

Introduction to Clubs For Families with Alcohol- Related Problems

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February 1999

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I wish to thank the Alcohol Advisory Council, Nga Manga Puriri and the Goodfellow Unit in the Department of General Practice at the School of Medicine for their funding support. I wish to particularly acknowledge the generosity of Dr Francesco Piani and his family with their hosting and patient conversations with my relentless questions. Thanks also to Visjna Hudolin, Paola Gosparini, Guido Guidoni, Andrea Mattei, Ennio Palmesino and Michele Sforzina for their openness and sharing of their experience and advice. I want acknowledge Pam Armstrong for her generous response to the challenge and Ian MacEwan for embracing the idea in the first place.

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Introduction

What are CAT Clubs?

CAT Clubs (*I Club Degli Alcolisti in Trattamento*) are multiple family support groups for families with members who have alcoholism or other dependencies. Over three thousand of these self-help groups are currently meeting weekly in Italy. They operate at a community level and offer both the alcohol or drug dependent persons and their families a local system of support for achieving the goal of long-term abstinence.

Origins to a New Zealand Interest

I first found out about CAT Clubs from talking for about ten minutes to an Italian visitor to our Department at a barbecue in 1995 (I did not realize this was Francesco Piani who I was to later visit in San Daniele). Six months later I was at a WHO collaborators meeting in Liverpool and managed to speak with two Italian collaborators, Dr Franco Marcomini and Dr Valentino Patussi, who discussed their respective involvement in Clubs in Padua and Florence. They spoke highly of the widespread influence Clubs were having in the treatment of alcoholism. They also urged me to contact Professor Pieroluigi Morisini in Rome because he had been trying to evaluate the effectiveness of the Clubs. On returning to New Zealand I contacted Professor Morisini who in turn encouraged me to communicate more with Dr Francesco Piani in San Daniele (50km north of Trieste). Both recommended a visit to Italy to collect information first hand. I subsequently organized the visit with the assistance of Dr Alessandro Guidi and Dr Piani.

In May 1997 I made a three-day visit to Italy, visiting first Alessandro Guidi in Rome and Francesco Piani in Udine. In the absence of anything translated into English, I was able to collect first hand information about Clubs and watch them in action. On returning to New Zealand I prepared a report (Adams, 1997) which was circulated widely and asked people within the field to consider piloting Clubs within their area. The strongest expressions of interest came from Northland and from Ian MacEwan of the Alcohol Advisory Council (ALAC). Putting the two together and we obtained funding to initiate Clubs within Northland.

The Northland project came under the freshly erected umbrella of Nga Manga Puriri and began by forming a steering group to oversee its development. In September 1998 two people, myself and Pam Armstrong (manager of Northland's alcohol and drug services) attended a fifty-hour basic training programme for Clubs conducted in Lignano, a beach resort in northeast Italy. The programme was conducted in English and it was the Italian's first significant attempt to assist a range of countries in establishing Clubs. Other people attending came from Norway, Sweden, Denmark, Croatia, the Czech Republic, Slovakia, Poland, Bulgaria and Lithuania. We came from the only English-speaking country and yet people found us the hardest to understand!

With very little translated, I have put together this report as an introduction to the methodology based mainly on the information and discussions that Pam and I have gathered from our visit.

Why are CAT Clubs needed?

Two issues regarding the way our current policy and services approach alcoholism and other dependencies fuelled my interest in CAT Clubs. These relate, first, to the narrow interpretation of “harm” in current alcohol and drug policy and, second, to the provision of short term services for what is a long term problem.

The Narrow Interpretation of Harm

Alcohol and drug policy in New Zealand has been based on the pivotal notion of harm reduction (see MOH, 1996; North Health, 1995). The strength of this concept is based on the assumption that alcohol and drug use will continue in our society and rather than questioning the morality of this, the key task is to find ways to promote healthy rather than risky relationships to our drug use. This means seeking out various ways to minimise harms associated with drug use. However, on close scrutiny of how “harm” is interpreted in these policy documents, the term tends to be used with a narrow focus on one aspect of the complex of relationships surrounding drug consumption, namely the relationship between the drug and the drug-user. “Harm” is consequently located in direct association with the drug consumer (Adams, 1996). Indeed many harms are of this type; harms such as: organ damage, financial loss and problems with the law. However a large range of significant harms occur indirectly from association with the drug user (Dear, 1996). These harms include: the emotional impact on family members, the impact of poor work performance in the workplace and the long-term effects on children. Policy documents are less specific on how these aspects of harm will be managed.

