Scale-up of prevention and management of alcohol use disorders and comorbid depression in Latin America
Design and Baseline Results

Peter Anderson
On behalf of all Scientists in the
SCALA Project Consortium (www.scalaproject.eu)

Presented by Amy O'Donnell
Institute of Health & Society, Newcastle University

Background

Programmes based in primary health care that measure the alcohol consumption of adult patients and give brief advice to heavy drinkers are effective in reducing alcohol consumption:

> ➤ meta-analyses of many studies worldwide find a reduction in consumption of 12%

The problem

...is one of implementation.

In Europe, which has some of the best programmes, the proportion of patients that have their alcohol consumption measured rarely gets above 10%

> ➤ this compares with 67% of patients who have had their blood pressure measured.

The potential solution

Two previous international studies aimed at increasing the proportion of patients attending primary health care centres who have their alcohol consumption measured:

1. Phase III World Health Organization study, which included four high income countries;

2. ODHIN study financed by the European Commission, which included five European countries (https://www.odhinproject.eu/).

✓ Both studies found that relatively short and simple training programmes could double the proportion of patients whose alcohol consumption was measured.

The SCALA Project

In the SCALA project, we plan to do better than this – and, also test out implementation in middle income countries.

The **Phase IV WHO** study indicated that it might be possible to increase the proportion of patients whose alcohol consumption is measured by providing community support to the primary health care providers.

SCALA implements a range of **community-based adoption mechanisms, support systems and communication campaigns** based on a model prepared by the Institute for Health Care Improvement.

SCALA implements the study in **Colombia, Mexico and Peru** at municipal level.

Two distinguishing features of SCALA

1. We use a **higher cut-off score** for AUDIT-C: 8, rather than the customary 5

2. We also assess and manage **co-morbid depression**

As of now, we are nearing the end of the second year of the four-year project, and are just starting the 18-month implementation period that will test our hypotheses.

Progress to date

The first 18 months of the project was setting up our interventions:

✓ Tailoring and adaptation of clinical material to use in the primary health care centres in the three Latin American countries to measure alcohol consumption and to give brief advice to heavy drinkers;

✓ Tailoring and adaptation of the training programme to train primary health care providers in the three Latin American countries; and,

✓ Specification of the adoption mechanisms, support systems and communication campaigns to support the work of the primary health care providers.

➢ All the material is available on the project website: www.scalaproject.eu.

You will hear more about the tailoring later:

A O'Donnell: Development of locally-tailored intervention packages to address heavy drinking, depression and alcohol health literacy

Outcomes and hypotheses

Our main outcome measure is the proportion of the registered adult population that has had their alcohol consumption measured.

Our hypotheses are:

i.   Providers who work in primary health care centres that receive <u>both</u> training and community support will measure the alcohol consumption of double the proportion of patients than providers who work in centres that only receive training;

ii. Which, in turn will measure <u>double</u> the proportion of patients' alcohol consumption than providers who work in centres that receive neither training nor community support.
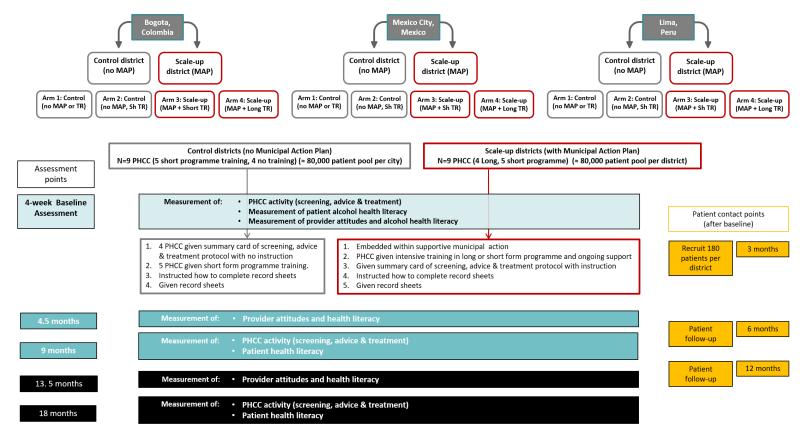
Study design

Thus, the **design of our study** has three main arms with primary health care centres allocated:

1. **Control group**, which receive neither training nor community support;

2. **Training only group** in which providers receive training;

3. **Training and community support group** in which providers receive both training and community support.

