

Round-table Discussion: “Prevention and early intervention for alcohol-related harm: Learning from best-practice examples in Europe”

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PORTUGAL

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Guiding Questions for the discussion

#1 Which national data on the use of alcohol exist (consumption, costs, health damage)?

#2 Are there scientific studies, for instance, on the success of preventive measures concerning alcohol consumption as well as the abuse of alcohol?

Portugal, a wine producer country, is one of the countries worldwide where alcohol is most consumed. Alcohol production and consumption is well spread all over de country inclusive over associated with Portuguese gastronomy and has a big economic impact.

Portugal vs. WHO Europe Region (2016-2018)

- **According to estimates by the Global Information System on Alcohol and Health (GISAH)** for 2016-2018, in Portugal the alcohol consumption per capita (15+ years) was 12,3 liters of pure alcohol per year, representing a decrease compared to 2010 (13.1%), similar to the global tendency in the WHO Europe Region (9,8 liters in 2016 and 11,2 liters in 2010);
- Considering **only alcohol consumers**, differences are almost non-existent: 17,8 liters of pure alcohol per year in Portugal vs. 17,2 liters in WHO Europe Region;
- In relation to the type of consumption: in Portugal there are much higher proportions of wine consumption and much lower of spirits comparing to Europe Region;
- Nevertheless, between the last few decades there was a considering increase in the consumption of beer and spirits drinks in our country, especially among the

youngest (the binge drinking pattern traditionally associated to North European countries).

- Projections point to a decline in alcohol consumption per capita in Portugal by 2015 (11 liters) and to a stability in the WHO Europe Region (9,8 liters).
- **According to RARHA SEAS 2015 – Standardized European Alcohol Survey, 2015 (Joint Action RARHA, 19 European countries) Portugal:**
 - Presented the second highest prevalence of alcohol abstinent throughout life (16%) and in the last 12 months (28%);
 - Had the highest rate of abstinence among women and the second highest among young adults (18-43 years);
 - Showed a prevalence of 11% for binge drinking and 10% for drunkenness in the last 12 months.
 - These data were the lowest among European countries, although the frequency of drunkenness was high.

Statistics National Data

According to recent epidemiological studies conducted in Portugal, alcohol consumption in the Portuguese population represents an important public health problem.

- National estimates (e.g. INE,IP, Portuguese Food Scale) points to an average daily consumption of 19,4 grams of alcohol *per capita* in 2016, corresponding to:
 - 58% to wine consumption,
 - 25 % of beer,
 - 13% of spirits and liqueurs
 - 4% to the consumption of fermented beverages.
- **The most common alcoholic beverage likely to be consumed is wine.**
- Data released from the **IV National Survey on the Use of Psychoactive Substances in the General Population (15-74 years old)** (IV Inquérito Nacional ao Consumo de Substâncias Psicoactivas na População geral , Portugal 2016/17), show that:
 - the prevalence of alcohol consumption was 85% throughout life,
 - 58% in the last 12 months and 49% in the last 30 days.
 - At the 15-34 age group the prevalence's were slightly lower (83%, 52 and 41% respectively).
 - Regarding patterns of harmful use and / or alcohol dependence:
 - 2.8% (4.9% of consumers) had an alcohol consumption considered to be a **high harmful use** in the last 12 months;
 - and 0.8% (1.3% of consumers) had symptoms of **alcohol dependence** (AUDIT - The Alcohol Use Disorders Identification Test, WHO);

- **Comparing to 2012 vs. 2016/2017**
- **A positive evolution** of some of the indicators such as:
 - The decrease in per capita consumption;
 - The decrease in the prevalence of consumption among men and the youngest;
 - The perception of less easiness of access to alcoholic beverages in ages inferior to the legal minimums (18 years old);
 - The delay in the beginning age of consumption in the young population;
 - These two findings are directly related to the investment made in the legislation recently produced, increasing the minimum legal age from 16 to 18 years and reinforcing the supervision of sales to minors in public and consumer establishments;
 - Important health gains due to the decrease in hospitalizations with a diagnosis of alcoholic hepatitis or cirrhosis;
- On the other hand, **a negative evolution** of some indicators such as:
 - An increase consumption of harmful use and alcohol dependence in the general population (15-74 years old);
 - This increase was more relevant among women and in consumers over 45 years old (worrying extreme values);
 - An increase number of situations reported of children and young people exposed to behavior related to alcohol consumption, affecting their well-being and development), the most higher data from the last five years;
 - Increased mortality in road accidents under the influence of alcohol;

