Structured Preparation for Detoxification from Alcohol (SPADe)

A pre-habilitation approach for the treatment of alcohol dependence

Intervention step by step guide for

The Abstinence Preparation Group

Every detox matters for a sustainable outcome

Authors

Dr Christos Kouimtsidis and the SPADe trial group

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“We are what we repeatedly do. Excellence, then, is not an act, but a habit.”

Aristotle 384 BC - 322 BC

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Disclaimer

This group therapy manual is based on the intervention manual used in the SPADe trial, funded by the National Institute of Health Research, Research for Patients Benefit (PB-PG-0815-20014), started in 2017 and completed in 2019. This was a feasibility study of an intervention for Structured Preparation before Detoxification in Alcohol Dependence. The work was in three stages: (1) The development, adaptation, and implementation of the intervention; (2) a randomised feasibility study with economic evaluation; and (3) a qualitative study. The protocol of the study is available: Pilot Feasibility Stud 5, 59. https://doi.org/10.1186/s40814-019-0446-1.

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Introduction

The concept of pre-habilitation

Pre-habilitation proposes the identification and proactive management of (i) any factors anticipated to compromise the successful outcome of an intervention and (ii) the potential side effects associated with this intervention. This represents a pro-active rather than a reactive approach aiming for sustainable outcomes. It is described as a shift away from an impairment driven reactive model and as an opportunity for long term changes in lifestyle. Pre-habiliation does not negate rehabilitation. It rather compliments and facilitates rehabilitation.

The concept of pre-habilitation has been introduced recently in the field of orthopaedics and describes a set of exercises and training routines introduced to certain groups of people or athletes, which aim to maximise physical strength and reduce the risk of expected harm or frequent injuries. The concept has also been applied in surgery with the aim of preparing patients for a surgical intervention (1).

This concept is not new. Identifying risks and planning in advance, is considered to be a crucial determinant of the interaction between humans and the environment. From an evolutionary point of view the ability to expect and plan are crucial abilities associated with the individual progress and development of human civilisation as a whole. Planning is crucial in all aspects of everyday life. The ability to predict or anticipate certain harm or assess certain risks is associated with the human ability of learning from experience, modify behavioural responses and develop long-term and sustainable response strategies. To that effect, planning in advance, in anticipation of risks can be considered as an essential strategy and quality, associated with individual survival and progress. Planning is not restrictive of improvisation and innovation, to the contrary it provides a stable environment for progress and positive change to take place.

Learning and habit development

We, humans, in comparison with other primates, have better developed the ability to test new behaviours when we face a challenge. If the new behaviour provides a solution to the given challenge we repeat this behaviour. If we assess that the outcome was not successful we abandon the behaviour. This assessment of outcome could be an elaborated in depth one or a very fast one, depending amongst other factors, on the circumstances, such as the real or perceived threat, as well as the ability of the person to engage in such an activity. Whatever the extent of the assessment, this is a conscious process, which is time consuming and could evoke difficult emotions and lead to cognitive and emotional tiredness.

Following the initial assessment of outcome, the repetition of the successful behaviour leads to consolidation of this behaviour as a response initially in similar situations and later in different situations (2). Over time a successful behaviour becomes automatised. This means that the behaviour is repeated very fast, bypassing the conscious and careful consideration of pros and cons, as this analysis has been done in the past and it is not required anymore. The ability to automatise successful behaviours allows us to continue with further learning and accumulation of new skills and expertise. This ability to bypass conscious decision-making, has two major disadvantages: as we are not able (i) to monitor the appropriateness of the behaviour as a solution to new situations (similar or different) and (ii) to assess the need for possible ongoing modifications. In other words the behaviour which started as a rational informed choice from a pool of alternative options, is not a choice anymore. There is no freedom, nor learning nor developing of new skills. Instead, it can become a repetition of a fixed and potentially harmful behaviour.

In the case of drinking (as well as other substance misuse), following the initial positive reinforcement (confidence in social settings, popularity) or negative reinforcement (reduction of emotional pain, trauma), this leads to the state where habitual drinking, dominates all other behaviours and is repeated despite the loss of effectiveness and accumulation of evidence of associated harm. This leads to a person experiencing a paradox of not wanting to drink but liking to drink (3). From a psychological perspective any explicit cognitions, such as positive and negative expectancies of the effect of drinking, which are conscious and under the control of the individual, become implicit, bypass the conscious decision-making pathway and fuel continuation of drinking (2). Furthermore, the person will try to prevent any uncomfortable feelings and thoughts (cravings) or even physical symptoms associated with low levels of blood alcohol by ongoing drinking. This is described as loss of control, which is the common underlying theme of Alcohol Use Disorder in both ICD 10 and DSM-5 classification systems (4, 5).

Unlearning and changing a habit

Whenever an automatised behaviour requires to be modified, either when we need to correct the way we perform a musical piece, or when a UK trained driver needs to drive in Europe, the learning process needs to be slowed down, in order for the decision making process to become conscious again. In other words, we need to reverse the process of learning to the extent that what was ‘wrongly’ learned be eradicated and replaced with the new ‘correct’ learning. In the case of a habit the automatised behaviour is repeated with minor stimulation or provocation. To change a habit, we need to create a safe space, in which we resist an automatic act, coping with uncomfortable physical or emotional symptoms. Under those very challenging conditions, we then explore new behaviours and new solutions. This means that the implicit cognitions need to become explicit again and

the individual needs to regain conscious control in order to modify the behaviour. This is the main aim of all cognitive behavioural interventions for addictive behaviours (6).

This reversal process is easier to be achieved in (i) a safe and friendly environment, (ii) where both external factors and (iii) internal factors necessitating fast reproduction of a behavioural response are kept under control. Factors such as stress, threat or uncomfortable physical symptoms usually provoke instinctive responses of a habitual nature. We tend to think clearer and wider and can explore more alternative solutions when we do not face immediate threat or are under stress. Therefore, a pre-habilitation approach aims to predict and manage those generic factors as well as those specific factors associated with the detoxification process itself.

In conclusion, from a pre-habilitation perspective, a habit or an addictive behaviour is considered to be the outcome of false learning. The process of developing a habit is associated with the process of learning. In other words, we face the risk of losing control and developing harmful habits because we have this ability to learn and repeat fast new behaviours in order to survive.

Alcohol Use Disorder and treatment

What is alcohol dependence?

The term "alcohol dependence" was first introduced in 1976 by a World Health Organisation (WHO) Group of Investigators to replace the term alcoholism (7). The term was roughly equivalent between the Diagnostic and Statistical Manual (DSM-IV) and the International Classification of Diseases (ICD-10) classification systems and in ICD-10 is defined as "a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state" (4). Therefore, dependence in both classification systems refers to both physical and psychological elements. Psychological dependence refers to the experience of impaired control over drinking, while physical dependence refers to tolerance and withdrawal symptoms. In ICD-I0, the diagnosis of dependence syndrome is made if three or more of six specified criteria were experienced within a year (4). DSM–5 integrates the two DSM–IV disorders, alcohol abuse and alcohol dependence, into a single disorder called alcohol use disorder (AUD) with mild, moderate, and severe sub-classifications (5).

What is alcohol withdrawal syndrome?

Alcohol withdrawal syndrome is a collection of symptoms that occur after an alcohol dependant patient stops consumption (8). According to the criteria for diagnosing AUD outlined in the (DSM–5) withdrawal symptoms include, sleep disturbance, tremor, restlessness, nausea, sweating, tachycardia, seizures and delirium. The syndrome of alcohol withdrawal can generally be categorised into three stages: sympathetic hyperactivity in the initial 24 hours after cessation, this can be followed by epileptic seizures 24-48 hours later and finally delirium and tremens can occur 3-7 days following cessation (8). Alcohol withdrawal syndrome can also lead to death due to respiratory and cardiovascular failure. Withdrawal from alcohol has also been associated with cognitive impairments in recovering alcoholic patients (9). It has been demonstrated that relapses after withdrawal is associated with a cognitive deficit (10).

What are current NICE guidelines treatment recommendations?

Current treatment guidelines suggest that treatment for moderate to severe alcohol dependence needs to be planned and emphasis should be given on the provision of structured aftercare. Medically assisted detoxification should be provided at the first available opportunity, either in the community as an outpatient or as an inpatient as clinically indicated based on risks due to acute withdrawals such as epileptic fits. This recommendation makes the assumptions that either the intervention is free from non-acute side effects or that they could be managed effectively with medication. The type of detoxification has no effect on treatment outcomes (completion of detoxification or long-term abstinence). The choice depends on a list of health risk factors and availability of social support to reduce these factors during the detoxification process (11).

Structured aftercare follows completion of detoxification and should include interventions based on Cognitive Behaviour Therapy either on an individual basis or Relapse Prevention Group work, as well as family interventions. Attendance at peer support groups such as SMART recovery groups or Alcoholic Anonymous is highly recommended. Pharmacological interventions such as anti-craving agents such as Acamprosate, Naltrexone and Disulfiram are recommended. Existing evidence does not favour residential treatment over community treatment nor longer versus shorter duration residential treatment programmes. Access to residential rehabilitation, although available is only recommended for homeless people and efforts should be made to address accommodation issues prior to discharge (11).

Risk factors associated with relapse following medically assisted detoxification

Relapse into drinking is a common phenomenon. Research studies show that 65–70% of people will relapse within 1 year, with about 50% relapsing within 3 months. Relapse is most

likely to result from a combination of various factors including the individual characteristics of the person, alcohol addictive potentials and environmental reinforcers. Among treated individuals, more severe alcohol related problems, greater social pressure, lack of self-efficacy, poor coping skills, co-morbid mood disorder and anxiety disorder have been associated with short-term relapse (11). To reduce those risk factors CBT, family interventions, peer support and pharmacological management of cravings are suggested as above.

There are two major disadvantages with this approach: (i) it is expected that these interventions have an immediate impact on reducing risk factors and improve the ability of the person to cope with them and (ii) that all the people that have been detoxified would attend aftercare interventions. It is common clinical experience though that this is not the case. Local data suggests that only 60% of people who have completed medically assisted detoxification engaged in aftercare interventions (12).

A third major disadvantage is the assumption that the medically assisted detoxification, the intervention itself, does not have any side effects and that those anticipated are (i) well managed with existing pharmacological options and (ii) there is no risk of exaggeration of those side effects over time or with the repetition of the intervention (i.e. with repeated detoxifications).

