Barcelona 1st Meeting
Agenda

Integrating health promotion interventions for hazardous and harmful alcohol consumption into primary health care professionals' daily work

First Meeting of Partners
24-25th February 2003, Barcelona

Monday 24 February 2003

Chair	*Joan Colom*
09.00	Registration and Coffee
09.30	Welcome and introductions Joan Colom
10.00	Introduction to the project Peter Anderson Antoni Gual
10.30	Coffee break
11.00	Presentation and discussion of country profiles: Synthesis Peter Anderson
11.30	Country presentations Country partners
13.30	Lunch break
15.00	Country presentations Country partners
Chair	*Antoni Gual*
15.30	Evidence for screening and brief intervention programmes Mats Berglund
16.00	Coffee break
16.30	Evidence for engaging general practice in screening and brief intervention programmes Peter Anderson
17.00	Development and Implementation of clinical guidelines: general principles Miranda Laurant
17.30	Close of day

Tuesday 25 February 2003

Chair *Peter Anderson*

09.30 Training programmes for managing hazardous and harmful alcohol consumption
Antoni Gual

10.00 Internet site database for the treatment of alcohol use disorders
Caroline Howe

10.30 Managing and implementing the EU project:
The work to be done
Lidia Segura
Antoni Gual
Peter Anderson

11.00 Coffee break

11.30 Managing and implementing the EU project:
Relationship with WHO Phase IV meeting
Roles and responsibilities of partners
Roles and responsibilities of experts
Management and administration
Financial issues
Reporting arrangements
Products
Timetable
Next steps
Dates of meetings 2003/2004
Lidia Segura
Antoni Gual
Peter Anderson

13.15 Close of meeting
Joan Colom

13.30 Lunch

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Barcelona 1st Meeting Minutes

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First Meeting of Partners
24-25th February 2003, Barcelona

Monday 24th

09.30 Welcome and introductions
Joan Colom

Dr. Colom welcomed the participants (experts, partners, participants and EC representative) to the first Meeting of the European Project on behalf of the Health Department of the Catalonia Government.

Dr. Colom introduced Catalonia, its political organization and the particular model to deal with alcohol related problems that has been developed by the Directorate General on Substance Abuse and Aids. He emphasized Catalonia's Commitment to the alcohol field by introducing the participation of the Catalan Government in the World Health Organization Collaborative Project on Alcohol and Primary Health Care since 1995 and finally by introducing the main aims and lines of the EC project.

The Project's challenge is to integrate health promotion interventions for hazardous and harmful alcohol consumption into primary health care professionals' daily clinical work. The Project aims to support the European Community's Public Health Strategy and the European Charter on Alcohol and the European Alcohol Action Plan, of the World Health Organization. The Project will also benefit the World Health Organization Collaborative Project on Alcohol and Primary Health Care in many ways, and specially by building a strategic alliance with the European Commission.

The Project aim will be achieved by preparing:
–European recommendations and clinical guidelines for health care purchasers and providers;
–European training program for primary health care professionals;
–Comprehensive Internet site database on good practice, providing the evidence base in the domains of efficacy, economics, health and policy; and
–A Series of country specific dissemination experiences and strategies.

Dr. Colom concluded with the aims of the meeting which were to start working together and to share and discuss with the participants the aims, the timetable, the methodology, the evaluation, the expected results and the activities to be done during the 24 months of project duration.

Introduction to the project
Peter Anderson
Antoni Gual

Dr. Anderson and Dr. Gual introduced in detail the project's rationale and products (see: introduction to the project.ppt) and the meeting outline (see: final agenda.doc).

Presentation and discussion of country profiles: Synthesis
Peter Anderson

Dr. Anderson synthesized the results of the survey on country profiles (see: Peter Anderson – Country Profile Synthesis.ppt) and concluded that:

- 2/3 have a governmental policy on management of alcohol use disorders, but only ¼ a non-governmental policy. Brief interventions in general practice are a core component of the policies;
- About one half have clinical guidelines, but there are very few studies of their implementation and very little implementation of training programmes;
- Specialist services are reasonably well developed, but primary health care services are not;
- About half the countries have undertaken efficacy studies, but there is very little cost effectiveness research;
- The AUDIT seems to be available and well studied;
- About half the countries have studied the attitudes of general practitioners, but there is very little implementation research; and
- While there are studies on the prevalence of alcohol use disorders, there is almost no information on the clients' experience of reducing alcohol consumption.

The following remarks were made.

Dr. Pas remarked that the questions were not clearly stated and that there could probably be some misunderstanding when answering them. He suggested reframing together the questions in order to clarify them to everybody.

Dr. Scafato suggested two points:

-First the source of information and the indicators used need to be mentioned and identified in order to be able to compare countries.
-The Expert Group need to identify core indicators to obtain information about the primary health care settings.

Finally, it was mentioned that the survey information, once revised in the light of the above remarks could be rewritten as a publishable paper form about the current situation in the European Countries.

Country presentations
Country partners

Country (file) **Country representative**	**Most significant advances in PHC since 1st January 2000**	**Barriers and challenges in implementation in 2003-2004**	**Key advances we would like to see in 2003-2004 in Finland**	**To make them possible we need**
Finland (see: Country Profile – Finland) Dr. Kaija Seppä Medical School University of Tampere,	-AUDIT as part of driving assessment -Finnish Alcohol Action Plan: to create a network of GPs in PHC responsible of alcohol and drug issues (2/2001) -Research evidence, public and professional discussion on the topic (increasing interest on prevention as part of alcohol policy)	-lack of physicians in communal health centres -lack of interest among GPs towards preventive (especially alcohol) issues -how to change attitudes and motivate – GPs not willing to participate in training	-key actors in PHC organizing regional activities -attractive training programme -extra fee for preventive work -topic-related vacancies at universities	-Political goodwill regionally and centrally. To gain this we need: -more research evidence (economical evaluation) -active experts to communicate -mass media and ministry level involvement
England (see: Country Profile – England) Dr Eileen Kaner University of Newcastle upon Tyne	-Publication of a National Alcohol Harm Reduction Strategy -But a consultation exercise only -Strong focus on young drinkers -Strong criminal justice slant -Under emphasis on health, hazardous drinkers, alcohol-related problems in mainstream population	-The strong alcohol lobby in the UK -A glut of health initiatives in PHC -Low morale of PHC professionals – recruitment & retention problems -Lack of incentives for alcohol-related work -Over-focus on alcohol dependence by PHC professionals	-A comprehensive national alcohol strategy -Top-down endorsement of alcohol-related intervention work -Financial or professional incentives for alcohol-related work -Recognition of the full range of alcohol-related problems -A balance in focus on illicit drugs versus alcohol	-Government will -Recognition of the issue -Confidence to act -Money for alcohol-related intervention & research
Sweden (see: Country Profile – Sweden)	-No significant advances regarding implementation but… -The topic is regularly	-Integrating screening into routine care in a natural way, not disturbing the existing daily routines.	-Integration of screening methods into the health care's normal office context -A national demonstration	-A new approach taking office routines into consideration -Gather and motivate some of the most experiences GPs

Preben Bendtsen Ass Professor, Dept of Social Medicine and Public Health, University of Linköping	discussed at scientific meetings and in the Swedish medical journal. -The government has passed an action plan for prevention of alcohol related problems (2000/2001) - Some few reports from regularly screening of primary health care patients has been published	-Testing screening in a more selective group of patients – i.e. hypertension, mental disorders, diabetes, etc. -Insufficient knowledge about simple procedures and possible results	study -Many more health professionals in basic education and training	in the field -Basic resources and support from purchasers of care

