Annex 3
ASSESSMENT TOOL AND REGISTRY

INDEX

INTRODUCTION

Hazardous drinking is defined as a quantity or pattern of alcohol consumption that places patients at risk from adverse health events, while harmful drinking is defined as alcohol consumption that results in adverse events (Saunders, 1993a). Harmful drinking is recognized by the World Health Organization (WHO) as a specific disorder. Hazardous drinking is not included as a diagnostic term in the ICD-10 but, despite the absence of any current disorder in the individual user, is an advisory term recommended by WHO that refers to patterns of use that are of public health significance.

There is no standardized agreement for the level of alcohol consumption that should be taken for hazardous drinking, and for some diseases, any level of alcohol consumption can carry risk (Corrao et al., 2004). A working definition of the World Health Organization describes it as a regular average consumption of 20g-40g of alcohol a day for women and 40g-60g a day for men (Rehm et al., 2004). On the other hand, based on the epidemiological data relating alcohol consumption to harm, the World Health Organization has adopted a working definition of harmful alcohol consumption as a regular average consumption of more than 40g alcohol a day for women and more than 60g a day for men (Rehm et al., 2004).

Although there are regional, national and local differences, estimates have suggested that at least 30% of the adult population in European countries is drinking alcohol at hazardous or harmful levels (World Health Organization [WHO], 2001). Prevalence estimates are different for hazardous and harmful alcohol consumption, with a range from 4% to 29% for hazardous drinking and from less than 1% to 10% for harmful drinking (Carrington, 1999). Harmful use of alcohol is one of the main factors contributing to premature deaths and avoidable disease burden worldwide. In 2002 the harmful use of alcohol was estimated to be responsible of 3.7% of global mortality and 4.4% of the global burden of disease (even when protective effects of low and moderate alcohol consumption on morbidity and mortality have been taken into consideration), and to be the leading cause of death and disability in developing countries with low mortality [1].

Alcohol problems are common among primary care patients. About 18% of subjects have a hazardous level of alcohol intake and 23% have experienced at least one alcohol-related problem in the previous year (Saunders, 1993b). There is considerable evidence of the efficacy of brief interventions programs in reducing alcohol consumption, with at least 10% to 16% of reduction (Moyer, 2002). The evidence also suggests that such interventions are highly cost effective (Effective Health Care Team, 1993; Solberg et al. 2008) and they have been recommended by the Commision of the European Communities on its strategy to support Member States in reducing alcohol related harm (COM(2006) 625).

A brief intervention consists of a single session, and up to a maximum of 4 sessions of professional engagement with a patient, in which the patient receives information and advice to reduce alcohol consumption and/or alcohol-related problems (Kaner et al., 2007). Brief interventions are are directed at hazardous and harmful drinkers who are not typically complaining about or seeking help for an alcohol problem and carried out in general community settings and are delivered by non-specialist personnel such as general medical practitioners and other primary healthcare staff, hospital physicians and nurses, social workers, probation officers and other non-specialist professionals. (Raistrick et al., 2006).

[1] Strategies to reduce the harmful use of alcohol. Report by the Secretariat. (2008). SIXTY-FIRST WORLD HEALTH ASSEMBLY A61/13

The Commission of the European Communities published in 2006 a communication which presents a strategy to reduce alcohol-related harm in Europe until the end of 2012[2]. In this communication it is stated that most Member States have put in place legislation and policies related to the harmful and hazardous consumption of alcoholic beverages. It is also highlighted that one example of national measures currently implemented in Member States is the allocation of the necessary resources in primary health care, to advice and treatment regarding hazardous and harmful alcohol consumption, to provide training for health care professionals.

Routine screening for hazardous and harmful alcohol consumption has been recommended for all primary care patients. However, such interventions have rarely been integrated into routine clinical practice (Heather, 1996) and adherence to clinical guidelines has been poor (Brotons, 1996; Spandorfer, 1999).

Many primary care health workers are reluctant to screen and advise patients in relation to alcohol use. Among the reasons most often cited are lack of time, inadequate training, fear of antagonizing patients, the perceived incompatibility of alcohol brief intervention with primary health care, and the belief that those who are dependent on alcohol do not respond to interventions. The challenge is to integrate these interventions into professionals' daily clinical work.

According to the WHO strategies to reduce the harmful use of alcohol (2008), adequate mechanisms for regular assessment, reporting and evaluation are necessary for monitoring progress at different levels, and special efforts are needed to formulate a comprehensive health-care sector response to alcohol-related problems, with particular emphasis on primary health care interventions.

In the Framework of the 24-country European platform of the Phepa Project (Primary Health Care European Project on Alcohol), an assessment tool to describe the available services for the management of hazardous and harmful alcohol consumption on the primary health sector and its mapping across the Phepa countries has been developed. The aim of this process was to identify the available infrastructures and also the deficiencies or areas that need further work and strengthening, both at the country and at the European level.

[2] Commision of the European Communities. An EU strategy to support Member States in reducing alcohol related harm (2006) - COM(2006) 625.

METHODOLOGY

2.1. Development of the questionnaire

The questionnaire is an adaptation of a tool to assess the available services for smoking cessation at country or regional level first developed in 2003. The starting point of this tool was based on the available World Health Organization questionnaires and enhanced in three phases by seeking specific input from a relevant and wide set of experts. The development included a focus group methodology and an examination by a European expert panel. The feasibility of implementing the tool was assessed in two phases by 14 individuals, and piloted in 18 countries. The main sections were reduced to its actual form, and ambiguous questions were removed or clarified (for a detailed explanation on the developmental process see: Anderson, 2006). The assessment tool on smoking cessation was adapted for the services for the management of hazardous and harmful alcohol consumption in the primary health sector by Peter Anderson in 2004 with assistance from the partners of the Phepa project[3].

2.2. Description of the questionnaire.

The questionnaire contains 24 questions distributed across 7 key sections, which includes the following topics:

- presence of a country coalition or partnership,
- community action and media education,
- health care infrastructure (integrated health care system, structures for quality of care, research and knowledge for health, health care policies and strategies, structures to manage the implementation of treatment within health services, and funding health service and allocating resources),
- support for treatment provision (screening and quality assessment systems, protocols and guidelines, reimbursement for health care providers),
- intervention and treatment (availability and accessibility),
- health care providers (clinical accountability and treatment provision),
- health care users (knowledge and help seeking behaviour).

2.3. Data collection

The participating countries were requested to complete the questionnaire by the end of September 2008. It was suggested that the tool would be completed by country or regional coalitions or partnerships that are set up to support the development of services for the managing hazardous and harmful alcohol consumption. It the coalition didn't exist, it was suggested that a coalition be formed, or completed through meetings with individual experts. For questions requiring opinion or expert judgement, it was especially suggested that a consensus be achieved at meetings of coalitions of partnerships.

The participants were asked to indicate the source of some data provided through document reference templates. When the data was not available, they were asked not to estimate it, but to mark that it was not available or not known.

[3] The assessment tool questionnaire can be found on: http://www.gencat.cat/salut/phepa/units/phepa/html/en/dir360/index.html

A preliminary analysis and overview of the data was carried out and presented in a Phepa meeting on the 4th and 5th of December 2008. The comments from the participants were collected and included on the first draft of the report. The draft was circulated among all the partners who were requested for their feedback.

15 partners, collecting the data from 13 countries (Belgium, Czech Republic, Germany, Ireland, Italy, Portugal, Slovenia, Finland, England, Greece, Lithuania, Poland, Hungary) and 2 country regions (Spain/Catalonia [4] and Friuli-Venezia/Italy[5]) sent their data on time for the final report, and 2 other countries sent their data (Bulgaria and Slovakia) althought not in time the inclusion of their data on this report[6]. For 9 of the countries (Belgium, Czech Republic, Germany, Ireland, Italy, Portugal, Slovenia, Finland, England) and for 1 region (Catalonia/Spain) the information had also been collected from September of 2004 to May of 2005, and comparative results of the main changes are reported in the report.

2.4. Data analysis

The data were introduced in SPSS. Descriptive statistics and graphs were calculated. The information was also reported qualitatively with comments from the partners, which are also reported.

[4] The data from Spain/Cataluña only shows the situation in Cataluña. Therefore, is not recommended to extrapolate the results to the whole country, since great differences can exists.

5 The data from the región Friuli-Venezia in Italy, complements the general picture from the Italian profile.

[6] The data from Bulgaria and Slovakia can be found on the Phepa webpage: http://www.gencat.cat/salut/phepa/units/phepa/html/en/dir360/index.html

RESULTS

3.1. European overview across 14 countries in 2008.

In this section, both a general overview across all the countries, but also the specific situation reported by the partners on their national/regional assessment tool questionnaires (in italics), are reported.

3.1.1. Presence of a country coalition or partnership.

Most of the countries (71%) have a country-wide or region-wide formal or informal coalition or partnership that deals with the management of hazardous and harmful alcohol consumption (See Figure 1 and Figure 2).

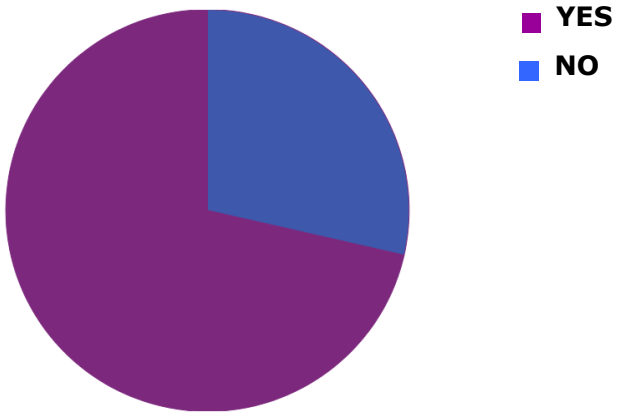


Figure 1. Is there a country-wide or region-wide formal or informal coalition or partnership that deals with the management of hazardous and harmful alcohol consumption?

Yes: Belgium, England, Finland, Germany, Hungary, Italy, Lithuania, Poland, Slovenia and Spain – Catalonia.

No: Czech Republic, Greece, Ireland, Portugal (in process of definition).

COUNTRY	YEAR OF CREATION	NAME	AIM OF THE COALITION
Belgium	2007	Flemish working group on EIBI province of Flemish Brabant	"To develop multidisciplinary coordination of training on EIBI and collaborative care for GP, pharmacists, social services and mental health".
England	1984	Alcohol Concern	"To reduce the incidence and costs of alcohol-related harm and increase the range and quality of services for people with alcohol-related problems".
Finland	2004	Alkoholiohjelma	"To prevent harm done by alcohol".
Germany	2003	Aktionsplan Drogen und	"National strategy for the management of substance-related problems".

		Sucht	
Hungary	1993	TÁMASZ Endowement (Regional Universal Preventive Endowment for Managing Alcohol Problems - RUPEMAP)	"To secure a better quality treatment for patients with alcohol use disorders and to reach them in a phase before irreversible changes develop in their health, family life and workplace".
Italy	2008	ALIA	"To highlight the rising levels of alcohol related harm, propose evidence based solutions to reduce this harm, influence decision makers to take positive action to address the damage caused by alcohol misuse. This Brings together research, social and medical bodies, patient representatives and alcohol-related health stakeholders".
Lithuania	2005 2006	1. I can live 2. Lithuanian national Tobacco and Alcohol Control Coalition (LNTACC)	1. "To seek effective solutions to substance abuse and related problems, and build a safe and healthy society, Based on the principles of humanism, tolerance, partnership and respect for human rights and freedoms". **2. "To influence the alcohol policy, to create projects and education programs ant to organize assistance for hazardous alcohol users".**
Poland	2007	No name yet	"To promote county-wide implementation of screening programmes and brief intervention practice among primary health care professionals".
Portugal	In creation	Primary Health Care Alcohol Group (GAAP)	"The aims are being defined now. There were structural changes in Primary Health Care Services and also according to the Governmental Organic Law; the Institute on Drugs and Drug Addiction is now responsible for Alcohol issues".
Spain - Catalonia	1998	No official name	"To support and facilitate the wide implementation of EIBI in Catalonia".
Slovenia		Flemish working group on EIBI province of Flemish Brabant	"To support the nationwide implementation of early identification and brief interventions on hazardous and harmful alcohol drinking".

