Plenary Session: Strategies to Help People Change

From Primary Health Care to Specialized Treatment Centers: a gap difficult to bridge

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Introduction

Usually, there's a strong relationship between alcohol production and attitudes towards alcohol. Some authors have suggested a division between 'wet' and 'dry' cultures[1], concerning alcohol. Alcohol consumption and attitudes towards alcoholic beverages are not equal all across Europe, even though they tend to harmonize[2,3]; and this harmonization probably tends to fall on the 'wet' side. 'Wet' cultures are characterized by high alcohol production and consumption, low prices and a high degree of tolerance towards alcohol. This high tolerance is based on the underlying assumption that alcoholic beverages are essentially 'good'.

But this idealization of alcohol leads to two important misleading assumptions: First, it puts the blame on the person who has an alcohol related problem (not in the substance), and second, it creates an artificial gap between two types of drinkers: those who can drink with no risk, even if they abuse, and those who will have problems.

Back in 1990, the Institute of Medicine[4] of the USA (Figure 1) developed a model that has become popular among specialists, but quite ignored among policymakers. The model clearly establishes the idea of a continuum. As stated by Anderson[5], 'Just as there is a continuum of both alcohol consumption and alcohol related problems, so there is a continuum of responses to such problems. The later ranges from primary prevention through brief interventions to specialized treatment.'

In most of the medical conditions, treatment facilities are organized in order to provide a continuum in the delivery of care. Usually, this continuum starts with PHC, where the emphasis is placed on preventive activities, early identification of diseases, and treatment of the less severe cases, while specialized settings and Hospitals are devoted to the treatment of the most severe cases, all of them within the frame of the Health System. This is certainly not the case for alcohol dependence in most of the European countries, where a tremendous gap exists between PHC services and addiction units, which are often placed outside the Health System, with poor or non-existing coordination with PHC Centers.

Alcohol as a problem for the Health Systems

PHC professionals face all kinds of alcohol related problems (Figure 2), ranging from risky drinking to severe alcoholics unresponsive to treatment. There's a general consensus to admit that properly trained GPs can deal with the low range of alcohol related problems[6] (hazardous and harmful drinkers and mild dependence), even though

a high proportion of GPs don't do it in a routine basis[7]. Anyhow, this is just a part of the alcohol related problems GPs have to face.

When the alcohol issue is raised among PHC professionals, they tend to think of alcoholism, and usually they tend to remember the most difficult alcoholics they've ever attended: patients who come intoxicated to the practice, patients who behave rudely and are not likely to admit their alcohol problem, etc. Obviously those are exceptions, but if PHC professionals cannot handle appropriately the difficult situations, they will tend to avoid the alcohol issue in most of their patients.

One of the reasons why GPs may feel overwhelmed by those situations is lack of training. There is evidence that GPs do not receive appropriate training to deliver screening and brief interventions for alcohol problems to their patients in many European countries. But it is even more obvious the lack of training concerning the basic skills on how to interview and assess patients with alcohol dependence and how to address their families.

Even if a GP has appropriate training and skills, a second problem acts usually as a deterrent: the lack of resources. In many European countries there are less specialized centers than needed, and referral to them is usually far from simple. The longer a patient has to wait, the bigger the problems a GP will have to face, and this acts also as a deterrent to raise the alcohol issue at the practice. Indeed, in many cases specialized centers are located outside the Health System, both physically and administratively. Since most of the patients fear the social stigma associated to alcohol, the fact that specialized centers are located outside the Health Centers increases the patients' reluctance and thus doubles the doctors' efforts to motivate him.

In many cases PHC professionals are unfamiliar with the specialized centers. There's a lack of knowledge of the kind of treatments offered, the type of patients that may benefit from them, etc. Quite often patients and GPs tend to think that just the most severe chronic alcoholics are referred to the specialist. The fact that addictions to illegal drugs may be treated there, just increases the feeling of stigma, and refrains both patients and doctors to consider that option until severe problems are evident.

The most dramatic gaps are evident in those countries where outpatient treatment is not currently available. There, PHC professionals have to face an important dilemma when they identify patients with alcohol dependence: to treat them in a PHC setting or to refer them for long inpatient psychiatric hospitalization. Obviously, patients who would benefit from an outpatient approach may receive just symptomatic treatments for years, while their dependence tends to worsen progressively.