Risks associated with repeated alcohol withdrawal and medication-assisted detoxification interventions

There is evidence from animal models, pharmacological studies, and psychological experimental studies to suggest that abrupt withdrawal from alcohol as well as detoxification may contribute to cognitive impairment, stress sensitivity and exaggeration of cravings. Furthermore, it seems that currently used medication for detoxification cannot protect from these adverse effects (13).

Despite their limitations, animal models demonstrate a variety of withdrawal-induced cognitive impairments such as in learning, cognitive flexibility, memory, sociability, as well as increasing anxiety and sleep disruption. In addition, they indicate the worsening of withdrawal symptoms given multiple withdrawal episodes, such as frequency of seizures, and worsening the effect on some of the associated cognitive impairments.

During recent years, accumulating evidence suggests that individuals who have experienced repeated episodes of withdrawal show changes to their affect, increased craving, as well as significant deterioration of cognitive abilities, when they are compared to patients with fewer withdrawals. Furthermore, several investigators have suggested that repeated episodes of detoxification increase the risk of withdrawal seizures.

Alcohol withdrawal and its complications develop as alcohol levels decrease. Treatment of alcohol withdrawal generally attenuates the risk of such consequences. Current clinical treatment with benzodiazepines may not be optimal in attenuating the hyperglutamatergic state of alcohol withdrawal and as a result, recurrent withdrawals result in an increase in severity of symptoms due to kindling effect. We discuss in detail the risks associated with repeated alcohol withdrawals with or without medication in our review paper (13).

The theoretical basis of SPADe interventions

Over the years several theories were developed with the aim to understand and explain the phenomenon of addiction. All the theories that aim to explain the process of how the reward seeking behaviour is initiated, then becomes out of control and is maintained irrespective of the harm experienced, could be seen under a common theory framework that focuses on the principle of choice. The therapeutic interventions (pharmacological, psychological or social) based on these theories, conceive addiction as a decision-making process which is conscious to start with, but becomes unconscious with time and, in order to be modified, needs to become conscious again.

One of the oldest theories of human behaviour is Operational (or operant) Conditioning. The theory aims to explain how the initial choice is made to use a substance. Operant conditioning suggests two types of reinforcements that increase the rate of an observed behaviour: negative reinforcement by removing or diminishing an unpleasant experience, and positive reinforcement by enhancing or the addition of a pleasant experience (14).

Another early model proposed to explain the concept of choice in addiction is the economic model of Rational Addiction. It is based on the concept of rationality, defined as a "consistent plan to maximise utility over time". The theory suggests that addiction is an increased consumption of a "good" as a result of past consumption (15).

Social Learning theory is a generic theory of human behaviour (16). This extremely influential theory, focuses on the individual and his/her choices within a social environment. Behaviour is regarded as the result of a continuous interaction between personal and environmental variables: personal variables include cognitive factors (competencies, intellectual abilities), cognitive strategies (ways of attending to and organising information), expectations (about consequences of behaviour), values, self-imposed standards, rules, morals etc. Environmental variables include effects of other people and interaction between individuals and situations. Social Learning introduces two main concepts: (i) outcome expectations, which are "the person's estimate that a given behaviour will lead to certain outcomes" and (ii) efficacy expectations (or self-efficacy) which refers to a person's belief "that one can successfully execute the behaviour required to produce outcomes" (16). The theory was expanded later to the Social Cognitive Theory in order to conceive the person as an agent of change that affects the person and the social environment (17).

The theory of Planned Behaviour, introduced by Ajzen, is a related theory, which proposes that behaviour is the result of intention to act, which is a combination of the individual's attitudes, perceived norm and perceived control (18). In a recent modification of this theory, Kuther proposed that both types of norms (parental and peer norms) have a direct effect on alcohol use, as well as an indirect effect through positive and negative expectancies from drinking (19).

Another related psychological theory is the Expectancy theory. Originally, Expectancy theory placed emphasis on initial conscious cognitive processes, which are related to the experience of craving. Evidence though suggested that the subjective report of craving is only moderately linked with substance use and relapse. As addiction progresses substance use is regulated by automatic cognitive processes, while craving represents the activation of non-automatic processes. These non-automatic processes are activated either to aid in completing interrupted substance use, or block automatic substance use sequences (20). As addiction develops the expectancy-based control system of behaviour becomes unconscious and therefore behaviour is influenced less by conscious expectancies involving controlled processes and more by unconscious expectancies involving automatic processes. Furthermore, Cognitive Bias theory introduces the concept of biases that affect conscious functions such as beliefs, attention and memories as well as unconscious processes in information recall from memory (21). It is hypothesised that representations of the behaviour are "linked" in long-term or semantic memory with propositions about outcome (e.g. relaxing, risky, etc.). Such links may be created by direct experience but are not likely to be solely determined by this, and may be formed by abstraction of information from the environment (22). Over time, activation of one part of the "network" (e.g. alcohol-representations) automatically triggers propositional links in other parts (e.g. relaxation concepts) and vice versa. Thus, an accessibility bias for positive information about the behaviour develops. Negative and behaviourally inhibiting information may be available, however, it is hypothesised that this information is less accessible and relies more on effortful and non-automatic cognitive processes, therefore its moderating impact on behaviour is compromised (22).

The Hedonic Homeostatic Dysregulation model provides a synthesis between biological and psychological models (23). In this model, addiction is presented as a cycle of spiralling dysregulation of brain reward systems that progressively increases, resulting in compulsive substance use and a loss of control. Neurobiological mechanisms such as the mesolimbic dopamine system, opioid peptidergic systems, brain and hormonal stress systems as well as social psychology concepts such as sensitization and counter-adaptation are hypothesised to contribute to this hedonic homeostatic dysregulation. Similarly the Incentive-Sensitisation model, provides an explanation of how the choice is lost and suggests that there are at least two distinct psychological processes involved in reward: a) subjective pleasure ("liking"), and b) incentive salience attribution ("wanting") (3). These two psychological processes are mediated by different neural systems. With the

development of an addiction, substances become pathologically wanted ("craved"), which can occur even if substances are liked less and less.

The Inhibition Dysregulation model also attempts to explain the progress from choice to compulsive use (24), by proposing that addiction involves a progressive dysregulation of ability to inhibit a behaviour that is rewarded. The model suggests that aspects of decision-making processes are compromised in perhaps either a direct way (i.e. dysfunctional inhibitory system) or indirectly via a dysfunctional reward system. These integrative psychobiological models provide a very promising synthetic approach consistent with the development of a single theoretical framework.

Identity Shift theory takes into account the principle of unstable preferences, which is considered a fundamental feature of human motivation, and proposes that increasing distress caused by behaviours associated with value conflict prompt to a small step towards behaviour change, which if successful begins to lead to an identity shift. Increased self-awareness and self-confidence then fuel continued change. At the core of the model is the on-going evaluation of benefits, costs and the build-up of dissatisfaction with the current situation. Then a trigger, small or major, results in an immediate and unplanned step of change that initiates the process of behaviour change (25).

West proposed a new theory of Motivation called PRIME, an acronym standing for the proposed five levels of motivation: plans, responses, impulses/inhibitory forces, motives, evaluations. Although it is described as a theory of motivation it could be regarded as a theory of addiction in general. According to this theory, addiction is conceived as a chronic condition of the motivational system in which the reward seeking behaviour has become out of control. This is a synthetic theory that aims to encompass all the elements of the previously discussed theories. The levels of motivation are hierarchical from low levels of responses that involve reflexes and automatic behaviours to higher responses that include evaluations, plans involving expectancies and the concept of identity (26).

The theory proposes that there are three types of abnormalities of motivation: (i) abnormalities of the motivational system that exist independently of the addictive behaviour such as a predisposition to anxiety or depression; (ii) abnormalities of the motivational system resulting from the development of the addictive behaviour itself, meaning the process of developing a habit; and (iii) abnormalities in the individual's social or physical environment such as the presence of strong social or other pressures to engage in an activity such as drinking or drug taking. That means that an activity becomes addictive if it affects an already unbalanced system (co-morbid anxiety, traits of impulsivity) which operates within an unbalanced environment (belonging to a social group where that activity is considered normal), in such a way of undermining the normal checks and balances that operate to prevent undesirable behaviour (activity becoming continuously rewarding).

Components of SPADe interventions

Therapeutic relationship and language

Similarly to any therapeutic interaction, for any SPADe based intervention, either group or individual, it is crucial to establish a warm and empathetic therapeutic relationship with the aim to empower the person to clarify and articulate the aims of his/her treatment or help requested, as well as to implement the changes required to achieve these aims. It is inherent with therapeutic relationships to be hierarchical, to be relationships of power between the professional and the person asking for help. We need to be aware of this, avoid it or use it for the person's benefit when appropriate.

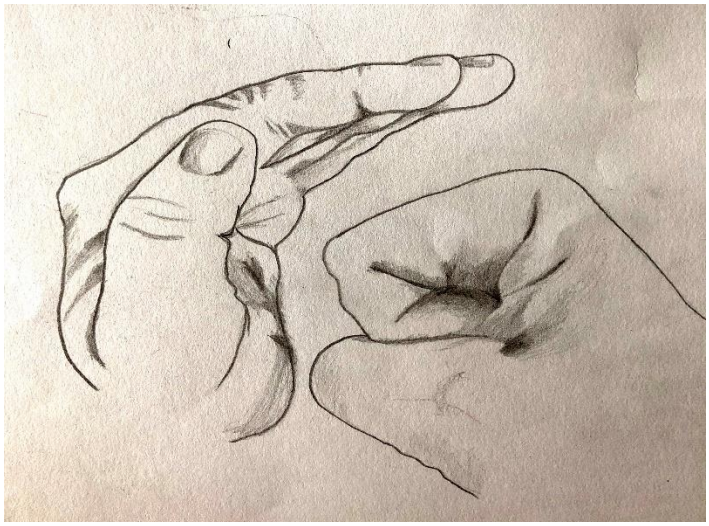
It is crucial to remember that from an evolutionary theory point of view, humans have the ability to metabolise substances, develop habits and therefore are at risk of losing control and getting addicted to substances. Not every drinking person is going to lose control but under adverse conditions or combination of risk factors everyone could. Therefore, there is no space for blame or judgement. To the contrary, for those brave enough to seek help and support, there is ample space or even obligation to approach these people with respect and admiration. They seek to change a behaviour that was, but is not anymore under their control and has caused harm to them and those around them. By seeking help, they acknowledge, even silently, their responsibility for the past as well as for the future. Therefore, they deserve to be respected.

