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# BRIEF INTERVENTIONS IN THE TREATMENT OF ALCOHOL USE DISORDERS IN RELEVANT SETTINGS

## The BISTAIRS Project

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# Content

- Introduction and background:
  - Alcohol-related harm in Europe.
  - Screening and Brief Interventions (SBI) for alcohol.
  - The BISTAIRS project.
- Alcohol SBI effectiveness in different settings.
- Development of good practice guidelines.
- Next project steps: the field-tests.
- Discussion points.

# Alcohol-related harm in Europe

- Alcohol is a significant risk to public health (Lim et al 2012):
  - 5th leading global cause of morbidity / premature death (after high blood pressure, tobacco smoking, household air pollution from solid fuels and a diet low in fruits),
  - Also costs in terms of impact on health services, criminal justice sector, social care and the wider economy.
- Alcohol consumption rates in Europe are highest in the world (Rehm et al 2009):
  - In 2009, average adult (aged 15+ years) alcohol consumption was 27g of pure alcohol or nearly 3 drinks a day - more than double the world average,
  - Europe has the greatest burden of alcohol attributable harm: with about 6.5% of deaths and 11.6% of DALYs attributable to alcohol.
- Risky drinking is now a major international public health priority, esp. in Europe (EC/WHO 2011).
- Range of interventions for tackling alcohol-related harm -> alcohol screening and brief intervention (SBI) both clinically/cost effective (Hutubessy et al 2003).

# Screening and Brief Interventions (SBI) for alcohol

- Key elements:
  - **Screening**: using a validated standardised questionnaire e.g. AUDIT (AUDIT-C, AUDIT-PC, FAST, S-SASQ).
  - **Brief intervention:** short focussed discussions; based on FRAMES principles (**F**eedback; **R**esponsibility; **A**dvice; **M**enu; **E**mpathy; **S**elf-efficacy).
  - *Referral to treatment: for dependent / non-responsive patients.*
- Robust evidence base supporting alcohol SBI, mostly in primary health (Kaner et al 2007).
- BUT potential identified for other settings (NICE, 2010).


**Alcohol Users Disorders Identification Test (AUDIT)**

| Questions | Scoring System 0 | 1 | 2 | 3 | 4 | Your Score |
|---|---|---|---|---|---|---|
| How often do you have a drink that contains alcohol? | Never | Monthly or less | 2 - 4 times per month | 2 - 3 times per week | 4+ times per week | |
| How many standard alcoholic drinks do you have on a typical day when you are drinking? | 1 - 2 | 3 - 4 | 5 - 6 | 7 - 8 | 10+ | |
| How often do you have 6 or more standard drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often in the last year have you found you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often in the last year have you failed to do what was expected of you because of drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often in the last year have you needed an alcoholic drink in the morning to get you going? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often in the last year have you had a feeling of guilt or regret after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often in the last year have you not been able to remember what happened when drinking the night before? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| Have you or someone else been injured as a result of your drinking? | No | | Yes, but not in the last year | | Yes, during the last year | |
| Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down? | No | | Yes, but not in the last year | | Yes, during the last year | |

**Scoring:** 0-7 = sensible drinking, 8-15 = hazardous drinking, 16-19 = harmful drinking and 20+ = possible dependence

How much is too much? Screening Tools

# BISTAIRS: aims and objectives

- To foster BI implementation in different settings by:

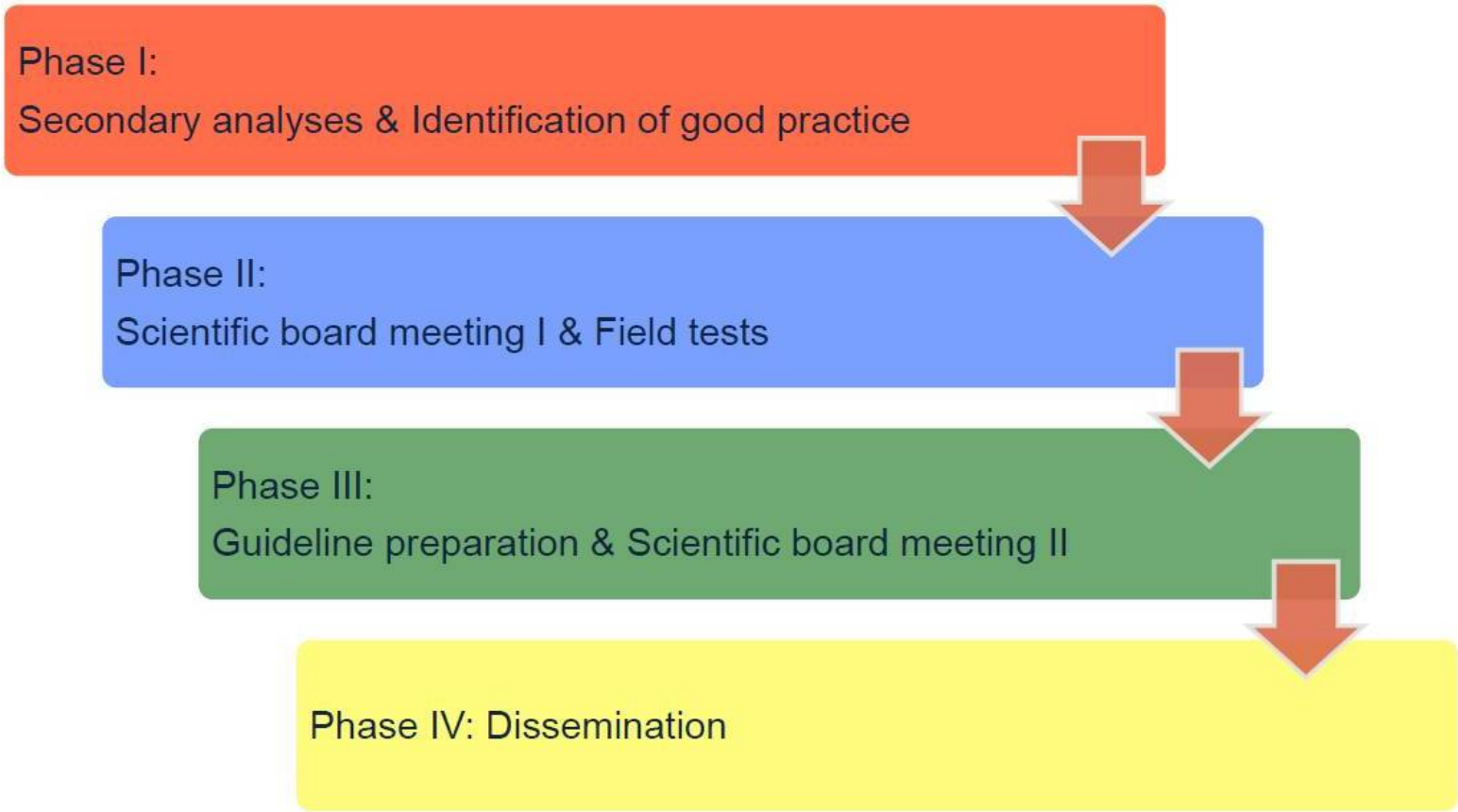
- reviewing implementation processes;
- providing information about mechanisms for BI-implementation;
- providing guidelines for the development and implementation of BI approaches; and
- providing a set of tailored toolkits and training manuals.

- Timescale: 36 months (01.05.2012 to 30.04.2015).

# BISTAIRS project partners

| Partner | Function |
|---|---|
| **University of Hamburg (CIAR)**<br>Hamburg, Germany | Work package leader<br>National field test coordinator |
| **University of Newcastle upon Tyne (UNEW)**<br>Newcastle, United Kingdom | Work package leader |
| **Fundacio Clinic per al la Recera Biomedica (FCRB)**<br>Barcelona, Spain (Catalonia) | Work package leader |
| **Instituto Superiore Di Santa (ISS)**<br>Rome, Italy | Work package leader<br>National field test coordinator |
| **Generalität de Catalunya (GENCAT)**<br>Barcelona, Spain (Catalonia) | National field test coordinator |
| **National Institute of Public Health (NIPH)**<br>Prague, Czech Republic | National field test coordinator |
| **Institute on Drugs and Drug Addiction (IDT)**<br>Lisbon, Portugal | National field test coordinator |

