

**DISSERTATION**

**ON**

**“ASSESS THE EFFECTIVENESS OF ALCOHOL SKILL TRAINING PROGRAMME ON ALCOHOL ADDICTION AMONG INDIVIDUALS ATTENDING DE-ADDICTION CLINICS OF INSTITUTE OF MENTAL HEALTH, CHENNAI-10”.**

**MSC (NURSING) DEGREE EXAMINATION**

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**A dissertation submitted to**

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**CHENNAI-600 032.**

**In partial fulfillment of the requirements for the degree of**

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## **CERTIFICATE**

This is to certify that this dissertation titled, “**Assess the effectiveness of alcohol skill training programme on alcohol addiction among individuals attending de-addiction clinics of institute of mental health, chennai-10**” is a bonafide work done by **Mrs.B.Vasanthi**, College of Nursing, Madras Medical College, Chennai-03, submitted to The Tamilnadu Dr. M.G.R. Medical University, Chennai, in partial fulfillment of the university rules and regulations towards the award of the degree of Master of Science in Nursing. Branch-V, Mental Health Nursing under our guidance and supervision during academic period from 2010-2012.

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## **ABSTRACT**

Addiction a psychological and physiological dependence on alcohol affects not only the lives of so many people but also leaves them in a state of denial that they can stop this at any time, which is not true. Realizing the importance of the need for information and education on alcohol moderation skills, enhancing awareness on myths about alcohol addiction and related problems the current study assessed the effectiveness alcohol skill training programme on alcohol addiction among the individuals attending de addiction clinic. The main objective of the study was to assess knowledge and drinking frequency before and after Alcohol Skill Training Programme (ASTP) and to find out the effectiveness of ASTP. The conceptual framework adopted for this study was modified Ludwig Von Bertalanffy's general system theory (1930). One hundred and twenty samples selected by convenience sampling were given ASTP for four weeks after assessing their preintervention knowledge and drinking frequency. The results on post intervention knowledge and drinking frequency showed significant improvement ( $P = 0.001$ ) on their knowledge and significant reduction ( $P = 0.001$ ) in their drinking frequency. The percentage difference of 31.3% in knowledge score with 95% confidence interval revealed the effectiveness of ASTP. The above findings revealed structural approaches to alcohol consumption. Therefore it is an important tool and can help to reduce for harm.

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## CHAPTER-I

### INTRODUCTION

**“To see what is right, and not do it, is want of courage, or of principle”.**

**-Confucius**

Alcohol is a depressant drug that slows down the activity of the brain contains absolutely no nutrients, does not help relieve tension, induce sleep or solve problems. All alcoholic beverages contain the same mood-changing agent - ethyl alcohol though in varying percentage. *About 10 to 15% of alcohol users develop alcohol dependence and become alcoholics.* Anybody can become an alcoholic - age, education, intelligence or socio-economic status has nothing to do with it. The person increases the quantity or frequency and continues drinking even though alcohol causes problems to his health, work life, family or social relationships. Alcoholism is characterized by the repeated drinking of alcoholic beverages to an extent that exceeds customary use or compliance with the social customs of the community and adversely affects the drinker's health or interferes with his social or economic functioning. Alcohol problems occur at different levels of severity and finally leading to life threatening situations. *Alcoholism is treatable.* With treatment it is possible to give up drinking totally and live without alcohol. However, as with other diseases, the earlier the help is sought, the lesser the damage and the better the recovery.

#### **Alcohol Consumption in India**

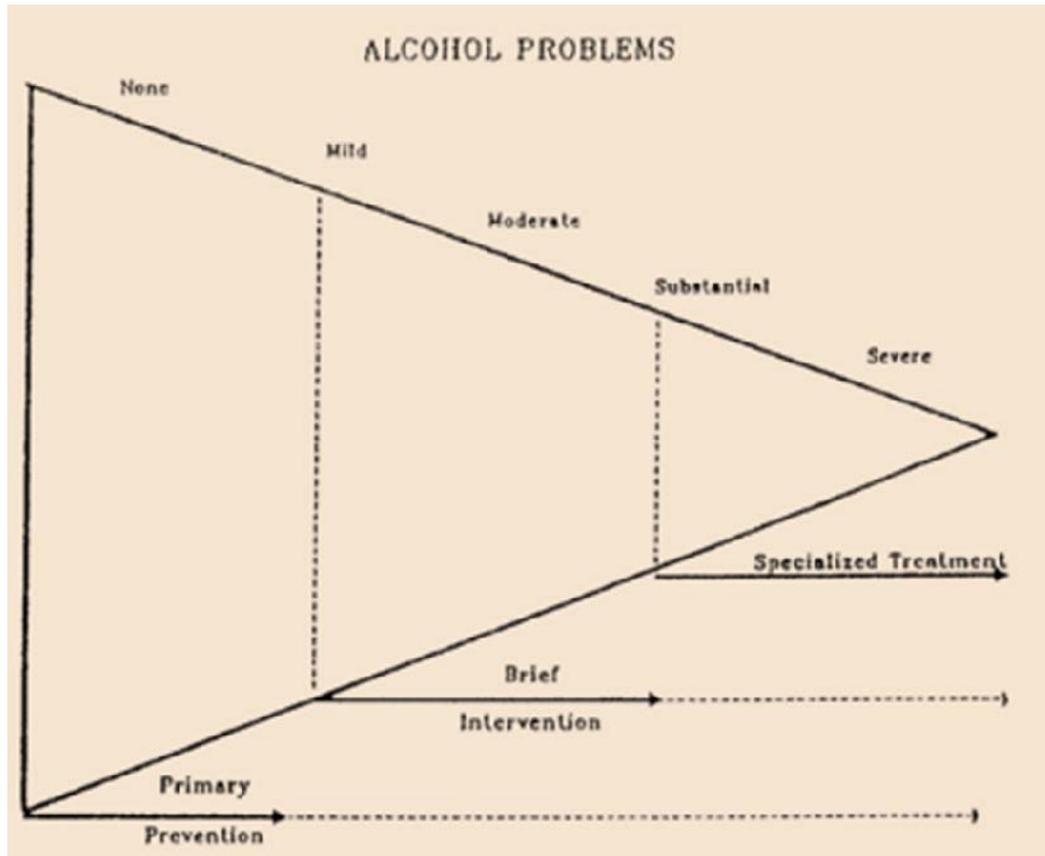
In India alcoholic beverages appeared during the Indus Valley Civilization, Alcoholic beverages have served as sources of needed nutrients and have been widely used for their medicinal, antiseptic and analgesic properties. Alcohol was considered to be a social lubricant facilitating relaxation, providing pharmacological pleasure, and also as an appetizer. But unfortunately alcohol has always been misused by humans especially young generation.

Alcohol consumption has been steadily increasing in developing countries like India and decreasing in developed countries since the 1980s. The pattern of drinking to intoxication is more prevalent in developing countries indicating higher levels of

risk due to drinking. In India it was estimated that 62.5 million population uses alcohol and per capita consumption of alcohol increased by 106.7% over the 15-year period from 1970 to 1996(WHO, 1999). Due to its large population, **India has been identified as the potentially third largest market for alcoholic beverages in the world** which has attracted the attention of multinational liquor companies. Sale of alcohol has been growing steadily at 6% and is estimated to grow at the rate of 8% per year. About 80% of alcohol consumption is in the form of hard liquor or distilled spirits showing that the majority drink beverages with a high concentration of alcohol. Branded liquor accounts for about 40% of alcohol consumption while the rest is in the form of country liquor. People drink at an earlier age than previously. The mean age of initiation of alcohol use has decreased from 23 years in 1960 to 19 years in 1990. India has a large proportion of lifetime abstainers (89.6%). The female population is largely abstinent with 98.4% as lifetime abstainers. This makes India an attractive business proposition for the liquor industry, (The Lancet, 2009). Changing social norms, urbanization, increased availability, high intensity mass marketing and relaxation of overseas trade rules along with poor level of awareness related to alcohol has contributed to increased alcohol use. **Taxes generated from alcohol production and sale is the major source of revenue in most states (Rs.25, 000 crores) and has been cited as a reason for permitting alcohol sale, (The Globe, 2001)**

The possible causes of alcoholism can be categorized into biological, psychological and social factors. The biological factors are genetic vulnerability, co-morbid medical disorder, reinforcing effects of drugs, withdrawal effects, craving and biochemical changes in the brain. The psychological factors include curiosity, social non-conformity, early initiation of alcohol, poor impulse control, attention seeking, low self esteem, and concerns regarding personal autonomy, poor stress management skills, childhood trauma, relief from fatigue and boredom and psychological distress. The social factors includes peer pressure, modeling, easy availability of alcohol, intra familial conflicts, religious reasons, poor social or familial support, perceived distance with the family, and rapid urbanization.

Fig.1.1



(Source: Families and alcohol problems: An overview of treatment research. By O'Farrell, Timothy J. Journal of Family Psychology, Vol 5(3-4), Mar-Jun 1992)

The International Classification of Diseases published by World Health Organization (ICD-10) uses the term “harmful use” to indicate a pattern of alcohol use similar to alcohol abuse. The extent of alcohol use is related to problems that have a significant impact on public health. The proportions of population in different groups of the drinking spectrum (Fig 1.1) vary considerably in different societies. A general rule, derived from European and American experience is that 10% of the alcohol drinking population consumes half the total amount of alcohol in that society (**Atlas of India 2006**)

According to **World Health Organization** (2004) there are about 2 billion people worldwide who consume alcoholic beverages and 76.3 million with

diagnosable alcohol-use disorders. According to the **Centre of Disease Control** (2006) 64% of Americans drink alcohol, with 50% as 'regular drinkers'.

The prevalence of alcohol use is still low in India, according to some studies done across the country (Indian Journal of Community Medicine, 2010), the consumption is 2 liters per person a year. However, patterns of consumption vary. Kerala, Punjab, Andhra Pradesh, Goa and the North-Eastern states have a much higher proportion of alcohol consumption. Women tend to drink more in Assam, Arunachal Pradesh, Sikkim, the North-east, Madhya Pradesh, Chattisgarh, Orissa and Andhra Pradesh than their counterparts in the rest of the country. The statistics showed that

- Percentage of adults who were current regular drinkers (at least 12 drinks in the past year): 50%
- Percentage of adults who were current infrequent drinkers (1-11 drinks in the past year): 14% (National Health Interview Survey 2008)
- Number of alcoholic liver disease deaths: 14,406
- Number of alcohol-induced deaths, excluding accidents and homicides: 23,199 (Centre of Disease Control 2007)

A survey conducted by Government of India (2001-2002) estimated 62.5 million populations in India were the alcohol users among which **17% of them are addicted to alcohol.**

Alcohol intoxication is characterized by maladaptive behavior, slurred speech, lack of coordination, unsteady gait, flushed face, irritability, impaired attention, excessive talk, euphoric mood etc. Some people become withdrawn; some sleep after alcohol consumption, in some there is a liability of mood with intermittent episodes of laughing and crying. Sometimes a person develops pathological intoxication characterized by sudden onset of marked behavioral change after consumption of small amount of alcohol. In this condition, Alcohol consumption results in impaired consolidation of new information: hence events happening during influence of alcohol are not remembered. This is called alcoholic black out. The person is confused and may experience illusions, increased psychomotor activity etc. The person may

become aggressive and may be dangerous to self and others. He may become depressed & may attempt suicide (**Gelder Michael 1999, Mohr k.wanda 2006**)

Alcohol withdrawal is a condition that follows the cessation of or reduction in prolonged or heavy drinking. Within hour's signs and symptoms develop including tremors, quick reflexes, increased heart rate, increased blood pressure, fatigue, weakness, nausea, vomiting, fits and hallucinations. (Hearing voices, illusions, night mares and disturbed sleep). Sometimes patients with alcohol withdrawal progress into delirium tremens. The patient is dangerous to self and to others (**Sadock, Benjamin 2005**)

### **1.1 Need for the study**

**Addiction**, a psychological and physiological dependence on a substance or practice, is a disease that affects the lives of so many people. It is an uncontrollably strong longing for something and in spite of knowing the harmful and negative effects of addiction the addicts still continue to use. This is the setback of addiction. An addict of alcohol or drugs is generally in a state of denial who believes that he or she can stop this at any time; however, it's not true. We will have to fight against addictions to remove it completely. Hence the need for information related to addiction, its nature, etiology and addiction treatment methods or addiction recovery programs is a must to lead a normal life.

Alcoholism has become a significant problem in India and is characterized by tremendous cultural variability with respect to beliefs and practices regarding alcoholic beverage consumption. Alcoholism in Indian communities is the tip of an iceberg, that is alcohol dependence sits on top of a huge mass of other underlying problems. Alcohol dependency frequently co-exists in Indian communities with other problems such as stress-related acting out, cultural shame, depression and self-stigma/hate. Earlier, alcoholism was believed to be the symptom of some other mental disorder. But the extensive research, on the problem established that alcoholism is a disease in itself - a disease that can be **controlled by medical and psychological treatment**. Research evident also suggest that broadening the base of treatment of alcohol problems by moving beyond treatment of chronic alcohol dependence to

prevention of alcohol abuse and early intervention for targeted group will improve their quality of living. Treatment matching should be based on the spectrum of alcohol consumption (fig 1.1) and hence the researcher felt that replacing the predominant myths about the alcohol consumption and treatment, educating them on alcohol moderation skills and enhancing the awareness of addiction related to problems will motivate and reduce drinking risk through skill building.

The key elements underlying the Alcohol Skill Training Programme include:

- Focused on skill and knowledge development
- Basic information about alcohol
- Relaxation strategies
- Alcohol resistance skills
- Avoidance of situation in which alcohol is likely to present

The programme consisted of

Session.1 Basic information about alcohol

Session.2 Drinking moderation skills

Session.3 Relaxation training

Session.4 Home exercises

Session.5 Relapse Prevention

## **1.2 Statement of the problem**

Assess the effectiveness of Alcohol Skill Training Programme on alcohol addiction among individuals attending de-addiction clinics of Institute of Mental Health, Chennai-10.

## **1.3. Objectives**

- Examine the level of knowledge of the alcohol dependent individuals on alcohol addiction before Alcohol Skill Training Programme
- Explore the level of drinking frequency before alcohol skill training programme.

- Examine the level of knowledge of the alcohol dependent individual on alcohol addiction after alcohol skill training programme.
- Identify the level of drinking frequency after alcohol skill training programme
- Evaluate the effectiveness of the alcohol skill training programme
- Find out the association of knowledge and level of drinking frequency with selected demographic variables.

#### **1.4 Operational definition**

##### Effectiveness

Effectiveness refers to the improvement on the level of knowledge on alcohol addiction and reduction in drinking frequency after the alcohol skill training programme.

##### De-addiction Unit

A place where the alcohol addicted individuals are treated to get rid of their alcoholism

##### Alcohol Skill Training Programme

It is the structured education programme aimed to improve knowledge and skills to reduce their alcohol consumption.

#### **1.5 Assumptions**

- Individual addicted to alcohol may have some knowledge regarding alcoholism
- Individual addicted to alcohol may modify or change the behavior of drinking after the alcohol skill training programme.

#### **1.6 Hypothesis**

There is a significant difference between the levels of knowledge about the alcohol addiction before and after the skill training programme.

#### **1.7 Delimitations**

The study is delimited to:

- The individuals attending de-addiction clinic at Institute of Mental Health.
- The individuals who consented to undergo alcohol skill training programme.

**Inclusion Criteria**

- Individuals who are attending the de-addiction clinic for treatment and willing to undergo alcohol skill training programme.
- Individuals diagnosed as alcohol dependence syndrome
- Individuals who can understand Tamil and English

**Exclusion criteria**

- Individual who diagnosed with alcohol dependence syndrome with psychosis
- Individuals suffering from other co-morbid illness
- Individuals with the diagnosis of multiple substance use

## CHAPTER-II

### REVIEW OF LITERATURE

This chapter presents similar research studies which have been conducted earlier by researchers. This chapter contains both Indian and International studies related to alcoholism, its effects and preventive management.

The literature found relevant to the study has been presented under the following headings.

- Studies related to prevalence and factors associated with the use of alcohol
- Studies related to problems and risk factors of alcoholism
- Studies related to intervention and outcome on alcohol addicted individuals

#### 2.1 STUDIES RELATED TO PREVALENCE AND FACTORS ASSOCIATED WITH THE USE OF ALCOHOL

**John A et al (2009)** conducted a study to examine the nature, prevalence and factors associated with hazardous use of alcohol among men in a rural community in Tamilnadu, India. The results revealed that the prevalence of life-time use in the past year and hazardous use of alcohol was 46.7% and 34.8% respectively. The study concluded that the relationship between the availability of illicit and commercial alcohol and its hazardous use warranted the need for an alcohol policy which takes into account the health and economic issues so as to prevent the negative impact of problem drinking.

**Eva YN Yuen,(2008)** in his research review identified that individual and group family interventions are increasingly being used to assist families to cope. A literature review was conducted to identify whether individual and group family interventions for adolescent substance abuse enhance the mental health of parents and other family members. This review also sought to identify the direct and indirect effects of family intervention processes on depressive symptoms and general distress among adolescents substance use. Three qualitative studies were included in the

review. Mechanisms that contributed to mental health improvements included: reduction of stress symptoms, improved coping, improved family functioning, more effective parenting behaviors, attitude changes, perceived changes in relative's substance use, and improved social support.