In addition, Arm 3 tests the **non-inferiority** of using a very short training and clinical intervention package as opposed to a standard package commonly used in most countries

Study design

KEY: MAP = Municipal Action Plan, TR = Training (Long/Short (Sh) form programmes), PHCC = Primary Health Care Centre

We will test the extent to which our interventions lead to **health and economic gain** for the municipalities in which the interventions are implemented. You will hear more about these shortly:

J. Manthey: Impact of increased alcohol screening and brief intervention coverage on mortality and morbidity in Columbia, Mexico and Peru: results from a modelling study

A. Solovei: Programme costs needed for implementing screening and brief interventions in primary healthcare in three Latin American countries
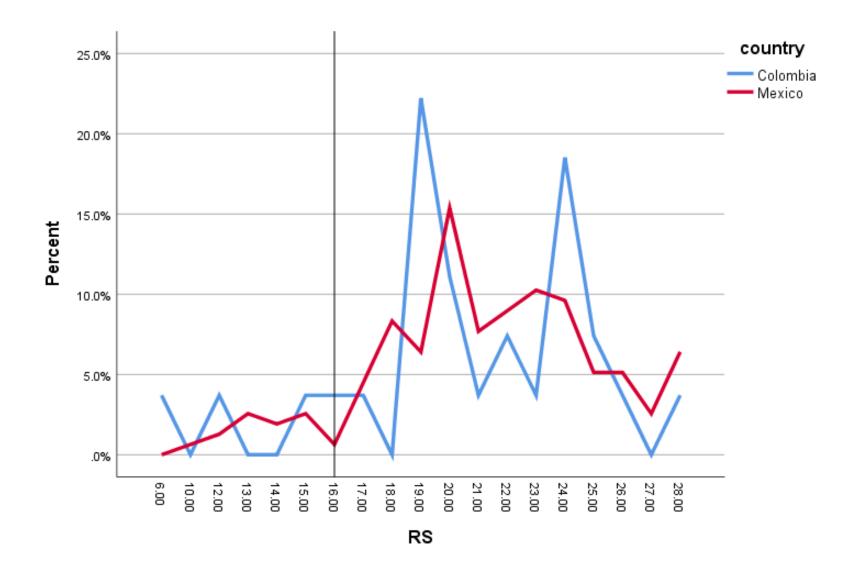
Provider assessment

First, providers:

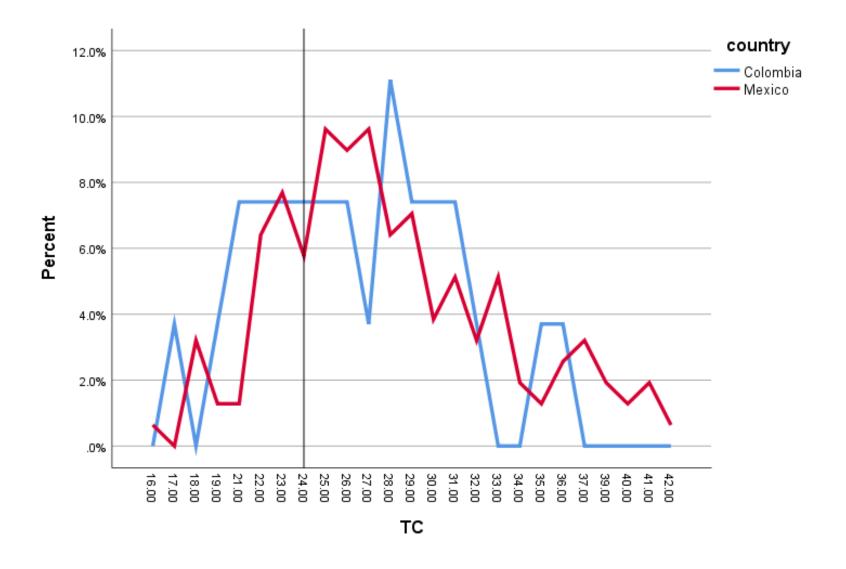20 Providers in Colombia; 96 Providers in Mexico