Every change, imposed or chosen provokes stress and anxiety. This needs to be acknowledged. To that effect attribution of meaning, understanding of the challenge, the available options with their pros and cons, as well as planning how to mitigate and work through those options will help the person and their social environment to make a start, maintain efforts and achieve sustainable outcomes. The theories supporting SPADe provides us the tools. We do not impose but we explore their views, reframe and promote a mutually shared understanding. To achieve this, we need to establish the same level of language. Whatever information we provide or scientific knowledge we share needs to be understood first by us and then explained to our clients. This is crucial as pre-habilitation might sound a bit strange or new to us as well as the client.

The "2 hands model" of addiction

This is a visual representation of the brain and the process of how habit and addiction is developed. It narrates that the brain is grossly divided in two parts (for simplicity): (a) the cortex which is responsible for planning, creating and imagining (represented by the left hand opened to form an arc), better developed in humans rather than other primates and (b) the midbrain which is responsible for survival (represented as the right hand closed as a

fist covering the space under the arc) shared by other primates and animals. The advantages and disadvantages of each part such as choice and ability to change and modify behaviour of the cortex and fast repetition of behaviours is controlled by midbrain, have been described above. The process of transformation of a chosen behaviour which is repeated because it is successful and controlled by the cortex into an automatic response which is controlled by the midbrain and repeated without control and re-assessment by the cortex is described in a simple narrative as an example of 'false learning'. During this description the process is compared with the process of learning and examples of positive behaviours and skills such as driving, riding a bicycle or playing a musical instrument are used in order to emphasise the point that everyone under adverse circumstances could lose control over a substance and become addicted.



Partial control

The concept of controlled drinking has generated intense conflict within the field of addiction medicine. It was presented as an alternative to lifelong abstinence, as the sole treatment outcome. In clinical guidelines such as NICE, controlled drinking within healthy limits is considered as an appropriate treatment target for harmful drinkers. For dependent drinkers (i.e. those with the most severe drinking behaviour) abstinence remains the preferred treatment aim (11).

Within the SPADe treatment approach for alcohol dependence, controlled drinking is referred to as "partial" for two main reasons: (a) it is an intermediate treatment stage rather than the final treatment aim, which remains to be abstinent; and (b) the amount and pattern of drinking during this process is not always within healthy limits.

Within SPADe, the main aim of the partial controlled drinking is the stabilisation of both the amount and pattern of drinking. Alcohol is considered as "if it was medication" with

frequent and regular dosing to prevent rather than treat withdrawal symptoms. This proactive elimination of symptoms is considered fundamental from a biological perspective as it protects against brain acute dysregulation, which in turn might sensitise the brain, leading to an exaggeration of the negative impact associated with the disturbance of the brain's homeostatic system. From a psychological perspective it empowers the individual into regaining some control of the decision making and reduces the impulsivity associated with the experience or avoidance of experiencing cravings and withdrawal symptoms. Furthermore, it provides a relatively stable environment for the individual and the close social environment to start implementing lifestyle changes (see next section), leading to an increase of self-efficacy, which is considered the final mediating factor in social learning theory and Cognitive Behavioural treatment models (16, 27).

The amount of drinking following stabilisation of patterns as described above, could be reduced gradually, following the principle of small sustainable changes. The aim is to avoid any heroic and dramatic change to the amount of drinking, which not only will be unsustainable but might lead to precipitation of withdrawal symptoms, which could be life threatening. Once stability is achieved then gradual reduction can be safely achieved. Our experience suggests that roughly half of the individuals will be able to come off alcohol without the use of detoxification medication (28). This model of detoxification is called "guided self-detox" (see below). It refers to the process of using alcohol as if it was medication and as a safe detoxification tool.

Early lifestyle changes

Stabilisation of drinking provides, for a short period, a relatively stable and safe environment for the individual and the immediate family and social network to develop and test lifestyle changes. Those early and gradual implementation of changes within the individual's lifestyle are necessary to provide (i) a routine in everyday life that would protect from early relapse, (ii) fill in the void that alcohol detoxification would leave behind, (iii) could be used as distraction strategies against cravings, (iv) would enhance personal responsibility, (v) would de-mystify alcohol and challenge the omnipotence of cravings or withdrawal symptoms, and finally (vi) would protect from the acute stress experienced in the early days of abstinence.

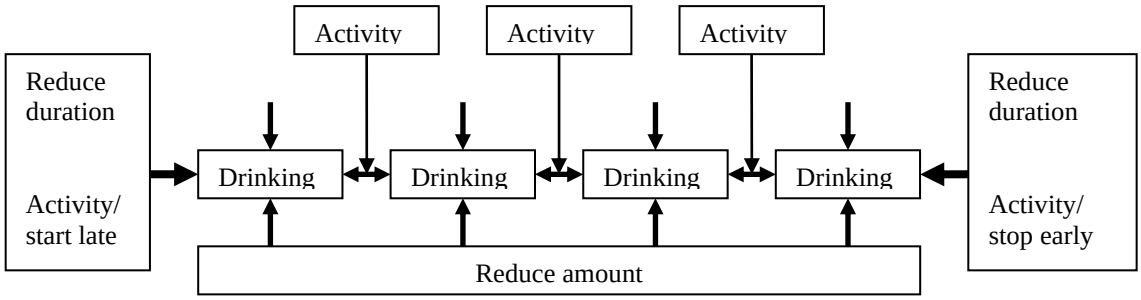


Diagram of controlled drinking strategies

As discussed above it is expected that during the detoxification as well as during the first few weeks post detoxification, major changes are taking place in the brain. To that effect it could be anticipated that the ability of the person to learn new information and adjust and adapt to a new reality might be compromised. This new learning and adaptation is expected to be easier within a protective clinical environment where real life stimulation is controlled. It could represent an additional advantage of inpatient detoxification of that of the safe management of severe withdrawal symptoms. This inpatient environment though carries a major disadvantage. It is artificial and prevents testing new skills in real settings. It postpones the challenge of real-life adaptation to a later time when the expected changes in the brain are settled. It is however well reported that the change from a protective to real social environment is linked with high relapse rate even if the stay in the protective environment is 6 months long. This indicates that the adaptation to a new reality could have been compromised either because new skills and behaviours were not tested in the real new social environment (which raises questions on the effectiveness of skills based interventions in an inpatient setting) or that the social environment itself has not been modified (i.e. expectations and behaviours of family members and levels of stress levels).

Hence, the SPADe model proposes that these lifestyle changes should be initiated and tested while alcohol is stabilised and to be augmented, as well as evaluated after the detoxification.

Empowerment of family and immediate social environment

As discussed above drinking is not happening in a vacuum. It is initially a conscious choice within a situational context which aims for positive reinforcement (fun) or negative reinforcement (removal of an unpleasant state). Family and immediate social environment could be contributing factors to the situational context that drinking takes place. This environment could cause or perpetuate drinking directly through modelling or in-directly

by escalating stress or emotional discomfort. Therefore family and significant others of the immediate social environment, could be part of the problem and part of the solution.

The involvement of family members and the immediate social support system into the treatment should help into providing education, modifying unrealistic expectations, supporting a more gradual adaptation to the new family dynamics (following the removal of alcohol), and will help managing anxiety and difficult feelings/emotions associated with broken trust, promoting a partnership approach. The fundamental reason is that recovery is easier and more sustainable within a respectful, stress-free and supportive environment.

This environment has been compromised to a greater or lesser degree by the person's drinking. Alcohol harmful use by a family member or a partner shares a lot of similarities with an extra-marital relationship or an external strong relationship that led to the neglect of all other relationships. Given that the aim of the SPADe intervention is to reverse the automatisation process and help the individual to reconsider alternative behaviours to cope with internal or external high risk situations as well as finding new sources of pleasure and satisfaction, this aim is better to be shared as a common project, involving both parties, all family members and close friends. This does not mean that the responsibility for change or treatment of addiction is displaced from the individual to others. It only means that it could be shared.

More specifically it is far easier for the individual in recovery to maintain abstinence, in particular during the first few weeks, within an abstinent family environment, which would have removed any proximal cues/triggers (smell or sight of alcohol) as well distant cues such as elevated levels of stress or emotional negativity. To that effect family members should be informed (see appendix 1) of their role, should be involved in treatment early and should consider themselves part of the changes that need to be made.

Guided self-detox

Guided self-detox can only be achieved if lifestyle changes are taking place at the same time and family and important others are aware and supportive of the plan. Relapse prevention medication such as Acamprosate and Naltrexone could be used during the process. This process could be extended to a maximum of 12 weeks. If prolonged further our experience suggests that it could lead to exaggeration of drinking, loss of motivation and burn out of the client, family and staff.

1) Step 1: stability of amount and pattern

For at least 1 week stabilise the amount of alcohol consumed per day. Depending on the amount consumed, the risk of severe withdrawal symptoms (for example recent history of epileptic fits, severity of morning shakes) and other existing risk factors, it is suggested: either to stabilise on the average amount consumed, or the amount that prevents

withdrawal symptoms, or in the case of a client that lacks confidence, the usual highest amount consumed (not the amount consumed following an attempt to stop).

For at least 1 week spread-out and stabilise the pattern of drinking, as if alcohol were medication, having the “stable dose” to prevent rather than to treat withdrawal symptoms.

2) Step 2: gradual reduction

Once the total daily amount and the pattern of drinking has been stabilised, then start reduction by no more than 20% of the daily amount at intervals no shorter than 4 days (preferably at weekly intervals).

This can be done with the use of detailed alcohol diary (preferably use a combined diary that records drinking slots and activity slots). Divide the day into three parts (start, middle, end).

It is safer to start reduction in the middle part of the day first by (i) either skipping alternative “doses” in steps keeping first and last parts stable; or (ii) prolonging the periods between drinks.

Depending on the experience of the client (e.g. the longest time prior to experience of withdrawals) aim to prolong periods between doses in a gradual way; i.e. extending by no more than 50% of the duration.

Continue these steps and aim to achieve a daily pattern spread throughout the day with an overall total amount drunk that is lower than 10 units daily.