**Marchand A (2008)** conducted a study to examine contribution of occupation and work organization conditions to alcohol use and misuse among 10,155 workers in Quebec, Canada. The results revealed that work place harassment is an important determinant of both low-risk and high-risk drinking which is moderated by occupation. Family situation, social support outside work and personal characteristics of individuals are also associated with alcohol use and misuse. Non-work factors mediated/suppressed the role of occupation and work organization conditions and it concluded that occupation and workplace harassment are important risk factors associated with alcohol use and misuse.

**Sringeri SK et al (2008)** conducted a retrospective study on association between attention/deficit/hyperactive disorder (ADHD) and early-onset alcohol dependence among 70 male subjects with alcohol dependence presenting to the de-addiction services of the National Institute of Mental Health and Neurosciences (NIHMHANS), Bangalore, India. The results showed a high incidence of ADHD in early-onset alcoholics.

**Ganaraja B et al (2007)** conducted a study to evaluate the responses to comprehensive alcohol expectancy questionnaire (comprehensive effects of alcohol-CEOA) in order to test the tendency towards alcohol intake among the First year Medical (MBBS) students of KASTURBA Medical College, Mangalore, India. The aim of the study assessed the negative reinforcement they would expect if they consume alcohol. The results showed negative expectancies among females and stronger positive expectancy among male.

**Chagas Silva M et al (2003)** conducted a study to describe the prevalence and associations of hazardous drinking in a male industrial worker population (n=984) from a randomly selected sample of 1013 workers from four industries in Goa, India. The results revealed that hazardous drinking was significantly associated with severe health problems, such as head injuries and hospitalization, whereas common mental

disorder was found to be a confounder in its association with adverse economic outcomes.

## **STUDIES RELATED TO PROBLEMS AND RISK FACTORS OF ALCOHOLISM**

**Michael Livingston et al (2010)** conducted a study to assess the degree of relation with heavy drinkers affected health and well-being among 2649 Australians. The results revealed that negative effects on both health and well-being related to the number of heavy drinkers identified outside the respondent's household, whereas heavy drinkers within the household were negatively related to health but not well-being. The study suggests that other people's drinking can have substantial effects on health and well being. This study concluded that all sectors including education, health, legal and judicial must work in liaison. Gender inequality must be eliminated and equal participation of women in the decision-making and development processes must be ensured.

**Kaur R Garg S (2010)** conducted a qualitative study on domestic violence in a rural community of India among married women in the age group of 18 to 35 years. The results revealed that alcoholic husband emerged as the main cause for domestic violence and physical violence as a major cause of concern among these women

**Mc Bride O et al (2009)** conducted a descriptive study on the impact of alcohol symptoms on three domains: physical illness, drinking patterns and the occurrence of negative life events among current drinkers (n=26,946) in the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) in United Kingdom. The study results revealed that the dependence groups were more likely to experience higher estimates of social problems compared to one criterion orphans. One-criterion orphans were more likely than the abuse group to experience financial problems but less likely than the dependence group to experience family-related legal problem

**Milne BJ et al (2009)** conducted a longitudinal cohort study to examine the Predictive value of family history on severity of illness on alcohol dependence to associate with 4 clinical indexes of disorder (recurrence, impairment, service use and

age at onset) in relation to psychiatric disorders (major depressive episode, anxiety disorder, alcohol dependence and drug dependence) in New Zealand among 981 members. The results revealed that the family history was associated with the presence of all 4 disorder types. In addition, family history was associated with a more recurrent course for all 4 disorders, worse impairment and greater service use. The study concludes that family history plays important role in determining patients' clinical prognosis.

**Nayak MB et al (2009) conducted** a comparative study to detect alcohol related problems among 743 male drinkers in Goa, India using the full and shorter versions of AUDIT and RAPS 4-QF as screening measures for alcohol use disorders. The results revealed that all measures were efficient at detecting alcohol use disorders and suggested to select an appropriate screening measure and cut-off score necessitates careful consideration of the screening context and resources available to confirm alcohol- related diagnoses.

**Park S, Kim H (2009)** conducted a study on relationships between parental alcohol abuse and social support, peer substance abuse risk and social support, and substance abuse risk among South Korean adolescents of age group between 15-22 years. The results revealed that the influence of social support on substance abuse risk among adolescents depended on the source of support-parents or peers. These findings need to be considered in the development of intervention programs for adolescents at risk for substance abuse.

**Poulose B, Srinivasan K (2009)** conducted a study to examine the association between high risk behaviors and alcohol abuse among patients admitted to an inpatient facility for treatment of alcohol dependence syndrome in India. The results revealed that most common high risk behavior was road traffic accident following alcohol use and it indicates that severity of drinking and personality factors were associated with occurrence of high risk behavior as a consequence of heavy drinking.

**Reinaldo AM, Pillon SC (2008)** conducted a descriptive study to identify the effects of alcoholism on family relations and by means of case management to encourage the recovery of these relationships. The results showed that the problems caused by alcohol abuse impose profound suffering to family members, which

contributes to high levels of interpersonal conflict, domestic violence, parental inadequacy, child abuse and negligence, financial and legal difficulties in addition to financial problems associated to it.

### **STUDIES RELATED TO INTERVENTION AND OUTCOME ON ALCOHOL ADDICTED INDIVIDUALS**

**Smeyedsland.G. et.al (2011)** assessed the motivational interviewing (MI) for substance abuse. The method they adopted was randomized central trial with persons' dependent or abusing substance (n=13,342). The author concluded that MI can reduce the extent of substance abuse compared to no interview

**Angela H Jackson,(2010)** in his research article explained the development of unhealthy substance use related competencies, and described a curriculum in unhealthy substance use that integrates these competencies into internal medicine resident physician training. He outlined strategies to facilitate adoption of such curricula by the residency programs. This provides an outline for the actual implementation of the curriculum within the structure of a training program, with examples using common teaching venues. He described and linked the content to the core competencies mandated by the Accreditation Council for Graduate Medical Education, the formal accrediting body for residency training programs in the United States. Specific topics are recommended, with suggestions on how to integrate such teaching into existing internal medicine residency training program curricula. To conclude, given the burden of disease and effective interventions available that can be delivered by internal medicine physicians, teaching about unhealthy substance use must be incorporated into internal medicine residency training, and can be done within existing teaching venues

**Charles Alan Walker (2010)** in his study on alcohol addiction combined Twelve step approach in conjunction with Buddhist philosophies, complementary therapies, or both. The subject requirements were a minimum of five years of continuous sobriety, possession of at least a bachelor's degree, as well as no physical or sexual abuse experienced in the family of origin. The researcher utilized an ad hoc meaning generation approach for interpreting each subject's interview responses.. Results supported the hypothesis that Buddhist philosophies and complementary therapies can be utilized to effectively support and enhance recovery. The subjects

reported that the programs provided a culture of support for their recovery by attending meetings, working the Twelve Steps with a sponsor, as well as providing a spiritual path for living life sober. The author concluded that Buddhist philosophies enhanced their Twelve Step recovery by teaching nonattachment to ego, focus, and awareness through meditation, as well as connection with a collective spirituality and complementary therapies enhanced their Twelve Step recovery by providing various methodologies to reduce cravings, enhance detoxification, as well as provided ongoing practices to enhance their physical and spiritual connection.”

**Tomey.et.al (2009)** studied the effect of preventive intervention on underage drinkers in United State (n=785).His intervention model was implemented on adolescents’ families that include life skill training and alternative activities. The results showed significant effect and author concluded that life skill training and activities as effective preventive measures in reduction of alcohol abuse.

**Pratima Murthy (2009)** attempted to determine the effects of continued care on subjects with alcohol dependence. Study participants were recruited from a slum in Bangalore. The control group comprised individuals from a lower socio-economic status. Both groups received identical treatment from a specialized de-addiction facility. The study group also received weekly continued care in the community, either at a clinic located within the slum or through home visits. Those patients without stable jobs were referred for employment. The control group was given routine hospital follow-up visits. Both groups were evaluated on the Alcohol Problem Questionnaire and quantity/frequency of drinking at baseline and every 3 month interval for one year after discharge. Follow-up support and continued care appear to significantly improve longer-term recovery in alcohol dependents. The study demonstrated that the sustaining effect of continued care will have direct effect on alcohol dependence. The author stressed the need for a more comprehensive and continuing care approach to maintain gains of initial interventions as her conclusion.

**Cox.Miles et.al (2008)** examined whether or not motivational interviewing is more efficacies than no intervention in reducing alcohol consumption. A literature search followed especially a meta analytic review of randomized control trials revealed efficacy of brief Motivational Interview with aggregate effect size of 0.43. (95% CL) and permitted especially MI’s long term efficacy effectiveness.

**Miller et al (2008)** assessed the effectiveness of social skill training among alcohol addicts (n=750) and found that statistical significant results. He concluded that social skill training referred as rubric treatment approach that not only overcome addiction deficiencies but also lead to more adaptive behavior.

**Lok Raj, (2005)** in his study described about a camp approach in which professionals reached the community at their doorstep. With the help of local resources, they started to find out the drug and alcohol dependence patients who do not prefer hospitals for various reasons. Also, community-based programmes for drug and alcohol dependence are almost non-existent. De-addiction camps have been organized sporadically in some parts of India, particularly in Jodhpur, around Chennai and Chandigarh. The camp approach has been advocated as an effective alternative to hospital-based treatment of drug and alcohol dependence, offering many advantages such as direct participation of the community in the treatment process, better acceptance by the patients, better compliance and cost-effectiveness. Apart from abstinence, changes in the dose, and frequency and status of compliance were assessed to determine the outcome. The camp approach is a cheap, feasible and effective alternative to hospital-based management of alcohol/drug dependence and paves the way for rehabilitation of these individuals because of the active involvement of the community in the treatment process

**Miller and Rollmier (2002)** studied the effectiveness of brief motivational and skill training programme with college students heavy drinking (n=508) for 4 years. The high risk drinkers in both experimental and controlled group reported a mean decrease in consumption of alcohol at two years follow-up.

**Corce.s.et.al (2002)** in their research review evaluated informational or knowledge based approach on seven studies, that assessed information and knowledge base. All the studies demonstrated changes in knowledge or awareness level following Alcohol Skill Training Programme, but only one study, (kivlahan.et.al.1990) of the seven study reported significant reduction either in alcohol consumption or negative consequences.

**Corrigan et al (2001)** in their Meta analysis on social skill training evaluated the effectiveness of skill training programme among alcohol addicted individuals

(n=1025). The components of skill training included training instruction, modeling, rehearsal, feedback and home work. The study identified that the skill training showed statistically significant effect to overcome the deficiencies of addicts. The authors concluded that this training would improve adaptive behaviors among alcohol addicts.

**Flay (2000)** studied the effectiveness of skill training programme among school children in her Meta analytic review of 143 preventive programmes. These studies showed significant improvement in knowledge and reduction in alcohol consumption after Alcohol Skill Training Programme. The author concluded that these programme effects tend to decay over time and Alcohol Skill Training Programme could be sustained with use of booster sessions.

## **2.2. Conceptual Framework**

The conceptual frame work is a set of inter related concepts that symbolically represent and convey only a mental image of a phenomena. Conceptual framework acts as a building block for the research study. It serves as a spring board for the generation of research hypothesis. The overall purpose of the framework is to make scientific findings meaningful and generalisable. The framework can guide the researcher's understanding of not only what is natural phenomena but also the way of their occurrence.

The present study aims at evaluating the effectiveness of alcohol skill training programme on alcohol addiction among individuals attending de-addiction clinics of Institute of Mental Health, Chennai. The conceptual framework of the present study was developed by the investigator based on Bertalanffy's general system theory. Ludwig Von Bertalanffy described this theory in the late 1930s.

According to this theory a system is a set of interrelated parts that comes together to form a whole. Real system is open and interacts with their environment and they can acquire qualitatively new properties. This theory describes how to break whole things into parts and then learn how the parts work together in a system.

In the present study the patients attending de-addiction clinic are considered as an open system. Because they receive the information from the environment, the system uses this input to maintain homeostasis.

## **FUNCTIONING OF SYSTEM**

The system functions as:

### **Input**

The first component of a system is input, which is the information, energy or matter that enters a system. For a system to work well, input should contribute to achieve the purpose of system. In the present study the existing knowledge of patients attending de-addiction clinics on alcohol addiction will be assessed initially by using a structured knowledge questionnaire and input will be given in the form of Alcohol addiction and its consequences.

### **Throughput**

According to the theorist throughput refers to the process used by the system to convert raw materials or energy from the environment into products that are usable by the system itself or by the environment. In this active phase the patients convert the information gained from the alcohol skill training programme regarding the alcohol addiction into useful way in the form of knowledge acquisition and skill development.

### **Output**

According to theorist output refers to the product or service which results from the system's throughput. The information provided as throughput to the system is continuously processed by the system and is released as output in an altered state. Here the output refers to the outcome of ASTP measured in terms of change in knowledge after the administration of ASTP.

### **Evaluation**

Evaluation is the information about some aspects of data or energy processing that can be used, to evaluate and monitor the system and to guide it to more effective performance. In the present study evaluation measures the success or failure on knowledge and drinking frequency. Based on the set criteria if the knowledge level is found inadequate, rectification can be done by strengthening the existing knowledge through continuous teaching, skill developing and monitoring which is not under the purview of this study.

## **Feed back**

The final function is feedback, which is the process of communicating what is found in the evaluation of the system. It is the information given back to the system to determine whether or not the purpose or the end result of the system has been achieved. The final part of the feed back is communicating what is found in the evaluation and it tells whether the skill training programme was effective in enhancing the knowledge and drinking frequency of the individuals attending de-addiction clinic.

## **CHAPTER III**

# **METHODOLOGY**

This chapter explains the methodology in detail. It includes research design, setting of the study, sampling technique, tools, pilot study, data collection process and plan for the data analysis. The study was conducted to assess the effectiveness of alcohol skill training programme regarding the alcohol addiction among individuals attending de-addiction clinics of Institute of Mental Health, Chennai.<sup>10</sup>

### **3.1 Research Approach & design**

Quantitative approach and quasi experimental design

- Pre and post intervention

### **3.2 Variables**

- Independent variable-Alcohol Skill Training Programme
- Dependent variable-knowledge and drinking frequency

### **3.3 Research Setting**

De-addiction clinic at Institute of Mental Health, (IMH) Chennai is one of the biggest Institution in South Asia. The bed strength of the hospital is 1800. There is a separate de-addiction unit with 50 beds and separate de-addiction clinic conducted every Wednesday around 150-250 patients attending de-addiction clinic every week

### **3.4 Study Population**

Individuals attending the de-addiction unit for the treatment at IMH

### **3.5 Sample characteristics and selection**

#### **3.5 .1 Sample size**

120 individual attending de-addiction unit of IMH for treatment were considered as the subjects for this study by convenience sampling.

#### **3.5. 2 Criteria for Sample selections**

##### **Inclusion Criteria**

- Individuals who are attending the de-addiction clinic for treatment
- Individuals diagnosed as alcohol dependence syndrome
- Individuals who can understand Tamil and English

### **Exclusion criteria**

- Individual who diagnosed with alcohol dependence syndrome with psychosis
- Individuals suffering from other co-morbid illness
- Individuals with the diagnosis of multiple substance use

### **3.5.3 Sampling technique**

Convenient sampling technique.

All individuals admitted to de-addiction in-patient unit with the diagnosis of Alcohol dependent syndrome who fulfilled the inclusion criteria were conveniently selected

### **3.6 Tools used for data collection**

Tool used for the research purpose are:

- 1) Socio demographic information schedule
- 2) Modified student alcohol questionnaire (Ruth G.Engs)
- 3) Drinking quantity and frequency (Cahalan's) index

### **3.7. Description of the tool and scoring technique**

**Part A:** This was developed by the researcher for the present study. It consists of demographic details of patients attending de-addiction clinic. It includes the age, marital status, education, occupation, religion, income, family type, number of children, sources of information about de-addiction, reason for first drink, the amount of alcohol which the individual consumes per drink etc.

**Part B:** It is a standardized scale consists of 33 items 3 point rating scale measuring the general, physical and psychosocial aspects of alcohol addiction

**Part C:** Drinking quantity and frequency (Cahalan's) index

Drinking behaviors were assessed via modified version on Cahalan's Drinking Questionnaire. Participants indicated the frequency of alcohol consumption with the pattern of drinking behavior.

### 3.7.1 Score interpretation

For the assessment of the level of the knowledge, the responses of the subjects were assessed as

Each correct answer carries 2 marks

Each incorrect answer carries 1 mark

Each unknown answer carries 0 mark

Correct statements

5,7,9,10,11,13,14,15,16,17,18,19,20,21,22,23,24,27,28,29,30,31,32,33

Incorrect statements

1,2, 3,4,6,8,12,25,26

The total score was categorized as follows

Raw Score	Percentage	Level of Knowledge
0-22	0-33%	Inadequate knowledge
23-44	34-66%	Moderately adequate knowledge
45-66	67-100%	Adequate knowledge

### 3.8 Content Validity of the Tool

To find out the applicability and suitability of the tool for the present study the content validity of the scale was obtained from experts in the field of psychiatry, psychology and psychiatric nursing and statistics.

### 3.9 Reliability of the Tool

The reliability of the tool was assessed by using Corn Buch Alpha Method using test retest method. Calculated coefficient was .80. This high score indicates the excellent reliability of the tool.

### 3.10. Pilot Study

After obtaining permission in Institute of Mental Health, pilot study was conducted with 30 samples from 21.3.11 to 25.3.11. The samples were selected on the basis of selection criteria. The questionnaire was administered before skill training programme and also after the programme. Based on the pilot study and the expert's opinion the modification done in the teaching plan and also it was taught to the samples through the laptop with power point slides.

