



SNAMID
Società Nazionale di Aggiornamento
per il Medico di Medicina Generale

A survey on the early identification and brief intervention for hazardous and harmful alcohol consumption in the Primary Health Care.

The European project AMPHORA

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AMPHORA

Alcohol Public Health Research Alliance

INEBRIA

International Network on
Brief Interventions for
Alcohol & Other Drugs





Istituto Superiore di Sanità – ISS

<http://www.iss.it>



- ISS is the leading technical/scientific body of the Ministry of Health (MoH) and of the National Health System (NHS)
- Since its foundation, 1934, it's the key body of health research in Italy
- It promotes programmes instrumental with the achievement of the objectives of the National Health Plan with tasks of technical guidance and coordination in the field of health protection and promotion



National Centre for Epidemiology, Surveillance and Health Promotion -CNESPS

Director: S. Salmaso



CNESPS, at the ISS, is the formal body whose mission, mainly set by law, is to develop and to apply epidemiological methods to monitor and protect human health.



National Observatory on Alcohol-NOA

Director: E. Scafato

The NOA, at the CNESPS, integrates epidemiology, health monitoring and health promotion through studies, population surveys, monitoring, health counselling and training in PHC



AMPHORA- Alcohol Measures for Public Health Research Alliance



"Alliance for the development of research and the study of European policies on alcohol and public health"



2008-2012

AMPHORA

Alcohol Measures for Public Health Research Alliance

AMPHORA is a Collaborative Research Project funded by the European Commission Seventh Framework Programme



Amphora is lead by:



AMPHORA

Alcohol Measures for Public Health Research Alliance

A four year Europe wide project involving more than 50 researchers and over 30 research institutions from all EU member states and project partners from 13 European countries.

AMPHORA will:

- Advance the state of the art in alcohol policy research and enhance cooperation among researchers in Europe.
- Provide new scientific evidence for the most effective public health measures to reduce the harm done by alcohol.
- Promote the translation of science into policy and disseminate new knowledge to policy makers.

Coordinated by Hospital Clínic de Barcelona (HCB), Catalonia, Spain
AMPHORA is a collaborative project funded under the European Commission Seventh Framework Program (FP7).

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AMPHORA

Alcohol public health research alliance



A The European Research Alliance brings together AMPHORA partners, other researchers and policy makers and representatives of government and non-governmental organisations.

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European Alcohol Policy Research Alliance

AMPHORA has created a European Alcohol Policy Research Alliance of internationally renowned alcohol policy researchers from a wide range of disciplines.

The Alliance will undertake new empirical research to strengthen European research knowledge of the impact of public health measures and interventions to reduce alcohol related harm and to contribute to integrated policy making.



- 1 Coordination: Hospital Clinic de Barcelona (HCB), Spain
- 2 Agenzia Regionale di Sanità della Toscana (ARS), Italy
- 3 Alcohol & Health Research Unit, University of the West of England, UK
- 4 Anderson, Consultant in Public Health, Spain
- 5 Anton Proksch Institut (API), Austria
- 6 Azienda Sanitaria Locale della Città di Milano (ASL MILANO), Italy
- 7 Budapesti Corvinus Egyetem (BCE), Hungary
- 8 Central Institute of Mental Health (CIMH), Germany
- 9 Centre for Applied Psychology, Social and Environmental Research (ZEUS), Germany
- 10 Chemisches und Veterinäruntersuchungsamt Karlsruhe Technische Universität (CVUA/KKA), Germany
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- 23 Norwegian Institute for Alcohol and Drug Research (SIRUS), Norway
- 24 State Agency for Prevention of Alcohol-Related Problems (PARPA), Poland
- 25 Stockholms Universitet (SU), Sweden
- 26 Swiss Institute for the Prevention of Alcohol and Drug Problems (SIPA), Switzerland
- 27 Technische Universität Dresden (TUD), Germany
- 28 Trimbos-instituut (TRIMBOS), Netherlands
- 29 University of Bergen (UiB), Norway
- 30 Universiteit Twente (UT), Netherlands
- 31 University Maastricht (UM), Netherlands
- 32 University of York (UoY), UK

