What countries can learn from the Scottish and Catalans when implementing Alcohol Brief Interventions

DEEP SEAS

DEVELOPING AND EXTENDING EVIDENCE AND PRACTICE FROM THE STANDARD EUROPEAN ALCOHOL SURVEY

CLÍNIC BARCELONA Hospital Universitari

Generalitat de Catalunya
Public Health Agency of Catalonia
Programme on Substance Abuse

SICAD Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências

NHS Health Scotland

DEEP SEAS
DEVELOPING AND EXTENDING EVIDENCE AND PRACTICE FROM THE STANDARD EUROPEAN ALCOHOL SURVEY

Scotland

Debbie Sigerson

Niamh Fitzgerald

NHS Health Scotland

Catalonia

Joan Colom

Lidia Segura

Estela Diaz

Jorge Palacio-Vieira

Carla Bruguera

Antoni Gual

Generalitat de Catalunya
Public Health Agency of Catalonia
Programme on Substance Abuse

CLÍNIC BARCELONA
Hospital Universitari

Portugal

Manuel Cardoso

Patricia Pisarra

Graça Vilar

SICAD
Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências

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- **Introduction**
- **The Catalan and the Scottish experience**
- **Portugal pilot: work plan**
- **Open discussion / debate**

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LARGE-SCALE IMPLEMENTATION OF SBI (1/2)

1. Despite their **potential cost and high-demanding resources**, large scale SBI implementation could lead to **great health benefits and avoid alcohol-related diseases**.

2. Large-scale SBIRT should be **evidence-based and well-integrated** within medical and addiction treatment systems, **producing changes in the major components of systems** of care (facilities, tasks and linkages) and improvements in treatment system accessibility, equity, and efficiency.

3. Country-wide implementation of SBI programs are **not easy to compare** due to both, the different context and implementation strategies used and the **diversity of the outcome and output indicators used** (Colom, 2014).

4. There is **a lack of research** on how SBI strategy can be implemented in large-scale settings (implementation research).

LARGE-SCALE IMPLEMENTATION OF SBI (2/2)

5. **Phases of large-scale implementation** of SBI include:
    - Set-up: preparing the ground for the intervention
    - Develop the Scalable Unit
    - Test of Scale-up: proving that the strategy could represent different contexts
    - Go for Full Scale: enable a larger number of sites to adopt and replicate the intervention

6. **Facilitators include the availability of funding**, **having nationally co-ordinated and locally supported training opportunities and a national and health board support.**

7. In addition, having individuals within local settings acting **as champions**, support from senior staff, adapting the intervention to the practice and stablishing an **effective information technology system** to record and give feedback are key (Niamh Fitzgerald., 2015)

DEEP-SEAS

Service contract with CHAFEA with the following tasks and aims:

1. Continue analysis and evaluation of data collected by the first wave of Standardised European Alcohol Survey in 2015-201625;
2. Implement the second wave of the Standardised European Alcohol Survey in 2018/2019;
3. Support the Member States' capacity building in the area of control on alcohol marketing and advertising, taxation of alcoholic beverages, EU Common Agricultural Policy and alcohol related harm, inequalities and alcohol related harm, as well as alcohol consumption and nutrition; and
4. **Prepare a pilot implementation of brief interventions in local alcohol policies as a validated best practice, including awareness raising at the level of national and local authorities and stakeholders.**

TASK 4

The main actions and activities:

1. **Feasibility study:** of the implementation by Primary Health Care (PHC) providers in hazardous/harmful drinkers and alcohol dependent patients of a short and multi-contact alcohol brief intervention (BI) including screening and referral to treatment (RT).

   - **Preparation:**

     Analyse baseline circumstances
     Define objectives
     Identify barriers and facilitators
     Study the best way to embed the BI in the local context
     Estimate the number of eligible patients, study their alcohol literacy, willingness to participate and recruit them
     Identify the number of professionals willing to participate, their attitudes, knowledge and alcohol related literacy
     Characterize the most appropriate components of the BI strategy (screening questionnaire, BI), RT and the training
     Develop, translate and adapt materials, intervention protocol and assessment tools

   - **Pilot testing and evaluation**

2. **Development of an implementation plan:** to promote more large-scale implementation and research on BI among EU Member States.

3. **Dissemination at MS level** of a pragmatic and practical guidance toolkit allowing flexibility and customization to the different baseline country circumstances.

INEBRIA WORKSHOP

The main aim:

- **To present and analyse the Catalan and Scottish experiences including positive and not so positive results, extracting main lessons learnt and, where possible, their most effective components**.
  - Special attention will be paid to **understanding their rationale and implementation strategies, describing the activities undertaken at organizational, professional and population level**.
- **Collaborative exercise aimed at stimulating the decision-making process for the completion of the scaling up protocol in Portugal**.

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Similar political situation

Similar population sizes: Scotland (5.45m) and Catalonia (7.52m)

Glasgow (1.6m) and Barcelona (1.7m)

significant health inequalities

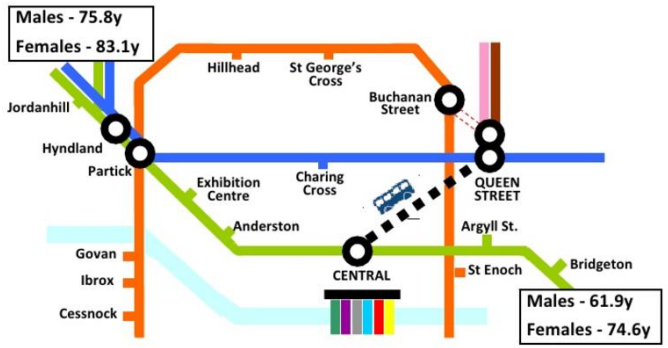
Alcohol rooted in the traditions

- **Why?**
- **Where?**
- **What?**
- **How?**
- **What results?**
- **Lessons learnt**
- **What comes next?**

WHY?

Scotland

- Alcohol-related hospital admissions have reduced 20% since 2007/08, but are still over **four times** higher than in the early 1980s
- Survey in 2018 identified only 17% awareness in general population of low risk drink guidelines
- **8 x as many stays o**f alcohol related general acute hospital admissions in areas of deprivation, rising to 14 for psychiatric admissions



Catalonia

- Alcohol is the most consumed substance
- Low perception of risk
- Changes in the consumption pattern from “Mediterranean” to more risky consumption – binges specially in youth
- 50% of the treated patients in specialist settings are addicted to alcohol
- Huge treatment gap (1 in 9 only intervened)
- Lack of alcohol early detection programs and referral pathways in the HS
- Alcohol problems not seen as health problems (stigma)

WHERE?

Scotland

- Delivered nation wide in primary care, accident and emergency, antenatal and wider settings e.g prisons
- Co-ordinated by local *Alcohol & Drug Partnerships*, or Public Health teams, with some commissioning to charities to deliver in community settings
- Targets for each Health Board area set annually by the Scottish Government

Catalonia

- Nation wide in the reformed network of PHC (around 260 at that time- 360 nowadays) settings
  - prevention duties
  - covering 70% of the total population
  - Experience with tobacco prevention initiatives
- Interest in extrapolating to other services if succeeding
- Co-ordinated by Program on Substance abuse of the Public Health Agency of the Government of Catalonia,
  - In coordination with the PHC professional societies
  - The support of the purchaser authority
  - With the collaboration of the well stablished treatment network of centers and professionals specialists in alcohol and ready to receive referrals from other health services

WHAT FOR?

Scotland **Catalonia**

- Raise awareness among the general population about the risks of alcohol consumption
- Reduce risky alcohol consumption and alcohol related problems among population visited in PHC.
- Reduce treatment gap (improving referral pathway)

WHAT?