### 3.11. Data collection procedure

The formal written permission was obtained from the Director, Institute of Mental Health, Chennai. After a brief introduction, the researcher explained about the proposed study, to the individuals attending de-addiction clinic. It was planned to generate 60-80 samples on the first week. There was an initial resistance and only 50 samples could be generated for the first week. After collecting the pretest knowledge and drinking frequency Alcohol Skill Training Programme was given to the subjects continuously for one week in groups as follows:

S.No	Session	Activity	Time
	Introduction and support establishment	-	5mts
1.	Basic information about alcohol	Power point presentation	20mts
2.	Drinking moderation skills	Group discussion with pamphlets	15mts
3.	Home exercise	Discussion	10mts
4.	Relapse prevention skills	Power point presentation	10mts

At the end of the first week of training they were given home exercise (Annexure-2A) on decision making on their addiction and on relapse prevention strategies. All the participants were asked to report on 4<sup>th</sup> week on a prescribed date. Post test followed by small group discussion was conducted. Similar pattern was followed for the second week also. But on the first day of the second week more numbers of patients expressed their willingness to participate in the study but based on inclusion criteria only 70 willing clients were selected for the study.

After Alcohol Skill Training Programme for one week the participants were given home exercises and were asked to report on the end of the third week and post test was given. There were totally 20 dropouts from the study during the training period and on follow up in 4<sup>th</sup> week. So the sample size was reduced to 100 participant.

### **3.12. Plan for Data Analysis**

- Demographic variables in categories will be given in frequencies with their percentages
- Knowledge score will be given in mean and standard deviation
- Association between demographic variables and knowledge score will be analysed using Pearson Chisquare test
- Quantitative knowledge score in pretest and posttest will be compared using student's paired t-test
- Qualitative level of knowledge in pretest and posttest will be compared using Stuart Maxwell test/extended McNemar test
- Differences between pre and post score will be analyzed using proportion with 95% CI and mean difference with 95% CI (Confidence Interval)

### **3.13. Protection of Human Subjects**

The proposal was approved by the experts prior to pilot study and for the main study. Permission was obtained from Dean, Madras Medical College, Chennai, Director, Institute of Mental Health, Principal, College of nursing. An informed consent was obtained from the study participants with assurance that confidentiality and privacy would be maintained.

## **CHAPTER IV**

### **ANALYSIS AND INTERPRETATION**

This chapter deals with the analysis and interpretation of the data obtained from the individuals attending de-addiction clinics and Institute of Mental Health, Chennai-10

- SECTION I : Socio demographic characteristics of the study subjects
- SECTION II : Level of knowledge of the respondents before Alcohol Skill Training Programme (ASTP)
- SECTION III : Knowledge of the respondents at various knowledge domains before ASTP
- SECTION IV : Level of drinking frequency before ASTP
- SECTION V : Level of knowledge of the respondents after ASTP
- SECTION VI : Knowledge of the respondents at various knowledge domains after ASTP
- SECTION VII : Level of drinking frequency after ASTP
- SECTION VIII: Percentage distribution of samples on knowledge before and after the ASTP
- SECTION IX : Comparison of knowledge score before and after ASTP in various knowledge domains
- SECTION X : Effectiveness of alcohol skill training programme
- SECTION XI : Association between knowledge score and socio demographic characteristics
- SECTION XII: Association of drinking frequency with socio demographic characteristics.

## SECTION: I

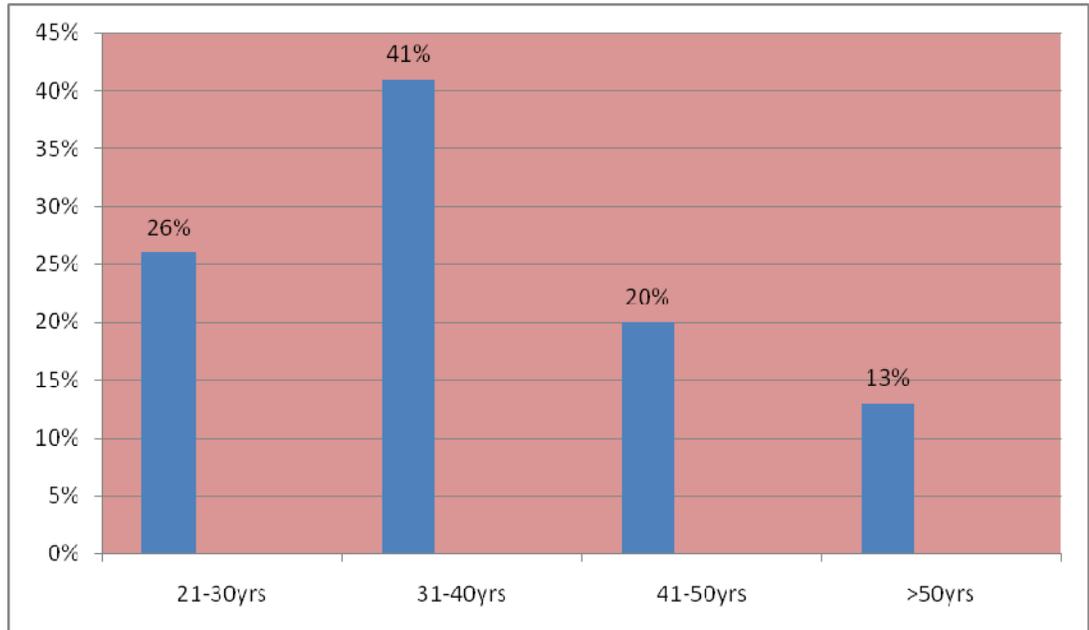
Table 4.1: Socio demographic characteristics of the study subjects

Demographic variables		No.of patients	%
Age	21 -30 yrs	26	26.0%
	31 -40 yrs	41	41.0%
	41 -50 yrs	20	20.0%
	>50 yrs	13	13.0%
Marital status	Single	20	20.0%
	Married	45	45.0%
	Separated	32	32.0%
	Divorced	3	3.0%
Education status	Illiterate	17	17.0%
	Basic schooling	15	15.0%
	Middle schooling	38	30.0%
	Higher secondary	20	20.0%
	Graduate	10	10.0%
Religion	Hindu	60	60.0%
	Christian	27	27.0%
	Muslim	13	13.0%
Occupation	Daily wages	36	36.0%
	Private company/work	31	31.0%
	Government	14	14.0%
	Pensioner	10	10.0%
	Business	9	9.0%
Monthly income	< Rs.2000	21	21.0%
	Rs.2000 – 5000	35	35.0%
	Rs.5001- 10000	24	24.0%
	>Rs.10000	20	20.0%

Demographic variables		No.of patients	%
Type of family	Nuclear family	56	56.0%
	Joint family	44	44.0%
Children	No children	22	22.0%
	One	22	22.0%
	Two	34	34.0%
	Three	15	15.0%
	Four and above	7	7.0%
Source of information	Family members/friends	67	67.0%
	Media	7	7.0%
	Medical professionals	18	18.0%
	Books	8	8.0%
Family members	Grand father	22	22.2%
	Father	38	38.4%
	Uncle	14	14.1%
	Brother	25	25.3%
Reason for first alcohol consumption	Family Problem	18	18%
	Peer pressure	56	56%
	Occupation environment	13	13%
	Social gathering	13	13%

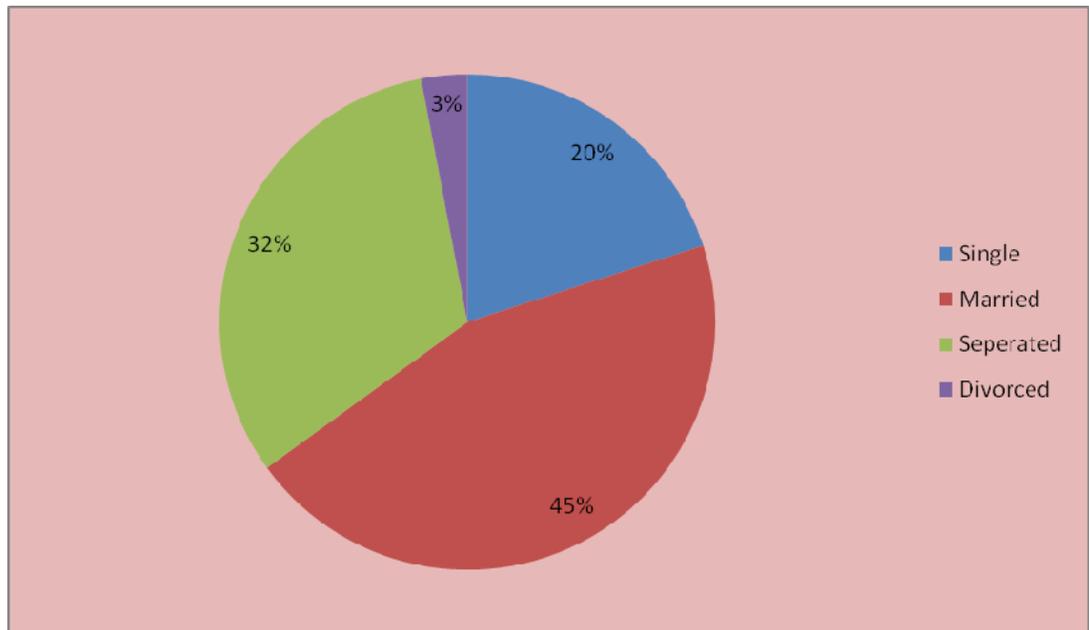
Table 4.1 shows the demographic information of the respondent. Majority of the respondent (41%) are in the age group of 31-40 years. Nearly half of the participants (45%) are married and 30% of them had middle schooling. Most of the respondents (60%) are Hindu by religion, and about 36% of the samples were daily wages. Of all the participants only 21% of the sample's income was less than 2,000 per month. More than half (56%) of the study population belongs to nuclear family. Only 7% of respondents had 4 and more children, high proportion (57%) of the study population's source of information was either family members or friends and 38% of the respondents' fathers were alcoholics. More than half (56%) of the respondents stated that peer pressure as the reason for their first alcohol consumption.

Fig 4.1 AGE WISE DISTRIBUTION OF THE ALCOHOL DEPENDENT STUDY SUBJECTS



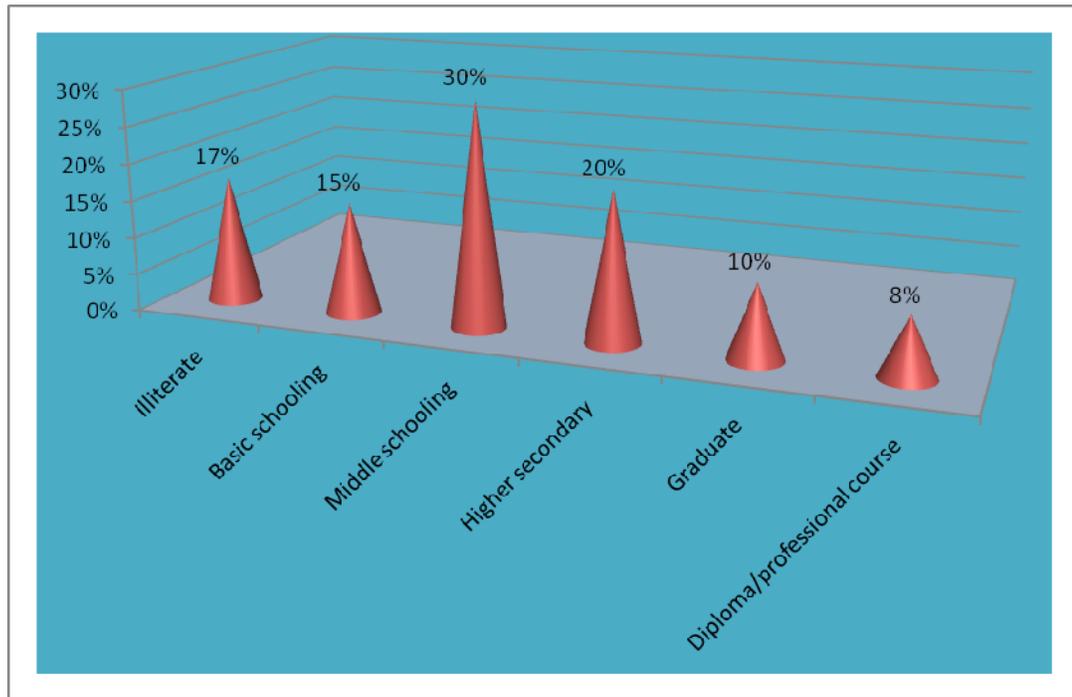
Majority of the subjects were between the age of 31-40years

Fig4.2 DISTRIBUTION OF MARITAL STATUS OF THE RESPONDENTS



Majority of them are married (80%) of which nearly half of the study subjects (45%) were living with their wife.

Fig.4.3 DISTRIBUTION OF THE RESPONDENTS EDUCATIONAL STATUS



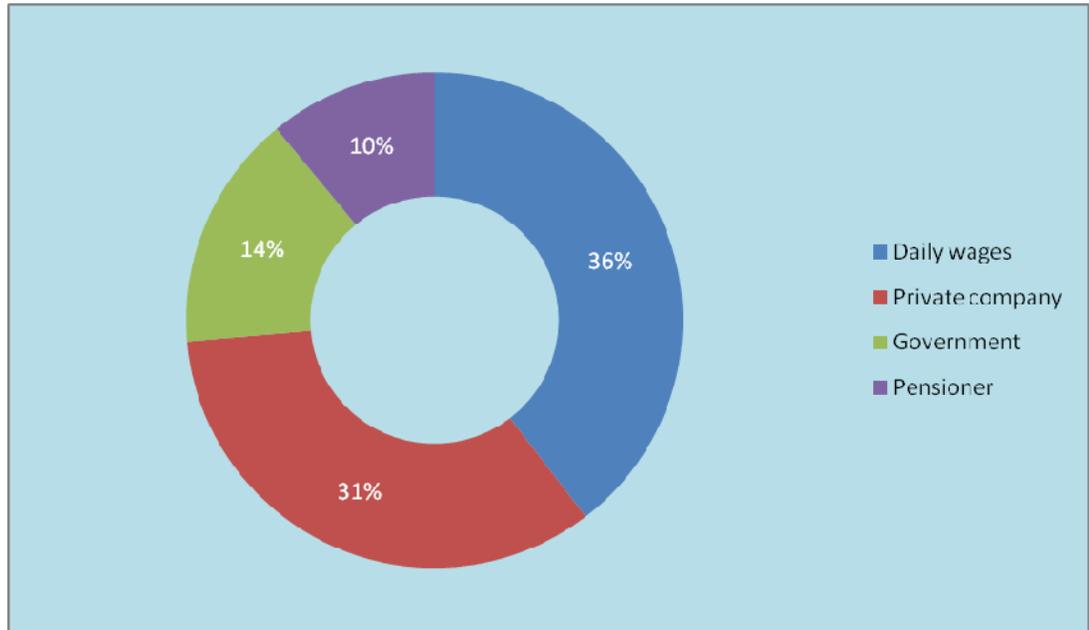
Nearly one third of the study participants (30%) were educated upto middle school level

Fig.4.4 DISTRIBUTION OF THE RESPONDENTS' RELIGION



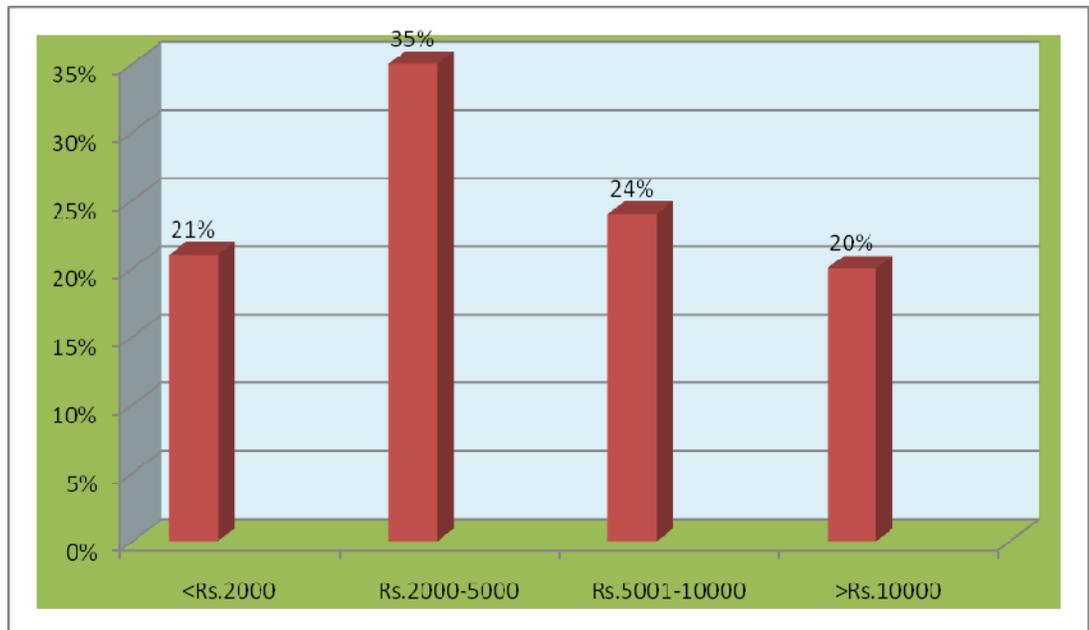
Majority of them (60%) were Hindu by religion

Fig.4.5 DISTRIBUTION OF OCCUPATIONAL STATUS OF THE STUDY SUBJECTS



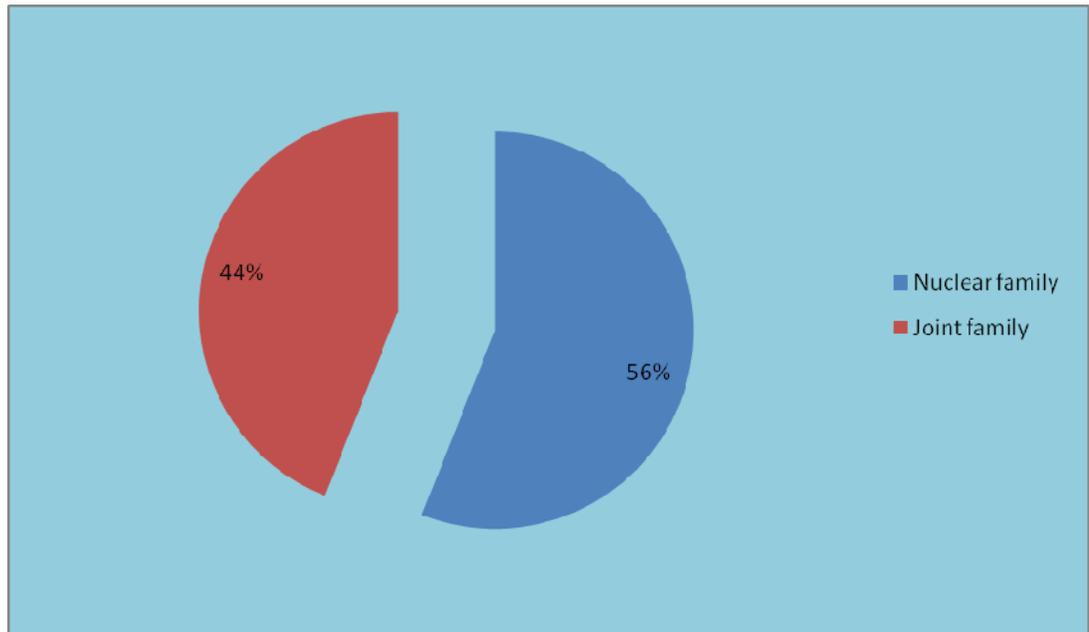
Majority of them (36%) were daily wagers.