INTRODUCTION

- In Europe, alcohol is the second risk factor for premature death and disability and of many diseases and conditions
- In daily professional practice, PHC professionals frequently deal with subjects with HHAC, very often unaware of the risks of their alcohol consumption
- Individuals who have not yet developed alcohol dependence can reduce/stop drinking receiving adequate care and support. Once the dependency has been established, to stop alcohol consumption is more difficult and may require specialist treatment (promotion of EIBI programs)
- **EIBI for HHAC in the PHC is an opportunity to communicate to patients the risks and to introduce life styles compatible with a good health status**



The integration of EIBI for HHAC into health policy in Italy



- **EIBI in the PHC of the NHS** started to be formally strengthened by the frame law on alcohol 125, 2001
- **EIBI for HHAC in all national public health documents:**
 - ✓ **the National Plan for Alcohol and Health (PNAS)**, approved by the State-Regions Conference in 2007, with the aim 8 *“to increase the dissemination of the methods and make available tools for the EIBI in the population at risk“*
 - ✓ **the National Prevention Plan 2010-2012** (where a prominent part is given to the prevention of habits, behaviors, unhealthy lifestyles) that incorporated the strategic areas of intervention of the PNAS
 - ✓ **the National Health Plan 2011-2013**, with different objectives to be achieved including *“to promote EIBI for the prevention of alcohol related problems in PHC and in the workplace“*



AIMS



- In the context of the **AMPHORA** project, in 2012 **a survey on national knowledge, attitudes and perceptions of general practitioners (GPs) on the use of EIBI for HHAC** has been carried out by the NOA-CNESPS of the ISS

- **The survey**, part of the Italian contribution to the AMPHORA Work Package 6 “*Early diagnosis and treatment*”, **has been performed in 6 EU countries** (Germany, Italy, Catalonia-Spain, Switzerland, Austria and England-UK) **aiming at the identification of the main barriers and facilitators for the implementation of EIBI in PHC**

METHODS

- In order to collect information, a **questionnaire has been prepared, adapted and translated** to meet different national languages and contexts
- The activity aimed to survey a random sample of **almost 100 GPs in each of the 6 countries**, selected using national databases of GPs or registers of relevant professional organisations
- Survey implementation: participants of the 6 countries either completed an **electronic version of the questionnaire (online or via email)**, a **paper version by post**, a **personal interview**, in order to achieve the sample size as quickly and efficiently as possible



SAMPLING



- **In Italy** the survey (activated on January 2012) has been conducted in collaboration with the “**Società nazionale di aggiornamento per il medico di medicina generale**”-**SNAMID**, a scientific society for the training of GPs, to all members of the society (1482 GPs to 31 December 2011)
- The questionnaire, **anonymous** and treated in accordance with the regulations in terms of privacy protection, has been fulfilled **on-line** by participants on the SNAMID website
- We collected 198 questionnaires and the collection continued until 22 March 2012, for 2 months period



DISTRIBUTION % OF PARTICIPANTS BY REGION



SNAMID

Società Nazionale di Aggiornamento
per il Medico di Medicina Generale



91 (46.0%) North

39 (20.0%) Center

68 (34.0%) South and islands

DESCRIPTION OF THE QUESTIONNAIRE

The questionnaire included **20 main questions organized into 4 parts, analyzing the following areas:**

1. Socio-demographic characteristics of participants (including training on alcoholology)
2. Information on the Early Identification of HHAC and alcohol dependence
3. Information on the Brief Intervention for HHAC and alcohol dependence
4. The opinion of the participants on the importance of preventive and therapeutic alcohol interventions in the PHC

Socio-demographic characteristics of participants

- age, gender
- time devoted to post-graduate training on alcohol and alcohol-related problems
- years worked in primary health care
- hours per week devoted to primary care practice
- average number of patients seen in a week
- average number of patients identified with HHAC or alcohol problems in the past 4 weeks
- average number of patients seen and identified with HHAC or alcohol problems although this was not their presenting problem during the past 4 weeks
- average number of family members of people with alcohol-related problems approached during the past 4 weeks