During the gradual reduction it is important to review the client regularly and stop and review the process of reduction if the client feels uncomfortable. It is crucial to clarify and emphasise to the client, family and significant others that each step of reduction should be taken only when stability on the previous amount of alcohol has been achieved. When gradual reduction is done properly the client should not feel any withdrawal symptoms. It is key to this approach that alcohol is understood and used as medication to prevent withdrawal symptoms rather than to treat them.

3) Step 3: stopping

Once the amount of alcohol has been reduced to a level <10 units daily for at least 1 week, and taking into consideration the absence of a history of severe withdrawals, then if the client is happy and lifestyle changes have been consolidated, the client could stop alcohol rather than continuing with gradual reduction.

Overall instructions about APG

Session topics

Group interventions as part of the Structured Preparation for Alcohol Detoxification (SPADe) model for the treatment of alcohol dependence started in 2004, and were named Preparation for Alcohol Detox (PAD) group. The name Abstinence Preparation Group (APG) was suggested by service users in 2014, during the second implementation of the treatment model in Surrey. The new name better describes the aim of the group, which is not just preparing for detoxification (given that almost half of participants do not need one as they are able to complete a gradual reduction), but preparing people to achieve and maintain abstinence. The new name helps also to differentiate this approach from other previously or newly developed interventions which just aim to plan and manage expectations around the detoxification intervention per se.

APG is a theory-based group intervention. It follows the principles of pre-habilitation as described in the previous section and the evolution theory. APG is a modified Cognitive Behaviour Therapy intervention. It is based on the Relapse Prevention model proposed by Marlatt and Donovan (29), the Coping Skills Training by Monti et al (30) and the Cognitive model of addiction by Beck et al (31). Concepts such as high-risk situations, positive and negative expectancies from drinking, self-efficacy and agency of change are key ingredients.

The content of the six group sessions has evolved over the years, taking into account ongoing evaluation from service users and facilitators, as well as local needs of the treatment system. The skills and talents of the facilitators are very important for the successful delivery of the APG.

The balance between the generic group effect and the background theory was addressed in a qualitative study. Key benefits of group attendance from the participant perspective included: not feeling ‘alone’, being supported by, and supporting peers. Participants demonstrated self-efficacy and coping strategies for reducing drinking and managing high-risk situations (32).

For each session the balance between education and therapy, passive participation and interaction has been addressed. Clients felt able to participate actively despite the structured nature of the sessions. The positive response might be related to: the therapeutic approach taken by group facilitators; inviting clients to engage in active exploration of their difficulties; practice of potential solutions; and/or achieving a balance between didactic and experiential style (33).

The question regarding the effective ingredients of the intervention, was explored in a process research project. All key CBT investigated concepts (cravings, positive and negative expectancies from drinking and self-efficacy) have changed for the clients significantly both during the period of intervention and one month afterwards with the exception of negative expectances, for which change was significant only in one-month post detoxification. All the above changes were consistent with theory prediction (34).

The above evolution and evaluation of the content of the sessions led to the current manual which was implemented and formally evaluated within the SPADe trial set up and research protocol. All group sessions were observed and scored for compliance with the intervention manual and CBT principles, at least once by the Chief Investigator (CK) and an independent rater, using the YACS II (2005) (35). All observed sessions were found to be acceptable and compliant with the manual as well as CBT

principles. An interview with each of the APG facilitators was conducted with CK, following completion of the intervention. Suggestions on training, supervision and support are included in the current publication. Facilitators made comments and suggestions on the content of the sessions, which has informed this current publication.

Type of group

Open rolling

The APG is the main treatment ingredient for alcohol dependence and the first stage of a three stage pathway. It is followed by medically assisted withdrawal (if required) and an intensive aftercare package that should combine psychological individual and group interventions (such as Relapse Prevention, family interventions, mutual aid participation) and pharmacological interventions if appropriate. The APG is run as an open rolling group consisting of six weekly sessions run sequentially on a rolling basis. The rationale for running an open group is that a closed group programme would require a waiting list to be formed which could jeopardise the whole pathway.

There are both advantages and disadvantages to open rolling groups. The main advantage is seamless progress for each new client entering treatment (no waiting list), additionally participants who have been attending the group longer may become instant role models for the new starters, giving a strong message that structured preparation is possible. The negative impact of a potential drop out to the rest of the group is mediated by this open constitution of the group. A disadvantage is that the open structure of the group does not allow for strong bonding between group members and reduces the positive impact of generic group factors such as camaraderie and altruism.

Therapeutic rather than educational

The APG should not be a psycho-education group. Every effort should be taken by facilitators to promote interaction between group members and facilitators too. Every session should be therapeutic rather than educational, and learning should be experiential rather than purely cognitive. We should approach discussion points from the participants' point of view and aiming to provide additional information or evidence that might help participants to challenge their assumptions.

Facilitators

We advise that APG is run by two facilitators. This is important given that participants are actively drinking and they might experience physical symptoms during group delivery. Furthermore, they might not be familiar with groups and the principles of participating in a group intervention, such as mutual respect of space and opinion, or they might have participated in a different type of group and might therefore not be familiar with the rules and expectations of the APG.

The distribution of responsibilities between facilitators might be flexible or facilitators might alternate in their roles as long as they are explicit to the group about this. For each session, one

facilitator is the lead. S/he is responsible for the overall running of the group, paying attention to the dynamics and interaction taking place during the session. The lead facilitator is usually the most experienced of the facilitators. S/he might be responsible for setting and running the agenda of the session. The second facilitator's role is more supportive and includes provision of a second or alternative opinion, welcoming late comers (within group rules) or escorting out participants when required, as in a case of physical symptoms (nausea) or escalation of an argument. These scenarios have proved extremely rare over the last 14 years of our experience in running these groups. Nevertheless, participants are actively drinking and they are at the very beginning or early steps of their treatment.

Training, supervision and support

Training

APG is a theory-based group intervention. It is expected that success of the intervention would depend on changes happening according to the theory, as well as the group nature itself as described by I. Yalom (36). Evidence, however, suggests that the final moderator of the outcome is the quality of the facilitation. Given that not all professionals have the skills or enjoy providing group work, it is good practice that potential facilitators volunteer themselves to be involved. Their enthusiasm, background skills and personality traits is a crucial ingredient to the successful delivery of the intervention.

Un-learning or changing established behaviours is more challenging than learning new skills or behaviours. This needs to be taken into consideration when we provide training, and allow space and time for the change to take place. Our experience suggests that if there is an established APG programme, the trainee facilitator should be first an observant of the group in all sessions, then a co-facilitator before becoming the main facilitator of the group.

Alongside the observation of the group sessions, there should be a supervision meeting where the experience, observations and potential questions are discussed. At the initial stage of training this supervision should take place as soon as possible after the observation. If possible, joint observation of a few sessions would be very helpful as trainee and trainer would discuss the same facts. Coaching of a trainee facilitator by an existing facilitator is a good option.

The manual of the intervention should be the basis for the training. The theory behind the group should be discussed alongside the manual and the observation of the sessions. Like any manual based intervention (individual or group) a balance between fidelity to the manual on the one hand, and therapeutic flexibility during the session might be a challenge at the initial stages of training. Challenges as well as difficult cases or scenarios provide an excellent opportunity for learning. With experience, the manual becomes just a guide and a reference point. It provides support and an aid memoir for the facilitators. In some groups the co-facilitator is responsible for the fidelity to the manual whereas the main facilitator just focuses on the group interactions and participants.

Supervision and support

Monthly group observation followed by face-to-face discussion of experience with facilitators is very helpful in the initial stages. Experienced facilitators could do well with remote or less often

supervision. Remote or face-to-face supervision of a group of facilitators from different groups and services is an option. On such an occasion group rules and principles should be followed with the supervision group in the similar manner as the treatment group.

Weekly review of groups including number of participants, administration aspects, difficult clients or sessions or people that might not be appropriate to start the group or should be treated outside the pathway altogether, could be incorporated within the weekly multi-disciplinary team meeting. This provides the opportunity for informal learning for all members of the clinical team.

The manual of the APG is just a guide. In real life clinical practice (outside the research setting) the facilitators should be free to improvise, modify or add components, move sections from one session to another, as long as they are aware of the aims and expected outcomes of those changes. Although we encourage facilitators to bring their experience and skills into the sessions, we remind and encourage them to stick to the theory, definitions and language of the manual and of the background theory.

Room set up

Group members should sit around in a circle, with facilitators sitting separately from each other at an angle of 90-120 degrees. Access to a board or flipchart may be required during the session, when this occurs it is advisable that the group opens the circle for these particular exercises rather than all not sitting together in a circle to start with.

It is advisable that facilitators only stand up when required and they spend most time sitting down at the same level as the participants.

Duration

The APG runs for one hour every week. It is preferable that the groups are held in the morning. Participants are advised to have consumed the amount of alcohol which is necessary for them to prevent morning withdrawal symptoms. We should advise clients to have consumed alcohol at least 30 minutes before the start of the group and not to bring alcohol onto the premises. This is important as alcohol levels can rise for a period of 30 minutes following consumption and cognitive level and associated behaviour could be compromised as the group is progressing.

Making the APG longer is not advisable as this might increase the risk of withdrawal symptoms for the participants. The gap in between drinks should not be longer than two hours (one hour group and one hour commuting to and from home) at the early stages of treatment for safety reasons. There are earlier versions however, of APGs running for 90 minutes.

Having a longer APG session with a short break, during which participants are allowed to have a drink of alcohol (as if it was medication) is not advisable, this could increase the risks of intoxication as described above.

Dealing with missed sessions

Given that the APG is the first stage of treatment it is expected that some clients might miss some sessions, particularly the early ones. In the SPADe trial, treatment compliance, defined as attending 6 sessions over 12 weeks, was 47% (8/17) and 37.5% (3/8) for the first and second site respectively, which was considered acceptable for this type of population.

Different strategies have been used over the years to manage this. These strategies depend on the resources available to the service to actively manage it. We recommend proactive monitoring of client's attendance, compliance and involvement in the session. If possible, this should be done every week and clients should be offered (i) a replacement session as one-to-one with one of the group facilitators or their key worker to cover the content of the missed session; (ii) to be allowed to attend the group session at the end of their course; or (iii) at least to continue with the programme until all sessions are covered.