Fig.4.6 DISTRIBUTION OF MONTHLY INCOME OF THE RESPONDENTS



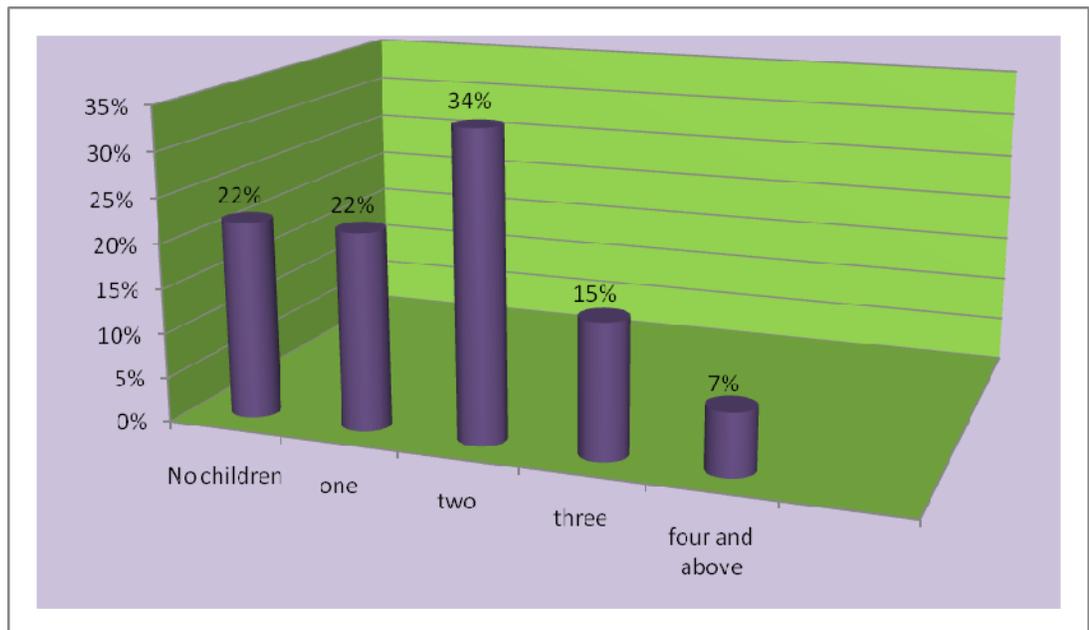
Majority of them (35%) were having their income between Rs.2,000-5,000 per month

Fig.4.7 DISTRIBUTION OF FAMILY TYPE



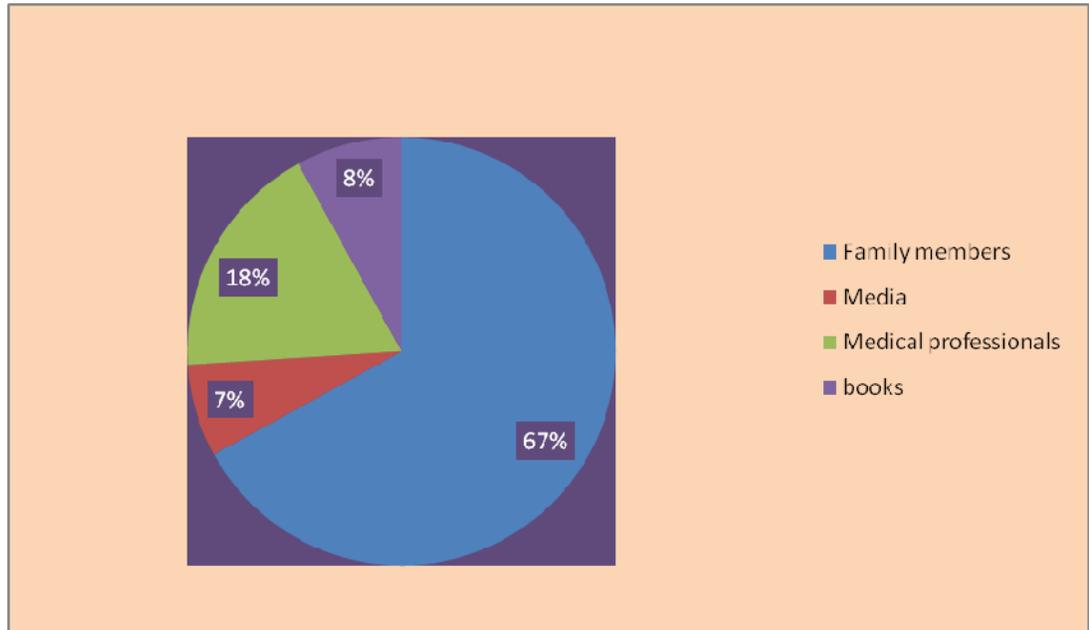
More than half (56%) of the respondents belongs to nuclear family

Fig.4.8 DISTRIBUTION OF NUMBER OF CHILDREN OF THE STUDY SUBJECTS



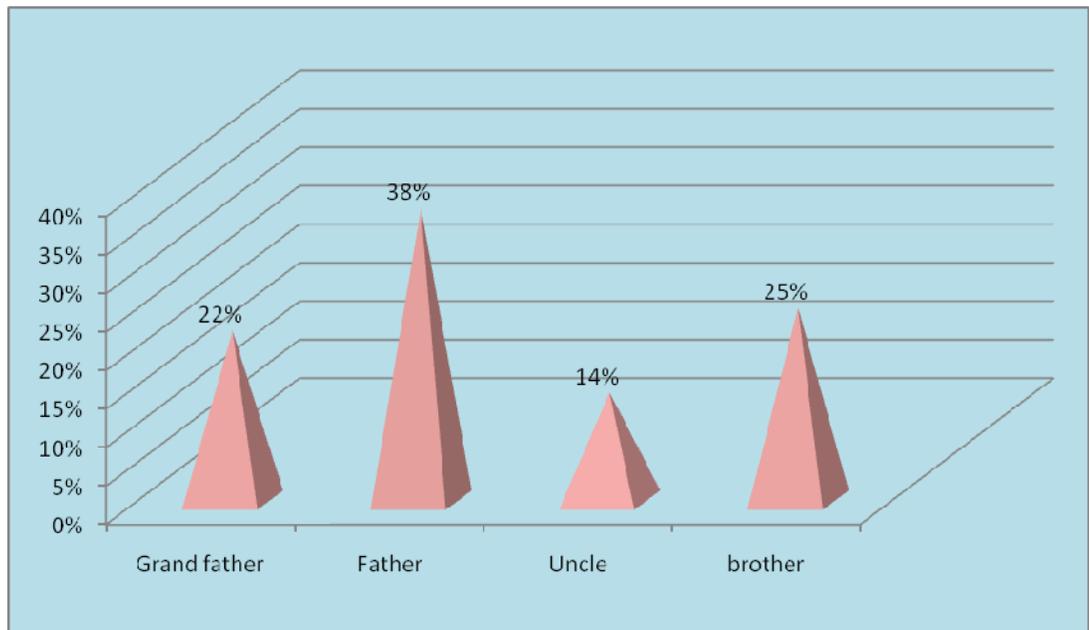
Majority of them have more than two children (56%)

Fig.4.9 DISTRIBUTION OF THE RESPONDENTS BASED ON THEIR SOURCE OF INFORMATION



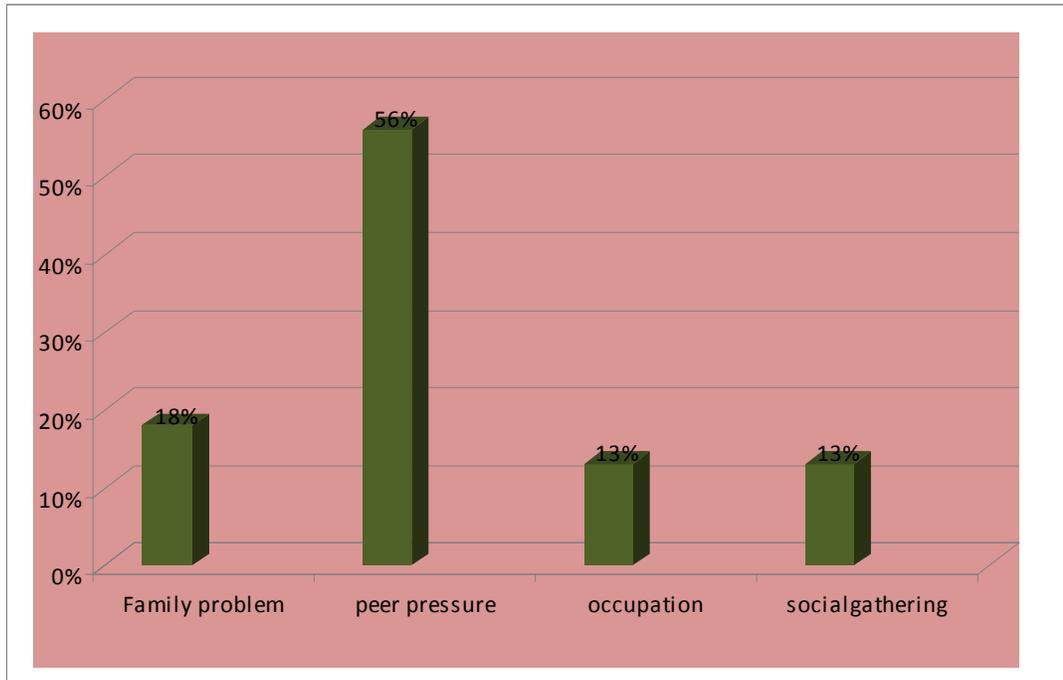
Majority of (67%) the respondents got the information about de-addiction from the medical professionals

Fig.4.10 DISTRIBUTION OF FAMILY MEMBERS WITH ALCOHOL ADDICTION



Majority of the respondents' (38%) fathers were addicted to alcohol.

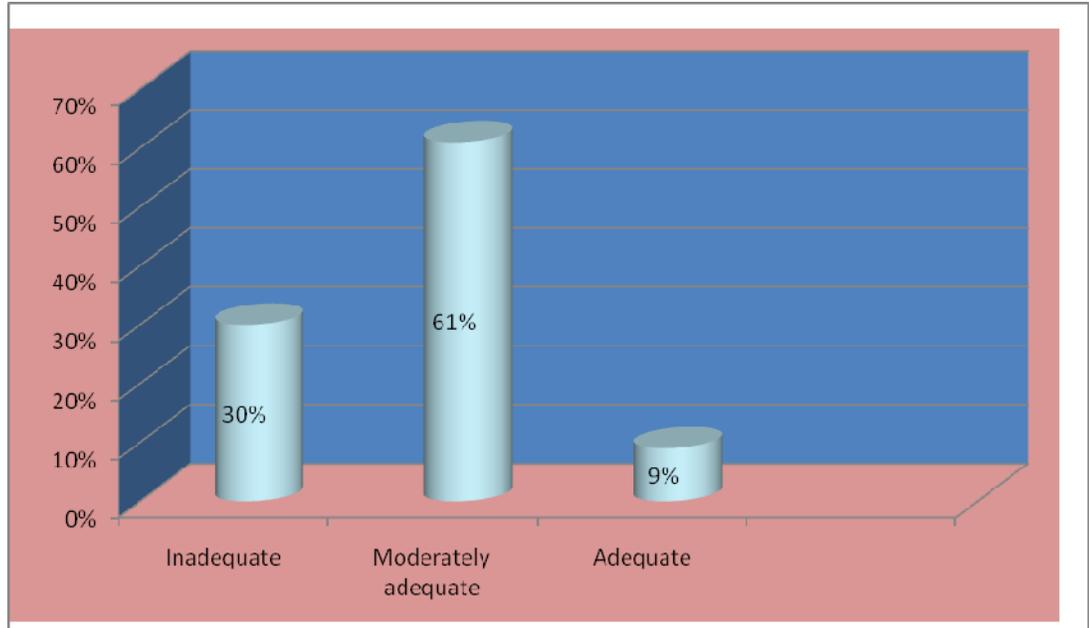
FIG.4.11 DISTRIBUTION BASED ON REASON FOR FIRST ALCOHOL CONSUMPTION



Majority of respondents (56%) mentioned the peer pressure as the reason for their first alcohol consumption

## SECTION II

Fig.4.12: LEVEL OF KNOWLEDGE OF THE RESPONDENTS BEFORE ALCOHOL SKILL TRAINING PROGRAMME



The above fig.4.12 showed the level of knowledge of the respondents before alcohol skill training programme. It was found that majority of them 61% had inadequate level of knowledge about alcohol addiction

### SECTION:III

Table 4.2 Knowledge of the respondents at various knowledge domains before ASTP

<b>Knowledge</b>	No. of questions	Min –Max score	Knowledge score	
			Mean $\pm$ SD	%
General Information	11	0 -22	11.35 $\pm$ 3.54	51.6%
Physical changes	11	0 -22	11.24 $\pm$ 3.50	51.1%
Family and social aspects	11	0 -22	10.14 $\pm$ 3.71	46.1%
Overall	33	0 - 66	32.73 $\pm$ 9.36	49.6%

The above Table 4.2 depicts the respondents' knowledge score in different domains of alcohol addiction. The Mean score was 32.73 and the standard deviation was 9.36 and the percentage was 49.6%

SECTION:IV

Table.4.3 Level of drinking frequency before ASTP

Level of Drinking frequency	Pre intervention	
	n	%
I did not drink at all	0	0.0%
About once a month	4	4.0%
Two to three times a month	13	13.0%
Once or twice a week	18	18.0%
Three to four times a week	19	19.0%
Nearly everyday	20	20.0%
Once a day or more	26	26.0%

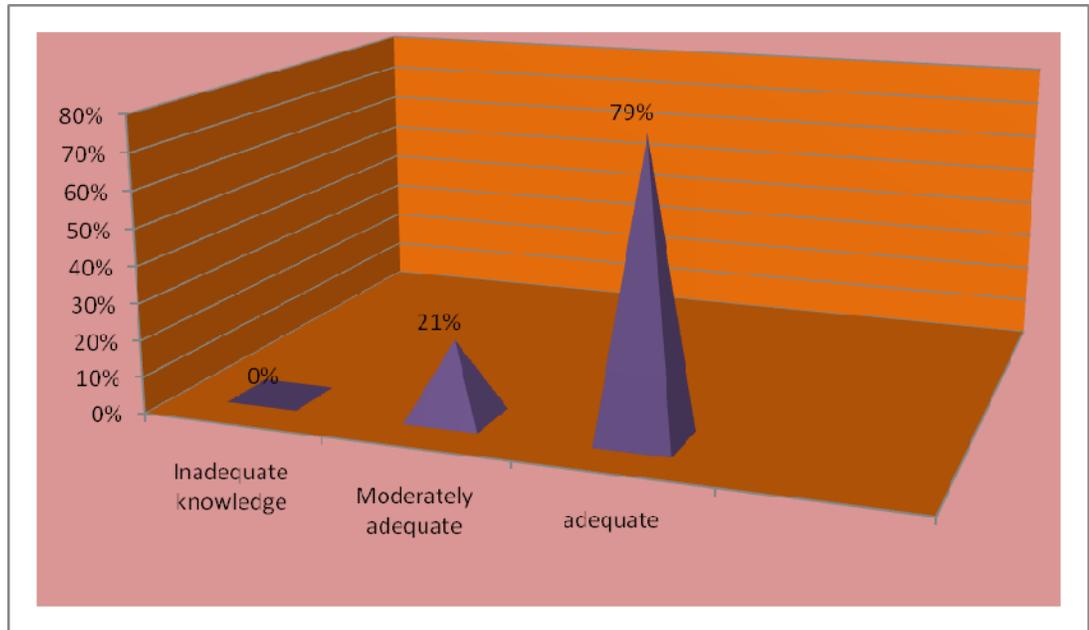
The above table 4.3 showed the level of drinking frequency before ASTP. About 26% of the respondents consumed alcohol once a day.