# BISTAIRS project structure

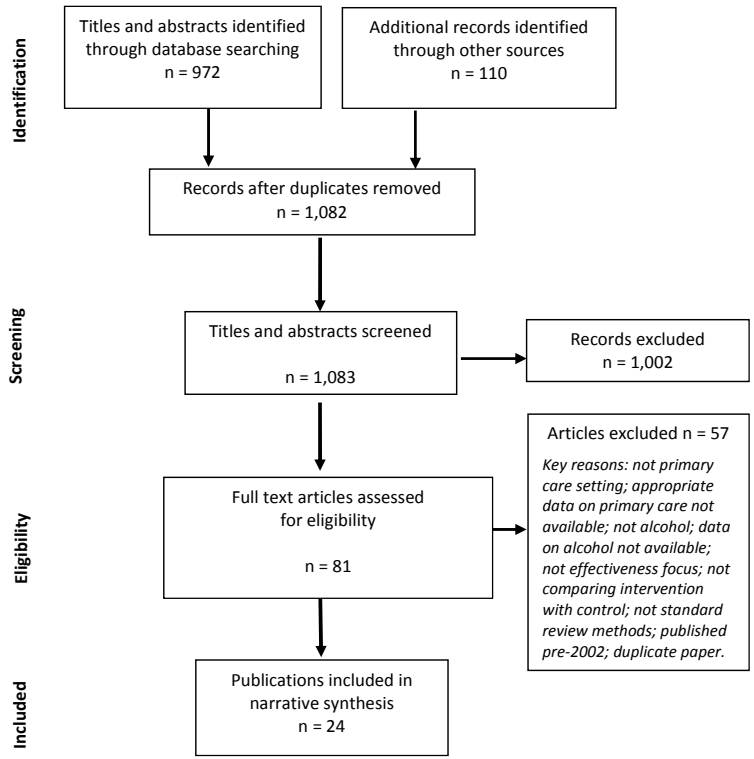


# Phase 1: reviews of alcohol SBI effectiveness

- Systematic review of reviews for alcohol SBI effectiveness in primary healthcare *(Newcastle)*
- Systematic reviews for alcohol SBI effectiveness *(Hamburg)* :
  - Emergency services.
  - Workplace.
  - Social services (inc. CJS but not education).
- Eligibility:
  - published 2002-2012.
  - BI defined as 1-4 sessions; up to 30 mins per session.
  - Reduction in consumption and / or other alcohol-related outcomes.
  - English language only.

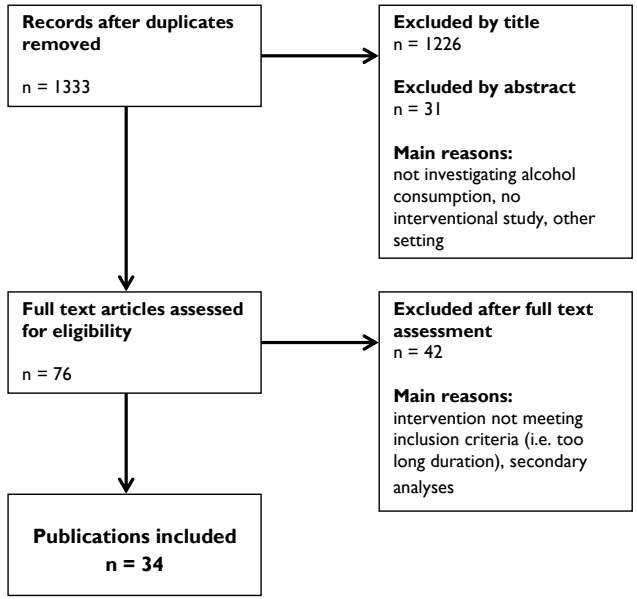
# Alcohol SBI effectiveness in primary healthcare

- 24 eligible reviews.
- Results confirmed:
  - Alcohol BI effective in addressing harmful drinking in PHC.
  - Reduces weekly consumption by 38g (Kaner et al, 2009) to approx. 23-49g (Jonas et al, 2012).
  - Can be delivered by a range of practitioners.
  - Short, simple interventions as effective as longer, more intensive input.
- The evidence gaps:
  - Ethnic / geographic bias.
  - Gender, particularly pregnant women.
  - Younger and older drinkers.
  - 'Control' question; active ingredients; longer-term effectiveness.



