Project: Nordic exchange of knowledge in substance abuse care

LOCAL INNOVATION IN SUBSTANCE ABUSE CARE

Alcohol and drug problems among young people – Substitution treatment –
Alcohol problems in somatic care

norden

Nordic Centre for Welfare and Social Issues

ABOUT THE PROJECT

In all of the Nordic countries, the question has been asked how substance abuse treatment and healthcare resources can be better organised in an age when resources are increasingly limited. Is there room for local solutions in the treatment systems?

You have in your hand a report from the Nordic exchange of knowledge in substance abuse care project (NoLoM), which was initiated by the Nordic Centre for Welfare and Social Issues in 2011. Our objective has been to compare and highlight local solutions in three areas of substance abuse care – Young people with extensive substance abuse, concealed alcohol consumption among patients in primary care and patients who break off substitution treatment. Four Nordic municipalities have participated in the project – Aarhus, Stavanger, Umeå and to some extent Espoo.

In the report, we compile examples of good local efforts that have been illustrated in the project. We hope that they will serve as inspiration to challenge procedures and working methods.

Do not hesitate to contact us if you are interested in our work.

Project: Nordic exchange of knowledge in substance abuse care - NoLoM

Local innovation in substance abuse care

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CONTENTS

MUCH TO LEARN FROM PUBLIC LOCAL SERVICE DEVELOPMENT IN THE NORDIC REGION

In the Nordic tradition of universal welfare, the objective has been to be able to offer the same range and quality of services, regardless of a person's place of residence in the country and socio-economic status. The extensive involvement of the state in terms of deciding how services should be organised, what professional guidelines should be followed, and what rights users have to services must be considered against the backdrop of such a tradition. At the same time, there is a strong tradition of local and regional service development in the Nordic countries. Local and regional self-government and the adaptation of services to suit the conditions of specific local/regional communities is also frequently highlighted as being a major asset of the Nordic welfare model, albeit with different emphases placed on various aspects of this issue in each of the Nordic countries.

This apparent dichotomy between strong national guidance and active local service development is the starting point for the NoLoM, a comparative service development and research project carried out in the Nordic region. The idea for the project emerged during a workshop about service systems focused on substance abuse treatment, organised by the Kettil Bruun Society. It was then further developed through an initiative led by the Nordic Centre for Welfare and Social Issues. The research communities in Finland, Denmark, Sweden and Norway joined in the effort, and began coordinating with service development researchers in Århus (Sweden), Umeå (Sweden) and Stavanger (Norway). Service developers in these three cities immediately showed great interest in participating in the project. Their interest was aroused both by the chance to learn from the experiences of the other cities, and the opportunities presented by increased dialogue between the research community and those involved in service development.

At the very first joint workshop in 2012, those involved in the project agreed to conduct a study of the regulatory framework for local service development in the Nordic countries[1]. They also agreed to focus the project on three target groups, which later constituted the subprojects undertaken by NoLoM: a) the somatic health care system's identification of alcohol-related issues, b) a web-based survey of substance abuse, mental health and well-being, as a basis for preventive and health-improving measures aimed at young students (16-year-olds) and c) measures to prevent the unplanned interruption of substitution treatment.

It soon became clear that the best research data could be gained if each of the projects involved at least two of the three cities, and if a close dialogue was maintained between researchers and service developers during every phase of the initiative. Therefore, we are excited to now be in a position to summarise the concrete experiences and information that have been gleaned from this development project.

Ewa Persson Göransson

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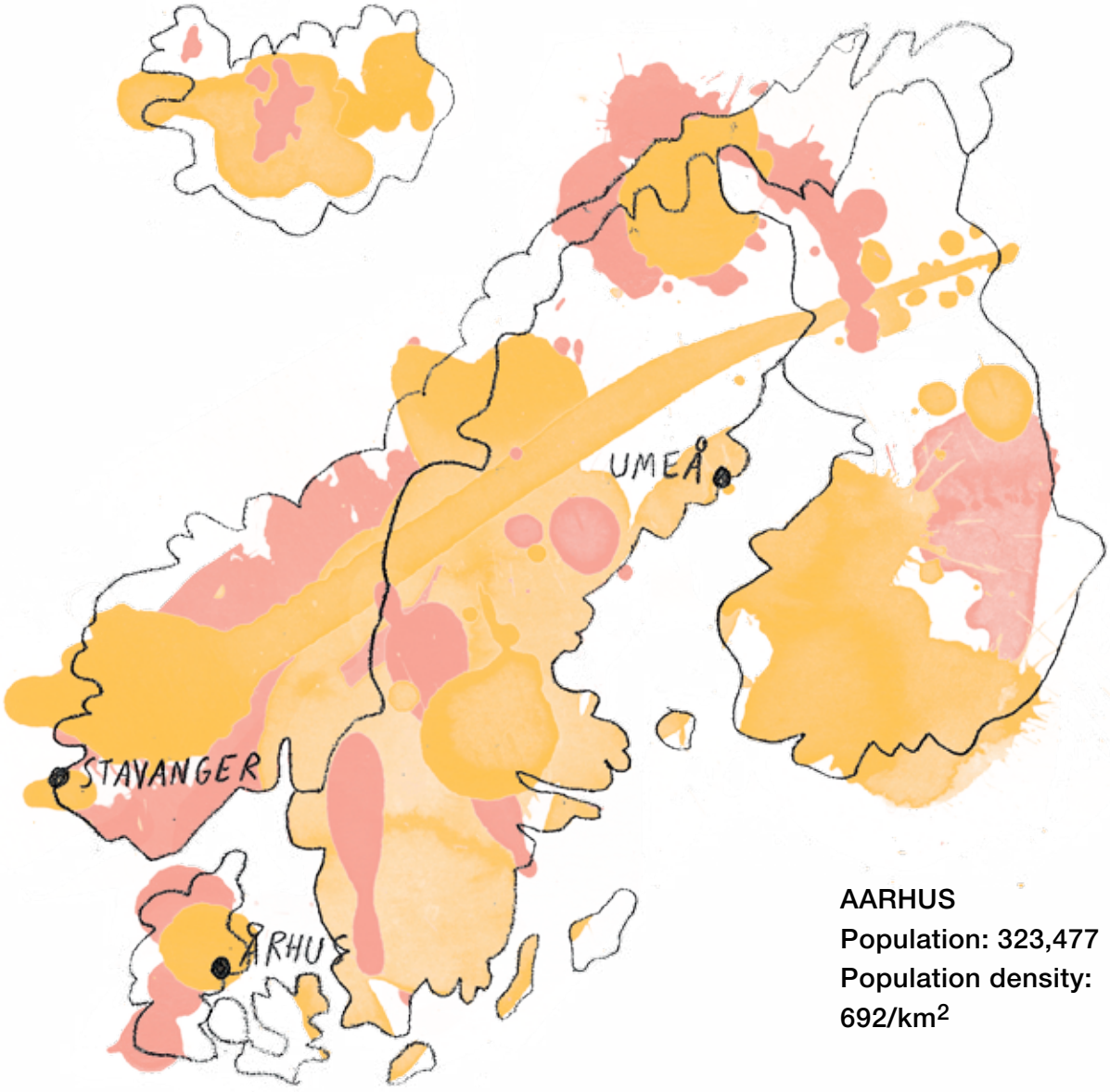
[1] Næss, O., Opedal, S. & Nesvåg, S (2014): Room for action? How service managers in three Scandinavian cities experience their possibilities to develop their services. Nordic Studies on Alcohol and Drugs 31(3), 289-307



