

The Risk Drinking Project

Background,
Strategy
and Key Primary
Health Care Results
+ tentative data from
a population-based
survey



Per Nilsen, Linköping University, Sweden

BACKGROUND



Traditional emphasis on **primary prevention**: high alcohol taxes, a national retailing monopoly, limited private imports of alcohol from abroad and municipal control of table licenses



Joined the EU in 1995 - possibilities of pursuing this strategy were reduced

Alcohol consumption increased by 30% 1996-2004.

Small reduction since then; today, around 9.5 litres per person and year (Ramstedt et al., 2009).



Negative trend attributed to Sweden's entry into the EU: weakening of control instruments

Increased importance of developing **secondary alcohol prevention**

THE RISK DRINKING PROJECT

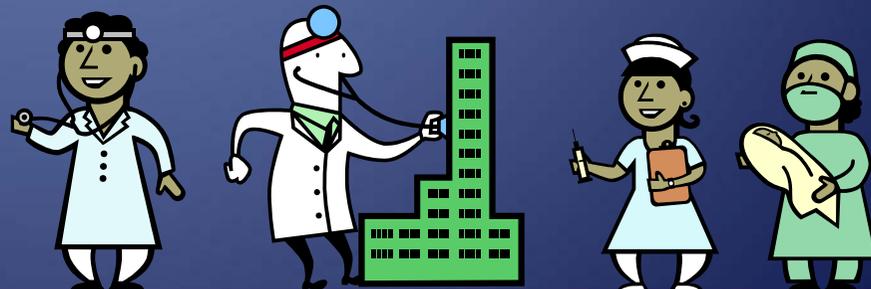
A Government assignment.



Part of **national action plans** to prevent harm from alcohol from 2001 and 2005.

Work commenced in **2004** and was given more priority in the **2005** action plans (applicable up to 2010).

Initially targeted at those who work in **primary care, child health care, maternity care** and the **occupational health services**, but work was later expanded to also include universities and hospitals.



STRATEGY

(GOALS-AND-MEANS HIERARCHY)

VISION

Alcohol habits
have an obvious
place in daily healthcare

OBJECTIVES (1)

Health care personnel bring
up alcohol issues
frequently in routine care

OBJECTIVES (2)

Health care personnel have strong self-efficacy,
good knowledge and positive attitudes
with regard to alcohol issues

ACTIVITIES

Training, information, conferences for health care personnel

CORNERSTONES

Focus on hazardous use, discharging the alcohol issue, a patient-centred
approach (MI), cooperation with county councils and working life,
cooperation with the professions, a broad arena strategy

VISION



“Questions about drinking habits have an obvious place in daily healthcare in a way that corresponds to the significance of alcohol to the origins of various harms and diseases.”

An expression of the basic idea that alcohol should become an obvious issue addressed in health care in the same way as other issues that are of major significance to public health.

OBJECTIVES

To realise the vision, healthcare personnel are required who:

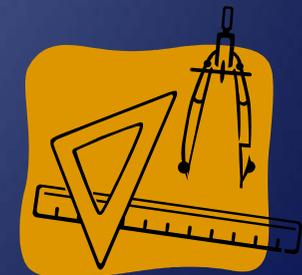
- **actively** bring up the alcohol issue with patients in routine care.

This in turn demands healthcare personnel who:

- have a good **knowledge** of alcohol and hazardous use issues.
- are **confident in their own ability** (have **self-efficacy**) to discuss alcohol with patients and are able to influence patient drinking habits.
- have **positive attitudes** to bringing up the alcohol issue and discussing the patients' drinking habits with them.

Aim: **influence attitudes** and **improve knowledge** to provide caregivers with **greater faith** in their ability (**self-efficacy**) to discuss alcohol and in their possibilities of influencing patient drinking habits.

The objectives for activity, perceived ability (self-efficacy), attitudes and self-assessed knowledge are **measurable**.



ACTIVITIES

An **extensive training and information** endeavour was deemed to be the most suitable strategy to achieve the objectives for activity.

The main activities that were carried out were:

- **Educational** (training, seminars, and information) **efforts concerning alcohol and risk/hazardous use issues**
- **Training in motivational interviewing (MI)**
- **Conferences/networking**



CORNERSTONES

The project's training and informational activities were built up of certain cornerstones:

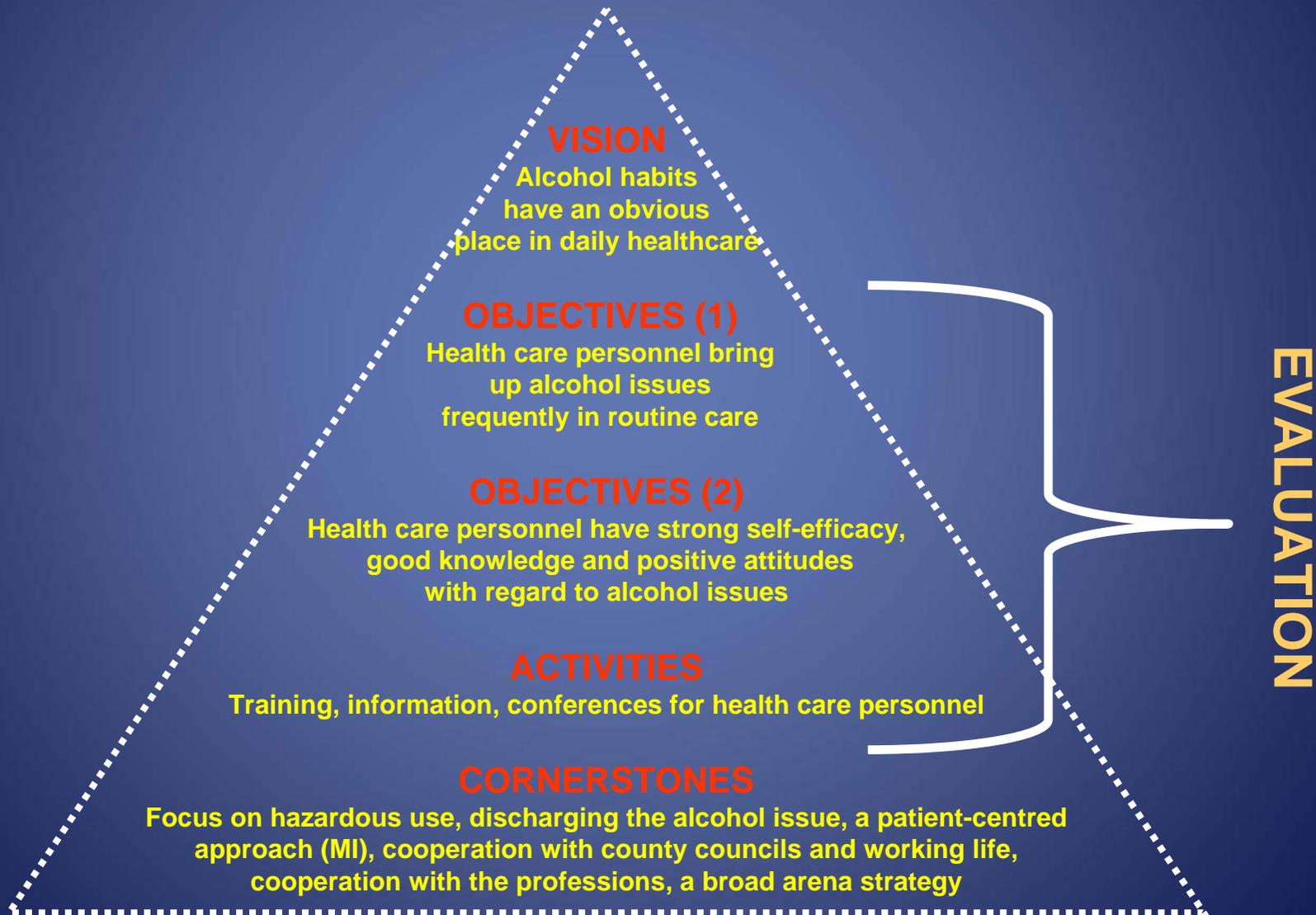
- **focus on hazardous use**
- **defusing the alcohol issue**
- **a patient-centred approach/MI**
- **cooperation with county councils and working life**
- **cooperation with the professions**
- **broad arena strategy**