Figure 2. Name, year of creation and objectives of the coalitions.

3.1.2. Community action media and education

This section explores whether there have been public education campaigns implemented, in the 24 months before the completion of the questionnaire, that provide information about why heavy drinkers should reduce their alcohol consumption and how to reduce their alcohol consumption. Where possible, it is inidcated whether the campaign was publicly funded.

EDUCATION CAMPAIGNS ON MEDIA ABOUT HHAC REDUCTION – AVAILABILITY AND FUNDING	WHY REDUCE - TV	HOW TO REDUCE - TV	PUBLICLY FUNDED - TV	WHY REDUCE - RADIO	HOW TO REDUCE - RADIO	PUBLICLY FUNDED - RADIO	WHY REDUCE - NEWSPAPERS/MAGAZINES	HOW TO REDUCE - NEWSPAPERS/MAGAZINES	PUBLICLY FUNDED - NEWSPAPERS/MAGAZINES	WHY REDUCE - BILLBOARDS	HOW TO REDUCE - BILLBOARDS	PUBLICLY FUNDED - BILLBOARDS	WHY REDUCE - OTHER	HOW TO REDUCE - OTHER	PUBLICLY FUNDED - OTHER
Belgium	■		F												
Czech Republic															
England	■		F	■		F	■		F	■		F	■		F
Finland	■	■	F	■	■	F	■	■	F	■	■	F	■	■	F
Germany				■						■	■	F	■	■	F
Greece															
Hungary															
Ireland		■	P		■	P		■	P		■	P			P
Italy	■		F	■		F	■		F	■		F	■		F
Lithuania															
Poland	■	■	F	■	■	F	■	■	F	■	■	F			
Portugal													■	■	
Spain - Catalonia													■	■	F
Slovenia	■		P				■	■	P	■	■	P	■	■	P
PERCENTAGE (%)	42,8	21,4		31,7	21,4		35,7	28’6		42,8	35,7			31’7	

■ YES
F Campaigns fully publicly funded
P Campaigns partially publicly funded
N Campaigns no publicly funded

Figure 3. Implemented media education campaigns with information about why heavy drinkers should reduce their alcohol consumption and how to reduce it.

The results (Figure 3) show that implemented media education campaigns on alcohol consumption, in general are not widely available, especially in some countries. When available, they are generally fully publicly funded (71,8% from those campaigns where the type of funded was reported), with a minor proportion of those being partially funded (28,2%).

In Belgium *A progressive annual national campaign was launched by the Flemish association against alcohol and drugs and received public attention on TV after press releases. It is oriented towards use of alcohol by younge people, in the workplace, by women, and in sports facilities.*

In England *Since October 2006, there has been a joint Department of Health and Home Office mass media campaign urging young drinkers to know their limits and stay within them. The advertising campaign uses television ads, posters and a Know Your Limits website to get the message across that too much alcohol*

actually makes you vulnerable, even while it makes you feel tough[7]. Earlier this year, under the same title of "Know Your Limits", the Department of Health introduced a campaign to help members of the public to accurately calculate the numbers of units in alcohol beverages. In addition to mass media promotion, this campaign involves website jointly funded by the alcohol industry[8]. Lastly the Department of Health has just launched a social marketing campaign aimed at reducing the alcohol consumption of 35+ regular excessive drinkers. This involves various media, including an alcohol screening website, a telephone helpline and widespread distribution of a self-help booklet.

In Germany — *An important instrument is the internet media[9] with a clear focus on adolescents and young adults.*

In Hungary — *There is no systematic alcohol education programme in any media. However four or five times a year alcohology specialists get a chance to speak for five minutes in the media about the danger and the harms done by excessive alcohol consumption and also about the possibilities of getting some kind of treatment.*

In Ireland — *The Drinks Industry Social Organisation group, MEAS (Mature Enjoyment of Alcohol in Society) - Irish for respect - run elaborated campaigns which are of course funded by the drinks Industry. All alcohol advertisements include the advice to learn more by consulting 'drinkaware.ie' which is run by Meals/Drinks industry and therefore by definition is inadequate. The Health Service Executive (Government funded) also ran a media campaign (all listed media outlets) directed at young people. The Road Safety Authority who would receive public funding also runs a media campaign on drink driving.*

In Italy — *There are annual national campaigns by Minister of Health- Istituto Superiore di Sanità (ISS) that are regularly evaluated. Since 2003 the Osservatorio Nazionale Alcol and the WHO CC for Research on Alcohol at the ISS Dr Scafato are in charge for the realization and implementation of the National Alcohol Prevention Day[10] of the campaigns and the communication strategy on alcohol set on a yearly base by the law 125/2001 (formal agreement between Istituto Superiore di Sanità and Ministry of Health)[11]. A detailed description of the activities can be also found with specific links to the initiatives and the original booklets and posters of the campaigns at the web site of the European Commission[12].*

In Lithuania — *The Government of Lithuania established in 2008 the Temperance year programme. The aim on this program is to spread temperance idea and to promote society healthy lifestyle.*

In Poland — *The TV campaigns refer only to regional TV. Education campaigns promotes stop drinking in certain situations (pregnancy and before driving).*

In Portugal — *There is an Action Plan concerning Alcohol Related Problems that includes campaigns addressed to priority groups such as people in workplace, young*

[7] http://www.alcoholpolicy.net/2006/10/know_your_limit.html

[8] http://www.alcoholissues.co.uk/portman-group-drinkaware.html

[9] http://www.bist-du-staerker-als-alkohol.de, conducted by the Federal Agency for Health Education.

[10] http://www.epicentro.iss.it/temi/alcol/adp08.asp

[11] http://www.epicentro.iss.it/temi/alcol/alcol.asp

[12] http://ec.europa.eu/health/ph_determinants/life_style/alcohol/documents/italy_en.pdf

people, drivers, etc.

In Spain - Catalonia: *No public education campaigns in mass media have been implemented yet. Information to the general public consulting PHC has been provided in parallel to the implementation of the "Beveu Menys" ("Drink less") program in Catalonia.*

Slovenia: *Other campaigns refer to cinemas, health centres, universities, public places, e-mails, and the website.*

3.1.3. Health care infrastructures

3.1.3.1. Integrated Health Care System

This section explores to what extent the management of hazardous and harmful alcohol consumption is integrated in the health care system, including co-operation or relationships between primary health care and secondary health care, similar to that for other chronic diseases such as hypertension or diabetes. Partners were asked to give their opinion to this issue, in a scale from 0 to 10. Caution is recommended in the use of this information for official purposes, since it reflects a consensus opinion given the difficulty to measure the question with objective data, but it can be helpful as an orientation towards the issue.

INTEGRATION OF THE MANAGEMENT OF HHAC IN THE HEALTH CARE SYSTEM	SCALE 0-10
Belgium	1
Czech Republic	4
England	6
Finland	8
Germany	1
Greece	4
Hungary	2
Ireland	2
Italy	6
Lithuania	2
Poland	1
Portugal	5
Spain - Catalonia	7
Slovenia	5
MEAN	3,8

Figure 4. Integration of the management of hhac in the health care system. The question is pointed in a scale from 0 (no integrated) to 10 (fully integrated), and the intensity of the colour on the scale column is degraded according to the score.

The results show a great difference between countries (See Figure 4). Further support for the information of Figure 4 can be found in the following paragraphs:

Belgium	*In the health care system, cardio vascular risk assessment and diabetes receive a lot of attention, but alcohol almost none.*
England	*The Government has recently made a concerted attempt, using a variety of methods, to "mainstream" the management of hazardous and harmful consumption in the health care system. This has resulted in considerable improvements in the response to alcohol-related harm but there is still some way to go before full integration can be claimed, mainly because of difficulty in finding effective ways to incentivise medical and other professions for this work.*
Hungary	*Training primary health care professionals started in the year 2000, as a part of public health program, but after the 2002 change in the government all the public health program was taken out from the financing system and so the training process stopped short. The Public Health Policy of the present Government has put an end in 2008 to the functioning of the National Institute of Psychiatry and the National Institute of Alcohology, and they have taken away the stable financing from the health centres treating alcoholic patients.*
Ireland	*The Health Service Executive was asked for their opinion in answering this question.*
Italy	*In the last few years an increased interest arose in Italy in relationship with the need to develop, validate and implement instruments and methodologies devoted to the early identification and brief intervention (EIBI) of hazardous use of alcohol in the Primary Health Care settings. The Istituto Superiore di Sanità (ISS) has played a pivotal role in carrying out a formal activity in preparing a Country strategy[13], aimed at the implementation and dissemination of a common standard of training and at the coherent application of the EIBI.* *The main specific actions and activities in Italy are currently directed to the need to decrease the impact of hazardous use of alcohol whose number is estimated by the Osservatorio Nazionale Alcol at the ISS and by the Italian Society of Alcohology (SIA) at 5 million individuals in 2006, with the 8,4% of the population 15+ binge drinking at least one time during the year. The consequences of the increasing trend in at-risk population in Italy are further borne out by the increase in the number of people with alcohol problems (56000 in 2005; 21000 in 1996) actually in the care of the National Health Service bodies.* *According to the previous PHEPA experience and the Country strategy implementation already outlined for Italy and in line with the new PHEPA aims, the national working teams of the Osservatorio Nazionale Alcol and the WHO Collaborating Centre for Research and Health Promotion on Alcohol at ISS started in April 2006 to deliver a communication strategy and to organise conferences to announce, promote and disseminate the IPIB training programme. IPIB (Identificazione Precoce e Intervento Breve) is actually the formal institutional standard of training in Italy partially funded by the Ministry of Health allowing to participants for each of the planned courses to be trained themselves and to train other professionals.*

[13] http://www.gencat.net/salut/phepa/units/phepa/pdf/155_03strategia.pdf

Lithuania	*Mental health centres are obliged to render primary outpatient health care services for patients, used alcohol in the hazardous or harmful way or are dependent on alcohol. General practitioners, if they suspect alcohol or drug problems, can direct such patient for help to the Mental health centre. Specialized addiction disease treatment services are provided in the Addiction disease treatment centres. In-patient treatment services in cases of alcohol psychosis or hard withdrawal state are possible in psychiatric hospitals. In cases of hard intoxication with alcohol or alcohol surrogates health care services for such patients can be organized in the toxicological departments of somatic hospitals.*
Portugal	*An Action Plan that includes screen and brief interventions for Primary Health Care after the New Organic Law is being defined (Decreto-Lei nº 221/2007, de 29 de Maio)*
Spain - Catalonia	*The implementation of the "Beveu Menys" program has contributed to improve the situation but there is still a lot to be done to guarantee the systematic identification and intervention.*

3.1.3.2. Structures for quality care

In Figure 5, the results to the question: "is there a formal governmental organization, or organization appointed or contracted by the government that with responsibility of managing HHAC?" are provided.

EXISTENCE OF FORMAL GOVERNMENTAL ORGANIZATION, APPOINTED OR CONTRACTED BY THE GOVERNMENT, WITH RESPONSIBILITIES FOR MANAGING HHAC	PREPARING CLINICAL GUIDELINES	MONITORING HEALTH OUTCOMES	MONITORING THE QUALITY OF CARE	COST-EFFECTIVENESS REVIEW OF INTERVENTIONS	REVIEWS THE SAFETY OF PHARMACOLOGICAL TREATMENTS	PROVIDES INFORMATION TO HEALTH CARE PROVIDERS
Belgium	■	■				■
Czech Republic		■				
England	■	■	■	■	■	■
Finland	■				■	■
Germany						■
Greece					■	
Hungary	■	■	■		■	■
Ireland		■			■	
Italy	■	■	■	■	■	■
Lithuania						
Poland			■		■	■
Portugal	■	■	■		■	■
Spain - Catalonia	■	■	■		■	■
Slovenia						
PERCENTAGE (%)	**50**	**57-1**	**42,8**	**14,2**	**64,2**	**64,2**

■ YES

Figure 5. Structures for quality of care for the managing of HHAC. The names of the structures for each country can be found in the assessment tool document for each country on the Phepa official website[14].