AARHUS
Population: 323,477
Population density: 692/km^2

STAVANGER
Population: 130,000
Population density: 1,815/km^2

UMEÅ
Population: 120,000
Population density: 50/km^2

Practitioners and researchers from Stavanger, Aarhus and Umeå participated in the project.

LARGE DIFFERENCES IN SUBSTITUTION THERAPY IN THE NORDIC REGION

BACKGROUND

Opioid substitution therapy has been controversial in the Nordic countries. This treatment reached Sweden and Denmark as early as the 1960s, but has since gone different directions in the two countries. In Denmark, it quickly became a central part of substance abuse care, while its structure was strictly regulated and, after this study, became more liberal in 2015 in Sweden.

In Norway and Finland, the therapy was not begun at a national level until the 1990s. In Norway, the number of patients has increased sharply since a legislative change in 2010 liberalised regulation. Finland also reduced control and increased availability, but the number of patients is not increasing at the same rate there. Since 2008, the percentage of Finnish patients that only receive medication without other care

increased. The national guidelines for care in Finland give those who offer the therapy a free hand, which means that there are many small units with different practitioners.

LOCAL CHALLENGES IN CARE

Substitution therapy varies between the different countries, but in all of the countries, there are unplanned interruptions of treatment. Why? What are the reasons behind the discontinuations? To map the background of patients discontinuing their substitution therapy and thereby be able to improve care practice, people who discontinued and resumed their treatment were interviewed.

Although the practice differs between the countries, the patients interviewed in Sweden, Denmark and Finland say that they are not heard enough in their treatment. They describe how they falter between seeing the substitution therapy as a positive, choosing to live a drug-free life and occasionally a desire to return to the drug use. But they feel that healthcare does not see their wishes and is not adapted to their individual needs for support and care, which can also vary from one day to the next. The therapy becoming routine is a major risk to forms of care that have strict rules and are surrounded by control. These interviews show, surprisingly, that patients both from Denmark, with its liberal care, and Sweden, which was found at the other end of the spectrum, express the same criticism: not being heard.

THE PATIENT'S OWN OPINION IS IMPORTANT IN SUBSTITUTION THERAPY

In the NoLoM project, patients who discontinued and resumed therapy were interviewed in Aarhus, Umeå and Espoo/Helsinki. The aim has been to understand why the treatment was discontinued, why it is resumed and what the time without therapy looked like.

AARHUS: LISTEN TO THE PATIENTS' WISH TO BECOME DRUG FREE

Denmark's substitution therapy has the lowest threshold in the Nordic region. The patient shall receive care within two weeks, but the waiting period is often much shorter in practice. Parallel substance abuse and criminality during treatment is not sanctioned and the patient also does not need to have permanent housing. The patient can take home doses after two weeks in treatment.

A user survey that was done at the Centre for Addiction Treatment in Aarhus in 2013 showed that almost half of the patients wanted to be rehabilitated to be free from drugs. The high percentage surprised the healthcare staff.

Many of those interviewed in Aarhus expressed a desire for an opioid-free life, to be independent of both therapy and narcotics. They falter between seeing the advantages of being in treatment on one side and wanting to live a drug-free life on the other. The fear of relapse can prevent them from trying a life without medication, and sometimes even from expressing a desire for it. The patients do not express their wishes, but they feel that the staff also do not ask for them.

A central problem that comes forth in the interviews is that the patients are not systematically interviewed during the course of the treatment. Consequently, the staff does not notice if the patients change their treatment goals. At the beginning of treatment, the primary wish is often to stabilise life, but the goal can change with time. Some are satisfied with the substitution therapy; others are not.

The staff should be sensitive and provide support and advice to those who want to decrease their medication dose. Support from the patient's family and relatives in cooperation with healthcare personnel is important during every phase: when the patient wants to stabilise his or her life, decrease the dose or live a drug-free life.

If care is suddenly discontinued because the patient wants to live entirely without opioids, it can result in a relapse, which happens for about 60 per cent of the patients. It is easy to be readmitted to therapy in Denmark, but a relapse is nonetheless often perceived as a failure and can have dramatic consequences for the patient's future treatment.

A systematic follow-up of patients who left therapy is sought for as a way to follow-up the causes behind the discontinuation. Similarly, systematic interviews with those who resume treatment could shed light on the reasons why a life without therapy did not succeed.

UMEÅ: AMBIGUOUS RULES FRUSTRATE THE PATIENTS

At the time of the survey, patients had to be at least 20 years old and have one year of undocumented opioid use behind them to be admitted to substitution therapy in Sweden. Nor may pa-

tients test positive for drugs other than opioids during one month before therapy begins. After six months in therapy, the patient can begin to take doses home with them.

The patients interviewed in Umeå say that it does not feel as if the staff listen to them. Above all, they describe a frustration over the treatment's rules being unclear: that the rules for being expelled from therapy are applied arbitrarily and that they are treated unfairly.