Data released from different studies carried out with students:

- HBSC/WHO 2014
- Flash Eurobarometer 2014
- ECATD-CAD, 2015
- ESPAD, 2015 – European School Survey Project on Alcohol and Other Drugs (2015)

Comparing to 2011 vs.2015

- Overall, results show a decrease in prevalence of consumption among young people, more pronounced among 13-16 years, and a tendency to decrease recent and current consumption;

- There was a decrease in the prevalence of drunkenness and binge drinking (more pronounced in young males);
- Like in 2011, Portugal in 2015 presented prevalence of consumption and harmful consumption lower than the European averages, which have also been decreasing.
- 41% of the 16-year-old students had started drinking alcohol at 13 years or younger (51% in 2011), and 5% had been drunk at 13 years or younger (8% in 2011). These proportions were lower than the European averages (4% and 8%).
- Concerning the perceptions of risk associated with alcohol consumption: 25% of the 16-year-old students considered the daily intake of 1 to 2 drinks to be high risk, rising to 70% in the case of 4/5 drinks (binge drinking). These proportions were higher than those registered in 2011 and 2007 and in relation to the European averages of 2015 a higher risk attribution was attributed to these consumptions.

Health Damage

- In 2017 we had 13828 users with alcohol related problems in outpatient treatment in the public network,
- 4399 began treatment in 2017. Of those who started treatment in 2017, 1047 were readmitted and 3352 were first admissions.
- Since 2009 there is a tendency of continuous increase of users with alcohol related problems related who seek treatment.

Deaths:

- There were 2515 deaths related to alcohol (2.27% of total deaths), an increase of 9% compared to 2015 and the highest figure in the last five years.
- the mean number of years of life lost due to alcohol related diseases was 13.6 years (13.7 years for men and 11.7 years for women).

Social and legal problems:

- Data from the **National Commission for the Protection of Children and Young at Risk** revealed **302** situations reported of children and young people exposed to behavior related to alcohol consumption, affecting their well-being and development), the most higher data from the last five years.
- There are several national measures (legal frameworks) to protect these children regulated by the Ministry of Justice. Families with alcohol related problems are referral to specialized treatment in the Public Health System.

- There were **19 848 alcohol-related driving offenses with BAC above 0,12%** (blood alcohol concentration limit above 0,12% it is considered as a criminal offence (Código Penal, artº 292º n.1), representing 28% of all crimes against society and 6% of crimes filed in 2017.
- The driver license is suspended and several criminal sanctions are imposed by law: fines, probation, police record, prison, community work, treatment requirements and/ or attending a rehabilitation program at the Public Health System (Ministry of Health).

#3 Which legal provisions and initiatives to avoid the abuse of alcohol do exist in your country? Are there special protective regulations for children and youths?

Recently (2013) Portugal implemented a new legislation to protect citizens' health by introducing more restrictive measures on the availability, sale and consumption of alcoholic beverages and alcohol-based driving.

- The current age limit for selling and serving alcohol (all beverages) is 18 years old.
- It is forbidden by governmental law selling or serving alcoholic beverages to those who are under 18 years old, already intoxicated or apparently suffer from mental illness.
- It is also legally prohibited selling and drinking alcoholic beverages in restaurants, coffees and bars located inside any health institution/organization.
- It is also prohibited by law selling alcoholic beverages in automatic machines nationwide;
- The national BAC (blood alcohol concentration limit) is 0.05%. Driving with a BAC equal to or greater than 0.5 g / l for "common" drivers is prohibited.
- For new drivers, (during the first 3 years of validity of the driving license), drivers of emergency vehicles, or urgent services, collective/public transports, children transports, it is forbidden to drive with a BAC equal to or greater than 0,2 g / l;

#4 How is the care of alcoholics organized, what do you see as positive and what is problematic?

