When general practitioners talk about alcohol: EXPLORING FACILITATING AND HAMPERING FACTORS FOR PRAGMATIC CASE FINDING

AIMS
A qualitative study exploring individual and system factors facilitating or hampering the implementation of pragmatic case finding in general practice.

METHODS
General practitioners from four different group practices participated in a four-session seminar on alcohol and complex drug problems. Focus group interviews held initially on the first and third day, focused on conditions for talking about alcohol, views on collaboration with colleagues, how they deal with complex issues, and strategies for learning and quality improvement.

FINDINGS
Analysis showed that their stories on how they talked about alcohol with their patients coincided well with pragmatic case finding. The duality between shame and normality, time constraints and a need for structure were the most important individual barriers to an open and respectful conversation about alcohol with patients. Some practices had more common strategies for learning and quality improvement. There was a tendency to avoid discussing complex case stories or potentially controversial topics with colleagues.

CONCLUSIONS
Pragmatic case finding is applicable in general practice, as an alternative to screening and brief intervention for risky or harmful alcohol use. Implementation is facilitated in practices where strategies for quality improvement and learning together already are in place.

BACKGROUND
Screening and brief intervention (SBI) for risky or harmful alcohol use has shown some efficacy, but the effectiveness and feasibility are questionable. Recent large scale intervention studies to implement SBI in general practice have not been promising. Pragmatic case finding (PCF) is an alternative identification strategy based on clinical signs and targeted screening, emphasizing the need for different strategies in different clinical situations. This means, most importantly, to explore potential relevance together with the patient who has a symptom, illness or worry that may be related to alcohol consumption, and secondly; to ask in some routine situations, as initial pregnancy check-up or with new patients, where informal screening strategies are suitable.
WORK-RELATED DRINKING and processes of social integration and marginalization in two Norwegian workplaces

BACKGROUND AND AIM
Different research traditions on alcohol and work have either focused on the functional or the problematic aspects of work-related drinking. The aim of this study was to investigate the role of drinking in two Norwegian workplaces, focusing on how the drinking may contribute to both the social integration and the disintegration and marginalization of employees.

METHOD
The two workplaces were a division of a multinational oil company and a public library in one of Norway’s larger cities. Data were collected through ethnographic fieldwork, including using participant observation, qualitative interviews and brief surveys.

FINDINGS
The meaning of drinking was strongly defined by dominant cultural ideals of why and how to drink, but also by ambivalent attitudes, opposition and even conflicts with these ideals. Most of the employees never drank in a way that could jeopardize their integrated position in the workplace, but a surprisingly large proportion of them were involved in drinking situations in which their drinking behaviours contradicted the dominant cultural ideals. In addition, some groups of employees and individual employees became occasionally or more permanently marginalized because of their excessively rebellious drinking, their abstinence from alcohol, or their inability to conform to dominant ideals.

CONCLUSIONS
This study contributes to a more elaborate understanding of how alcohol becomes physically, socially and culturally available in the workplace, how both social control and opposition to it create unique workplace alcohol cultures, and how different forms of deviant drinking (and non-drinking) may lead to both social marginalization and exclusion, and the creation of marginalized and excluded subgroups or individual employees.
PERSISTENT SLEEP PROBLEMS among people in recovery from substance use disorders - a mixed methods study

BACKGROUND AND AIMS
Research has shown that persistent sleep problems are prevalent among people recovering from substance use disorders. Research has also shown that sleep problems are among the most important predictors for short-term relapse among people with alcohol use disorders, while the results are more inconclusive for people using other substances. The aim of this sub-study of the Stayer study, is to investigate the prevalence and experience of persistent sleep problems among people with substance use disorders who struggle to stay drug-free.

METHODS
In this study we used a mixed methods design. We first utilised baseline and one-year follow data from the whole Stayer sample (the PSQI and SCL90 instruments and psychosocial surveys). We then interviewed sixteen of the participants who had been assessed as drug free and with the most severe sleep problems at the first annual follow up, and whom where still drug free at the time of the interview (qualitative in-depth interviews). In these interviews we focused on how the sleep problems affect their daily living and their struggle to keep drug-free, and what kind of strategies they use to cope with their sleep problems.