The double role that the healthcare personnel have in substitution therapy – treating and controlling – makes it difficult for the patients to feel any trust for the staff. It is therefore important that the patients know what is expected of them, but also that the staff realise the care to which the patients are entitled. Trust between the staff and patients can then be built.

Those interviewed wanted more psychosocial support in connection with the medication. The dual responsibility between medical care services and social services requires that there is close cooperation in order to provide the patients a suitable treatment. Since medical care staff is also responsible for the disciplinary measures, the psychotherapy must be handled by a therapist who does not work at the clinic.

ESPOO/HELSINKI: BECOMING ADDICTED TO THE THERAPY

Substitution therapy has two goals in Finland, to rehabilitate and become drug free or reduce the risk of damage and improve the quality of life. After the patient has been deemed to be in need of care, he or she usually has to wait three months to enter substitution therapy.

Those interviewed in Espoo/Helsinki say that they not only feel addicted to opioids, but are also addicted to the actual therapy. They may consider the quality of life with therapy to be better than when they were drug users, but they often seek a life without substitutions or opioids. This is despite being aware of the risk of relapsing. If they discontinue therapy, they also have to wait three months to resume it.

The treatment should take the patients' wishes into account and support those who want to end their treatment, so that it takes place in a controlled manner. Those interviewed had been expelled from therapy because they acted violently, provoked by the therapy's rules.

Recommendations

- Carry out questionnaires among the patients to survey what they feel about how your operations are structured. Use the answers to develop the operations.
- Systematically document the discontinuations in the substitution therapy and their causes. Many people who discontinue therapy also have mental problems and there is also a large risk that they will also discontinue mental health therapy.
- Strive to exchange knowledge and ideas with neighbouring municipalities to compare local practices. Even if you work under the same rules, the work can differ in practice.
- Be clear about what rules are in place for the therapy. Only then can the patients understand what is expected of them. Strive to make decisions together with the patient.

Chief Medical Officer Mikael Sandlund says that it is problematic to balance the rules with the treatment.

SKILLS TRAINING AND INDIVIDUAL SOLUTIONS ARE SOUGHT

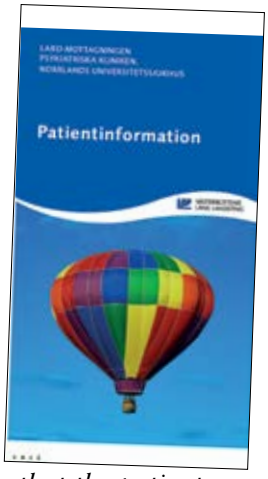
When the clinic for substitution therapy at Norrland University Hospital in Umeå interviewed their patients, they expressed a desire for clearer information about the rules of the therapy. Ambiguities led to uncertainty and frustration among those who were released. They got the clinic to review its procedures.

edication-assisted rehabilitation for opioid dependence (LARO) in Sweden was, by Nordic measures, strictly regulated in 2015. The National Board of Health and Welfare's regulations provide limited room to manoeuvre for those providing therapy, but there is, however, freedom in how patients are personally treated and how work is done in practice. This is according to Mikael Sandlund, Chief Medical Officer at the Department of Psychiatry in addiction psychiatry at Norrland University Hospital.

"Work with the rules is done in slightly different ways. For me, a very important ambition in my LARO work is to tone down the disciplinary part of the operations. One can very easily end up in a more disciplinary than treating role towards the patient," says Sandlund.

Sandlund describes a problematic situation for the staff, where the care – what the staff has been trained in – is easily overshadowed by the work of calling the patients' attention to various rules.

As a pilot study in the NoLoM project, patients who had been released from the LARO clinic were interviewed. The interviews showed that many patients were uncertain of the rules and wished they had been clarified. A prerequisite for the treatment to succeed is that the patients know from the beginning what is required of them. The clinic now hands out a brochure with information for the patients. The brochure describes the treatment programme in brief points, from the application and investigation process, to the care plan and rules for travel, for example.



The brochure that the patients receive described the therapy in brief. The brochure (in Swedish) is available for download at nordicwelfare.org/ANDTgodpraktik.

"There are people who do not require much commitment from the team. Then there are those who have a harder time. I wish there were two programmes in LARO. A formalised programme for functioning individuals, who collect the medication at the pharmacy and see the doctor once a year, and a clinic with a lower threshold and greater tolerance for deviations and greater intervention preparedness. The therapy now does not provide room for individual solutions," says Sandlund.

WE NEED MORE METHOD DEVELOPMENT

Sandlund says that he lacks specific methods for psychological treatment in connection with LARO. Many want to have the medication and not much other treatment, while others want therapy in addition to the medication.

"For many clients, medicine is 99 per cent of what they want and in some cases, the only thing they need. Then there are a large number of people who are in need of more treatment. Here, method development would be needed. There is little research about psychosocial efforts combined with LARO," says Sandlund.

Sandlund also says that the new life that many patients begin when they are admitted to LARO treatment places great demands on the individuals. There are new procedures to be followed, not just to follow the rules of the therapy, but also to adjust to a so-called normal life. Sandlund talks about skills training, how to handle daily life.

"There is a need for concrete help to structure and plan one's day. Strategies are needed to remember things and to obtain a daily rhythm. Many come from a background that has not been so structured," says Sandlund.

In 2016, a project about sleeping disorders among LARO patients was begun in Aarhus, Umeå and Skellefteå. Sleeplessness is common among the patients and can strongly influence the treatment.

"Nearly everyone sleeps badly, wants sleeping medicine and some get it. But sometimes, they have to go to a different doctor to get medicine and then problems can arise if they are a LARO patient," says Sandlund.

The interview was done in spring 2015.

THE THERAPY IS STRUCTURED ACCORDING TO THE CLIENT'S NEEDS

A user survey at the Centre for Addiction Treatment in Aarhus showed that nearly half of the patients in the medication-assisted treatment wanted to become entirely drug free. The problem is that myths and fears cause the patients to not share their wishes with the staff.

Vinnie Thomsen, Director of the Centre for Addiction Treatment, says that the high number is not surprising. Earlier studies have shown the same results.