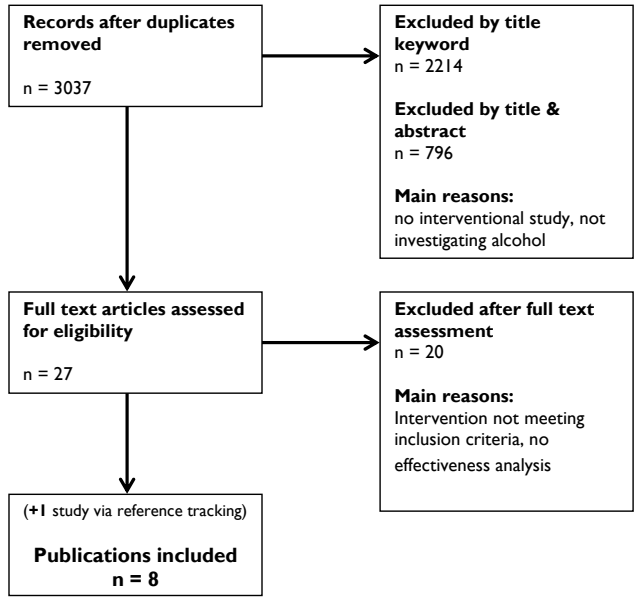
# Alcohol SBI effectiveness in emergency care

- 34 primary studies (all RCTs):
  - Settings: emergency departments and trauma units.
  - Target population: injury patients.
- Heterogeneous outcome criteria:
  - AUDIT score, no. heavy episodic drinking days, rehospitalization, DWI arrests, negative consequences, etc.
- Mixed evidence of effectiveness:
  - Lack of significant difference between control and intervention group – both showed improvement.
  - Mixed effects according to level of risk.
  - Little evidence on longer term effects.



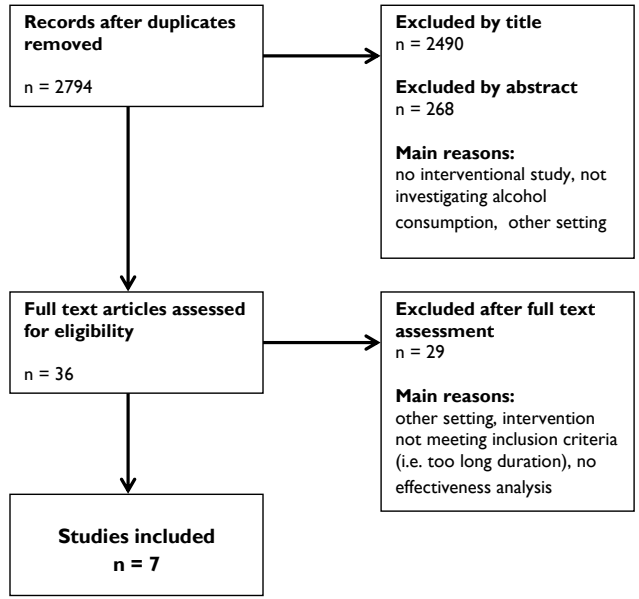
# Alcohol SBI effectiveness in the workplace

- 8 primary studies (RCTs)
- Majority (7/8) showed significant impact on alcohol consumption.
- However:
  - Mainly involved large companies; mainly from USA.
  - Various research barriers, e.g. recruitment, protecting privacy, preventing group contamination.
  - Limited evidence on long-term impact.