The long-term effects on family members are particularly important. For example, children living with an alcohol dependent parent may experience periods of emotional neglect or abuse that have a profound impact on their psychosocial development (see West & Prinz, 1987). Alcohol and drug service initiatives that target the drinker may in time help other family members by assisting the drinker in successful change. Harm stops because the drinking stops. However, even if the drinking stops, how will the long-term effects of previous drinking on the children be addressed? Their psychological problems and difficulties with intimate relationships may continue for years to come. Furthermore the adaptations they will need to make during the process of their parent's recovery will introduce a further range of risk factors. A broader conception of “harm reduction” would include some attempt to address their needs.

The Long-term Process of Change

Alcohol and drug services are currently limited by the dominance of short-term interventions for alcoholism and other dependencies. A large proportion of service budgets concentrate on providing brief counselling interventions. Even longer-term residential admissions are brief compared with the long time required to establish sobriety. With regard to the 3-6% of the population with major alcohol and other drug

dependencies, the process of change typically takes years and will go through a number of phases before it is consolidated. On the adjacent graph I have divided the process of change into six hypothetical phases:

Family realisation: Family members might be the first to openly identify that another member shows signs of dependency. This recognition usually takes time (perhaps years) and family members will go through a number of stages from blaming themselves to blaming the substance before full acknowledgement of the extent of the problem.

Drinker realisation: Dependent drinkers will typically avoid recognising the seriousness of their drinking until major losses pull them up. The process of realisation involves a slow and painful recognition of the negative consequences of their drinking.

Drinker experimentation: The early period of change often involves trying out different ways of handling the problem. Dependent drinkers typically begin by pursuing changes by themselves without seeking assistance from others. They may try unsuccessfully to cut down, or to avoid any association with alcohol or even to stop drinking without attending to other issues.

Instituting abstinence: Following the unsuccessful experiments with change, dependent drinkers form an understanding of the enormity of the task of maintaining abstinence and begin to call on all available resources to achieving this goal. They identify abstinence as a priority, they seek help from books, from support programmes, from others with dependency and from health professionals.

Family relationship adjustment: Once the task of maintaining abstinence is well established, couples and families begin to attend seriously to relationship issues. Parents begin addressing harms to children, couples examine issues of conflict and communication and everyone in the family starts exploring what they want from their relationships in the future.

Consolidation: The emotional and cognitive adjustments made in relation to drinking and in relation to each other will take time to consolidate. The new framework needs to withstand the insults of stressful times and periods of boredom loneliness and bereavement. This phase will require persistent vigilance and support in maintaining the sense of purpose.

All six of these phases will take time. For some families several of the phases may take years. For others the same phases may take only a few months. However, for most families facing serious dependency problems the combination of phases will entail a process which is likely to extend between five and ten years. Furthermore, as indicated on the graph, in contrast to the episodic involvement with alcohol and drug service, the Clubs seek to provide a continuous involvement with the family. This involvement helps to sustain and support all the changes that have been initiated through the briefer episodes of counselling and treatment.

Broadening Services to Include Families and Communities

An adequate response to harm needs to include family members not just as a peripheral but as a central part of service planning. The problem is

that the provision of sustained family counselling and support over many years using trained professionals would cost the State amounts well beyond the scope of the alcohol and drug allocation in the current Vote Health budget. An alternative approach is to seek the participation of communities in providing their own support systems. Alcoholics Anonymous have adopted this approach for some time through a network of self-help groups which use the notion of fellowship to encourage alcoholics to assist each other. In a similar fashion, a network of self-help groups focusing specifically on the needs of families as a whole could offer a low-cost way of providing easily accessed long-term support.

How Clubs Started?

Vladimir Hudolin

Vladimir Hudolin was a psychiatrist in charge of the Alcohol and Drug services in Zagreb who during the 1960s was looking for a way to provide widespread support for alcoholics attempting to change. He originally devised CAT Clubs as a response to the lack of services for alcoholics within the former. He was heavily influenced by the concepts of “therapeutic community” advocated by Maxwell Jones, except that he extended the notion beyond the micro-level of a residential programme, and applied it to communities as a whole.

Hudolin had a strong and guiding influence over the development of Clubs in both Croatia and later in Italy. People with whom I met described him variously as a charismatic and inspired and that he maintained an active involvement in the evolution of the methodology. He maintained ongoing communication with the Italian psychiatrists supporting the Italian Clubs and participated in their annual congresses in which major changes in philosophy and direction were debated. He died in December 1996.

The History of CAT Clubs

Vladimir Hudolin formed the first CAT Clubs in Zagreb in 1964. They spread steadily throughout Croatia, Slovenia and Bosnia and by the 1990 numbered over two thousand. The wars following the break up of Yugoslavia devastated social and health services in the region and today only a small number remain.