Those structures in charge of reviewing the safety of pharmacological treatments for managing alcohol dependence (in 62, 4% of the countries) and also of providing information on managing hazardous and harmful alcohol consumption to health care providers (in 62, 4% of the countries), are widely available. In half of the countries, there are structures for monitoring health outcomes at the population level from managing hazardous and harmful alcohol consumption, and to a lesser extent for preparing clinical guidelines (50%) and for monitoring the quality of care provided (42,8 %) for managing hazardous and harmful alcohol consumption. The structures for reviewing the cost effectiveness of interventions for managing hazardous and harmful alcohol consumption are unavailable in almost all the countries (just available in 14,2%, in England and Italy).

In Finland	*The responsibilities are on level of alcohol, not on level of hazardous and harmful consumption.*
In Germany	*The Federal Agency[15] is also responsible for monitoring the quality of projects and coordination.*
In Ireland	*The Irish Medicines Board has the responsibility for reviewing the safety of the pharmacological treatment while the responsibility to provide information on the managing of HHAC is unclear, although both The Health Promotion Unit of Department of Health (Government policy) and the Health Service Executive (implementation of government policy) have responsibility in this area. The responsibility of preparing clinical guidelines is also unclear as it is not formal.*
In Lithuania	*Vilnius University organize postgraduate training for doctor psychiatrist and general practitioners on dependency diseases health care, including alcohol dependence diagnosing and treatment.*

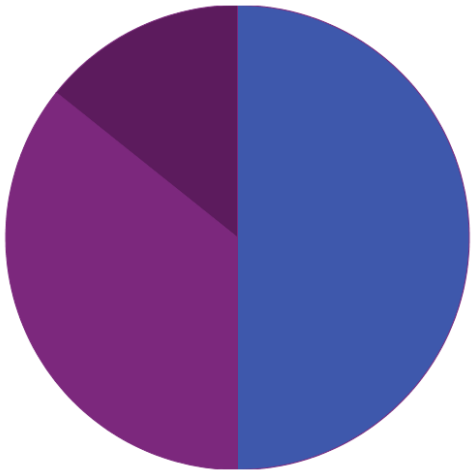
3.1.3.3. Research and knowledge for health

3.1.3.3.1. Formal research programme

In this section it explored whether there a formal research programme for managing hazardous and harmful alcohol consumption with specifically allocated funding from governmental, government appointed or non-governmental organizations (excluding the pharmaceutical companies and the alcohol industry). Half of the countries don't have such a research platform. Those who have a formal research programme are general from governmental organizations (in 5 countries/regions from the 7 that have them). However, in the countries where a research platform is not available, research activities are also reported.

[14] http://www.gencat.cat/salut/phepa/units/phepa/html/en/dir360/index.html

[15] http://www.prevnet.de



- **No** (Czech Republic, Finland, Greece, Hungary, Ireland, Lithuania, Slovenia)
- **Yes, from governmental organizations** (Belgium, Germany, Poland, Portugal, Spain – Catalonia)
- **Yes, from governmental and non governmental organizations** (England, Italy)

Figure 6. Formal research programmes.

In Belgium	*There is a pilot project on EIBI in occupational health.*
In England	*The Department of Health and the Home Office have funded a large cluster randomised controlled trial (SIPS/ Trailblazer Project) "to test how best to use a variety of models of screening and brief intervention (SBI) in primary and secondary healthcare settings, focussing particularly on value for money and mainstreaming". The 3 settings involved are primary health care, accident and emergency services and criminal justice services. Funding is currently £3.8 million, 6-month follow-up results will be available in 2009 and 12-month follow-up results in 2010. In addition to this funding, a range of organisations (eg, Wellcome Trust, Alcohol & Education Research Council) continue to fund research on alcohol SBI.*
In Greece	*EKTEPN which was responsible for this formal research is currently not operational. Some non-governmental organizations have announced their interest and plans for starting such research activity. Psychiatric department of the Medical Schools of Greek Universities informally have some research activities.*
In Ireland	*There is not a formal funding as such, though the Health Research Board does conduct excellent research.*
In Italy	***The Osservatorio Nazionale Alcol at the Istituto Superiore di Sanità is together the WHO CC for Research on Alcohol, the Focal point , National counterpart, scientific and technical expert and advisor appointed by the Minister of Health in the quality of the Italian Government representative on the issues of a) Alcohol and alcoholism , b) Alcohol Policy , c) research, prevention and health promotion in relationship with alcohol use and abuse, d) governmental campaigns and initiatives set by law 125/2001.***
In Lithuania	*State mental health centre have done survey about harmful alcohol consumption and its impact for public health in 2007. State alcohol control programme founded this survey.*
In Poland	*Research programmes into drinking patterns are conducted every 3 years.*
In Spain - Catalonia	*In the framework of the "Beveu Menys" Program, research activities are conducted.*

3.1.3.3.2. Education in the curriculum of professional training

The estimation of the formal inclusion on managing hazardous and harmful alcohol consumption as a formal education of the curriculum of undergraduate/basic professional training of several health care providers is considered in this section (See Figure 7).

There are great differences among countries in all the estimations. The clear trend is the lack of formal education on managing hazardous and harmful alcohol consumption for pharmacist in all the educational levels considered. For all the health care providers considered here, taking into account the media values, it seems that there is a tendency to have more formal education on the managing of HHAC in the curriculum of postgraduate and continuing professional training, compared to the undergraduate curriculum. The opposite trend can be observed in a lot of situations at the country level. However, the data provided are only estimation; therefore it should be only considered as a suggestion to explore deeply the question.

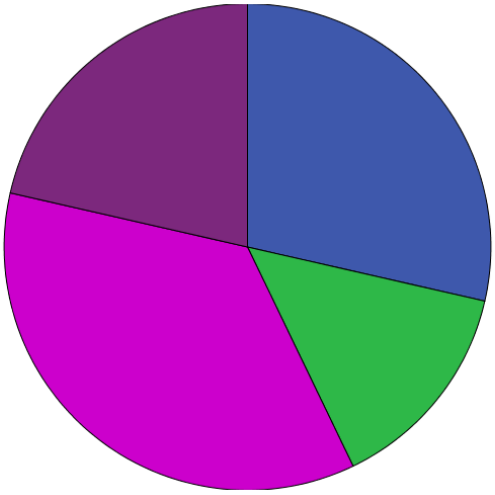
EDUCATION ON MANAGING HHAC IN THE CURRICULUM OF UNDERGRADUATE, POSTGRADUATE AND CONTINIUNG PROFESSIONAL TRAINING	MEDICINE			NURSING			PHARMACY			SOCIAL WORKER			PSYCHOLOGY		
	UNDERGRADUATE TRAINING	POSTGRADUATE TRAINING	CONTINUING EDUCATION	UNDERGRADUATE TRAINING	POSTGRADUATE TRAINING	CONTINUING EDUCATION	UNDERGRADUATE TRAINING	POSTGRADUATE TRAINING	CONTINUING EDUCATION	UNDERGRADUATE TRAINING	POSTGRADUATE TRAINING	CONTINUING EDUCATION	UNDERGRADUATE TRAINING	POSTGRADUATE TRAINING	CONTINUING EDUCATION
Belgium	2	4	4	1	1	1	1	2	2	1	8	8	3	8	8
Czech Republic	3	3	3	3	3	3	0	0	0	1	1	1	1	1	1
England	5	6	4	3	3	3	2	3	2	2	2	2	3	4	3
Finland	9	7	8	7	7	8	3	3	5	2	2	4	2	2	3
Germany	2	7	2	2	2	2	0	0	0	2	6	2	2	7	2
Greece	4	6	6	2	4	5	3	3	3	3	5	5	3	6	6
Hungary	2	4	2	2	2	2	2	2	2	4	4	4	2	2	2
Ireland	2	4	3	2	2	2	1	1	1				3	2	2
Italy	4	5	5	5	5	5	5	5	5	5	5	5	5	5	5
Lithuania	0	1	1	0	0	1	0	0	0	1	0	0	0	0	0
Poland	5	5	5	5	5	7	4		2	8	8	7	3	5	2
Portugal	5	6	6	4	4								5	5	
Spain - Catalonia	2	4	5	2	4	5	0	0	0	0	3	4	0	3	4
Slovenia	4	1	5	0	0	5	0	0	0	2	2	1	2	4	2
MEAN	3,5	4,5	4,2	2,7	3	3,7	1,6	1,5	1,6	2,5	3,8	3,5	2,4	3,8	3,0

Figure 7. Education on managing HHAC in the curriculum of undergraduate, postgraduate and continuing professional training. The question is pointed in a scale from 0 (no included) to 10 (fully included), and the intensity of the colour on the scale column decreases according to the score.

In Belgium	*VAD mainly provides training to social services and mental health delegates; they are well attended. Domus Medica mainly organises quality circles training and intervision of GP trainers; they are less well attended.*
In Finland	*Except medical and nursing students the concept of hazardous drinking is not clear, not even to the teachers. Social workers have minimal education on alcohol during basic training - first after graduating some start working in alcohol field with vocational training. But this is not systematic to all social workers. The same is true with psychologists.*
In Germany	*Especially in CME there are opportunities to learn about managing alcohol problems ("Fachkunde Sucht"), but participation is voluntary.*
In Ireland	*There is very informal and unstructured training, except for GPs where the situation is a lot better thanks to the Irish College of General Practitioner's alcohol project.*
In Italy	*A poor inclusion of alcohol issues in the training in the curricula still affects the professional competencies of the health and social personnel in Italy even after the solicitation of the law 125/2001 and by the national Committee on Alcohol.*
In Lithuania	*Vilnius University organizes postgraduate training and continuing medical education for doctor psychiatrist and general practitioners. One of training topics is dependency diseases health care, including alcohol dependence diagnosing and treatment. It can be information about nursing in case of dependency diseases (including alcohol dependency) in the course of continuing medical education of psychiatry nurses.*
In Poland	*Nursing (Postgraduate training) and some of the nursing subspecialisations (e.g. Longitudinal care, School medicine, Paediatrics, Psychology) do have managing hazardous and harmful alcohol consumption in their curriculum but others do not. For pharmacy students (Postgraduate training) there is no typical (like for medical doctors) Postgraduate professional training (specializations) for chemists in Poland. Postgraduate training of Public Health with a specialization of Social Work do have such items in their curriculum. This applies as well to Psychology students in case of completing a clinical specialization.*
In Portugal	*Protocols for undergraduate and post-graduate curricular programs for different institutions are being implemented.*
In Spain - Catalonia	*There is the Master on Drug Addiction, "Beveu Menys" Program, from the Institute of Health Studies.*

3.1.3.4. Health care policies and strategies

At the end of 2008, about 57% of the countries had an official written policy on managing hazardous and harmful alcohol consumption from the Government or Ministry of Health, mostly as a part of a more general policy strategy (See Figure 8).



No, there are no governmental policies (Hungary, Ireland, Lithuania, Slovenia)

No, but it is in preparation (Greece, Portugal)

Yes, a policy within an overall alcohol policy strategy (Belgium, Czech Republic, Finland, Italy, Poland, Spain-Catalonia)

Yes, a governmental stand alone policy (England, Germany)

Figure 8. Policies on managing hazardous and harmful alcohol consumption from the Government or Ministry of Health.