We recommend that the overall duration during which APG is expected to be completed, to be 12 weeks (twice the duration of APG). It is a fine balance between boundaries to promote compliance with treatment and collusion with client's ambivalence and justification of ongoing drinking without active changes in the name of "attending treatment". Our experience suggests that the motivation and momentum of actively taking responsibility of, and making changes to, their life and drinking is not sustainable if it is prolonged beyond a 12 week period.

Capacity

APG is a therapeutic, theory based group intervention. As such it has a structure based on an agenda which is presented during the first part of the session and effort should be made to adhere to it. As a therapeutic group, the facilitators should establish rapport and interaction with each one of the participants and encourage interactions amongst the participants too. To that effect the appropriate size of the group should be between four and eight participants. With less than four clients the group effect is lost, whereas if there are more than eight participants the interaction with each individual is compromised and there is a risk that the group becomes a psycho-educational one.

Pre-group mini assessment & post completion review

Given that the APG is an open rolling group, new participants can join at any time in the cycle of sessions. To that effect it is important that both new starters and the facilitators are prepared. Over the years there have been several ways to try and address this issue. We consider that the best way is for one of the facilitators to have a short 10-15 minute individual meeting with a new starter before the first group session. The aims of this meeting are two fold:

1. To complement the written information about the APG, as well as providing basic information about the alcohol pathway that the assessing key-worker has already discussed with the participant.
2. It gives the opportunity for the group facilitator to assess any personal factors that might interfere with the participant's ability to take part in the sessions, such as personal trauma, abuse, previous difficult group experience, communication needs etc.

From an operational point of view this pre-group meeting time required by the APG facilitator could be protected and incorporated in the overall time allocated to the group. For example it could be planned that 30 minutes are available before every session for a maximum of two new starters, while the second facilitator is preparing the group room.

Given the open rolling format of the group, most of the clients will enter and complete the group at different times, without session 6 being their last session. To that effect it is important that the group facilitator is aware of the completers in order to offer an additional 5-10 minutes at the end of the session to do homework allocation related to session 6: (i) make a list of questions for final review with the doctor or the detox nurse; (ii) develop their personal aftercare folder; (iii) develop a daily activity schedule for the 1st week of abstinence.

Alcohol Pathway

A typical alcohol pathway for alcohol dependence based on the pre-habilitation model consists of three stages. Stage 1 includes the SPADe interventions such as the APG. Stage 2 consists of the medically assisted detoxification either at home, community or inpatient setting. Stage 3 includes all aftercare interventions as described in NICE guidelines. It is important that information on the alcohol pathway, written in simple and empowering language, is given to clients. An example is shown in Appendix 2. Any other aspects of treatment such as liaison with acute hospital or mental health services or treatment for non-dependent alcohol users or for people who misuse alcohol and other drugs could be added. Examples are shown in Appendix 3 & 4.

Session structure

We recommend that each session should be divided into three parts. In a typical 60 minute session the division should be as follows:

First part- 15 minutes
Second part- 30 minutes / main part of the session
Third part- 15 minutes

First part

1. Introduction and welcome of new members

Welcome the group and introduce yourselves as the group facilitators and invite participants to introduce themselves and say whether this is their first week or that they have been before and which sessions they have attended.

2. Re-visit and then reiterate group rules and group process

Introduce the importance that the group members experience the group as a safe environment for participants to access support and explore their habit. Draw attention to the Group Guidelines and leave them visible.

3. Review the overall alcohol pathway, explain the aim of the group and review progress so far.

Focus on stabilisation of amount and pattern of drinking, lifestyle changes, regaining partial control over drinking and preparing a post –detoxification aftercare plan. Alert relevant participants about the mid-way key-working session (after session 3) and the final review key-working session (after session 6).

4. Review briefly the topic from last week and homework from last week. Explore experiences from last week.

5. Set the agenda for the session, i.e. “today we are going to explore how your drinking habit has developed and what is dependence on alcohol”.

Main part
This part of the session is the one described below under separate sessions headings.

Third part
This is the part of the session that it is crucial to have adequate time to complete. If all previous steps were done properly, there should be enough time to summarise and prepare for the week to come.

1. Elicit clients’ views

Do not hesitate to ask for feedback about what you have discussed in the main part of the session. If you identify any signs of poor co-operation address them at this point. You still have 15 minutes to build on collaboration and to enhance motivation. Encourage honest feedback. Propose to explore the issue further next time. Allocate practice which aims to explore ambivalence and promote co-operation. Remember to acknowledge your responsibility for what went wrong in the session. Don’t forget therapy itself is a learning process for both client and therapist.

2. Out of session practice for the coming week/homework

Out of session practice is a very important part of the treatment. In order to encourage the clients to practise, they must be able to understand why it is important. It is also important for the clients to have written instructions about this practice/homework and to make a note of this agreed out of session practice. If the out of session practice exercise has not already been discussed in the session, time should be kept to practise the exercise and ensure that the client understands what is expected of him/her and the purpose of the exercise. If a client has reading/writing difficulties, a non-written format of the exercise should be agreed and practised with the client. This means that the format of the out of session practice might be slightly different.

The following are some basic principles about out of session practice:
- be clear with your instructions
- be specific
- be succinct and prioritise what is important and what is not
- do not allocate too much
- make clear links with the session

Remember the best practice is the one that is proposed and undertaken by the client, you are only there to facilitate review and learning from it; therefore, stay back and give the initiative to the client.

Session One
Understanding habit and alcohol dependence

Learning Outcomes:

- Understand habit and alcohol dependence
- Understand one's own relationship with alcohol
- Complete the Cost Benefit Analysis
- Calculate units and complete Drink Diaries

Session Plan

PART A: Introduction (for details see section on general rules)

- Introduction and welcome new members.
- Re-visit group rules and group process.
- Review the overall alcohol pathway and the aim of the group.
- Review briefly the topic from last week and homework from last week. Explore experiences from last week. Assess number of sessions attended by each participant and alert them about relevant reviews with the key-worker (mid-way and final reviews).
- Set the agenda for the session, i.e. "today we are going to explore how your drinking habit has developed and what is dependence on alcohol".

PART B: Main session

1. **What people understand as habit? How does a habit develop?**

Discuss people's experiences such as repetition of behavior, reward, solution to a problem, solution to all problems, loss of control, "I don't want to but I still drink", cravings, withdrawals.

If possible formulate how a behavior that we had control over and gave us reward, through repetition over time, becomes automatic, is not rewarding anymore or only partially, and creates problems.

Ask group members: *"Where do you see yourself? What do you think you do?"*

Discuss what people think about habit and dependence. Share key terms with the group if required regarding dependence. Discuss loss of control, cravings and presence of physical withdrawal symptoms as a sign of dependence.

2. Cost-benefit analysis *Individual exercise and group discussion*

Introduce the Cost-benefit Analysis Worksheet and explain each section, ask the group to provide examples to demonstrate completion of the worksheet.

- *Handout: Cost-benefit Analysis Worksheet*

Ask the group participants to complete the worksheet and advise them that they will be expected to feed these back to the rest of the group. Offer assistance to those that need it.

Bring participants back to the group and ask them feedback on their cost-benefit analysis worksheets, each providing an example. Discuss issues raised and clarify understanding of the purpose of the exercise.

3. Drink Diary *Discussion and handouts*

Handouts: Basic Drink Diary and Unit calculator

- What is a unit?
    - One unit is 10 ml of pure alcohol. 1 Litre of alcohol has as many units as the %. For example 1 litre of vodka has 40 units if it is 40%.
    - It takes an average adult around an hour to metabolise one unit so that there's none left in their bloodstream, although this varies from person to person.
- Guidelines
    - Men – should not regularly exceed 3-4 units per day
    - Women - should not regularly exceed 2-3 units per day
    - No more than 3 consecutive days of drinking (4^{th} day mood is lower and cravings appear).
- Introduce drink diary
- Discussion of its importance of accurate and honest recording

PART C: Homework allocation (for details see section on general rules)

- Give basic drink diaries to be completed every day (either after drink or at the end of the day).
- Give a new Cost-Benefit Analysis sheet for completion at home.
- Give information about units/units calculator.

Thank the group for participation. Remind them time and place for next week. Remind them if appointment with keyworker is required (if information is available).

Session Two

Stabilise and Control drinking

Learning Outcomes:

- Understanding of stability/control
- Identify ways to control alcohol use
- Explore daily activities

PART A: Introduction (for details see section on general rules)

- Introduction and welcome new members
- Re-visit group rules and group process
- Review the overall alcohol pathway and the aim of the group.
- Review briefly the topic from last week and homework from last week. Explore experiences from last week. Assess number of sessions attended by each participant and alert them about relevant reviews with the key-worker (mid-way and final reviews).
- Set the agenda for the session, i.e. "today we will discuss and explore ways to stabilize and control your drinking for a short period of time as you prepare to stop drinking".

PART B: Main session

Explore most difficult alcohol symptoms people have suffered.

Make a list of the symptoms and if possible draw a body map and indicate what part of the body is affected. The aim of this exercise is to prepare people to understand the concept of control and stability and how symptoms would be reduced.

What does stability mean?

Discuss stability of daily amount and daily pattern of drinking. Explore separately, if appropriate, weekdays and weekends.

- Use alcohol "as if it were medication" to prevent symptoms
- Discuss generic rules of how we take medication, same dose at specific times

What does partial control mean?

Help the clients to establish: (1) the average dose of alcohol per day; this could be the dose that prevents withdrawal symptoms or the maximum or the average dose; (2) the daily pattern of drinking; this involves starting and end times and then frequent doses slots in between; (3) identify with them how much they need at each time. Give a reminder of the principles: no more fluctuations, no heroic reductions

Drinking times stable
Strength stable
Alternate alcohol with soft drinks, while keeping amount stable

Good hydration and nutrition

Introduce importance of daily activities

Facilitators emphasize the importance that partial control for a short period of time is useful as a way of organising a daily life structure while using alcohol as medication.

Group exercise

- Using drink diaries on flipchart/board storm identify: important activities in the day (i.e. breakfast, lunch, school run, work, socialising, dinner, relaxing, hobbies, housework).
- The purpose of this exercise is to encourage group participants to focus on where they can control alcohol use around their daily activities and identify where they can begin to make changes.

