

**WHO COLLABORATIVE PROJECT ON IDENTIFICATION AND
MANAGEMENT OF ALCOHOL-RELATED PROBLEMS IN PRIMARY
HEALTH CARE: PHASE IV - DEVELOPMENT OF COUNTRY-WIDE
STRATEGIES FOR IMPLEMENTING EARLY IDENTIFICATION AND
BRIEF INTERVENTION IN PRIMARY HEALTH CARE**

CHAPTER 5

CATALONIA

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5.1. Introduction

5.1.1. General information

Catalonia is one of 17 autonomous communities in Spain with an area of 32,000 km. It is located at the north-east coast of the country. At the end of 2001 the Catalan population was 6,506,000, of whom 3,318,000 (51 %) were female and 310,307 (4.8%) legal foreign residents. The age distribution of the population was: 13.8% under 15, 68.8% between 16-64 and 17.4% over 65 years old. The population density was 204 inhabitants/km². Unemployment rate was 9%. The proportion of the population with tertiary studies was 18%.

In 2001, Catalonia had 5 beds and 4.7 doctors per 1,000 inhabitants. GDP per inhabitant was €20,120¹. Life expectancy at birth was 76.8 years for males and 83.4 for females. Life expectancy without disabilities was 66.8 for males and 69.0 for females. For men and women respectively, mortality rates related to neoplasia were 34% and 22%, related to the circulatory system 28% and 37% and related to the respiratory system 13% and 10%. Infant mortality rate (per 1,000 live births) was 3.2. Life expectancy in Catalan men is reduced by car accidents, cancer of the trachea, bronchi and lung and cardiovascular diseases. In women life expectancy is reduced by breast cancer, followed by car accidents and cardiovascular diseases².

5.1.2. Organization of health services

The *Generalitat* is the institution under which the self-government of Catalonia has been politically organised since democracy was restored in 1977. The Government of Catalonia is divided into departments and the Health and Social Security Department is responsible for health. The Catalan Parliament is authorized to legislate on all aspects of health. The Catalan health care model was established in 1990 under the LOSC (the Health Care Organisation of Catalonia Act). The LOSC created the Catalan Health Service (CatSalut), consolidated a mixed health system, organized all areas of health care services and integrated the public use of all health resources (hospitals, primary health care, mental health, etc.) into a single network. CatSalut is the cover provider of health services in Catalonia and guarantees their provision to the public. CatSalut plans, purchases and evaluates health services according to the population's needs. CatSalut purchases services from its various providers, of which the Catalan Health Institute (ISC) is the main example, through the use of contracts that state the health objectives and services being bought. The Catalan health system is a publicly-funded system with comprehensive coverage and which all the citizens of Catalonia are able to access.

Primary Health Care (PHC) is the citizen's first level of access to the health care system and there are 345 PHC centres disseminated around the territory. 82% of PHC centres are managed by the ISC while the rest are managed by private organisations. PHC centres are composed of multidisciplinary teams and integrate health promotion strategies with preventive and curative interventions. There were 36 million PHC visits during 2002 and the mean number of consultations per inhabitant per year was 6³. In an evaluation study in PHC settings it was found that the total number of patients visited by professionals is about 2,000 (700-2,800) and the mean visits per week 126±62⁴.

Specialist health care is the citizen's second level of access to the health care system. It includes hospital admissions, social health, psychiatric and mental health care, drug dependency and pharmaceutical care. Most of these resources are organised in complementary networks. In 2001 Catalonia had 65 hospitals (17 with psychiatry units and 11 with hospital-based detoxification units), with 15,000 beds admitting 664,000 inpatients, 9 million outpatient visits and 3 million emergencies³.

5.1.3. Alcohol consumption and alcohol-related problems

In 1989 the Program on Substance Abuse was created in the Health Department mainly to direct and manage services and propose or resolve governmental concerns within the area of substance abuse. A Catalan Drug Addiction Network (CDAN) with 60 centres was organized to offer different treatment modalities (methadone maintenance, etc.) to all dependent patients⁵.

Catalonia has developed a particular model to deal with alcohol-related problems within the framework of a global strategy on drug dependencies. Excessive alcohol consumption has always been considered a major public health problem and a priority by the Catalan Health Strategy. In the current Health Plan for Catalonia (2002-2005) alcohol appears as one of 20 main priorities and there is a whole chapter devoted to tackling the problems derived from the risky consumption of alcohol⁶. Alcohol consumption is rated third as a risk behaviour factor for health, causing 5.5% of total mortality⁷. Other studies indicate a total of 6.6% of annual mortality⁸.