On the other side of the System, problems are quite similar. Specialized Centers are usually too much involved in their own world, with scarce information on what happens in PHC. Alcohol specialists usually lack information on PHC priorities, problems and interests. Also, alcohol specialists tend to focus on alcohol dependent patients, while the focus in PHC is on hazardous and harmful drinking[8].

Since quite often PHC and specialized settings seem to be in different worlds, coordination appears as an impossible task, and the lack of coordination poses patients into severe risk of not receiving the appropriate treatment at the appropriate time. It

should be acknowledged here, the important tasks that a great variety of NGO's across Europe are doing, trying to help people who have fallen in the gap between PHC and specialized services.

To sum up, an overall analysis of how alcohol services are implemented across the Health Systems in Europe, would lead to the conclusion that alcohol is not among the priorities of policymakers. Society should make healthy choices easy choices[9], but in the case of alcohol it looks quite the opposite: as a young adult it is easier to drink than to abstain, and if you suffer any alcohol related problem, again it is easier to keep on drinking than to receive appropriate medical care.

In the search of solutions

If we want to address this problem in a correct way, a bottom up philosophy must be used, starting with the needs of patients with alcohol related problems, in accordance with the idea of a patient-centered approach[10]. As stated in previous presentations, patients need a self-change friendly environment, which means change must be made as easy as possible. Obviously this includes easy access to the PHC center, and a friendly atmosphere that allows raising the alcohol issue with the GP, enhancing the likelihood of early identification of problems.

Once problems are identified, patients should be allowed to discuss freely if treatment should be delivered at the PHC Center or at a specialized setting. But to make discussion fruitful the patient should be ensured of two essential conditions: referral should be an easy and fast choice, and coordination between GP and specialist should be guaranteed. Even if quite a few patients initially prefer to be treated by their GP, this approach would allow referral of chronic cases at an earlier stage than usual.

If we continue with the bottom up philosophy, the next step is to assess which are the needs of PHC professionals in order to suit the needs of their patients. There is a general consensus on the need of training, especially in the field of early detection and brief interventions for alcohol related problems. What is usually less emphasized, is the need of appropriate training on how to manage and how to refer more severe patients. And this is also an important need, since those patients do appear at the practice and if GPs feel uncomfortable with them, they will tend to ignore the whole alcohol issue.

But training is just a first step. Once the GP is trained he still has some basic needs: referral centers available, feedback on the clinical evolution of referred patients, and specialized support when shared care is a feasible option. If those conditions are fulfilled, PHC professionals will be in the best position to meet their patients' needs.

Finally, alcohol specialists have also their needs. If training is a main priority in PHC, integration is the magic word in specialized settings. Most of the alcohol specialists benefit from training, especially in areas like screening and brief interventions and also through training the trainer's strategies, which allow them to be more skilled when addressing PHC colleagues for training or clinical purposes. But the main problem in most specialized centers is that they are not fully integrated in the Health System, and this integration is essential if we want to normalize treatment and referral of alcohol dependent patients.

In summary, to bridge the gap between PHC and specialized centers we need appropriate training of all Health professionals and full integration of specialized centers in the Health System. Those two basic steps are necessary to allow good coordination between professionals that should finally ensure continuity of care.

From theory to practice: the Catalan experience

In the frame of the WHO Collaborative Study on Alcohol and Primary Health Care[11], Catalonia has developed a particular approach to the Phase IV of this Collaborative study: the dissemination stage. In the following lines we will summarize the most relevant characteristics of the work done and some of the preliminary results, in order to show an example of how theory can be put into practice.

Catalonia is an autonomous country in the northeastern part of Spain, with 6.090.040 inhabitants. The Health System includes 344 Primary Health Care Centers with more than 7000 Health Professionals working on them (approximately 40% of them are GPs). There is also a network of specialized centers called Xarxa d'Atenció a les Drogodependències (XAD), which includes 60 outpatient treatment centers and inpatient facilities. Approximately 85 physicians are part of the staff, and 63 out of those physicians have been trainers of the Beveu Menys Program (Drink Less Program). The total number of trainers has been 72, most of them physicians (88%), 10% psychologists and 2% nurses. We deliberately choose doctors in order to lower PHC professionals resistances, but psychologists and nurses highly motivated were also accepted as trainers.

The Beveu Menys Program (BMP) constitutes the Dissemination Stage (Phase IV) of the WHO Collaborative Study on Alcohol and Primary Health Care. Its aim is to disseminate the use of early detection and brief intervention techniques for hazardous and harmful drinkers to all PHC centers. Moreover, in the case of Catalonia the Program has broadened its approach, and includes a module of training in the identification, management and referral of alcohol dependent patients.