PART C: Homework allocation (for details see section on general rules)

- Complete activity drink diaries (give enough copies for 1 week)
- Give a copy of handout “strategies to regain control”

Thank the group for participation. Remind them time and place for next week. Remind them if appointment with keyworker is required (if information is available).

Session Three

Lifestyle Changes for the person and the people around

Learning Outcomes:

By the end of the session all participants will be able to:

- Explore current lifestyle (you and people around you)
- Explore lifestyle changes (practical tips)
- Explore lifestyle changes (schedule)

Session Plan

PART A: Introduction (for details see section on general rules)

- Introduction and welcome new members
- Re-visit group rules and group process
- Review the overall alcohol pathway and the aim of the group.
- Review briefly the topic from last week and homework from last week. Explore experiences from last week. Assess number of sessions attended by each participant and alert them about relevant reviews with the key-worker (mid-way and final reviews).
- Set the agenda for the session, i.e. "today we are going to explore how you and the people around you spend your time and what you and they can do in order to prepare you for stopping drinking alcohol".

PART B: Main session

You and those around you *Exercise and flipchart*

- You: using flip chart write down what the group shares about:
    - Individual baseline of drinking (using unit graph/drink diary)
    - Progress so far – over the last 2/52
    - What else would you like to do? Baseline of activities per day or week

- Those around you: on a separate part of the flip chart:
    - What is the lifestyle of those around you?
    - What is their drinking like?
    - What do you think they should do about drinking?
    - Focus on skills and techniques to engage others in the client's treatment.

The concept of the void left behind when alcohol is stopped

Explore with people how they would expect to feel when alcohol consumption stops. Discuss the void, what they think about it and what they could do to cope with it.

Activity Schedule *Exercise*

- Explain purpose and usefulness of having a daily structure which is not based on alcohol use (i.e. using the planner to begin the process of identifying a typical day)
- Discuss practical tips in order to structure the day. Use the activities list from the homework exercise.
- Discuss the financial benefits of stopping; explore alternative investment of savings; encourage individual planning; "what could you do with this money?"
- Rehearse ways of having the conversation with important others about lifestyle changes required by them.

PART C: Homework allocation (for details see section on general rules)

- Complete Activity Drinking (give enough for 1 week)
- Make a list of new activities to be incorporated in daily schedule
- Make a list of alternative activities to invest savings from stopping alcohol
- Practice conversation with people around you about changes

Thank the group for participation. Remind them time and place for next week. Remind them if appointment with keyworker is required (if information is available).

Session Four

Reduction of drinking

Learning Outcomes:

- Understanding reduction and what is safe reduction
- Understanding of alcohol withdrawal and risks
- Identification of reduction strategies

Session Plan

PART A: Introduction (for details see section on general rules)

- Introduction and welcome new members
- Re-visit group rules and group process
- Review the overall alcohol pathway and the aim of the group.
- Review briefly the topic from last week and homework from last week. Explore experiences from last week. Assess number of sessions attended by each participant and alert them about relevant reviews with the key-worker (mid-way and final reviews).
- Set the agenda for the session, i.e. "today we are going to explore how you could reduce your drinking safely".

PART B: Main session

1. **Reduction** *Group discussion and flipchart*

- What is reduction?
- Why do we do it? (to reduce amount below 30 units per day for easier and safer detoxification)
- How do 'you' begin?
- How NOT to do it and why. Explain the "spring effect"

Explain reduction is safe and productive only if drinking is stable. Make a straight line (represents stable drinking); now turn this line to angle slightly downwards (represents correct reduction). Compare with inappropriate major reductions that would lead to increased drinking and overall deterioration you could draw a fluctuating line. Then angle this line to face upwards.

2. **Alcohol withdrawal and risks** (use if available flip chart from session 2)

- What are withdrawal symptoms (you could link this with the exercise done in session 2)
- Types of withdrawal symptoms: mild, moderate and severe
- Risk minimization; review strategies of controlled drinking from session 2

Explore people's personal experience of withdrawals and emphasise risks of sudden changes to amount and pattern of drinking. Discuss again the concept "alcohol as medication" and reduction of "this medication". Link with session 2.

3. What is your drinking pattern? *Exercise and discussion*

- Consider your drinking pattern using most recent drink diary:
    - What time you start drinking?
    - Identify everyday activities (i.e. drinking and watching tv, eating, going to the shop, etc.) which could be grouped together as "blocks" to be used in between "drinking slots"

4. **Build a reduction plan** *Discussion*

- Ways to reduce (menu handout)
- In line with daily structure
- SMART goals

If there is ambivalence around abstinence or change, then explore this further
Exercise and handout Readiness questionnaire (either during the session or as homework)

- If done during the session participant should complete the questionnaire on their own. Explore/challenge answers where appropriate.
- Any group members scoring 'No' answers should be challenged as to their readiness to commit to abstinence as their treatment goal.

PART C: Homework allocation (for details see section on general rules)

- Complete activity drinking diaries (give enough for 1 week)
- To bring back an example of a SMART goal.

Thank the group for participation. Remind them time and place for next week. Remind them if appointment with keyworker is required (if information is available).

Session Five

Achieving Abstinence

Learning Outcomes:

- Understanding of the treatment pathway
- Understanding of different detoxification options
- Development of personal detoxification plan

Session Plan

PART A: Introduction (for details see section on general rules)

- Introduction and welcome new members
- Re-visit group rules and group process
- Review the overall alcohol pathway and the aim of the group.
- Review briefly the topic from last week and homework from last week. Explore experiences from last week. Assess number of sessions attended by each participant and alert them about relevant reviews with the key-worker (mid-way and final reviews).
- Set the agenda for the session, i.e. "today we are going to discuss the different detoxification options and we will discuss the different options available to you".

PART B: Main session

Treatment pathway

- Give overview of the Alcohol Treatment Pathway (draw this on flipchart)
- What is expected (refer to information leaflet)

Personal treatment plan *Exercise*

- Go round the group to ascertain what the individual clients' plan is at this time, and reiterate that this session is to help with the decision making process and provide information. This is not the final decision about the next steps.
- Ask: What previous experience of treatment have clients had?
  What can they do themselves?

Decision making *Group exercise and discussion and flipchart*

Explore the aim, facts and myths of detoxification. Try to de-mystify the process and empower people to take responsibility for change. Below are some examples of how to approach the discussion.

Aim. We use medication to 'cheat' the brain and replace alcohol with benzodiazepines as well as protecting the brain with high dose vitamins to prevent memory problems.

Facts.

- No medication provides absolute protection from withdrawal symptoms. There are limitations to the medications we use for detoxification as they do not fully protect the brain.
- Detox medication does not prevent relapse.
- Detox medication is only prescribed (and appropriate) for a short period of time.
- During the detox there is burden on the liver and kidneys as we use high amounts of medication.
- All types of detox have the same rate of success. Thus, the medical risk for each client determines the appropriate option and setting for them.

Myths.

- More detoxes does not mean better chances to change life. It seems that repeated detoxifications make the world look more stressful and make the person less able to cope with this stress. Periods of abstinence become shorter and relapses longer and more severe.
- Detox is the treatment. Structure preparation and post stopping support seem to be the most important parts of treatment.

Consider the types of detoxification options that are available and the criteria:

- Complete gradual reduction
- Home Detox
- In-patient

- Explore clients' understanding beliefs on advantages and disadvantages. Emphasise that the process has already begun.
- Treatment is structured with a focus on control, reduction and lifestyle changes.
- Reiterate the importance of commitment to lifestyle changes during the planning and actual detoxification period.

PART C: Homework allocation (for details see section on general rules)

- Complete activity drinking diaries (give enough for 1 week)

Thank the group for participation. Remind them time and place for next week. Remind them if appointment with keyworker is required (if information is available).

Session Six

Relapse Prevention

Learning Outcomes:

- Identify support required post-detoxification
- Understanding of aftercare options and the importance of a personal plan
- Understanding lapse and relapse
- Coping with cravings
- How to generate a personally supportive environment

Session Plan

PART A: Introduction (for details see section on general rules)

- Introduction and welcome new members
- Re-visit group rules and group process
- Review the overall alcohol pathway and the aim of the group.
- Review briefly the topic from last week and homework from last week. Explore experiences from last week.
- Set the agenda for the session, i.e. “today we are going to discuss ways to prevent relapse back to drinking”.

PART B: Main session

What support do you need after the detox? *Group discussion and flipchart*

- Discuss with the group the things they think they will need in place after the detox. And write these on the flipchart. (Do not remove this as it will be revisited before the end of the group – see ‘4.’)
- Use a different colour pen and highlight that these fall into four categories
    - Maintaining motivation
    - Coping with cravings
    - Managing thoughts, feelings, and behaviour
    - Lifestyle balance (refer to SMART Recovery model)

- Establish what is in place for after the detox?
- Explain what the alcohol service offers after the detox.
- Identify what lifestyle changes have you made/are you going to make?

After care options *Discussion and handout*

- Community
- Residential

Cravings *Exercise and discussion and handout*

- What are cravings? Explore own experience of:
    - Physical
    - Emotional
    - Thoughts
    - Environment
    - Actions

Lapse and Relapse *Group exercise and flipchart*

- What do the terms 'lapse' and 'relapse' mean? Discuss with group, write on flipchart and define.
- Discuss what 'learning from mistakes' means.

Relapse prevention

- Write on the board the following quote and ask the group what they think it means. (optional)

"I have always found that plans are useless but planning is indispensable."

- Dwight D. Eisenhower

or use examples of planning ahead i.e. traveling, shopping etc.

- Clarify the meaning with the group and explain that relapse prevention is very similar – a plan may not work out perfectly, however, the more we can prepare the better we will cope in the future and possibly find other ways to meet our goals – in this case, maintaining abstinence.
- Explain the importance of making a plan and practising this plan – this is called "relapse prevention".
- Start personal 'Relapse Prevention' plan in the session. This could be developed as they attend groups post-detox and navigate their way through recovery.

Significant others. How ready and supportive is the environment. *Exercise and discussion and handout(review exercise done in session 3*

- Who can be involved in the recovery?
- What role can they plan?

PART C: Homework allocation (for details see section on general rules)

- Complete activity drinking diaries
- Make a list of questions for final review with doctor
- Develop personal aftercare folder (get folder ready with all available leaflets)
- Develop a daily activity schedule for the 1st week of abstinence

Thank the group for participation. Remind them time and place for next week. Remind them if appointment with keyworker is required (if information is available).