# Alcohol SBI effectiveness in social services (inc. CJS)

- 7 primary studies (controlled trials)
- Highly heterogeneous evidence base:
  - Target groups (eg homeless people, clients of community-based drug-counselling centres, driving offenders, violent offenders).
  - Outcome criteria (although most focussed on consumption).
  - Intervention intensity.
  - Types of settings / definitions of social services.
- Inconclusive evidence:
  - Again, both control and intervention groups achieved reduction.

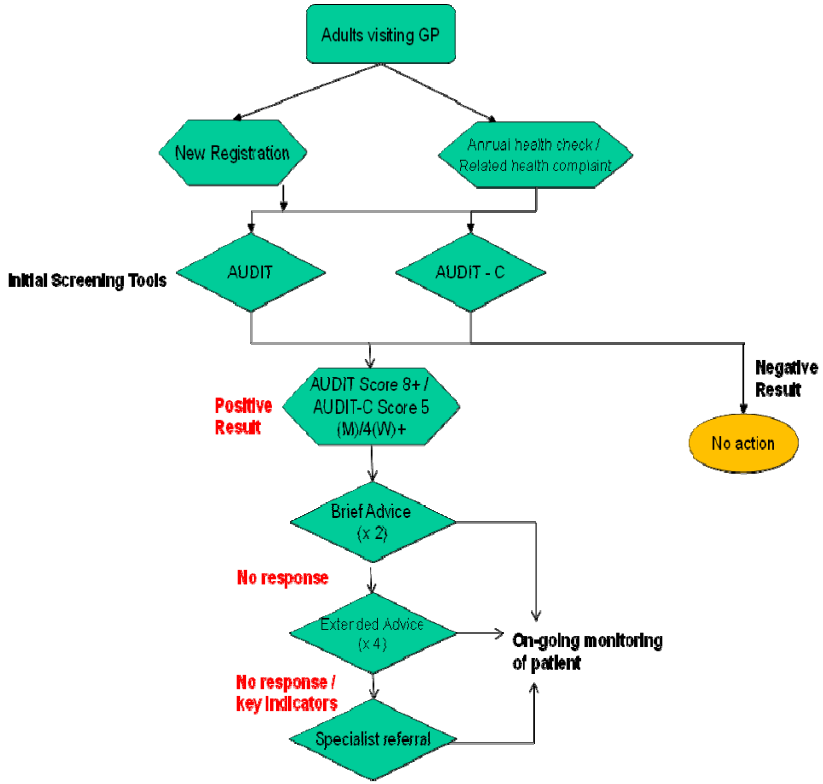


# Phase 1: Good practice guidelines

- Aim:
  - Guidance document on the implementation of alcohol SBI in a range of settings.
- Target audience:
  - Providers and commissioners of key services (primary healthcare, social services, emergency departments, workplace).
- Content:
  - Evidence summaries of SBI effectiveness.
  - Focus on barriers and facilitators.
  - Practical recommendations.

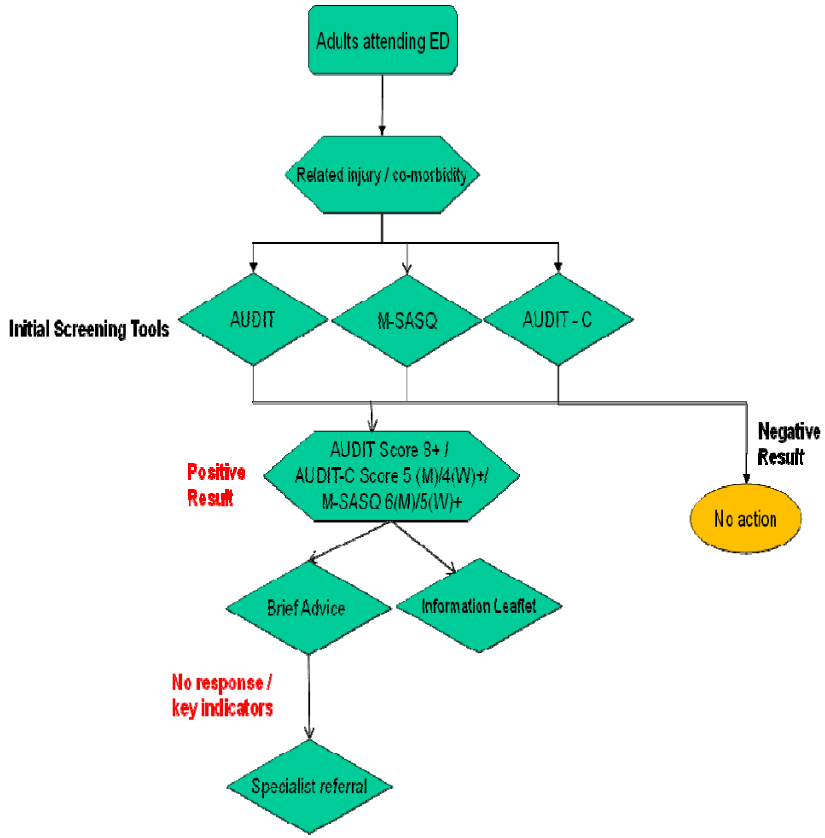
# Guidelines for primary healthcare settings