Annual per capita alcohol consumption has decreased in the last 10 years and has stabilized at around 10 litres pure alcohol per inhabitant per year⁶. As in other Mediterranean countries, wine consumption is culturally rooted in Catalan nutritional habits. In 2002 pure alcohol consumption in litres per capita was 10.49 litres (12.25 for age 15+); of this 2.4 l was spirits, 4.3 l wine and 3.8 l beer⁹. In the European league table (of 15 countries), Spain is in the last position for the percentage of people who have drunk alcohol in the previous month, in 3rd place regarding the number of days on which alcohol was drunk, and in 11th place regarding number of drinks per day¹⁰. According to the World Drink Trends, in 2002, Spain was located in 8th place in alcohol consumption¹¹.

In 2003 the prevalence of any alcohol consumption in the last month was 67.7% in the Catalan population (15-65 years) and 72% among younger people (15-29 years). The prevalence of risky drinkers was 9.5% (11.8% males and 7.8% females) of the Catalan population between 15-65 years. Among those between 15-29 years, 12.7% were risky drinkers (12.1% males and 13.3% females)¹². In short, alcohol consumption patterns are now more similar to other European

Countries, females have increased their alcohol consumption and young people drink mostly during weekends and in leisure activities, and drink more beer than wine.

In 2002, 5,619 (44.2%) of patients treated in the Catalan Drug Addiction Network (CDAN) showed alcohol problems: 79% males, mean age 42.9 years, 56% with primary education and 47% employed⁵. In 2002, 85% of total emergencies caused by drugs were related to alcohol¹³. In 2000, 562 (41.2%) of the total of 1,363 alcohol tests carried out following fatal car accidents in Spain were positive for alcohol. In 2002, in 17.8% of the 11,135 alcohol tests carried out after a car accident, the driver had consumed alcohol¹⁴. In 1999 the figure for annual health and social costs of alcohol to Catalonia was €570 million⁸.

5.1.4. Previous research on brief alcohol interventions

Over the last 10 years substantial research has been carried out in Spain on brief interventions. Efficacy and effectiveness have been evaluated in a range of studies¹⁵⁻²⁰. The results of a recent meta-analysis support the efficacy of brief intervention for excessive drinkers in Spanish PHC settings²¹. The effect size found for the decrease in alcohol consumption was $d=-0.46$ (95% CI, -0.29 to -0.63; $p<0.0005$) and the intervention group outperformed the control group by 22%. For the decrease in the frequency of excessive drinkers the effect found was $OR=1.55$ (95% CI 1.06 to 2.26; $p=0.02$) and the intervention group outperformed the control group by 11%. In the meta-analysis by Ballesteros and colleagues²², SBI worked better ($OR 1.54$, 95% CI 1.26 to 1.89, NNT 12, 95% CI 8-20) and results were similar among males and females ($OR 2.32$; 95% CI = 1.78-2.93 y $OR 2.31$; 95% CI = 1.60-3.17; respectively)²³. A dose-response effect was not found.

5.2. Customisation

Catalonia has developed a specific strategy to provide adequate training and support to PHC professionals to implement SBI in their daily clinical work. A training-the-trainers program targeted at professionals from the addictions field was delivered in two consecutive workshops. Specialists then became responsible for delivering training and giving sustained support to PHC teams. Before holding the training workshops, preliminary activities, such as the translation of an SBI package of materials, validation of screening instruments and 3 focus groups with PHC professionals (GPs, nurses and health planners) aimed at adapting materials to local needs, were completed. The training process and the design of the training package ran in parallel in a two-step procedure. The program was entitled *Beveu Menys*, the Catalan translation of Drink- less.

5.2.1. Early identification (screening) package

The AUDIT questionnaire has been validated in both the official languages of Catalonia (Catalan and Spanish)²⁴⁻²⁵. Additionally, a Systematic Interview on Alcohol Consumption (SIAC) was developed with 3 quantity-frequency questions and validated to detect risky drinking in PHC settings²⁶. Later, the AUDIT-C²⁷ was also validated. All instruments showed acceptable sensitivity and specificity levels for the cut-off scores recommended by WHO to detect hazardous and harmful drinking. All screening tools have been included in the intervention package and their selective or systematic use is decided by each PHC centre.

5.2.2. Brief intervention package

Three different focus groups (FGs) with PHC professionals were held in order to provide feedback on the PHC view of alcohol issues. These focus groups were attended by PHC nurses (1st FG), GPs who participated in the Drink-less programme during Strand 3 of the WHO Phase III project (2nd FG) and PHC Centre Coordinators (3rd FG). FGs addressed the following issues: a) qualitative analysis of the Drink-less package, b) changes to be introduced, c) guidelines for community action, d) the role of each professional, e) how to improve patients' acceptance of the package, and f) how to minimize resistance from professionals.

FG recommendations were taken into account and, together with the basic module and the Alcohol Module of the Skills for Change package²⁸, constituted the main documents to be discussed in FGs during the trainers' workshops. The aim was to develop, through FGs and workshops, a specific Catalan training package customised to the trainers' and trainees' needs.

