Screening and brief intervention for high-risk alcohol use in Mae La refugee camp, Thailand: a pilot project on the feasibility of training and implementation

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Many populations that are displaced by conflict experience health and social problems connected to alcohol use. Screening for high-risk alcohol use and brief intervention is a core public health strategy for decreasing the harm related to alcohol use. Experience among populations displaced by conflict is, however, limited. The authors conducted a pilot project in a long standing Burmese refugee camp in Thailand, using the Alcohol Use Disorders Identification Test (AUDIT) as a screening instrument. The intervention was piloted through the existing primary health care system. Screening and brief intervention for high-risk alcohol use was feasible in this refugee camp setting. More work is required to assess the effectiveness of this intervention in settings of forced displacement, as well as the feasibility of incorporating such interventions into community mobilisation strategies and measures, addressing the drinking environment more generally.

Keywords: alcohol, Burma, conflict, Mae La, refugees, screening and brief intervention (SBI), Thailand

Background and rationale

High-risk alcohol use is a neglected problem among many populations displaced by conflict (Weaver & Roberts). Increasing attention to chronic illness (Spiegel et al., 2010) and mental health needs (IASC, 2007) among these populations has so far failed to address alcohol use. Yet alcohol use is known as an important risk factor for many of these problems (Room, Babor, & Rehm, 2005). There are several evidence based interventions, among these is screening and brief intervention (SBI), for which there are many years of multi-country experience (Anderson, Chisholm, & Fuhr, 2009). We report here on a pilot study of implementing SBI in a long standing refugee camp in Thailand.

Refugees from Burma (Myanmar) have been living in Mae La refugee camp since 1984. This camp is the largest of nine camps along the Thai–Burma border, with a current population of around 45.000. Two rapid assessments conducted in the last four years show that alcohol use is considered an important public health issue by camp residents and service providers (Barrett, 2007; Macdonald, 2006). According to these reports, alcohol use is seen as widespread, particularly among adult men, and locally produced rice wine or distilled liquor is cheap and readily available throughout the camp. Although prevalence data on alcohol use and related health effects are unavailable, alcohol use is also seen as an important cause of insecurity in the camp. An analysis

of refugee protection incidents from all border camps reported to UNHCR (2003–2006) showed that a quarter of physical assaults (n = 45) and a *'high proportion'* of reports of sexual and gender based violence (n = 170) were alcohol related, and 'alcoholism' was given as the eighth cause of suicide (n = 29) (UNHCR, 2007). A household survey conducted in 2006 in three camps (including Mae La) showed that the majority of respondents (7% unprompted, 75% prompted, n = 2239) identified alcohol use in the community as an important cause of insecurity. The prevalence of harmful drinking among women is likely to be low (antenatal screening of alcohol use has ceased in view of the very low positive response rate and lack of evidence of alcohol use problems among pregnant women, Rose McCready, personal communication).

From a public health perspective, SBI programmes are among the most important programmes to put in place to decrease the harm associated with alcohol use (Casswell & Thamarangsi, 2009). Population measures, such as increased taxation on alcohol, may not be effective where there is a large informal market (Anderson et al., 2009). SBI aims to detect current or potential problems with alcohol use and motivate those at risk to change their substance use behaviour (Babor et al., 2001). The World Health Organisation (WHO) uses the terms *'hazardous drinking'* for those who are at risk of alcohol related harm, and *'harmful drinking'* for those who are already experiencing alcohol related harm. SBI is aimed at hazardous and harmful, but not dependent, drinkers. This is because, in most communities, the number of people who drink alcohol at risky levels far exceeds the number of people who are alcohol dependent, and therefore this group of people accounts for the majority of the alcohol related harm. People experiencing alcohol dependence may require more sophisticated and intensive support. In this respect, SBI can be conceptualised as an *'early intervention'*, helping people to change their drinking behaviours to prevent the development of dependence. Globally, there are numerous systematic reviews and meta-analyses that demonstrate the effectiveness of brief intervention in reducing hazardous and harmful drinking, compared to control conditions in developed countries (Bien, Miller, & Tonigan, 1993; Wilk, Jensen, & Havinghurst, 1997). There is evidence that SBI is also effective in developing countries (Pal et al., 2007; Simão et al., 2008; Tsai et al., 2009). Evidence from many different settings shows that SBI in primary care can be effective in decreasing the amount of alcohol used, and harmful consequences of using alcohol. It also shows that 5 minutes of brief advice are as successful in decreasing alcohol intake as longer interventions for hazardous and harmful drinkers (Kaner et al., 2009a). There is some evidence to suggest that organisational, logistical, and attitudinal barriers to introduction of the SBI can be important, and prevent its uptake in primary care (Beich, Gannik, & Malterud, 2002). Research has now shifted towards identifying different implementation models to improve the uptake of SBI (Kaner et al., 2009b). There is little evidence on implementation of SBI in refugee camps or humanitarian contexts.