- Barriers:
  - time constraints; fear of upsetting patient; lack of training; unsupportive delivery context.
- Recommendations:
  - Locally relevant clinical guidelines / supporting materials.
  - Training for all PHC healthcare providers.
  - Monitor and evaluate delivery of SBI programmes.
  - Provide financial support for SBI programmes.
  - Ensure adequate specialist services are available.



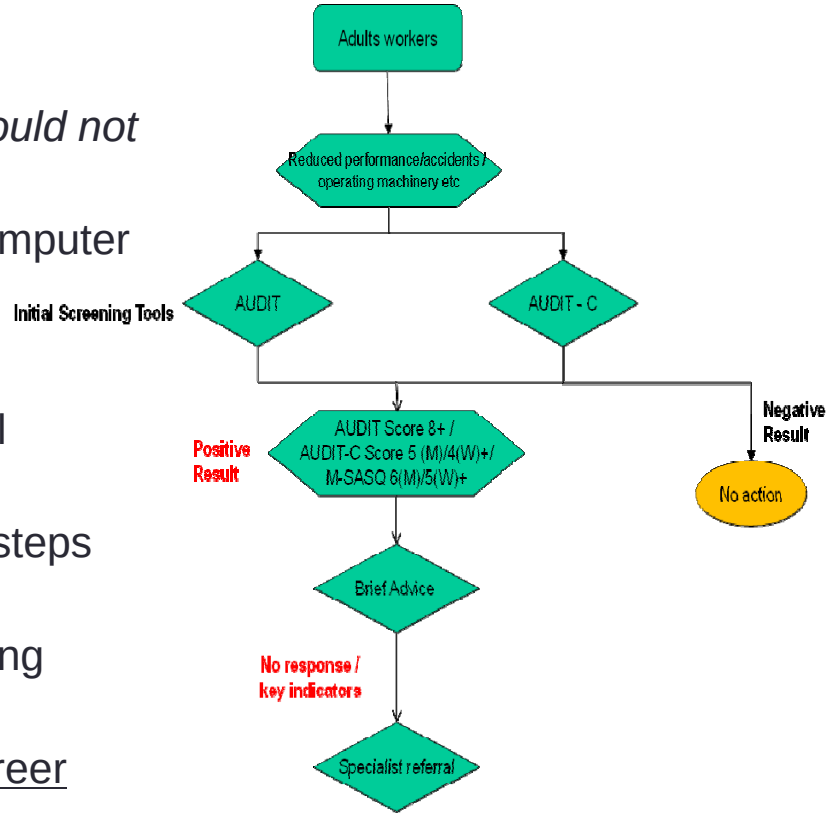
# Guidelines for emergency care settings

- Considerable barriers to implementation:
  - Low levels knowledge / understanding amongst ED clinicians.
  - Time constraints / workload pressures.
  - Lack of training.
  - High staff turnover.
  - Lack of specialist referral options.
- Recommendations:
  - Develop and disseminate clinical and operational guidelines.
  - Programme sustainability requires:
    - Keen clinical champion on-site.
    - Managerial support.
    - Alcohol health worker.
    - External specialist support for alcohol.