"The users don't dare say that they want to become drug free because there are many who believe that they cannot be in treatment if becoming drug free is a goal. At the same time, they feel that they're addicted to the actual treatment and I don't think anyone thinks that's pleasant," says Thomsen, referring to the rules in the treatment that govern the patients' lives.

"We have to teach the staff who distribute the medication. They're the first ones to notice if users miss their treatment. They're the ones who talk with the users and have the possibility of saying that we can also help achieving freedom from drugs if it's what they want," says Thomsen.

Many of the patients, or the users, who are in treatment are used to living a life where they sometimes use narcotics and sometimes do not. In therapy, however, they feel that they are always medicated – that it is all or nothing. This perception should be changed, says Thomsen.

"We focus on those who end their treatment. If they want to become drug free, we should include them in the therapy and show that they can also use the therapy to cut back."

INTERVIEWS SHOW THE WAY

Patients who are admitted back after a relapse receive a new treatment plan. The staff interviews the users about their perspectives of and goals in the treatment. A time frame is planned and after every talk, how the situation progresses is monitored and the relationship between the client and the staff is evaluated. This takes place through so-called Feedback Informed Treatment (FIT).

"Cutting back is planned as a part of the treatment plan according to the client's individual treatment objectives. We plan when they want to begin cutting back and during what time perspective," explains Thomsen.

What also came forth in the user survey from 2013 is that most want to have an individual treatment over group therapy and that the supervision will support them in achieving their goals, whether this is becoming drug free or not.

"Our treatment is primarily based on individual treatment models when it concerns substitution therapy, but we always evaluate what sort of treatment the user wants," says Thomsen.

Thomsen generally emphasizes the importance of the client's social surroundings.

"We pay attention to the importance of the social network in the work of becoming drug free. We try to say that it plays an important role and encourage them to let relatives to familiarise themselves with the treatment. But it's not easy. It's hard to take in relatives since the substance abuse isn't something one talks about," says Thomsen.

COLUMN:

INNOVATION EMERGES FROM LOCAL ENTREPRENEURSHIP

Ole Naess
Korfor Resource Centre, Stavanger

In 2014, we carried out a study of substance abuse treatment service systems in Stavanger, Århus, and Umeå. Our question was simple. We asked 23 directors of drug abuse treatment centres about what opportunities and limitations they saw for local service development work, within the context of treatment that is characterised by registration systems and standardised therapies.

First of all. There was no doubt that the respondents to our survey were sick and tired of reporting key figures and statistics over and over again. They felt that they spent a lot of time delivering data to various authorities and government agencies, without really being able to see the benefit of doing so. Certainly. Many felt overwhelmed by all the forms for ordering/carrying out treatment models. Oh, yes. Many thought that there were too many guidelines to keep track of. And of course, there are. The challenges of coordinating between services has not diminished in recent years. One outpouring of frustration from a participant working in Denmark (where they have recently carried out a comprehensive structural reform) reads as follows:

"Say hello to Norway and Sweden from me, and tell them that coordination challenges don't disappear when you merge municipalities and restructure your organisation. They just get shifted elsewhere."

But wait! Another story emerged. It became clearer and clearer as our analysis progressed. Workers and leaders in this line of work tended to cross paths. They attended the same follow-up and continuing training courses, participated in the same seminars, and they were in contact with their respective research communities. Researchers also met each other at conferences, read the same articles, and conducted collaborative research projects. In summation, it became clear to us that the drug treatment services in these three Scandinavian cities were also affected by other conditions than government-imposed organisation models and guidelines. These services are made up of strong, professional and autonomous groups of participants who make their own decisions about how they choose to relate to the guidelines set forth by their higher-ups. These players assimilate the guidelines and convert them in a manner that better suits them to the current reality, so that they can be applied to any situation, at any time.

In Stavanger, local leaders initiated and started a low-threshold outreach treatment team in partnership with the municipal government and the specialised health services organisation. In Umeå, Västerbotten County and Umeå Municipality have founded a low-threshold alcohol and drug treatment centre. Århus took inspiration from the model used by NICE (National Institute for Health and Care Excellence) in England, and built its own alcohol abuse treatment centre from the ground up. The commonality between these three examples (there were many more) is that they have evolved in communities characterised by their local entrepreneurship, dedicated managers, and employees who engage in various forms of interdisciplinary and intersectoral collaboration.

– HIDDEN ALCOHOL CONSUMPTION IS MORE COMMON THAN MANY BELIEVE –

The consequences of risky alcohol consumption can take different shapes. It can affect the development of diseases or lead to accidents. In many cases, the risky alcohol consumption is hidden from doctors and employers, but sometimes also family and friends. There are clear advantages of calling attention to the risks of alcohol at an early stage. The NoLoM project has identified two arenas for such interventions.

Most alcohol-related problems go unnoticed in the healthcare services. The problems can vary from cardiovascular diseases and liver damage to fatigue, infections and cancer. A Norwegian study shows that no more than 20 per cent of the alcohol-related problems in Norway come to the attention of the social or healthcare services. There is a large number of unreported cases, which in the long run can have a major impact on both quality of life and costs to society. Among the group with a concealed alcohol consumption are those who have a harmful or risky alcohol consumption. The alcohol-related problems are not always the typical issues like cirrhosis of the liver or addiction, but may instead be indirect illnesses or damage caused or exacerbated by alcohol consumption. Accidents, high blood pressure, infections that never pass or sores that never heal are some of the consequences that may come from a harmful alcohol

consumption. Among this category are also individuals who only have risky alcohol consumption and whose alcohol consumption may in the future lead to complications.

In the NoLoM project, two arenas were identified where attention to hidden alcohol consumption can be brought and it can be discussed and methods developed. The first is somatic hospitals, where patients seek care for illnesses or symptoms that may be related to alcohol consumption. The second is low-threshold clinics for alcohol and drug treatment.

PRIMARY CARE A KEY ARENA

A person's harmful alcohol consumption is often known among family and friends, but is not always as visible to colleagues and other networks. Here, somatic hospitals play a key role for identifying and calling attention to risky alcohol consumption. Repeated visits to the healthcare centres for the same problem or traces of alcohol in the blood may signal that a talk about alcohol would be appropriate. Clearly explaining the connection between the patient's state of health and how it is affected by alcohol is a good basis for the talk and reduces the risks of stigmatisation and moralising around a person's drinking habits.