Early identification of HHAC and alcohol dependence

- Information on the knowledge and the use of screening tools for HHAC and alcohol dependence
- Cases in which the screening tools are used (when I see patient for the first time, in routine medical check up, as a point of general practice, if I suspect HHAC, if they present with specific conditions)
- Opinions on the usefulness of alcohol screening tools for general practitioners
- The main barriers to the use of alcohol consumption screening tools

Brief intervention for HHAC

- Information on the knowledge and the use of brief intervention for HHAC and alcohol dependence in the clinical practice of GPs
- Cases in which brief intervention is offered (..as a point of general practice, if I suspect alcohol use disorders, if they are positive to a standardised alcohol screening test, if they present specific conditions)
- Information on the brief intervention technique(s)
- Opinions on the usefulness of brief intervention for general practitioners
- The main barriers to offer a brief intervention on alcohol consumption

WHO. *International Classification of Diseases (ICD 10)*

<http://www.who.int/classifications/icd/en/>

- **Hazardous drinking**, a pattern of consumption that increases the risk of harmful consequences, physical or mental. It refers to patterns of consumption that are of public health significance, despite the absence of any current disorders
- **Harmful drinking**, a pattern of consumption that is causing damage to health, physical or mental, with evidence of alcohol-related problems, often without this having resulted in seeking treatment
- **Alcohol dependence** refers to drinking associated with an established moderate or severe level of dependence on alcohol, “a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state”

OTHER DEFINITIONS

- **Systematic alcohol screening:** Refers to the regular use of a **standardized alcohol screening tool** (paper or electronic based) for the identification of individuals with HHAC, such as the AUDIT, brief AUDITs (e.g., AUDIT-C), CAGE, FAST, SASQ or others
- **Brief intervention:** Refers to **intervention carried out in non specialist settings, by non-specialist personnel** (not alcohol treatment specialists), **for individuals** with HHAC who are **not complaining or seeking help for an alcohol problem** (from 5 minutes to 30/40 minutes, from a single session to more repeat sessions)



RESULTS

Socio-demographic characteristics of participants



Age: Yrs(M±SD)	56.1±6.8
Gender: N (%)	M: 147 (74.0%) F: 51 (26.0%)
Years worked in the PHC: N (%)	1-10 yrs: 14 (7.1%) 11-20 yrs: 56 (28.3%) 21-30 yrs: 68 (34.3%) >30 yrs: 60 (30.3%)
Hours per week devoted to primary care practice	Mean±SD: 34.3±13.7 hours Max: 72 hours, Min: 9 hours Moda: 40 hours, Mediana: 35 hours
Average number of patients seen in a week: N (%)	Mean±SD: 117.1±65.9 <50 patients: 28 (14.1%) 50-150 patients: 37 (69.2%) >150 patients: 33 (16.7%)
Average number of patients identified with HHAC or alcohol problems in the past 4 weeks	Range: 0-25 patients None: 64 (32.3%) 1-5: 112 (56.6%) >6: 22 (11.1%)
Average number of patients seen and identified with HHAC or alcohol problems although this was not their presenting problems during the past 4 weeks	Range: 0-50 patients None 34 (17.2%) 1-5: 111 (56.1%) >6: 53 (26.8%)
Average number of family members of people with alcohol-related problems approached during the past 4 weeks	Range: 0-10 family members None: 89 (44.9%) 1-5: 97 (49.0%) 6-10: 12 (6.1%)

CHAPTER 9. ALCOHOL INTERVENTIONS AND TREATMENTS IN EUROPE

Amy Wolstenholme, Colin Drummond, Paolo Deluca, Zoe Davey, Catherine Elzerbi, Antoni Gual, Noemí Robles, Cees Goos, Julian Strizek, Christine Godfrey, Karl Mann, Evangelos Zois, Sabine Hoffman, Gerhard Gmel, Hervé Kuendig, Emanuele Scafato, Claudia Gandin, Simon Coulton & Eileen Kaner



Alcohol Policy in Europe: Evidence from AMPHORA

Edited by Peter Anderson, Fleur Braddick, Jillian Reynolds and Antoni Gual



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2012

The AMPHORA project has received funding from the European Commission's Seventh Framework Programme (FP7/2007-2013) under grant agreement n° 223059 - Alcohol Measures for Public Health Research Alliance (AMPHORA). Participant organisations in AMPHORA can be seen at http://www.amphoraproject.net/view.php?id_cont=32.