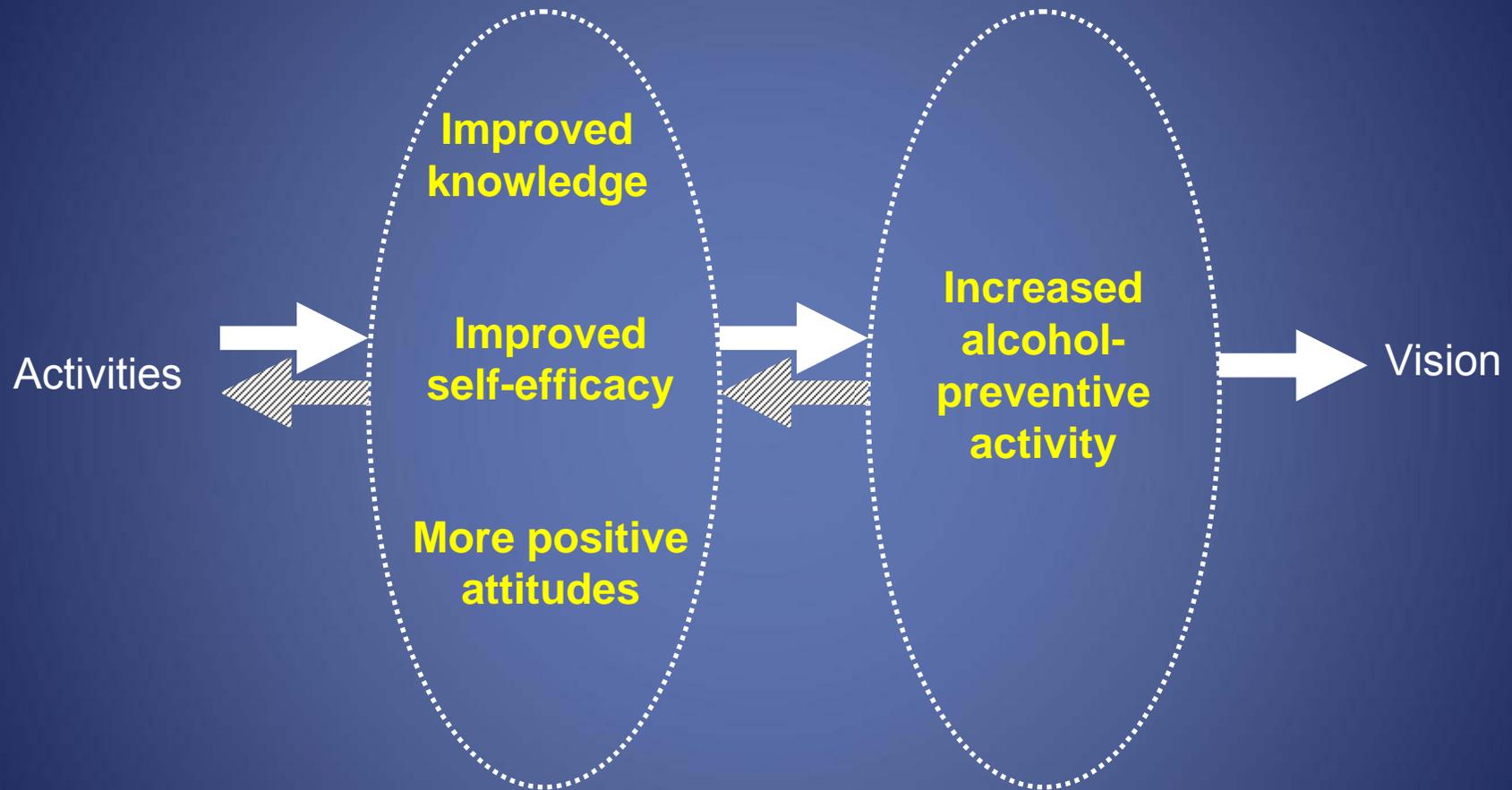
Cornerstones were based on existing knowledge (research results, theories concerning learning and behavioural modification, and prior experience).

STRATEGY

(GOALS-AND-MEANS HIERARCHY)



EVALUTATION FRAMEWORK



ACTIVITIES → OBJECTIVES → VISION

Response frequency and number of questionnaires analysed

Professional group	Year	Response frequency %	Number of questionnaires analysed
General practitioners	2006	47	1 809
	2009	62	2 702
Medical specialists ("doctors in training")	2006	46	418
	2009	48	555
District nurses	2006	52	2 507
	2009	47	2 881

Training in handling hazardous alcohol consumption

	GPs		Medical spec.		District nurses	
	2006	2009	2006	2009	2006	2009
None	42	10	55	19	63	18
≤ half day	28	28	24	34	23	37
1-2 days	18	32	13	30	9	26
≥ 3 days	12	29	7	18	5	19