Before implementing the SBI across a number of camps, the authors aimed to test if it was feasible to implement it throughout the existing primary health services in Mae La. A French nongovernmental organisation (NGO), Aide Médicale Internationale (AMI), provides general health and HIV services in the camp. In view of operating constraints and high workloads in the

primary curative care services, exacerbated by recent loss of health staff due to resettlement (estimated at more than 50% since 2007 (Banki & Lang, 2007)), the SBI was to be implemented as a pilot programme through the psychosocial care programme. This programme provides individual counselling care from the primary care and group support (including yoga and art therapy). There are 20 psychosocial caregivers (camp residents) who receive on-the-job training and supervision by two external psychologists (one Thai trained and one French trained) and are supervised by a Burmese trained mental health worker (camp resident). The rationale for implementing the SBI through the psychosocial support programme was threefold: workers had time available to implement the SBI through existing structures; they had sufficient communication and counselling skills necessary to facilitate the delivery of the SBI; and they could provide direct linkages with mental health and psychosocial support for any other mental health issues that might arise through the process of administering the SBI.

Pilot intervention

Adaptation of screening instrument We selected the 10-item Alcohol Use Disorders Identification Test (AUDIT), the current *'gold standard'* (Kaner et al., 2009b), as the screening instrument of choice in view of the accumulated experience globally in using this test, in a variety of cultural settings, including in developing countries (Babor, et al., 2001; Saunders et al., 1993). The AUDIT is a 10 item screening test with up to five responses for each item. Three questions concern use, the remaining questions concern problems. We adapted and translated the English language AUDIT into Burmese and Sgaw Karen languages, the dominant languages used in the camp. Informal group and individual discussions were held with 10 psychosocial caregivers to determine the range of different types of drinks and volume of container. Four samples of the commonly used artisanal distilled rice liquor were sent for estimation of alcohol content (23%, 26%, 27%, 29% ethanol, respectively, 0% methanol), and approximation of the number of standard drinks available in commonly purchased measures. We created a photographic aid, translated into Burmese and Karen. For each language, the instrument was translated by an independent translator, reviewed by an expert committee consisting of two bilingual health workers and two project coordinators, revised, piloted in the camp with the psychosocial care giving team, then back translated into English by a different translator.

Training We developed a three-day training course adapted from existing brief intervention manuals (Babor & Higgins-Biddle, 2001; Gomel et al., 1994; University of Sydney, 1993). The materials were translated into Burmese and Karen. Ten psychosocial care workers were trained over three days (five men, five women; 15–17 September 2009) in Burmese, English and Karen.

A one-month supervised induction period followed the training (1–31 October, 2009), in which health workers integrated the SBI into their usual workloads, as an addition to routine health care. At the conclusion of the induction period, a one daylong feedback workshop was held (3 November 2009).

We briefly assessed trainees' attitudes, confidence and knowledge using a five-item questionnaire immediately prior to, and on completion of, the training, and again one month later. The proportion of attendees scoring 5/5 increased from 50% (13/27) to 75% (20/27) over the course of the training period, remaining at 70% (14/20) one month

later. At the one month review, their confidence in talking about alcohol use with clients and ability to help them to decrease their drinking increased from 55% (11/20) at pre test to 90% (19/20) at post test, and remained at 80% one month later (16/20).

A structured assessment of attitudes towards the SBI was made using a modified Short Alcohol and Alcohol Problems Perception Questionnaire (SAAPPQ, (Anderson & Clement, 1987)). The 10 questions covering five domains were modified so as to be easier to translate into Karen and Burmese, and responses decreased from 7-point to 5-point Likert scale in which respondents were asked to demonstrate their agreement with a statement. Respondants were asked to choose from five options – *YES!, yes, ?, no NO!* – rather than simply agree or disagree, and was shown to be easier to administer and less likely to be subject to courtesy bias (Gifford et al., 2007). The questions were administered verbally in Burmese, English and Karen at the one month post implementation feedback meeting. The majority of respondents (70–100%) gave responses indicating a good sense of role adequacy, task specific self-esteem, role legitimacy, and motivation. By contrast, work satisfaction was mixed: while all respondents felt it was rewarding to work with alcohol drinkers only three '*liked*' people who drink alcohol.