Until 2007 treatment and rehabilitation of alcohol related problems at public health care system were under the custody of the **Regional Alcoholology Centres** (nowadays Alcoholology units), autonomous services of the Ministry of Health which tended to follow a medical model based predominantly on an individual approach steeped in the prevailing "abstinence-only" ideology.

In 2006 a new law framework (Decreto-Lei n.º 212/2006, published October 27th, 2006) extinguished the three Regional Alcoholism Centres and its competences were integrated in the Institute on Drugs and Drug Addiction, I.P. (IDT, IP), an autonomous service of the Ministry of Health created by law (Decreto-Lei n.º 221/2007, published May 29th, 2007).

In 2013, the Health Regional Administration from the Ministry of Health succeeded, in some of the functions of the Institute on Drugs and Drug Addiction, IP, namely in the operational component of intervention in the field of care and understanding substance use problems and other addictive behaviors.

Therefore 5 Divisions of Intervention in Addictive Behaviors and Dependencies were created all over the country, comprehending 4 Detoxification Units (inpatient units), 3 Residential Drug Free Treatment (public therapeutic communities), 3 Alcoholism Units (outpatient and inpatient care services), 2 Day Care Centers and 45 Outpatient Treatment Centers distributed by 22 Integrated Units which provide prevention, harm reduction, treatment and rehabilitation activities throughout the country.

This public supply is complemented by allocated beds and placements from the private sector.

In these sense, regarding care of alcoholics, we are nowadays organized in a **National Alcohol Referral Network (NARN)** aimed at provide each patient with an appropriate intervention at every service from the Ministry of Health based on the level of risk:

- a) **Level 1: precocity detection, hazardous drinking patterns, harmful use** (e.g. primary care settings, general practitioners and family physicians or staff);
- b) **Level 2: harmful use, mutual consumption, light/moderate alcohol dependence** (e.g. Integrated Units from ARSLVT, IP, Emergency rooms);
- c) **Level 3: alcohol dependence, psychiatric and substance use disorders/dual diagnosis, particular/specific populations** (e.g. General Hospitals, Mental Health Services and Alcoholism Units).

Using a **stepped-care approach**, patients can be managed first at the lowest level of intervention in Primary Health Care services and if they do not respond to initial intervention or need a diagnostic evaluation and specialized treatment, they should be referred to the next level of care: ARSLVT structures (e.g. Integrated Units, Detoxification Units, Alcoholism Units and Therapeutic Communities), Mental Health Services, Religious Health Care structures and NOG's.

The main goals of the NARN are:

- To develop and maintain a continuum of care;
- To deliver services in the most effective and appropriate manner;

- To provide a system of mutual case information exchange;
- To coordinate and plan healthcare services referral and monitoring;
- To reduce fragmentation and or duplication of services
- To develop system-wide patient treatment plans;
- To implement high quality and useful research.

We still need to work better this network, specially concerning this main goals.

#5 Of which significance are psychotherapeutic interventions within the framework of prevention and early intervention and which role do psychotherapists have in the treatment of alcoholics, both as inpatients and outpatients?

A. Psychotherapeutic Interventions: prevention and early intervention

Within the framework of prevention and early intervention – primary care setting, we still have in Portugal a **huge lack of psychotherapeutic interventions** specially because of the lack of contracted psychologists to these health structures.

Brief and early advice related to alcohol consumption are usually done by doctors and nurses in primary health centers using simple advice and patient education materials mainly based on Babor and Hoggins-Biddle manuals (2001,2001a):

- “Brief Intervention for Hazardous and harmful drinking. A manual for use in Primary Care”;
- “AUDIT. The Alcohol use disorders identification test. Guidelines for use in Primary Care”, both from World Health Organization.

When patients underestimate the risk associated with drinking or are not prepared to admit and address their dependence, specific motivational interventions using Motivational Interviewing (Miller & Rollnick, 2004) are used to address patient resistance. Clinical examination is also provided. Information about what constitutes a standard drink is often provided and educational brochures are available.

However, we need further implementation of Brief Interventions and **there are still some barriers between primary health care workers regarding patients with alcohol related problems**. There is an imperative need of formation inside this professional group. This demand is one of the up to date priorities, **as well as hiring more psychologists**.