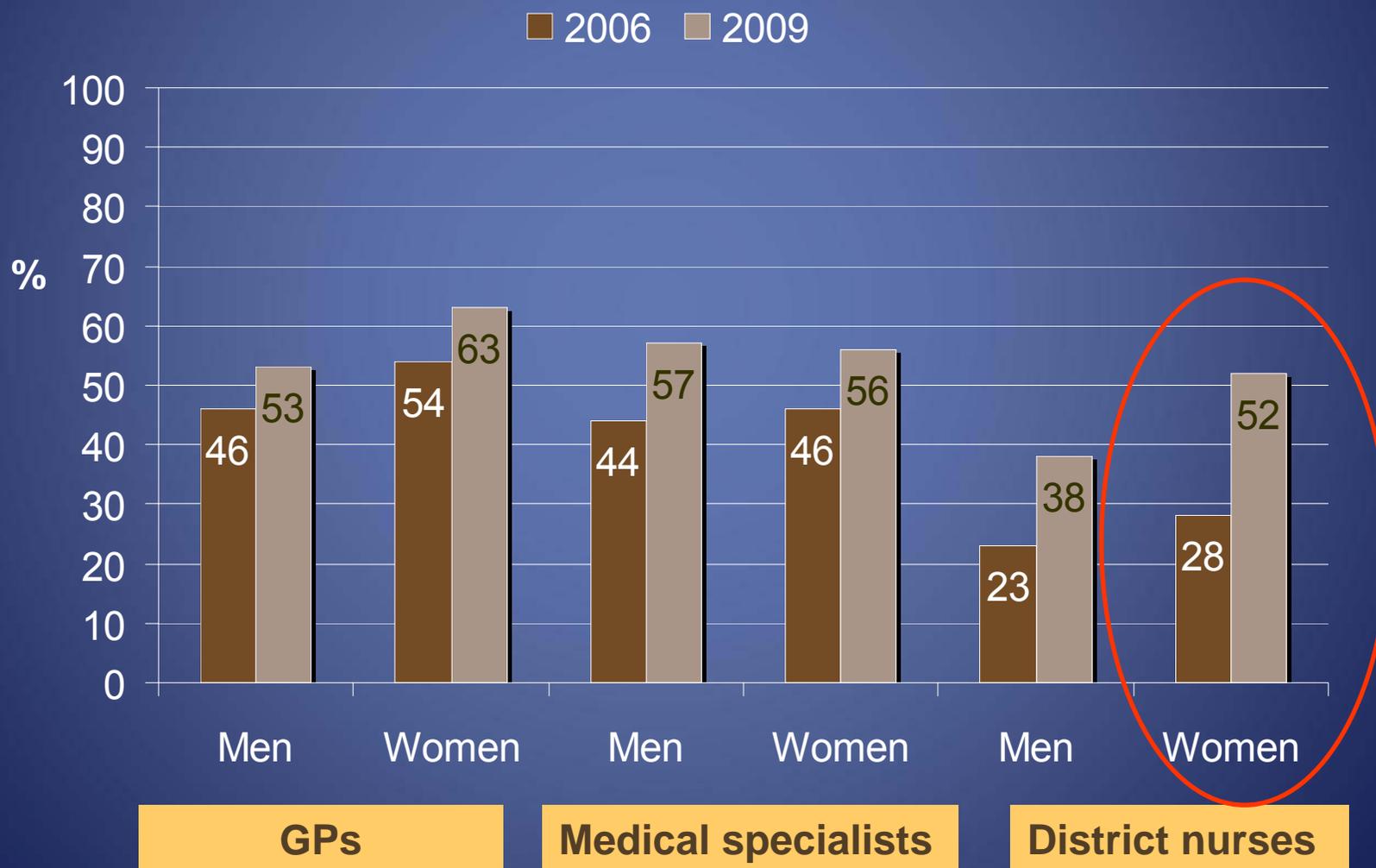
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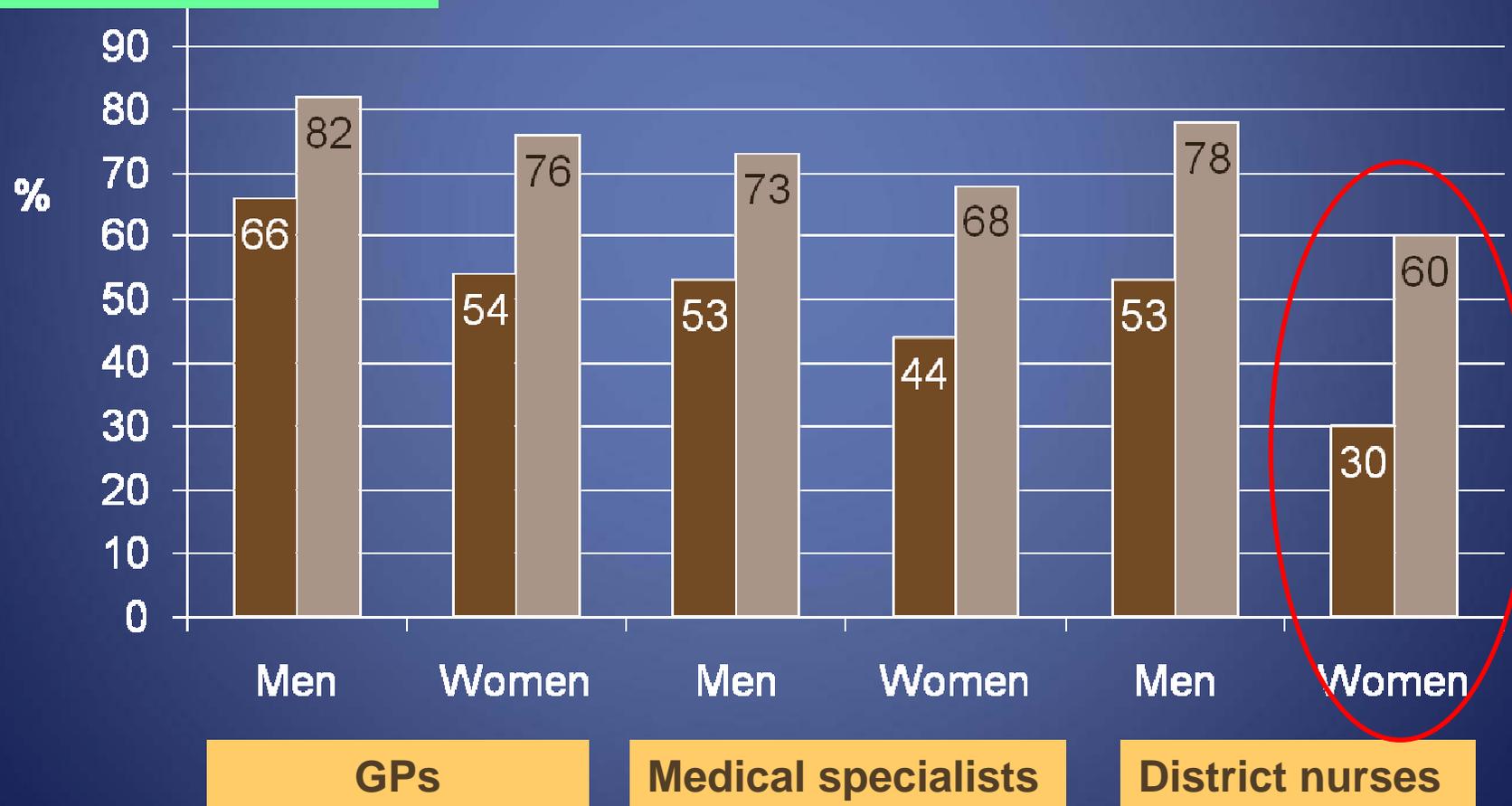
Activity – always or often discuss alcohol with their patients



Knowledge concerning counselling patients with hazardous alcohol consumption

Proportion who judged themselves to be **very or somewhat knowledgable**

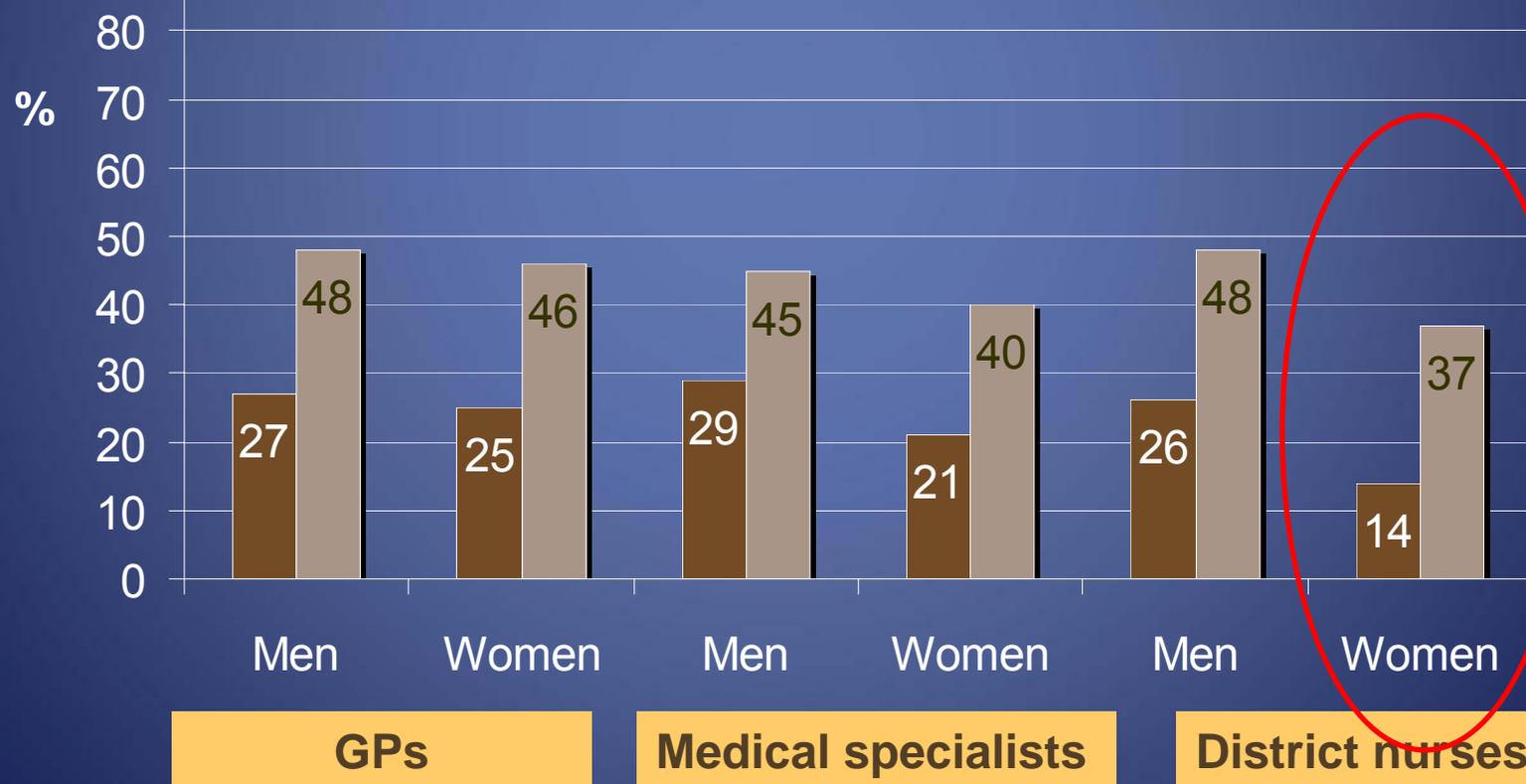
■ 2006 ■ 2009



Self-efficacy concerning helping patients reduce their hazardous alcohol consumption

Proportion who judged themselves to be **very or somewhat effective**

■ 2006 ■ 2009



Association between training and activity

	Training in handling risky drinking			
	None %	Half day or less %	1-2 days %	3 day or more %
GPs	50.6	54.1	56.0	65.7
Medical specialists	51.0	53.8	57.7	65.6
District nurses	36.4	47.2	55.5	68.2

Activity = proportion who **always** or **often** discusses alcohol with their patients

SUMMARY OF PHC FINDINGS

PHC providers became more **active** in discussing alcohol with patients, obtained more **knowledge** about counselling patients regarding alcohol and gained greater confidence in their own ability (improved **self-efficacy**) to help patients reduce their hazardous alcohol consumption.