The Beveu Menys Program is inspired in the Skills for Change[12] Package of the WHO, and was customized through an interactive process that included alcohol specialists and PHC physicians. The package can be delivered in 5 hours, which are usually part of the CME routinely provided to PHC Centers.

Trainers are alcohol specialists (n=72), who work in the same geographical area, and who have been trained themselves through intensive workshops based on a training the trainers strategy.

Dissemination started in 2002 and will finish in 2005. At the end of April 2004 more than 65% of PHC Centers had already received the BMP training. Even though data are now just preliminary, some interesting trends can be shown.

Training is generally well received by PHC professionals. The BMP is usually delivered in five sessions of one hour, once a week. So, attendance to sessions is one indicator of interest. Provisional data from 4237 PHC professionals who have attended the BMP courses, show that 85% of trainees have attended at least 80% of sessions (Figure 3), which means 4 out of 5 sessions. This high rate of attendance might show the level of interest in the topic, and is in accordance with feedback obtained from trainers through

the questionnaire they fill at the end of the sessions. Using a scale ranging from 0 to 5, punctuality of trainees was rated at 4,16 by their trainers. Interest shown by trainees during the sessions was rated 3,3 and in fact all measurements were rated above 3 points, which implies a good level of perceived satisfaction. Those data account for more than 60% of the sample, since dissemination is not finished yet.

Even though our data are still preliminary, since dissemination hasn't finished yet, some figures look promising. In Catalonia referral to specialized centers is systematically registered and published annually. This has allowed us to calculate the referral rates for alcohol from PHC and other settings since 1998. Results show an important increase in the rate of referrals of patients with alcohol related problems from PHC settings (Figure 4), in the last two years. From 1998 to 2000 referrals to the XAD have increased at an annual rate of 1,7%, with a 2,0% of increase on other drugs, and 1,4% in the case of alcohol. Instead, referrals due to alcohol increased a 6,1% in 2001 (the year BMP was launched) and 8,2% in 2002. Referrals for other drugs remained stable for the same period of time.

Interestingly, the increase of alcohol referrals to the XAD seems to be due to an increase in the referrals from PHC Centers. Absolute figures from 2002 are quite clear. In 2002 alcohol referrals accounted for 5619 patients, which means an increase of 430 patients compared to the previous year. 2014 of those patients were referred from a PHC Center, which also means an increase of 516 patients compared with the previous year. In other words: we have observed an 8,2% of increase of referrals of alcohol related problems to the XAD, and this is hundred percent attributable to an increase of referrals from PHC settings.

Even though we cannot assume a direct relationship between the BMP and this increase of alcohol referrals, there are some facts that point in this direction. First, alcohol referrals have increased, while referrals for the rest of drugs have remained stable. Second, alcohol referrals from PHC have increased, while alcohol referrals from the rest of settings have not experienced any change. Third, the trend appears in 2001, and it becomes more robust in 2002, and this is the period of time when BMP was launched and training started.

Obviously those are preliminary results that need to be confirmed when dissemination is completed and data from 2003 and 2004 referrals become available. Anyhow, the increase of alcohol referrals from PHC settings can be seen as an improvement of coordination between PHC and specialized centers, and may suggest that the strategy of training PHC professionals through alcohol specialists working in the same geographical area has a positive impact in the management of alcohol related problems.

The BMP approach has an impact on trainees, but it also may influence alcohol specialists. 9 Focus Groups have been conducted with 49 alcohol specialists during the spring of 2004, as part of the action research design that is essential to the Phase IV study. Data from the focus groups are still being processed, but participants also filled in a questionnaire that allows us to draw some conclusions. As seen in Figure 5, trainers have a positive view of their work with PHC professionals, they think coordination is important and feasible, and training of GPs is seen as a rewarding activity.

In summary, the available data suggest that the BMP approach is well received by both PHC professionals and alcohol specialists. The increase in the rate of alcohol referrals from PHC can be seen as a first step in the reduction of the gap between PHC and specialized services.

Conclusions

Alcohol poses a difficult challenge to health systems all over Europe. The challenge is to cover the whole range of alcohol related problems with a stepped care philosophy. Treatment options must begin at a PHC level, and continue seamlessly through outpatient and inpatient specialized services. There's a need for coordination between PHC and specialized centers, and this coordination must be organized taking into consideration every country's Health System. Coordination is essential and possible, but infrequent. Policymakers should give priority to the full integration of alcohol specialized services into the Health System as a necessary step to allow effective coordination of services.

