-regulation front.

Ironically on the day "Marketing Alcohol to Young People" was reported in The Daily Telegr same newspaper announced a "ground-breaking" appointment at Bacardi-Martini, one of t Portman Group's major funders: a marketing director with special responsibility for "the yo market" and audiences at musical events.

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