Attitudes towards identifying patients with hazardous consumption and offering them advice regarding alcohol generally remained positive with little change.

PHC providers' **activity** in the form of discussions concerning alcohol **increased more than for other lifestyle issues**.

Providers with **more training** were generally **more active**.

Knowledge, self-efficacy and activity **improved in all three PHC personnel categories** – but the **district nurses'** knowledge, ability and activity that consistently improved the most.

POTENTIAL SUCCESS FACTORS IN THE RBP

A **comprehensive educational undertaking** → achieved a critical mass that facilitates the translation of the new knowledge into action

Active and engaging continuing professional education → most effective in influencing the practice of caregivers.

Targeted and **removed barriers** (perceived lack of knowledge, training and education in alcohol-related issues; uncertainty in one's ability to discuss alcohol-related issues; doubt about the effects of discussing alcohol; insufficient screening instruments and information material about alcohol).

Learned to **use MI** → facilitates discussions concerning “sensitive” issues and is perceived as “sympathetic” by many who use it

Bottom-up project approach: planning and implementation in close cooperation with the professions → created participation, which is an important promoting factor in all change work.

SOME TENTATIVE FINDINGS FROM A POPULATION-BASED SURVEY CONCERNING SECONDARY ALCOHOL PREVENTION IN SWEDEN

Nationally representative sample of 6,000 individuals, 18-64 years,
from Statistics Sweden's (SCB) total population register

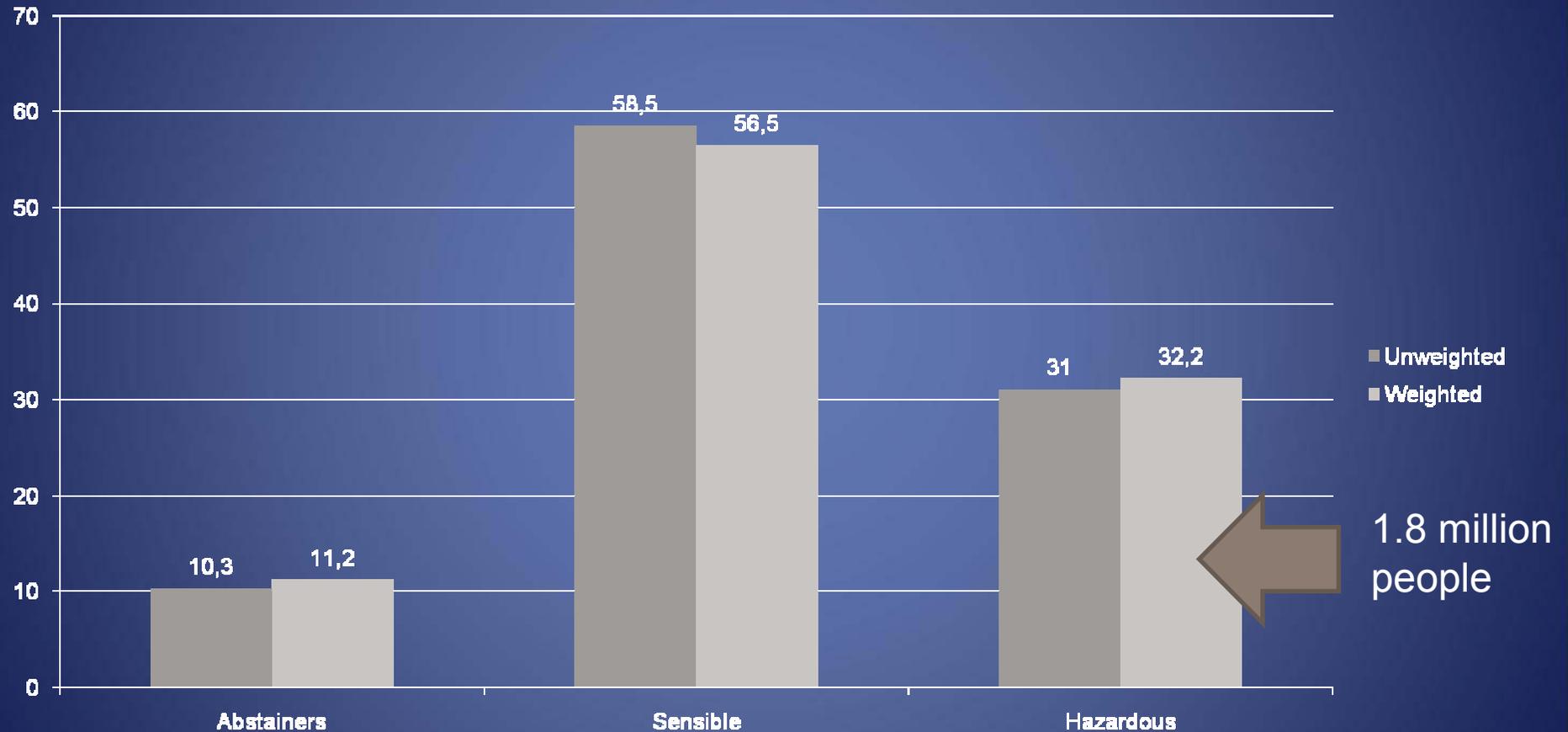
Response rate: 53.5%

→ Comparable to SoRAD's (Centre for Social Research on Alcohol and
Drugs) rates for telephone surveys on which Swedish official alcohol
statistics are based – response rates: 60% until 2004; approx. 50% 2005-
2006; approx. 45% 2007-2008 (Ramstedt *et al.*, 2009)

→ National Institute of Public Health (FHI) *National Public Health Report
2009* – response rate 52.1%

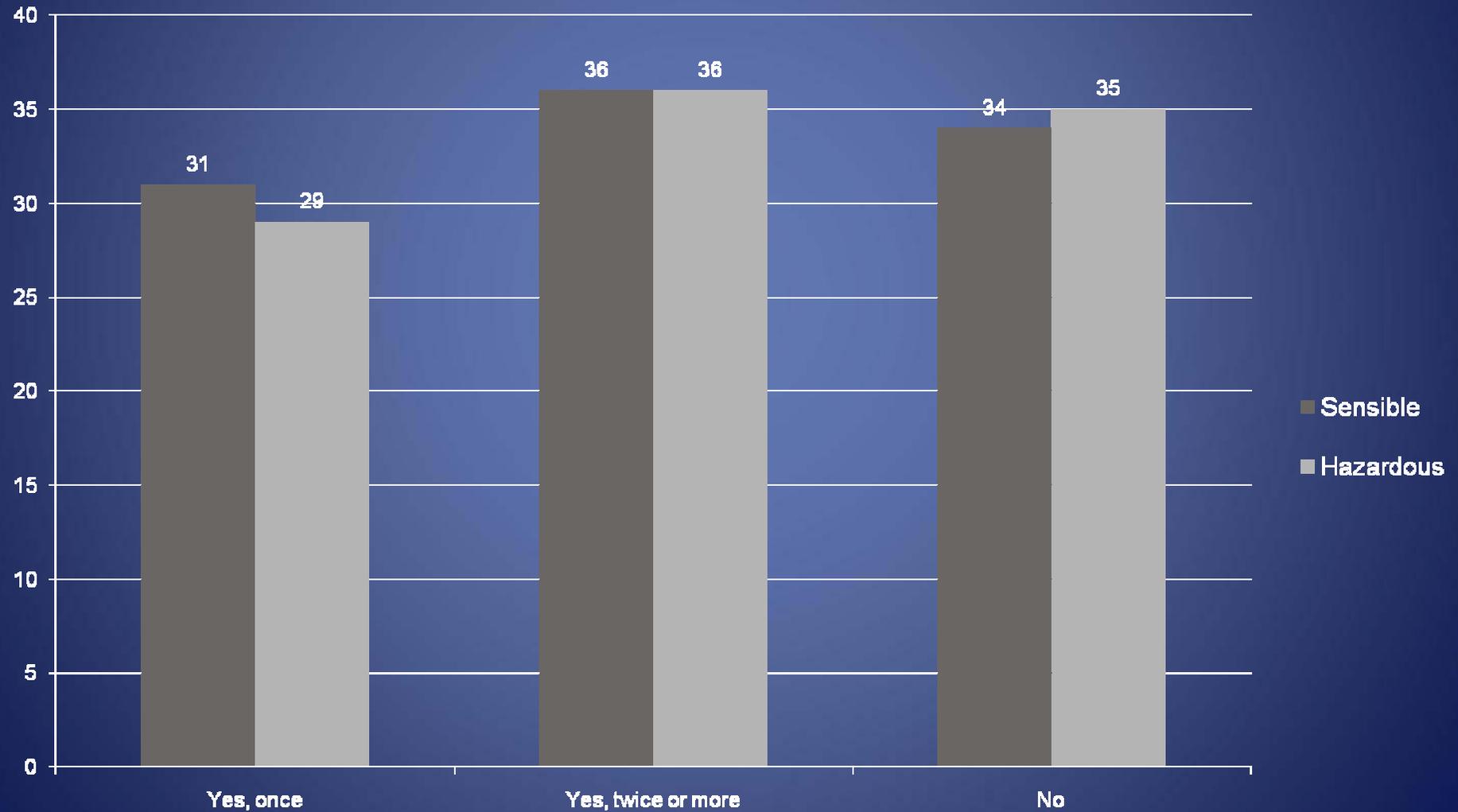
Weighting was used to compensate for varying response rates across
different sub-populations → makes it possible to produce estimates that
relate to the total Swedish population 18-64 years (5.6 million).