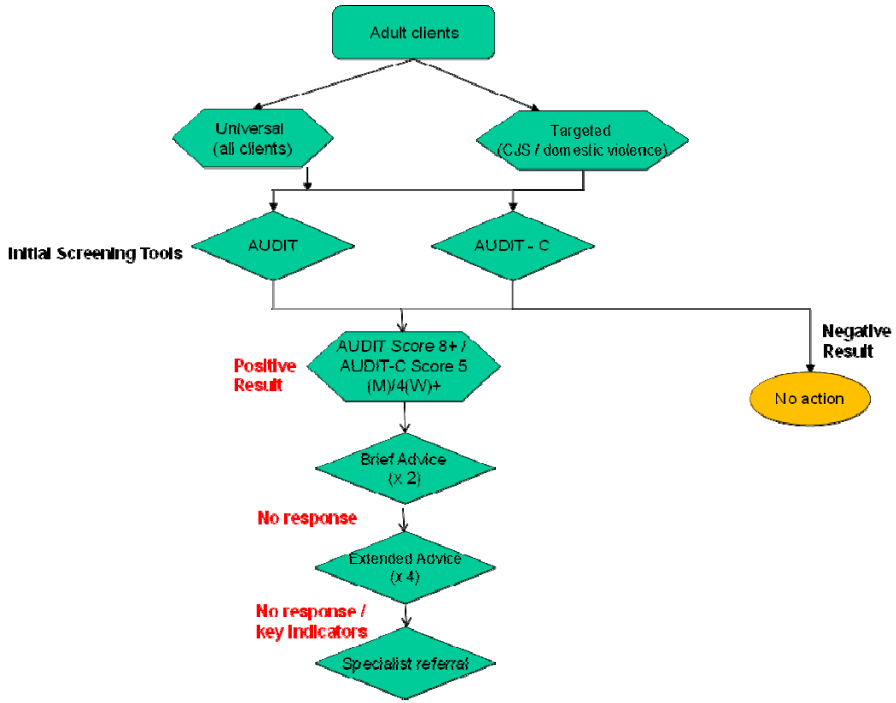
# Guidelines for workplace settings

- Barriers:
  - Insufficient and equivocal evidence base to determine (cost-)effectiveness; or fully understand barriers.
  - *But no reason why such programmes should not be effective.*
  - Positive examples exist (EWA project; computer delivered interventions; etc).
- Recommendations:
  - SBI provision needs to be tailored to local context
  - Break the process down into acceptable steps and negotiate where flexibility exists.
  - Provide clear written policies for addressing alcohol issues.
  - Vital to ensure privacy – and focus on career preservation.
  - Programmes should be implemented under the wider umbrella of 'well-being'.



# Guidelines for social services (inc. CJS)

- Barriers:
  - Equivocal / highly heterogeneous evidence base →difficult to identify clear positive impact of SBI in terms of (cost-) effectiveness.
  - Workload pressures / necessary focus on criminogenic needs of offended.
- Recommendations
  - Embedding brief advice programmes into routine practice requires a long-term approach.
  - Strong local 'champion' / managerial support facilitates easier training.
  - External alcohol specialist support can improve sustainability.
  - More research needed!



# Phase 2: Finalising toolkits and national field-tests

- Toolkit (recommendations & practical tools) (December 2013).
- Consensus meeting (mid-December 2013).
- One field test per setting, per country (Jan – April 2014)
  - PHC, emergency, workplace, social services.
  - Catalonia, Czech Republic, Germany, Italy, Portugal.
- Evaluation focus groups (May 2014).
  - Based on RE-AIM principles (reach, effectiveness, adoption, implementation, maintenance).

# Discussion points

- Managing heterogeneity:
  - Across health / social care / CJS systems etc; between different European partners.
  - Agreeing definitions (risky drinkers; settings; etc).
- Implementation challenges:
  - Determining appropriate SBI field-tests in novel settings with equivocal evidence-base.
  - Tackling resistance to routine SBI delivery in more established ones (esp. to use of formal screening tools).

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