5.2.3. Training the trainers

The choice of Addiction Specialists as trainers was made because of their high degree of interest and motivation in the field and their skills in alcoholism treatment. In addition, the similar geographical distribution of the networks (specialists and PHC) facilitated team co-ordination and contributed to stimulating interest in and maintenance of the interventions. Through motivational techniques, the training process aimed to strengthen the professional's commitment to training GPs and to identify barriers that might interfere with the training process. The complete training strategy was developed in two stages and under 3 main principles:

- Use the Stages of Change model and motivational strategies, not only to approach patients but also to approach change in the whole health system (GPs, trainers, Health Authorities, etc.);
- Enable changes in the design and allow maximum flexibility and customisation in order to make trainers as comfortable as possible with the training package;
- Follow directions established by the Phase IV Co-ordinating Centre in Newcastle.

Training the trainers: first stage

Two intensive one-and-a-half-day workshops, with 30 participants each, were held in Sitges (Barcelona) aimed at:

- introducing trainers to the philosophy of the Skills for Change package;
- identifying barriers and roadblocks for implementation;
- reaching consensus on the model of intervention with allowance for personal customisation.

The two workshops were organized with identical aims and similar agendas but progress made in the first workshop was used to modify the starting-point for the second. Whereas the first was aimed mainly at addressing the usefulness of the Skills for Change package, the second was aimed at designing our customized training package.

The first workshop was held in December 1998 with 30 physicians, lasted one-and-a-half working days (14 working hours) and was sponsored by the pharmaceutical industry. The agenda included:

WHO COLLABORATIVE PROJECT PHASE IV

- Introduction and presentation by the General Director of Alcohol Policy in Catalonia, the scientific evidence for the efficacy of SBI in the alcohol field, the results of the previous WHO study (Phase III) and the future Phase IV strategy;
- Four parallel FGs organised during the one-and-a-half hours to shed light on the following issues: should CDAN physicians train GPs? how can CDAN co-ordinate with PHC Centres? is shared care a feasible option? what are the needs of the CDAN in training and supporting PHC centres?
- Presentation and revision of the Skills for Change package (relevant chapters and practical exercises) and the theoretical basis of the Stages of Change and of motivational interviewing strategies. Comments from participants were carefully recorded and suggestions taken into consideration in order to introduce changes to some of the exercises and to decide which would be suitable for the final version;
- Summary and discussion of the main findings of the 4 FGs;
- Proposal and discussion of the intervention model (training package) structured in 4 one-hour sessions to be delivered weekly over one month in PHC centres and with the following contents:
 - Introduction: project aims, impact of alcohol consumption on society, on the health system and in the PHC Centre, drinkers' classification (degrees of risk and levels of intervention)
 - Risky drinking: definition, screening tools and clinical approach (brief interventions)
 - Alcohol Dependence Syndrome (diagnostic criteria, treatment protocols in PHC, criteria for referral and shared care)
 - Co-ordination procedures between PHC and specialist teams
 - Agreement on level of implementation of SBI in this particular PHC Centre.

Conclusions reached from the workshop were, in summary:

- i. More work was needed to fit the training package to PHC needs and facilities
- ii. Training should be directed to the PHC team as a whole
- iii. Every PHC centre should have someone responsible for co-ordinating training and follow-up
- iv. Training should be interactive and based on the Skills for Change package
- v. Meetings to introduce the project should be arranged in every county
- vi. Pilot training interventions should be held before widespread training
- vii. Training materials need to be strongly adapted to our social context
- viii. Special attention should be paid to communication between PHC centres and the CDAN
- ix. Special emphasis must be placed on detecting and resolving resistance coming from both sides
- x. All professionals in the CDAN (psychologists, social workers, nurses and doctors) should be able to participate in the training sessions
- xi. This program should be included in the contracts that the Catalan Health Services establishes with Health Regions and PHC Centres.

The structure of the second workshop was informed by the recommendations reached during the first. Main differences between workshops were:

- A. Fewer GPs were invited to attend. Their opinions about the suitability of the program and the design and customization of the training package were important. The workshop was also attended by 4 psychologists and one policy-maker from the Catalan Health Service (CatSalut).
- B. Focus groups were aimed at discussing different topics and practical issues. Five groups were run covering the following topics:
- a. Advantages and disadvantages of working with PHC teams
 - Advantages:
 - better relations with PHC improve practice with risky drinkers and alcoholics
 - less inappropriate referrals and better treatment options for patients
 - the opportunity to integrate with the Drugs Network in the Health System
 - improvement of shared care treatment.
 - Disadvantages:
 - excessive expectations that might lead to frustration
 - possible overload by systematic referral.
 - co-ordination and ongoing support might be time-consuming
 - the focus on alcohol might lead to reduced interest in other drug users.
 - b. What should Health Authorities do to facilitate dissemination of SBI in PHC settings? What can be done by addiction specialists? Health Authorities have a definite role at 3 levels: PHC, CDAN and mass media. At the PHC level alcohol should be part of contracts, CDAN facilities should be more publicized and the CDAN itself should be fully integrated with the Health System. At the CDAN level, special attention should be paid to facilitating communication between CDAN and PHC teams, and training work with PHC should be funded and fully acknowledged as part of routine activity. At the mass media level, campaigns to promote population changes in drinking habits should be promoted, with special emphasis on the risky drinking concept. On the other hand, addiction specialists should make an effort to improve their co-ordination with PHC teams, trying to acquire a better knowledge of PHC and demonstrating clearly the activities and characteristics of the CDAN.
 - c. Barriers and roadblocks in addiction specialists. How can they be removed? Reluctance on the part of CDAN professionals could come about for several reasons: lack of confidence in training capacities, different 'languages' used, fear of receiving too many referrals, perception of lack of interest in primary prevention in PHC, fear of rejection, and fear of weak support from Health Authorities to implement the program. To overcome these barriers, several solutions were proposed: The program should be strongly supported by Health Authorities, including a public presentation; it should be included in contracts; training of CDAN professionals is essential; specific funding for these activities is required.

- d. Barriers and roadblocks in PHC professionals. How can they be removed?
PHC professionals may be reluctant to accept the efficacy of SBI. They may fear the work overload the program could produce. Assessing risky drinkers might uncover alcoholics. There is some confusion between alcoholism and risky drinking. Treating alcohol problems generates defensiveness. Strong support from CDAN should be provided to PHC teams.
- e. How to set clear criteria for treatment or referral in PHC?
Clear and consistent referral criteria should be defined. GPs should be able to refer any patient they think they should. No waiting lists should exist. Shared care would probably help to clarify referral guidelines.

C. The Skills for Change session was shortened and the contents of each training session and guidelines for the 'Session Plan' sheets were agreed. Agreement was also achieved on the duration of training sessions (one hour) and their delivery as regular Continuing Medical Education sessions in each PHC centre.

Evaluation

As part of the design, evaluation of the training procedures and of professionals' attitudes was completed at the end of every workshop and results from 57 participants were obtained. 70% of the trainers thought that training PHC teams in SBI was very important and they were willing to do it. 75% of professionals from the CDAN thought that being a trainer of PHC team was important work, and 88% had a very high degree of interest in becoming trainers. GPs and nurses were seen as the essential targets, although social workers were also to be taken into account. 93% of addiction specialists agreed that they were in good position to train PHC teams, and 79% also believed training should be conducted in group sessions. Consensus was not reached on which professionals from the CDAN should act as trainers but, in the focus groups conducted with GPs, it was stated that doctors working in a CDAN were seen as better trainers than other professionals in the CDAN. An ability to link training with support and referral appears to be the underlying reason for choosing doctors as the best trainers.

The number of hours that should be used to train and support PHC teams appeared as one of the possible barriers to overcome. Even though it was planned to dedicate 5 hours to training, most trainers thought this was not enough. In fact, 75% of trainers thought that 7 or more hours were needed for training, and 67% thought that providing support would also require more than 7 hours per year. Finally, the workshop was seen as a good way to train the trainers. 100% of the participants found the workshop very useful, rating the contents and the methodology as good or very good in more than 90% of cases. The Skills for Change Package was also accepted by 84% of the participants, although quite a few adaptations were suggested.

Training the trainers: second stage

Information collected in the previous meetings was used to design the definitive package and model of intervention and to allow personal customisation without changing any essential aspect of the package. The final edited package contains documentation for the trainer (didactic guide, 36 overheads, CD-Rom with all materials and CD-Rom with examples) and for the trainee (Handouts and SBI package). The SBI package includes general guidelines, AUDIT and ISCA questionnaires with templates, a management guide, diagnosis and intervention flowcharts, self-help booklets and posters and leaflets for the waiting room.

The training sessions finally agreed were 5: 1) Alcohol and PHC (introducing the Drink-Less Program); 2) Risky drinking and screening tools; 3) Brief interventions for risky drinkers; 4) Diagnosis and treatment of the Alcohol Dependences Syndrome; 5) Action plan and co-ordination strategies (treatment policies, referral criteria). Although trainers suggested the need to increase the number of training sessions, reluctance by PHC teams to dedicate more time to alcohol and budget limitations were the main constraints.

In a second stage of the training-the-trainers strategy, alcohol specialists were trained in small groups (8-10) in how to use the final training package. A total of 7 half-day workshops were held in the Program on Substance Abuse.

In summary, data collected from workshops, together with evaluation results and the package design, showed that the methodology used was suitable to begin the dissemination process of SBI in PHC in Catalonia.