To bridge the gap between PHC and alcohol specialists there are three key points to be met: a) training of both PHC professionals and alcohol specialists, b) full integration of alcohol services into the Health System, and c) effective coordination between PHC and specialized units, that ensures continuity of care. Even though those are goals difficult to reach, our experience shows that the umbrella of WHO Phase IV Collaborative Study on Alcohol and Primary Health Care offers good opportunities to improve the baseline situation.

Figure 1. Alcohol consumption, related problems and associated responses (Adapted and modified from Institute of Medicine[4] and Peter Anderson[5])

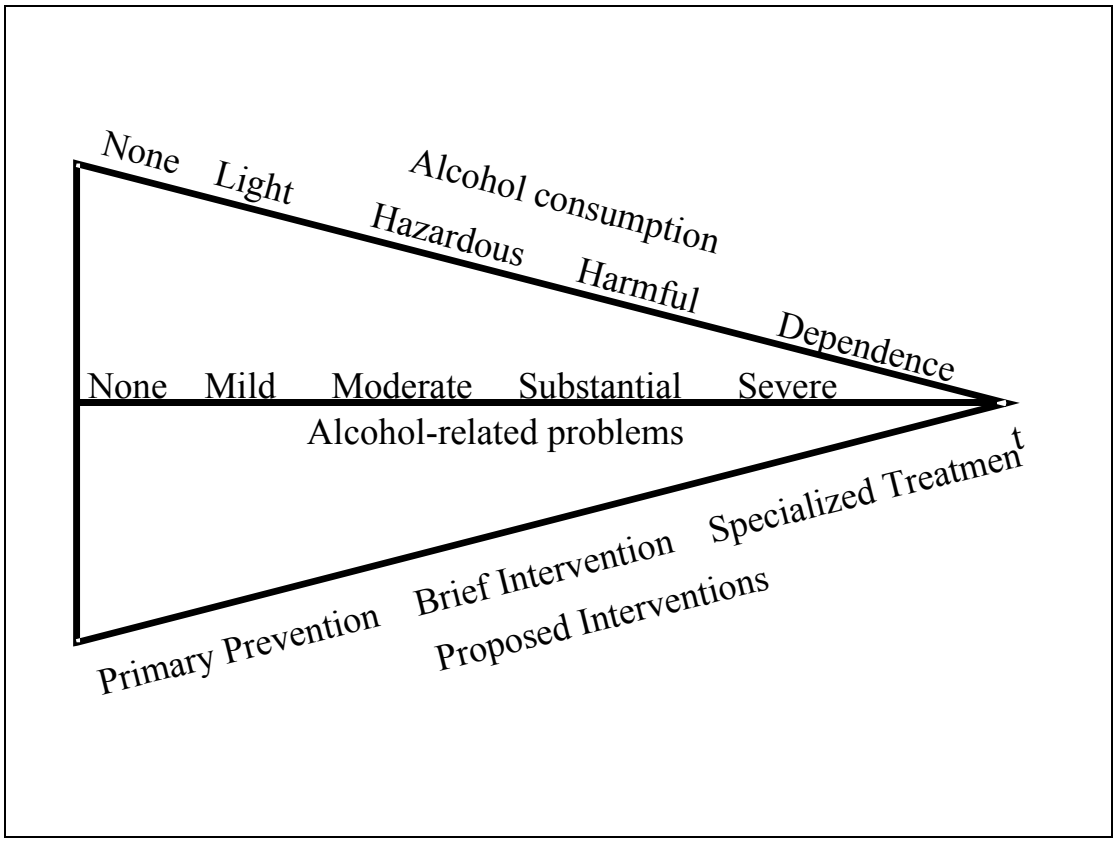

Figure 2. Areas of coordination between Primary Health Care (PHC) and alcohol specialists (ST)