Scotland

ABIs continue to be implemented nation-wide, since 2008, in routine practice

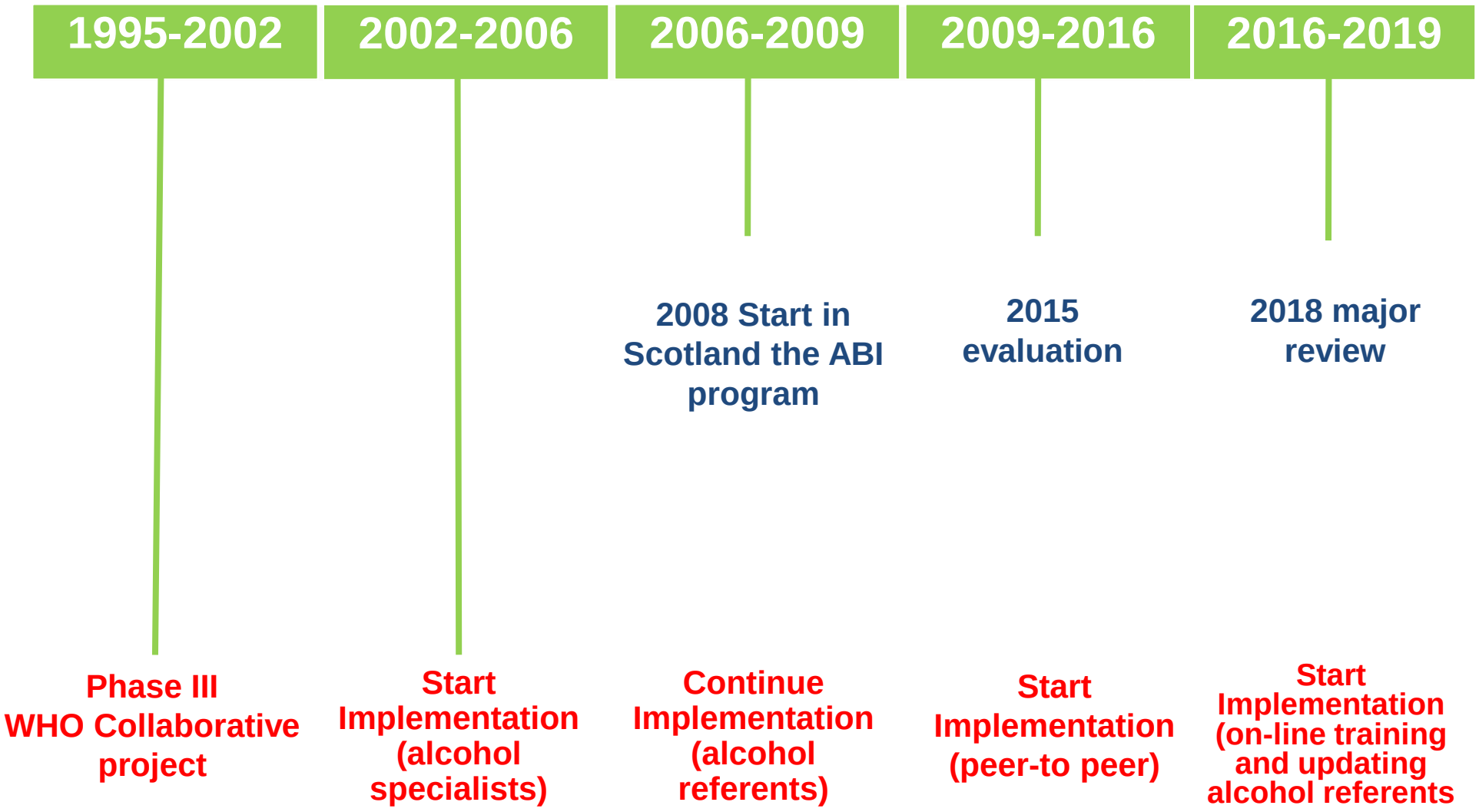
A review of the programme began in 2018, re-establishing a Programme Board which reports directly to the Minster. Aims agreed are to:

- Gather perspectives about the local operating landscape, to guide decisions on what improvements are needed and the future direction of the programme
- Review the evidence base and invest in new areas of research
- Improve data collection and review the annual target
- Make recommendations to the Minister for Public Health for the next 10 years delivery

Catalonia

- SBIRT to be implemented nation-wide since 2002
  - Screening tools: AUDIT/ AUDIT-C
  - Brief intervention: FRAMES and adapted to patients motivation
- Setting limits of risky drinking and introducing SDU (10g)
- Improving referral pathways between PHC and specialists centers

HOW (iteration over time)?



HOW?

Scotland

- Led by the Scottish Government alcohol policy team
- Supported by NHS Health Scotland and Information Services Division (to come together to become Public Health Scotland in April 2020)

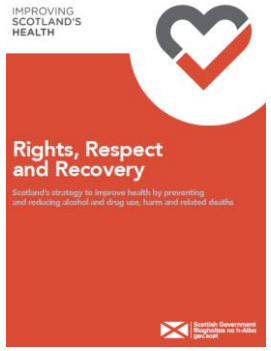
Catalonia

- Led by the Program on Substance Abuse (PSA) of the Health Department
  - Creation of a specific unit (1 nurse / 1 administrative staff / 1 psychologist)
- Inspired by existing initiatives on tobacco
- Implementation research approach
- Sustainability
- Creation of a specific unit in the PSA

'Based on motivational interviewing and behavior change techniques'

HOW? (strategic)

Scotland



'We will review **evidence on current delivery** of Alcohol Brief Interventions to ensure they are being carried out in the most **effective** manner , look at how they are working in **Primary Care settings** - where the evidence is strongest – and whether there would be benefit in **increasing the settings** in which they are delivered .'

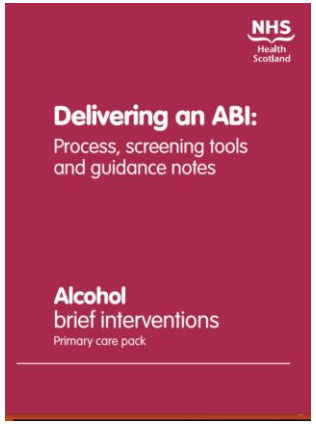
Catalonia

- Embedding the program in the general objectives of Catalan Government and in the Health Plan for Catalonia
- Aligning the program with the major strategic mental health and addiction plans
- Introducing the objectives of the program in the contract with PHC providers
  - Setting specific performance objectives year by year (first increasing screening rates, second improving quality and then BI)

HOW? (professionals and training)

Scotland

- On-line suite of resources and training materials
- Major update due to bring in line with WHO ABI guide and digital first (on-line e-modules) approach
- Public Health Scotland will be developing a new workforce development strategy for the public health workforce, to include ABI s and reviewing links with health behavior change training and sllo approaches



Catalonia

- Mobilizing and involving PHC professionals by involving major associations
- Targeting medical and nursing professionals
- Giving alcohol experts a major role in training PHC professionals
- Training of trainers (20h + end users 5-10h)
- Motivational training approach
  - Adapted to professionals motivation
  - Changing attitudes (reduce stigma)
  - Skills not only theory
- Continuous, iterative and updated
- Accredited (trainers and trainees)
- Territorialized
- eLearning course (20h accredited – 4 editions – open to any professional – pharmacist, pediatricians, post-graduate students.
- Giving visibility to PHC professionals and specialists by creating a network of referents