Czech Republic	*The duty to provide EIBI is enacted by § 19 of the Law No. 379/2005 Coll., on protection against harm done by tobacco products, alcohol and other psychoactive substances.*
England	*In 2006, the Department of Health published guidance to commissioners and treatment providers on the provision of treatment for alcohol misusers and SBI was prominent in this guidance (National Treatment Agency for Substance Misuse, Models of Care for Alcohol Misusers, Department of Health, London). Also, in 2005, the Department of Health published "Alcohol Misuse Interventions: guidance on developing a local programme of improvement." This contained "practical steps to improve screening and brief interventions for hazardous and harmful drinkers and treatment for dependent drinkers." The extent to which this guidance has been implemented is unknown.*
Germany	*The stand alone policy for alcohol prevention is called the "Nationales Aktionsprogramm zur Alkoholprävention"*[16]*.*
Lithuania	*The Government of Lithuania confirmed State alcohol control programme in 1999. Programme aim to reduce alcohol supply and demand, hazardous alcohol consumption and harm for public health and economy. This programme is being review and renewed now by work group of Ministry of health of Lithuania.*
Portugal	*Plano de Acção contra o Alcoolismo, Resolução do Conselho de Ministros Nº 166/2000 refers the importance of policies to manage hazardous and harmful consumption*

When the policy is available, a strategy to support interventions in primary care is included in half of the countries, and to a lesser extent intensive support for managing alcohol dependence in

[16] http://www.bmg.bund.de/cln_117/SharedDocs/Downloads/DE/Drogen-Sucht/Alkohol/Nationales-Aktionsprogramm-Alkohol,templateId=raw,property=publicationFile.pdf/Nationales-Aktionsprogramm-Alkohol.pdf

specialised treatment facilities (42%) and a strategy on training for health professionals (35%). A national research funded strategy is not included in any of the policies (See Figure 9).

In Belgium *Managing alcohol dependence is organised at national level by health insurance system.*

In England *Research is mentioned in Safe, Sensible, Social, including the SIPS project and other government funded projects.*

In Germany *The "Nationales Aktionsprogramm zur Alkoholprävention" contains a strategy to support interventions in PHC settings, which possibly leads to improved funding or reimbursement.*

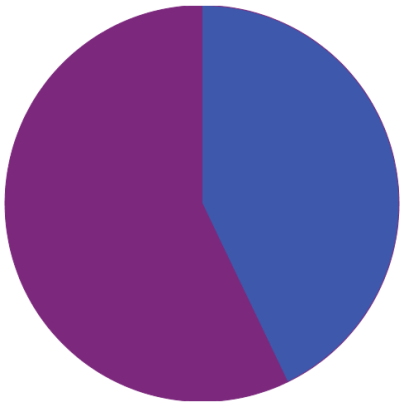
In Poland *A strategy to support interventions by primary care professionals is being prepared.*

AREAS INCLUDED ON THE GOVERNMENTAL POLICY ON MANAGING HHAC INCLUDES	POLICY FOR THE MANAGEMENT OF HHAC	STRATEGY ON TRAINING HEALTH PROFESIONALS	NATIONAL FUNDED REASEARCH STRATEGY	STRATEGY TO SUPPORT INTERVENTIONS IN PRIMARY CARE	SUPPORT FOR ALCOHOL DEPENDENCE IN SPECIALIZED TREATMENT FACILITIES
Belgium					
Czech Republic					
England					
Finland					
Germany					
Greece					
Hungary					
Ireland					
Italy					
Lithuania					
Poland					
Portugal					
Spain - Catalonia					
Slovenia					
PERCENTAGE (%)	**57**	**35**	**0**	**50**	**4 2**

Figure 9. Areas included in the policies on managing hazardous and harmful alcohol consumption from the Government or Ministry of Health. The first column shows the countries with the existence of a policy (coloured), following the colour criteria of Figure 8.

3.1.3.5. Structures to manage the implementation of treatment within health services

In 57% of the countries there is there an identified person within the Department of Health or Government, or who is contracted by the Department of Health or Government, who oversees or manages services for hazardous and harmful alcohol consumption (See Figure 10).



Yes: Belgium, Czech Republic, England, Finland, Italy, Lithuania, Portugal, Spain-Catalonia
No: Germany, Greece, Hungary, Ireland, Poland, Slovenia.

Figure 10. Countries with an identified person within the Department of Health or Government who manages services for HHAC.

3.1.3.6. Funding health service and allocating resources

In seven of the countries (50%) there government funding for services for the management of hazardous and harmful alcohol consumption, whereas in two more funding is being prepared (See Figure 11). In these cases, the amount of funding is usually reviewed from time to time. There is only one country, Poland, where a proportion of alcohol taxes specifically earmarked or allocated to fund the costs of services for managing hazardous and harmful alcohol consumption.

GOVERNMENTAL FUNDING FOR HHAC	GOVERNMENTAL FUNDING	REVISION OF FUNDING	PROPORTION OF TAXES FOR HHAC SERVICES
Belgium	Yes	Yes	No
Czech Republic	No		No
England	Yes	Yes, every 2-5 years	No
Finland	No		No
Germany	No		No
Greece	In preparation		No
Hungary	Yes	No	No
Ireland	Yes	Yes	No
Italy	Yes	Yes, annually	No
Lithuania	No		No
Poland			Yes, and it is reviewed
Portugal	In preparation	Yes, annually	No
Spain - Catalonia	Yes	Yes, annually	No
Slovenia	Yes	No	No
MEAN	50%	42.85%	7.14%

Figure 11. Governmental funding health service and allocating resources

In Finland *Funding for health promotion exists, but it is not allocated in this detail.*

In Greece *The National Health plan for Alcohol which is ready to be implemented.*

In Ireland *The Irish College of General Practitioners project is funded by the Health Service Executive. Funding for managing alcohol problems is not ring-fenced and is likely to be reduced during current recession every year. Also the funding is only part of overall funding. Some of the funding for alcohol comes through mental health services. The funding for alcohol problems, such as it is, is mostly directed towards dependence services.*

In Portugal *This activity is financed by the general budget of the Portuguese Government.*

In Slovenia *It's not really funded by the government because national budget for health insurance is separated from the government budget, but this national insurance budget pays for brief interventions done.*

3.1.4. Support for treatment provision.

3.1.4.1. Screening and quality assessment systems.

In this section, partners were again asked their opinion on a scale from 0 to 10, about to what extent they consider that the following screening and support systems are available for primary health health care providers in managing hazardous and harmful alcohol consumption. Results are reported in Figure 12.

SUPPORT FOR TREATMENT PROVISION	SCREENING INSTRUMENTS FOR AT RISK DRINKERS	CASE/COMPUTER NOTES TO RECORD ALCOHOL RISK STATUS	PROTOCOL CHARTS OR DIAGRAMS FOR HHAC CONSUMPTION	FACILITATORS OR ADVISORS FOR HHAC CONSUMPTION	FOLLOW-UP SYSTEMS FOR MONITORING AND ADVICE PATIENTS
Belgium	4	3	7	0	2
Czech Republic	5	0	0	2	1
England	8	8	8	8	8
Finland	1	1	1	1	5
Germany	8	2	2	2	2
Greece	5	3	3	4	3
Hungary	7	4	2	6	5
Ireland	8	4	8	5	7
Italy	7	5	5	7	9
Lithuania	2	0	0	0	0
Poland	6	4	0	0	0
Portugal				0	
Spain - Catalonia	7	7	7	7	5
Slovenia	1	1	1	6	8
MEAN	5,3	3,2	3,3	3,4	4,2

Figure 12. Availability of support systems for primary health health care providers in managing hazardous and harmful alcohol consumption.

In Belgium	*There are collaborative care protocols developed but not promoted and material available on web but little in use.*
In England	*All these treatment provisions are fully available to providers but not necessarily accessible.*
In Germany	*Elements like computer-based records or feedback systems have been evaluated in several research projects on a regional level over the last years.*
In Hungary	*There are only a very few facilitators and advisors supporting and helping the management of hazardous and harmful alcohol consumption.*
In Ireland	*There are freely available Irish guidelines on alcohol for use in primary care; however it is not clear how much they are used. There are also training programmes. Both these developments have emerged as a result of hard work in Ireland but encouraged by the existence of both Phepa phases. We need more capacity to provide support to Primary Care providers. Computerised records are available too but not used widespread.*
In Lithuania	*The screening instrument for to identify risk or harmful drinkers - AUDIT questioner is available for both - general practitioners and doctor psychiatrist.*
In Poland	*There is a computer program called "Dr Eryk" for family physicians which has a "case notes" function. There is also place for screening tests in traditional paper patient files.*
In Portugal	*There are experimental models of computer records being tested and the new action plan for alcohol will propose protocols and other kind of supports for Primary Health Care Providers.*
In Slovenia	*Support and materials are available but are not used very often yet.*

3.1.4.2. Protocols and guidelines.

Multidisciplinary guidelines

Most of the countries (64%) have already developed multidisciplinary guidelines, while two more (14%) are developing them (See Figure 13). The majority are stand alone guidelines (80%) as opposed to a part of other clinical guidelines. However, there is still a great lack of studies about their adherence and implementation (just in 21% of the countries, or in 33% of those who reported having clinical guidelines).

PROTOCOLS AND GUIDELINES	MULTIDISCIPLINARY CLINICAL GUIDELINES FOR MANAGING HHAC		STUDIES ON ITS IMPLEMENTATION OR ADHERENCE
Belgium	No, they are being prepared	Stand alone guidelines	
Czech Republic	Yes	Stand alone guidelines	No
England	Yes	Stand alone guidelines	No
Finland	Yes	Part of other clinical care guidelines	Yes
Germany	Yes	Stand alone guidelines	Yes
Greece	No		
Hungary	Yes	Part of other clinical care guidelines	No
Ireland	No		Yes
Italy	Yes	Stand alone guidelines	No
Lithuania	No		No

Poland	Yes	Stand alone guidelines	No
Portugal	No, they are being prepared		No
Spain - Catalonia	Yes	Stand alone guidelines	No
Slovenia	Yes	Stand alone guidelines	No
MEAN	64,28%	8/10 stand alone guidelines	21,42%

Figure 13. Availability of support systems for primary health care providers in managing hazardous and harmful alcohol consumption.

In Belgium *A group is preparing an adaptation of the PHEPA guidelines.*
In England *The SIPS research project is using an SBI pack very similar to How Much Is Too Much? and will report on acceptability to providers, adherence and extent of implementation.*
In Germany *Further publications are in preparation.*
In Greece *In general, guidelines that are followed are those of WHO.*

In Ireland *Guidelines are available for primary care but are not multidisciplinary.*

3.1.4.3. Reimbursement for health care providers

In several countries, a high proportion of general practitioners (57%) and nurses in general practice (57%) are reimbursed for managing HHAC (See Figure 14). The most common practice, however, is reimbursement as a part of their normal salary (See Figure 15), especially for general practitioners (71%), doctors in hospitals (71%) and addiction specialists (85%).

REIMBURSEMENT OF HEALTH CARE PROVIDERS FOR MANAGING HHAC	GENERAL PRACTITIONERS	NURSES IN GENERAL PRACTICE	DOCTORS IN HOSPTIALS	NURSES IN HOSPITALS	PHARMACISTS	DENTISTS	ADDICTION SPECIALISTS
Belgium	■	■					
Czech Republic		■					
England	■	■					
Finland	■						
Germany							
Greece							
Hungary	■	■					■
Ireland		■					
Italy	■	■					
Lithuania							
Poland							
Portugal	■	■					
Spain - Catalonia	■	■					
Slovenia	■						
PERCENTAGE (%)	**57**	**57**	**0**	**0**	**0**	**0**	**7**

■ **YES**

Figure 14. Reimbursement of health care providers for managing HHAC.