PROPORTIONS ABSTAINERS, SENSIBLE DRINKERS, AND HAZARDOUS DRINKERS

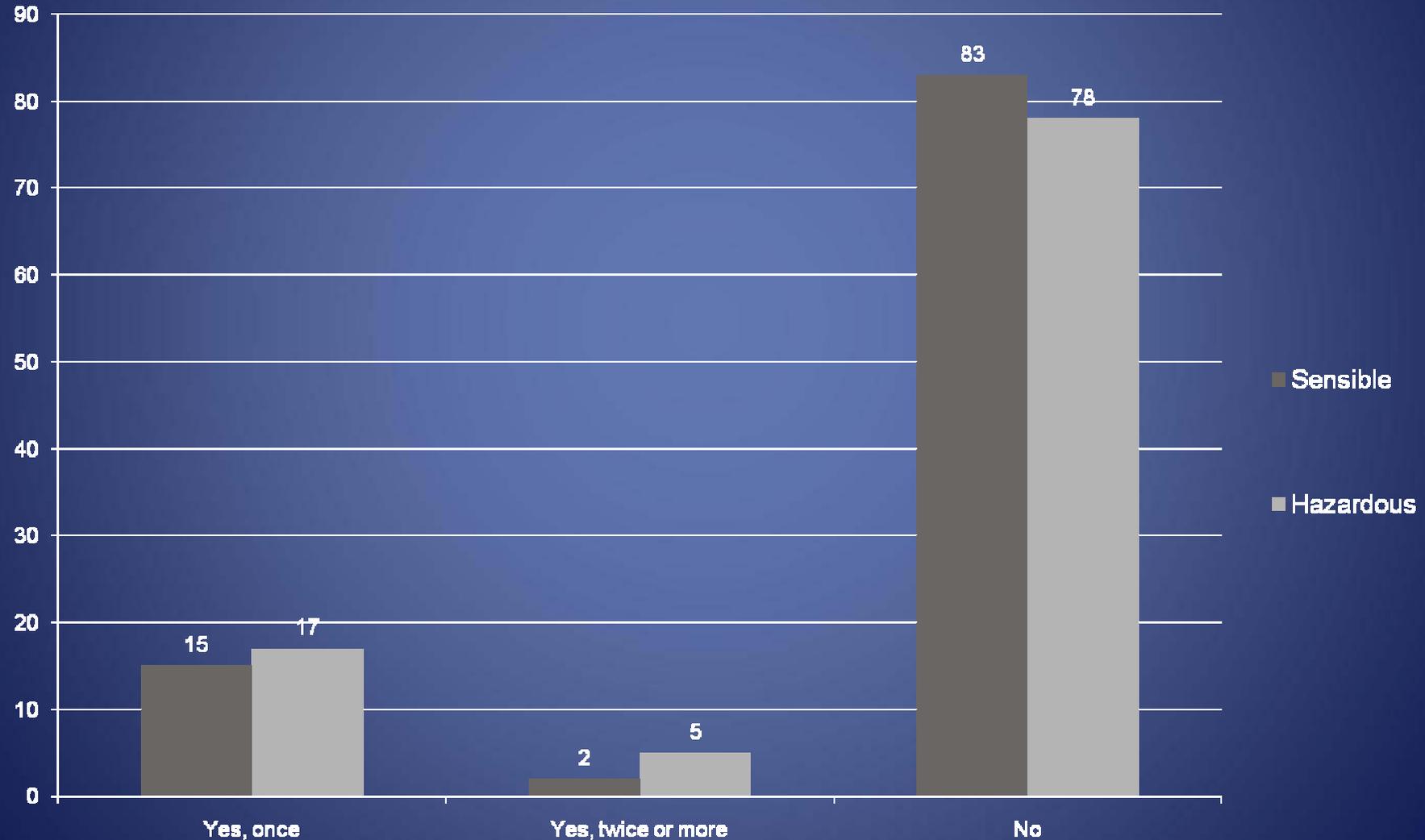


Hazardous: >9/14 glasses per week and/or heavy episodic (binge) drinking (4/5 glasses on one occasion) monthly or more often [1 glass = 12 grams alcohol]

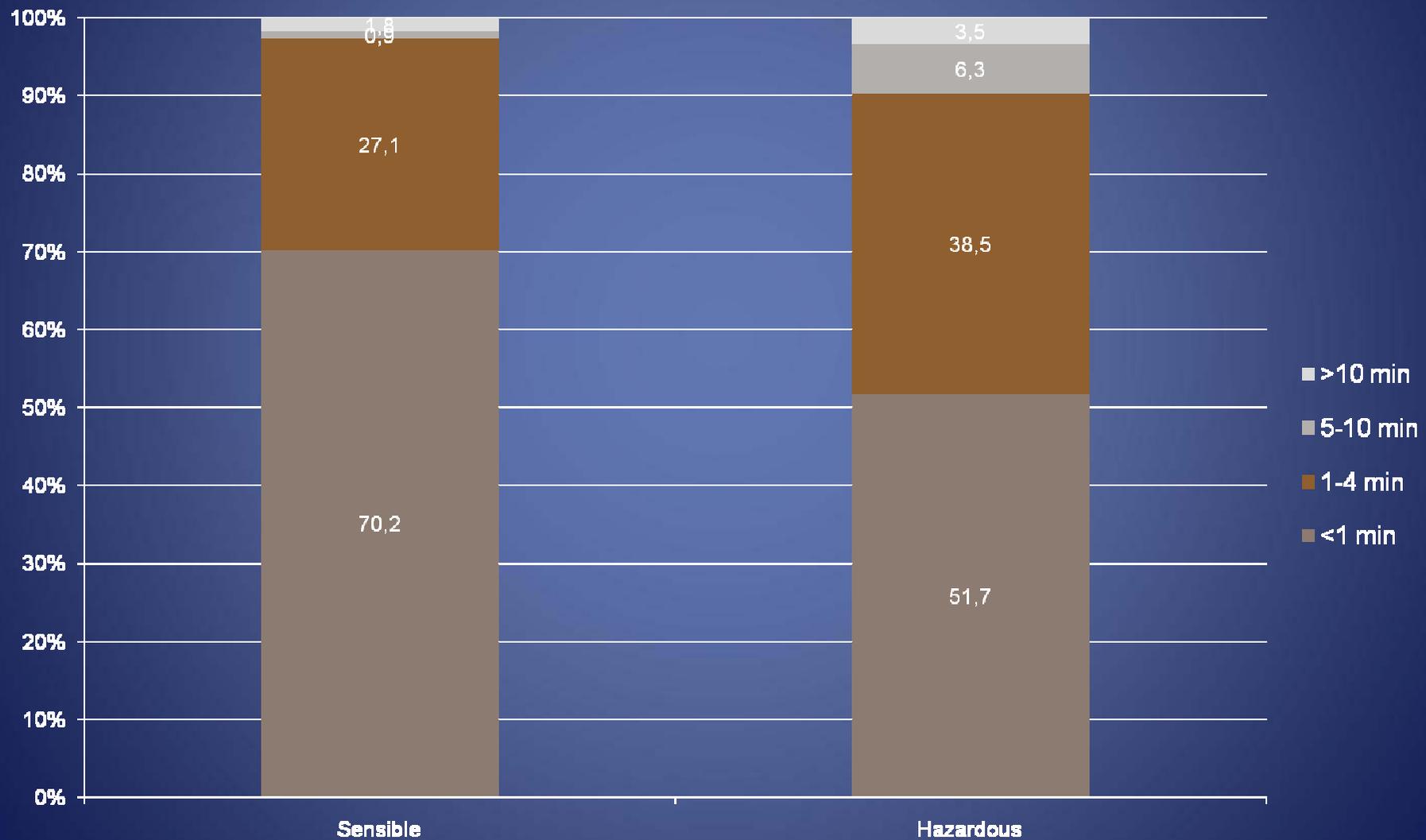
Have you visited health care in the last 12 months?