Country (file) Country representative	**Most significant advances in PHC since 1st January 2000**	**Barriers and challenges in implementation in 2003-2004**	**Key advances we would like to see in 2003-2004 in Finland**	**To make them possible we need**
Germany (see: Country Profile – Germany) Michael N. Smolka Central Institute of Mental Health Department of Addiction Medicine Mannheim	-Implementation of a special training with certificate for Addiction Medicine -Publication of a manual for Brief Intervention in alcohol use disorders -Start of federal funding of four addiction research networks -Action plan "Drogen und Sucht" of the health ministry -Reimbursement of Brief Intervention in alcohol use disorders during a 2 year pilot phase by the health insurances in Mecklenburg-Vorpommern	-No evidence based guidelines published -No funding for implementation of Brief Intervention available -No sufficient reimbursement of Brief Intervention in alcohol use disorders by GPs -Insufficient training of GPs in addiction medicine -Lack of interest among GPs	-Publication of guidelines for Primary Health Care -Internet access to these guideline -Action plan for implementation of interventions according to these guidelines -Training programs for GPs	-Funding for implementation and evaluation of evidence based management of alcohol use disorders in Primary Health Care -Financial incentives for GPs treating patients with alcohol use disorders -More interest and support by government and health insurances
Italy (see: Country Profile – Italy)	- interest by the medical associations in co-operating to the implementation of a	-lack of financial incentives for GPs -lack of a specific	-a specific policy early detection and brief intervention for GPs and PHC	-Support and solicit the political willingness to share the responsibility of the

Emanuele Scafato Director, Istituto Superiore Di Sanita' Roma	few specific training programs for GPs - interest by the local health authorities in co-organising training programs for PHC professionals on the subject of identification and management of alcohol risk and problems among their clients - the "pilot" design of an early detection strategy (IPREDA/ISS) in collaboration with GPs to be further tested and evaluated in a demonstration project (PRISMA) involving public and private partners at the community level	National/Regional programme for general practice and PHC -co-operation among addiction services and formalised linkage with GPs still to be promoted -lack of "evaluated" results to prove the efficacy of the pilot chosen strategy -the idea of process, evaluate and evaluate effective HP strategies by health authorities and administrators is still missing	settings -training courses in the alcohol field for GPs and PHC professionals -Harmonised implementation studies for the management of alcohol use disorders -co-operation among the relevant Alcohol Centres	prevention and management of AR problems -Regional or national funds -Contribute to share a common perspective among the Italian relevant Alcohol Centres

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Slovenia (see: Country Profile – Slovenia) Marko	-Implementation of systematic training for EIBI during specialisation of family medicine (winter 2000/2001) -3-Q AUDIT included in a	-lack of time and trainers for training GPs for EIBI -GPs work overload (so they are not motivated enough to learn new approaches) -how to change attitudes	-Agreement on alcohol policy nation wide -Implementation of the new project for reframing understanding and EIBI training supported by the	-Money and human resources to run the project and other plans -Willingness of the Ministry of Health -motivation of GPs

Kolsek Department of Family Medicine Medical faculty University of Ljubljana,	cardio-vascular risk questionnaire that is used by GPs for systematic preventive check-ups for adults (20% of patients from GP's list should be screened per year) – January 2002 -beginning collaboration with the Ministry of Health to support wide reframing understanding among PHC teams all around the country and among the population as a whole (winter 2002/2003)	towards alcohol that are based on alcohol culture	Ministry of Health -Implementation of the basics for the management of alcohol use disorders in PHC at curriculum for nurses	
Netherlands (see: Country Profile – Netherlands) Dr. Brigitte Boon, NIGZ Institute for Health Promotion and Disease Prevention	-Project "scoring results" - Government policy to define guidelines - RCT's on minimal interventions - Standardisation of registration	- National policy is interpreted by regional policy makers -No progress in development of guidelines - Not enough attention for implementation	- National guidance of regional policy -Definite conduction of all policy plans -Better cooperation between scientists and prevention workers - Structural finance of evidence based projects	
Portugal (see: Country Profile – Portugal) João Breda General Health Directorate	-National Alcohol Action Plan: to develop legal and health promotion policies on alcohol, GP training included... -National brief intervention pilot project to begin in 2003.... -Constitution of an expert group and training on brief	-GP adherence... -Money -Some important agents don't believe in BI -lack of interest among GPs towards health promotion -Change in governmental policy over Primary Care and Health Centres...	-Pilot study in 10 health centres on brief intervention... -Research publication on effectiveness... -2004 generalization to all country...	

	intervention...			

Country (file) Country representative	**Most significant advances in PHC since 1st January 2000**	**Barriers and challenges in implementation in 2003-2004**	**Key advances we would like to see in 2003-2004**	**To make them possible we need**
Czech Republik (See: Country Profile – Czech Republic) Ladislav Csémy PhD MD Prague Psychiatric Centre Dept. Soc. Psychiatry	- First attempt to work with GPs in the field of alcohol prevention Supportive factors: • Goals are congruent with the objectives of the health policy of the country • More understanding from the side of the general public as well as the media • Well functioning network of regional centres of public health	-Unclear position in the project -Insufficient funding from domestic resources -Modest interest of GPs to be involved in alcohol related problems of the patients -Lack of experience with community oriented prevention projects	-Creating network for support of the project (public health centres, medical students, professional associations, health insurance agencies etc.) • Adapt and publish guidelines, manuals.. • Organize training seminars • Evaluate feedback	
Ireland (see: Country Profile – Ireland) Rolande Anderson, Project Director, Irish College of General Practitioners,	-ICGP Project "Helping Patients with Alcohol Problems" March 2000-February 2003. -National Conference – "Alcohol and Young People", October 2001. -Alcohol Aware Practice Pilot Study (six months) commenced 4 September	-Funding -GP Attitudes -GP Confidence	-Expanded AAP Study -Central Government Funding -Training for GPs and Practice Nurses -More committed personnel -Special Type Consultation Fees	-Belief that it is worthwhile amongst GPs -Shifts in attitudes – GPs – Governmental – Health Boards -Funding increases

Dublin	2002			
Catalonia (Spain) (See: Country Profile – Catalonia) Lidia Segura Directorate General of Substance Abuse and Aids Government of Catalonia	-SBI in Health Plan -Adaptation of the Drink less Program -Development of the training package for GP -Validation of the ISCA and the AUDIT short forms -Dissemination of the SBI training to 25% of all PHC centres of Catalonia	-Difficulties in the coordination between PHC centres and Specialist Treatment Services -Lack of time to implement interventions in PHC -Difficulties in maintaining support strategies to GP -Difficulties in maintaining training strategies -Difficulties in designing appropriate Media Campaigns	-Effective dissemination of the SBI in the PHC centres -Increase in the coordination activities among professionals -More strategic alliances -Increase in the sensitizing of population at risk through media campaigns -Shared Treatment between PHC centres and specialist centres	-More reinforcement to GP -More time per visit -Maintaining the training strategies to GP -To increase coordination resources -Change in professionals attitudes