REIMBURSEMENT AS A PART OF NORMAL SALARY OF HEALTH CARE PROVIDERS FOR MANAGING HHAC	GENERAL PRACTITIONERS	NURSES IN GENERAL PRACTICE	DOCTORS IN HOSPTIALS	NURSES IN HOSPITALS	PHARMACISTS	DENTISTS	ADDICTION SPECIALISTS
Belgium	■		■				■
Czech Republic	■		■				■
England	■	■	■	■			■
Finland							
Germany	■		■				■
Greece	■		■				■
Hungary	■	■	■	■	■	■	
Ireland	■	■	■	■	■		■
Italy	■	■	■				■
Lithuania							■
Poland							■
Portugal	■	■	■	■			■
Spain - Catalonia	■	■	■	■			■
Slovenia							■
PERCENTAGE (%)	**71**	**42**	**71**	**35**	**14**	**7**	**85**

■ **YES**

Figure 15. Reimbursement as a part of normal salary of health care providers for managing HHAC.

Belgium	*The role of pharmacists in health education and advice is under discussion. There is a common training pilot planned by the Phepa team.*
England	*Special payment for alcohol SBI, where it exists, is made to primary care practices, not individual practitioners, although practitioners benefit indirectly from this payment. Although it may not always or even often be carried out, managing hazardous and harmful alcohol consumption just technically come within the terms of service of medical practitioners and other health care professionals.*
Ireland	*There is no routine reimbursement though we did reimburse practitioners in the Alcohol Aware Practice Service Initiative which proved to be a great success.*
Portugal	*A specific Primary Health Care Reform was implemented and there are primary health care professionals that receive an extra payment for providing services in areas such as tobacco and there is now a preparation of a specific additional service for alcohol problems.*

Protocols, policies and training for professionals

In at least half of the countries (See Figure 16), there are specialized guidelines or protocols for managing HHAC for general practitioners (64%), psychiatrist (57%), addiction specialists (57%), and nurses in general practice (50%). On the contrary, there are almost no guidelines or protocols for special nurses (14%), obstetricians (14%), and nurses in general hospitals (7%), midwives (7%) and pharmacists (0%).

SPECIALIZED GUIDELINES OR PROTOCOLS FOR MANAGING HHAC	GENERAL PRACTITIONERS	NURSES IN GENERAL PRACTICE	NURSES IN GENERAL HOSPITALS	SPECIAL NURSES	PHARMACISTS	MIDWIVES	PSYCHIATRISTS	OBSTETRICIANS	ADDICTION SPECIALISTS
Belgium									
Czech Republic	■						■		
England	■						■		■
Finland	■	■	■	■		■	■	■	■
Germany	■	■					■		■
Greece									
Hungary							■		■
Ireland	■	■					■		
Italy	■	■					■	■	■
Lithuania									
Poland									
Portugal	■	■							■
Spain - Catalonia	■	■		■					■
Slovenia	■	■					■		■
PERCENTAGE (%)	64	50	7	14	0	7	57	14	57

Figure 16. Specialized guidelines or protocols for managing HHAC.

In at least half of the countries (See Figure 17), there are written policies by professional association for managing HHAC for general practitioners (57%) and addiction specialists (57%). For psychiatrist the percentage is lower (57%), and much lower for the rest of the professionals considered (up to 28%).

WRITTEN POLICIY BY PROFESSIONAL ASSOCIATION FOR MANAGING HHAC	GENERAL PRACTITIONERS	NURSES IN GENERAL PRACTICE	NURSES IN GENERAL HOSPITALS	SPECIAL NURSES	PHARMACISTS	MIDWIVES	PSYCHIATRISTS	OBSTETRICIANS	ADDICTION SPECIALISTS
Belgium	■								
Czech Republic									
England	■						■		■
Finland	■	■	■	■		■	■	■	■
Germany							■		■
Greece									
Hungary							■		■
Ireland	■								
Italy	■	■	■	■	■	■	■	■	■
Lithuania									
Poland									
Portugal	■	■							■
Spain - Catalonia	■	■		■					■
Slovenia	■						■		■
PERCENTAGE (%)	57	28	14	21	7	14	42	14	57

Figure 17. Written policies for managing HHAC.

In almost three quarters of the countries (See Figure 18), there is training for managing HHAC within professional vocational training for psychiatrist (64%), addiction specialists (64%), and to a lesser extent for general practitioners (57%). There is also training in some of the countries for special nurses (42%), nurses in general practice (35%), and to a much lesser extent for nurses in general hospitals (21%), obstetricians (21%), midwives (21%) and pharmacists (7%).

TRAINING FOR MANAGING HHAC WITHIN PROFESSIONAL VOCATIONAL TRAINING	GENERAL PRACTITIONERS	NURSES IN GENERAL PRACTICE	GENERAL HOSPITALS	SPECIAL NURSES	PHARMACISTS	MIDWIVES	PSYCHIATRISTS	OBSTETRICIANS	ADDICTION SPECIALISTS
Belgium									
Czech Republic									
England	■	■	■	■			■		■
Finland	■	■	■	■		■	■	■	■
Germany							■		■
Greece	■			■		■	■	■	■
Hungary	■			■			■		■
Ireland	■	■					■		■
Italy	■	■	■	■	■	■	■	■	■

Lithuania									
Poland									
Portugal	■	■		■			■		■
Spain - Catalonia									
Slovenia	■						■		■
PERCENTAGE (%)	**57**	**35**	**21**	**42**	**7**	**21**	**64**	**21**	**64**

Figure 18. Training for managing HHAC within professional vocational training.

The availability of training for managing HHAC within accredited continuing medical education is slightly superior to the training for managing HHAC within professional vocational training, for general practitioners and nurses in general practice (See Figure19).

TRAINING FOR MANAGING HHAC WITHIN ACCREDITED CONTINUING MEDICAL EDUCATION	**GENERAL PRACTITIONERS**	**NURSES IN GENERAL PRACTICE**	**NURSES IN GENERAL HOSPITALS**	**SPECIAL NURSES**	**PHARMACISTS**	**MIDWIVES**	**PSYCHIATRISTS**	**OBSTETRICIANS**	**ADDICTION SPECIALISTS**
Belgium	■								
Czech Republic	■	■	■	■			■		
England	■						■		■
Finland	■	■	■	■		■	■	■	■
Germany							■		■
Greece	■			■		■	■	■	■
Hungary									
Ireland	■	■					■		■
Italy	■	■	■	■	■	■	■	■	
Lithuania									
Poland									
Portugal	■						■		■
Spain - Catalonia	■	■		■					■
Slovenia	■	■		■			■		■
PERCENTAGE (%)	**71**	**42**	**21**	**42**	**7**	**21**	**64**	**21**	**57**

Figure 19. Training for managing HHAC within accredited continuing medical education.

In England — *Training for managing hazardous and harmful alcohol consumption is probably available for most of the professions but whether or not it is taken up is a different question.*

In Hungary — *Training of general practitioners for EIBI started in 2000-2002, but the program stopped short because of termination of the Public Health Program.*

In Italy — ***The national working teams of the Osservatorio Nazionale Alcol and the WHO Collaborating Centre for Research and Health Promotion on Alcohol at ISS started in April 2006 to deliver a communication strategy and to organise conferences to announce, promote and disseminate the IPIB training programme. IPIB (Identificazione Precoce e Intervento Breve) is actually the formal institutional standard of training in Italy partially funded by the Ministry of Health allowing to***

participants for each of the planned courses to be trained themselves and to train other professionals.

In Poland *The PHEPA guidelines translated into Polish can serve all the above specified groups. There are no more specific guidelines designed for the groups listed above.*

In Portugal *Guidelines and written policies are being prepared.*

In Slovenia *Psychiatrists and addiction specialists are not trained for managing hazardous drinking but only for addiction and partly for harmful drinking.*

3.1.5. Intervention and treatment: availability and accessibility

In this section, partners were again asked about their opinion on a scale from 0 to 10, about how much they consider that patient help for HHAC is obtainable in different settings. Results are reported in Figure 20.

In Belgium *There are few addiction centres. Many GP disregard asking about alcohol.*

In Hungary *In the 90s there were several specialist clinics treating alcoholic patients, but after the year 2002, most of them stopped functioning due to financial reasons.*

In Ireland *The issue of training for brief interventions and the whole paradigm shift towards a focus on hazardous and harmful drinking (as opposed to a narrower focus on dependence) is growing in Ireland and there are more requests for training in this area as well as increasing realisation of the importance of prevention and reducing hazardous and harmful consumption.*

In Poland *Addiction services usually are interested in treatment of addicted people.*

In Portugal *There is a specific training program at national level and also training programs in hospitals and addiction units.*

In Slovenia *There are addiction services, but not for hazardous drinking.*

PATIENT HELP FOR HHAC IS OBTAINABLE IN DIFFERENT SETTINGS	GENERAL/FAMILY PRACTICE	HOSPITAL CLINICS	PHARMACISTS	SPECIALITS CLINICS	ADDICTION SERVICES
Belgium	3	2	1	7	5
Czech Republic	0	0	0	0	0
England	5	4	2	3	6
Finland	9	7	2	6	1
Germany	3	3	1	7	1
Greece	3	5	1	8	7
Hungary	1	2	0	7	9
Ireland	6	3	1	2	2
Italy	6	7	6	8	1
Lithuania	2	2	0	3	4
Poland	1	1	1	2	5
Portugal	6	6		7	8
Spain - Catalonia	7	3	0	3	9
Slovenia	7	3	0		1

MEAN	4,2	3,4	1,1	4,8	4,2

Figure 20. Patients help for HHAC obtainable in different settings.

3.1.6. Health care providers.

3.1.6.1. Clinical accountability.

ESTIMATION OF THE EXTENT TO WHICH THE FOLLOWING CARE PROFESSIONALS DO CONSIDER ADVICE FOR HHAC AS PART OF THEIR ROUTINE CLINICAL PRACTICE	GENERAL/FAMILY PRACTICE	HOSPITAL CLINICS	PHARMACISTS	SPECIALITS CLINICS	ADDICTION SERVICES
Belgium	6	1	3	5	3
Czech Republic	3	1	0	0	0
England	5	4	2	4	2
Finland	8	8	3	9	2
Germany	3	0	0	0	2
Greece	3	2	1	3	0
Hungary	2	0	0	0	0
Ireland	6	6	1	1	1
Italy	5	6	4	4	4
Lithuania	2	2	0	0	0
Poland	2	5	1	9	
Portugal	6	6			
Spain - Catalonia	6	6	4	4	4
Slovenia	8		0	2	0
MEAN	4,6	3,6	1,4	3,1	1,5

Figure 21. Estimation of advice for HHAC as part of the routine clinical practice.

In Belgium *There is an actual involvement of GP being evaluated by euro preview study.*

3.1.6.2. Treatment provision.

In this section a summary of the main findings reported on different areas is provided in the tables.

STUDIES, SURVEYS OR PUBLICATIONS IN PRIMARY HEALTH CARE	PATIENTS ARE ASKED OR SCREENED ABOUT THEIR ALCOHOL CONSUMPTION			
	Y/N	YEAR	MAIN FINDINGS	REFERENCE
Belgium	Yes	2000	More patients with alcohol problems are asked about it ; this is about 15 %	Regional survey of CENTRUM LOGO

Czech Republic	Yes	2006	16 GPs examined in total 2,589 patients aged 18 to 64.	(Sovinová et.al., 2006)
England	Yes	2005	The General Practice Research Database (GPRD) study found extremely low levels of formal identification, treatment and referral of patients with alcohol use disorders by general practitioners (GPs). GPs tended to under-identify younger patients with alcohol use disorders compared with older patients	Drummond 2005. Alcohol Needs Assessment Research Project (ANARP)
Finland	Yes	2008	Increasing	(Seppä, 2006)
Germany	Yes	2006		http://www.ncbi.nlm.nih.gov/pubmed/16608159?ordinalpos=10&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_DefaultReportPanel.Pubmed_RVDocSum
Greece	No			
Hungary	No			
Ireland	Yes	2006	Patients have no problem being asked about alcohol consumption	Alcohol Aware Practice Service Initiative - April 2005 - March 2006
Italy	Yes		No difficulties for about 60% of GPs	http://www.who.int/substance_abuse/publications/identification_management_alcoholproblems_phaseiv.pdf
Lithuania	No			
Poland	No			
Portugal	No			
Spain - Catalonia	Yes	2003	32.2%	Atención primaria; 2003
Slovenia	Yes	2003	73.8% of patients in 2 communities have never been asked about their alcohol drinking, only 10.8% have been asked in the last 12 months	(Marko and Djordje, 2006)
PERCENTAGE	68 %			

Figure 22. Studies, surveys or publications in primary health care about patients screened about their alcohol consumption.