Clubs spread into Italy following an exchange of visits with Hudolin and a client, Giovanni Pitacco in Trieste. Those involved were initially sceptical about the chances of adapting Clubs to the Italian context. Reasons given for why Clubs would not work in Italy were as follows:

- Italian culture is very different from Yugoslavia, more modern, affluent and mobile, particularly in Northern Italy.
- It was humiliating to think that what Italians considered a third-world country could develop an approach their more modern society could learn from.
- Families and communities in Yugoslavia worked differently from the Italians.
- Italy is not under the authoritarian rule and the independent nature of Italians would work against such an organisation.

These reservations were found to have little substance. In the sixteen years since the first Clubs were formed in Trieste, they have spread rapidly throughout Italy. They now number over three thousand.

The Distribution of the CAT Clubs

The adjacent map shows the current numbers of Clubs in the different regions of Italy. The concentration of Clubs is greater in the northern regions and I was given two reasons why this might be the case. Some I spoke with argued that the spread of Clubs was progressive and hence the number of Clubs varies as a function of the distance from where they first started in Trieste. Another group argued that Clubs spread according to need, and that since the consumption of alcohol is much greater in northern regions then that is where Clubs are likely to be more concentrated.

On inquiring into the best contexts for Clubs, most I met commented that they formed more easily in smaller population settings than in the larger urban centres. Since Clubs rely on informal networks within local communities, the complex and fluid nature of major urban settings make their formation more difficult.

The concentration of Clubs varies from region to region. In the Udine region with a population of approximately 50,000 there are 30 Clubs, which means about 300 families actively attending meetings. In small towns such as San Daniele with a population of about 5,000, they usually have about two to three Clubs meeting weekly. Larger towns such as Udine, with a population of about 100,000 have about 30 Clubs. This works out at a rough concentration for this region of about one club per 2,000 people. This contrasts sharply with the concentration in Rome, where in a city of several millions less than fifty Clubs are active.

CAT Club Philosophy?

The CAT Club is based consistently on an ecological perspective of alcoholism and other dependencies. This perspective places less emphasis on dependency as a disease, and more on it as a particularly intense relationship occurring amongst other relationships. The key relationships being to substances, family and community. The following section will explain the origin and consequences of holding such a view.

Systems Theory

Systems theory is a broad category for a cluster of theoretical positions. The approaches all share a critical stance towards the preoccupation of psychology over the last seventy years with reducing matters to the qualities of individuals. In contrast, system theorists argue that psychology could focus more productively on the way individuals are defined by the relationships they are active within rather than the characteristics of the individual. The emphasis shifts away from personality, intellectual and biological factors, and instead social context, family relationships, community and culture attract greater interest.

Ecological Theory

Hudolin spent time in England and was influenced strongly by the therapeutic community movement that flourished during the 1960s. He was particularly influenced by the ideas of Maxwell Jones and Joshua Bierer. Their perspective questioned the role of highly trained mental health professionals in guiding the rehabilitation of those in need. The presence of experts can tend to undermine the confidence of families and communities to resource their own solutions. When given the opportunity and adequate supports, most people will derive their own approaches to a problem and the process of unravelling these solutions is critical to their ownership and confidence in attempting a programme of change.

Ecological systems theory differs from other forms of systems theory (such as family therapy) in emphasising relationships within a broad social context. The individual is understood in the context of intimate relationships, family relationships, relationships to the community and the broader societal, political and cultural contexts. The health professional using this approach seeks to facilitate individuals, families and communities in searching out and owning their own responses to the problem at issue. Expertise becomes contested and negotiated according to the contexts in which the problems are being managed.

In Italy this approach has attained wide support within mental health services. For instance, they have developed strong applications of Ian Falloon's integrated health-care model, which places emphasis on support for "carers" (namely the family) in providing care for long-term mental health problems such as schizophrenia.

Applying Ecological Theory to Addictions

The people with whom I spoke took care to point out that CAT Clubs explicitly espouse an ecological theory of addictions. They argue that

involvement of the family and the community is critical at all points in the management of dependency. Their absence would mean only partial addressing of the problem and consequently only a partial review of the solutions.

I interpret this perspective as viewing dependency as like a very intense relationship, perhaps an “intimate” relationship with alcohol or other drugs. The relationship is dynamic, and whereas in the past the person may have had a degree of control over the substance, the person’s relationship to the substance has slowly come to dominate the person. The intensifying of this relationship has consequences for the complex of family and community relationships that surround the person. Each person with some connection is drawn into the web. Consequently, when it comes to change, the network of relationships faces an adjustment process as well. Significant change would require not only shifts in the relationships between the person and the substance, but also changes to the entire major family and social relationships in which that person participates.