In Stavanger, a model with so-called alcohol and drug counsellors was developed. The core of the model is that doctors and nurses at somatic hospitals learn to identify patients with risky alcohol consumption and refer them to an alcohol and drug counsellor for talks. The objectives of the talks can vary from patient to patient with the main objective being making the patient aware of his or her alcohol consumption.

In the five years that Stavanger University Hospital has had alcohol and drug counsellors employed full time, growing numbers of patients have been referred to talks and the model has proven to be effective to reach people with a concealed alcohol consumption. At the beginning of the pilot, mostly patients with liver and cardiovascular diseases were referred to the counsellors, but over time, the perception of what is risky drinking has been expanded, and patients with other symptoms have begun to be referred to the counsellors. On page 16, we interviewed the alcohol and drug counsellor Hege Tvedt about how she works in practice.

AVAILABILITY IMPORTANT TO REACH CONCEALED ALCOHOL CONSUMPTION

Another area that received attention in the research team is the need for clinics for persons who largely live stable lives, but are worried about their alcohol consumption. This is a group that may feel that contacting the social services would go too far and that all they actually need is to discuss their alcohol consumption with somebody.

The alcohol and drug clinic in Umeå is an example of such a low-threshold clinic that was founded to fill a gap in the healthcare offering. The principle is that people who contact the clinic – including relatives who can phone in – shall be offered an appointment as quickly as possible. The clinic requires no referral, but rather it can be like phoning the dentist, as the clinic's coordinator Lena Häggström says in the interview on page 20.

Just like with the alcohol counselling at the hospitals in Stavanger and Umeå, the goal is that the person with the substance abuse shall him or herself become aware of the consequences that the substance abuse may have – both on others in the surroundings and on one's own health.

Nathalie Idsøe (first from the right) and Hege Tvedt (second from the right) have worked as alcohol and drug counsellors at Stavanger University Hospital for three years. More than 750 patients were referred to them in 2014, a marked increase from previous years.

ALCOHOL AND DRUG COUNSELLORS REACH THE HIDDEN ALCOHOL CONSUMPTION

Since 2010, Stavanger Hospital has had two alcohol and drug counsellors who are employed with a single task – discussing risky alcohol or drug use with patients who are admitted to somatic hospital wards. In seven years, the number of talks increased tenfold and now, several other hospitals in Norway have begun similar activities.

Up to one out of five patients admitted to Stavanger University Hospital need care for diseases or symptoms that are alcohol related. This may involve somebody falling down while intoxicated, cardiovascular disease or epileptic seizures. If attention can be brought to the patients' risky alcohol consumption, it can hasten the recovery and prevent the diseases from developing. The solution may be as simple as reducing the alcohol consumption.

At Stavanger University Hospital, Hege Tvedt works together with her colleague Nathalie Idsøe as alcohol and drug counsellors. Tvedt has a background as a social worker and Idsøe as a nurse in the alcohol and drug field. They are both employed full time to talk with patients who have risky alcohol consumption.

HEALTHCARE STAFF IDENTIFIES, THE ALCOHOL AND DRUG COUNSELLOR INTERVENES

The set-up is simple. The department personnel, i.e. the doctors and nurses, identify patients who may have risky alcohol consumption – illegal drugs also belong to the area of the alcohol and drug counsellors, but most cases are alcohol-related – and refer them when necessary to an alcohol and drug counsellor, who sits down and talks with the patient.

"An important part of the work is the doctor making the patient aware of the alcohol consumption. If the patient comes in with alcohol in his or her blood, the doctor must take this into account and it provides a reason to refer to the alcohol and drug counsellor," says Tvedt.

Alcohol is a sensitive topic to bring up. It is surrounded by a stigma that can easily be reinforced by how the patients are personally treated.

"For some, it sounds as if one is considered to have a major alcohol problem when referred to us. This is very much due to how the doctor takes up the subject. They ask if the patient would like to talk with a counsellor, and many say no. Nobody wants to talk with a stranger about a topic like this."

Tvedt emphasizes how important it is that the patient him or herself feels that a talk with the alcohol and drug counsellor is relevant to health. It is important that the doctors refer to the patient's state of health when they bring up the issue of alcohol so that the patient sees the benefit of the talk.

The alcohol and drug counsellors have information meetings with new doctors twice a year to inform about their work. The number of patients referred to the alcohol and drug counsellors has increased tenfold since the service was introduced on a pilot basis in 2008 – this figure has risen from some 80 referrals to more than 750 in 2015. The referrals come from ever more departments and the symptoms among those referred have become broader.

"Previously, the referrals were due to clear, alcohol-related diagnoses, like alcohol poisoning, abstinence or delirium. But now, more and more are due to indirect diagnoses, like chest pains, cramps or accidents in an inebriated state," says Tvedt.

It is precisely this that has been the main goal of the substance abuse service – to reach the concealed alcohol consumption. A person with a clear addiction is easy to identify, but when harmful or risky consumption is involved, it may be harder to see the problems that can arise due to alcohol.

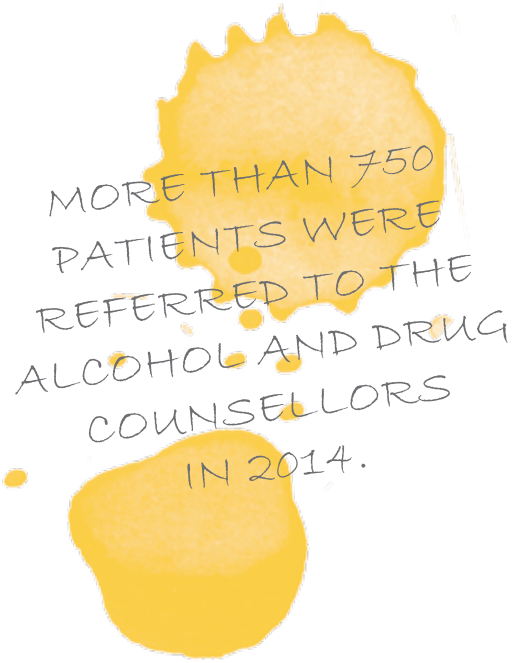
"Those who have hidden consumption might never talk with healthcare staff about alcohol. It's easier to reach somebody at an early stage than somebody who has been drinking for 30 years. Early interventions are therefore important."