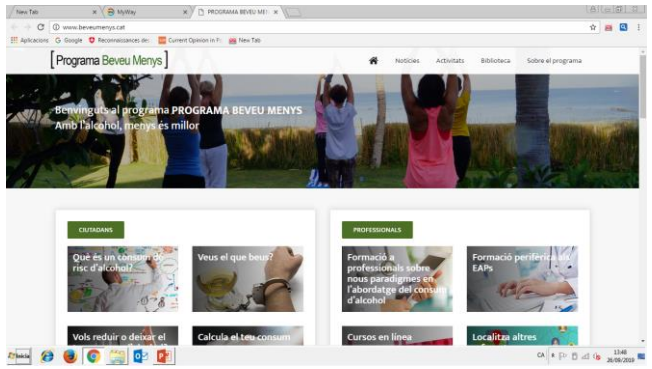
HOW? (support)

Scotland

- Scottish Government alcohol policy team issues annual ABI planning guidance and provides networking opportunities for ADPs
- Data collection and analytics by ISD
- NHS Health Scotland maintains resources for the public and professionals

Catalonia

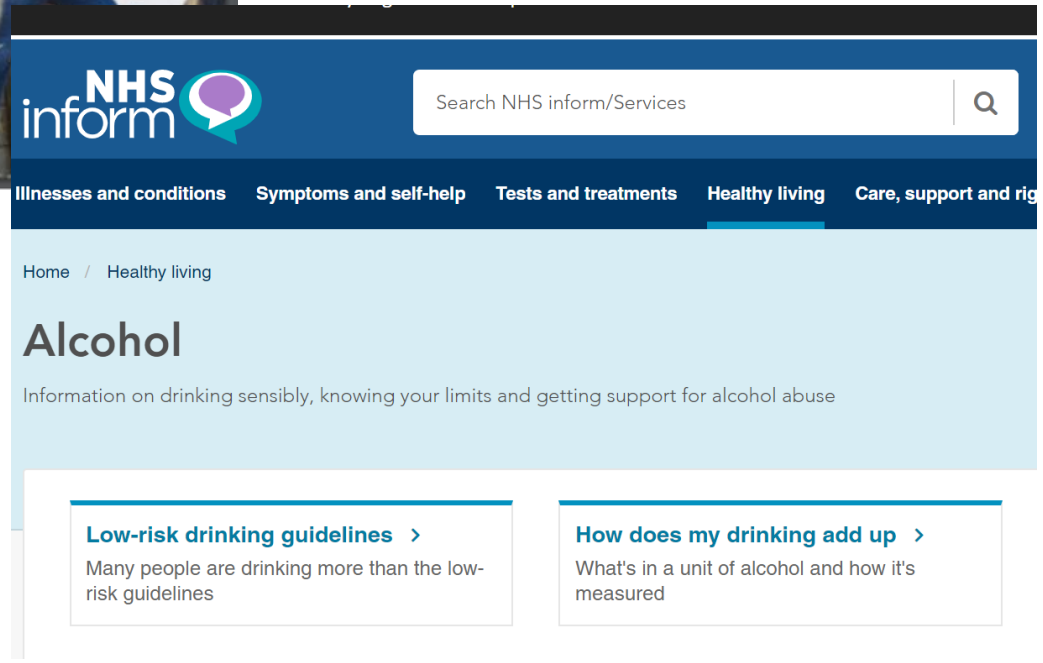
- Changes in the medical records – inclusion of screening tools, BI instructions, diagnostic codes and recommendations
- Specific website and communication platform of the program (http://beveumenys.cat)
- Development of materials and recommendations for professionals to be used in the consultancy
- Acknowledgement of professionals activity (performance indicators and recognition as referents)
- Hotline and e-mail to communicate with the coordination team



HOW? (population)

Scotland

https://www.count14.scot



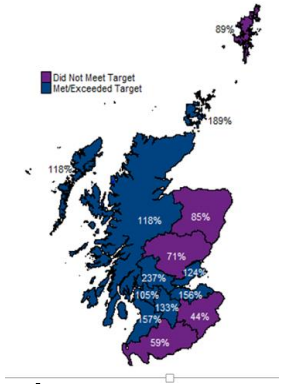
Catalonia

- Raising awareness materials (leaflets “see what you drink” , videos in PHC waiting rooms, http://www.beveumenys.cat/ etc.
- Year-to-year campaign (November) “Alcohol raising awareness and screening week”
  - “Alcohol is everyone’s responsibility”
- Alcohol risk calculator (age/gender, health condition adapted screening tool, individualized feedback and advice)

HOW? (evaluation)

Scotland

- 2011/15 evaluations part of MESAS
- 2019 survey of current practice
- ISD annual/quarterly report of targets local and national decision makers
- One active trial in the prison setting and one review of alcohol screening in pregnancy in press.



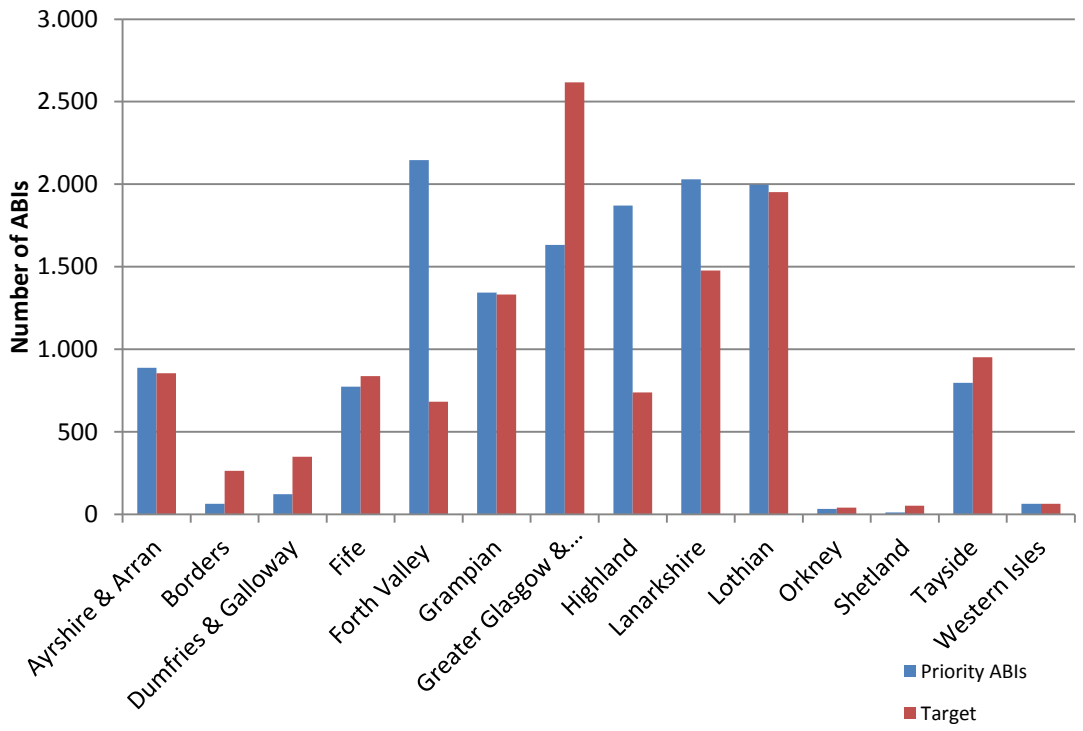
Catalonia

- Pre-post initial evaluation
- Process evaluation
  - Trainings participation and satisfaction
  - Centres coverage
  - Professionals coverage
  - Population coverage
- Outputs (data from electronic health record
  - % screened
  - % risk consumption
  - % dependency
  - % intervention
  - Number of referrals
  - Changes in perceptions and attitudes of professionals

WHAT RESULTS?

Scotland

Since the programme has been rolled out in 2008/9, over **915,000** ABIs have been delivered across 4 settings



Catalonia

- Increase alcohol screening to 74%
- 792 alcohol referents (105 from substance abuse centres & 687 from PHC centres)
- 95% of PHC centres and 66% have trained professionals
- Professionals claimed the program has contributed to increase the detection of risky drinkers (84%), to facilitate and improve the relationship with specialist centres (20%) and to increase their confidence (15%).