Country	Gender (% males) of respondents	Age (Mean) of respondents	Patients per week	Patients screen positive/week (%)
Austria	46.5%	55.2	285	6.54 (2.5%)
Germany	53.4%	53.8	203	7.76 (3.8%)
Italy	74.2%	56.2	117	5.18 (4.4%)
Spain-Catalonia	23.3%	47.3	149	4.14 (2.8%)
Switzerland	61.8%	52.5	98	4.40 (4.5%)
UK -England	52.4%	46.5	110	3.87 (3.5%)
Total (mean)	56.3%	52.7	154	5.34 (3.5%)

- The number of patients seen each week by GPs was highest in Austria (n=285) and lowest in Switzerland (n=98)
- The number of patients screened +ve in a 4 week period was highest in Germany, lowest in England. However, when adjusted for the number of people seen, GPs in Switzerland and Italy were able to identify more subjects with AUDs (4.5 and 4.4%) than GPs from other countries



TRAINING ON ALCOHOLOGY

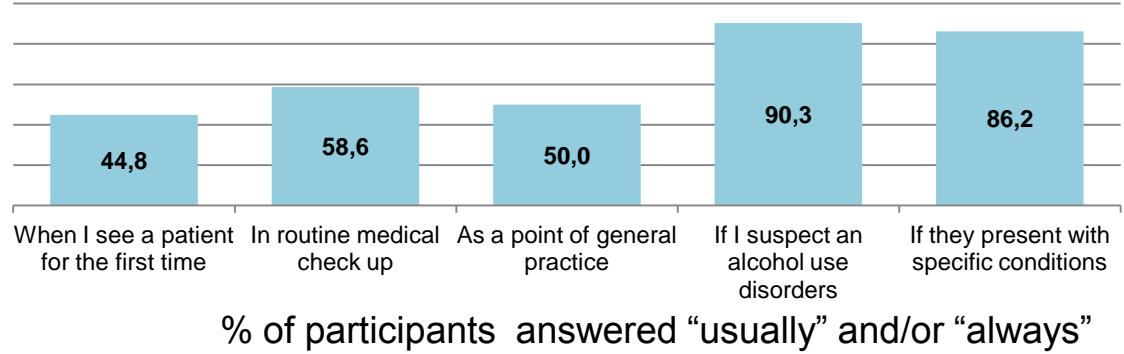


- Most of participants did not receive training on alcohol and alcohol-related problems:
 - ✓ 24% did not receive training at all
 - ✓ 26% “less than 4 hours”
 - ✓ 28% “from 4 to 10 hours”
- Only 7% of participants received more than 40 hours of specific training across the professional life

EARLY IDENTIFICATION

○ Only **31.9%** said to be **familiar with standardized screening instruments for HHAC and alcohol dependence** (AUDIT, AUDIT C, CAGE, FAST, others) of which only nearby half (**51%**) used tools in their clinical practice

“If you use screening tools for HHAC and alcohol dependence, how often do you use them in the following cases?”



○ Among those who said to know and to use a screening tool for HHAC and alcohol dependence, **73.9%** said to use the **AUDIT** (**60.9% AUDIT**, **13.0% the short version, AUDIT C**), the instrument studied specifically for the identification of hazardous drinkers

○ Nearby all participants considered useful the alcohol screening tools in their clinical setting. **Only 2 partecipants (1%) said that screening tools are not useful at all**