Tvedt and Idsøe do not have their office at the actual hospital, partly because the departments are spread out over the city and partly to include and give responsibility to the hospital staff in the identification of alcohol problems.

"If we were at the department, we would have very easily been given the responsibility for everything concerning substance abuse and then, the staff would not have learned much about the identification of risky consumption. It shall be a dual responsibility that can increase the competence of the entire staff," says Tvedt.

UP TO ONE HOUR'S TALK

The alcohol and drug counsellor only visits patients who are admitted to hospital, meaning they must stay at the hospital longer than five hours. If the doctor or nurse believes that there is a need for talks, a referral is sent to Tvedt and Idsøe.



"People are not admitted to the hospital for long, so we have to be quick. We read the referral and relevant parts of the medical records. Then we decide if it is a patient in our target group," says Tvedt.

Patients are divided into two target groups, the primary and the secondary. Among the primary group are people with hidden risky alcohol consumption. The secondary group includes people with a past of alcohol problems.

"Our talks can last up to an hour if needs be, depending on the patient's condition and how talkative the patient is. We ask about his or her family situation, work, social network and lifestyle. It is important to understand what the patient him or herself thinks about his or her alcohol consumption, about what function it has and if they desire a change. We want the patient to become aware of his or her alcohol consumption so that they can decide on changes that they themselves consider to be reasonable."

The need for intervention is mapped. This can vary from long-term treatment to making a plan for how one can cut back on the consumption. Three out of four people who Tvedt talks with are referred by the observation division at the emergency ward. They are patients who are released somewhat quickly so only one talk is usually held with the patients at the hospital. Around 10 per cent of all talks are follow-ups after the hospital stay.

"We have these meetings if the patient wants a change. Some decide at the hospital to not drink anymore and then we can have a talk four weeks afterwards to ask how it went. We can help make up a plan or discuss a more long-term substance abuse treatment if there is a need for it," says Tvedt.

MODEL SPREADING IN NORWAY

Stavanger's model with alcohol and drug counsellors is considered to be a successful way of reaching people with a hidden risky alcohol consumption and has helped the hospital staff bring up the alcohol issue with patients. Since 2013, several Norwegian hospitals have begun focusing on alcohol consumption among patients admitted to somatic hospitals. The alcohol and drug counsellors from the various hospitals meet twice a year to exchange experiences.

The staff at the wards identify individuals with risky alcohol consumption and refer them to the alcohol and drug counsellors. The alcohol and drug counsellor assesses the need for action together with the patient.

What the staff at the ward can think about:

– Could the hospital visit be alcohol related?

– Are there signs in blood samples or from previous visits?

– Is the patient worried about his or her alcohol consumption?

– Discuss the patient with a colleague and send a referral.

– Inform the patient and justify why you are referring to the alcohol and drug counsellor. E.g. "You have fallen and your blood tests show that..." or "Here, it is routine to refer to an alcohol and drug counsellor when alcohol can be a contributing factor to the hospital visit".

Alcohol and drug counsellor's task:

– Read the patient's medical records

– Are there earlier hospital visits related to alcohol?

– Does the patient have prior contact with substance abuse care?

– Does the patient have family, children, work or other networks?

– Talks with the patient. What does the patient think him or herself? Call the patient's attention to his or her alcohol consumption and the connection between alcohol and health.

– Action. Investigate the need for follow-up at their own doctor or with municipal services.

– The patient's own doctor* is notified of the talk.

**** Since 2001, every Norwegian is entitled to their own general practitioner (GP), a "permanent doctor", to whom one often goes for a long time.***

MISSION: OFFER EASILY ACCESSIBLE TALKS ABOUT ALCOHOL

The alcohol and drug clinic in Umeå has one main mission: to be as easily accessible as possible. The clinic was founded to reach the people who cannot control their alcohol intake, but do not yet feel they are in need of contacting the social services. One can call around the clock and a meeting can be arranged as early as the next day, but the clinic is still struggling with distorted perceptions of what alcohol abuse is.

Some time ago, attention was called to a group of patients who regularly visited the hospital's emergency ward. They could return with similar symptoms time and again and could show signs of risky alcohol consumption, which is often hidden from doctors and other social networks and therefore rarely discussed. The person who drinks might not feel he or she has a problem or do not realise the consequences alcohol consumption can have on health.

"Politicians and employees realised that there was a gap in the care offering and that there was no substance abuse clinic in primary care for persons who realise that they have problems, but would not seek contact with the social services. We received an assignment with the specific task of being readily available for this group," says Lena Häggström, who is the Coordinator for the Alcohol and Drug Clinic in Umeå.

The clinic began its activities in September 2008 for this target group, but also for relatives of people with substance abuse. A multi-professional team works at the clinic with counsellors, social worker, psychologists, nurses and doctors. The clinic can be reached by phone and anyone calling can speak with somebody directly.

"Callers are offered the opportunity to come in for a talk as early as the next day. You don't need a referral, kind of like calling the dentist," says Häggström and emphasizes that it is an offering activity, meaning that those seeking support shall themselves perceive their alcohol consumption as problematic and want to have help.

RELATIVES ARE ALSO WELCOME

The clinic welcomes people who themselves have substance abuse problems, as well as relatives. The phone calls are evenly distributed over the two different groups, but Häggström has a feeling that the percentage of relatives increased in 2015.

"The relatives rarely book an appointment for a talk, but rather ask for advice. With relatives, it's important to get help immediately as it's often a sudden event that brought them to call," says Häggström.

Those who seek support are offered five appointments to discuss their living situation and determine the need for treatment. General strategies are also discussed for reducing daily alcohol consumption. For the relatives, the talks are about how to handle problems that arise with another person's alcohol abuse.

"Those who have been in for five talks are called after six months for a follow-up about what their living situation looks like and to follow-up whether the action had an effect. We want there to be a link left to the treatment and everyone is offered the opportunity to come in for a new talk," says Häggström.