Have you talked about your alcohol habits at a health care visit in the last 12 months?

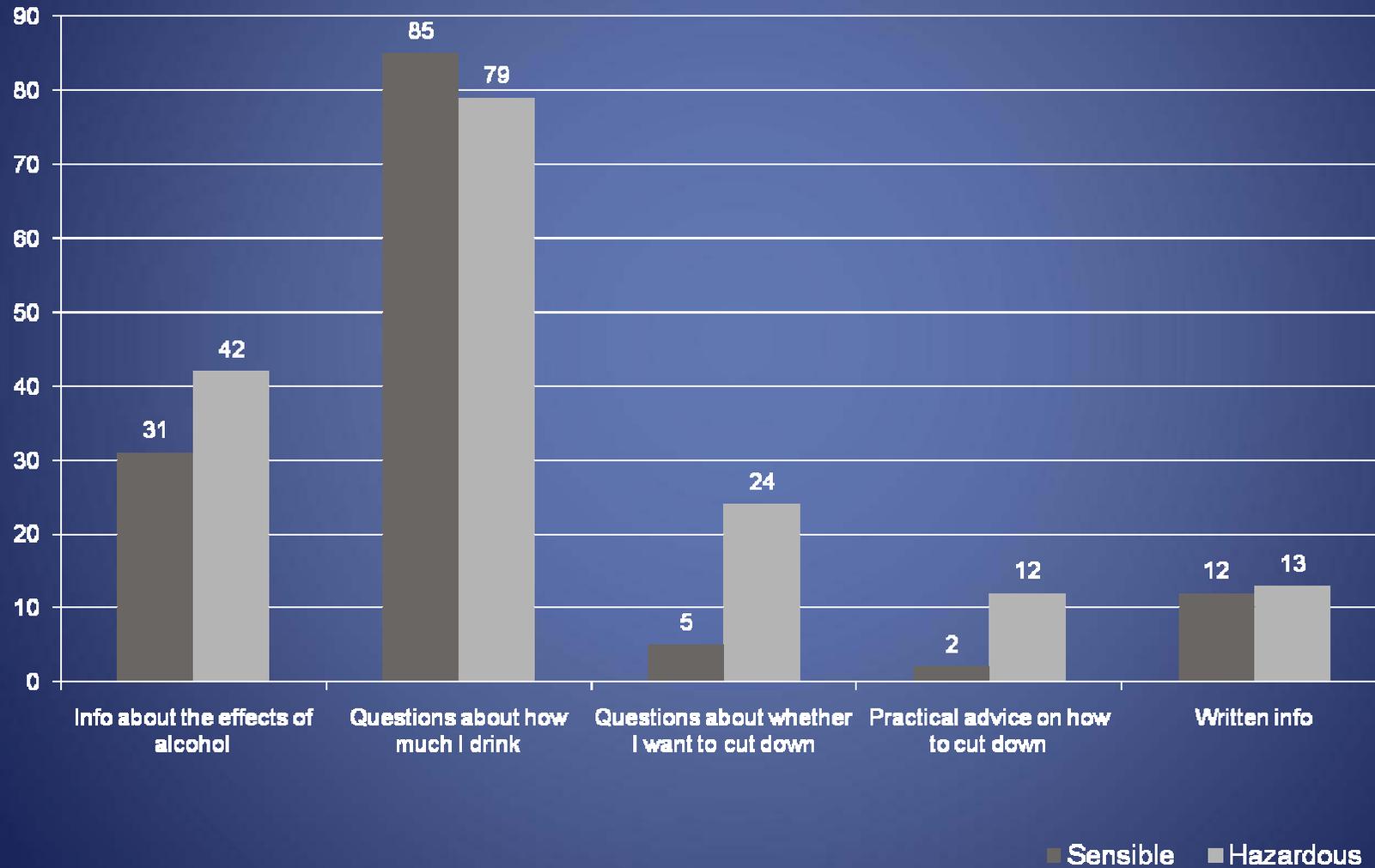


How long did the conversation last?



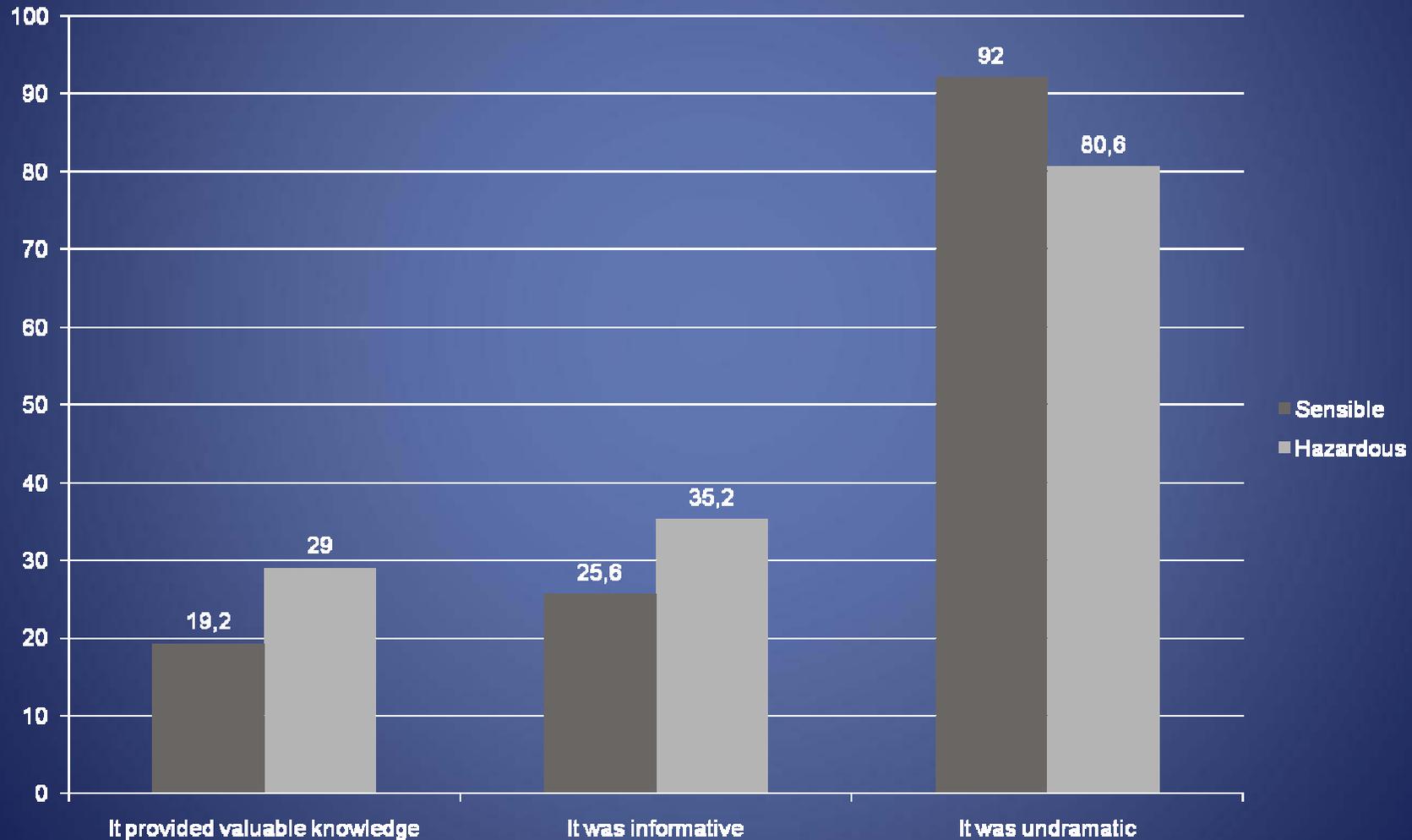
What were the contents of the conversation?