Project implementation In consultation with the psychosocial caregivers, it was decided to implement the SBI pilot through the outpatient services in both outpatient departments. In view of the likely low levels of alcohol use among women, strong cultural norms proscribing alcohol use by women, and important cultural barriers to disclosure of drinking by women, the assumption was that younger men would be less likely to drink dependently. Therefore, in order to reduce workload, adult men aged 15-49 were targeted for annual screening. One worker screened all eligible men in a private room, checked they had not already been screened, noted the score on the health record, and conducted a brief intervention where indicated. The screening instrument took around 10 minutes to administer for those who scored higher than 0 and the whole SBI around 30 minutes per client. Whereas administering the whole SBI for those scoring 0 took around 3 minutes or less. Those scoring over 16 were offered referral to a specialist residential addiction service, Drug and Alcohol Recovery and Education (DARE).

Over a four month period (1 February – 31 May, 2010), 1256 male attendees at the two outpatients departments aged between 15 and 49 were screened opportunistically (representing a programme coverage of 30% of target population attending the clinic). Of these, 36% (446) scored 8 or higher and were therefore considered positive for high-risk alcohol use. Four percent (49) scored 20 or higher, and were therefore considered suggestive of dependence. Those having positive score received a brief intervention, consisting of information on possible harmful consequences of alcohol use, advice on cutting down and were offered further individual counselling appointments (with a very low acceptance of 2%, 10/ 446). Those scoring 20 or greater were offered referral to the specialist service, DARE (with 6% uptake, 3/49 people attended). The project did not allow for further follow up. There was a marked downward trend in the numbers screened (526 month 1, 158 month 4). The date and score was noted in the health record book.

Ethical considerations

The project was conducted in accordance with the Declaration of Helsinki, and was

conducted as operational research for the purposes of programme implementation. It received approval from the Ethics Committee of the London School of Hygiene and Tropical Medicine, as part of a larger project on alcohol use in Mae La, complied with ethical procedures of AMI, and received approval from the camp leadership.

The experiences from the induction period were presented, and next steps discussed in a community feedback meeting with the camp leadership, NGOs and community based organisations. The authors established referral procedures with DARE for people requesting assistance in recovering from dependence. As the authors were concerned that the introduction of the SBI may result in an increased incidental withdrawal in the medical services, 20 medics working in acute care on alcohol withdrawal and the use of the Alcohol Withdrawal Scale were trained.

Discussion

From this pilot, it seems that opportunistic, targeted SBI can be feasibly introduced through the primary health system. In general, the workers gave positive qualitative feedback about the experience of piloting the SBI. They felt that it was feasible and acceptable to conduct the intervention, it did not add greatly to their workload, and that it was a valuable contribution to improving the quality of health and life in the camp. Participants at the community feedback meeting with the camp leadership, NGOs and community based organisations (CBOs), gave positive reception and encouragement to continue with the SBI through primary health care services. Acceptability of this intervention to the population was not addressed here and is partially addressed in a separate study.

There were a number of limitations to the pilot. The disincentive to self-disclose in view of perceived possible negative repercussions and social stigma (Lopes Cardozo, 2004), may encourage under reporting of alcohol use. Despite alcohol use by men being culturally acceptable, this is a closed camp setting characterised by pervasive mistrust. Most alcohol consumed is illicit, informally produced alcohol, and public disruption due to drunkenness can be a cause of imprisonment. Thus, health workers were concerned that respondents may be afraid of retribution, affecting their eligibility to receive food rations, affecting resettlement, or simply '*getting in trouble*'. This disincentive to disclosure was exacerbated by a lack of privacy. Even though the authors offered a separate space for conducting the screening and workers were reminded of the important of confidentiality, in reality, confidentiality and privacy are difficult to maintain in a refugee camp setting. However, in other settings where respondents may under represent their use, they may still score quite high (Babor and Higgins-Biddle, 2001). This perception undermined the confidence of the workers in the effectiveness of intervention. Additionally, the pervasive sense of hopelessness and dispossession meant that health workers and community members alike felt that this would limit people's motivations to change their risk behaviour. A better understanding of the contextual context making up the risk and enabling environment for the intervention is required.

The authors do not know if the SBI is effective (much less cost effective) in this setting. We tested only the feasibility of introducing the SBI through existing primary care services, based on evidence of effectiveness of SBI in a range of other settings. More work is required to assess the effectiveness of the intervention in reducing alcohol related

harm in this population. However, testing the effectiveness of this intervention is subject to considerable operational constraints, particularly in a setting of high mobility of an estimated one third of the target population, young adult men (John-Leader, 2009). In addition, efforts need to be made to improve monitoring and programme evaluation. Data on the public health magnitude of chronic disease prevalence, in general, and alcohol use problems, in particular, are required. Routine data collection should include AUDIT scores by age, and sex. Baseline and follow up prevalence data from household surveys may be useful, although in our experience in other refugee settings, this has been subject to under reporting bias, and in this setting is subject to extreme mobility of the adult male population, affecting both numerator and denominator estimates. More work is required on methods to improve population estimates in settings of displacement.