When I attended Club meetings, the topic of conversation was predominantly about relationship issues. Topics were various: If you stop drinking then where do I stand? Why can’t you trust me now that I have changed? It’s always you who decide when to change and I resent you never changing when I needed it? Why do you keep protecting me from situations where people are drinking? And so on. The Clubs approach addressing these types of concerns as the critical zone for establishing a lasting sobriety. As with most relationship issues there is no one correct response. The groups provide a forum for family members to listen to other family members discuss a variety of responses to common problems. In this way families are empowered to review possibilities, discuss judgements and then come to their own consensus on how to proceed.

The Importance of Community

The Club functions as a multi-family community functioning in and connected with the local community. This is a core principle to the Clubs. Grounding a Club in a locality means it is owned and identified by that community. The local administrators, the local GPs and local counsellors and service workers know of the Club. The families themselves are likely to know each other and interact outside of their meetings. Furthermore, the Club, as an autonomous unit, will be reflect the composition of the local community. In a predominantly Maori community the families will mostly be Maori which means that over time the Club will evolve ways of operating that reflect Maori social and family values. Communities with other combinations of different people will similarly develop Clubs with characteristics that reflect this composition. This strong identification with locality is a key to the ownership and success of the Clubs. A specialised Club for specific cultures (eg. Pacific Island, Chinese, gay and lesbian, youth etc) would deviate from this important principle: Clubs are locality based, communities within a community, and not a coalition of similar people.

How CAT Clubs Operate?

The Composition of a CAT Club

Everyone who attends the Club is seen as a member of it. But in order to ensure the operation of the Club, every person attending will have a Club-role. The main roles are as follows:

The “*Servant Teacher*”

The *servant teacher’s* role is central to the functioning of Club meetings. The term may seem odd, but it accurately describes their central role. Servant teachers are not there to run, facilitate, advise, or, most importantly, they are not there as therapists for the families. *Servant teachers* are there to serve the families; to enable families to run their Club in the fashion that assists their change. Also the *servant teacher* provides the initial teaching which introduces new families to the functioning of the Clubs. Their central tasks include:

- Listening and promoting the listening of others,
- Supporting the members facilitating the meeting,
- Connecting with and introducing new members to the Clubs,
- Maintaining the psychological safety of all those present,
- Providing new members with basic information and advice regarding the nature of alcohol and drug dependency,
- Reflecting the central purposes of the Club movement within the meeting.

Servant teachers are required to attend a fifty-hour “*sensibilization*” programme during which they are schooled in the basic principles of the Club. No formal qualifications are required to become a *servant teacher*.

The Administrator

Administrators are appointed for one year through an informal process of suggestion and nomination. Their primary role is to oversee practical issues regarding the functioning of the Club. They might negotiate the use of the room, arrange meetings with members of the local community (the Mayor, local GPs etc) and they usually represent this Club at district meetings.

The Secretary

Secretaries are appointed like *administrators* for one year through an informal process of suggestion and nomination. Their primary tasks include maintaining roles, managing financial records and responding to correspondence.

The Recorder

Recorders are responsible for recording what happens in a meeting, that is the main issues and goals expressed during discussion. They occupy the role for a week, and write up the content in a book ready for the *recorder* at the next meeting.

The Process of CAT Club Meetings

Clubs do not operate on a formal or fixed set of rules. Clubs are expected to negotiate their own code, however the *servant teachers* are provided some guidelines on what ground rules tend to support effective group process. Their rules typically include the following:

- Punctuality – lateness is disruptive,
- No violence,
- No smoking,
- No drunkenness,
- Family members must come as much as possible,
- Speaking in the first person (I think, I feel),
- Speaking in the here and now,
- Acknowledge the right to a view and to disagree,
- Allowing people to finish what they are saying,
- Confidentiality (what is heard here, stays here).

The rules are not rigid. For instance, when a person attends while intoxicated, the Club meeting may discuss this openly with the person and negotiate a response that may or may not involve asking the person to leave.

Some Clubs have accepted mandatory court referrals, but only a few at any one time. They keep records of those attending and will feed attendance records back to court and justice officials. Not all agree on the acceptance of mandated referrals. This can change the dynamics of the interaction and it may lead to difficulties engaging other family members. The Clubs involved are reviewing whether to continue accepting coerced referrals.

Clubs also vary in how they respond to members who continue drinking. They tend to try to keep track of members who relapse and will sometimes nominate someone to visit them to check whether they wanted any assistance. This increased visibility for members makes it harder for them to relapse. Club members spoke of how when they initiated a relapse they might travel to an outside town where members of their own community would not see them drinking.