Proportion "yes" answers



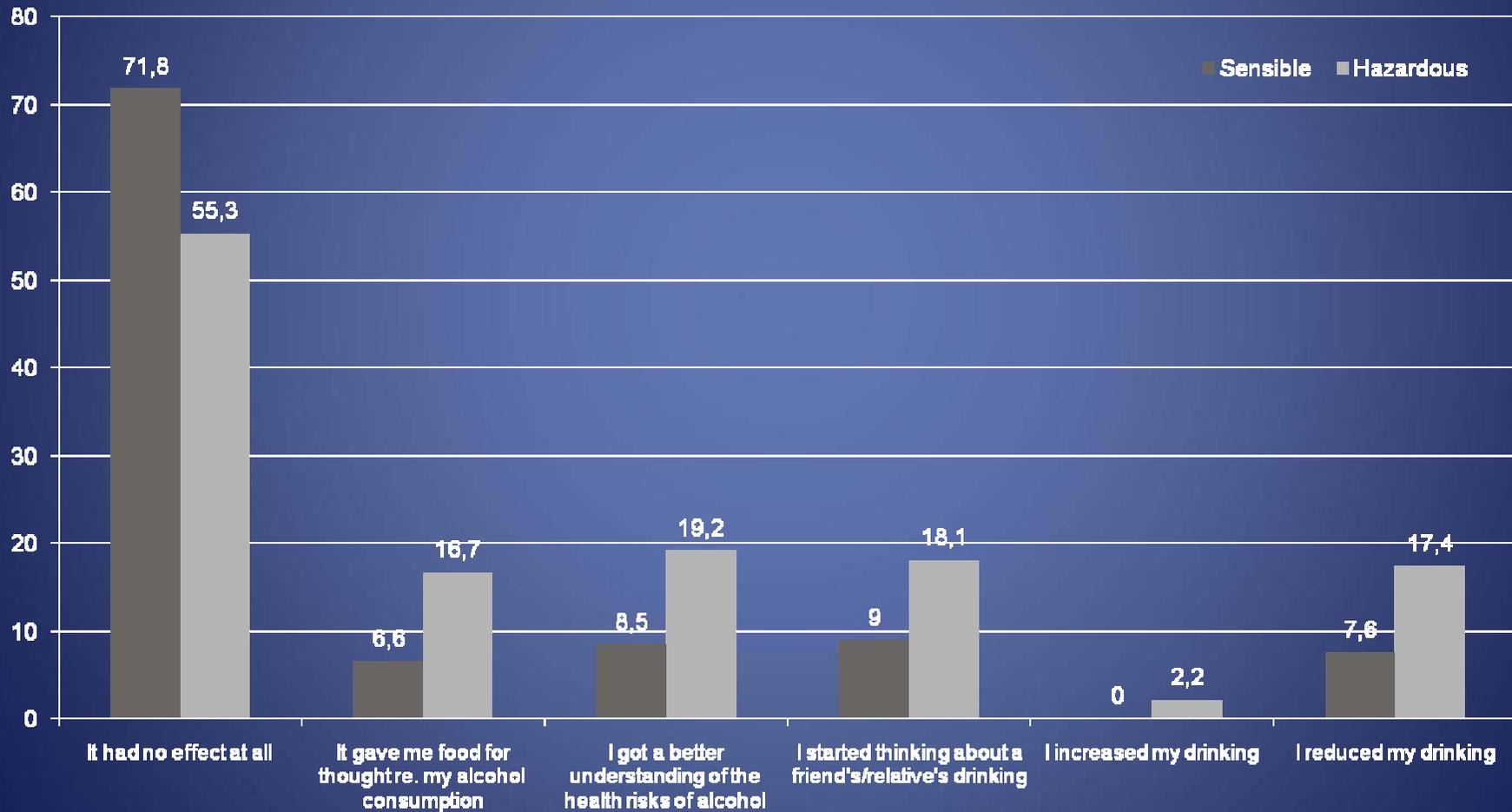
How did you experience the conversation?

Proportion "agree completely" and "agree to a large extent"



Did the conversation affect you in any way?

Proportion "agree completely" and "agree to a large extent"



HOW MANY HAZARDOUS DRINKERS DO HEALTH CARE REACH AND INFLUENCE?

32% hazardous drinkers (H.D.) of the population aged 18-64 years = 1.8 million H.D.

65% of the H.D. have visited health care 1 or more times the last 12 months = 1.16 million H.D.

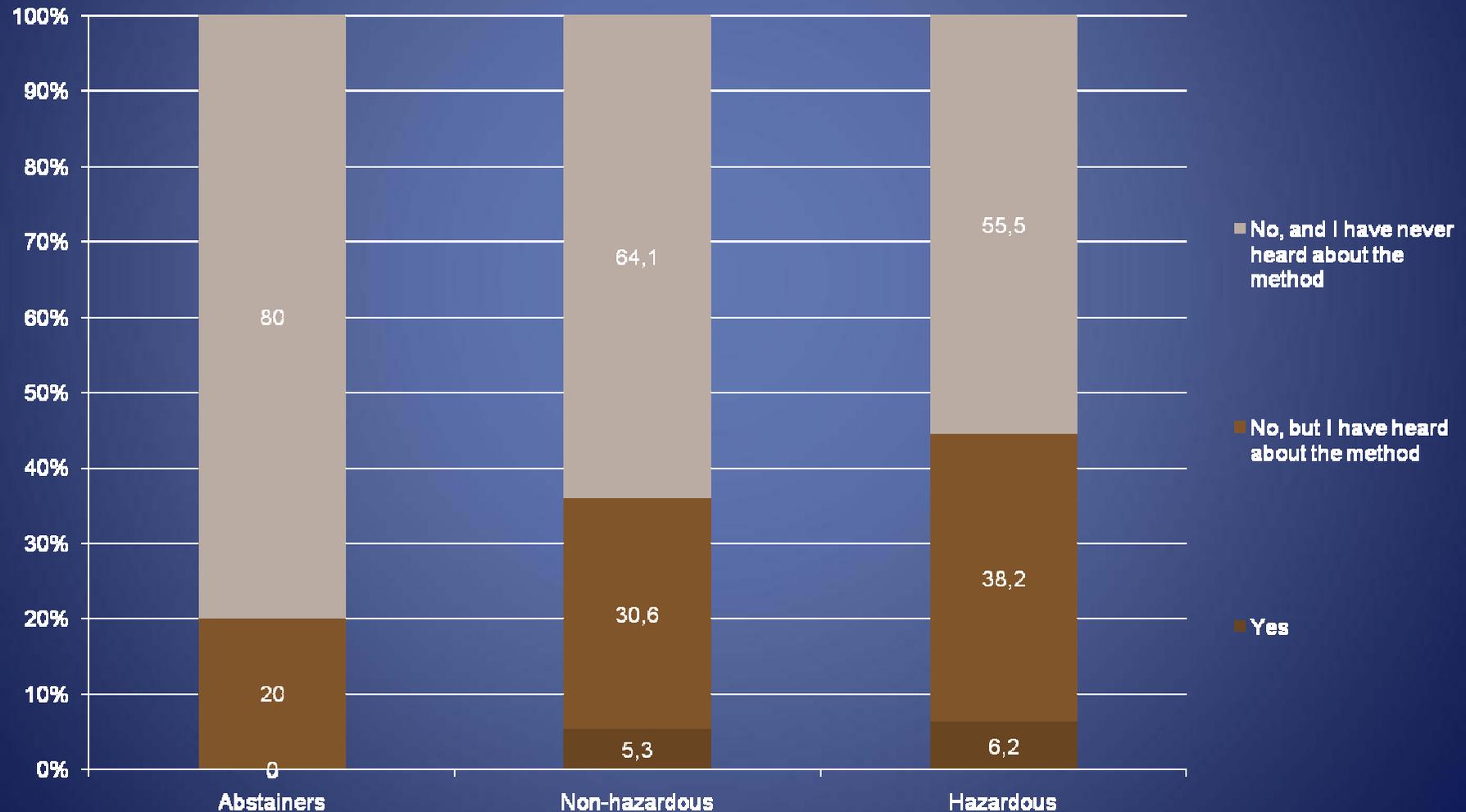
22% of the H.D. have talked about their alcohol habits 1 or more times in the last 12 months = 255,000 H.D.