PRELIMINARY RESULTS
Persistent sleep problems are prevalent and a great challenge to people with substance use disorders in their struggle to maintain a drug-free lifestyle. This struggle seems to drain self-regulation energy and may lead to long-term relapse. This calls for an increased attention to deal with sleep problems in substance abuse treatment.

The Stavanger project on addiction and trajectories: THE STAYER-STUDY
In the Stayer-studie, 150 people entering treatment and 39 healthy controls were recruited to a long-term prospective longitudinal study on trajectories of addiction. They were tested with a broad range of neuropsychological tests, standardized instruments and psychosocial surveys, quarterly and annually, and a twice a month sms-tracker. The aim of the study is to investigate how and how fast drug-use related disorders, such as nevrocognitive disorders, sleep-wake cycle disorders, problems related to social integration and others, normalize during short and long-term abstinence.
ROOM FOR ACTION?
How service managers in three Scandinavian cities experience their possibilities to develop their services

METHODS
We conduct 23 interviews with service managers in the three Scandinavian cities, Stavanger (Norway), Umeå (Sweden) and Århus (Denmark). These cities have in common that they are relatively big, but not capitals. We conduct individual interview using a semi structured interview guide. Our Informants work within a health care system that in general, has many features in common. Our informants where selected by research colleagues with local knowledge. The interview was taped and transcribed. We conduct a follow up meeting with 2 informants from each city presenting and discussed preliminary data. The article is based on a multiple case design. We analyzed our data searching for factors that could tell us something about whether there was local freedom for development or not. The data was managed by using Nvivo 10.

RESULTS
All three urban cities provide us with examples where the services themselves have taken initiative to local development. This kind of initiative was not necessarily developed as a result of central control and management. We found a number of examples of local initiatives which were based on local needs. Our results show that another important factor for local development was that models and methods proven success elsewhere was completely or partially adopted.

CONCLUSION
New Public Management-inspired solutions to alcohol and drug treatment services do not necessarily hinder the consideration of local professionalism and flexibility in developing the services.

BACKGROUND
The study is based on the ongoing public debate concerning a limited scope for local service development in alcohol and drug treatment-related services - and that the main cause of local "paralysis" is to be found in health policy micromanagement of these services. It is argued that New Public Management models place too much emphasis on financial control and performance measurement, and that this leads to less interest in quality improvement in the provision of services.

AIM
The article aims to describe whether the practical field in alcohol and drug treatment services lacks the necessary freedom from central control to pursue local development.

KEY WORDS
Service development, alcohol and substance abuse treatment services, innovation, cooperation, quality improvement, New Public Management.
ASSESSMENT TOOLS IN SUBSTANCE USE TREATMENT – useful for patient and clinician?

METHOD
15 clinicians and 28 of their patients were recruited from five out-patient clinics in Stavanger and Hamar, Norway (May 2013 to February 2014). The procedure included i) patients responding to Alcohol-E/DUDIT-E, ii) follow-up session reflecting on responses from Alcohol-E/DUDIT-E and iii) completion of questionnaire concerning perceived usefulness of Alcohol-E/DUDIT-E. The study is based on 28 relations between clinician and patient, and includes a total of 56 responded questionnaires as regards the usefulness of Alcohol-E and DUDIT-E. Analysis was conducted using mainly mean value and frequency distribution. Comparable responses from clinicians and patients were tested for statistical significance using Mann-Whitney Test and Pearsons Chi-square.

RESULTS
The study shows a broad consensus among clinicians and patients perceptions of Alcohol-E and DUDIT-E as useful and clinically relevant. Both patients and clinicians reported that the tools complemented the therapeutic dialogue and contributed to a focused conversation, and was not perceived as time consuming. Clinicians experienced Alcohol-E and DUDIT-E to be affirmative and insightful, considering the patient’s perception of their situation, and to enhance patient participation. None of the clinicians experienced the tools as disturbing for the relation to their patients. Patients reported raised awareness, reflection and insight as regards their own situation. Compared to the clinicians, the patients had significantly greater negative experiences using standardized assessment tools (p=0.048) and preferred a therapeutic dialogue over the use of standardized assessment tools (p=0.010).