STRUGGLING WITH STEREOTYPES

It has become easier to talk about alcohol, according to Häggström, and the picture of what substance abuse is is continuously broadening. Celebrities tell about their alcohol abuse and substance abuse from the perspective of relatives is increasingly covered in the media. But the stereotypical view of a person with substance abuse problems is still difficult to change. The clinic's target group – people who besides risky alcohol consumption have a stable life: work, family and housing – initially did not receive attention in somatic care.

"When the clinic had been under way for some time, we discovered that there were people who were known in somatic care due to repeated alcohol-related visits, but who were entirely unknown to the social services and had never had any treatment for their alcohol problems. There was no tradition in somatic care to guide patients further towards the social services or other substance abuse care. This is something that, for example, the alcohol and drug nurses have helped change," says Häggström.

YOUNG PEOPLE WANT TO KNOW WHO THEY ARE TALKING WITH

The teenage years can be a sensitive time for many. Mental illness, well-being problems and drug and alcohol problems can be factors that affect their school years and how future life forms. Consequently, it is important to find the young people who show signs of these problems. The Centre for Alcohol and Drug Research in Aarhus has developed a questionnaire that combines questions about well-being with questions about drug habits.

Many young people would like to talk about their problems with a counsellor, but the threshold for doing so voluntarily can feel high if the counsellor was not previously known. This is one of the experiences of a pilot project to combine a questionnaire with an intervention that was conducted in Aarhus in 2014. The goal was to identify young people aged 16 to 17 who developed substance abuse and experience mental illness or problems with well-being.

A fundamental idea behind the YouthMap questionnaire, which has been developed by the Centre for Alcohol and Drug Research at Aarhus University, was to survey young people's mental health and well-being together with questions about alcohol and drug habits. Drug use may be due to problems in general well-being or vice versa and understanding the situation of young people requires knowledge about all of these areas of life. A central idea behind YouthMap was to develop a simple method that surveys student well-being, but that does not burden the school.

The YouthMap tool consists of a web-based questionnaire and a computer program that

compiles the results. The questionnaire consists of questions about externalising factors (conflicts, hyperactivity or truancy), internalising factors (depression, anxiety or suicidal thoughts) and social factors (contact to parents and friends) that affect well-being. In a pilot project in Aarhus in 2014, it was also tested to see if the survey could at the same time be used to identify students with problems. The students were given the opportunity to ask for personal feedback to their responses. Everyone who asked for feedback, including those who did not show signs of illness, were given a personal written statement. The young people who were considered to be in the risk group for developing psychological problems, substance abuse problems or other social problems were encouraged to contact a youth counsellor.

MANY SHOW SIGNS OF PROBLEMS, FEW SEEK HELP

In the 2014 school survey, students in Aarhus in year 10[1] were asked to complete the questionnaire. The students had the chance to fill it out electronically during school hours, either anonymously or with contact information if they wanted feedback on their responses.

Two of three students completed the questionnaire, of which one third asked for feedback. Many of them had experienced bullying or felt neglected by their parents. Half of all those who said that they felt strongly affected by loneliness, depression or suicidal thoughts in the past month asked for feedback. The same was true of one third of those who used illegal drugs in the past month.

All of those who sent contact information received personal responses from a researcher at Aarhus University. Besides comments on their answers, the young people received a phone number to a youth counsellor if they wanted to talk with somebody. Those who showed clear signs of mental illness or a high consumption of alcohol and drugs were explicitly recommended to contact the counsellor.

LESSON LEARNED: A MORE PROACTIVE STRATEGY?

None of the students contacted the counsellor although they had shown signs of serious problems, such as suicidal thoughts, loneliness, bullying and drug use. Many young people appear to gladly tell about their problems, but feel obstructed from voluntarily contacting an unknown counsellor.

The pilot showed that the phone number did not work in approaching young people with problems. The counsellor being an anonymous person at the other end was confirmed to be a major challenge. YouthMap is still being used, without the hotline part, to survey student well-being and drug and alcohol habits. This has opened the door to other forms of interventions. On page 24, Professor Mads Uffe Pedersen tells about how YouthMap is used as a way for schools to survey their student's well-being and show what resources they need for their work with the young people's well-being.

[1] Year 10 is an extra year that is possible to take between compulsory school and upper secondary school. Some choose year 10 to improve their grades or take a year in between before continuing education.

YOUTHMAP CALLS TEACHER ATTENTION TO STUDENT WELL-BEING

The YouthMap web survey is used in Denmark to survey how school youths are doing. It has become a tool for the schools to show what problems their students experience and what resources they need from the municipality.

YouthMap is Denmark's most used screening tool in substance abuse care for young people under the age of 18. The tool is actually developed to survey how young people's alcohol and drug use relates to their general well-being. The questionnaire package is collected from a number of different screening and intervention tools, but is based on the idea that young people's networks and well-being have a major impact on the use of drugs and alcohol. The actual tool consists of an electronic questionnaire and a computer program that processes the material.

The young people who reach the substance abuse treatment systems in Denmark are largely those who have what can be called externalising problems. They are the ones who may have difficulty concentrating and easily get into conflicts and fights and skip school. Another group is young people with internalising problems, such as depression and anxiety, says Mads Uffe Pedersen, Professor at the Centre for Alcohol and Drug Research at Aarhus University, which developed YouthMap.

"We have two groups of young people. The group with externalising problems are those who are often associated with drug abuse. If we see who comes to treatment, it is this particular group and it is also this group that is the most difficult to keep in treatment," says Pedersen.

YOUTHMAP AS A POLITICAL TOOL

A school survey among the year 10s in Aarhus was conducted in 2014 to investigate the students' well-being and to be used as an intervention component where young people with problems or in the risk zone for problems were encouraged to call a phone number. Nobody used this opportunity and one of the challenges identified was that the students did not know who it was they would be talking with.

The feedback part has been removed, but the YouthMap survey remains and is now playing a different role in the schools. With the questionnaire, the schools can see how their students are getting on, which has proven very successful for convincing politicians of resources.

"We have not included the feedback part in the survey in the past two years. The schools have used YouthMap politically to show which young people they have in their class and what resources they need to help those who have problems," says Pedersen.