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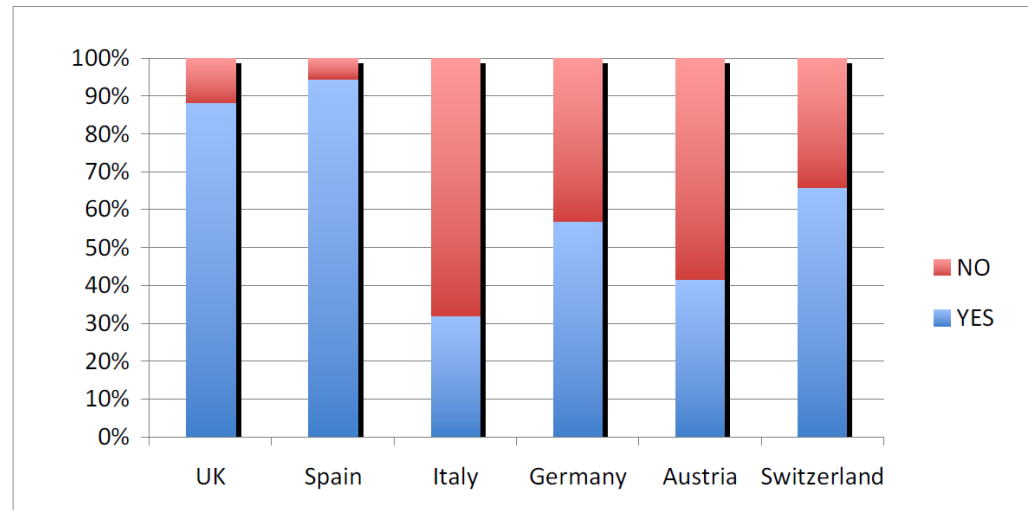
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Figure 1. Are GPs familiar with standardized alcohol screening tools?



✓ Spain (Catalonia) and UK (England) were top of the list with 94.6% and 88.2% respectively

✓ GPs in Italy are the least aware of standardized tools for the identification of people with HHAC



Barriers to the use of alcohol screening tools



Barriers to the use of alcohol screening tools

1=very important, 5=less important	% of answers					Mean	SD
	1	2	3	4	5		
Lack of time	23,8	17,6	18,1	13,0	10,4	3,2	1,69
Lack of financial incentives	21,9	8,3	15,6	12,0	10,4	3,76	1,68
Risk of upsetting the patients	12,5	20,8	18,8	24,0	11,5	3,39	1,78
Lack of training	21,8	20,2	22,3	11,4	10,9	3,1	1,63
Lack of services available	18,2	19,3	21,4	16,1	12,5	3,23	1,54
Lack of knowledge of the screening tools	25,9	22,3	16,6	11,4	13,5	2,95	1,94

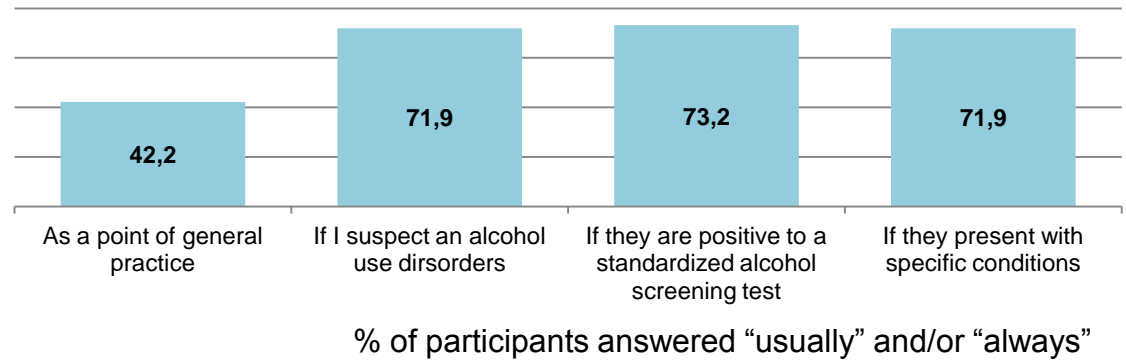
Participants identified the following potential barriers to the use of screening tools (in order of decreasing importance):

- ✓lack of knowledge of the screening tools
- ✓lack of training
- ✓lack of time
- ✓lack of services available
- ✓the risk of upsetting the patients
- ✓the absence of financial incentives

BRIEF INTERVENTION

○ Only **37.5%** said to be familiar with the concept of Brief Intervention for HHAC and alcohol dependence of which 88.9% use it in their clinical practice

“If you use brief intervention for HHAC and alcohol dependence, how often do you use it in the following cases?”