Country (file) Country representative	**Most significant advances in PHC since 1st January 2000**	**Barriers and challenges in implementation in 2003-2004**	**Key advances we would like to see in 2003-2004**	**To make them possible we need**
Belgium (see : Country Profile – Belgium) L Pas and B Garmyn	-Creation of ministerial drug coordination ? 8 ministers of health ; 38 ministers total ! 17/4/02 Roundtable Fed Min Health : access youth alcohol + industry : own code of deontology …. ? - Alcohol related press releases reactions of politicians + drugs & safety hot topics	-Fitting different agenda's -Local municipality actions autonomy -Community health promotion area's with preset health targets -Need of comprehensive approach to GP -Keeping GP involved -Demonstration of PHC benefits (effects) <u>Policy Needs</u> -Alcohol not formal (Flemish)	<u>Planned Steps</u> -Further documentation reducing AUDIT questions -Pilot integrated psycho social assessment -Recommendation followed by QA guide end 2003 -Renewed pre-test in local GP groups of QA 2003/2004 -Incorporation in community health promotion : Provincial & Flemish Communication strategy about safe use autumn 2003	-Means for disseminating available knowledge -Priority setting for alcohol compared to drugs -Acceptation of guideline by validation committee : postponed end 2003 at request WVVH -Comprehensive communication strategy adults planned 2003 -Proof of effectiveness of PHC role added to Community action

	-Simple strategies worthwhile as Audit -Awarenenss of multidisciplinary collaboration need	health target -Insufficient facilities for skills Training -Conditions collaboration with mental health	Round table conferences in EU project ? Collaboration with French branch WHO IV ? -Increased collaboration/support mental care : -Projects HBC, depression , suicide , violence <u>incl alcohol</u> -<u>Specific project :</u> (demonstration project WHO IV?)	

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Bulgaria (See: Country Profile – Bulgaria) Dr. Alexander Kantchelov,	-National Health Care System reorganized -GP system established -Policy-making levels, namely Ministry of Health and National Health Insurance Fund, sensitized about	<u>Political Level</u> -Overall situation in the country relatively unstable, political parties focused on short-term and ignoring long-term health investments -Strong alcohol lobby	-Alcohol-related problems and interventions included in the GP package stated by the National Frame Contract -Training programs for GPs on alcohol-related problems and interventions given	-Willingness and support from the Ministry of Health, National Health Insurance Fund and Parliament Health Commission -Lobby of politicians and policy-makers to be formed

M.D. National Centre for Addictions	alcohol-related problems and the issue of PHC and BI raised -Alcohol and drug-related problems included among the priorities of the National Health Insurance Fund	-Focus on drugs, alcohol issues largely neglected <u>Cultural level</u> -Culture traditionally tolerant to alcohol consumption -High levels of alcohol consumption regarded as signs of strength and bravery -Alcohol-related problems attached solely to alcoholism <u>Professional Level</u> -GPs overloaded and not interested in prevention and Health Promotion -Understanding – focused on alcoholism and dependence	training credits -National Strategy on Alcohol created	-Increased activity of the institutions, organizations and experts, working in the field of PHC and alcohol-related problems
Poland (see : Country Profile – Poland) Professor Jerzy Mellibruda The State Agency for Prevention of Alcohol Related Problems and Institute of Health Psychology	-Training of physicians -Training of medical students -Training of nurses -Short cooperation with one of regional insurance system	-Low level of motivation of physicians for implementation of early intervention -High level of drinking among physicians -Lack of financial resources -Invasion of pharmacy business into health care -Lack of general knowledge and skills necessary for effective cognitive-behavioural influence on patient attitudes and behaviour	Elaboration of more advanced and effective method of intervention - finding of research based evidence of effectiveness - Creating of international source on support and promotion of early intervention policy - Cooperation from the side of health authorities - New pilot projects - Public campaign	

Annex 2. Meetings

Country (file) Country representative	Most significant advances in PHC since 1st January 2000	Barriers and challenges in implementation in 2003-2004	Key advances we would like to see in 2003-2004	To make them possible we need
France (See: Country Profile – France) Dr. Phillipe Michaud	-continuing development of alcohol care units within hospitals and outside - introduction of early detection and brief intervention as one of the three major objectives of public alcohol strategy - mass media campaigns on health-threatening drinking and 'risk levels' - creation of a National agency for prevention and health education, which endorses the objectives - availability of a intervention kit for GPs	-GPs work alone in their offices : we need to adapt the screening techniques - fears about 'loosing the client' - lack of time (# lack of money ?) - lack of knowledge, of know-how, of interest about alcohol-related problems - A challenge : a consensus among French alcohol specialists and policy-makers on alcohol-related harm and hazardous drinking	-Integration of EIBI training in medical curriculum - training of trainers (more is better) - mass media campaigns on the theme 'it's normal to speak about drinking with your doctor' - an extra-fee for preventive acts during medical consultation	-No major changes in governmental policy about drugs - Convinced medical opinion leaders about the effectiveness, cost-effectiveness and feasibility of brief interventions in medical routine - a commitment of government and of national social insurance fund - money for the implementation of a national training strategy
Denmark (see : Country Profile – Denmark) Dr. Barfod	- In more counties in Denmark local CME-groups are working with the alcohol matter inspired by the work of the Danish Alcohol Group. -As the only representative from general practice/family medicine the leader of the WHO-collaborative project in Denmark was asked to join the committee mentioned in P2a (Ministry of Health). The report from the committee is very good by means of	-GPs still think it is too difficult to raise the subject in the consultation. -Training GPs in helping people change drinking behaviour takes long time. -Most traditional educational methods are not efficient. Training with simulated patients is probably the best but too expensive in daily CME -The reorganization of the National Board of Health has	-That the National Board of Health takes the leader role of promoting in education GPs, more actively than just sending out a book now and then, a book which nobody reads. In Denmark education is offered by advisory boards of the counties, scientific, industrial and professional groups, colleges or councils of very different kinds.	-Last year The National Board of Health was reconstructed, and a department called Centre of Prevention was formed. I believe the new employees will be ready to meet (some of) my thoughts.

	handling alcohol problems in primary and secondary health care.	paralysed the Center of Prevention for one to two years. -We are now facing serious recruitment problems in general practice and the problems will increase the coming 10-15 years. Only few GPs can be expected to take in new fields of work which will augment their workload.		

Discussion during the country profile presentations:

Dr. J. Chick gave the experience in Scotland:
-We have legislation but no money to implement interventions.
-Scotland is a small country and we can obtain data about health costs related with alcohol.
-Cost data have to be included in guidelines.

Dr. Scafato remarked:
-We need to clarify the GP funds in the different countries because it can affect the strategies.
-We have to include paediatricians because they also can implement strategies"
-Region is the level in Italy

Prof M. Berglund noted:
The problem is to introduce the interventions in the PHC centres and not to do trials.

Dr. Chick commented two points:
We have to help to develop linkage between the addiction centres and PHC centres. We have to contribute to top down and down-top links by stimulating action from both sides.

Dr. Pas suggested that:
We have to look for a harmonization of all regional and national strategies.

Dr Boon said that:

1.1.1.1 In the Netherlands, the National policy is interpreted at regional level

Miranda Laurant added:
Guidelines are good but more important is to have the implementation strategies.

Dr. Bendtsen asked:
Who is going to train the GP?
Nick Heather answered:
GP have to receive support from the addiction professionals
Leo Pas added:
We have to think in a variety strategies: refer to services, extensive counselling ... and they will have to choose.

Professor Mellibruda stated:
We have to teach the GP and help them to change their behaviour because they are only used to pharmacological treatment.

Dr. Phillipe Michaud talked about the difficulties to find a consensus among professionals because of the French Paradox

1.1.1.1.1Dr. Madianos talked about the insufficient training of GPs and that in Greece there is not enough epidemiologic data. He also says that culturally they are not ready to talk about reducing the alcohol consumption. He mentioned a Pilot study in the island of Crete.