STUDIES, SURVEYS OR PUBLICATIONS IN PRIMARY HEALTH CARE	PATIENTS WITH HHAC ARE GIVEN ADVICE			
	Y/N	YEAR	MAIN FINDINGS	REFERENCE
Belgium	No			
Czech Republic	Yes	2006	363 of 2,589 patients aged 18 to 64 complied with the criteria for BI (8 to 19 points in the AUDIT). These patients were given a brief advice.	(Sovinová et.al., 2006)
England	Yes	2005	The General Practice Research Database (GPRD) study found extremely low levels of formal identification, treatment and referral of patients with alcohol use disorders by general practitioners (GPs). GPs tended to under-identify younger patients with alcohol use disorders compared with older patients.	Drummond 2005. Alcohol Needs Assessment Research Project (ANARP)
Finland	Yes	2008	Increasing	(Seppä, 2006)
Germany	Yes	2006		Röske et al.: Familiy Medicine & Primary Care Review, 8, 1223-1227
Greece	No			
Hungary				
Ireland	Yes	2006	There are differences in consultation styles but most practitioners can do this work with a modicum of training and support.	
Italy	Yes			http://www.who.int/substance_abuse/publications/identification_management_alcoholproblems_phaseiv.pdf
Lithuania	No			
Poland	No			
Portugal				
Spain - Catalonia	Yes	2003		"Atención primaria, 2003"
Slovenia	No			
PERCENTAGE	50 %			

Figure 23. Studies, surveys or publications in primary health care about patients with HHAC given advice.

STUDIES, SURVEYS OR PUBLICATIONS IN PRIMARY HEALTH CARE	ADVICE MEETS QUALITY CRITERIA			
	Y/N	YEAR	MAIN FINDINGS	REFERENCE
Belgium	No			
Czech Republic	Yes	2006	GPs were trained in BI and the advice met criteria given in Guidelines.	(Sovinová et.al., 2006)
England	No			
Finland	Yes	2008	Getting Better	(Seppä, 2006)
Germany	No			
Greece	No			
Hungary				
Ireland	Yes	2006	Outcomes indicated that 30% of patients made some significant adjustments to their consumption after three month follow-up	
Italy				
Lithuania	No			
Poland	No			
Portugal				
Spain - Catalonia				
Slovenia	No			
PERCENTAGE	21 %			

Figure 24. Studies, surveys or publications in primary health care about advice meet quality criteria.

STUDIES, SURVEYS OR PUBLICATIONS IN PRIMARY HEALTH CARE	PRACTICE PROTOCOLS AND GUIDELINES ARE FOLLOWED			
	Y/N	YEAR	MAIN FINDINGS	REFERENCE
Belgium	No			
Czech Republic	Yes	2006	GPs followed the Guidelines published in Czech.	(Sovinová et.al., 2006)
England	No			
Finland	Yes	2008	More and more	(Seppä, 2006)
Germany	No		In preparation	
Greece	No			
Hungary				
Ireland	Yes	2006		
Italy	Yes		EIBI programme has been implemented at national level from 2007 (according to PHEPA recommendations)	http://www.who.int/substance_abuse/publications/identification_management_alcoholproblems_phaseiv.pdf
Lithuania	No			
Poland	No			

Portugal	Yes		In preparation	
Spain - Catalonia				
Slovenia	No			
PERCENTAGE	36 %			

Figure 25. Studies, surveys or publications in primary health care about practice protocols and guidelines.

STUDIES, SURVEYS OR PUBLICATIONS IN PRIMARY HEALTH CARE	EFFECTIVENESS OF INTERVENTIONS FOR HHAC			
	Y/N	**YEAR**	**MAIN FINDINGS**	**REFERENCE**
Belgium	No			
Czech Republic	Yes	2006	Patients were reexanined after 6 months. Improvement was found in 38 % of patients.	(Sovinová et.al., 2006)
England	Yes	2006	Opportunistic brief interventions (BI) delivered to hazardous and harmful drinkers in primary health care are effective in reducing alcohol consumption to low risk levels.The public health impact of widespread implementation of BI in primary health care is potentially very large. NNT for alcohol BI in primary health care is about 8 and this compares favourably with advice to quit smoking. BI in primary health care are equally effective among men and women, and are effective among older adults.	(Raistrick, 2006)
Finland	Yes	2001	Challenging as part of every day work	(Mauri Aalto, 2001)
Germany	Yes	2008		http://www.ncbi.nlm.nih.gov/pubmed/18207336?ordinalpos=3&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_DefaultReportPanel.Pubmed_RVDocSum
Greece	No			
Hungary				
Ireland	Yes	2006	In this study we provided Practice Staff with an Alcohol Counsellor on site to help with more difficult cases	
Italy	Yes		Aims, methodology and preliminary results of a	(Mezzani et al., 2007)

			national pilot study are described.	
Lithuania	No			
Poland	No			
Portugal	Yes		In preparation	Not published
Spain - Catalonia	Yes	2003	IB reduced significantly alcohol consumption d=-0.46; IC95%, -0.29 to -0,63; p<0,0005) and prevalence of risky drinkers (OR=1,55; IC 95%, 1.06-2.26; p=0.02	Gaceta Sanitaria 2003
Slovenia	No			
PERCENTAGE	57 %			

Figure 26. Studies, surveys or publications in primary health care about effectiveness of interventions for HHAC.

STUDIES, SURVEYS OR PUBLICATIONS IN PRIMARY HEALTH CARE	**COST-EFFECTIVENESS OF INTERVENTIONS FOR HHAC**			
	Y/N	**YEAR**	**MAIN FINDINGS**	**REFERENCE**
Belgium	No			
Czech Republic	No			
England	Yes	2006	Brief interventions delivered opportunistically are cost-effective compared to no interventions.	(Raistrick, 2006)
Finland	Yes	2004	Highly cost-effective.	(Seppä et al., 2004)
Germany	No			
Greece	No			
Hungary				
Ireland	Yes	2006	Clear evidence from the study that cost effectiveness was achieved and specifically on the basis of admissions avoided.	
Italy	No			
Lithuania	No			
Poland	No			
Portugal	No			
Spain - Catalonia				
Slovenia	No			
PERCENTAGE	21 %			

Figure 27. Studies, surveys or publications in primary health care about cost-effectiveness of interventions for HHAC.

STUDIES, SURVEYS OR PUBLICATIONS IN PRIMARY HEALTH CARE	THE USE OF AUDIT QUESTIONNAIRE			
	Y/N	YEAR	MAIN FINDINGS	REFERENCE
Belgium	Yes	1997		Anderson's thesis
Czech Republic	No			
England	Yes	2008	The full 10-item Alcohol Use Disorders Identification Test (AUDIT) should be the gold standard for screening tools but, within routine consultations, a shortened version of the AUDIT should be used. Among shortened version of the AUDIT, practices felt most positive about the AUDIT-C and, in particular, the FAST as pre-screening tools.The AUDIT could also be administered as a part of a population-led data collection exercise.	(Heather et. al., 2008)
Finland	Yes	2008	Increasing.	(Seppä, 2006; Aalto and Seppä, 2005)
Germany	Yes	2005	a) Evaluation of a German AUDIT version b) Item sequence does influence reports.	a) Rumpf et al.: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=12003915 b) Bischof et al.:Drug Alcohol Depend, 79, 373-377
Greece	No			
Hungary				
Ireland	Yes	2006	Perhaps a bit lengthy and we have subsequently advised practice staff to use the 'Audit C.'	
Italy	Yes		The ten-question-AUDIT national validation study; the short AUDIT are predictive of the same results obtained by the ten questions-AUDIT.	(Piccinelly 1997; Struzzo 2003)
Lithuania	No			
Poland	No			
Portugal	Yes		In preparation	
Spain - Catalonia	Yes	2002	AUDIT-C is useful for detecting hazardous and harmful alcohol consumption.	
Slovenia	No	1997		
PERCENTAGE	57 %			

Figure 28. Studies, surveys or publications in primary health care about the use of AUDIT questionnaire.

STUDIES, SURVEYS OR PUBLICATIONS IN PRIMARY HEALTH CARE	THE ATTITUDES OF HEALTH CARE PROVIDERS TO MANAGING HHAC			
	Y/N	YEAR	MAIN FINDINGS	REFERENCE
Belgium	Yes	1997		Anderson , thesis
Czech Republic	No			
England	Yes	2005	A quantitative survey conducted with a sample of 424 GPs in England showed a higher level of awareness of alcohol use disorders than the GPRD study or earlier surveys.	Drummond 2005. Alcohol Needs Assessment Research Project (ANARP)
Finland	Yes	2005	Positive	(Kääriäinen et al, 2001; Aalto M et al, 2005)
Germany	Yes	2006	GPs feel responsible but untrained	Berner et al.: Primary Care and Community Psychiatry, 11, 29-35.
Greece	No			
Hungary				
Ireland	Yes	2006	Some GPs and Practice Nurses still need persuasion that routine questioning about hazardous, harmful drinking is effective. Also some disblief in limits as regards daily/weekly consumption	
Italy	Yes		Nearby 60% of GPs have no difficulties in talking about these issues with their patients. Critical points: Lack of time; Lack of support staff; Lack of specific training.	(Mezzani et al., 2007; Struzzo et al., 2003; Polvani et al., 2000; Patussi et al., 2003; Bartoli et al., 2002; Bartoli et al., 2001)
Lithuania	No			
Poland	No			
Portugal	Yes		In preparation ; improvement	Not published
Spain - Catalonia	Yes	2003	Improvement	Not published
Slovenia	Yes	2008	It is important a GP gives advice to hazardous drinkers	(Marko et al, 2008)
PERCENTAGE	64 %			

Figure 29. Studies, surveys or publications in primary health care about the attitudes of health care providers to managing HHAC.

STUDIES, SURVEYS OR PUBLICATIONS IN PRIMARY HEALTH CARE	INCREASING THE INVOLVEMENT OF HEALTH CARE PROVIDERS IN MANAGING HHAC			
	Y/N	YEAR	MAIN FINDINGS	REFERENCE
Belgium	Yes	1997	Telephonic promotion followed by personal contact is most effective stratgey toward implementation in practice of screening.	Kaner et al, Anderson et al.
Czech Republic				
England	Yes	2007	It was agreed to develop and use two levels of BI: simple structured advice (simple BI) and brief behavioural counselling (extended BI). Simple BI, needing only a few minutes to deliver, should be offered to all patients screening positive for hazardous or harmful alcohol consumption. Extended BI, taking 20-30- minutes and often involving repeat consultations, should be offered to harmful drinkers, those who have failed to respond to simple BI and patients who wish to discuss their alcohol consumption further.	(Heather et. al., 2008)
Finland	Yes	2008	It takes time but happens	(Seppä, 2008; Aalto M et al., 2003)
Germany	No			
Greece	No			
Hungary				
Ireland	Yes	2006	Very gratified that three out of 8 Practice sites have managed to retain their Alcohol Counsellors after funding ran out for the study	
Italy	Yes		Focus groups to collect information about their experience, knowledge and needs; Distribution of brochure and other information materials; Providing support staff; Providing specific training and incentives.	(Mezzani et al., 2007; Struzzo et al., 2003; Polvani et al., 2000; Patussi et al., 2003; Bartoli et al., 2002; Bartoli et al., 2001)
Lithuania	No			
Poland	No			
Portugal				
Spain - Catalonia	Yes	2005	Improvement	Not published
Slovenia	No	1997		
PERCENTAGE	43 %			

Figure 30. Studies, surveys or publications in primary health care about increasing the involvement of health care providers in managing HHAC.