By choosing the target group (men attending outpatient services aged 15–49), the pilot may have missed many people for whom the intervention could be effective (all women, older men, men not attending health services). The decision to exclude women was driven partly by the perception (and our experience in the antenatal services) that women would be unlikely to disclose their problem alcohol use. Nevertheless, this decision may also have served to reinforce the perception that women did not drink, which may have the unintended consequence of further excluding and stigmatising those women who did drink. More experience is required on different implementation models using community health workers, curative health staff, and targeting different groups.

In Mae La, implementation through the primary (nonpsychosocial) health programme was limited by competing health care priorities (vaccination programmes, urgent curative care, etc.). As a result, some categories of health worker and managers in the primary health programme were resistant to the introduction of a screening programme for a chronic health problem. Indeed, this is the first such screening programme to be implemented in Mae La. To improve uptake in clinical services, more experience is required with shorter tests such as a single item screening questionnaire.

Furthermore, the adaptation of the AUDIT in a situation where most alcohol is informally produced and home poured, as in Mae La, is challenged by the concept of standard drink. This required lengthy explanation (although reasonably intuitive as the informal alcohol trade was in units that were more or less equivalent to 10 g of ethanol). Experience of alternative screening instruments, such as the alcohol portion of the Alcohol Smoking and Substance Involvement Screening Test (ASSIST (WHO, 2003d)), which does not rely on the notion of a standard drink, may be useful in offering a choice of screening instruments in other settings.

Depending on the score, health workers orientated the initial intervention towards simple brief advice, with the option to refer for more lengthy assessment and follow up or to tertiary care as indicated, consistent with standard practice. Using AUDIT scores to guide the choice of intervention is limited in this setting, as the authors do not have any data on the specificity and sensitivities of the different cut off points of the AUDIT in this setting. The cut off point of 8 that was chosen for administering the brief intervention is in accordance with standard practice, and has been shown to be valid in many settings (Babor et al, 2001), including developing countries (e.g. Giang et al.,

2005; Lima et al., 2005). However, basing a more complex stepped care model on intermediate AUDIT scores alone would require more work on assessing the validity of different cut offs in this setting. Instead the choice was made to offer further assessment and counselling routinely to each person who scored 8 or higher, and encourage attendance at the specialist residential unit for those scoring very highly (20 or higher). Nevertheless, the uptake of counselling interventions was low, which may present a barrier to the '*stepped care*' approach whereby interventions are matched to the individual needs (Benegal, Chand & Obot, 2009). Furthermore, the evidence base on very brief interventions is limited (Whitlock et al., 2004b), and the exact content of effective '*brief intervention*' needs further study (Kaner et al., 2009a).

Long term planning for the incorporation of SBI into camp based health services was limited by short term funding frames, typical of many humanitarian situations. Furthermore, the psychosocial caregivers, themselves refugees and camp residents, are subject to the many of the same stressors as their clients. Project implementation was also limited by high staff turnover due to resignation and resettlement. Towards the end of the pilot period, psychosocial caregivers began to lose interest in the intervention, and found the screening process repetitive. Therefore, the introduction of the SBI project represents an opportunity for community mobilisation created by the increased interest and attention to risky alcohol use in the community. More work is required on integrating SBI into a comprehensive, community controlled, multisectoral, inter-agency response (Babor & Higgins-Biddle, 2001). Alcohol use disorders should be integrated into general noncommunicable disease control strategies, rather than seen as stand alone interventions (Benegal, Chand & Obot, 2009). More work is required on cross-sectoral, community based mobilisation strategies and on interventions to modify the risk environment.

Conclusions

We have demonstrated that incorporating the SBI into the existing disease prevention and health promotion activities in the camp is feasible, even in the face of competing health priorities. The range of interventions available for alcohol use disorders in resource constrained settings is limited; SBI is one of the few with an acceptable level of evidence to warrant trials in adaptation into a displacement setting. However, before scaling up any of these interventions across displaced populations elsewhere, more work is required to assess whether the intervention does indeed reduce alcohol related harm in the target population. In addition, efforts should be made to improve data for programme monitoring and evaluation, as well as estimating the magnitude of alcohol use problems. Finally, to comprehensively address alcohol use problems in refugee and displaced settings more work is required on non individualised approaches, including community mobilisation strategies and interventions to modify the risk environment.

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