*SECTION :V*

*Table 4.4 Level of knowledge of the respondents after ASTP*

<b>Level of knowledge</b>	<b>No. of patients</b>	<b>%</b>
Inadequate knowledge	0	0.0%
Moderately adequate knowledge	21	21.0%
Adequate knowledge	79	79.0%
Total	100	100%

FIG.4.13 THE LEVEL OF KNOWLEDGE OF THE RESPONDENTS AFTER ASTP



SECTION: VI

Table 4.5 Knowledge of the respondents at various knowledge domains after ASTP

<b>Knowledge (Domain)</b>	No. of questions	Min –Max score	Knowledge score	
			Mean $\pm$ SD	%
General Information	11	0 -22	18.33 $\pm$ 2.98	83.3%
Physical changes	11	0 -22	17.75 $\pm$ 3.31	80.7%
Family and social aspects	11	0 -22	17.36 $\pm$ 3.76	78.9%
Overall	33	0 – 66	53.44 $\pm$ 8.95	80.9%

The above Table 4.5 showed the post intervention knowledge score of the respondents in different domains

*SECTION :VII*

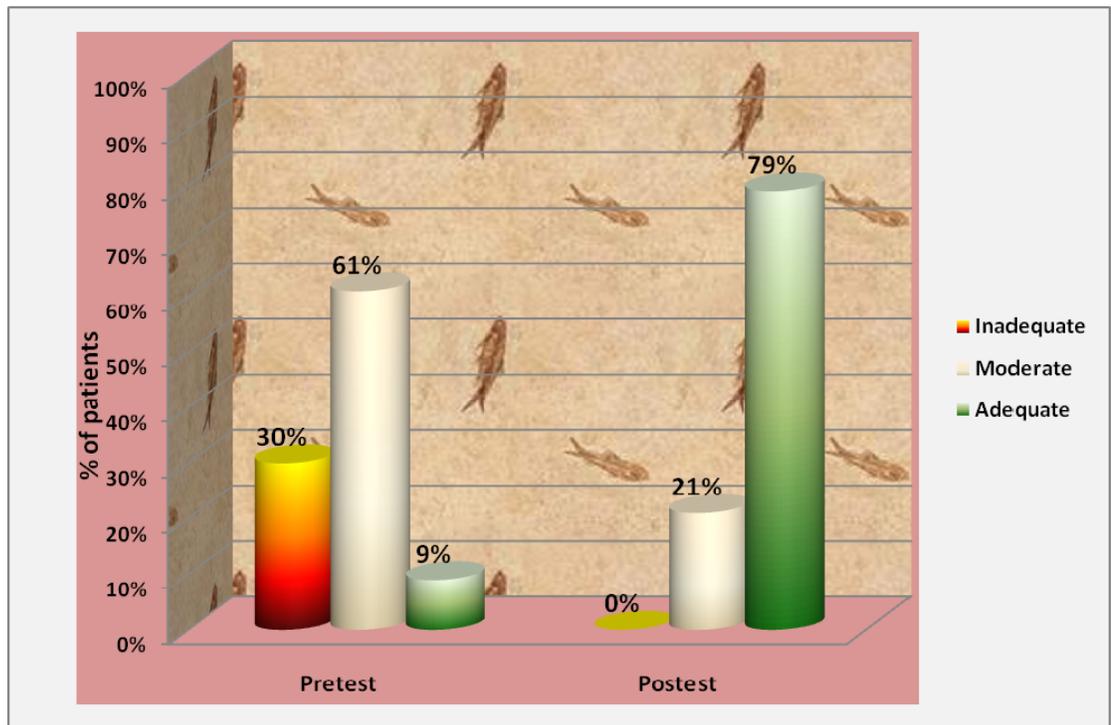
Table 4.6 Drinking frequency after ASTP

Level of Drinking frequency	Post intervention		Chisquare test
	n	%	
No drinking	39	39.0%	$\chi^2=95.82$ P=0.001*** DF=3 Significant
Monthly	41	41.0%	
Weekly	18	18.0%	
Daily	2	2.0%	

The above 4.6 Table showed significant relationship ( $p=0.001$ ) between pre and post test level of drinking frequency. When motivation increases ( $\chi^2=95.82$  P=0.001) level of drinking frequency decreases.

*SECTION: VIII*

Fig.4.14 Percentage distribution of samples on knowledge before and after the ASTP



SECTION : IX :

Table.4.7 Comparison of knowledge score before and after alcohol skill training programme in various knowledge domains

Knowledge domain	No. of patients	Pretest Mean±SD	Posttest Mean±SD	Student's paired t-test
General Information	100	11.35±3.54	18.33±2.98	t=16.76 P=0.001 *** DF=99 significant
Physical changes	100	11.24±3.50	17.75±3.31	t=15.39 P=0.001 *** DF=99 significant
Family and social aspects	100	10.14±3.71	17.36±3.76	t=16.91 P=0.001 *** DF=99 significant
Overall	100	32.73±9.36	53.44±8.95	t=19.77 P=0.001 *** DF=99 significant

\* Significant at  $P \leq 0.05$  \*\* highly significant at  $P \leq 0.01$  \*\*\* very high significant at  $P \leq 0.001$

Table 4.7 compares the before and after ASTP knowledge score. In all the domains the knowledge score improved, and showed statistical significant difference ( $p=0.001$ )

Fig 4.15 Comparison of level of knowledge before and after alcohol skill training programme

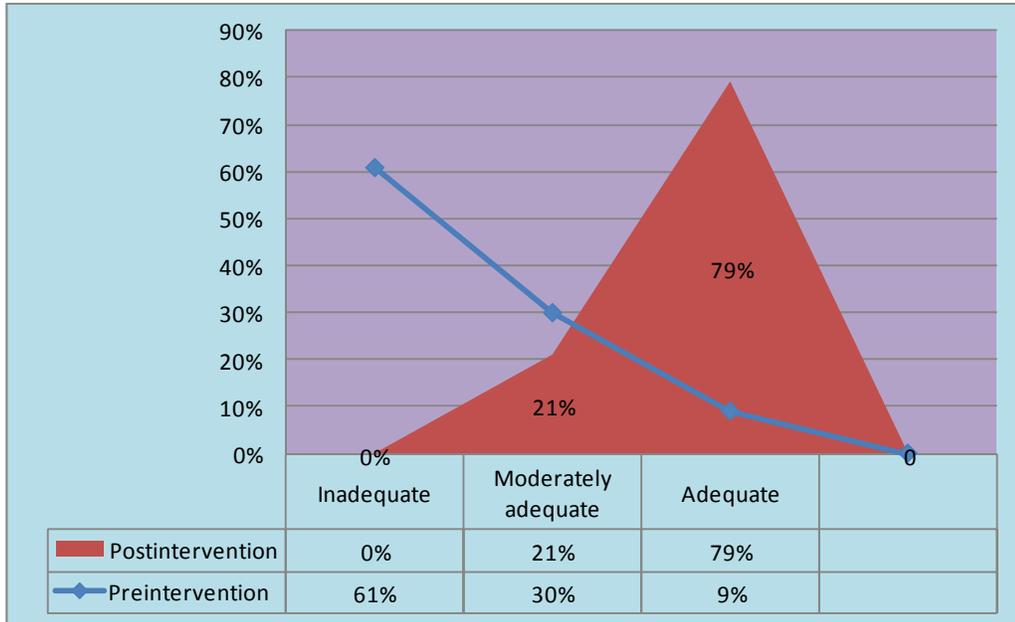
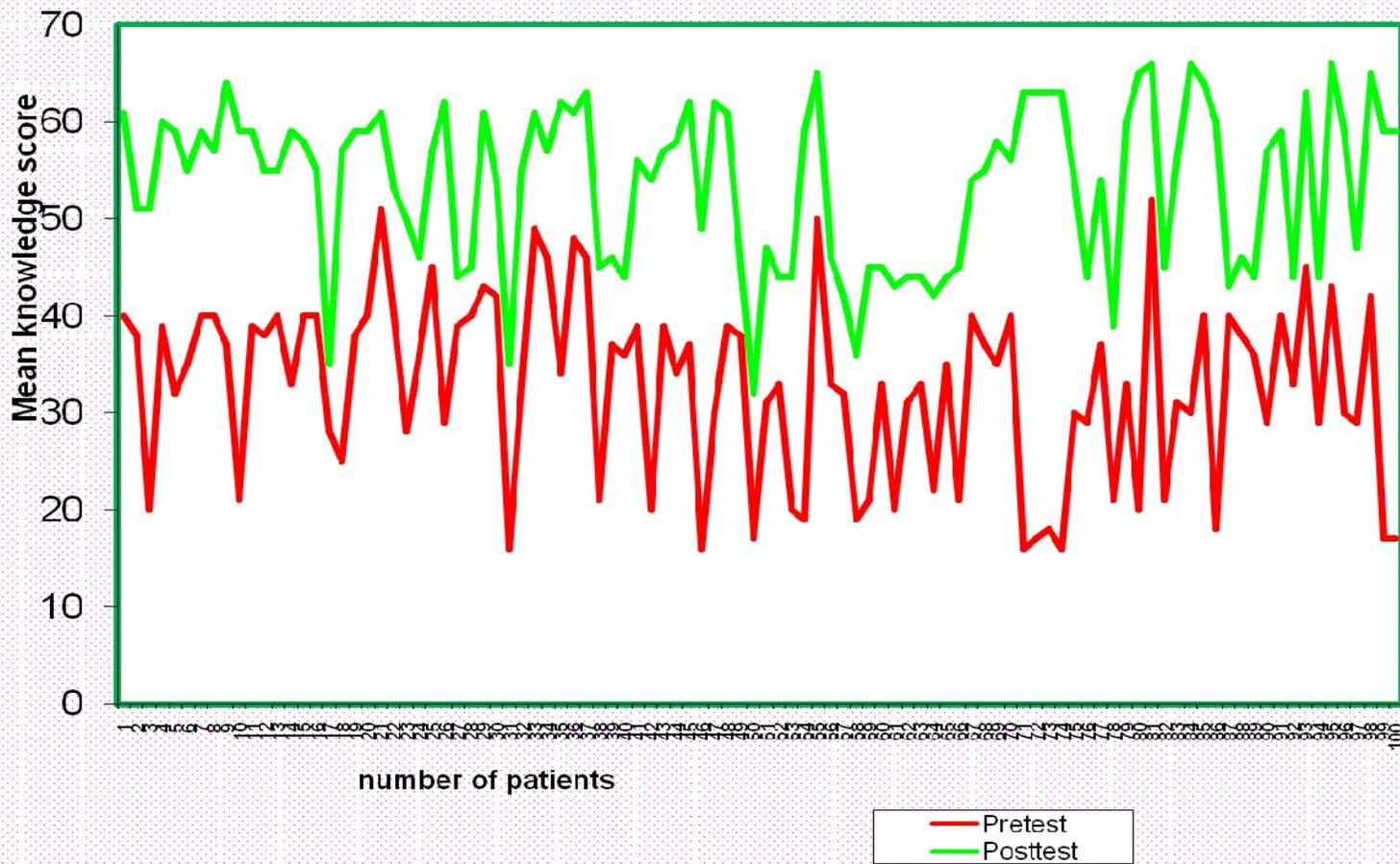


Fig.4.16 COMPARISON OF KNOWLEDGE BEFORE AND AFTER THE ASTP SCORE



SECTION :X

Table 4.8 Effectiveness of alcohol skill training programme

	Max score	Mean score	Mean Difference in knowledge score with 95% Confidence interval	Percentage Difference in knowledge score with 95% Confidence interval
Pre intervention	66	32.73	20.71(18.15 – 23.26)	31.3 % ( 27.5% –35.2%)
Post intervention	66	53.44		

The above Table 4.8 showed 31.3% percentage difference in knowledge score. This improvement in knowledge score revealed the positive effect of Alcohol skill training programme.

## SECTION: XI

Table 4.9 Association between knowledge score and socio demographic characteristics

Demographic variables		Level of posttest knowledge						Total	Pearson chisquare test
		Inadequate		Moderate		Adequate			
		n	%	n	%	n	%		
Age	21 -30 yrs	0	0.0%	9	34.6%	17	65.4%	26	$\chi^2=7.66$ P=0.05* DF=3
	31 -40 yrs	0	0.0%	10	24.3%	31	75.7%		
	41 -50 yrs	0	0.0%	1	5.0%	19	95.0%		
	>50 yrs	0	0.0%	1	7.7%	12	92.3%		
Marital status	Single	0	0.0%	3	15.0%	17	85.0%	20	$\chi^2=1.97$ P=0.58 DF=3
	Married	0	0.0%	8	17.8%	37	82.2%		
	Separated	0	0.0%	9	28.1%	23	71.9%		
	Divorced	0	0.0%	1	33.3%	2	66.7%		
Education status	Illiterate	0	0.0%	7	41.1%	10	58.9%	17	$s\chi^2=11.03$ P=0.05* DF=5
	Basic schooling	0	0.0%	6	40.0%	9	60.0%		
	Middle schooling	0	0.0%	4	13.3%	26	86.7%		
	Higher secondary	0	0.0%	2	10.0%	18	90.0%		
	Graduate	0	0.0%	1	10.0%	9	90.0%		
	Diploma/Professional course	0	0.0%	1	12.5%	7	87.5%		
Religion	Hindu	0	0.0%	7	11.7%	53	88.3%	60	$\chi^2=3.82$ P=0.43 DF=2
	Christian	0	0.0%	7	25.9%	20	74.1%		
	Muslim	0	0.0%	7	53.8%	6	46.2%		
Occupation	Daily wages	0	0.0%	9	25.0%	27	75.0%	36	$\chi^2=2.01$ P=0.73 DF=4
	Private company/work	0	0.0%	5	16.1%	26	83.9%		
	Government	0	0.0%	4	28.6%	10	71.4%		
	Pensioner	0	0.0%	1	10.0%	9	90.0%		
	Business	0	0.0%	2	22.2%	7	77.8%		
Monthly income	< Rs.2000	0	0.0%	8	38.1%	13	61.9%	21	$\chi^2=7.68$ P=0.05* DF=3
	Rs.2000 - 5000	0	0.0%	8	22.9%	27	77.1%		
	Rs.5001- 10000	0	0.0%	4	16.6%	20	83.4%		
	>Rs.10000	0	0.0%	1	5.0%	19	95.0%		
Type of family	Nuclear family	0	0.0%	12	21.4%	44	78.6%	56	$\chi^2=0.01$ P=0.91 DF=1
	Joint family	0	0.0%	9	20.5%	35	79.5%		
Children	No children	0	0.0%	4	18.2%	18	81.8%	22	$\chi^2=3.93$ P=0.41 DF=5
	One	0	0.0%	7	31.8%	15	68.2%		
	Two	0	0.0%	4	11.8%	30	88.2%		
	Three	0	0.0%	4	26.7%	11	73.3%		
	Four and above	0	0.0%	2	28.6%	5	71.4%		

Source of information	Family members/friends	0	0.0%	11	16.4%	56	83.6%	67	$\chi^2=6.45$ P=0.09 DF=3
	Media	0	0.0%	4	57.1%	3	42.9%	7	
	Medical professionals	0	0.0%	4	22.2%	14	77.8%	18	
	Books	0	0.0%	2	25.0%	6	75.0%	8	
Family members	Grand father	0	0.0%	3	13.6%	19	86.4%	22	$\chi^2=1.48$ P=0.68 DF=3
	Father	0	0.0%	7	18.4%	31	81.6%	38	
	Uncle	0	0.0%	4	28.6%	10	71.4%	14	
	Brother	0	0.0%	6	24.0%	19	76.0%	25	
Reason for first alcohol consumption	Family problem	0	0.0%	3	16.7%	15	83.3%	18	$\chi^2=2.50$ P=0.47 DF=3
	Peer pressure	0	0.0%	13	23.2%	43	76.8%	56	
	Occupation environment	0	0.0%	4	30.8%	9	69.2%	13	
	Social gathering	0	0.0%	1	7.7%	12	92.3%	13	

The above Table 4.9 showed the association between post test level of knowledge and demographic variable. Among selected demographic variable age, education and monthly income had significant association ( $p=0.05$ ) with knowledge score.