In Czech Republic	*All information from this section is based on the extensive pilot study carried out by the National Institute of Public Health. GPs in the study were from Prague and towns close to Prague.*
In England	*A recent Cochrane systematic review carried out in Engaldn by Kaner and colleagues reached similar conclusions to the NTA review cited in Figures 26 and 27 [PHEPA22.2England.doc] except that SBI was not found to be effective specifically among women. Reasons for this difference in findings are unclear. With regard to increasing the involvement of health care providers in the management of hazardous and harmful alcohol consumption, the findings of the SIPS project, when they become available, will provide important information on this issue.*
In Hungary	*The use of AUDIT C questionnaire is about to spread among GP-s but there is no special literature discussing this subject. Certain GP-s may collect data concerning the treatment procedure of their patients, but up till now they have not published their results.*
In Ireland	*The main study is The Alcohol Aware Practice Service Initiative, (referenced in Phepa17Ireland.doc)*

3.1.7. Health care users.

3.1.7.1. Knowledge

In this section a summary of the main findings reported on studies about people knowledge on the danger of HHAC to their health is provided in the table.

STUDIES, SURVEYS OR PUBLICATIONS	PEOPLE KNOW THAT HHAC CAN BE DANGEROUS TO THEIR HEALTH			
	Y/N	YEAR	MAIN FINDINGS	REFERENCE
Belgium	Yes	2000	Awreness of safe drinking levels is generally available for mean weekly consumption, not for number of drinks per occasion.	Not reported
Czech Republic				
England				
Finland				
Germany				
Greece				
Hungary				
Ireland	Yes	2006	The study found that there was widespread mis-information on gender differences, weekly limits etc but that when patients were engaged within primary care settings, they readily and easily accepted simple advice when given in a structured way.	Alcohol Aware Practice Service Initiative - April 2005 - March 2006
Italy				
Lithuania				

Poland				
Portugal				
Spain - Catalonia	Yes	2003	People do not know the harzardous and harmful limits	Not published
Slovenia	Yes	2003	More than 80% of patients in two communities know that	(Marko and Djordje, 2006)
PERCENTAGE	28 %			

Figure 31. Studies, surveys or publications in primary health care about

3.1.7.2. Help seeking behaviour

In this section a summary of the main findings reported on studies about people knowledge on help seeking methods to reduce HHAC is provided in the tables.

STUDIES, SURVEYS OR PUBLICATIONS	**PEOPLE KNOW ABOUT EFFECTIVE METHODS TO REDUCE HHAC**			
	Y/N	**YEAR**	**MAIN FINDINGS**	**REFERENCE**
Belgium				
Czech Republic				
England				
Finland				
Germany				
Greece				
Hungary				
Ireland	Yes	2006	The protocols we used helped Practice Nurses, Counsellors and GPs to tackle this issue with ex	'Alcohol Aware Practice Service Initiative'
Italy				
Lithuania				
Poland				
Portugal				
Spain - Catalonia				
Slovenia				
PERCENTAGE	7 %			

Figure 32. Studies, surveys or publications in primary health care about

In England *Although there may have been local surveys to address these two issues, there is no national data. Evaluations of the Government's "Know Your Limits" campaign amd the social marketing campaign among older harmful drinkers may throw light on this question.*

In Ireland *The 'Alcohol Aware Practice Service Initiative' was a follow-up and much enlarged study to another one conducted by the ICGP in 2003 called 'The Alcohol Aware Practice.*

STUDIES, SURVEYS OR PUBLICATIONS	PROVIDE INFORMATION ON THE PROPORTION OF HHAC USERS WHO HAVE EVER USED ONE METHODS* TO REDUCE THEIR ALCOHOL CONSUMPTION			
	Y/N	YEAR	MAIN FINDINGS	REFERENCE
Belgium	Yes		**Help from a doctor.**	Under progress in europreview study.
			Advice from the internet	Under progress by VAD pilot project.
			Specialist clinics one third of all problems dealth with in mental health relate to alcohol or alcohol and other drug use	see document collecetd for Flemish Policy on alcohol :url : http://www.zorg-en-gezondheid.be/uploadedFiles/subsite02/cijfers/Middelengebruik%20in%20Vlaanderen,%20een%20stand%20van%20zaken_def(1).pdf
			Self help group does not specify specific problems for which help is provided on drugline	Annual report of vad on drugline.
Czech Republic	Yes	2006	**Help from a doctor.**	(Sovinová et.al., 2006)
England	Yes	1996	**Help from a doctor.** A household survey in England by OPCS published in 1996 found that, of current and former drinkers who had spoken to a medical practitioner or other health professional in the last year, only 7% (men = 12%; women = 5%) reported having discussed alcohol consumption with their GP at the surgery	(Malbon e al. 1996).
Finland				
Germany	Yes	2004	**Help from a doctor.**	http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=14994210
			Advice from the internet	In preparation

			Specialist clinics	http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=14994210
		2004	**Self-help group**	http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=14994210
		2006	**Willpower alone**	http://www.ncbi.nlm.nih.gov/pubmed/16490790?ordinalpos=11&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_DefaultReportPanel.Pubmed_RVDocSum
Greece				
Hungary	Yes		**Help from a doctor.**	The National Institute of Alcohology has issued some publications in this subject.
Ireland				
Italy				
Lithuania				
Poland				
Portugal				
Spain - Catalonia				
Slovenia				
PERCENTAGE	35 %			

*Methods include the followings: help from a doctor, nurse, pharmacist, dentist, friends or family; advice from the internet; specialist clinic, self-help group; help line service; or willpower alone.

Figure 33. Studies, surveys or publications in primary health care about proportion of HHAC users using methods to reduce their alcohol consumption.

In Greece	*There are general surveys for alcohol consumption (use) in different populations with no specific interest in the issue of hazardous and harmful alcohol use.*
In Hungary	*While existing, the national Institute of Alcohology every year published statistics concerning the number of patients having been treated in the treatment facilities for alcohol problems.*
In Lithuania	*State mental health centre has done a survey about harmful alcohol consumption and its impact for public health in 2007. The state alcohol control programme founded this survey.*

3.2. Longitudinal change across 10 countries.

3.2.1. Presence of a country coalition or partnership.

During the year 2004/5, 7 of 10 countries (70%) had a country coalition or partnership, while in 2008, 10 of 14 (71%) had such a coalition. 6 of the 8 countries or regions (Belgium, England, Finland, Germany, Slovenia and Spain – Catalonia) that had a country coalition or partnership in 2004/5, kept it by year 2008. The only country where a country coalition was not present by year 2004/5 was Italy, where such a coalition has been created by year 2008. In Ireland it has disappeared, and in Portugal it is currently being created a new one.

3.2.2. Community action media and education.

EDUCATION CAMPAIGNS ON MEDIA ABOUT HHAC REDUCTION – AVAILABILITY AND FUNDING	WHY REDUCE - TV	HOW TO REDUCE - TV	WHY REDUCE - RADIO	HOW TO REDUCE - RADIO	WHY REDUCE - NEWSPAPERS/MAGAZINES	HOW TO REDUCE - NEWSPAPERS/MAGAZINES	WHY REDUCE - BILLBOARDS	HOW TO REDUCE - BILLBOARDS	WHY REDUCE - OTHER	HOW TO REDUCE - OTHER
Belgium	■				O					
Czech Republic										
England	■		■		■		■		■	
Finland	■	■	■	■	■	■	■	■	O	O
Germany			■				O	O	O	O
Ireland		■		■		■		■	O	O
Italy	O		O		O		O		O	
Portugal									O	■
Spain - Catalonia									■	■
Slovenia	■				■	■	■	■	O	O

O YES - 2004/5

■ YES – 2008

Figure 34. Comparative results 2004/5-2008. Implemented media education campaigns with information about why heavy drinkers should reduce their alcohol consumption and how to reduce it.

The results (Figure 34) show that implemented media education campaigns on alcohol consumption, in general are not widely available in all the countries, but a clear increase is observed compared to 2004/5. In general, when such education campaigns exit in a country, an overall strategy that includes all or almost all the media is used. Besides the specified categories, the website is also one of the mass media reported.

3.2.3. Health care infrastructures

3.2.3.1. Structures for quality care

EXISTENCE OF FORMAL GOVERNMENTAL ORGANIZATION, APPOINTED OR CONTRACTED BY THE GOVERNMENT, WITH RESPONSIBILITIES FOR MANAGING HHAC	PREPARING CLINICAL GUIDELINES	MONITORING HEALTH OUTCOMES	MONITORING THE QUALITY OF CARE	COST-EFFECTIVENESS REVIEW OF INTERVENTIONS	REVIEWS THE SAFETY OF PHARMACOLOGICAL TREATMENTS	PROVIDES INFORMATIONS TO HEALTH CARE PROVIDERS
Belgium						O
Czech Republic					O	O
England		O	O	O	O	O
Finland						
Germany						O
Ireland						
Italy	O	O	O		O	O
Portugal						
Spain - Catalonia	O	O	O		O	O
Slovenia						

O YES - 2004/5

YES - 2008

Figure 35. Structures for quality of care for the managing of HHAC. The names of the structures for each country can be found in the assessment tool document for each country on the Phepa official website[17].

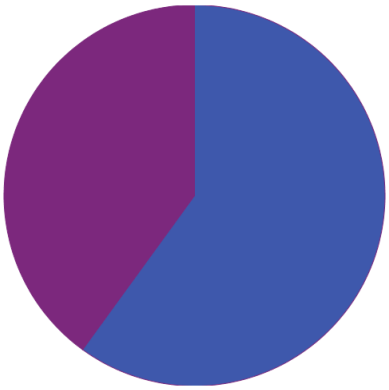
There has been an increase in the existence of formal governmental organizations, appointed or contracted by the government, wich responsibilities of managing HHAC for all the categories (see figure 35). This development is more clear for the structures that prepare clinical guidelines and for those that monitore the quality of care provided (altought its existence is no more than 50 %), and specially scarce for those structures in charge of reviewing the cost effectiveness of interventions for managing HHAC, which are unavailable in almost all the countries.

[17] http://www.gencat.cat/salut/phepa/units/phepa/html/en/dir360/index.html

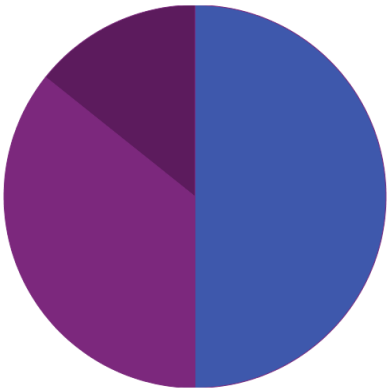
3.2.3.2. Research and knowledge for health

3.2.3.2.1. Formal research programme

2004/5



2008



- **No** (2004/5: Belgium, Finland, Ireland, Portugal, Spain-Catalonia, Slovenia; 2008: Czech Republic, Finland, Ireland, Slovenia)
- **Yes, from governmental organizations** (2004/5: Czech Republic, England, Germany, Italy; 2008: Belgium, Germany, Portugal, Spain – Catalonia)
- **Yes, from governmental and non governmental organizations** (2008: England, Italy)
- **Yes, from non governmental organizations**

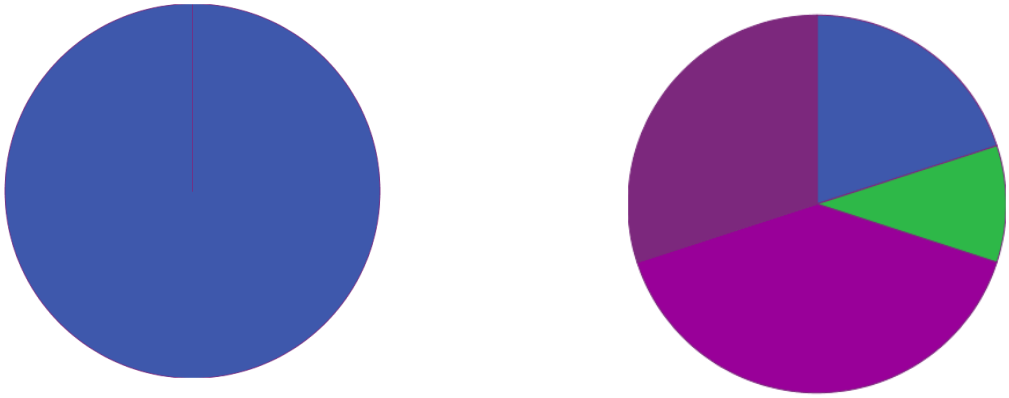
Figure 36. Formal research programmes.