Educational Introductory Groups

In most regions, families are encouraged to attend introductory education groups to learn about alcoholism and the Club approach to change. These introductory groups were organised differently in different regions, but they usually involved ten evening sessions conducted by a combination of Club members and alcohol and drug service staff. All the newly referred families would be encouraged to attend the sessions and it would mean attending two sessions per week for the first ten weeks.

Description of Two CAT Club Meetings

Meeting 1: Rome

Late on a Friday afternoon my hosts in Rome, Professor Ceccanti and Dr Guidi, walked me to a Club meeting close to their hospital. They had also invited one of Professor Ceccanti's graduate medical students to

help me with translation. The building, *Dopolavoro Ferroviario*, was established by railway employees as a resource for workers, their families and their community. Within the building many different training and social support agencies operate. People learn about computing, driving, car maintenance, languages etc. I was first taken into council meeting of the workers who manage the organisation. They showed me a magazine they publish monthly and distribute to all railway workers. Each issue devotes two pages to the stories and concerns of people with alcohol problems. The president of the council commented on the contribution of alcoholism to rail accidents and poor work performance. The others in the meeting spoke enthusiastically of the significance of the CAT Clubs as a resource for workers and their families.

I was then led up two more levels in the narrow old building. In the corridors my hosts pointed out a brightly painted poster advertising the work of the Clubs. I entered a large room with about 15 people sitting around two rough tables joined together lengthways. At one side parts of about 20 old (XT) computers line steel shelving in the walls. The group was sitting on the other side close to windows overlooking a dilapidated courtyard. Dr Piani and Professor Ceccanti began by introducing me to the group. The participants appeared open and accepting of my presence, and we were found seats to join them sitting around the table. I was immediately struck by the range of ages and the variations in dress of those present. The *servant teacher* was a tall thin elderly man in a white shirt and tie; a middle-aged women in warm coats sat next to him and next to her was a younger man in overalls, and so on. The group continued what they were discussing before we arrived. They appeared unperturbed by the constant drone of Professor Ceccanti's student translating into my ear.

The woman who writes in the book (she was that meeting's *recorder*) talked about being tempted to drink some vinegar in the house. Another person advised it is best not to keep any form of alcohol in the home. This expanded into a debate, some saying it is both unrealistic to avoid opportunities to drink and that you need to adapt to the effect. Her husband sat opposite her across the table. He seized the opportunity to launch into a speech about having to face the responsibility of looking after children when she was drinking and how hard that had been. Their eight year old son was crouching over a colouring-in book and appeared unaffected by the heated discussion developing between his parents.

The *servant teacher* encouraged a man in his late forties to speak. He has his arm in a sling and looks in some pain. He talks of having stopped drinking many times only to eventually relapse. About six months ago his 24-year-old daughter spoke to him directly about how much his drinking was hurting her emotionally. Her frank words worked as a catalyst for change. Soon after that he stopped his drinking. He acknowledged his abstinence is in its early phases, but also notes that he has continued his change despite his frustrations and pain associated with his arm injury.

A woman with red cardigan with gold buttons then started speaking frankly to her husband about the difficulties she was having adjusting to his sobriety. He has had three years of sobriety and their relationship is becoming more difficult. She had grown accustomed to holding the moral high ground. Now he challenges her decisions and appears to be seeking a better quality of relationship with her. This has been very

unsettling. At that point a tall man in his early thirties walks in straight from work with fresh plaster and paint splats dotted over his clothing. He talks of 951 days sober. His fiancée arrives ten minutes later. They speak of their impending wedding. One man at the end of the table started to speak. He is the fiancée's father. He spoke of how despite the three years of sobriety, he still feared what might happen to his daughter if her future husband began drinking again. He spoke of his affection for his future son-in-law but also of his difficulties fully trusting his sobriety. Others at the meeting acknowledged this fear and discussed ways it could be handled. The meeting continued in much the same way. The content invariably concerned relationships, and the *servant teacher* consistently encouraged people to share their views and experiences openly on each issue.

Meeting 2: Monteriale Vallcalleina

Dr Piani drove me late on Saturday afternoon to a meeting in a small town in the foothills of the Alps about sixty kilometres north of Udine. The *servant teacher* was waiting outside to show us the way. We passed through a large courtyard to a small room filled with about eighteen people. As in other meetings, I am introduced and the group appeared welcoming of my presence. They continued speaking with Dr Piani translating into my ear. A man in his late fifties with hair waxed back spoke of having given up drinking recently and feeling very good about the change. One very small man whose father is alcoholic asked how he can be so sure of the change this time. The older man admitted he is very good at giving up drinking and has done some many times before, but has always returned after a short time. He claimed his fame at giving up is widely known and that he will now be famous for it in New Zealand; but this time is different. He is more committed, more confident and realizes he has to change for good. Some members muttered supporting sounds, others are quiet.