1.1.1.1.2Dr. Barfod said that:

In Denmark GPs do not want to work on alcohol alone, motivational Interviewing is being wide-spread and that National Board of Health is reorganizing and nobody knows how it will evolve.

Managing and implementing the EU project:

The Work to be done
Relationship with WHO Phase IV meeting
Roles and responsibilities of partners
Roles and responsibilities of experts
Management and administration
Financial issues
Reporting arrangements
Products
Timetable
Next steps
Dates of meetings 2003/2004

Dr. Anderson introduced the work plan that was enclosed in the participants documentation (see: Work plan.doc)

Dr. Pas and Dr. Scafato asked for clarification about the meaning of country level in the EC Project. Dr. Anderson talked about being flexible in that point, at least one representative from each country, no matter if he/she talks or not from the national level or from a regional level.

European Commission Representative (Mr. Gottfried Thesen) Commentaries

The key message is that the Project has to remain within the framework of Health Promotion Program and not to Health Care. Health Care is a matter of the Member States. The project also has to support the framework of the Council conclusions. Project must be able to provide inputs about policy. The project will have to obtain concrete outcomes and if possible to follow the spirit of the new Health Action Plan (the project must be also targeted to young people and alcohol).

For candidate countries there is no legal base for funding. There is no money to pay the work of these countries. The project has to mention that it is not primary prevention. It is secondary prevention. We have to send an official letter asking for the official acceptance of the title, mentioning that even though the name includes Health Care words it will be focused on health promotion.

Relation with The Who Phase IV Study

Proferssor Heather stated that only Russia and Switzerland that are also working in the Phase IV study are not included in the EC Project. He emphasized that there is no competition between the two projects They are mutually supportive and mutually reinforcing projects. The EC project will help the WHO study by translating the Brief Interventions into guidelines.

Dr. Gual added that the WHO study has undertaken a lot of regional activities but the EC project will introduce a European perspective.

Professor Heather added that there will be a mutual benefit. "Let us find what possibilities come from the relation of the two projects". The European project can develop European guidelines to be implemented at European level.

Dr. Garmyn stated that we could title the product: the Clinical guidelines or Recommendations on Health Promotion Strategies.

Dr. Anderson added that we do not have to begin from zero, we have done a lot.

About the role of the partners Dr. Anderson clarified:
-Attend each of the meetings;
-Provide the background data for the country profiles;
-Complete project reports as detailed below;
-Provide expert advice to the project and its outputs; and
-Create a country based action group of public sector, health care professional non governmental.

-The Project Leaders were urged to include participants from all countries Luxembourg and Austria were finally not included.

-Guidelines do not have to be disseminated; the strategy to do it in every country is what we need to have.

Mats Berglund stated:
Guidelines must be based on evidence but do not forget that experts can not force the politics to accept a strategy.

Dr. Scaffato, asked about what is called country-based action group. Dr. Anderson said that in his opinion we have to be flexible and practical. Regional level can be accepted as country level. We will produce these products at a European Level, but we have to keep working at the country level.

Dr. Pas suggested including to the Project Experts from other sectors.

Dr. Anderson added we have to learn and share experiences. We have to have good documented and discuss about what we have done, why we did wrong.

Roles and responsibilities of European Expert Group.
-Attend the meeting,
-Technical advice to the products and results.

About reimbursement of travel expenses
-The money for travel expenses is not huge. Participants will have to book cheap tickets, and buy apex fares if possible.

Reporting arrangements
We have to adjust to the formal requirements of the Commission.

Money for the procedure
Gottfried Thesen says that money has to be arisen from other sources because the Commission only gives 70% of the total costs. He stressed the importance of not forgetting the dates to write the reports for the Commission.

Dr. Scafato stated that maybe we have to include experts on economics costs.

Tuesday 25th

Mats Berglund Presentation "Evidence for screening and brief intervention programmes"
(see: Mats Berglund - Evidence for screening and brief intervention programmes.ppt)

Peter Anderson Presentation "Evidence for engaging general practice in screening and brief intervention programmes"
(see: Peter Anderson - Evidence for engaging general practice.ppt)

Miranda Laurant Presentation "Development and Implementation of clinical guidelines: general principles"
(see: Miranda Laurant - Development and Implementation of clinical guidelines.ppt)

Jonathan Chick Presentation "What is SIGN"
(see: Jonathan Chick – SIGN.ppt)

Caroline Howe Presentation "Internet site database for the treatment of alcohol use disorders"
(see: Caroline Howe - Internet site database for the treatment of alcohol use disorders.ppt)

Antoni Gual Presentation "Training programmes for managing hazardous and harmful alcohol consumption"
(see: Antoni Gual - Training Programmes.ppt)

Next meeting date
Thursday and Friday 9 and 10th October 2003 in the Netherlands

Leiden Meeting
Agenda

INTEGRATING HEALTH PROMOTION INTERVENTIONS FOR HAZARDOUS AND HARMFUL ALCOHOL CONSUMPTION INTO PRIMARY HEALTH CARE PROFESSIONALS' DAILY WORK

Second meeting
9-10 October 2003
Leiden, Netherlands

Thursday 9 October 2003

12.30 Lunch

Chair *Joan Colom*

13.30 Introduction and objectives of the meeting
Summary of the products
- Guidelines and recommendations
- Training manual
- Web and Internet site database
- Evaluation of the project
- Introduction to group work

14.30 Group work

Group 1: Internet site database
Facilitator Nick Heather
Rapporteur Alexander Kantchelov

Group 2: Training manual
Facilitator Kaija-Liisa Seppä
Rapporteur Jerzy Mellibruda

Group 3: Guidelines
Facilitator Preben Bendtsen
Rapporteur Rolande Anderson

15.30 Coffee break

15.45 Group work continued

17.00 Close of day

18.00 Pre-dinner Debate
The Future of Brief Interventions in General Practice
Debated by Peter Anderson and Steve Rollnick

19.30 Dinner in the hotel

Friday 10 October 2003

Chair *Sverre Barfod*

08.30	Introduction to the day Administrative matters
08.45	Report back of the group work and general discussion
10.00	Coffee break
10.30	Group work Three groups each to present and discuss country profiles, country based teams and preparing country specific dissemination strategies

Group 1:
Facilitator Hana Sovinova
Rapporteur Marko Kolsek

Group 2:
Facilitator Joao Breda
Rapporteur Pierluigi Struzzo

Group 3:
Facilitator Michael Smolka
Rapporteur Leo Pas/Bart Garmyn

12.00	Lunch
Chair:	*Ton Drenthen*
13.00	International Network on Brief Interventions for Alcohol problems Nick Heather
13.30	Report back from groups and general discussion
15.00	Coffee break
15.30	Next steps
16.30	Close of meeting
18.30	Optional social programme and dinner

Leiden Meeting
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Leiden Meeting Minutes

INTEGRATING HEALTH PROMOTION INTERVENTIONS FOR HAZARDOUS AND HARMFUL ALCOHOL CONSUMPTION INTO PRIMARY HEALTH CARE PROFESSIONALS' DAILY WORK

Second Meeting of Partners
9-10th October 2003, Leiden (Netherlands)

Thursday 9 October 2003

Chair ***Joan Colom***
Introduction and objectives of the meeting

Dr. Colom welcomed the participants (experts, partners and participants) to the second Meeting of the European Project on behalf of the Health Department of the Catalonia Government. He expressed his gratitude for the extent of the partners' contribution to the project and with their participation in the Second Phepa Meeting in Leiden.

Dr. Colom congratulated Dr. Anderson for his thesis defense and said that it had been a magnificent prologue to the Phepa Meeting.

