What countries can learn from the Scottish and Catalans when implementing Alcohol Brief Interventions
Scotland
Debbie Sigerson
Niamh Fitzgerald

Catalonia
Joan Colom
Lidia Segura
Estela Diaz
Jorge Palacio-Vieira
Carla Bruguera
Antoni Gual

Portugal
Manuel Cardoso
Patricia Pisarra
Graça Vilar

NHS Health Scotland

CLÍNIC BARCELONA
Hospital Universitari

SICAD
Introduction

The Catalan and the Scottish experience

Portugal pilot: work plan

Open discussion / debate
- Introduction
- The Catalan and the Scottish experience
- Portugal pilot: work plan
- Open discussion/debate
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).
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 establishing an **effective information technology system** to record and give feedback are key (Niamh Fitzgerald., 2015)
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.
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.
Introduction

The Catalan and the Scottish experience

Portugal pilot: work plan

Open discussion/debate
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 of 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 established treatment network of centers and professionals specialists in alcohol and ready to receive referrals from other health services
WHAT FOR?

- 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)

Scotland

Catalonia
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)?

1995-2002: Phase III WHO Collaborative project

2002-2006: Start Implementation (alcohol specialists)

2006-2009: Continue Implementation (alcohol referents)

2009-2016: Start Implementation (peer-to-peer)

2016-2019: Start Implementation (on-line training and updating alcohol referents)

2008: Start in Scotland the ABI program

2015: Evaluation

2018: Major review
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'
‘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.’
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](https://www.count14.scot)

- 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)

**Catalonia**

- 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%).
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 good things
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
Introduction

The Catalan and the Scottish experience

Portugal pilot: work plan

Open discussion/debate
MANUEL CARDOSO
DEPUTY GENERAL-DIRECTOR . SICAD

General-Directorate for Intervention on Addictive Behaviours and Dependencies

SEPTEMBER 2019
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.
Relationship among levels of consumption, risk and intervention in the field of CAD


Eligible PHC patients
Ask permission to screen

AUDIT - C

Positive

ASSESSMENT AUDIT and ICD-10

Hazardous / harmful drinker

Ask permission to feedback and advice

Brief Intervention

Face-to-face BI + leaflet
e-BI + leaflet

Referral to treatment

Booster session and follow-up

Negative

Leaflet

If permission is not given, offer leaflet and inform of the possibility to discuss about alcohol in the future

Model of delivery will depend on professional and patient shared decision

Screening and brief intervention proposal
Training for Trainers

BI Specialists

56 (MD and Nurses)

5 ACES

Training for local group of Primary Health Care Units (ACES)
How does it work

Application of the questionnaires

• AUDIT
• ASSIST
• SOGS

SIM

= SCORE

Brief intervention

Medical appointment

PATIENT

SCLINICO

Notifications

Notifications

Medical discharge
Questionnaire application: AUDIT

Clinical algorithm*

AUDIT-C Questions 1, 2, 3

≥ 5 points

Add questions 4 to 10 on AUDIT

Yes

≥ 4 points

No

Screening every 4 years

≥ 8 points

No

Yes

Rate consumption level

Risk Consumption (8 to 15 points)

Harmful consumption (16 to 19 points)

Dependence (≥ 20 points)

Counseling

Brief Intervention Follow-Up

Reduce consumption

Follow-Up

Yes

No

Referral to specialized consultation, effective within 60 days

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
GP
Enquires about alcohol consumption
Clinical file
Screen Instruments: AUDIT, ASSIST, SOGS
Nurse
Assesses: alcohol consumption; illicit substances use (drugs and drug abuse); gambling

Referral

Notifications

Brief Interventions

Notifications

Notifications

Notifications

SCLINICO

SIM

1

2
Nurse | automatically notifies GP
GP | receives notification

3
Schedules first appointment

4
Places the patient on a ABD* specialised medical team.

5
... Places the patient on a ABD* specialised medical team.

6
Patient drop-out

7
ABD specialised medical team clinical discharge

*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
www.sicad.pt

LISBON ADDICTIONS 2019
Third European Conference on Addictive Behaviours and Dependencies

Reserve na sua agenda!

📅 23 – 25 October 2019
📍 Lisbon Congress Centre, Portugal
🌐 www.lisbonaddictions.eu
遑 #LxAddictions19
- Introduction
- The Catalan and the Scottish experience
- Portugal pilot: work plan
- Open discussion / debate
Discussion / debate

- Should governments invest in large-scale implementation projects?
  - Balance and mix between individual and societal level interventions investments?
  - 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 willing 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!