LESSONS LEARNT? The good things

Scotland

- The Scottish Government (SG) have sustained their commitment to supporting ABI delivery over 10 years.
- The alcohol policy team in SG are working with all stakeholders to review the last 10 years of delivery (2009-2019) and make recommendations to the Minister for Public Health, Sport and Wellbeing for the next 10 years of investment.
- The Scottish Government have encouraged appropriate planning and delivery of ABIs in wider settings e.g. justice.
- We also support a focus on communities where deprivation is greatest. The Triple I modelling tool provides a good rationale for new approaches to deliver ABI in a targeted way, 3 tests of change underway

Catalonia

- The program has contributed to:
  - Increase SBIRT in PHC
  - Improve knowledge and skills of the professional.
- Key professionals and alcohol referents at PHC are essential for the sustainability of the program.
- Changes are possible but rather slow and need iteration, a multicomponent and strategic approach, the involvement of all stakeholders and ongoing support

LESSONS LEARNT? The not so good things

Scotland

- In 2012, when NHS HS realigned our resources around our new corporate strategy, we moved away from the provision of dedicated support for the delivery of the ABI programme.
- Anecdotally we know that opportunities for sharing practice are lacking and needed, and we hear local challenges of people lacking ‘buy in’ and prioritising investment in delivery.
- There is gaps in research evidence on the impact on consumption and the quality of ABIs.
- We have limited evidence of the quality of the interventions being delivered, across a varied geography.

Catalonia

- Professional level:
  - Lack of time
  - Lack of training
  - Work overload
- Organizational level:
  - Limitations regarding alcohol registration in the health record
- Implementation level:
  - Reduction of the intervention in the last two years
  - Professionals rotation
  - Struggle to increase coverage

WHAT COMES NEXT?

Scotland

- The new Research Expert Advisory Group will be convening in early 2020, with a role to review the evidence base and advise on new research for the Programme Board to commission
- Analysis of the Scotland wide survey, establishing current challenges and opportunities in the operating landscape
- Promoting the Chief Medical Officers (CMO) low risk guidelines, and improving referral pathways
- Begin update to training programme and linked resources
- Involving those with lived experience in review

Catalonia

- Keep improving the medical records by facilitating registration by PHC professionals and monitoring better
- Rethinking how to change practice habits (more time, incentives and recognition)
- Promote more awareness-raising campaigns aimed at professionals and at the population in general.

Also:

- Liaising with other initiatives (other life-styles (physical activity) and drugs (tobacco, illegal drugs?)
- Extrapolate to other settings (workplace, pregnancy, hospitals).

OVERCOMING BARRIERS

- Insufficient co-ordination and communication
- High turn over of professionals
- Insufficient monitoring tools
- Low awareness of population

- Invest in national programme support team with government support
- Develop continuous training opportunities eLearning and face-to-face
- Improve indicators and collect follow up data and demographics and change of those receiving an ABI
- Repeat and enhance (via targeting) national awareness campaigns

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INEBRIA

MANUEL CARDOSO

DEPUTY GENERAL-DIRECTOR . SICAD

General-Directorate for Intervention on Addictive Behaviours and Dependencies

Generalitat de Catalunya
Public Health Agency of Catalonia
Programme on Substance Abuse

ARSC ADMINISTRAÇÃO REGIONAL DE SAÚDE DO CENTRO,I.P.

SEPTEMBER 2019

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DEVELOPING AND EXTENDING EVIDENCE AND PRACTICE FROM THE STANDARD EUROPEAN ALCOHOL SURVEY

Main Goal

Reduce alcohol related harm in the EU Member States

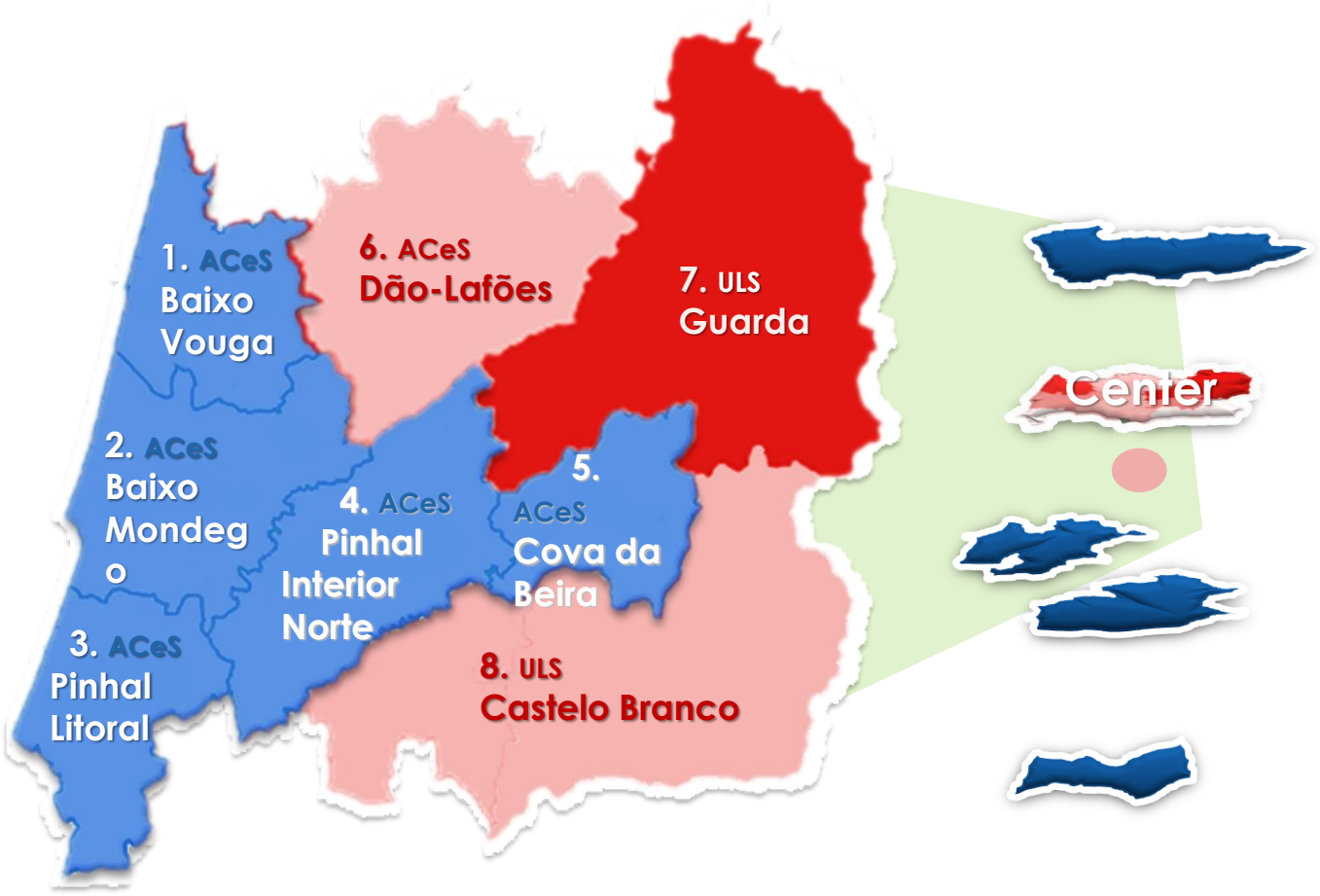
Deep Seas Operational Goal

Define the possibility of implementing Brief Interventions in all units of the Central Region (ACES)

Portugal
Center Region

1. ACeS - Baixo Vouga
2. ACeS - Baixo Mondego
3. ACeS - Pinhal Litoral
4. ACeS - Pinhal Interior Norte
5. ACeS - Cova da Beira