Material to be used by group facilitators

Cost-Benefit Analysis

Drinking Label each item short-term (ST) or long-term (LT)	
Benefits (rewards and advantages)	**Costs** (risks and disadvantages)
▪ ▪ ▪ ▪ ▪ ▪ ▪	▪ ▪ ▪ ▪ ▪ ▪ ▪
Not Drinking Label each item short-term (ST) or long-term (LT)	
Benefits (rewards and advantages)	**Costs** (risks and disadvantages)
▪ ▪ ▪ ▪ ▪ ▪ ▪	▪ ▪ ▪ ▪ ▪ ▪ ▪

Basic drinking diary

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							
Night							

Daily Drinking Diary and activities schedule

Day and date:

	TIME	AMOUNT	ACTIVITIES
Start of day			
Drinking slot			
Drinking slot			
Drinking slot			
Drinking slot			
Drinking slot			
Drinking slot			
Drinking slot			
Drinking slot			
Drinking slot			
Drinking slot			
End of day			

Notes: Establish how many drinking slots/doses of alcohol you need. Start with first and last drink then fill in the rest of the diary. This diary is made for 10 drinking slots. Shadow the slots that you don't need to use. In the activity box next to drinking slot record the planned activity before that drinking slot. As drinking slots are reduced during the course of the APG, activities recording should expand into the relevant empty boxes. Fill in a schedule per day or for the typical day of the week and a separate one for weekends (if appropriate).

Strategies to regain control of your drinking

- Pace yourself
- Keep a drink diary
- Set a time 'I will not drink before…'
- Decide how long you will make each drink last and stick to it

- Take smaller sips
- Put your glass down between sips
- Don't drink alcohol to quench your thirst. Start with a soft drink, and alternate alcoholic and soft drinks

- Change your drink to something weaker
- If you drink spirits, use mixers. Try to gradually reduce the proportion of alcohol and increase the proportion of mixer

- Keep yourself busy with activities in between the scheduled drinking
- Try different activities every day. Keep and repeat those that help you maintain your drinking pace stable

- Avoid frequenting the places you drink most
- Eat before you go out to drink
- Don't drink 'in rounds'. Order your own drink.
- Don't let people 'top you up' at social events

Significant Others

Who is in my Recovery Plan?

What do I need to do with them?

How can they assist me?

Who can help me organise this?

Build your reduction plan

1. Identify total daily units

2. Commit to realistic reduction amount

□ Put off the first drink for 20 minutes
□ Identify stopping time
□ Bring last drink of the day back 20 minutes (REMEMBER – THIS WILL REDUCE YOUR UNITS, NOT GIVE PERMISSION TO DRINK THE SAME AMOUNT OF ALCOHOL IN LESS TIME!)
□ Replace higher strength % with lesser strengths i.e. 1 can alternate days
□ Pour away first glass (remember it is easier to do this rather than pouring the last glass)
□ Measure volume of alcohol
□ Have less alcohol in the house
□ Use a smaller glass
□ Change environment you usually drink in
□ Avoiding supermarket alcohol aisles/off licence/pubs
□ Avoiding automatic routines

Group ideas

□ ……
□ ……
□ ……
□ ……
□ ……
□ ……
□ ……

SMART goals


S
• Specific: State exactly what you want to accomplish (Who, What, Where, Why)
M
• Measurable: How will you demonstrate and evaluate the extent to which the goal has been met?
A
• Achievable: stretch and challenging goals within ability to achieve outcome. What is the action-oriented verb?
R
• Relevant: How does the goal tie into your key responsibilities? How is it aligned to objectives?
T
• Time-bound: Set 1 or more target dates, the "by when" to guide your goal to successful and timely completion (include deadlines, dates and frequency)

Types of Detoxification

Complete Gradual Reduction
Advantages: Real environment; safer than any detoxification; involves lifestyle change; better and more sustainable outcomes

Disadvantages: Reduction should take place within 6-12 weeks; might be difficult for certain heavy drinkers

Home Detoxification
Advantages: Real environment; more sustainable effects post-detoxification; involves family and carers; awareness of lifestyle changes they may need.

Disadvantages: Potentially limited and/or inappropriate support; medical risks; more challenging in terms of increased self-responsibility.

Inpatient Detoxification
Advantages: Increased level of medical and psychological support; time out of reality; reduces the risks; can meet complex needs better.

Disadvantages: Artificial environment (doesn't translate to real life – parallel with holidays); increases the number of relapses; potentially 'suffocating; environment – living in a 'bubble'; lose focus; not enough preparation to return home.

Ask the group to add more and write on flipchart

ARE YOU READY?

Q1 Have you made a completely honest commitment to yourself to totally cease all alcohol use for at least a period of months after detox?

Please circle: Yes or NO

Q2 Are you prepared to suffer disturbed sleep, feelings of agitation and to resist sometimes overwhelming cravings for alcohol for many months after your detox?

Please circle: Yes or No

Q3 Are you prepared to keep on working at staying dry or drinking at safe limits for the rest of your life?

Please circle: Yes or No

Q4 Do you honestly believe that the gains you will make by ceasing alcohol use far outweigh the losses?

Please circle: Yes or No

Q5 Are you absolutely 100% convinced that your overall quality of life will be improved by stopping drinking?

Please circle: Yes or No

Q6 Are you aware that for the rest of your life you will remain at high risk of relapsing to damaging levels of alcohol consumption within a matter of days after taking your first drink?

Please circle: Yes or No

Q7 Are you prepared to be on guard for the rest of your life against the repetitive thought that will enter your head when most unexpected saying: 'Go on – just one drink can't hurt – how could it?'

Please circle: Yes or No

Q8 Are you prepared to do whatever it takes to stay off alcohol long term, and give this absolute priority over everything else in your life?

Please circle: Yes or No

Q9 Are you planning to drop drinking because you want to do this for yourself and not solely for the benefit of another person?

Please circle: Yes or No

Q10 Do you take full, personal responsibility for all the problems in your life, whether or not they are caused by drinking?

Please circle: Yes or No

Community Aftercare Options

- Structured Groups
- Activity Groups
- Re-Training
- Personal Growth Courses
- Volunteering
- Increasing Family Commitments
- Linking with Friends
- Building Social Links
- Exercise (alone or in a group)
- Personal Projects
- SMART Recovery
- Fellowship Meetings

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APPENDIX 1

INFORMATION
for family members, friends and carers

Recognition and seeking treatment for an alcohol problem is a brave act. It is a huge but scary step forward in someone's life. This person needs support and encouragement not only by professionals but by family members, friends and carers. Treatment for alcohol abuse and **dependence** is long (sometimes life-long) and challenging. It has to be structured and depends mostly on the person's commitment and willingness to change the overall lifestyle.

The following **3 stages treatment programme** for people who are **alcohol dependent** has good evidence supporting its effectiveness. We hope that you will find this information helpful and empowering.

The clinical part of the treatment is structured, time limited and consists of 3 stages. It is complemented by lifelong aftercare support options such Alcoholic Anonymous, SMART Recovery and other community initiatives.

PRINICIPLES of TREATMENT for ALCOHOL DEPENDENCE

- Stopping alcohol abruptly is extremely risky even if they take medication. The person can have severe withdrawal symptoms such as seizures or hallucinations that can put life at risk.
- The person should keep drinking at a stable level until they have their assessment by us and advised how to proceed. They should consider alcohol "as if it was medication". We appreciate this advice might sound bizarre to family members and friends.
- Abstinence for life (stop drinking for life) is the best and easier option for dependent drinkers. It should be achieved in a structured and planned way and be maintained for life.
- Having several detoxifications and relapses increase the risk and make future attempts for abstinence more difficult.
- The person should be empowered to take full responsibility for both the problem as well as the solution to the problem.
- The person is extremely vulnerable to stress and need as much support as possible.
- Trust is usually broken and communication between the person, family and friends has been compromised and takes long-time to be restored.
- Change and recovery is easier within a supportive and abstinent environment.

STAGE 1: PREPARATION

The aim of this stage is to help the person stabilise drinking, regain some control, reduce gradually and safely and most importantly, start preparing and organising the support needed after stopping alcohol.

During this stage:

- The person is expected to attend 6 group sessions (Abstinence Preparation Group). Information about this group is available.
- The person is expected to complete the sessions within a maximum period of 12 weeks.
- The person will have at least 2 sessions with a member of the team who will be known as the Key Worker. He/she might receive additional individual sessions by other members of staff depending on his/her needs. You are welcome and encouraged to attend these meetings.

- Session 1 is offered after completing 3 group sessions. The aim is to explore and start developing the support options available for the person after stopping alcohol.
- Session 2 is offered after completing all 6 sessions and is a joint one with the psychiatrist. The aim is to finalise the above post-detoxification plan and in particular have a detailed plan for the 1st week of abstinence.

- The person is asked to see the GP in order to have blood investigations that will show the condition of the liver and the overall state of physical health.
- The person is expected to drink alcohol in a structured way "as if it was his/her **medication"**. This means that they need to drink specific amount at specific times to prevent withdrawal symptoms. This plan will be developed and monitored by the key worker and in the APG.
- The person should not have alcohol within half an hour prior to appointments at the service and should not bring alcohol in the building.

Your role:

- YOU as family, friend or carer are expected to consider reducing and even stopping YOUR drinking, as well as changing your overall lifestyle to compliment and support your beloved person to achieve and maintain abstinence.
- YOU are expected to support the person to follow the programme.
- YOU are welcome to attend the reviews with the keyworker and in particular the second one when we plan the detox.

FACTS

If the person completes this stage, there is 74% chance (as opposed to 43%) to maintain abstinence for the first month and 49% (as opposed to 40%) for 3 months.

Furthermore there is 50% chance that the person will be able to reduce and stop drinking gradually during this stage without needing a detoxification.

The person will be better prepared to attend and make best use of the aftercare support provided by this service as well as AA and SMART Recovery.

STAGE 2: DETOXIFICATION

Progress to this stage depends on the person's progress during the previous stage. In order to progress to detoxification the person has (1) to complete all the 6 sessions **within the 12** weeks; (2) have active participation in the group; (3) stabilise and reduce drinking; and (4) have made those lifestyle changes required to maintain abstinence following detoxification.