CONCLUSION
Alcohol-E and DUDIT-E is perceived as useful. Further research should explore what the tools may add to the therapeutic dialogue.

KEY WORDS
DUDIT-E, Alcohol-E, assessment tools, substance use treatment.

BACKGROUND
National Guidelines on Concurrent Substance Abuse and Mental Health Disorders recommend Alcohol Use Disorder Identification Test – Extended (Alcohol-E) and Drug Use Disorder Identification Test – Extended (DUDIT-E) integrated in the assessment of substance use and motivation to change. However, research on Alcohol-E and DUDIT-E is limited and little is known about its clinical relevance.

AIM
Explore clinicians and patients perception of the usefulness of Alcohol-E and DUDIT-E, in a relational context.
INTRODUCTION
Chronic substance abuse is associated with neurophysiological and neuroanatomical changes, as well as cognitive impairment, that affect quality of life, occupational functioning, and the ability to benefit from therapy. Neurocognitive assessment services are costly and not widely available. Therefore, in a busy clinical setting, a procedure that included readily available measures targeting core cognitive deficits would be beneficial. This paper investigates the utility of “cold” and “hot” neurocognitive measures of executive functions, as well as a questionnaire-based inventory for assessing adults with a substance use disorder.

MATERIAL AND METHODS
Subjects with polysubstance abuse (n = 129) and healthy controls (n = 38) were compared on “hot,” (Iowa Gambling Task), “cold,” (Computerized Stroop Color Word Test and the Trail Making Test parts A and B), and inventory-based (the Behavior Rating Inventory of Executive Function - Adult version, BRIEF-A) executive function measures.

The neurocognitive measures were independent variables, while groups (SUD patients vs controls) and social adjustment indicators were used as separate dependent variables in a regression analysis.

RESULTS
Measures of “cold” executive function did not distinguish between patients with polysubstance abuse and controls, but did differ on one indicator of social adjustment. The Iowa Gambling Task, a measure of “hot” executive function, did not differentiate between the groups and was not associated with social adjustment. The BRIEF-A differentiated between groups and was associated with three of five social adjustment indicators (”criminal lifestyle,” “conflict with caregiver,” and “stable housing.”)

CONCLUSIONS
The BRIEF-A inventory was the most sensitive measure of executive function in patients with substance use disorder, followed by measures of “cold” executive function. We did not find any support for the hypothesis that “hot” executive function measured with the Iowa Gambling Task was associated with substance use disorder or social adjustment in this sample. Our data support the utility of the BRIEF-A and similar inventory-based evaluations for diagnostic and prognostic purposes in a clinical setting with patients with substance abuse disorder.

The Stavanger project on addiction and trajectories:

THE STAYER-STUDY
In the Stayer-studie, 150 people entering treatment and 39 healthy controls were recruited to a long-term prospective longitudinal studie on trajectories of addiction. They were tested with a broad range of neuropsychological tests, standardized instruments and psychosocial surveys, quarterly and annually, and a twice a month sms-tracker. The aim of the study is to investigate how and how fast drug-use related disorders, such as neurocognitive disorders, sleep-wake cycle disorders, problems related to social integration and others, normalize during short and long-term abstinence.
INTRODUCTION
The onset of alcohol use is common in adolescence, but the individual development of alcohol use varies. During adolescence, there is also a general increase in depressive symptoms. Less is known, however, about the association between alcohol use trajectories and symptoms of depression during adolescence.

AIMS
To identify trajectories of alcohol consumption and drinking to intoxication from early to late adolescence (13-18 years), and examine to what extent different trajectories of alcohol use were associated with symptoms of depression over the same age span, from early to late adolescence.