6. ACeS - Dão Lafões
7. ULS – Guarda (ACeS Guarda)
8. ULS Castelo Branco (ACeS Pinhal Interior Sul; ACeS Beira Interior Sul)



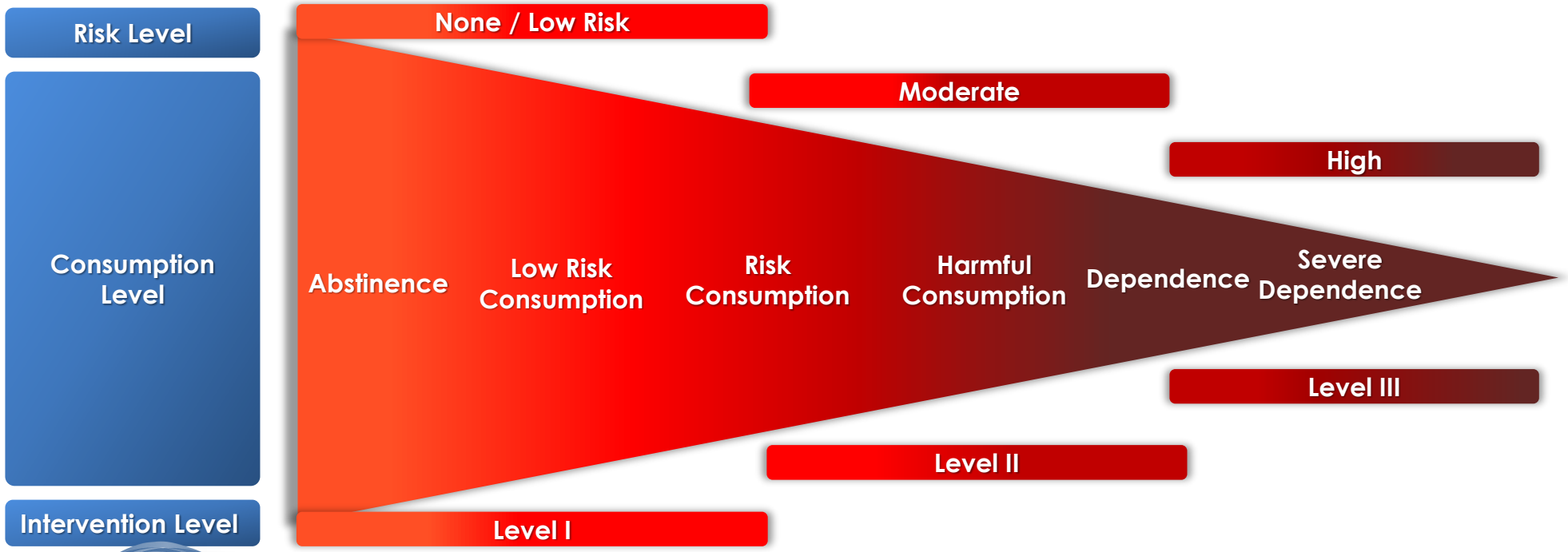
Challenges

- Overall prevalence of alcohol consumption;
- Prevalence of the most harmful alcohol consumption patterns: binge and intoxication;
- Prevalence of alcohol dependence (AUDIT);
- Hospitalizations due to alcohol related harm;
- Alcohol related mortality.

Source: Dossier temático • padrões de consumo e problemas ligados ao álcool • uma análise regional

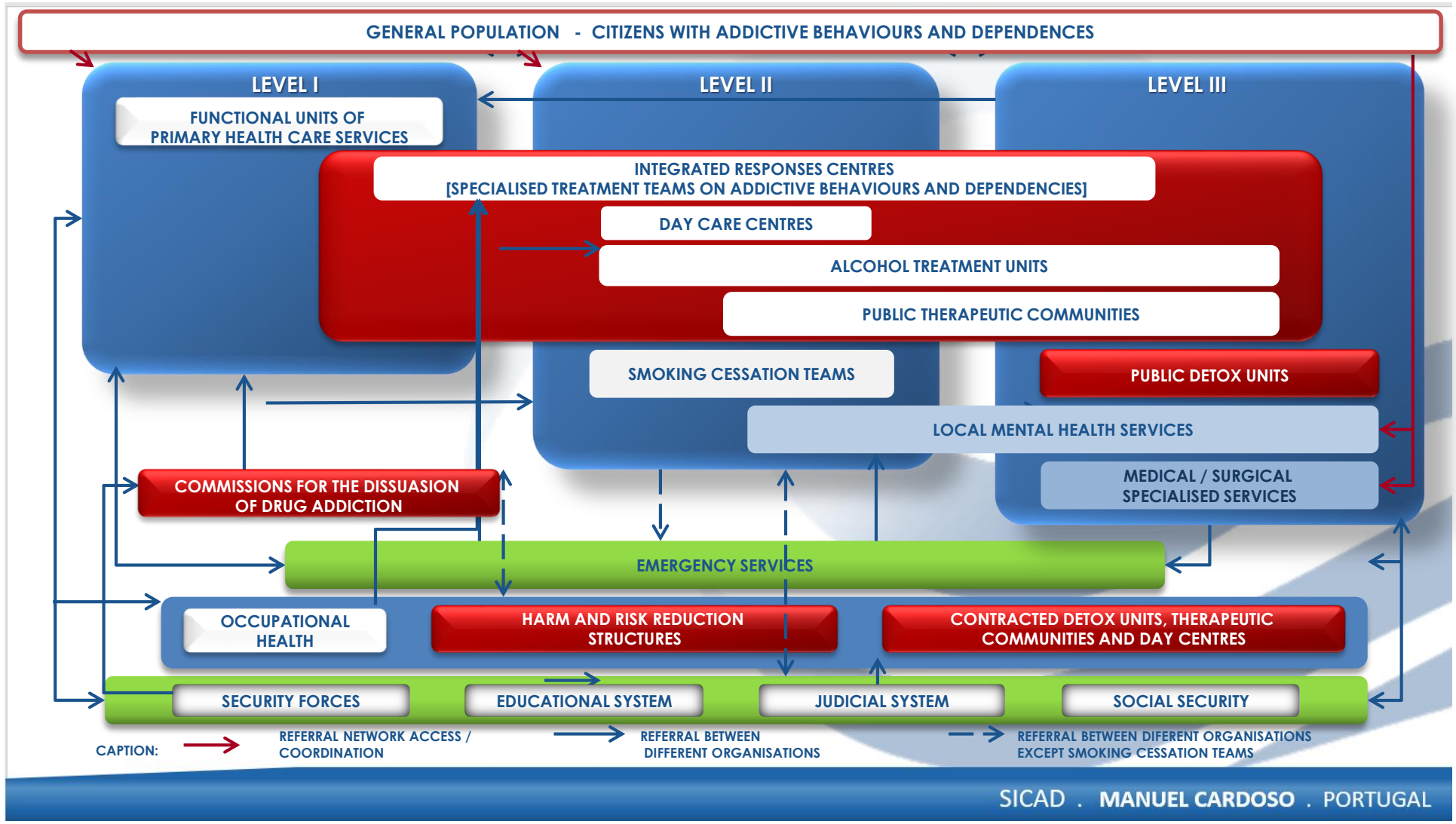
Referral Network

Relationship among levels of consumption, risk and intervention in the field of CAD



Adapted from Springer, IOM - J.F. & Phillips, J. (n.d.), *The Institute of Medicine Framework and its implication for the advancement of prevention policy, programs and pratice*. Washington: CARS

Ferreira-Borges, C. e Cunha Filho, H. (2007), *Intervenções Breves: Álcool e Outras Drogas – Manual Técnico e Cd-Rom*, Lisboa: CLIMEPSI