5.3. Reframing

In Catalonia the reframing of alcohol concepts is a huge task because consumption of alcohol, especially wine, is rooted in the culture and even seen as a healthy habit. There are still some social prejudices against those with alcohol problems that also influence the attitudes of health professionals. In recent years, the work of the CDAN in making treatment for alcohol dependence available to all citizens, the work on brief interventions conducted by some PHC organizations, and the targets for alcohol consumption set by the Catalan Health Plan have consistently contributed to a better understanding by health professional groups of the reframed alcohol concepts (risky drinkers, hazardous and harmful drinkers, excessive drinkers, etc.) and the rationale for SBI. There is still much to be done towards changing general public's perceptions and attitudes to alcohol.

The communications strategy in Catalonia was linked to the Demonstration Project and specially targeted at health professionals groups (specialists and PHC professionals) and the general public. Addiction specialists who acted as *Beveu Menys* trainers attended a workshop on *Beveu Menys* SBI concepts and techniques and were able to attend additional workshops to improve their communication skills aimed at changing behaviour and attitudes. As part of the communications strategy aimed at disseminating SBI to specialists, in May 2003 we launched a monthly *Beveu Menys* Bulletin targeted at professionals, containing relevant information on the project and contributing to reframing by including and updating relevant evidence-based studies of SBI methods.

User-friendly PHC professionals' packages were developed to include complete information aimed at reframing alcohol concepts and at convincing them of the widespread damage to public health and welfare from risky drinking and of their responsibility for detection and intervention.

No widespread mass media campaign targeted at general public has yet been delivered but a communication strategy has already been implemented by including messages on posters and leaflets in waiting rooms. Messages on the concept of risky drinking according to gender differences and slogans aimed at encouraging the general public to ask their GP about their drinking behaviour have been included. Alcohol consumption limits and the idea that assistance can be provided have been also strongly reinforced.

Media advocacy was also encouraged by inviting all journalists in the region to a press conference some days before the official launch of the project (November 2001). The conference was aimed at introducing the new project, increasing the media's interest in alcohol-related issues and encouraging them to promote the concept of risky drinking in their work. Over the last two years no additional media advocacy has been possible.

The communications strategy and the specific messages were evaluated as part of the evaluation of the Demonstration Project by pre- and post-strategy measures of the extent to which respondents understood and accepted the concept of risky drinking and other related matters. Among the general public, face-to-face interviews were conducted in a random sample obtained in PHC settings. Among health professionals, mailed questionnaires and personal interviews were used to record changes in attitudes to SBI and risky drinking. Data from the evaluation have not yet been analyzed but the need to carry out a media campaign targeted at general public with specific messages aimed at youth is being considered. No decision on this has yet been made.

5.4. Building Strategic Alliances

The successful dissemination of the project in the whole of Catalonia can be explained by the fact that the leading organization is the Health Department itself. The features of the Catalan Health System and the roles of health institutions were also well-known and have been taken into account since the beginning. The main alliances were aimed at bringing together individuals and organizations with a common interest and included institutions that play an essential role in the Catalan Health System to assure the implementation of the project:

- Catalan Drug Addiction Network
- Catalan Health Service (CatSalut)
- Catalan Health Institute (ICS)
- Continuous Health Education Institute (IES)
- Spanish Scientific Society on Alcoholism (Socidrogalcohol)
- Catalan Scientific Society on Family Medicine (SCMFiC)

The Program Substance Abuse of the Health Department of the Autonomous Government of Catalonia is the leading organization and has funded the entire project. It has been received

advice since the beginning by one of the major Spanish scientific societies in the addictions field, the Spanish Scientific Society on Alcoholism (Socidrogalcohol). Since the start of the project, the *Beveu Menys* executive team has been lead by Dr. Joan Colom (Director General) and Dr. Antoni Gual (Public Health Consultant and expert in the alcohol field) with the support of the Program on Substance Abuse technical and administrative members (Lidia Segura, Olga Montserrat, Claudia Fernández, Montserrat Rodriguez and Encarna Moreno).

One of the first decisions taken was to establish a co-operative relationship regarding SBI with all centres of the Catalan Drug Addiction Network and their health professionals and specialists on addiction. A total of 60 centres were involved and around 83 professionals (psychiatrists, psychologists, nurses and social workers) have worked as trainers and also proved to be useful in the wider, country-wide dissemination effort to all PHC centres and professionals.

At the same time, and since Catalonia joined the WHO series of projects in 1998, the Program on Substance Abuse developed, adopted and promoted a plan to endorse the dissemination of the SBI techniques among PHC and other settings by including the *Beveu Menys* objectives as risk reduction targets and prevention activities in the alcohol chapter of the Health Plan for Catalonia. The Health Plan states the objectives and the services being bought during that period, so by including the *Beveu Menys* aims purchasers (Catalan Health Service) and service providers (Catalan Health Institute) have been forced to look forward to the achievement of those targets through the establishment of contracts. The CatSalut has the power to vary the reward structures and conditions of service in PHC. The alliance built with the Health Education Institute (IES) allowed the accreditation of the *Beveu Menys* course by the Catalan Council for Continuous Medical Education (CME) and assured the financial reimbursement and professional accreditation of the trainers and the accreditation of the trainees.