METHODS
Data from the Norwegian Longitudinal Health Behaviour Study (NLHB) was employed. Latent class growth analyses were used to identify trajectories of alcohol consumption and drinking to intoxication. The resulting trajectories for each participant were used to estimate the gender-adjusted association between different development of alcohol use and symptoms of depression.

RESULTS
Four trajectories of both alcohol consumption and drinking to intoxication were identified (see figures 1 & 2). All of the trajectories with an early onset of alcohol consumption or drinking to intoxication were associated with higher levels of depressive symptoms during adolescence (mean difference ranging 0.24-0.60 standard deviations, all p<0.05) compared to late onset or stable low use trajectories.

CONCLUSIONS
The findings from the present study suggest that early onset developmental trajectories of alcohol use are associated with depression. Therefore, a broad assessment and intervention targeting both alcohol and depression maybe indicated among early onset alcohol consumers, especially if they report increasing levels of consumption.
AIM
Analysing the stress-strain-coping-support (SSCS) model and the social-ecological (SE) model in a search for theories that can serve as a foundation for improving the assistance and support provided to families affected by addiction and alcohol and drug problems.

METHODS AND MATERIAL
The basis for the analyses was a critical realist one, viewing addiction as a multilayered and necessarily laminated phenomenon.

RESULTS

<table>
<thead>
<tr>
<th>Theoretical roots</th>
<th>Coping support model from health psychology</th>
<th>Social theory, system and ecological theories from family therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imperative</td>
<td>The situation of the group of affected family members living under stress, and their individual needs</td>
<td>The social opportunity for change in intimate relationship</td>
</tr>
<tr>
<td>Method</td>
<td>5-Step: 1. Listen, reassure and explore concerns 2. Provide information 3. Explore coping responses 4. Discuss social support 5. Discuss and explore further needs</td>
<td>Maximizing the first contact Social assessment Reintegration plans Facilitation of meetings including family members</td>
</tr>
<tr>
<td>Positioning in the field</td>
<td>Critique of the general lack of attention given families in the field. Critique of pathological approaches to affected family members (e.g. co-dependency and family system models).</td>
<td>Critique of the dominant “particle” way of understanding addictive processes. Critique of primarily “individualistic” methods in approaching affected family members.</td>
</tr>
<tr>
<td>What is addiction?</td>
<td>A psychological phenomenon</td>
<td>A social phenomenon</td>
</tr>
</tbody>
</table>

DISCUSSION
The two models approach two different layers of reality: the SSCS model highlights the importance of dealing with mechanisms at the psychological level for affected family members, while the SE model emphasizes the importance of intervening in relationships and systems at the social level of reality. Both models are essential for dealing with the complexity of the phenomenon of addiction, and could work in a complementary way in a clinical setting - for the betterment of families and individuals.
DO GUIDELINES FOLLOW ADDICTION THEORY?

METHOD
European Monitoring Centre for Drugs and Drugs Addiction, EMCDDA, collects guidelines developed for alcohol and drug treatment in Europe, Australia and in USA. We chose five guidelines that encompasses alcohol and drug treatment relatively broad and studied them closely to see how they treated accessibility/availability, individualization, continuity and feedback systems. We studied the sources of knowledge the guidelines used and whether it had been done a grading of the recommendations from the strength of the evidence.

RESULTS
In three of the five guidelines we studied these themes were absolutely central. The evidence base was a wide range of scientific publications. But one did not grade the available evidence. The fourth guideline raised the need for individualization, continuity and feedback systems, but did not touch on the question of accessibility/availability. The evidence base was primarily randomized controlled trials comparing tool for diagnosis, tool to assess needs for assistance, what medication should be used and treatment methods. Some of the evidence where graded and some not. The fifth guideline we studied also built on primarily controlled randomized studies. Here the whole evidence base was graded. This guideline did not relate to the need for accessibility/availability, individualization, continuity and feedback systems.

CONCLUSION
Our study suggests that the more one is concerned with building guidelines on the highest graded evidence, the less it gives room for the themes of accessibility, individualization, continuity and monitoring treatment.