GENERAL POPULATION - CITIZENS WITH ADDICTIVE BEHAVIOURS AND DEPENDENCES
LEVEL I
LEVEL II
LEVEL III
FUNCTIONAL UNITS OF PRIMARY HEALTH CARE SERVICES
INTEGRATED RESPONSES CENTRES [SPECIALISED TREATMENT TEAMS ON ADDICTIVE BEHAVIOURS AND DEPENDENCIES]
DAY CARE CENTRES
ALCOHOL TREATMENT UNITS
PUBLIC THERAPEUTIC COMMUNITIES
SMOKING CESSATION TEAMS
PUBLIC DETOX UNITS
LOCAL MENTAL HEALTH SERVICES
MEDICAL / SURGICAL SPECIALISED SERVICES
COMMISSIONS FOR THE DISSUASION OF DRUG ADDICTION
EMERGENCY SERVICES
OCCUPATIONAL HEALTH
HARM AND RISK REDUCTION STRUCTURES
CONTRACTED DETOX UNITS, THERAPEUTIC COMMUNITIES AND DAY CENTRES
SECURITY FORCES
EDUCATIONAL SYSTEM
JUDICIAL SYSTEM
SOCIAL SECURITY
CAPTION:
REFERRAL NETWORK ACCESS / COORDINATION
REFERRAL BETWEEN DIFFERENT ORGANISATIONS
REFERRAL BETWEEN DIFERENT ORGANISATIONS EXCEPT SMOKING CESSATION TEAMS
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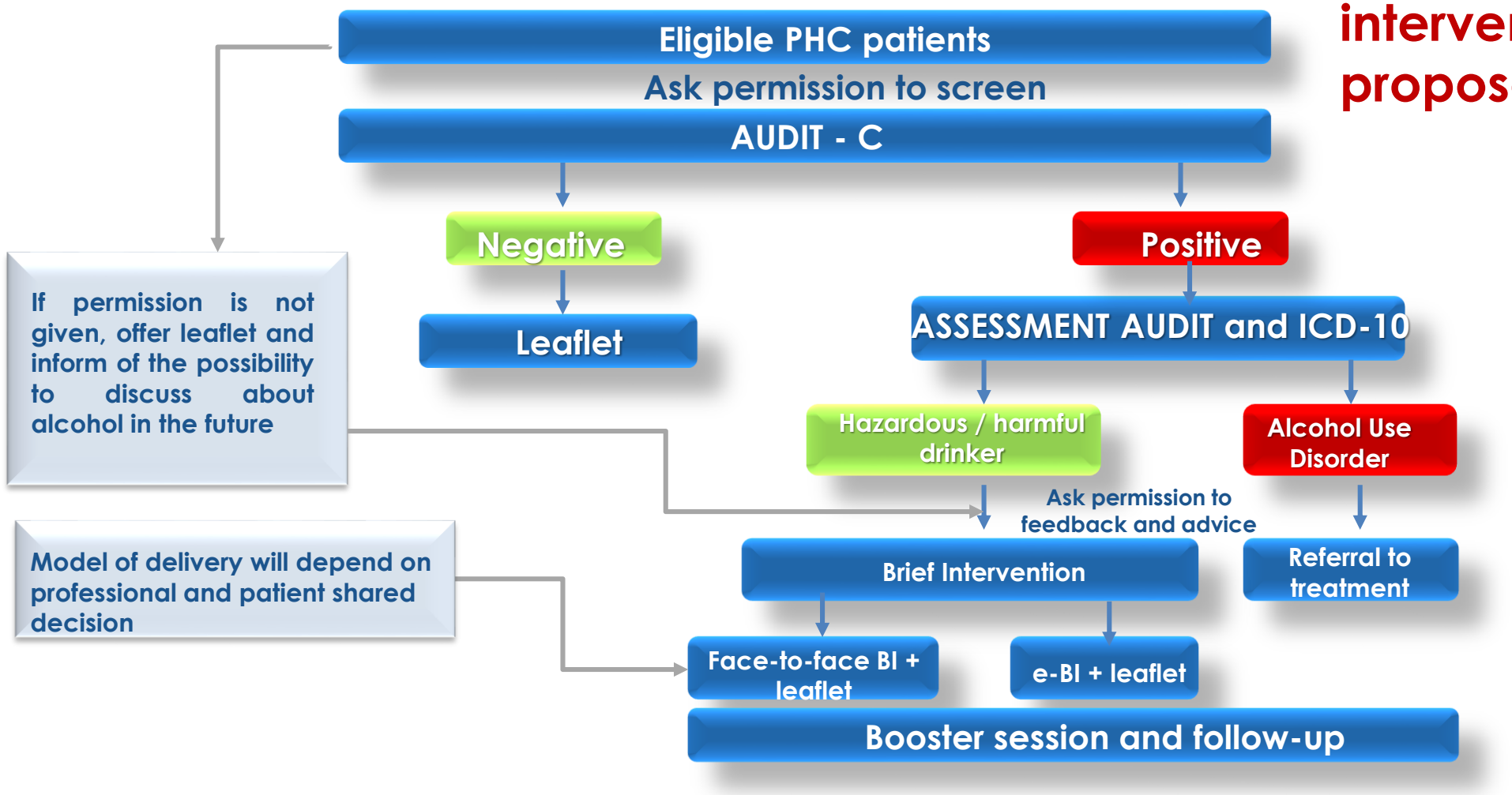
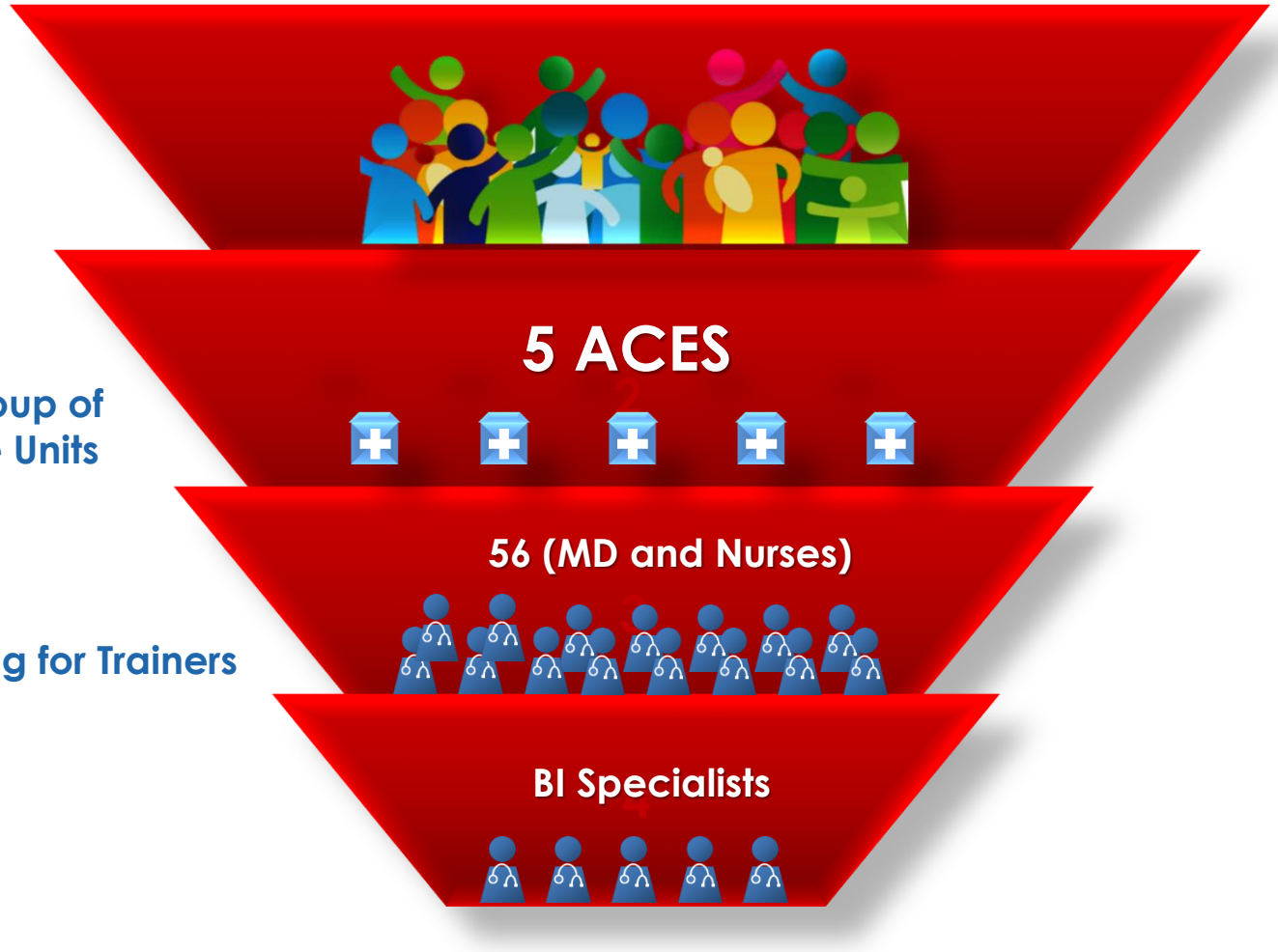
Screening and brief intervention proposal