Given the prevalence of problems related to alcohol consumption in our country, in 2016 The Portuguese Psychologists Association (OPP) **published a guideline for psychological intervention on alcohol related problems**, as well as for the necessary referral. This document resulted from a collaboration with several entities with which the OPP shares common interests and objectives and that form the National Alcohol and Health Forum (FNAS) in order to help psychologist and psychotherapist learn how to conduct

psychotherapeutic interventions within the framework of prevention and early interventions, as well as how to referral to specialized Units all over the country.



https://www.ordemos psicologos.pt/ficheiros/documentos/guia_orientador_da_intervencao_psicologica_nos_problemas_ligados_ao_alcool_2016.pdf

B. Psychotherapeutic Interventions: treatment

In the treatment of alcoholics, psychotherapists usually work integrated in multidisciplinary teams, both in inpatient and outpatient settings, and do have an important role in fostering positive change in people with alcohol related problems and their families.

For psychotherapists treatment is understood as a complex and dynamic process, a biopsychosocial process in alternative to the “disease model of addiction.

In fact, there is much higher ratio of psychologists in our treatment facilities (level 2 and level 3 from NARN), than in other mental health structures in Portugal.

The therapeutic relationship anchors the patient in treatment, it sets the stage for other therapeutic tasks during the recovery process and offers the possibility of a new relational experience that may constitute a healing alternative to the early ones that contributed to the addictive vulnerability.

For patients that have problematic primary relationships histories (e.g. traumatic loss, abuse, lack of attunement), it is hoped that therapy (individual and /or group therapy) will provide them a relational experience that is attuned and affirming.

In this way, the therapeutic relationship may constitute the basis for developing a greater capacity to trust and depend on others and feel worthy of being loved. As it becomes internalized, it will allow patients to decrease their reliance on substances for a sense of well-being and, instead, increasingly turn toward people:

- Main goal: motivate people made good use of therapy, leading to positive and meaningful changes in their alcohol use and a wide range of other related and unrelated issues.
- Initial goal: to learn about the nature of one’s drug use from a collaborative exploration.

From a psychological perspective, all drugs, and alcohol in particular, have some benefits for the user, at least at an early stage of the consumption relationship, otherwise they would not be consumed (Nutt, King, & Phillips, 2010).

In the first person we are told that alcohol reinforces or rewards in a way its social, sexual, creative behavior because:

- gives pleasure, it removes anxiety, it facilitates social relations, it gives a sense of power;
- because it anesthetizes or self-destructs unpleasant memories, inhibitions, fears and insecurities of repeating the separations, abandonments, losses, and rejections that were often targeted by significant figures (António, 2008) .

Thus, in our clinical practice at the Alcoholology Unit of Lisbon (UAL) as psychologists, our psychological intervention has at least two distinct levels of objectives, which are necessarily interconnected:

1) to promote changes in behavior, first in the behavior related to the consumption of alcohol and / or other psychoactive substances and then in relation to the more global aspect of changing their lifestyle. Here, there is a need to devote time to transforming extrinsic motivation (external pressures) into intrinsic motivation by gaining a personal awareness of the danger posed by its addictive disease to itself.

2) to promote changes in mental functioning, towards self-knowledge and personal autonomy, less dominated by impulses and immediate satisfaction, less dependent on external objects, more capable of thinking and thinking about others and to see them as autonomous subjects and separate from themselves.

Transversal to this two levels of intervention is always the work of relapse prevention, which we can carry out in individual format in the psychological consultation or in a group format referring to the Intensive Outpatient Relapse Prevention Programs which the main source of inspiration is the Marlatt and Gordon Relapse Prevention Model.

In short, it is not enough for the individual to achieve abstinence from alcohol, it is very important that psychotherapeutic work helps transform this particular mode of apprehension of the world under all prisms: the relation with the other and with the substance, the relation with the time and the relation with the body. It is the restoration of satisfactory bonds that we must have in view.

The impulsiveness we observe, their difficulty in postponing gratification, or tolerating frustration often reflects their limited ability to symbolize affections, their lack of knowledge about their true long-term needs, and how they will be able to satisfy them.

Ambivalence, mistrust, and dependence can be extreme challenging and recurring. The psychotherapeutic work is often slow and it is up to us psychologists to tolerate periods of absence and chaos while maintaining our availability and the consistency of our help.