## SECTION :XII

**Table 4.10** Association of drinking frequency with socio demographic character

		Post intervention Level of Drinking frequency								Total	Chi square test
		No drinking		Monthly		Weekly		Daily			
		n	%	n	%	n	%	n	%		
Age	21 -30 yrs	6	23.1%	17	65.3%	3	11.6%	0	0.0%	26	$\chi^2=17.34$ $P=0.05^{**}$ DF=9
	31 -40 yrs	19	46.3%	13	31.7%	9	22.0%	0	0.0%	41	
	41 -50 yrs	7	35.0%	7	35.0%	4	20.0%	2	10.0%	20	
	>50 yrs	7	53.8%	4	30.8%	2	15.3%	0	0.0%	13	
Marital status	Single	5	25.0%	11	55.0%	3	15.0%	1	5.0%	20	$\chi^2=11.87P=0.22$ DF=9
	Married	15	33.3%	21	46.7%	9	20.0%	0	0.0%	45	
	Seperated	16	50.0%	9	28.1%	6	18.8%	1	3.1%	32	
	Divorced	3	100.0%	0	0.0%	0	0.0%	0	0.0%	3	
Education status	Illiterate	6	35.3%	6	35.3%	4	23.5%	1	5.9%	17	$\chi^2=8.14P=0.92$ DF=15
	Basic schooling	6	40.0%	7	46.7%	2	13.3%	0	0.0%	15	
	Middle schooling	12	40.0%	12	40.0%	5	16.7%	1	3.3%	30	
	Higher secondary	8	40.0%	10	50.0%	2	10.0%	0	0.0%	20	
	Graduate	3	30.0%	3	30.0%	4	40.0%	0	0.0%	10	
	Diploma/Professional course	4	50.0%	3	37.5%	1	12.5%	0	0.0%	8	
Religion	Hindu	24	40.0%	27	45.0%	8	13.3%	1	1.7%	60	$\chi^2=8.80P=0.19$ DF=6
	Christian	12	44.4%	7	25.9%	8	29.6%	0	0.0%	27	
	Muslim	3	23.1%	7	53.8%	2	15.4%	1	7.7%	13	
Occupation	Daily wages	9	25.0%	14	38.9%	13	36.1%	0	0.0%	36	$\chi^2=27.76P=0.01^{**}$ DF=12
	Private company/work	18	58.1%	11	35.5%	2	6.5%	0	0.0%	31	
	Government	6	42.9%	5	35.7%	2	14.3%	1	7.1%	14	
	Pensioner	5	50.0%	4	40.0%	0	0.0%	1	10.0%	10	
	Business	1	11.1%	7	77.8%	1	11.1%	0	0.0%	9	
Monthly income	< Rs.2000	8	38.1%	10	47.6%	3	14.3%	0	0.0%	21	$\chi^2=3.42P=0.95$ DF=9
	Rs.2000 - 5000	12	34.3%	14	40.0%	8	22.9%	1	2.9%	35	
	Rs.5001- 10000	10	41.7%	10	41.7%	3	12.5%	1	4.2%	24	
	>Rs.10000	9	45.0%	7	35.0%	4	20.0%	0	0.0%	20	
Type of family	Nuclear family	23	41.1%	19	33.9%	14	25.0%	0	0.0%	56	$\chi^2=7.73P=0.05^*$ DF=3
	Joint family	16	36.4%	22	50.0%	4	9.1%	2	4.5%	44	
Children	No children	5	22.7%	12	54.5%	4	18.2%	1	4.5%	22	$\chi^2=11.84P=0.46$ DF=8
	One	11	50.0%	8	36.4%	3	13.6%	0	0.0%	22	
	Two	11	32.4%	14	41.2%	9	26.5%	0	0.0%	34	
	Three	8	53.3%	5	33.3%	1	6.7%	1	6.7%	15	
	Four and above	4	57.1%	2	28.6%	1	14.3%	0	0.0%	7	

Source of information	Family members/friends	21	31.3%	31	46.3%	14	20.9%	1	1.5%	67	$\chi^2=12.77P=0.17$ DF=9
	Media	3	42.9%	3	42.9%	0	0.0%	1	14.3%	7	
	Medical professionals	10	55.6%	5	27.8%	3	16.7%	0	0.0%	18	
	Books	5	62.5%	2	25.0%	1	12.5%	0	0.0%	8	
Family members	Grand father	7	31.8%	9	40.9%	6	27.3%	0	0.0%	22	$\chi^2=9.51P=0.39$ DF=9
	Father	19	50.0%	15	39.5%	3	7.9%	1	2.6%	38	
	Uncle	3	21.4%	6	42.9%	5	35.7%	0	0.0%	14	
	Brother	10	40.0%	10	40.0%	4	16.0%	1	4.0%	25	
Reason for first alcohol consumption	Family problem	3	16.7%	9	50.0%	6	33.3%	0	0.0%	18	$\chi^2=5.97P=0.43$ DF=9
	Peer pressure	28	50.0%	21	37.5%	7	12.5%	0	0.0%	56	
	Occupation environment	4	30.8%	7	53.8%	1	7.7%	1	7.7%	13	
	Social gathering	4	30.8%	4	30.8%	4	30.8%	1	7.7%	13	

Table 4.10 showed the post-intervention association of frequency of drinking with selected socio demographic variables. Among the selected variables Age (p=0.05), Occupation (p=0.01), Family type (p=0.08) had quantity of alcohol, statistically significant association.

Fig :4.17

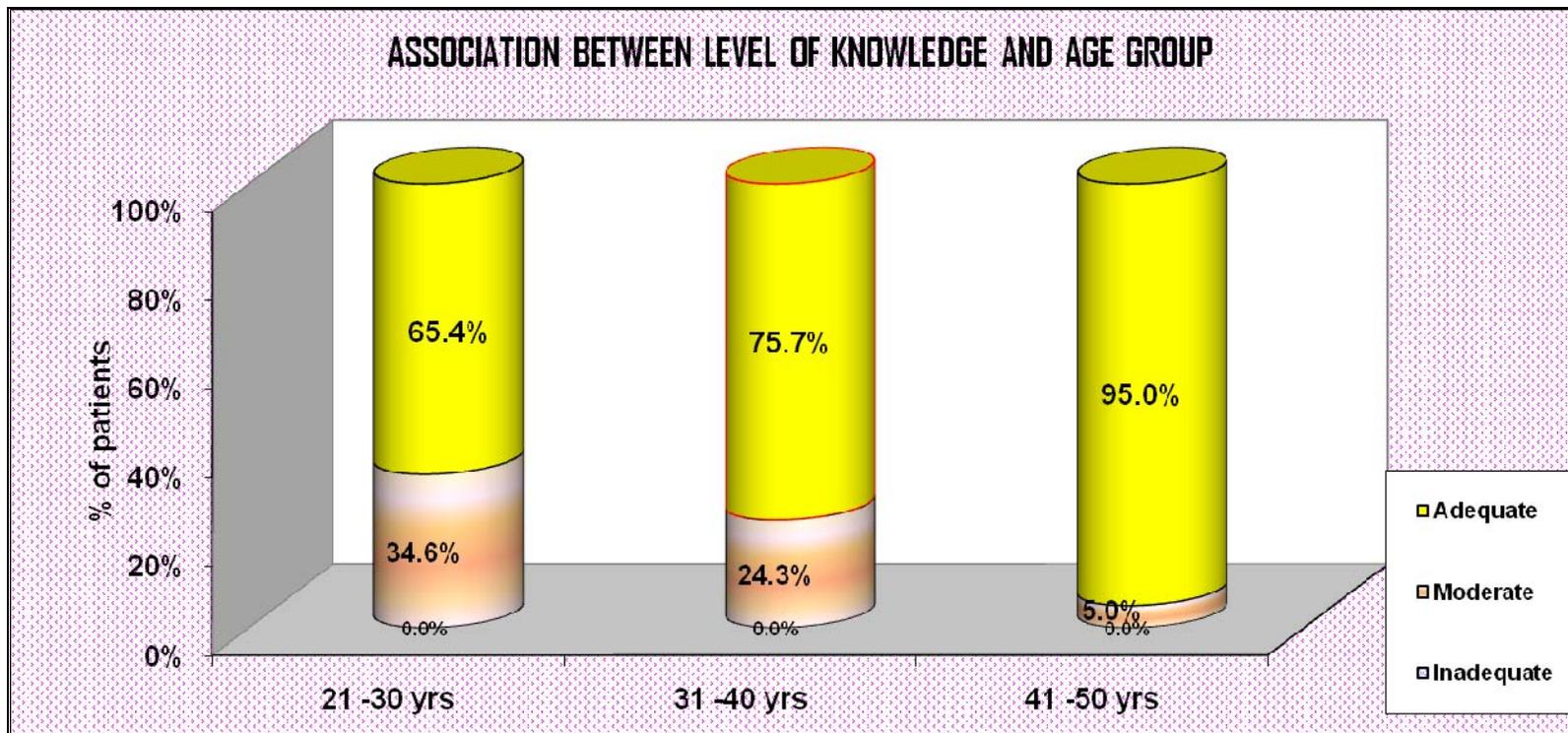


Fig : 4.18

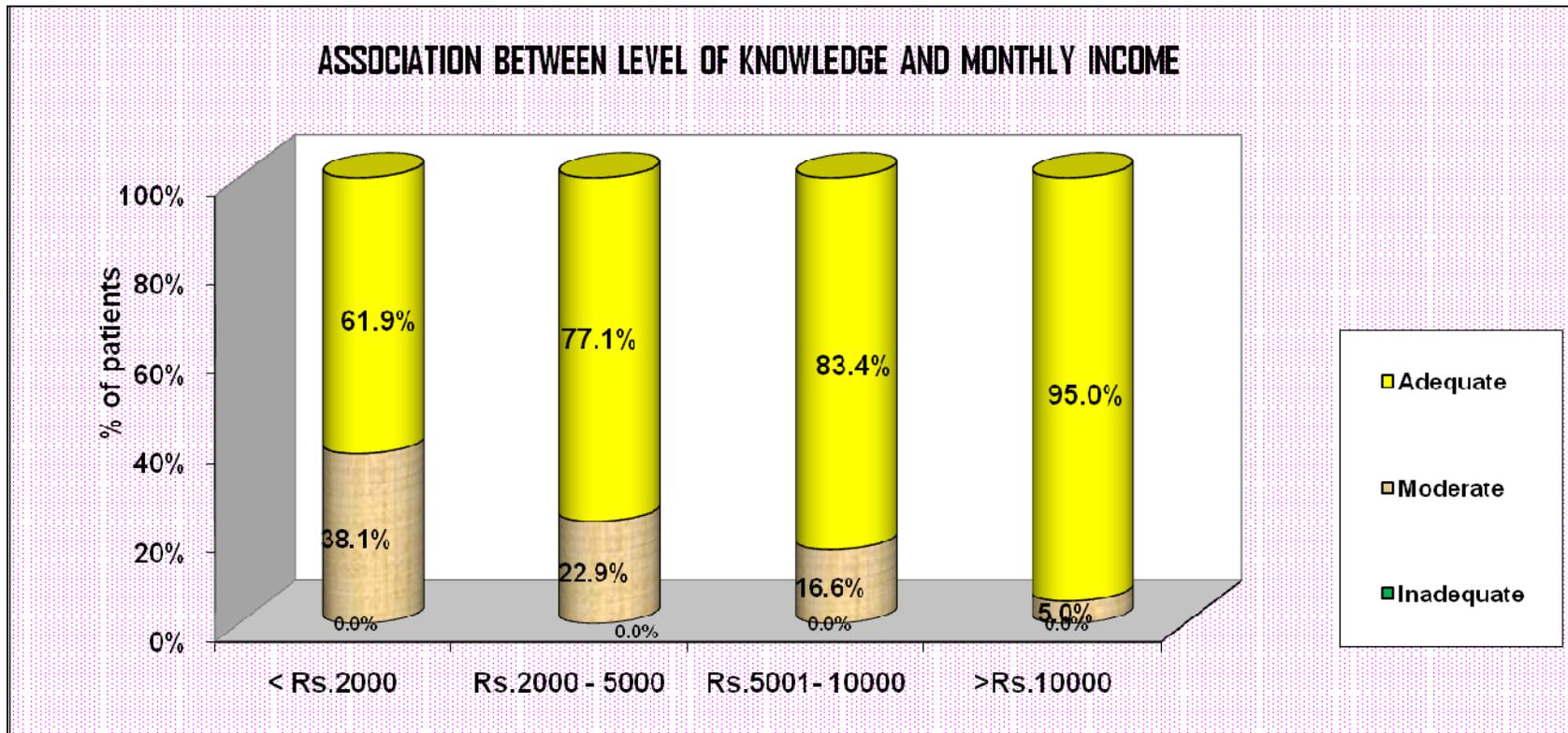
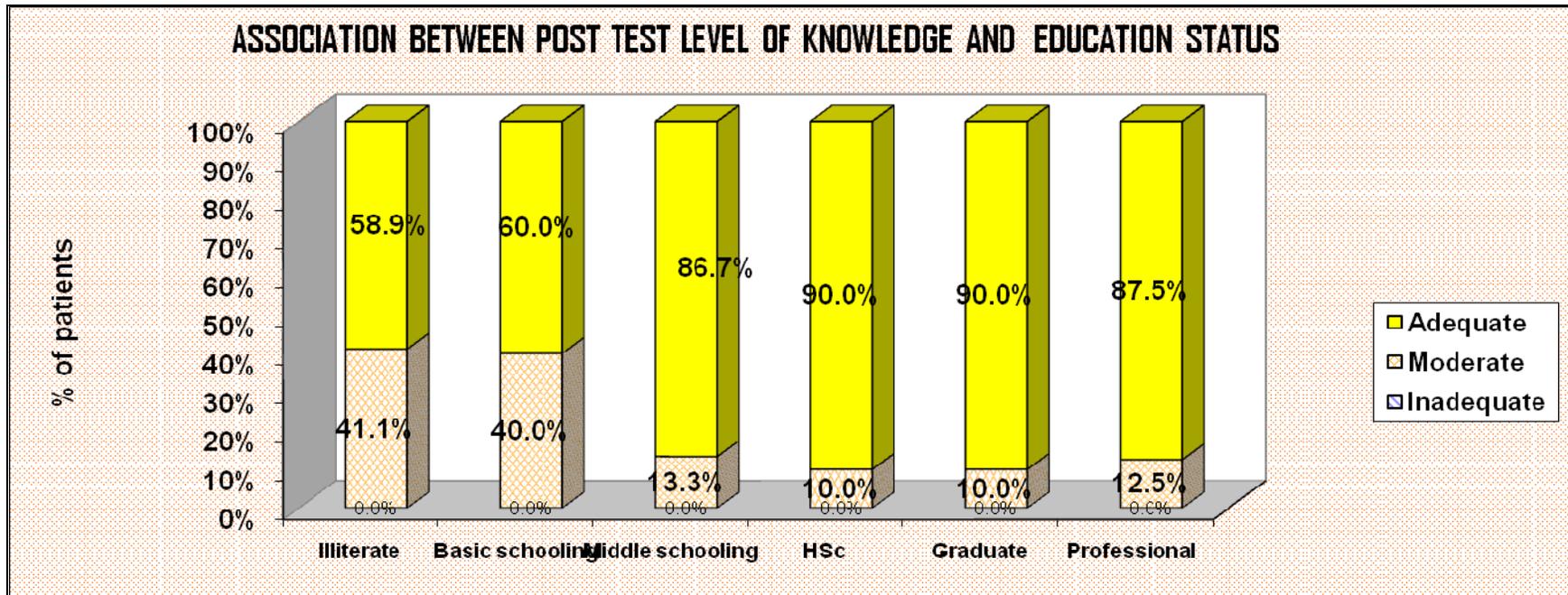


Fig: 4.19



## CHAPTER V

### DISCUSSION

This chapter deals with detailed discussion on the findings of study-interpreted from statistical analysis. The findings are discussed in relation to the objectives of the study.

Table 4.1 described the socio demographic characteristics of the study subjects. Majority of the respondent (41%) are in the age group of 31-40 years. Nearly half of the participants (45%) are married and 30% of them had middle schooling. Most of the respondents (60%) are Hindu by religion, and about 36% of the samples were daily wages. Of all the participants only 21% of the sample's income were less than 2,000 per month. More than half (56%) of the study population belongs to nuclear family. Only 7% of respondents had 4 and more children, high proportion (57%) of the study population's source of information was either family members or friends and 38% of the respondents' fathers were alcoholics. More than half (56%) of the respondents stated that peer pressure as the reason for their first alcohol consumption.

**The first objective of the present study** is to examine the level of knowledge of the alcohol dependent individuals on alcohol addiction before alcohol skill training programme. Fig.No.4.12 projected the level of knowledge of the study subjects. It was found that high proportion (61%) of the subjects had moderate level of knowledge. In spite of their moderate knowledge they continued drinking. This in turn reflected on their lack of skills to cut down their drinking pattern. Cox.Miler et.al (2008) observed similar pattern in their Meta analysis review and concluded that motivational interviewing is effective in such alcohol addicted individuals.

**The second objective of the present study** was to explore the frequency of drinking before alcohol skill training programme. Table No.4.3 showed the level of drinking frequency. Almost equal number of participants drink alcohol either once or twice a week (18%) or three to four times a week (19%) and 20% of the respondent drink almost every day. These findings constitute with the study findings by Chaga S.M (2003) in which hazardous drinking pattern was found in individual workers.

**The third objective of this study** was to examine the post intervention knowledge score. Figure 4.13 projected the post intervention knowledge score of the respondents. The respondent knowledge score improved from inadequate knowledge

(30%) to moderately adequate (21%) and adequate (79%) with regard to domains of knowledge (Table.4.5). The overall difference of improvement in knowledge was 31.3%. This improvement revealed that continuous and consistent skill training programmes will not only improve their level of knowledge but also will improve their awareness of creating problems. This awareness in turn will alter their drinking behavior.