A woman in her late forties begins to speak about a man who has missed two meetings. Dr Piani informs me that she was married to an alcoholic who died two years ago, but that she has continued to attend. The woman stated she had heard through others that the absent man might have relapsed. The others echoed her concerns and spoke of how important the Club meetings had been to him. They then discussed whether they should make contact with him to check that he was coping. After some discussion they settle that one member who had formed a good friendship with the man should call in on him and discuss his needs.

The meeting continued much as the others I had attended. The discussions focused primarily on relationships and adaptations to change.

How are Clubs Set Up?

Forming Clubs

The Clubs were initially set up in Italy through the support of the alcohol and drug services together with a range of health professionals who were keen to try out being *servant teacher*. The initial training programmes for *servant teacher* were important. They provided the nucleus for setting up meetings throughout the Friuli region. From then on Clubs multiplied by division. When one Club reaches 12 families it divides into two Clubs with six families.

Recruitment and Training of the Servant Teacher

Since the role of the *servant teacher* forms a pivotal point in the Club approach, their recruitment and training is a high priority.

Selection of *Servant Teacher*

Servant teachers are either nominated by their communities or apply to the regional office on the basis of their previous experience and facilitation skills. Some who apply are health professionals; GPs, psychologists, social workers etc. Others are concerned community members with strong leadership and facilitative skills and perhaps have had direct exposure to dependencies in their own lives. All take the task on knowing they will receive no pay, but many of the health professionals will seek the role because it adds to their practice experience. All nominees are interviewed by regional Club representatives, and those selected move into the training programme. The co-ordinator of the training programme monitors their performance and may discuss their suitability when concerns arise.

Basic Training

The one-week 50 hour intensive basic training course is run by a mixture of alcohol and drug professionals (eg. psychiatrists or psychologists) and experienced servant teachers. These usually occur on a regional basis once every several months. The programme includes detailed coverage of Club philosophy. It aims particularly at changing the way of thinking, to shift people away from pathology-oriented approaches to dependency and to introduce them to the ecological model. The programme also includes; practice at listening and other facilitative skills, basic education regarding alcohol and drug problems and dependency and a knowledge of local resources and how to access them.

Relationships with Other Services

Alcoholics Anonymous

AA is active in Italy. Club members quite often attend meetings by both organisations. People did not express difficulty in being involved in both organisations. Both approaches recognise the importance of family, and aim to support the alcoholic in maintaining abstinence. The Clubs place less emphasis on anonymity that allows them to work more visibly within communities and to form stronger relationships with health services.

Specialist Alcohol and Drug Services

Service workers are clear that much of their efforts would be ineffective without the long-term support of the Clubs. The services I saw actively sought to integrate the Clubs into their programmes, they work hard at connecting consumers into meetings and many of the staff work voluntarily as *servant teacher*.

Mental Health Services

Dual diagnosis is recognised as an important issue. Psychiatrists have played an active role in the Club movement and because of this the Clubs maintain ongoing contacts with mental health services. The emphasis is on identifying early warning signs and implementing early psychiatric interventions.

Finance

Since most aspects of the Club movement involve voluntary contributions, the whole operation costs very little. The rooms are hired either for free or for a nominal fee that is covered by a small contribution from members. The only major costs are: payment of the health professionals who train and supervise the *servant teacher*, some costs for postage and stationary, some money for travel, finance for the regular publication of a national glossy magazine, accommodation and food for the annual congress. Dr Piani stated that taking into account all these items, the annual cost of running one Club is around \$800 per year.

The Club Political Structure

The Club system has evolved a national structure with consumer representation at all levels. Every 15 to 20 Clubs form a local association (ACAT) with an executive with one or two members from each Club. The ACATs meet monthly and organize supervision and resolve administration issues (such as the formation of new Clubs). Members of all Clubs will meet every 3 months for 2 to 3 hours to share views and present alcohol certifications. Each ACAT will send two representatives to a regional executive, the ARCAT. They meet regularly to plan regional resources and select and develop training programmes for *servant teacher* and to manage supervision processes. Two members from each ARCAT are voted as representatives on a national board, the AICAT, which provides an overseeing function and defines mission, policy and relations with outside organizations such Government. Each year the AICAT organizes a national congress at which over 1200 people attend.

How Effective are CAT Clubs?