The alliance with the Catalan Scientific Society on Family Medicine (SCMFiC) provided support and legitimacy since it is seen by GPs as 'their' scientific society. Special attention has been paid to acquire the reputation of a laboratory of learning where PHC professionals can find research evidence on SBI in a user-friendly form and associated materials.

The building of strategic alliances is an evolving process and will continue until an effective implementation of SBI in Catalonia is reached.

5.5. Demonstration Project

The Demonstration Project started on November 2001 and is expected to be finished by the end of 2005. It is aimed at achieving a widespread dissemination of SBI methods to all PHC settings and professionals in Catalonia following the guidelines of the *Beveu Menys* Program. The demonstration was initially planned in 3 different stages and centres were randomly assigned to receive training in the first (2002), second (2003) and third stage (2004) but the recent reorganization of PHC services has enlarged the network with 48 centres and has compelled us to plan a new stage (2005).

A communication strategy was organized in order to start the dissemination process:

- The Official Presentation was held on 21 November 2001 and all relevant stakeholders (health authorities, PHC coordinators, addiction specialists, media and policy makers) were personally invited.
- Written Communication announcing the start of the dissemination was delivered to:
 - all health stakeholders, with detailed information on the procedure that was planned
 - PHC co-ordinators, with detailed information about the program, the consequences for their centers and the procedures planned. They also received a complete BM package.
- A BM co-ordinator visited all centres in the Catalan Drug Addiction Network to introduce the final package and to discuss with trainers the dissemination procedure planned and the list of PHC centres assigned.

To reinforce professionals and to guarantee the sustainability of the dissemination procedure BM courses were also declared of Medical Interest and, as a result, their acceptance by all participants was facilitated. Additionally, funds were raised to pay for training carried out by the specialists (€300 per course).

5.5.1. Procedure

According to the geographical distribution of health services in Catalonia, each centre in the Catalan Drug Addiction Network was asked to train those PHC centres located in their area that usually referred patients to them. Training courses were delivered in 5 hours, following the guidelines of the BM package, but trainers were allowed to customize it regarding their and PHC professionals' preferences, resources and needs. Courses were originally scheduled for between 14-15 hours (the time usually dedicated to CME in all PHC settings) but trainers' flexibility was encouraged to adapt training to PHC centre needs.

To schedule courses the following procedure was established:

- A. The CDAN professionals contact the PHC centres assigned to negotiate the most suitable dates for the course.
- B. Agreed dates and total list of participants are notified to the BM coordinator at least one month before the start of the course.
- C. BM coordinator sends the following documents:
 - i. To the trainer:
 1. A list of participants and a registration sheet for signatures (attendance is proved by the signature)
 2. A questionnaire evaluating the training course (quantitative and qualitative data)
 - ii. To the PHC coordinator:
 1. BM packages for all participants
 2. A set of materials addressed to patients (3 posters and 20 leaflets)
- D. Once the course is finished, evaluation documents and registration sheets are sent back to the BM coordinator. Accreditation for all participants who attended at least 80% of the course and certificates for those who attended less than 80% are then sent. At the same time trainers' reimbursement and accreditation are arranged.

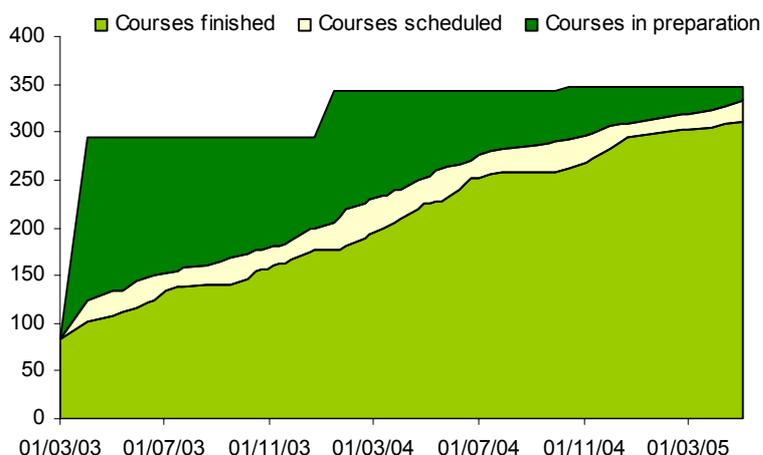
To encourage the scheduling of courses and the use of materials and to overcome roadblocks, new marketing and creative strategies were launched during 2003:

- A “Beveu Menys” Bulletin has been targeted at general practitioners and specialists and is published monthly by electronic mail. Contents include Drink-less news, dissemination data, information on alcohol, news in the media, courses and activities, articles in scientific journals and interviews with to professionals.
- Telemarketing targeted at PHC coordinators and BM trainers. This has contributed to the continuous updating of the database and to raising awareness.
- PHC proposals for Course Dates are proposed to trainers who can then fit them into their diaries.