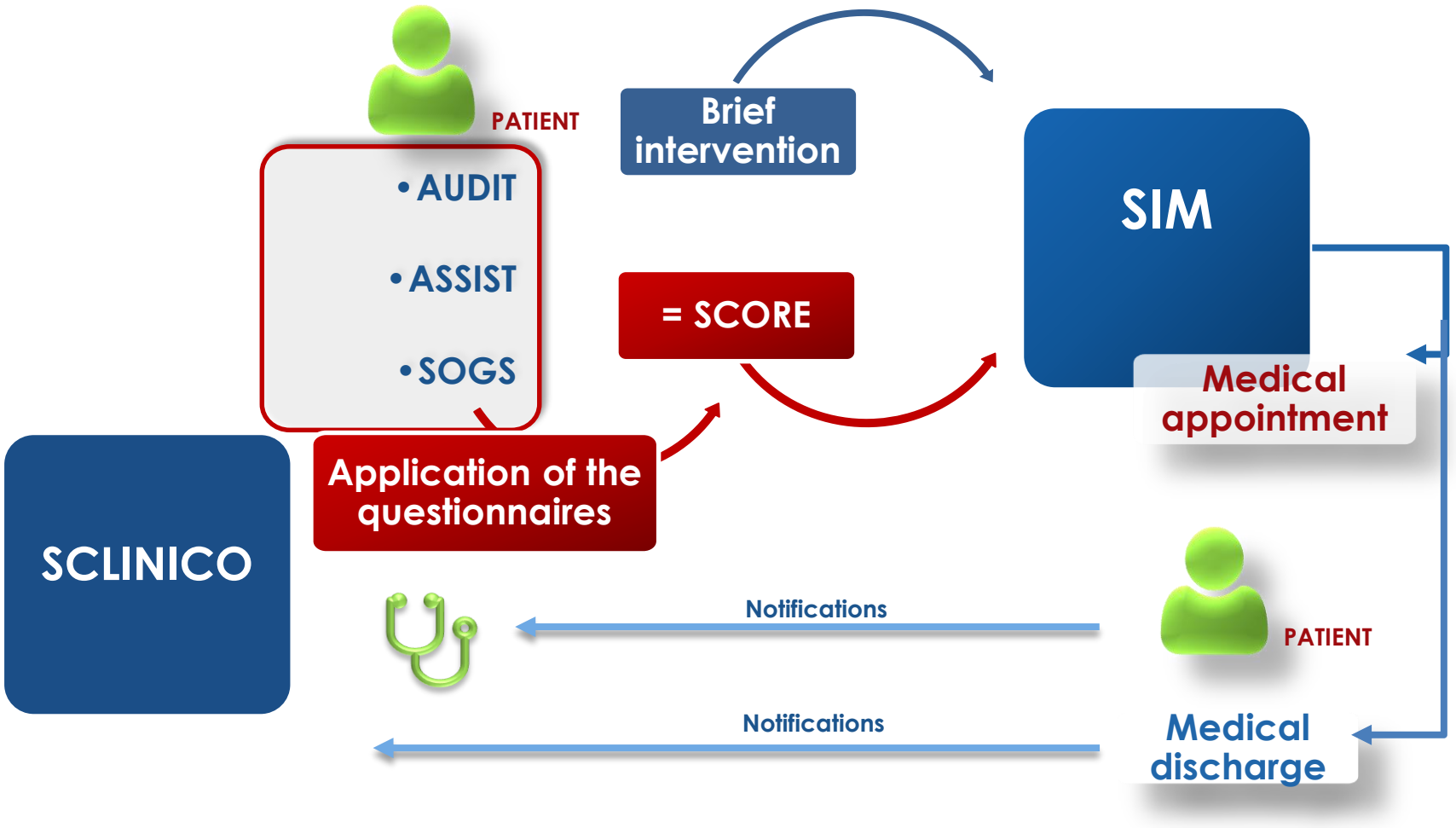
Training

Training for local group of Primary Health Care Units (ACES)