It is only at a later stage that the psychotherapeutic process unfolds in the direction of knowledge: progressive recognition of the type of anxiety and primary defense mechanisms and the discovery of what lies behind them, taking into account the personal history of each user. The ultimately need is for the patient to change his relationship with the world in his daily life relationship.

Finally, we think that psychotherapy, in the addiction problems must continue to be assessed and that it has to be updated, adjusting to the real issues, like introducing harm reduction psychotherapy programs. This is because we believe that it is human relationships, sufficiently flexible, safe and enlightened, the only antidote against alcohol and / or other substances and all other contemporary addictions.

#6 What would in your opinion be a good environment for a moderate consumption of alcohol?

From a psychological perspective, all drugs, and alcohol in particular, have some benefits for the user, at least at an early stage of the consumption relationship, otherwise they would not be consumed (Nutt, King, & Phillips, 2010). This relationship will fall along a continuum from healthy to unhealthy just like relationships with people do.

Learning to live with pleasure and with alcohol and, at the same time, knowing its risks and limits can be learned. The vast majority of alcohol users, like most consumers of other substances, will not become addicted. They experience lifelong and manage the pleasure and risks associated with their consumption: it is only for a small part that develops harmful use and/or dependence. Overall, people are agents of transformation and not the structures, the laws or the policies of control and prohibition.

In my opinion, a good environment for moderate consumption of alcohol needs:

- Firstly, at home, very early in the relationship with parents and / or other attachment figures, the pleasure of play, with affection, empathy, availability, respect and safe and clearly defined limits.
- Then, as growth develops, the presence of rituality in the family, celebrations activities and conversations at the table are needed, with the exchange of different interests and others shared about alcohol and pleasure and ways of drinking and its consequences.
- It is always up to the adult, the role of being able to read and translate hazardous or harmful use, to meet the meaning of this behavior and ensure its protection concerning the youngest.

Every moment of celebration should be the story of an encounter, more or less achieved and this is the experience in today's society that we seem like less able to share. Relation between alcohol consumption and young people today must force the presence of adults. Because the relationship and family cultures only become headlights that illuminate the growth path, when they compromise people in an encounter, a relationship.

To conclude, at the heart of human development is the bond, the attachment and it is also this relationship that is at the center of our interventions.

**#7 How should existing services for the treatment of alcoholics be developed further?
What needs to change in your country in order to warrant this development?**

- More human resources, especially psychiatrists and psychologists specialized in addiction in our multidisciplinary teams, able to develop innovative treatment responses outside the traditional “abstinence-only” addiction treatment model;
- We have a lot the “pressure of numbers” for new admissions, press time for our interventions but our clinical practice shows us that alcohol consumers need the safety, structure and therapeutic space provide by psychotherapy traditions as essential ingredients in the effective treatment of this populations;
- In Portugal, we still have in many care services a treatment model fundamentally based on the disease model of alcoholism, geared towards abstinence and lifestyle change leaving many users across the spectrum of severity out of health treatment facilities because they did not seem to be identified or to be interested in what our programs are offering. We must change treatment paradigm. For that, we need to invest more in formation and training in alcoholology filed by introducing training programs for health care professionals to increase ability to treat hazardous, harmful and alcohol dependence and reduce cultural prejudices and moral judgments;
- A better connection with doctors and nurses from primary heath care centers will be fundamentally.
- On the other hand, in our country despite the model of HARM REDUCTION (HR) is widely recognized as an essential strategy for intervention among people who use drugs, the same is not true for those who consume alcohol.
- We need teams capable of integrating and thinking about this approach on a daily basis. Teams that encourage innovative responses within the most formal treatment structures, able to include consumers, discussing with them alternatives adapted to their different social contexts and needs.
- Bringing HR into a treatment unit specialized in alcohol-related problems is putting the HR in favor of the National Health Services users;

- We need to form HR teams, to intervene with alcohol consumers in their different contexts and meet their different needs, as well as to facilitate the referral of these users to the treatment structures;
- Teams more articulated with the community, betting on more and better synergies, innovative, human, pragmatic and comprehensive responses. The common goal: alcohol being no longer “the poor relative” of harm reduction in Portugal.
- Finally, we also need to prioritize preventive actions, which have been losing continuity in the last years and reinforcement.