What is detox:
Detox means that we prescribe medications in a reduced regime over 7-10 days, in order to protect the brain from stopping alcohol and reduce the risk from major withdrawal symptoms such as seizures or hallucinations. This medication does not protect the person from relapsing back to drinking. There are other medications that could help with this (see next section).

What type of detox:
Most people are detoxified at home with our support. The detox usually lasts for 5-7 days and we visit the person at home every day to monitor the process.
Only a small minority of complex needs clients will be detoxified in a specialist detoxification unit. This lasts 10 days and the unit is located in London. This is a clinical decision that will be taken during the second appointment with the Key Worker and the psychiatrist. More information about this stage will be offered by the Key Worker and will be covered in the Pre-detox Group.

As we have discussed above half of the people completing the APG should be able to reduce and stop drinking without the need of the detox. This is the best potential option as it does not compromise future treatment in the case of relapse.

Your role:

- YOUR support is necessary to reduce the risk associated with the detox. We can only provide home detox if you (with the support of other members of the family) are able to be with the person for at least the first 3 days of the detoxification for 24 hours per day. For the final days of the detox you are required to be at home for as much as possible.
- We will expect to see YOU with your beloved person at the 2nd session offered at the end of APG (see above). In this meeting we will give you all the necessary information to support and keep the person safe during the home detox.

FACTS
All types of detoxifications are equally effective. The choice of which one (if any) is appropriate, depends on medical risk factors and it is a medical decision.

Medically assisted detoxification is a risky clinical intervention and should be done with the full support and monitoring of compliance provided by our team.

Not all people need a medically assisted detoxification. Some people can safely reduce and come off alcohol during the APG. Others can reduce to such a low level that a detox is not required and might be advised by the doctor to take the final step and stop. This is solely a medical advice.

There is very limited budget for inpatient detoxifications. To that effect we will make every effort to provide a safe home detox.

STAGE 3: RELAPSE PREVENTION

Our service offers immediate support for the first 6 weeks following completion of detoxification in the form of a Relapse Prevention Group (RPG). This group is similar in format to the APG and usually involves a small number of clients. There is no waiting list for this group and the person is expected to attend this group immediately after completion of detoxification.

Additional support is also available within our service, such AA, SMART Recovery as well as other specialist groups to address mental health issues, relaxation, acupuncture and others. There is a timetable at our reception, with all the activities offered within the service.

During this stage the person could have a follow up appointment with the psychiatrist to consider relapse prevention medication to reduce cravings, vitamins necessary to protect the nervous system or medication to treat underlying mental health problems.

Following this stage the person will be put on "Recovery Support" for a period of 6 months. The person will be encouraged to attend social groups, AA, SMART Recovery and will have immediate access to his keyworker in case of lapse or if additional support is required.

Your role:

- YOU are crucial into supporting the person in staying off alcohol.
- YOU are extremely important into providing an alcohol-free environment at home, make all the changes to your drinking that were agreed during stage 1, and be proactive into supporting the person to implement all the strategies necessary to maintain abstinence.

FACTS

We expect that the person's mental health will improve within the first 2-4 weeks following stopping alcohol, without any additional psychiatric support than the above support offered as part of the aftercare treatment plan.

It is crucial for the person to attend RPG and all other treatment options agreed with their key worker. Unfortunately only half of the people having the detox continue to attend the 3rd stage of treatment. Without this early support and further change of lifestyle, the person is likely to relapse back into drinking. Around 90% of people who only had a detoxification without preparation nor aftercare would relapse within the first month.

Relapse Prevention medication can increase the chances for the person to stay abstinent BUT ONLY when they do the psychological work.

During the first month post detox, cravings can be very high. During the second and third months, people start experiencing more and more thoughts telling them to have "A DRINK" to reward themselves, as they have done well. Be aware ONE drink is enough to get them drinking as bad as before treatment. Furthermore next treatment would be more challenging.

APPENDIX 2

COMMUNITY ALCOHOL TREATMENT INFORMATION

You have done very well to seek help to address your alcohol problem. Treatment for alcohol problems is long (sometimes life-long) and difficult. It must be structured and depends mostly on your commitment and willingness to change. The following treatment programme offered by this service has very good evidence to prove its effectiveness and we hope that you will also find it helpful. The service we offer is structured and time limited and consists of 3 stages. The focus is for people who are physically dependent on alcohol and wish to consider detoxification and abstinence as their target.

STAGE 1: PREPARATION

The aim of this stage is to help you stabilise your drinking, regain some control, reduce gradually and safely and most importantly, start preparing and organising the support you will need after stopping alcohol use.

During this stage:

- You are expected to attend 6 group sessions of the Abstinence Preparation Group (APG).
- You are expected to complete the sessions within a maximum period of 12 weeks.
- Prior to your first group session you will have a brief assessment with the group facilitator.

During this stage you will have at least 3 sessions with a member of the team who will be known as your Key Worker. You might receive additional individual sessions by other members of staff depending on your needs.

- Session 1 is a brief assessment of your needs (triage assessment).
- Session 2 is offered after completing 3 group sessions. The aim is to decide the appropriate type of detoxification (in the community or as inpatient).
- Session 3 is offered after completing all 6 sessions. The aim is to finalise your post-detoxification plan.

STAGE 2: DETOXIFICATION

Progress to this stage depends on your progress during the previous stage. In order to progress to detoxification you will have (1) to complete all the 6 sessions within the 12 weeks; (3) have actively participated in the group; (3) stabilise and reduce your drinking; and (4) have made those lifestyle changes required to maintain abstinence following detoxification.

Most clients are detoxified at home with our support. Only a small minority of complex needs clients will be detoxified in a specialist detoxification unit. This is a clinical decision that will be taken during the second appointment with your Key Worker. More information about this stage will be offered by your Key Worker and will be covered in the APG.

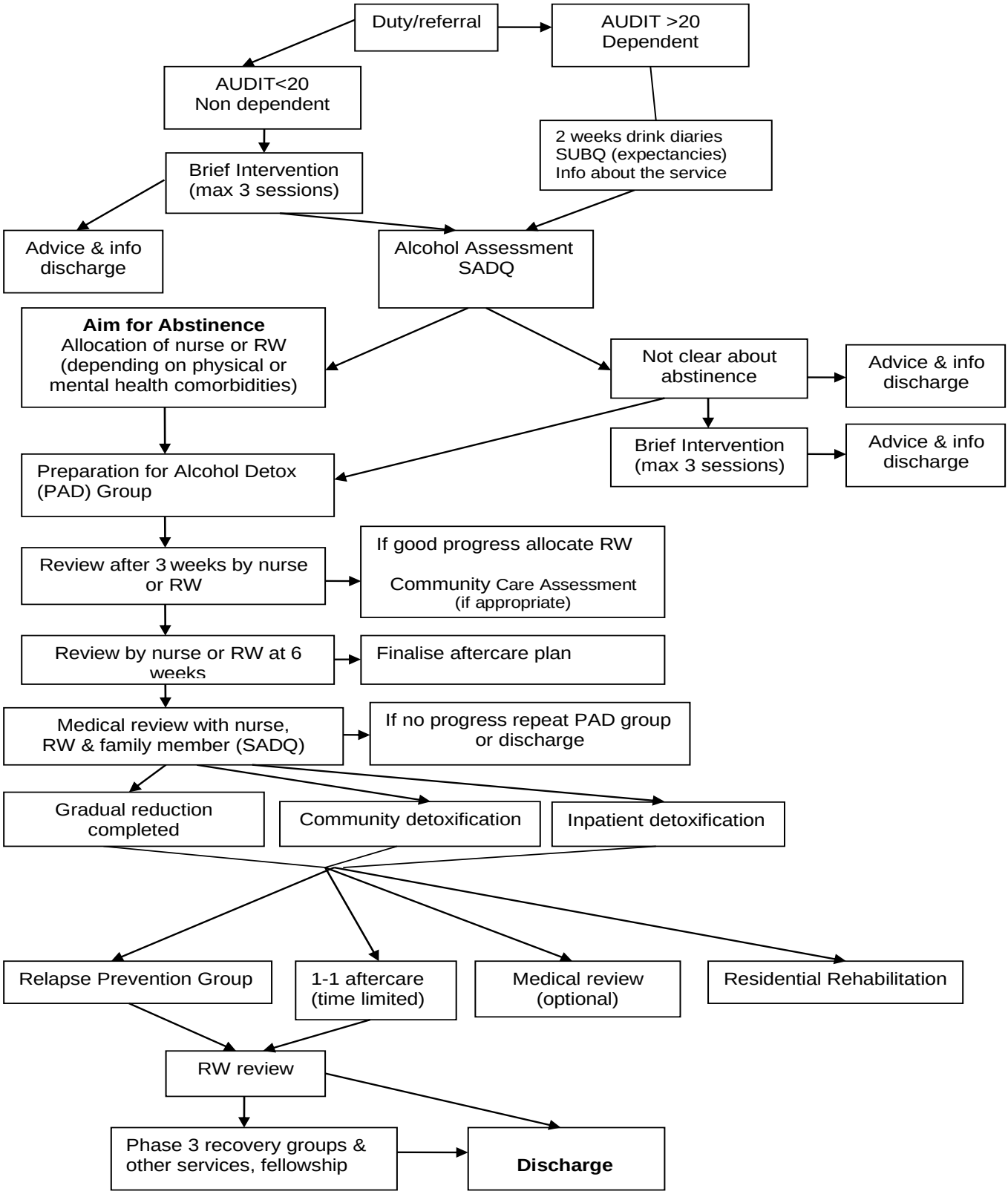
STAGE 3: RELAPSE PREVENTION

Our service offers support for the first 10 weeks following completion of detoxification in the form of a Relapse Prevention Group. This group is similar in format to APG and usually involves a small number of clients. You are expected to attend this group immediately after completion of detoxification. We advise you to seek support from Alcoholic Anonymous, SMART Recovery or other local services too.

In the unlikely event of lapsing during this period you might restart the whole programme from stage 1 or might be discharged and referred to a more appropriate service. The decision will depend on the severity of lapse and your overall commitment to address your alcohol problem as manifested during the previous stages of treatment.

We hope that this information helps you to understand what this service provides and what is expected from you. Please do not hesitate to ask us any questions for clarification.

APPENDIX 3: Pre-habilitation model for one-stop shop



APPENDIX 4: Pre-habilitation model and acute hospital liaison model