**The fourth objective of the study** was to identify the level of drinking frequency after alcohol skill training programme. Table 4.4 showed the statistically significant improvement in their level of drinking frequency. Similar findings were observed in the study of Kivlahan et.al in which alcohol skill training programme not only reduced frequency level but also reduced the negative consequences

**The fifth objective of the study** was to evaluate the effectiveness of alcohol skill training programme. The effectiveness was evaluated on knowledge score (Table 4.8) and level of frequency in drinking (Table. 4.6) after alcohol skill training programme. When compared to pre intervention knowledge score showed highly significant. Improve with regard to knowledge domains the post intervention scores showed highly significant, improvement of knowledge in all the three domains ( $p=0.001$ ). On an average after ASTP respondents gained 31.3% difference in knowledge score. Similar findings were observed in the study conducted by Flay (2003) and Kivlahan et.al (1993) which demonstrated significant improvement in knowledge or awareness level after ASTP.

**The sixth objective of the study** was to associate post intervention (ASTP) knowledge score with selected demographic variables. Among selected demographic variables age, educational status and monthly income had significant association with knowledge score. These variables could be discussed in the context of study variable co-relation. Younger the age inadequate life experience contributes to perceptions of more problems and drinking as crutches. As the age advances consolidation of life experience makes the individuals to perceive problems of alcohol addiction hence knowledge score showed significant association.

With regard to education, educated samples gains the knowledge about the problems solving skills, but the inadequate knowledge above specific problem as in addiction prevent them to utilize the existing skills. After ASTP the resulting improvement in knowledge and skills help them to regain their problem solving skills.

## **CHAPTER VI**

### **SUMMARY AND CONCLUSION**

#### **6.1 Summary**

Most people who consume alcohol beverages experience few problems as a result of drinking. However for some individuals alcohol consumption is associated with harmful health and social consequences. Structural approaches to alcohol consumption are therefore an important tool and can help to reduce the risk for harm. Guided with the Research evidence that individuals addicted to alcohol can learn to moderate their drinking with the aim to raise awareness, share knowledge and skills that will enable the alcohol addicted individuals to make healthy and informed choices about drinking. The researcher stated the problem of present study as to “Assess the effectiveness of alcohol skill training programme on alcohol addiction among individuals attending de-addiction clinics of institute of mental health, chennai-10”.

The data was collected for the period of four weeks from 29/08/11 to 28/07/11. The descriptive analysis was done using percentage, mean, standard deviation and inferential statistical methods used were Chi-square test, Students paired t-test, Stuart Maxwell test/extended McNemar test. The following were discussed based on objectives.

#### **6.2.1 FINDINGS ON SOCIO DEMOGRAPHIC DATA**

1. Majority of the respondents were between 31-40 years of age.
2. Majority of them were Married (80%) and 45% of them were living with their wives.
3. Only 17% of them are illiterate.
4. Higher proportions of them (60%) were Hindus.
5. Almost equal number of participants was either daily wagers (36%) or working in private companies (31%).
6. Nearly one third of the study population's (35%) having their income between 2000-5000.
7. More than half of (56%) the respondents' family type is nuclear in nature.

8. Equal number of participants (27%) had either no children or one child.
9. Higher proportion (67%) of subjects' source of information is through family members/friends.
10. Nearly one fourth of the respondents' (25%) brothers were having the habit of alcohol consumption.
11. More than half of the respondents' reason for alcohol consumption is peer pressure.

### **6.2.2 FINDINGS ON LEVEL OF KNOWLEDGE BEFORE ALCOHOL SKILL TRAINING PROGRAMME**

1. Moderately adequate knowledge was seen in alcohol dependent individuals before alcohol skill training programme (Mean 32.73 and SD= ± 9.36).

### **6.2.3 LEVEL OF DRINKING FREQUENCY BEFORE ALCOHOL SKILL TRAINING PROGRAMME**

Nearly half of the respondents (46%) consumed alcohol on daily basis.

### **6.2.4 FINDINGS ON LEVEL OF KNOWLEDGE AFTER ALCOHOL SKILL TRAINING PROGRAMME**

Adequate knowledge was seen in majority of the respondents (79%). (After ASTP Mean=53.44 and SD=±8.95).

### **6.2.5 FINDINGS ON LEVEL OF DRINKING FREQUENCY AFTER ALCOHOL SKILL TRAINING PROGRAMME**

The frequency of no drinking was seen in 39% of respondents.

### **6.2.6 FINDINGS ON COMPARISON OF KNOWLEDGE SCORE BEFORE AND AFTER ALCOHOL SKILL TRAINING PROGRAMME**

The overall post intervention score showed significant improvement (Mean 53.44 and SD=8.95).

### **6.2.7 FINDINGS ON EFFECTIVENESS OF ALCOHOL SKILL TRAINING PROGRAMME**

On an average after ASTP the respondents gained 31.3% differences in knowledge score.

### **6.2.8 ASSOCIATION OF KNOWLEDGE AND LEVEL OF DRINKING FREQUENCY WITH SELECTED DEMOGRAPHIC VARIABLES**

There was a significant association between the age, educational status and monthly income and knowledge score. Age and family type had significant association with level of drinking frequency ( $p=0.05$ ) and occupation had highly significant association at 1% level ( $p=0.01$ )

### **6.3 Conclusion**

The study concluded that knowledge score of the alcohol dependent individuals showed significant improvement in the level of knowledge on their addiction and the level of frequency drinking reduced significantly after ASTP. Based on these findings the study concluded that ASTP demonstrated changes in knowledge and reported significant reduction in drinking. But these effects tend to decay over time. Hence ASTP could be sustained with use of booster session to maintain effects

### **6.4 IMPLICATION OF THIS STUDY**

The findings of the present study have important implication for Nursing Practice, Nursing Education, Nursing Administration and Nursing Research. Alcohol dependent was considered as family illness because of its impact on the individual biological, social and family health. The psychiatric nurses working in de-addiction centers and community centers have prime responsibility of understanding needs and problem of these clients. By broadening the base of treatment of alcohol problems and by moving beyond treatment of chronic alcohol dependence to prevention of alcohol abuse and early intervention for targeted groups will faster quality of life. Replacing the predominant myths about alcohol consumption and treatment, educating them with alcohol moderation skills and enhancing the awareness of problems of alcohol addiction will motivate and remove drinking risk.

### **Implications in Nursing Practice**

1. Nurses have the opportunity to improve the subject's knowledge about the alcohol addiction and related problems.
2. Nurse can conduct regular skill training programme to provide information related to the alcohol addiction and how to come out from the addiction
3. Nurse can organize group meetings of the alcohol addicted individuals to resolve their own problems related to alcohol addiction
4. Nurse can incorporate the techniques of behavioral modification along with the de-addiction treatment.
5. Nurse can prepare teaching materials and learning materials for the alcohol addicted individuals.
6. Nurse can provide individual counseling for the alcohol dependents
7. Nurse can provide information related to alcoholic anonymous, self help group and encourage the alcohol addicted individuals to participate in those group.

### **Implications in Nursing Education**

1. Nurse working in de-addiction centre can involve the alcohol addicted individuals in the alcohol skill training programme related to alcohol addiction and help them to overcome the problems related to alcohol addiction particularly by conducting various sessions of the skill training programme.
2. Nurse can give valuable suggestions for curriculum modification so that the problems related to alcohol addiction and the management of individual with alcoholism can be incorporated.
3. Nurse can involve in organizing workshops on alcoholism and substance use management.
4. Involving the students in the creation of awareness among the alcohol addicted individual can be encouraged during their training.

### **Implication to Nursing Administration**

1. Nurse administrator can plan for regular in service education for the nurses in the management of alcohol addicted individuals according to their need in the hospital as well as in the community.
2. Nurse administrator can conduct continuing nurse education programme on de-addiction for alcohol and other substance abuse for the nurses working in the ward especially in the de-addiction clinics
3. Nurse administrator along with the other multi disciplinary team can develop teaching modules for nurses and also for the care givers in providing care to the alcohol addicted individual according to their need.
4. Nurse administrator can encourage and provide opportunity for the nurses work in the de-addiction centers to participate and present scientific paper in the workshop and conferences.

### **Implications on Research**

The Nurses can conduct research activities to find out the

1. Effect of alcohol skill training programme for alcohol addicted individuals.
2. Training sessions and counseling sessions can be conducted for the alcohol addicted individuals
3. Effect of nursing intervention on behavioral problems related to alcoholism and the knowledge about the impact of the alcoholism can be studied.

### **6.5 RECOMMENDATIONS**

1. A comparative study can be done between the people residing in urban and rural areas
2. A comparative study can be done between drinking and non drinking individuals to assess social behaviors
3. This study can be replicated in various setting with large sample to facilitate generalization of results

### **6.6 SUGGESTIONS FOR FUTURE RESEARCH**

1. 1.Comparative study to assess the knowledge of the alcohol addicted individuals and also the other substance abuse

2. 2.Comparative study to assess the knowledge of the alcoholic addicted individuals and non alcoholics (general population)
3. 3.Study based on the knowledge counseling services to be offered to the alcoholic addicted individuals
4. Developing tool and standardizing the tool for assessing the knowledge regarding the ill effects of the alcohol

### **6.7 MERITS OF THE STUDY**

The present study assessed the efficacy of ASTP assessing the problems of alcohol addiction

Studies which examined the efficacy of skill training programmes are limited in nursing research.

### **6.8 LIMITATIONS**

1. The study was restricted to short duration.
2. The findings can't be generalized because of small sample size.
3. The drinking frequency data was given by the individuals addicted to alcohol themselves and hence findings could not be generated.

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#### NET SOURCES

- [www.addictionindia.org/](http://www.addictionindia.org/)
- [En.wikipedia.org/wiki/Alcohol](http://en.wikipedia.org/wiki/Alcohol)
- <http://www.eurojournals.com/ejsr.htm>
- <http://www.ciap.health.nsw.gov.au/hospolic/strincent/htm>
- <http://www.alcohol.in/treatment/html>
- <http://www.pubmed.gov/>
- [www.indianalcoholpolicy.org/](http://www.indianalcoholpolicy.org/)
- [www.hopetrustindia.com/](http://www.hopetrustindia.com/)
- [www.lonolulu.hawaii.edu](http://www.lonolulu.hawaii.edu)
- [www.tanijournal.htm](http://www.tanijournal.htm)
- [www.ncbi.nlm.nih.gov/pubmed](http://www.ncbi.nlm.nih.gov/pubmed)

APPENDIX-A  
SOCIO DEMOGRAPHIC DATA

A. Demographic Data

1. Age in years

- a. 21-30 ( )
- b. 31-40 ( )
- c. 41-50 ( )
  
- d. >51 ( )

2. Marital status

- a. Single ( )
- b. Married ( )
- c. Separated/Widower ( )
- d. Divorced ( )

3. Education

- a. Illiterate ( )
- b. Basic schooling ( )
- c. Middle schooling ( )
- d. Higher secondary ( )
- e. Graduate ( )
- f. Diploma/Professional course ( )

4. Religion

- 1. Hindu ( )
- 2. Christian ( )
- 3. Muslim ( )

5. Occupation

- 1. Daily wages ( )
- 2. Private company/work ( )
- 3. Government ( )
- 4. Pensioner ( )
- 5. Business ( )

6. Family income

- 1. Below Rs.2,000/- ( )
- 2. Rs.2001-5000/- ( )
- 3. Rs.5001-10,000/- ( )
- 4. > 10,000/- ( )

7. Type of Family ( )

1.Nuclear family ( )

2.Joint family

8. Children

1.No children ( )

2. One ( )

3.Two ( )

4.Three ( )

5. Four and more

9.Source of information about the de-addiction

1. family members/friends

( )

2.Medias

( )

3.Medical professionals ( )

4.Books ( )

10.Family member addicted to alcohol

1.Grand father ( )

2.Father ( )

3.Uncle ( )

4.Brother ( )

11.Reason for first alcohol consumption

1.family problem ( )

2.Peer pressure ( )

3.Occupation environment ( )

4.Social gathering ( )

B.KNOWLEDGE ABOUT ALCOHOL

	S.NO	QUESTIONS	DON'T KNOW	No	Yes
GENERAL INFORMATION ABOUT ALCOHOL	1.	Alcohol is a drug			
	2.	Drinking alcohol in little amount occasionally is not alcoholism			
	3.	Alcohol relieves depressed feelings			
	4.	Alcohol provides stimulation to the body			
	5.	Adulteration of alcohol with methanol is dangerous to health			
	6.	Alcohol consumption is not the reason for any physical health and societal problem of the individual			
	7.	Alcohol provides more calories which will increase the body weight			
	8.	Diet taken with the alcohol will not reduce the severity of the alcohol digestion			
	9.	De-toxification is a method of treatment for alcohol abuse			
	10.	Alcohol consumption interfere with the brain function			
	11.	Withdrawal symptoms are the powerful complication of continued substance abuse			
PHYSICAL CHANGES DUE TO ALCOHOL	12.	It is not necessary to join self help group to maintain abstinence			
	13.	De-addiction is a method of treatment that prevent alcoholism			
	14.	Alcohol in higher doses induces talkativeness and roughness to the person			
	15.	Alcohol consumption increases the chances of mental illness			
	16.	The person thinks that when he consumes alcohol, he is getting courage to face the problems in life			
	17.	The most serious thing of alcohol consumption is hangover in the morning	-		
	18.	All type of beverages like whisky, beer, wine, toddy, liquor contains alcohol			
	19.	Blood alcohol concentration is the amount of alcohol present in blood when consuming alcohol			
	20.	Alcohol dependence affects all parts of the body including brain, heart, liver, kidney, blood level, pancreas, stomach, intestine, bone and joints etc.			
	21.	Alcoholism develops through stages			
	22.	When the alcohol consumption becomes more vital to the individual than his family it is time to go for treatment			
FAMILY AND SOCIAL ASPECTS RELATED TO ALCOHOL	23.	Alcohol consumption affects family and all relationships			
	24.	Alcohol consumption will change the characters and behavior of the individual			
	25.	Alcohol consumption provides good status to the person			
	26.	Alcohol provides confidence to the person			
	27.	Alcohol consumption brings frequent quarrels in the family			
	28.	Alcoholism brings indefinite fears, suspicious and hearing unknown voices			
	29.	Alcohol consumption interfere with the decision making and judgements			
	30.	Alcohol consumption leads to theft and any other criminal activity			
	31.	Alcohol leads to more complication while taking decision in some important matters			
	32.	Alcohol consumption also a reason for the accidents occurs in the highway			
	33.	Alcoholic individuals will not be given proper respect by his family and society			

**C. Drinking Quantity/Frequency Index (Cahallan's Q/F Index)**

**1. How often did you drink during the last *month*?**

- a. I did not drink at all.
- b. About once a month.
- c. Two to three times a month.
- d. Once or twice a week.
- e. Three to four times a week.
- f. Nearly every day.
- g. Once a day or more.

**2. Think of a typical**

0 drink	8 drinks	16 drinks	24 drinks
1 drink	9 drinks	17 drinks	25 drinks
2 drinks	10 drinks	18 drinks	26 drinks
3 drinks	11 drinks	19 drinks	27 drinks
4 drinks	12 drinks	20 drinks	28 drinks
5 drinks	13 drinks	21 drinks	29 drinks
6 drinks	14 drinks	22 drinks	30 drinks
7 drinks	15 drinks	23 drinks	More than 30

**3. Think of the occasion (any day of the week) you drank the most during the last *month*. How **much** did you drink?**

0 drink	8 drinks	16 drinks	24 drinks
1 drink	9 drinks	17 drinks	25 drinks
2 drinks	10 drinks	18 drinks	26 drinks
3 drinks	11 drinks	19 drinks	27 drinks
4 drinks	12 drinks	20 drinks	28 drinks
5 drinks	13 drinks	21 drinks	29 drinks
6 drinks	14 drinks	22 drinks	30 drinks
7 drinks	15 drinks	23 drinks	More than 30

## **DRINKING MODERATION SKILL**

1. Put your drink down between sips
2. Use a can cooler to keep your beverage cold
3. Count usual sips and use more sips than usual
4. Time how long it takes for you to consume drink and take more time
5. Reduce size of sips
6. Avoid fast drinking/drinkers
7. Activate with non alcoholic beverages
8. Choose lower alcohol content beverages
9. Eat before while you are drinking
10. Avoid doing shots
11. Mix your over drink so that you can control amount of alcohol
12. Do not spend all your money for one drink, preserve it for three or more drinks
13. Keep in touch of how much you drank
14. Get involved in activities.

**DECISIONAL BALANCE GRID**

<b>Old behavior</b>	<b>New behavior</b>
<p data-bbox="440 344 613 373"><b><u>Pros/Benefits</u></b></p> <p data-bbox="245 422 537 451">Like the taste of alcohol</p> <p data-bbox="245 499 459 529">Helps me to relax</p> <p data-bbox="245 577 618 606">Source of fun and socialization</p> <p data-bbox="245 655 613 684">Makes me forget my problems</p>	<p data-bbox="1062 344 1235 373"><b><u>Pros/Benefits</u></b></p> <p data-bbox="829 422 1203 451">Better relationship with spouse</p> <p data-bbox="829 499 1019 529">No more DWIs</p> <p data-bbox="829 577 980 606">Save money</p> <p data-bbox="829 655 1127 684">Feel better about myself</p> <p data-bbox="829 732 1451 762">More time for other activities and people in my life</p>
<p data-bbox="451 884 602 913"><b><u>Cons/Costs</u></b></p> <p data-bbox="245 961 493 991">Costs a lot of money</p> <p data-bbox="245 1039 699 1110">Led to DWI-costly, embarrassing and inconvenient</p> <p data-bbox="245 1159 461 1188">Spouse gets upset</p> <p data-bbox="245 1236 586 1266">Poor role model for children</p> <p data-bbox="245 1314 516 1344">Feel bad about myself</p> <p data-bbox="245 1392 776 1472">If I lose my driver's license, I could lose my job</p>	<p data-bbox="1073 884 1224 913"><b><u>Cons/Costs</u></b></p> <p data-bbox="829 961 1192 991">Will miss my drinking friends</p> <p data-bbox="829 1110 1300 1140">Don't know how to have fun without it</p> <p data-bbox="829 1266 1273 1295">It will be harder to face my problems</p> <p data-bbox="829 1421 1166 1451">I'll feel left out, "different".</p> <p data-bbox="829 1577 1230 1606">I'll be more up-tight, less relaxed</p>

## **RELAPSE PREVENTION SKILLS**

### 1. Avoid High risk situations

#### a. Identify triggering events

Hungry

Angry

Lonely

Tired

These triggers cravings for alcohol

Assess: How do you feel at the end of the day and avoid the high risk situation

### 2. Aware/Avoid the following high risk situation

a) People - Who are related to your alcohol use

Who celebrate with alcohol?