The schools are under financial pressure and the municipality must save money. The schools have used the survey to show the politicians that they need resources to improve student well-being. There is now a youth counsellor from the addiction treatment centre in Aarhus who visits the year-10 class every week.

"The counsellors visit the schools and participate in activities once a week so that the young people know who the counsellor is. The counsellors are close to the students and have close cooperation with the teachers."

The students being able to put a face to the counsellor lowers the threshold in Pedersen's opinion. Phone numbers that young people

can call can work, but Pedersen is sceptical to whether the young people with major problems are reached by these efforts.

Pedersen says that a closer cooperation has been created between the youth sector and the year-10 classes in Aarhus in connection with the counsellors.

"The counsellor being at the school has increased the possibilities of reaching out to young people with problems."

A prerequisite for the YouthMap questionnaire has been that it does not increase the schools' workload, but Pedersen confirms that it has increased the teachers' interest in the students' health. This has also facilitated the contact and increased the understanding between teachers and counsellors.

"We have focused on the questionnaire not burdening the schools. The schools only use one hour on the actual YouthMap survey and that is all we need to do. But the results have generated interest among the teachers in the schools and given them insight into what their classes look like and how their students are doing," says Pedersen.

YOUTHMAP IS EASY TO ADAPT TO NORWAY

The YouthMap questionnaire has been used in two schools in Rogaland, Norway to survey problems with well-being, mental health and intoxication. Research team leader Sverre Nesvåg says that they did not have to adapt the questionnaire much for it to fit the Norwegian society. YouthMap is a good questionnaire, but will be of significance only when it is integrated into the school's work, according to Nesvåg.

Jåttå videregående skole and Randaberg videregående skole in Rogaland, Norway used the YouthMap questionnaire to survey student well-being, use of drugs and alcohol and their mental health. Around 440 students answered the questionnaire and the results surprised the schools.

"The scope of mental illness surprised the schools. But the results are similar to those in Denmark. Boys experience a greater extent of externalising problems, such as aggression and concentration difficulties, and girls experienced internalising problems, such as anxiety and depression," says Sverre Nesvåg, Research Leader at Alcohol and Drug Research Western Norway, which coordinates the study.

Those who have externalising problems use illegal drugs and alcohol to a greater extent, says Nesvåg. However, the use of medication is more common among those who have internalising problems.

"I have a feeling that those with the externalising problems are visible in school and can develop alcohol and drug problems very quickly. Alcohol and drugs might come in at a later phase for the internalising problems."

THE QUESTIONNAIRE WILL START DISCUSSIONS

The main goal of the study is to start a discussion about well-being, mental health and drugs and alcohol in schools. The results from the survey will be presented to the school board, the students and the teachers in the schools.

"If work is to be done with alcohol and drugs in schools, the detour through well-being and mental illness is a must. The connection is so strong that it cannot be ignored."

In Rogaland, the results will be used to see which patterns in the student's well-being and which preventive measures are needed among those who experience problems. With support from the results, Nesvåg hopes for integrated prevention of drug and alcohol problems and mental illness.

"We should connect the teaching environments and well-being more closely together in schools. Well-being should be seen as a prerequisite to learn," says Nesvåg. "And well-being can be linked to mental health and the use of drugs and alcohol."

Some studies are already being done of school youths' alcohol and drug habits, but the advantage of this study is that the schools get to see their own students' results. This creates a completely different commitment, says Nesvåg.

"YouthMap provides an overview, but it becomes significant only when the results are integrated into the schools' work. Doing comparative research is a positive side-effect," says Nesvåg and says that a comparative study between Denmark and Norway will be done.

The Danish YouthMap questionnaire was translated to Norwegian, but not many more changes were needed for it to fit Norwegian schools, explains Nesvåg. Questions regarding moist snuff were missing and were added.

"It's a questionnaire that can easily be adapted to the rest of the Nordic region."

NOLOM – AN INNOVATION MODEL FOR NORDIC WELFARE

Kerstin Stenius
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This report presents some results of the NoLoM project. The project identified three citizen groups in three Nordic cities – Stavanger, Aarhus and Umeå – where substance abuse care should be developed: people in substitution therapy with both social and medical difficulties, young people in their upper teens who are on the way into problematic alcohol and drug use, and people with risky alcohol consumption who are cared for in somatic medical care.

We naturally hope that the results and experiences in this publication will inspire other care units throughout the Nordic region to use the practical tools highlighted in the project.

But we also believe that the NoLoM-project can inspire much more.

As Project Manager Sverre Nesvåg points out in the introduction to this report, the NoLoM project was based on a special strength in the Nordic administrative model, namely the continuous dialogue between the local (municipal) and the central (state) level. New ideas and operating formats are born in the Nordic welfare sector at least as often at the local level as centrally. They can then in the best case be spread and possibly become a part of the national guidelines or recommendations.

In NoLoM, we wanted to start the development work based on local Nordic comparisons. There are many advantages of working locally with development work. Firstly, it is easier to describe and comprehend a smaller local system. NoLoM's work began with a survey of the local systems for substance abuse care. This provided the participants a new perspective of their own municipality's care: what cooperation problems exist, where the resources were too small and where could the local solutions be found? It was also educational to see how similar care units in other Nordic countries, with different basic conditions, tackled similar problems. The parts of the systems, the legislation and the existing care structures indeed provide important and different starting points. But there was nonetheless always a degree of freedom in the practical operations, independent of the system.

The second unique feature of the NoLoM project, which also strengthened its effect, was the close cooperation between researchers, administrators and practitioners. We had the advantage of being able to involve researchers with unique academic insights into welfare systems who at the same time had a local base and a strong commitment to improve care. The collaboration in the project was equally rewarding for all parties. It has already resulted in academic products and will also continue in the form of research projects.

The idea that NoLoM could serve as a working model for other parts of the welfare systems, such as elderly care or child protection, was already present at the beginning. The best local Nordic practices should become public property in the entire region. This may be particularly true of the welfare areas where the problems are complex or chronic and require collaboration over administration boundaries, knowledge of the state of research, as well as realism, imagination and innovative thinking. There is a large potential field of work for the Nordic cooperation here.

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