17.4% of the H.D. say that they have REDUCED their consumption, but 2.2% say they have INCREASED → approx. net **15%** of the H.D. have REDUCED = 40,000 H.D.

Approx. **40,000 hazardous drinkers** have a conversation about their alcohol consumption in health care each year and say that the conversation influenced them to reduce their drinking.

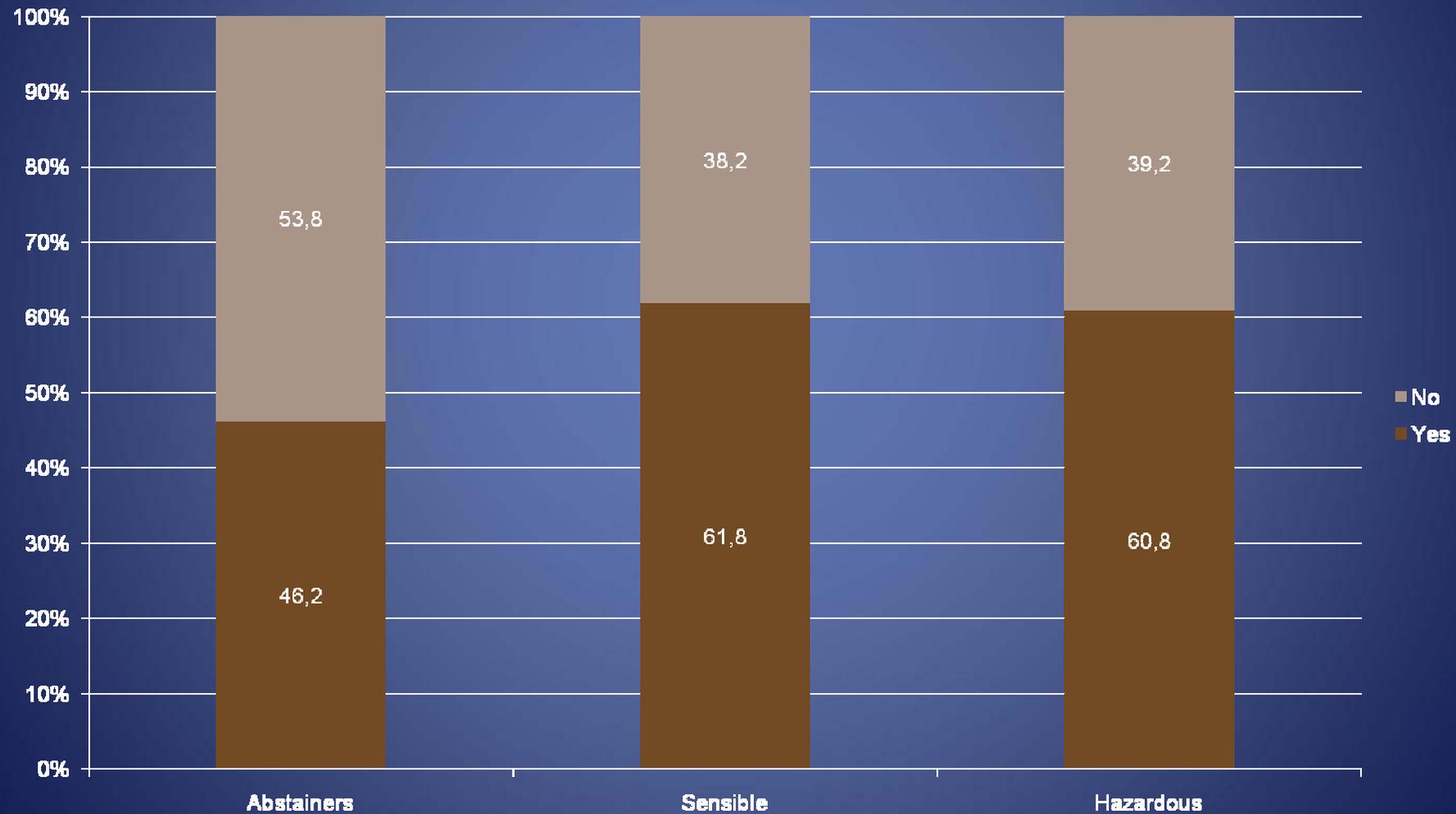
Do you use the standard glass method to estimate your alcohol consumption?

3 response options



Are you familiar with the concept of risk consumption of alcohol?

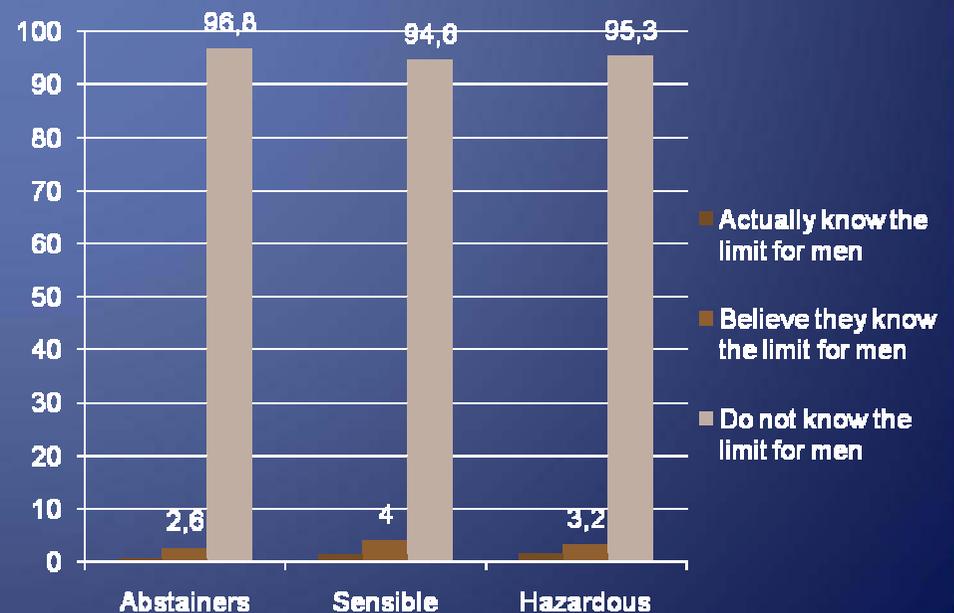
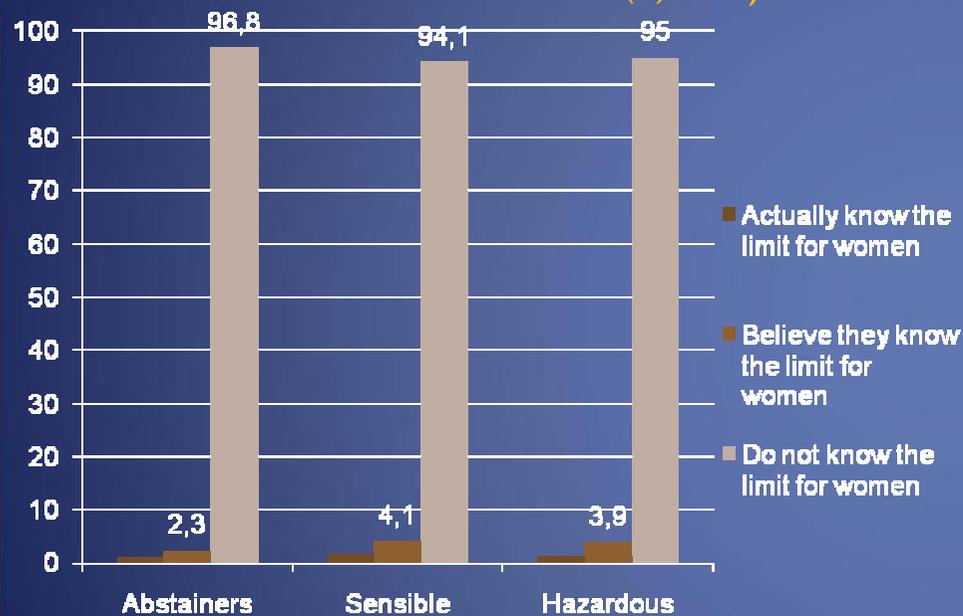
Yes or no



Do you know the limits for weekly risk consumption of alcohol?

Categorization of replies:

- (1) says YES and provides ACCURATE LIMITS (=actually know the limit);*
- (2) says YES, but provides INACCURATE LIMITS (=believe they know the limit);*
- (3) NO, does NOT KNOW the limit*



**THANKS
FOR
YOUR
ATTENTION**