Appendix 2

The management of harmful drinking and alcohol dependence in primary care – adapted from SIGN Guideline 74

In-house counselling should include the important elements of motivational interviewing.

Adapted from Miller and Rollnick, 2002.[158]

Portraying empathy

- use of open ended questions and avoiding premature closure
- respect for individual differences
- reflective listening so that patients sense you are trying to "*get on their wavelength*"
- expressing interest/concern
- acceptance that ambivalence is normal.

Developing discrepancy

- patients are helped to see the gap between the drinking and its consequences and their own goals/values - the gap between "*where I see myself, and where I want to be*"
- enhancing their awareness of consequences, perhaps adding feedback about medical symptoms and test results: "*How does this fit in?*" "*Would you like the medical research information on this?*"
- weighing up the pros and cons of change and of not changing
- progressing the interview so that patients present their own reasons for change.

Avoiding argument ("*rolling with resistance*")

- resistance, if it occurs (such as arguing, denial, interrupting, ignoring) is not dealt with head-on, but accepted as understandable, or sidestepped by shifting focus
- labelling, such as "*I think you have an alcohol problem*" is unnecessary, and can lead to counterproductive arguing.

Supporting self efficacy

- encouraging the belief that change is possible
- encouraging a collaborative approach (patients are the experts on how they think and feel, and can choose from a menu of possibilities)
- the patient is responsible for choosing and carrying out actions towards change.

Facilitating and reinforcing "self motivating statements"

- recognising that alcohol has caused adverse consequences
- expressing concern about effects of drinking
- expressing the intention to change
- being optimistic about change.

A tenet of motivational interviewing is "*People believe what they hear themselves say*".