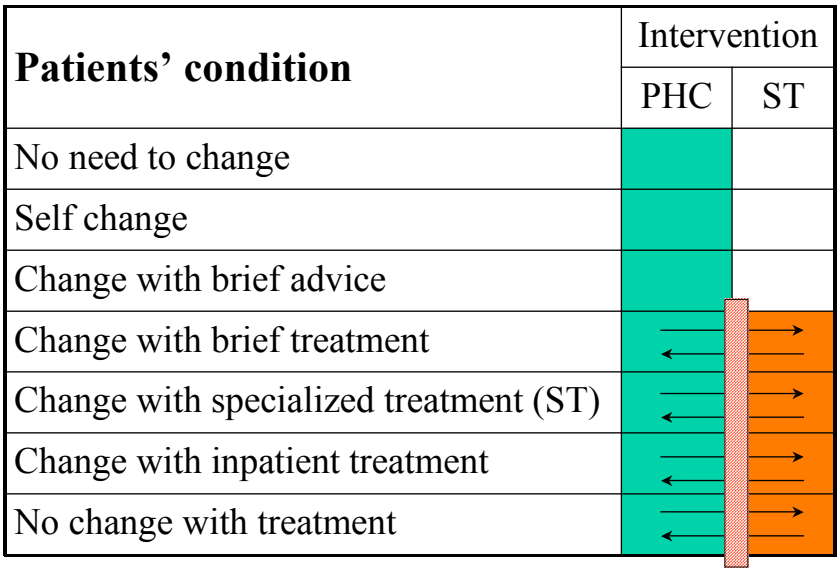

Figure 3. Rates of attendance to the training sessions

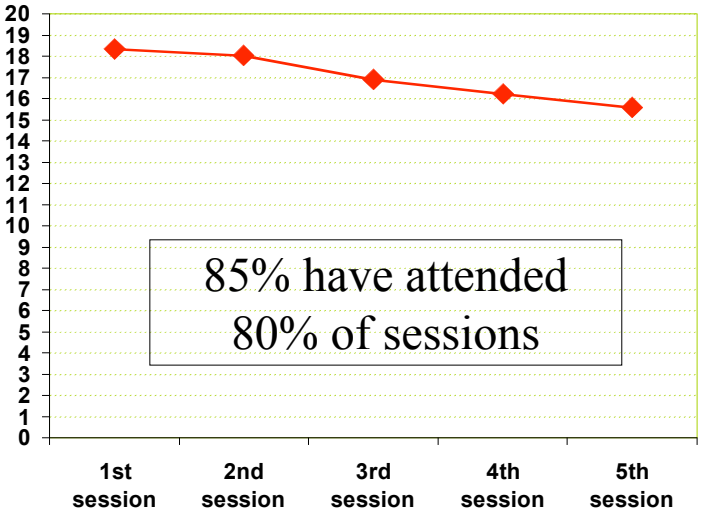

Figure 4. Evolution of alcohol referrals from PHC to the Specialized Network

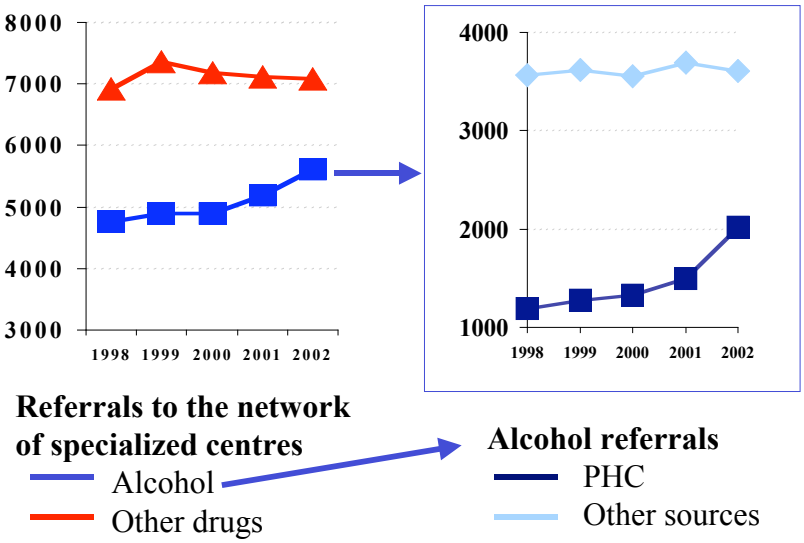

Figure 5. Opinions of alcohol specialists after training PHC professionals*

	Strongly disagree			+/-			Strongly agree
To have PHC teams trained in alcohol is important	0	2	0	2	4	29	63
Coordination between PHC and specialists is impossible	47	39	4	8	2	0	0
To train PHC professionals is useless	24	45	6	6	8	10	0
To train PHC professionals pays off	6	6	10	18	20	24	14

* Results are shown in percentages. N=49

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