5.5.2. Evaluation

Figure 5.1 shows the status of the training dissemination to date. Up to 5th May 2005, 325 (93.6%) courses had been conducted. A total of 5,823 PHC professionals (48% nurses, 42.1% GPs, 2% paediatricians, 1.4% physicians in education, 1.6% social workers and 4.9% other) have been trained and 76.5% of these have been accredited. Progress at the start was difficult but the rate of dissemination is steadily increasing; courses are welcomed by PHC professionals, trainers’ perceptions are positive and participants’ attendance is maintained through all sessions. The course structure preferred on 44.6% of occasions is 5 sessions.

FIGURE 5.1.
Training Dissemination Status



A parallel, ongoing, pre-post evaluation procedure has been implemented in 10% (n=28) of randomly selected centres but at present only baseline results are available. Two researchers were trained to sample data before and 3 months after the dissemination of the program. Variables measured were attitudes, knowledge and behaviour of both patients and PHC professionals. Attitudes and knowledge were measured through questionnaires and behaviour through audits of medical records in which clinical procedures are registered. Additional sources of information taken into account are the number of consultations for alcohol problems to the CDAN centres and the number of referrals from PHC centres. Sources of information comprised 973 (87% of the total planned) patients’ questionnaires, 80% (95%) GP and nurses interviews and 851 (101%) medical records audits.

32.2% of professionals were males and 68.8% females, with a mean age of 44.33 (\pm 8.54); 55% were physicians and 45% nurses. Mean years of experience in PHC settings was 14.09 (\pm 7.99), mean number of consultations per week was 125.88 (\pm 62.16) and the mean number of patients quoted was 1,982.72 (\pm 361.29). 48.8% had less than 4 hours training in the alcohol field and 48.7% used their clinical impression for screening. Regarding alcohol consumption (measured with AUDIT-C), 8% of males and 14.5% of females were risky drinkers. There is a gap between practitioners' perceptions and reality in terms of the importance of alcohol as a health determinant, they do not have enough training on alcohol prevention programs and they are not used to standardized instruments.

Medical records of 852 patients were randomly selected. 33.3% were from patients who attend PHC settings very often (once a month or more) and 36% were from patients who attend approximately once every 3 months. Alcohol consumption was registered in 26.4% of cases in 27.3% alcohol consumption had been screened by clinical impression. Risky drinking diagnosis (3.2%) were registered, less than suggested by the prevalence shown in surveys (9.5%) and brief interventions and shared care treatment were infrequent

Patients interviewed were a mean of 52.81 (\pm 18.57) years old; 35.8% were males, 28.3% were pensioners and 22.2% were housewives. 51.1% had never been questioned regarding their alcohol consumption and 30.4% had been questioned over one year ago. WHO limits on alcohol consumption were unknown for all patients interviewed. 18.3% of patients were risky drinkers (assessed by AUDIT-C).

When comparing Risky Drinkers (RD) with Non-Risky Drinkers (NRD) (see Tables 5.1 and 5.2) we found significant differences in gender, work status, familiarity with the centre, being screened and receiving advice.

TABLE 5.1.
Sociodemographic characteristics of patients

		NRD	RD	Analysis	
		N (%)	N (%)	X ² (gl)	Sig
Gender	Male	264(76,3)	82(23,7)	10,41(1)	<0,001
	Female	525(84,7)	95(15,3)		
Age	15-35 years	177(79,7)	45(20,3)	5,53(3)	0,14
	36-55 years	220(79,4)	57(20,6)		
	56-75 years	295(82,4)	63(17,6)		
	>76 years	97(89)	12(11)		
Education	Primary	521(82,2)	113(17,8)	1,46(2)	0,48
	Secondary	180(78,9)	48(21,1)		
	Tertiary	72(83,7)	14(16,3)		
Work Status	Pensioners	230(85,2)	40(14,8)	20,66(4)	<0.0001 ⁽¹⁾
	Students	16(84,2)	3(15,8)		
	Housewives	189(87,9)	26(12,1)		
	Unemployed	24(92,3)	2(7,7)		

WHO COLLABORATIVE PROJECT PHASE IV

	Employed	324(75,5)	105(24,5)	
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TABLE 5.2.
Differences among RD and NRD

		NRD	RD	Analysis	
		N (%)	N (%)	χ^2 (gl)	Sig.
Familiarity	First visit	16(84,2)	3(15,8)	15 (5)	0,01
	Once a month or more	275(85,9)	45(14,1)		
	Once every 3 months	242(84)	46(16)		
	Once every 6 months	137(76,1)	43(23,9)		
	Once every year	68(73,1)	25(26,9)		
	Less than once a year	38(74,5)	13(25,5)		
Screened	In the last two years	363(77,6)	105(22,4)	11,85 (1)	<0,001
	Never	422(86,1)	68(13,9)		
Advise	Yes	40(69)	18(31)	4,52(1)	0,03
	No	256(81,3)	59(18,7)		

When comparing the 3 sources of information (see Table 5.3.) we found that at least half of patients have never been screened on alcohol consumption. RD is scarcely ever identified (only 3.2% screened positive through medical record audit whereas around 18.3% screened positive by exit poll questionnaires) and advice is rare.