○ Among those who said to be familiar with the concept of Brief Intervention for HHAC and dependent drinking, **48.4%** said to use the cognitive behavioral approach of motivational interviewing, while **17.2%** said to use their personal communication style

○ Nearby all participants considered useful to offer brief intervention in their clinical setting (37,9% highly useful). **Only 4 participants (2,1%)** said that to offer brief intervention in the general practitioner setting is not useful at all

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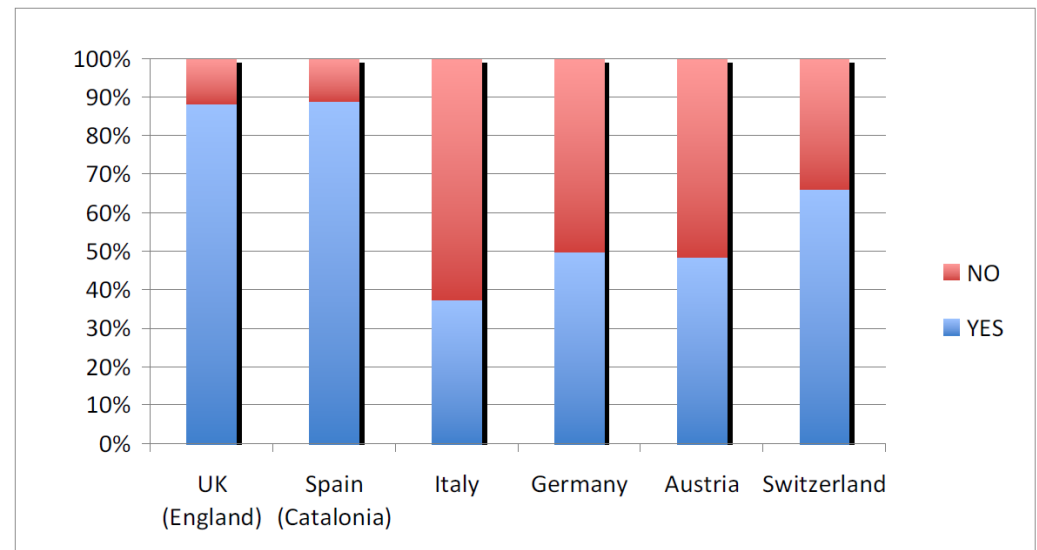
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Figure 2. Are GPs familiar with brief interventions?



Barriers to offer a Brief Intervention

Barriers to offer a brief intervention

1=very important, 5=less important	% of answers					Mean	SD
	1	2	3	4	5		
Lack of time	28,9	20,5	21,6	11,6	17,4	2,68	1,44
Lack of financial incentives	17,4	15,3	16,8	18,4	32,1	3,33	1,19
Risk of upsetting the patients	12,1	24,2	33,2	17,4	13,2	2,95	1,19
Lack of training	24,9	23,3	24,3	15,3	12,2	2,67	1,33
Lack of resources	20,0	30,0	18,4	14,2	17,4	2,79	1,38

Participants identified the following potential barriers to offer a brief intervention (in order of decreasing importance):

- ✓Lack of training
- ✓Lack of time
- ✓Lack of resources
- ✓Risk of upsetting the patients
- ✓Lack of financial incentives

CONCLUSIONS

This survey reveals at national level the following needs:

- To ensure the formal integration of training on alcoholology into university graduate and postgraduated courses (as provided by the Italian Frame Law on alcohol 125/2001, so far not done)
- To support formal education on EIBI for HHAC at local level, meeting the dynamic changes in demand, currently growing steadily, with respect to different priorities of the PHC
- To involve other health care professionals (GPs considered the lack of time, after the lack of specific training, one of the main barrier to offer a brief intervention)
- To ensure the implementation of the EIBI training courses with specifically allocated funding