Completed short alcohol and alcohol problems perception questionnaire (**SAAPPQ**) prior to training or baseline measurement
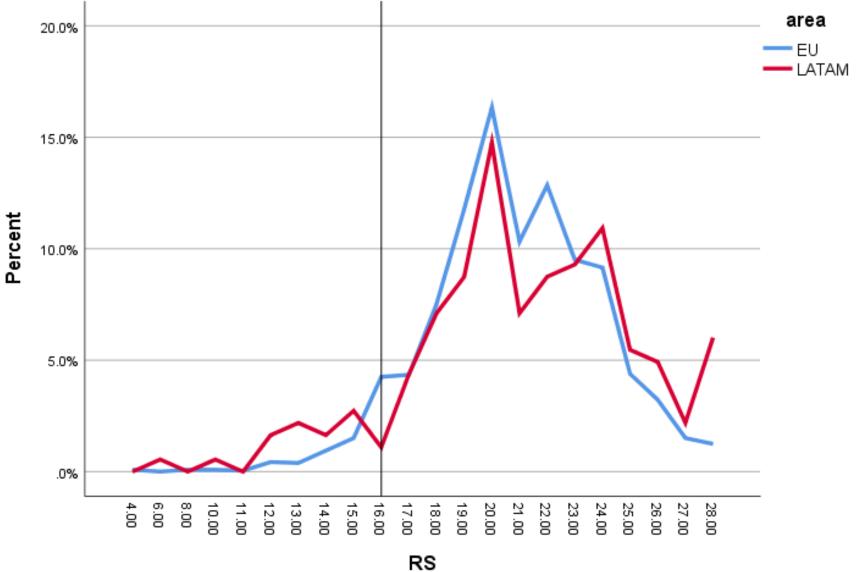
SAAPPQ measures:

➢ **Role security (RS)** - an assessment of perceived capability to manage heavy drinkers

➢ **Therapeutic commitment (TC)** - an assessment of emotional preparedness to manage heavy drinkers
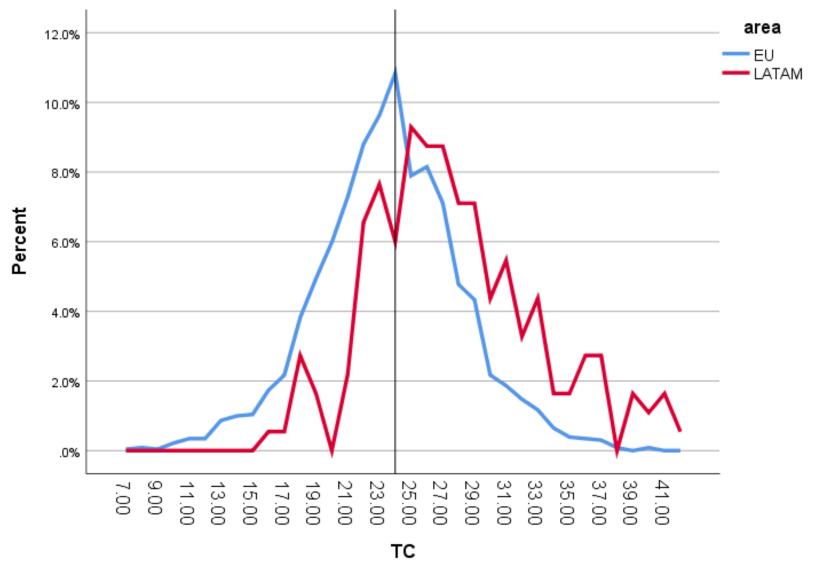
Distribution of Role Security by country: vertical line = neutral score.

Distribution of Therapeutic Commitment by country: vertical line = neutral score.