The changes on the existence of a formal research programme for managing HHAC with specifically allocated funding from governmental, government appointed or non-governmental organizations (excluding the pharmaceutical companies and the alcohol industry) are reported in Figure 36. In 2008, only half of the countries have a formal research programme for managing HHAC with specifically allocated funding. The general availability has not increased widely in relation to 2004/5. Compared to 2004/5, in 2008 in Belgium, Portugal, and Spain – Catalonia, governmental organizations for formal research programme exits; in England and Italy non governmental organization are also carrying out such activities; whereas in Czech Republic a governmental organization in charge of this kind of research does not exist any more.

3.2.3.2.2. Education in the curriculum of professional training

3.2.3.3. Health care policies and strategies

2004/5 **2008**



- **No, there are no governmental policies** (2008: Slovenia, Ireland)
- **No, but it is in preparation** (2008: Portugal)
- **Yes, a policy within an overall alcohol policy strategy** (2008: Belgium, Czech Republic, Finland, Spain-Catalonia)
- **Yes, a governmental stand alone policy** (2008: England, Germany, Italy)

Figure 37. Policies on managing hazardous and harmful alcohol consumption from the Government or Ministry of Health.

In 2004/5 there were no written policies for the management of HHAC in any of the countries (See Figure 37). In 2008 such policies have been written or are in preparation in 80% of the countries.

3.2.3.4. Structures to manage the implementation of treatment within health services

3.2.3.5. Funding health service and allocating resources

GOVERNMENTAL FUNDING FOR HHAC	2004/5	2008
Belgium	No	Yes
Czech Republic	No	No
England	Yes	Yes
Finland	Yes	No
Germany	No	No
Ireland	Yes	Yes
Italy	Yes	Yes
Portugal	Yes	In preparation
Spain - Catalonia	Yes	Yes
Slovenia	Yes	Yes
MEAN	70%	60% (10% in preparation)

Figure 38. Governmental funding health service and allocating resources

In 2004/5, 7 countries had government funding for services for the management of HHAC. In 2008 six of those countries had government funding for such services or it was being prepared, but in one of those countries (i.e., Finland) the funding has been suspended.

3.2.3.6. Protocols and guidelines.

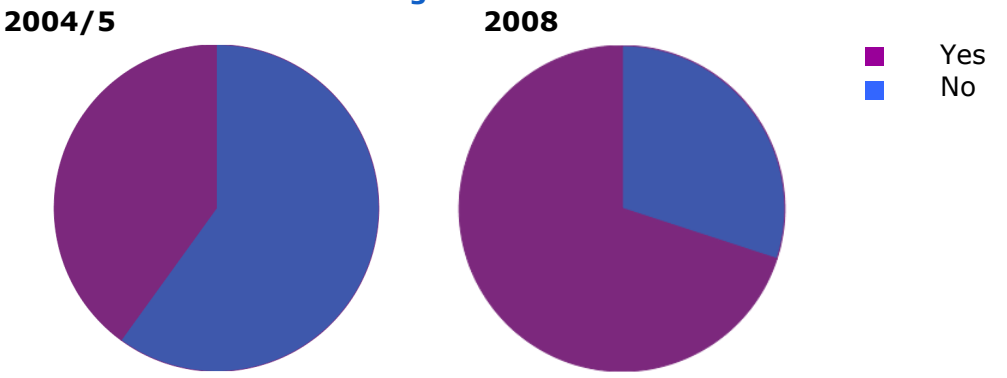


Figure 39. Protocols and guidelines

Multidisciplinary clinical guidelines have become widely available in 70% of the countries, compared to 2004/5, when only 40% of the countries had multidisciplinary guidelines (see Figure 39). Germany, Italy, Spain-Catalonia and Slovenia already had guidelines in 2004/5; Czech Republic, England and Finland have developed them from that year; and Belgium, Ireland and Portugal don't have them.

CONCLUSIONS

4.1. General conclusions: from 2004/5 to 2008.

- Most of the countries (71%) have a coalition for the management of HHAC.
- Implemented media education campaigns on alcohol consumption in general are not widely available. However, a slight increase has been observed compared to 2004/5. When available, they are generally fully publicy funded.
- According to personal opinions, in most of the countries the integration of the management of HHAC in the health care system is quite low.
- Most of the countries have formal governmental organizations for reviewing the safety of pharmacological treatments, and for providing information to health care providers. About half of the countries have structures for monitoring health outcomes at the population level from managing HHAC, for preparing clinical guidelines, and for monitoring the quality of care provided for managing HHAC. The structures for reviewing the cost effectiveness of interventions for managing HHAC are unavailable in almost all the countries.
- In 2008, only half of the countries have a formal research programme for managing HHAC with specifically allocated funding. The general availability has not increased widely in relation to 2004/5, and most of these structures are governmental organizations.
- In 2008, almost three quarters of the countries have some official written policy for the management of HHAC or are preparing such a policy, while none of the countries had such a policy in 2004/5. In the countries where such a policy exists, a strategy to support interventions in primary care is included in half of the countries, and to a lesser extent intensive support for managing alcohol dependence in specialised treatment facilities (42%) and a strategy on training for health professionals (35%). A national research funded strategy is not included in any of the policies.
- In more than half of the countries there is an identified person within the Department of Health or Government, who oversees or manages services for HHAC.
- In half of the countries there is government funding for services for the management of HHAC.
- In almost none of the countries is a proportion of alcohol taxes specifically earmarked or allocated to fund the costs of services for managing HHAC.
- Most of the countries have already developed or are developing multidisciplinary guidelines for managing HHAC. However, there is still a great lack of studies about their adherence and implementation.
- In 57% of the countries a high proportion of general practitioners and nurses in general practice are reimbursed for managing HHAC. The most common practice, however, is the reimbursement as a part of their normal salary.
- The training for managing HHAC is fairly available in some countries and for some professionals, but still not available in some countries.
- There are studies, surveys or publications in primary care, especially about:
    - patients screened about alcohol consumption (68%)
    - patients with HHAC are given advice (50%)
    - the effectiveness of intervention (57%)

  - the attitudes of health care providers (58%)
  - the use of AUDIT (57%)
  - the attitudes of health care providers to managing HHAC (64%)
- There is a lack of studies, surveys or publications in primary care on:
  - advice meet quality criteria (21%)
  - the cost-effectiveness of interventions for HHAC (21%)
  - people know that hhac can be dangerous to their health (28%)
  - people know about effective methods to reduce hhac (7%)

4.2 The assessment tool

The assessment tool is requesting information on the availability of the services for the management of hazardous and harmful alcohol consumption on the primary health sector. The aim of this process has been to identify the available infrastructures and also the deficiencies or areas that need further work and strengthening, both at the country and at the European level.

Strong points of the tool:

- It can be used as a baseline description to compare the situation across countries.
- It can provide a mechanism to compare the evolution of the situation over time.
- It can provide a general snapshot on the deficiencies or areas that need further work and strengthening can be drawed.

Points that need further development:

- For some of the questions (i.e., C.2, 15, 20 and 21 from the questionnaire), there is often no objective alternative source (i.e., universal indicators) of this information, and the validity of the answers rely on personal opinion and cannot always be guaranteed. The establishment of some standardized indicators could be useful to guarantee a stronger validity.
- For other questions, objective information could be achieved (i.e., question 5 from the questionnaire), but the amount of resources to get it would be beyond the resources of the PHEPA project.
- Since, within countries the knowledge of the available services can vary according to the respondent completing the questionnaire, it could be recommended that different professionals should answer the assessment tool (specially for the questions C.2, 15, 20 and 21 from the questionnaire).
- The establishment of some standardized indicators could be useful to guarantee a stronger validity.
- Currently, there is no agreement about a standardized and objective indicator that can serve as a gold standard of what overall identifies a good or acceptable service for the management of HHAC. The creation of such an indicator could pave the way to explore which of the sections of the assessment tool could be correlated to this indicator.

DISCUSSION

According to the WHO - Strategies to reduce the harmful use of alcohol from March 20th of 2008, adequate mechanisms for regular assessment, reporting and evaluation are necessary for monitoring progress at different levels, and special efforts are needed to formulate a comprehensive health-care sector response to alcohol-related problems, with particular emphasis on primary health care interventions. On the other hand, early identification and effective treatment in health-care settings of alcohol-use disorders, also in patients with co-morbid conditions, can reduce associated morbidity and mortality and improve the well-being of affected individuals and their families. Treatment is most effective when supported by sound policies and health systems and integrated within a broader preventive strategy. Health-care providers should concentrate on clients' health improvement and satisfaction through evidence-based and cost-effective interventions, and governments, in improving health systems, should take into consideration services for alcohol-use disorders and interventions for hazardous and harmful use of alcohol. As the main providers of health care, the many millions of health workers worldwide can contribute substantially to reducing and preventing harmful use of alcohol.

The assessment tool on managing on HHAC has provided an overall assessment of the availability of the services for the management of hazardous and harmful alcohol consumption on the primary health sector across 14 European countries/regions, and longitudinally across 10 European countries/regions. The relevance of the key sections of the assessment tool, are outlined in the following paragraphs:

Presence of a country coalition or partnership.

Partnerships and coalitions tend to be better at getting things done at country level, and therefore should ensure that all countries have a partnership that also informs the department of health.

Community action media and education.

Public education should focus on how to get help with harmful drinking, and people need to be aware of risk levels.

Health care infrastructures

These are the standard infrastructures that are needed to promote the delivery of good quality of care. One needs good research and knowledge and to ensure that this knowledge is disseminated to health care managers and providers.

Support for treatment provision.

Protocols and clinical guidelines are needed. There need to be reimbursement systems to help primary care deliver brief interventions.

Intervention and treatment: availability and accessibility

Obviously help has to be available and accessible

Health care providers.

We need systems to monitor what health care provides are delivering.

Health care users.

We need systems to monitor health care users needs and uptake of brief advice programmes.

Therefore, the assessment tool could serve as a mechanism for regular assessment, reporting and evaluation on the services for managing HHAC.

RECOMMENDATIONS

6.1. What need to be done?

- There is a need to implement media education campaigns on alcohol consumption. Public funding should be allocated for that purpose.
- There is a need to develop structures for reviewing the cost effectiveness of interventions for managing HHAC in most of the countries.
- There is still a need to create formal research programme for managing HHAC with specifically allocated funding in some countries.
- In some countries, there is a need to include in the written policies the support for managing alcohol dependence in specialised treatment facilities, and a strategy on training for health professionals.
- In all the countries, there is a need to include in the written policies a research funded strategy.
- Studies about the adherence and implementation of the clinical guidelines for the managing of HHAC should be carried out.
- Studies about advice meet quality criteria, the cost-effectiveness of interventions for HHAC, people know that HHAC can be dangerous to their health, and people know about effective methods to reduce HHAC, should be developed.

SUMMARY

- RESEARCH AS A MAIN PRIORITY, BUT ALSO MEDIA EDUCATION AND TRAINING OF PROFESSIONALS, SHOULD BE THE AREAS TO BE IMPROVED.

6.2. How can the assessment tool be improved?

- Establishment of some standardized indicators, especially of a gold standard of what overall identifies a good or acceptable service for the management of HHAC. This standard should be based on an objective indicator about overall alcohol consumption.
- Creation of a formal and stable coalition of experts whitin a country, in order to answer the assessment tool and reach consensus on those question that can’t been supported by an objective indicator.

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