VALCAT

Dr Piani and Professor Morisini have initiated an outcome evaluation study tracking the effectiveness of CAT Club participation. They titled the project VALCAT (*Progetto Nazionale di Valutazione Club Alcolisti in Trattamento*). It was initially funded in 1993 by a grant from the Italian Minister of Health of approximately NZ\$600,000. Since the project incorporates long-term follow-up, four years on data is still being collected. The ongoing support for the project has come mostly from the various participating services and departments of psychiatry. During my visit to San Daniele Dr Piani made available some of the early and preliminary findings.

Method

VALCAT set out to evaluate what impact the Clubs had over time on those who attended. It aimed to assess this impact across a broad range of social, mental and health variables.

Subjects

The participants consisted of all first time members of Clubs in the regions of Friuli, Trentino, Veneto, Lombardia, Piemonte, Toscana and a few from Puglia. They were provided information about the project by their *servant teachers* then asked whether they would be willing to participate in the evaluation.

Design

The study adopted a prospective longitudinal design. Measurement took the form of structured interviews of about one hour. Participants were interviewed at baseline shortly after their first group attendance during the period February to September 1993. The follow-up assessments were at 6 months, at 18 months and finally at three years.

Assessment

Assessment interviews covered five main sectors: general demographic details about the participant, detailed questions on alcohol and drug consumption, perceived quality of life and perceived self-efficacy, physical health status and self-care, and a general mental health status questionnaire focusing particularly on depression and anxiety (GHQ). The interviewers were trained in a three-day workshop. Twenty interviewers were used and all had a practice background in psychology, medicine or nursing.

Preliminary Results

The number of participants completing the baseline assessment was 1,026; at 6 months about 900 were interviewed, at 18 months the number was 854. The follow-up at three years has yet to take place. Data on the baseline has been collated, but analysis of two of the follow-ups was not available except for the six-month follow-up in the Friuli-Venezia Giulia region.

Baseline Results for All Participating Regions

Over three-quarters interviewed at baseline drank more than 10 standard drinks per day. 92% were diagnosed with alcohol dependence (DSM III-R) and 24% had dual diagnoses. The adjacent graph lists the major dual diagnoses.

Six Month Follow-up for the Friuli-Venezia Giulia Region

The three areas of Friuli-Venezia Giulia form a region in the north-east of Italy and has a population of approximately one million. After six months only 1% required inpatient hospitalisation for physical or psychiatric conditions compared with around 30% requiring hospitalisation during the year prior to them first attending a Club meeting. During the follow-up interviews 93% reported they were abstinent and only 7% indicated they were drinking. Also at the six month follow-up 75% stated they were still attending Clubs (see adjacent pie chart) and in contrast to baseline, “no problems” with self care had improved from 53% to 85%.

Are CAT Clubs Worth Pursuing?

The question upper-most in my mind during the visit was whether the Clubs might work within a New Zealand context. The following were the main issues that influenced my assessment.

Good Points

Integration with Specialist Alcohol and Drug Services

Dr Piani manages a mental health service for the Udine area and this service includes a residential alcohol and drug programme. I was invited to attend group sessions, admission interviews and to talk with staff about the programme. I was struck by extent to which the treatment programme reflected Club philosophy. Staff insisted at admission that family members attend the interview. The interview carefully reviewed any previous involvement with Clubs. Community meetings modelled on Clubs were held regularly in the programme and family members were required to attend. Those without available family members invited other members from their local Clubs. A social worker in the programme was employed with a primary task of linking participants up on discharge with local Clubs. Staff commented that similar integration of Clubs with specialist alcohol and drug services was occurring in many places throughout Italy. For instance out-patient units include Club meetings within their programmes and encourage people to attend Clubs as part of the goals for counselling.

Long Term Support

The Clubs are clearly designed to provide sustained support for family members over long periods of time. This continuous involvement would be far too expensive using publicly funded health professionals to provide family counselling. Yet the sustained involvement of both the dependent person and the families are critical to establishing the interactions and environments which facilitate the changes initiated during treatment interventions. The Clubs could, therefore, be seen as a vital resource standing alongside and augmenting other services by providing a backup facility to reinforce and support changes established during treatment.

Involvement with the Community.

In regions with a high concentration of Clubs (those approaching one Club per 2,000 people), Clubs develop a visible presence. These Clubs will often invite key members of their community such as local council members or local GPs to attend and get to know the people involved. People from Clubs will socialise outside and other members, and it would be difficult to find a member of the family who does not have a distant family member or friends who have some relationship to the Clubs. This high visibility in the community gives the Clubs a level of recognition and acceptance as part of these communities.