Who encourage you to use alcohol directly or indirectly?

b) Place - Where you use or drink alcohol

Where you get your alcohol

c) Things - That remind you of your using

### 3. Be Honest

Ask yourself: Will more lying, more isolating and more the same makes you better. When you are completely honest to yourself, your family, your therapist and your doctor you allow your addiction door sheet.

### 4. Show common sense

Don't be reluctant to tell the people close to you about your recovery and you should not feel ashamed that you are doing something about addiction

### 5. Change in Life

Feel that your addiction has given you the opportunity to change your life i.e recovery can help you to change your life, find inner peace and tranquility that most people crave.

### 6. Join self help groups and follow 12 step programme that maintains abstinence

### 7. After 5 years of abstinence relapse is rare

## **Respondents' View**

Thank you sister. I have really cut down my drinking after your teaching. It is easy and simple to follow

- Most of the time I felt that I don't have problems with my alcohol. But after the training programme I realized my problem of addiction
- I really understood how to moderate drinking
- I felt that abstinence may initiate drinking at a faster level, but this training helped me to reduce my level of drinking before complete abstinence.
- Drinking moderation skill helped me not to drink and fewer problems when compared to my previous drinking, we need regular programmes like this.

**kJTk; kJtpdhy; Vw:gLk;; tpiSTfs; gw:wpa Neh;Kf tpdhj;jhs;**

**jdp egh; tptuk;**

1. taJ (Mz;Lfspy;)

- m)21-30 taJ tiu
- M)31-40 taJ tiu
- ,) 41-50 taJ tiu
- <) 50 taJ;F Nky;

2. jpUkz tptuk;

- m) jpUkzk; Mfhjth;fs;
- M) jpUkzk; Mdth;fs;
- ,) gphpe;J tho;gth;fs;/ kidtpia ,oe;jth;fs;
- <) tpthfuj;jhdth;fs;

3. fy;tp jFjp

- m) gbg;gwptw;wth;fs;
- M) mbg;gilf;fy;tp mile;jth;fs;
- ,) eLepiyf;fy;tp mile;jth;fs;
- <) cah;fy;tp mile;jth;fs
- c)fyYhhpg;gbg;G;/gl;lag;gbg;G/njhoppw;fy;tp

4. kjk;

- m) ,e;J
- M) fpwp];jth;
- ,) K];ypk;

5. njhopy;

- m) jpdf;\$yp
- M) jdpahh; epWtdj;jpy; gzp
- ,) muRg;gzp
- <) Xa;T ngw;wth;/ Ntiyapy;yhjth;
- c) nrhe;jkhf njhopy; nra;gth;

6. FLk;g khj tUkhdk;

m) U.2000-f;Fk; Fiwthf

M) U 2001-5000

,) U 5001-10>000

<) U.10>000-f;Fk; Nky;

7. FLk;g tif

m) jdpf;FLk;gk;

M) \$!;L FLk;gk;

8. Foe;ijfs;

m) ,y;iy

M) xd;W

,) ,uz;L

<) %d;W

c) ehd;F kw;Wk; mjw;F Nky;

9. Fb Neha; rpfpr;ir gw;wp \$wpath;fs;

m)FLk;g mq;fj;jpdh;fs;/ez;gh;fs;

M); NubNah my;yJ njhiyf;fhl;rp %ykhf

,) kUj;Jtj;Jiwia rhh;e;jth;fs; %ykhf

<) Gj;jfq;fs;

10. FLk;gjppy; Fbg;gof;fk; cs;s egh;

m) jhj;jh

M) mg;gh

,) khkh /rpj;jg;gh

<) rNfhjuh;

11. Kjypy; Fbj;jjw;F fhuzk;

m) FLk;gg; gpur;id

M) ez;gh;fs; tw;GWj;jy;

,) mYty; fhuzkhf

<) tpNrr epfo;r;rpf;fhf \$ba NghJ

c) kw;w fhuzq;fs; VjhtJ

**kJitg;gw;wpa nghJthd tptuq;fs;**

<b>vz;</b>	<b>Nfs;tpfs;</b>	<b>Mk;</b>	<b>,y;iy</b>	<b>njhpaHJ</b>
<b>kJitg;gw;wpa nghJthd tptuq;fs;</b>				
1.	kJ vd;gJ kUe;J			
2.	vg;NghjhtJ rpwpjsT kJ Fbg;gJ vd;gJ Fb Neha; my;y			
3.	kJ vd;gJ xU Ntjgg;ngHUs;> kaf;fk; jUtJ kw;Wk; vhp;riy; jUk; xU nghUs;			
4.	kJ kdr;Nrh;itf;Fiwf;Fk;			
5.	kJ Cf;fj;j mspf;fpwJ			
6.	kJ goq;fs; kw;Wk; rpytif fha;fwpfis Gspf;f itg;gd; %yk; cUthf;fg;gLfpwJ			
7.	kJtpYs;s nkj;jdhy; vd;w nghUs; cYf;F CW tpistpf;ff;\$baJ			
8.	kJ mUe;Jtjhy; cly; kw;Wk; r%f; rhh;e;j gpur;idfis cUthtjpy;iy			
9.	kJ mUe;Jtjhy; cly; gUkd; mjpfpf;fpwJ			
10.	kJ mUe;JtJ kdjpw;Fk; cYf;Fk; rf;jpaspf;fpwJ			
11.	njlh;e;J kJ mUe;JtJ xUtdpd; cly; rhh;e;j gpur;idf;F fhuzk; my;y			
<b>kJtpdhy; clypy; Vw;gLk; khw;wq;fs;</b>				
12.	kJNthL Nrh;e;J cz;Zk; czT kJtpd; tPhpaj;ijAk; nrhpkhd;ijAk;fl;Lg;gLj;Jtjpy;iy			
13.	kJ mUe;Jtjhy; %is nray;jpwd; ghjpf;fg;gLfpwJ			
14.	kJ mUe;JtJ mjpfg;gbahd Ngr;irAk;> Kul;Lj; jd;ijAk; mspf;Fk;			
15.	kJ mUe;JtJ Gw;W Nehia cUthf;Fk;			
16.	Tho;f;ijapy; Vw;gLk; Gpur;idfis vjph; nfhs;sNtz;ba ijhpaj;ij kJ mspf;fpwJ vd;W kJ mUe;Jgth; ; epidf;fpwhh;			
17.	kJmUe;Jtjpd; kpf Mgj;jhd fl;lk; fhuyapy; tUk; kaff epiy MFk;			
18.	Tp];fp> gpuhz;b> xapd;> ruhak; Nghd;w vy;yh tif kJTk; Nghij mspf;ff;\$baJ			
19.	,uj;jj;jpy; cs;s kJtpd; msT vd;gJ kJ mUe;Jk;NghJ mJ ,uj;jj;jpy; fyg;gjhy; cz;lhfK; msT MFk;			
20.	kJ %is> ,jak> fy;yPuy;> kz;zPuy;> ,uj;jk;> vYk;G> fizak;> tapW> Fly; Nghd;w vy;yh cWg;GfisAk; ghjpf;Fk;;			
21.	kJ Neha; gy epiyfisf; fle;J xUtiu ghjpf;fpwJ			
22.	xUtUf;F mtUila FLk;gj;ijtpl kJ Kf;fpakhdjhF MFk;NghJ mth; cldb rpfpr;ir Nkw;nfhs;s Ntz;baJ mtrpak;			
FLk;gk; kw;Wk; rKfk; rhh;e;j Nfs;tpfs;				
23.	kJ FLk;g cwT kw;Wk; midj;J cwitAk; ghjpf;Fk;			
24.	kJ xUthpd; Fz;ijAk; eltb;f;ifiaAk; khw;wf;\$baJ			
25.	kJ mUe;JtJ xUtUf;F r%f;j;jpy; ey;y me;j];ijf;nfhLf;fpwJ			
26.	kJ xUthpd; jd;dk;gpf;ifia mjpfpf;fpwJ			
27.	kJ mUe;Jtjhy; FLk;gj;jpy; mbf;fb rz;il tUfpwJ			
28.	njlh;e;J kJ mUe;Jtjhy; gak;. re;Njfk;>kw;Wk; kdg;gpuk;ik Vw;gLfpwJ			
29.	kJ mUe;JtJ xUthpd; KbntLf;Fk; jd;ik kw;Wk; MuhAk; jd;ikia Fiwf;fpwJ			
30.	kJ kw;wgy Fw;wq;fis nra;aj;Jhz;LfpwJ			
31.	kJ mUe;JtJ Kf;fpakhd KbntLf;f Ntz;ba Neu;ijpy; Fog;gj;ij cz;Lgz;ZfpwJ			
32.	neLQ;rhiyfsy; elf;Fk; tpgj;jpw;F kJTk; xU fhuzk;			
33.	Fb Neha;f;F Mshdth;fSf;F mth;fspd; FLk;gKk; rKfKk; rhpahd kjpg;G mspf;fhJ			

fPNo nfhLf;fg;g;Ls;s midj;Jf; Nfs;tpfSf;Fk; tpilaspf;fTk;

**C.kJ mUe;Jk; msT kw;Wk; ,ilntspia mwptjw;fhd Nfs;tpfs;(Nffyh;]; ,z;nlf;];)**

- xU Fb vd;gJ 12 mTd;]; MFk;
- nfhQ;rkhf kJ mUe;JtJ vd;gJ xU ehisf;F 2 Fbia tpl Fiwthf ,Uf;Fk;
- kpjkhD msT kJ mUe;JtJ vd;gJ xU ehisf;F 2 Fb kl;Lk; MFk;
- mjpfkhf kJ mUe;JtJ vd;gJ xU ehisf;F 2 Fbia tpl mjpfkhf mUe;JtJ MFk;
- njhLh; kJ mUe;Jjy; vd;gJ xNu Kiwapy; 5 my;yJ mjw;F Nkw;g;l Fbia mUe;JtJ MFk;

**1. nrd;w khjk vj;jid Kiw kJ mUe;jpdPh;fs;?**

- 1) ehd; Fbf;fNt ,y;iy
- 2) nrd;w khjk; xU Kiw Fbj;Njd;
- 3) nrd;w khjk; ,uz;L my;yJ %d;W Kiw Fbj;Njd;
- 4) thuj;jpw;F XhpUKiw Fbj;Njd;
- 5) thuj;jpw;F %d;W my;yJ ehd;F Kiw Fbj;Njd;
- 6) fpl;l;j;l jpdKk; Fbj;Njd;
- 7) xU ehisf;F xU Kiwf;F NkNyNa Fbj;Njd;

**2. ePq;fs; rhjhuzkhf Fbf;Fk; msT**

0 Fb	7 Fb	14 Fb	21 Fb	28 Fb
1 Fb	8 Fb	15 Fb	22 Fb	29 Fb
2 Fb	9 Fb	16 Fb	23 Fb	30 Fb
3 Fb	10 Fb	17 Fb	24 Fb	30 Fbf;Fk; Nky;
4 Fb	11 Fb	18 Fb	25 Fb	
5 Fb	12 Fb	19 Fb	26 Fb	
6 Fb	13 Fb	20 Fb	27 Fb	

**3. nrd;w khjk; ePq;fs; kJ mUe;jpajpy; mjpfkhD msT vd;W ePq;fs; epidg;gJ**

0 Fb	7 Fb	14 Fb	21 Fb	28 Fb
1 Fb	8 Fb	15 Fb	22 Fb	29 Fb
2 Fb	9 Fb	16 Fb	23 Fb	30 Fb
3 Fb	10 Fb	17 Fb	24 Fb	30 Fbf;Fk; Nky;
4 Fb	11 Fb	18 Fb	25 Fb	
5 Fb	12 Fb	19 Fb	26 Fb	
6 Fb	13 Fb	20 Fb	27 Fb	

;

**Fbf;Fk; gof;fj;jpid Fiwg;gjw;fhd jpwd;fs; topKiwfs;**

- xU jlit kJ mUe;Jtjw;Fk; ,uz;lhk; jlit Muk;gpg;gjw;F Kd;Dk; mjpfgl;r ,ilntsp tpITk;
- kJ ghI;by;fis Fsph;rhjd ngl;bf;Fs;NsNa vg;NghJk; Fsph;r;rpahfNt itj;jpUf;fTk;.
- rhjhuzkhf xU jlit mUe;Jk; kJit mNj msit gy jlitahf mUe;jTk;
- miu kzpNeuj;jpw;Fs; Fbf;Fk; kJit xU kzpNeukhf Fbf;fTk;

- Fbf;Fk; mstpid Fiwj;Jf;nfhs;sTk;
- Ntf Ntfkhf Fbg;gij jtph;f;fTk;
- Fbg;gjw;F Kd; ed;whf rhg;gplTk;
- kJTld; jz;zPiu fyf;fp Fbf;fTk;. vdNt jhq;fs; Fbf;Fk; kJtpd; mstpid fl;Lg;gLj;j KbAk;
- xU jlil Fbg;gjw;Nf cq;fs; gzk; KOtijAk; nrytopf;fhjP;h.. mij Nrh;j;J itj;J 3 my;yJ mjw;F Nkw;gl;l jlil Fbg;gjw;F gad;gLj;jyhk;
- ve;jsT Fbf;fpwPh;fs; vd;gij vg;ngnOJk; epidtpy; itj;Jf;nfhs;Sq;fs;
- RWRWg;Gld; VjhtJ xU Ntiyapy; <Lgl;Lf;nfhz;NlapUq;fs;

**tPl;Lg;gapw;rp**

**epiyahd KbntLf;f nra;a Ntz;ba tpraq;fs;**

gioa eltb;f;f	Gjpa eltb;f;f
,yhgk;	,yhgk;
<ul style="list-style-type: none"> <li>• kJtpd; Rited;whf ,Uf;fpwJ</li> <li>• kJ ehd; ed;whf vd;id MRthrg;gLj;jpf;nfhs;s cjTfpwJ</li> <li>• tpiahl;lhfTk; kw;Wk; re;Njhrj;jpw;fhfTk; kJ gad;gLj;jg;gLfpwJ</li> <li>• kJ vd;Dila gpur;idfis kwf;f cjTfpwJ</li> </ul>	<ul style="list-style-type: none"> <li>• vd; kidtpAld; ey;y cwT vdf;F ,Uf;fpwJ</li> <li>• kJ mUe;jhkypUf;Fk;NghJ kJ mUe;jpNa Mf Ntz;b tUk; cly; rk;ge;jkhd gpur;idfs; vdf;F ,y;iy;</li> <li>• gzk; Nrh;fpwJ</li> <li>• vd;idg;gw;wp ehNd ed;whf czh;fpNwd;</li> </ul>

	<ul style="list-style-type: none"> <li>• vd;Dila tho;f;ifapy; vd; kdpjh;fSf;Fk; nray;fSf;Fk; nrytpl e;piwa Neuk; fpilf;fpwJ</li> <li>• kJtpdhy; cz;lfff;\$ba cly; gpur;idfs; ,y;iy</li> <li>• Ntiy nra;Ak; ,lj;jpy; vdf;F ey;y ngah; fpilf;fpwJ</li> </ul>
nryT	nryT
<ul style="list-style-type: none"> <li>• epiwa gzk; nrythfpwJ</li> <li>• kJ mUe;jhkypUf;Fk;NghJ tUk; cly; rk;ge;jkhd gpur;idfs; jhq;f KbahjjhfTk; NtjidahfTk; ,Uf;fpwJ</li> <li>• vd; kidtp kpfTk; tUj;jg;gLfpwhs;</li> <li>• vd; Foe;ijfSf;F ehd; xU Nkhrkhd Kd; cjhuzk;</li> <li>• vd;idg;gw;wp ehNd jtwhf czh;fpNwd;</li> <li>• ehd; vd;Dila tz;b XI;Leh; chpkj;ijj; njhiyj;J tpl;lhy; vd;Dila Ntiy Ngha;tpLk;</li> </ul>	<ul style="list-style-type: none"> <li>• vd;Dila Fbfhu ez;gh;fis ,of;fpNwd;</li> <li>• kJ ,y;yhky; vg;gb re;Njhrkhf ,Ug;Ngd; vd;W njhpatpy;iy</li> <li>• kJ ,y;yhky; gpur;idfis re;jpg;gJ fbdk;</li> <li>• kJ ,y;yhky; ehd; vd;idNa tpj;jpahrkhf czh;fpNwd;</li> <li>• kJ ,y;yhky;kpfTk; ,Wf;fkhf czh;fpNwd;. NkYk; Fiwe;j msT Xa;Nt vdf;F fpilf;fpwJ</li> </ul>