He introduced the contents of the first session chaired and started by introducing briefly the project.

He reviewed the aims of the Phepa Project, the plan to achieve them, the tools that are being developed and the work that has been done in both administrative and technical sides of the project.

Dr. Colom asked everyone for active participation in the group work sessions with the collaboration of facilitators and rapporteurs.

He also commented briefly about what will happen next. He stressed that we still have to face pressures against the idea of alcohol as a public health issue, even among health authorities and health professionals. He also mentioned that advocacy is needed, not only directed to public opinion, but also targeting health professionals. Finally he said that the Project is already having an impact in PHC.

He continued introducing the agenda of the meeting including the debate between Dr. Rollnick and Dr. Anderson, the presentations of Dr. Heather and Eurocare and the WHO Phase IV Collaborative Project.

He finished by thanking everyone and on behalf of the Health Department of the Autonomous Government of Catalonia for the collaboration and the support. He also wished a fruitful meeting and a pleasant stay in Leiden.
He apologised for not being able to stay in Leiden for the whole meeting but he mentioned that he will receive detailed information of all the work that will be done.

Before continuing with the summary of the products, some comments about logistics (meeting rooms) and administrative matters (reimbursement procedures) were also introduced by him.

Summary of the products

-Guidelines and recommendations
-Peter Anderson and Antoni Gual

-Training manual
-Antoni Gual

-Web and Internet site database
-Lidia Segura and Peter Anderson

-Evaluation of the project
-Lidia Segura on behalf of Angela Bueno-Belmonte

-Introduction to group work
-Peter Anderson

Participants were distributed in three groups to work separately on the different drafted products until the close of the day.

Group 1: Internet site database
Facilitator *Nick Heather*
Rapporteur *Alexander Kantchelov*

Group 2: Training manual
Facilitator *Kaija-Liisa Seppä*
Rapporteur *Jerzy Mellibruda replaced by Bart Garmyn*

Group 3: Guidelines
Facilitator *Preben Bendtsen*
Rapporteur *Rolande Anderson*

After the summary of the products were presented and the group work was introduced, the following remarks were made:

Dr. Heather needed clarification about how to proceed to give feedback to the group about the products discussed in other groups. Dr. Anderson replied that comments will have to be introduced in the general discussion session or sent by e-mail to the Phepa electronic address in Barcelona to be able to collect them all.

Leo Pas addressed a question about how comprehensive products must be regarding the differences among countries. Antoni Gual replied that there is a 6th session in the training manual where all countries must settle their own strategies.

Preben Bendtsen was worried about the translation of at least some pages of the products to country languages. Antoni Gual replied that there is money to translate the materials at least to 10 European languages.

Kaija Seppä asked for clarification about the different training documents.

18.00 **Pre-dinner Debate**
The Future of Brief Interventions in General Practice
Debated by Peter Anderson and Steve Rollnick

Friday 10 October 2003

Before starting the first session of the day, Peter Anderson and Florence Berteletti-Kemp introduced the Alcohol Conference of the Eurocare Project that will take place in Poland from Wednesday 16 to Saturday 19 of June 2004 (see file enclosed: Eurocare.ppt). All PHEPA participants were invited to attend. The agenda will be launched soon and the submission for workshops must be made as soon as possible. The information will be included in the EUROCARE Web Site on 1st December 2003 (http://www.eurocare.org).
The organizers will include the PHEPA participants list in their database to provide updated information and news about the conference.

Chair ***Sverre Barfod***

08.30 Introduction to the day
Administrative matters

Dr. Barfod chaired the first session of the day and he introduced the day plan. Mrs. Segura reminded the participants of the need to contact the Phepa Team Members to check the travel reimbursement document.

08.45 Report back of the group work and general discussion

The rapporteurs identified in each group were responsible to report back the discussion held in their group.

Group 1: Internet website and alcohol management database
Facilitator ***Nick Heather***
Rapporteur ***Alexander Kantchelov***

Group Participants
Nick Heather, Phillipe Michaud, Tizziana Codenotti, Joao Breda, Hana Sovinova, Alexander Kantchelov, Ton Drenthen and Lidia Segura.

Internet Website
-Front Page/Home Design and content:
Needs reorganization stressing the most important aspects
The Phepa Logo and title must be bigger
A Mission Statement presenting the aims of the project is needed

-Three levels of information depending of the type of visitor:
General Population
Professionals and Policy Makers
Phepa Members

-A password for Phepa Members and a registration procedure (tax free) for people interested in the website will have to be created.

-Some summarized drafts of the products will have to be provided for general population and journalist.

-Restricted access to documents is needed:
-Training Manual,
-Confidential documents
-Meeting documents

-To avoid competition between Phepa Project and what is being done in each country links will be provided.

-To avoid too much clicks in the Internet Web (maximum of three).

Alcohol Management Database
The questions suggested are discussed and answered.
1. The contents were agreed.
2. Some suggestions about the responsible for each section are listed:
-Definitions and Terminology: Catalan Team
-Effects on Alcohol: Dr. Anderson
-Screening: Dr. Gual
-Biological Markers: Dr. Chick
-Assessment: Nick Heather and Phillipe Michaud will think of some candidates.
-Brief Interventions: Dr. Heather
-Alcohol Dependence: Not decided
-Implementation: Miranda Laurant (or any other member of the DUTCH group)
-Cost effectiveness: Not decided but Dr. Chick will ask Richard Brook
-Policy: Peter Anderson

3. Possible additional sources of funding?
The possible sources of funding suggested are:
-Government of Catalonia and the European Union will have to continue supporting the website.
-Other Member State Government can be involved
-Other Scientific Foundations and Pharmaceutical companies must be contacted too.
-Dr. Sovinova will look for information about other specific sources of funding

The report back of the group finished by suggesting to the Catalan Team the need to provide the cost figures to be able to have an idea on how much money will have to be raised.

General Discussion
Dr. Heather emphasized the idea that in the future both the PHEPA and the INeBrIA Website will be only one.

About the Alcohol Management Database Dr. Anderson said that he will draft all sections and then all participants will be asked to collaborate in all headings.

Dr. Pas suggests that a list of people willing to provide information for all database sections and that would like to help Dr. Anderson will be of interest. He also asks if each country will have to develop a country webpage.

Dr. Heather stressed that some problems might occur (conflict) between the country issues and the European Issues, and that the web will try to clarify doubts. Each country will have space to include their particular information. Each country page will have a contact person (i.e.: "for the French adaptation of the Phepa Training Manual please contact Mr Michaud") and links to other pages related to the field in each country will also be provided.

Dr. Bendtsen does not agree with the idea of establishing three different levels of information? He thinks that the registration procedure acts always as a barrier for information accessibility for professionals.

Florence Bertelleti-Kemp will provide some information about the E-learning Program and the Life long learning program of the DG for Culture and Education of the European Commission.

Dr. Bendtsen emphasized the need to avoid a registration procedure and suggested taking a look to the tobacco example.

Group 2: Training manual
Facilitator Kaija-Liisa Seppä
Rapporteur Jerzy Mellibruda

Dr. Garmyn replaced Professor Mellibruda as rapporteur for this group.