Destigmatisation of Dependency

A consequence of the strong community involvement of Clubs is the high visibility they give to alcoholism within a community. In contrast with the anonymity traditions of AA, Clubs endeavour to relate openly with communities and often people come to know of which families are involved in Clubs. On the negative side this threatens the anonymity of those attending, but on the positive side people become considerably more aware of the presence of dependency in their community and it thereby gains greater acceptance and normality than when it is hidden and viewed as shameful. I was struck by the level of openness people had in discussing alcoholism. My hosts commented that the secrecy and shame associated with alcoholism had shifted markedly since the Clubs first started operating.

Public Health Impact

As Clubs develop credibility and visibility within a local community, they also begin to develop a base to influence local attitudes and practices regarding alcohol and drug use. Practices regarding drunkenness, drink driving, licensing, youth drinking, drug education and range of other issues come up naturally as part of meeting conversation. These discussions spread within family networks and members take on the task of speaking out and influencing others in their views about alcohol and drug consumption. The Clubs thereby become a focal point for community awareness and community action regarding alcohol related harm.

Linkage with Primary Healthcare

One of the WHO collaborators, Dr Pierluigi Struzzo, works as a GP in Udine and trained as a *servant teacher* in the first Italian Clubs. I talked with him in detail about his involvement in Clubs during our last WHO meeting in France. He emphasised the strong potential Clubs have at a local level in linking dependency services up with primary healthcare. The local GP trained in brief intervention skills and actively screening for alcohol problems will from time to time encounter patients with dependency problems. The local availability of the Clubs provides GPs with an easily accessed first step for families affected by dependency. Dr Struzzo envisaged the potential for local Clubs and GPs to work together on a variety of levels. The local Club *servant teacher* and the GP consult each other. They review progress and work together at linking family members up with specialist services.

Some Difficulties

Dominance by Those Slow to Change

While Clubs aim to provide extended support to people in the process of change and then assist them in moving on, some participants will not achieve adequate change and may remain attending meetings indefinitely. Those who manage to consolidate their sobriety adequately will eventually leave and no longer require Club support. But the small numbers of participants who are slower to change are likely eventually to assume seniority roles within the meetings and accordingly come to dominate their common wisdom. Their influential position in the meetings are problematic because they may provide poor role models for change (the good models have moved on) and they may tend to over-emphasise Club doctrine and the importance of continuing to

attend. Clubs have worked to minimise the risk of this by ensuring Clubs split in two every year. The split will either cut across a developing elite or it will allow a new Club to begin free of the elite.

Problems in Engaging the Dependent Person

My hosts in Rome spoke on several occasions of how the Clubs only ever managed to reach a small proportion of people with dependency problems. They spoke of their interest in finding other ways to engage a greater proportion of dependent people. In response to this concern Dr Piani pointed out that people with alcoholism have always resisted involving themselves in change. This is not unique to Clubs and is shared by all dependency services. He noted that because of the local availability of Clubs, considerable numbers of people who would never go near a professional service are seeking the assistance of Clubs.

On Balance

The Clubs' main strength lies in the way they influence and assist individuals, families and communities in taking up the challenge of alcohol and drug related change. Their main weakness lies in their vulnerability to dominance by members with rigid views regarding the pathology of addiction. The way in which the Clubs have flourished in Italy over such a brief period and the degree to which communities have embraced their presence suggests the approach has potential in other contexts. Many of the difficulties with them could be resolved by identifying problems at an early stage and devising strategies which reduce the risks.

Adapting Clubs for New Zealand

The opportunities Clubs offer in New Zealand will depend on the level of interest from community groups and service organisations. The following pilot is suggestive of how this approach might be applied here in New Zealand. Any application would require considerable discussion and negotiation with those interested.

Issues in Adapting Clubs to the NZ Environment

The Involvement of Alcohol and Drug Services

The Italian Clubs were initially established with strong support from staff in local alcohol and drug services. Their involvement was critical to ensure adequate training and supervision for local facilitators. Early attempts to set up Clubs in New Zealand would require some degree of sponsorship from local alcohol and drug agencies. The interested service would be required to provide a number of resources that include:

- hosting and co-ordinating local meetings,
- engaging interested family members,
- providing training and supervision for facilitators,
- conducting introductory family education programmes, and
- assisting in reviewing and evaluating effectiveness.

Facilitating Community Involvement

The engagement of people in local communities will require a range of strategies. Family members who have been affected by the dependencies of their partners, children or parents may have an interest in helping others who have similar problems. These people could be approached through services or by advertising the intention to establish a Club followed by a public meeting or hui to discuss how to proceed. Once a working group of interested people is formed, the group could work on the nomination of facilitators, finding a venue and selecting meeting times, and organising protocols such as referral and induction processes. (Training of facilitators could be conducted using educators at our Faculty of Medicine and Health Science.)

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