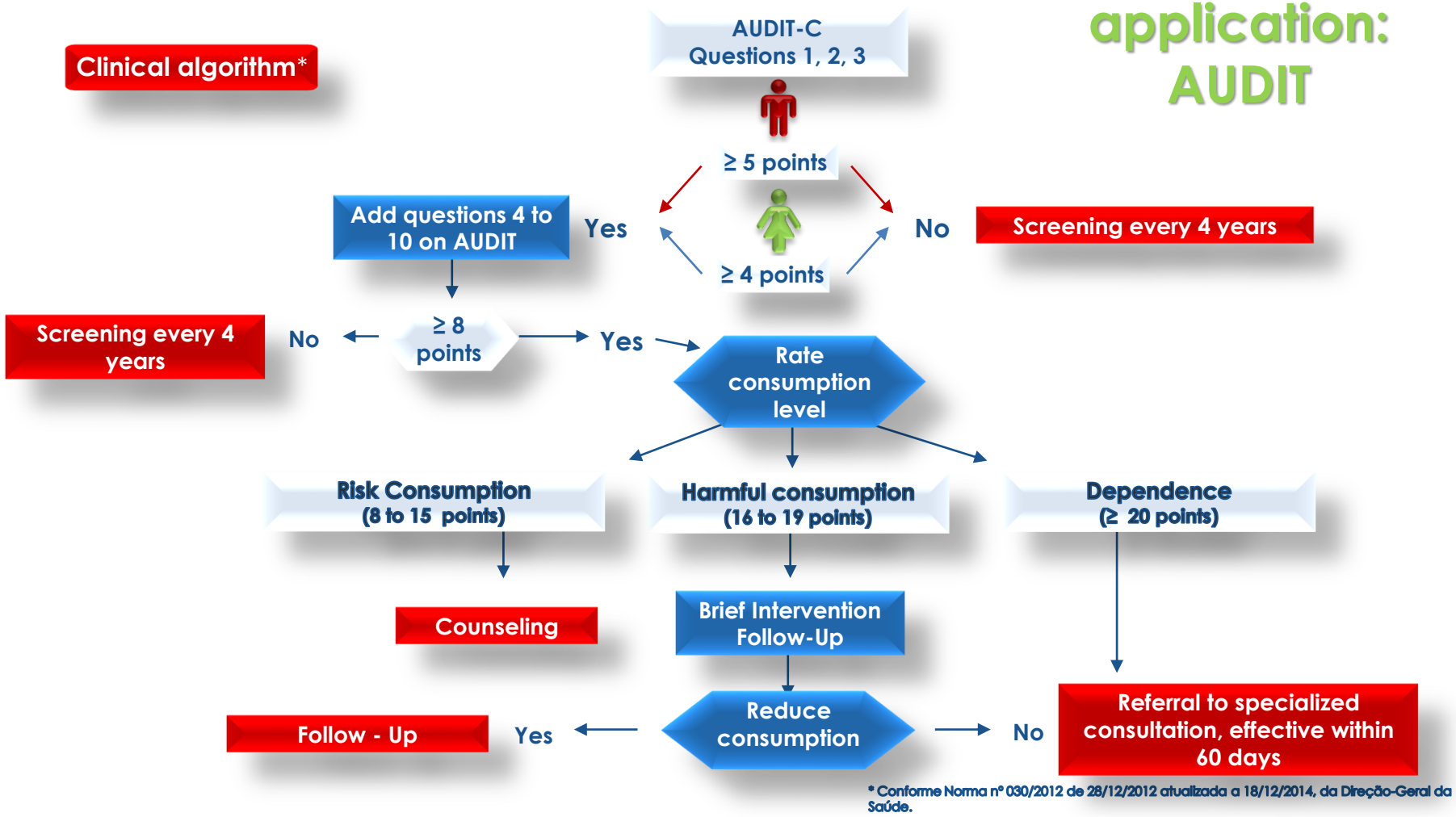
Training for Trainers



How does it work



Questionnaire application: AUDIT



* Conforme Norma nº 030/2012 de 28/12/2012 atualizada a 18/12/2014, da Direção-Geral da Saúde.

10 Indicators

1. Prevalence of adult users screened for alcohol / illicit psychoactive substances / gambling
2. Prevalence of alcohol abstinence in adults
3. Prevalence of alcohol consumption / low-risk illicit psychoactive substances increased in adults
4. Prevalence of risk consumption of alcohol / illicit psychoactive substances in adults
5. Prevalence of harmful consumption of alcohol / illicit psychoactive substances in adults
6. Prevalence of delivery of brief interventions for alcohol / illicit psychoactive substances / gambling
7. Prevalence of probable dependence for alcohol / illicit psychoactive substances / gambling in adults
8. Prevalence of referral to specialist consultation for alcohol / illicit psychoactive substances / gambling
9. Average time between referral and first consultation for alcohol / illicit psychoactive substances / gambling
10. Percentage of referral clients that return to PHC Services after referral and completion of treatment in specialized services, for alcohol/ illicit psychoactive substances / gambling

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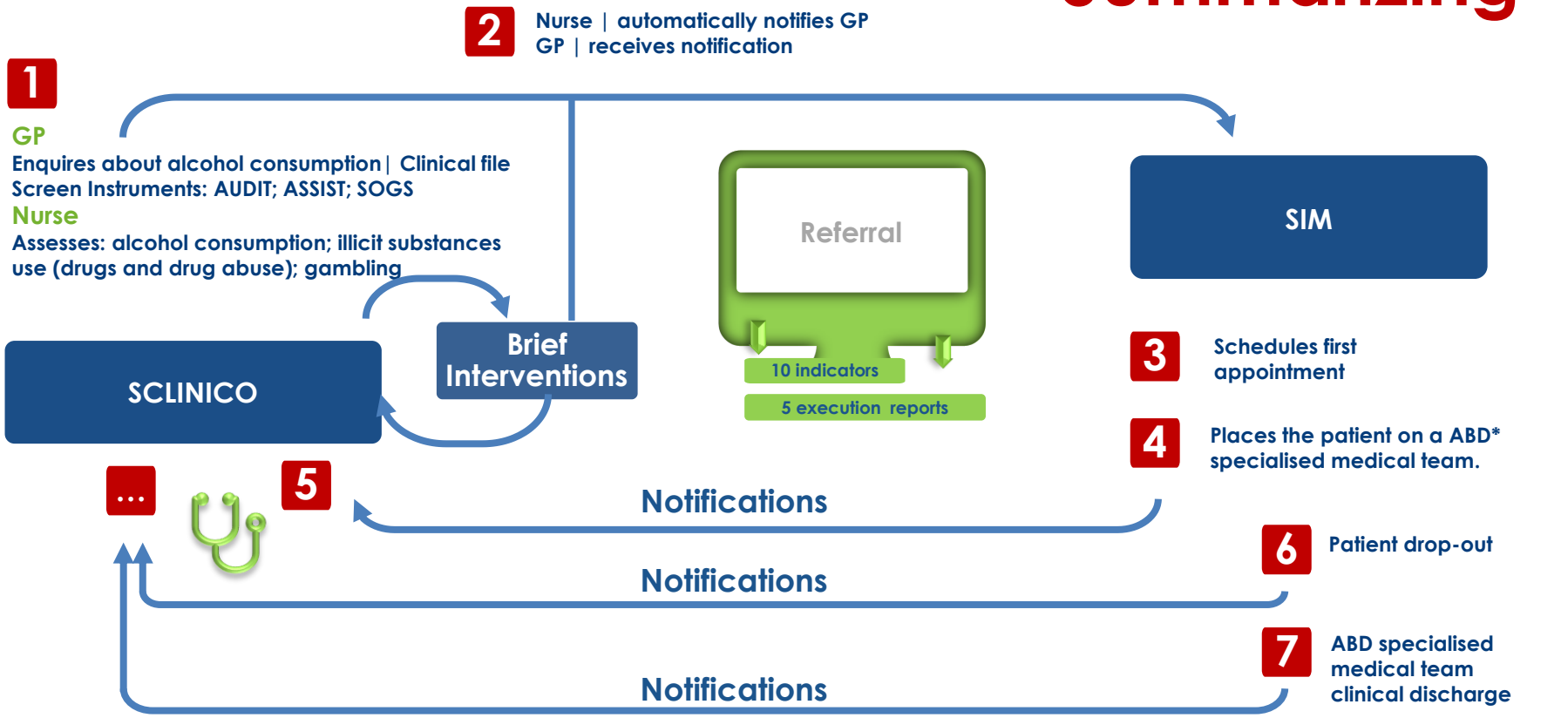
Summarizing



**Addicted Behaviours And Dependencies*

Thank You! ☺!

Manuel Cardoso

manuel.cardoso@sicad.min-saude.pt

SICAD Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências
TELEF: +351 211 119 000 | EMAIL: sicad@sicad.min-saude.pt

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- Introduction
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Discussion / debate

- Should governments invest in large-scale implementation projects?
  - Balance and mix between individual and societal level interventions investments? https://www.thespiritsbusiness.com/2019/09/minimum-unit-pricing-cuts-alcohol-spending-in-scotland/
  - What are the main arguments (efficacy/effectiveness/cost-effectiveness, relative advantage of BI in front other practices/ compatibility and consistency with context and needs / are results visible to the users?) we can use to promote it?
- If wiling to do so, how they should do it? What approach and adaptations should they have to do? What are the key issues they have to have in mind (implementation research, drinking culture / drinking habits of professionals – PHC practice culture and habits)?
- How can we ensure the sustainability of the BI strategy ?
  - Are electronic/web-based tools helpful and how can they be used in PHC?
- How can we ensure balance between fidelity (are SBI implemented adequately) and adaptation to a real-world practice?
- What potential barriers (professional/technical/organizational) are expected and how could we overcome them ?
- What is the best way to evaluate the strategy? What output/outcome indicators?
- What type of factors might ensure the translation of BI strategies in different countries, circumstances and settings?

Thank you for your attention!

DEEP SEAS

DEVELOPING AND EXTENDING EVIDENCE AND PRACTICE FROM THE STANDARD EUROPEAN ALCOHOL SURVEY