Group Participants
Svere Barfod, Bart Garmyn, Antoni Gual, Miranda Laurant, Kaija Seppä, Olga Montserrat, Tonka Poplas , Isidore Obot , Astri Brandell and Pierluigi Struzzo

Overall comments
Motivational methodology
The discussion started with an overall comment on the documents presented by Antoni Gual. He would like to get an agreement of the whole group on the fact that a lot of stress is put on the motivational approach of the training program. The aim of the training is to motivate GPs on taking up EIBI on alcohol. We would like the GP trainees to adapt the elements that are essential for a motivational approach into daily practice. To achieve this goal the training program itself is set up as motivational programme. The training is considered to be just a first step in this process. The aim is to motivate GPs to take up a motivational approach and to continue using it in daily work. The design of the manual contains different features which act with this motivational approach. There was a consensus among the participants that it is a good strategy to emphasise the motivational aspects.

Number of sessions - time needed to train properly
Antoni Gual asked the group if there was agreement on the number of sessions needed to cover all aspects of EIBI. The Catalan experience taught us to limit the training to 5 or 6 hours. There was some discussion about the length of the program. The system of continuous medical education differs a lot from country to country. In many countries GPs can choose among themselves the subjects of interest. The whole concept of EIBI has to compete with a lot of different subjects and some of the participants fear that only a small number of GPs can be motivated to spend so much time on a topic like EIBI.

Kaija Seppä feared that the majority of GPs will consider EIBI as too complicated and not feasible in daily practice. She suggests that a shorter training should be available also for GPs who just want to give a brief intervention and who are not really interested in too much theoretical background.

Pierluigi Struzzo thinks that a sort of introduction of the program is important. In Italy 4 hours of training is the maximum in which they plan to give all the essential information. The next sessions are only for the more motivated GPs. Bart Garmyn also suggests a minimal and a maximal training program.

Antoni Gual does not believe that such smaller programmes can have any impact on the behaviour of the GP. He emphasises that it is necessary to have several training sessions where there is feedback on the experiences of the GPs with EIBI.

Interactivity of the program: motivating the doctor

The construction of the training program seems logical to all participants of the discussion. The programme tries to be as interactive as it can. For Astri Brandell the programme is not interactive enough. To encourage GPs to change their behaviour she thinks that it is absolute necessary that we incorporate more techniques from "motivational interviewing" in the training program itself. She gives the example how these types of programs are presented in Swedish PHC settings. They always start to discuss the ambivalence that exists on the alcohol topic. They explore existing barriers and let the PHC workers raise the different problems they face in daily practice raising this issue. There is a kind of brainstorming why PHC workers are not involved in alcohol prevention. Than there is a discussion what the possible gains are. This helps to motivate the GPs to get involved in this kind of work.

Kaija Seppä agrees that this approach will be more motivating for GPs than an academic theoretical approach. Antoni Gual stressed the fact that the manual already takes these matters into account. In fact in the development of the package they followed the British or English approach. In session 1 where the objectives of the training manual are introduced we mention the objectives, the aims and the session plans. In the session plans you can notice the changes the Catalans made compared to the Pip Masson's original work.

Bart Garmyn adds to this discussion that the organisation of CME is so different in every country that we can not expect the program to be exactly the same in every country. Sverre Barfod says that each country will use this program and the package but probably will adapt it. It is just an example of a time plan that is considered to be useful. Miranda Laurant thinks the implementation of the program is a country item and that we should not mix this in this discussion. Kaija Seppä responded to this issue by saying that the manual should be considered as a kind of overall structure which can be adapted towards local customs in CME. This brings us to the discussion how much flexibility can be accepted.

Flexibility for the program to be used in different countries:

Antoni Gual wants a formal agreement that we need a motivational approach in the program. He wants agreement that the proportion of time is correct (Reframing 20% screening 20%, Intervention 40%, handling with dependence 20%) All participants agree on the content but there is no consensus about the practical time frame that is suggested. For Miranda Laurant 60 minutes per session is a short time to have both the theoretical background and some practical exercises. She suggests that every session should last for at least two hours. Pierluigi Struzzo comments that this kind of programs will only work for a small number of motivated GPs. The question is at what kind of audience are you talking to. This project can only be used for small groups of GPs because it is a very practical programme.

Antoni Gual emphasises once more the importance of a motivational approach. The aim of the program is to change the behaviour of the GP. The groups must be small enough to have practice exercise. A training manual of half an hour is impossible. That is only good as a marketing strategy. It is much better to have different sessions in a limited period of time than to have one or two long sessions.

Miranda Laurant stressed that we do not only have to comment on the package but also on the context (small groups, large groups …). Antoni Gual is convinced that you can not change the attitude of the GPs if you train them in large groups. Miranda Laurant lacks a kind of feedback on the practical outcome of issues raised at previous sessions (Did you see patients with hazardous alcohol intake? What are your problems?). For Miranda this

should be the starting point for every next session. Anton Gual responded to this remark that they did organise a feedback session at the start of every session and that this is mentioned in the trainers manual. The package is indeed more a training manual for the trainer. He has the handouts that he supplies to the GP.

Kaija raised the issue if we really need 6 hours training for such a simple procedure as EIBI. She understands that the whole package is developed to motivate the GPs and not only to teach them how to do it. Kaija agrees that GPs who are in the precontemplation or contemplation phase need such a broad approach to get them involved. She suggests that we should consider a different approach to GPs who already have passed the precontemplation and contemplation phase and who are ready for action. What is the minimum package for those who are already motivated?

Antoni Gual responded that in strand III of the WHO study on implementation of BI, we never measured the quality of the brief intervention. If we want to improve this quality so that we can have an impact on the patient, we need more hours of training. For Bart Garmyn this issue raises the problem of communication skills. Can we change these skills in 6 hours? Kaija Seppä is afraid that we will loose a lot of GPs if they have to take a full 6-hours session. The other GPs will think they can't do it because it is a difficult issue that needs a lot of training. Kaija asks if we should have an option to have a brief intervention core training for GPs who have only one hour time. Antoni Gual asks himself what is the limit? 1 hour, 2 hours 3 hours? It is a serious matter we can't deal with it in 15 minutes.

Sverre Barfod described the Danish experience. In Denmark they had a course of two hours. This training was very interesting for GPs but they considered it to be too difficult so they had to extend the course. Kaija Seppä still believes that we should offer a starter. Then we can offer more. Bart Garmyn wonders if this is a marketing strategy or a real training. It seems to be that we have different opinions about that.

Astri Brandell: We have a basis and we can build on it. The basic steps do not have to be the same in every country. It can be a menu. We can have different options with different blocks.

Miranda Laurant: We want to change the behaviour of GPs in the consultation. This asks for the same approach as we want them to use for their patients. We need to work with the same kind of stages. Different GPs will be in a different stage. We first need to get the GPs into the contemplation phase. If you want to get them into the "action" phase where they start counselling and where GP recognise the different stages of change in their patients and how to interfere with them, you need much more time.

Sverre Barfod: this depends from GP tot GP. For some it will only take a minute and some will never learn.

Antoni Gual: The structure where the motivational approach was developed was a one to one relationship. We try the same approach in small groups. 4 hours is the absolute minimum to deliver screening skills en BI skills. We should have a consistent training package to be delivered to small groups. Antoni Gual doesn't care how much time GPs think they need for training. The intervention must work and we must take the time to let it work.

<u>Marketing versus training</u>
For Antoni Gual there are two different issues: one is how do you sell the package and the other is what is in the package. The package is developed on the assumption that it is already accepted by the trainees to whom the programme is brought. Of course we have to handle with the motivational aspect. Antoni Gual can accept that in some

countries the issue of motivation and the ambivalence towards alcohol is taken into account in the start of the Program. He also agrees that a short introduction could work as a marketing strategy to get GPs involved in the formal training. These are aspects that have to be taken into account in the marketing of the training programme.