Distribution of Role Security by area: EU data from ODHIN (9 EU countries); LATAM data from SCALA. Vertical line = neutral score.

Distribution of Therapeutic Commitment by area: EU data from ODHIN (9 EU countries); LATAM data from SCALA. Vertical line = neutral score.

Conclusion: Providers and SAAPPQ

➢ Providers in Colombia and Mexico are similar to each other

➢ Providers in LATAM are just as role secure as providers in EU…

- but are more therapeutically committed

Baseline measurement

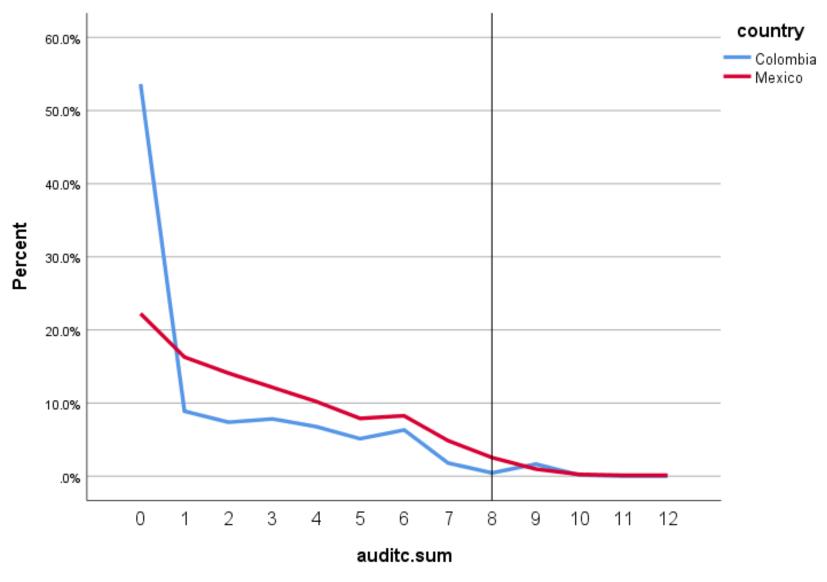**Four-week baseline measurement period:**

➢ 20 Providers in Colombia had 856 adult consultations

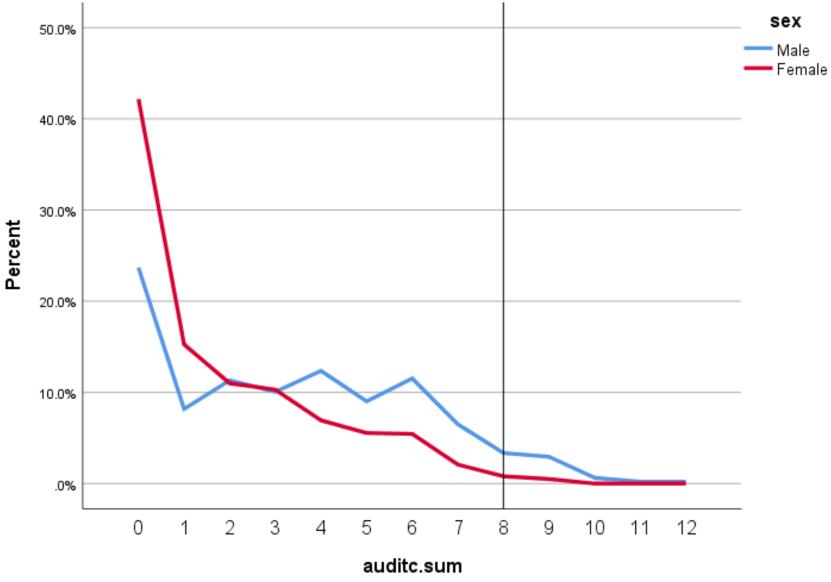➢ 96 Providers in Mexico had 12454 adult consultations.