TABLE 5.3.
Screening and Brief Intervention implementation level according to the three different sources

	Patients (%)	Medical Records (%)	Professionals (%)
Screening	49,9	26,4	46,7
Method			
None		24,1	14,5
AUDIT		---	7,9
Clinical Impression		27,3	48,7
Quantity/Frequency		39,6	---
Others (biomarkers)		10,6	28,9
Advice (in those screened)	16,9	9,2	51,3
Identified Risky Drinkers	18,3	3,2	3,9

Up to date 17 BM bulletin has been produced. It is regularly received by 91.9% of the PHC centres and 84% of the trainers, and has resulted in increased requests for materials and an increase in the number of courses scheduled. The evaluation of the telemarketing strategy shows that at least 4 'phone calls are needed till PHC coordinator is contacted.

5.5.3. Economic Evaluation

WHO COLLABORATIVE PROJECT PHASE IV

Although no formal economic analysis has been yet carried out, some information on the demonstration project direct costs is available (Table 5.5).

5.6. Future Plans

During the current year we aim to achieve a widespread dissemination of the BM program to all PHC settings in Catalonia. That means that the remaining centres will have to be trained in this period. Substantial efforts will have to be made to promote an improved coordination between PHC professionals and specialists in order to overcome roadblocks for the effective implementation of the SBI methods.

Some of the initiatives planned for this year are the following:

- Getting together to form the PHC alcohol reference professionals network (XaROH).
- Organization in June of training workshop, with the participation of the BM trainers and the XaROH members, aimed at renewing their motivation, updating them on the last research in the field and training them on the program continuity.

TABLE 5.5
Direct costs from Demonstration Project

PERSONNEL COSTS					
*Fees				EUROS	
years	n° of persons	daily rate	n° of days		
6	1	217	55	71.610,00	Leader
6	1	135	220	178.200,00	Coordinator
3	1	135	55	22.275,00	Evaluator
			Subtotal	272.085,00	
* Secretarial costs					
3	1	100	55	16.500,00	Administration
			Subtotal	16.500,00	
			TOTAL	288.585,00	
MISCELLANEOUS SERVICES					
* Information costs					
				2.000,00	Technical computer support for website
* Costs of reports / Translation					
				9.529,87	edition trainer package 109 x 87,43 euros /copy
				378.145,11	edition trainee package 8.687 x 43,53 euros /copy
				25.545,42	edition sensitivation materials
				25.110,00	CD Rom 3000 x 8,37 euros /copy
				6.896,00	Designer Costs
* Subcontracting					
344	courses	300		103.200,00	

WHO COLLABORATIVE PROJECT PHASE IV

* Audit / evaluation costs		
	Field Work	18.000,00
* Other services		
2	meetings with trainers	17.184,00
7	meeting with trainers	850,00
	TOTAL	586.460,40

PROJECT ADMINISTRATION

*** Equipment**

	1 sets of office furniture	550,00
	1 sets of computer equipment	1.900,00
	1 set of fax	600,00
	1 copy of SPSS software analysis	8.800,00

*** Cost of consumables and supplies directly**

	Office consumables	1.000,00
	Post costs	10.115,00
	Post costs euros	333,12
	Telephone calls	107,74

TOTAL	23.405,86
TOTAL COSTS	898.451,26

- Promotion of a yearly, 25-hour CME course entitled “BM training course in depth”, aimed at training and updating as many PHC professionals as possible in SBI methods.
- Redesign of the *Beveu Menys* Website in order to promote a better and more comprehensive understanding of the aims, concepts and tools of the program.
- Adaptation of the BM tools for the existing computerized medical records in PHC settings to facilitate their utilization in daily clinical routine.
- Introduction of an Alcohol Screening Indicator in the Health System Contract.
- Dissemination of SBI techniques to other settings (hospitals, emergency rooms, etc.).

The Program on Substance Abuse of the Health Department remains strongly committed to this work, as can be seen from the fact that it is leading the Primary Health Care European Project on Alcohol (PHEPA), project co-funded by the European Commission, and has endorsed together with WHO, the development of the International Network on Brief Interventions for Alcohol Problems (INEBRIA).

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