For practical reasons (lack of time) Kaija Seppä stoped the discussion on marketing issues. The discussion is very interesting because it is based on the cultural differences between countries which can lead to different options. She wants us now to comment on the manual and the work documents that are meant for the GPs.

Detailed comment on important content issues

Screening based on signs and symptoms of hazardous alcohol consumption

According to Astril Brandell, the Swedish will put more time on communication skills and also on specific symptoms and clinical signs that are related on alcohol issues. They will put less time on screening and dealing with dependence. Even GPs who are reluctant to EIBI are interested by this information.

Kaija Seppä adds to this discussion that GPs give wrong information to their patients because they are not familiar with the relation between symptoms and alcohol (e.g.: hypertension and alcohol). For Dr. Gual the whole issue of who should be screened is an important one, taking into account the recent publication of a meta-analysis on screening by Anders Beich et al. in BMJ. If we focus too much on clinical signs and symptoms we will miss a lot of risky drinkers. Pierluigi Struzzo made the comment that the debate about screening was going on before this publication. Sverre Barfod suggests that we should use another word than screening. He suggests early identification with a systematic approach to the subject. For Bart Garmyn this is a pure semantic discussion. You want GPs to screen but you give it a different name. Kaija Seppä returns to the original definition of screening in PHC. It is not everyone at the same moment. It can take a few years. You don't mail AUDIT to everyone in one month. Antoni Gual emphasises that GPs won't screen for everything you must stress the importance of the subject. Astri Brandell tells us that this is the main reason why they focus on clinical signs and symptoms. This is "the real world" for GPs and they will be more actively involved if they know what they can prevent by using a proactive approach with hazardous alcohol intake.

Different formats for the training program

Kaija asks which kind of formats should be developed. Do we only think about training sessions? What about E-learning and more interactive and other innovating methods for training?

For Antoni Gual the actual format consists of training sessions for small groups of GPs. There are lots of places where getting GPs together for training is too difficult. The package could be adapted for use on the internet. A more theoretical exposure could be combined with more interactive learning. Videotapes have been proven to be very effective for communication training. In the future we can develop different techniques for training (E-learning, DVD training …).

For Kaijä, these different types of training are a part of the marketing strategy. According to Miranda's opinion we can develop the basic manual into different techniques. This point was not planned in the project. We can make suggestions however how the material can be used. Video recorded material can be produced and later on used on DVD, the internet as well as in face to face learning where it makes the training more attractive. Antoni Gual has the experience that GPs love DVD training. It is very interactive and very interesting. Kaijä wants us to go through the paper, she suggests to mail all comments to Lidia.

Lack of training manual to the package
Kaija is a bit confused: there is so much material how can we find what is necessary in which session? Antoni Gual responds that some material is necessary in different sessions. The trainer gets the plan of the sessions and the background notes. This part of the manual is not yet distributed which makes it now a bit confusing. The overheads are always kept separated. You can place these on the website, free and downloadable for every participant to the training.

Safe drinking limits:
Tonka Poplas raises the issue of "safe drinking limits". The training manual only stresses on "risk" and not on potential benefit from small doses of alcohol. A very small dosage of alcohol might protect coronary hart disease. Antoni Gual responded that we deliberately do not focus on safe drinking limits because the subject is too difficult to deal with in the limited time available.

Isidore Obot thinks that in the concept of risk drinking (Risk: 28 SD for men and 14 SD for women) we should explain what is supposed to be "safe". The maximum is 4 SD/day. People want to know what "safe" drinking is. The GP should know when he has to intervene, when there is too much risk.

Miranda Laurant believes it is a cultural aspect where some countries are more interested in safe limits and other in risk limits.

Binge Drinking
The problem of Binge drinking is not dealt with in the actual manual and this is a typical problem in Scandinavian drinking patterns. Astrill Brandell asks for some tailoring to the program to let it fit also for hazardous drinkers who are typical binge drinking. We have some discussion of the definition of a binge drinking occasion. The idea of 6 drinks on one occasion is not considered to be good. It is proven that if the blood concentration goes up to 1 promille the trauma risk goes up as well. This 1 promille will be reached by different people by drinking different amounts of alcohol. We need more literature review to work this out.

Drinking "zones"
There is discussion about the concept of "safe drinking" and "hazardous" drinking. We suggest the use of different "zones" of drinking without really labelling these zones as safe or hazardous. This is meant to avoid semantic discussions.

Simple advice versus brief intervention
Gual considers changing the word "Simple advice" into a "standardised brief intervention". There is some discussion between the difference between minimal intervention and brief intervention. Antoni Gual mentioned that a detailed explanation is given in the clinical guidelines.

The use of different screening instruments and cut-off points
There is discussion over the Cut-off points used in the package. These differ from country to country. In the national adaptation it is essential to use the validation of the instrument in each country. Standard drinks are also different in every country and this is often base on empirical data which is not very well documented.

Tonka Poplas tells us that in Slovenia the AUDIT 5 is preferred. Antoni Gual mentions that the clinical guidelines give an overview of all the tests that have been validated: (AUDIT, AUDIT-C, FAST, SIAC, etc…) and a brief summary how these screening instruments can be used. For the training Antoni suggests to keep it simple: the AUDIT is proposed as the golden standard, if you want a shorter version: use the AUDIT-C.

Kaija Seppä raises the issue of the SIAC screening instrument. All quantity/frequency instruments have proven to have a very low sensitivity. That is the reason why the AUDIT was developed. The only publication about SIAC is the Spanish one. Kaija Seppä does not want this SIAC instrument to be a recommended screening instrument in the international training manual until further research has proven its success in different settings. Antoni Gual gives some explanation about the development of the SIAC. They looked in detail what GPs do use today in daily practice. GPs want an instrument that they can use in a face to face interview. That is why they developed SIAC and why they validated the instrument for the Spanish population. In this setting it has proven a high sensitivity and specificity compared to the AUDIT as a golden standard. Antoni is aware that this evidence is limited and that there are no other publications but in Catalonia they decided to offer a choice to the GPs. It is a practical adaptation to a real life situation. Bart Garmyn suggested that some validation work should be done also on an oral version of the AUDIT-C. This might also be an effective screening method.

Biochemical assessments (liver tests) for people who score high on AUDIT

Kaija Seppä wonders why the training manual introduces a biochemical screening after a positive AUDIT. Antoni Gual answers that in Spain the doctor loves it and the patients like it. Astri Brandell thinks that in the Swedish culture it is the responsibility of the GP to find people with liver damage. A biochemical assessment is therefore necessary. Also Sverre Barfod thinks that it is essential to know the liver function if you score high on the AUDIT. Bart Garmyn asks if the knowledge of the liver function will influence the therapy or the approach to the patient. It is only useful as a motivational factor for patients to change their behaviour (look your liver is already damaged. It is proven in your blood. You must cut down on your drinking). On the other hand this strategy might influence patients with normal values to think that the situation is still under control. Kaija Seppä stresses the fact that you can have liver cirrhosis and a normal GGT. She doesn't want any official recommendation to take blood with high AUDIT. This depends on clinical examination and asks for an individual approach. Sverre Barfod suggests the ideal compromise: a biochemical assessment should be considered for people with a high AUDIT score. This expression sounds much better as an official recommendation and is more widely accepted.

General Discussion

After the group reported back their discussion the following comments were made:

Leo Pas suggested that it will be interesting to use experiences in different countries and try to really integrate into practice.

Mats Berglund introduced the existence of a test that examines the skills on brief intervention strategies using a video with a rating scale.

Miranda Laurant asked about the information that every country will have to adapt and Antoni Gual suggests that the 6th session can be adapted according to the needs of each country.