Of these:

➢ Colombia providers administered AUDIT-C to 810 patients (94.6% of those who consulted)

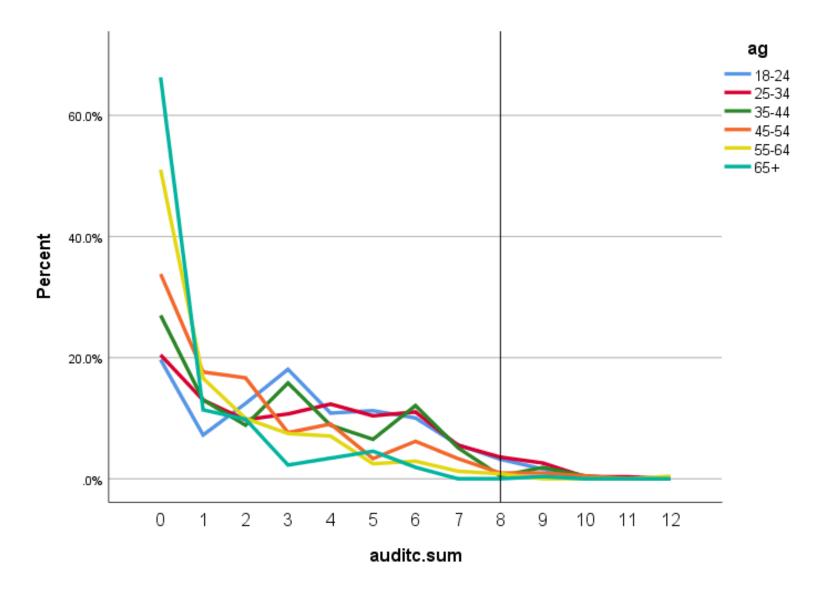➢ Mexico providers administrated AUDIT-C to 1151 patients (9.2% of those who consulted)

Of which:

➢ 143 of the 810 patients in Colombia (17.7%) reported having their alcohol consumption measured during the previous year, and did not complete AUDIT-C

➢ 312 of the 1151 patients in Mexico (27.1%) reported having their alcohol consumption measured during the previous year, and did not complete AUDIT-C

Distribution of AUDIT-C scores by country. Vertical line = cut-off score in SCALA

Distribution of AUDIT-C scores by sex of patient. Vertical line = cut-off score in SCALA

Distribution of AUDIT-C scores by age of patient. Vertical line = cut-off score in SCALA

Results: 4-week baseline measurement period

Mean AUDIT-C score by country (95% confidence intervals), **unadjusted**:

- ➢ **Colombia**: 1.71 (1.52 to 1.89)

- ➢ **Mexico**: 2.79 (2.63 to 2.96)

Mean AUDIT-C score by country (95% confidence intervals) **adjusted for sex and age of patient**:

- ➢ **Colombia**: 1.94 (1.72 to 2.16)

- ➢ **Mexico**: 2.60 (2.41 to 2.79)

Results: 4-week baseline measurement period

Proportion with AUDIT-C score 8+ **by country** (95% CI), **unadjusted**:

➢ **Colombia**: 0.023 (0.014 to 0.037)

➢ **Mexico**: 0.041 (0.029 to 0.056)

Proportion with AUDIT-C score 8+ **by country** (95% CI), **adjusted for sex and age of patient**:

➢ **Colombia**: 0.023 (0.013 to 0.040)

➢ **Mexico**: 0.023 (0.014 to 0.036)

Proportion with AUDIT-C score 8+ by **sex** (95% CI), **adjusted for age of patient**:

➢ **Male:** 0.073 (0.053 to 0.101)

➢ **Female:** 0.013 (0.008 to 0.022)

Conclusion for AUDIT-C (i)

➢ Patient AUDIT-C scores were higher in Mexico than Colombia, also when adjusting for the sex and age of the patients

➢ AUDIT-C scores were higher for men than for women, and higher for younger than older adults

Conclusion for AUDIT-C (ii)

➢ The proportion of patients with an AUDIT-C score of 8+ were similar for Colombia and Mexico (2.3%), when adjusting for the sex and age of the patients

➢ The proportion of patients with an AUDIT-C score of 8+ were higher for men (7.3%) than for women (1.3%)

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