Jerzy Mellibruda emphasized that the Stages of Change of Prochaska and Di Clemente are important. He says that the challenge is to change habits of the professionals trained. He suggests testing the stage of change in the beginning of the training and at the end to see what changes have occurred.

Antoni Gual said that this is one of the proposals of the third session.

Nick Heather emphasized the need of copyright for the documents.

Regarding the differences between cultures and experiences in the different countries, Stephen Rollnick suggested that some case study material (practical experiences) will have to be included at the beginning of sessions to help professionals address the emotional aspects of their work and to help to overcome barriers to changing attitudes.

Leo Pas emphasized the fact that no commercial use must be done with the products.

Lidia Segura clarifies the need to review the Grant conditions regarding the publicity of materials.

Preben Bendtsen says that even though we train people to intervene, we do not say to them when they have to do it.

Bart Garmyn emphasized the importance to counteract against the GPs' reluctance to do the screening.

Group 3: Guidelines

Facilitator Preben Bendtsen
Rapporteur Rolande Anderson

Group Participants

Florence Berteletti-Kemp (Eurocare), Brigitte Boon (Holland), Peter Anderson (Project Leader), Mats Berglund (Sweden), Jonathan Chick (Scotland), Marko Kolsek (Slovenia), Leo Pas (Belgium) and Jerzy Mellibruda (Poland, note; arrived very late)

The Facilitator opened the session by reminding delegates of the importance of this document. He checked that everyone had read the document and suggested that the best way to start might be to brainstorm around the contents of the Guidelines document.
The group agreed and after some work agreed on the following topics for discussion;

1. What sort of document do we want and for whom should it be directed?
2. Risk levels - Can we agree?
3. Omissions
4. Detection Strategy - Types of screening - Instrument/tools and ways to administer
5. Treatment/Intervention Goals
6. Marketing/Printing the product - Country specific issues
7. How to present scientific data?
8. Confidentiality issues
9. Alcohol Dependence issues - Medication - Relapse Prevention - should it be part of the guidelines?
10. Brief Intervention and 'Stepped Care'
11. Co- Morbidity --- and? Nicotine
12. Consumer Perspective

In addition the group decided we were obliged to deal with the specific questions so;

13. Answers to the specific questions for the 'experts' in the text.

The group agreed to look at these questions as follows;

What sort of document do we want and for whom should it be directed?

We agreed that there should in fact be three documents regarding Guidelines;

- The overall 'Bible'
- A smaller document with no more than two sheets
- Publications from the bible

The first document would allow the production of the other two. All agreed that the first document would be for GP managers and implementers. The smaller document would be for working GPs who were most unlikely to read the whole thing but could do so if they wished and were so inclined.

Other points;

- The group felt the document was quite comprehensive. Inspiration was drawn from the Scottish guidelines prepared by Dr. Chick.
- Every country might need to develop a shorter version.
- The 'Bible' should be called 'Clinical Guidelines - Background Document' (?)
- The documents should be closely related and linked with the training manual

Marketing/Printing the product - Country specific issues

While it was agreed that the country based teams may need to adapt the marketing strategies for each country it was felt that the focus should be on developing EU strategies.
The introduction is very important and it should be very readable.
It should be designed for;

- Key EU organisations
- Governments
- Press Releases
- Publications
- Conferences
- Websites with links to other websites

Omissions

The harm done section contains a lot of omissions;

§ Diabetes
§ Impotence/Sexual Problems
§ Hypertension
§ Social consequences
§ Dementia
§ Depression/Suicide
§ Skin conditions
§ Neurological issues
§ Bone disorders
§ Injury (other than RTA)

All of the above should ideally be linked to level of consumption and harm.

The section on positive effects should not be in 'Harm done' section.
Use of illustrations would be helpful, for example, burden of disease chart, life course of alcohol use and two of the slides from the training module regarding Men and regarding Women (Breast cancer).
All should be evidence based.
Methodology section is also relevant to how we classify recommendations
Drink driving issue to be more highlighted
A decision was taken not to include a section on patients (people) who naturally produce alcohol

Risk levels - Can we agree?

This section took up a lot of discussion time. The main issues were could we agree on what is 'safe' or 'low risk' and should we give daily or weekly limits.
All agreed these figure should be based on epidemiological evidence but countries differ greatly on these figures.
All agreed it is a really important question as patients will ask and deserve to be told guidelines regarding consumption.
We all liked the WHO publication by Babor et al and this could perhaps be adapted.
The 'less is better' concept by the WHO should be a guide to us.
Should the whole section be deleted?
What is hazardous? What is binge drinking?
There are three clear issues we need to agree on

- Daily or weekly consumption limits
- One off amounts that may be hazardous
- Context of drinking is vital

We should stick to grams of alcohol?
There were no clear outcomes to this discussion except that the levels should be age and gender specific

Detection Strategy - Types of screening - Instrument/tools and ways to administer

The Guidelines need to reach all GPs but some GPs may be willing to screen to some extent and will need to decide their level of intervention
Discussion around the use of 'Cage' - It can still be useful but two more questions are needed;

- What is the max consumption over the last two months?
- What is the max in one week?

Different types of screening possibilities - Targeted screening, Clinical specific screening and systematic screening
Systematic screening is of lower cost effectiveness
It was felt that GPs should be given the range of options and allowed choose
The AUDIT can be used as an educational tool as well. The cut outs (Q1 and at Q2+3) for Audit should be included in the appendices
Only screening instrument with good evidence should be used
Audit C has undergone some changes apparently and adapted by some countries
Concern was expressed about the SIAC screening tool as it has not been widely validated
The team approach is important to stress and the Nurse or the Doctor can do the screening
Ways to administer;

- As early as possible
- Orally
- With pen and paper
- By computer

Treatment/Intervention Goals

The book by Rollnick, Mason and Butler 'Health Behaviour Change' was commended as a useful aid to treatment
Simple advice is very useful but some patients need a lot more
Section 8.2., should read all patients should be *offered* etc.

Brief Intervention and 'Stepped Care'

Again the issue for discussion was the fact that all patients will not need the same amount of time
Issues re models of care should be put in implementation strategy

How to present scientific data?

Find the right balance so that it is readable and not too confusing

Recommendations should be graded depending on evidence

Confidentiality issues
This is a sensitive issue and concerns the possibility that screening results could be used 'against' patients. Some countries talked about this issue as a reality. The issue concerns 'flagging' on patient records. There is a danger that those patients who change successfully may be 'stuck' with the original classification (following screening) and affect their insurance premiums, car licenses etc.
All agreed that patients do not mind being screened but may not fully realise the consequences

Note; the other topics listed in the brainstorming received little attention as we ran out of time.

Specific questions in text;

Question no. 1 for the experts; methodology of data gathering
We decided that the table should be deleted
Question no. 2 for the experts; Limits for one drinking occasion
We decided that there should be a limit and it should be in line with the AUDIT questionnaire
Question no. 3 for the experts; should we include DSM IV and are there any other basic definitions that we should use?
We said yes to ADS and DSM IV and we should focus on grams and no to the second part of the question
Question no. 4 for the experts; regarding Assessment
Yes we should have something regarding assessment
Questions no. 5, 6 and 7 for the experts; regarding detoxification information and use of Benzodiazepines
Yes we should include this info but make it PHC relevant as opposed to Mental Health Care procedures
Question no. 8 for the experts; regarding placement of this section regarding evidence
Yes we do need this section here but not too long and evidence based as opposed to 'clinical guidelines'.
Question no. 9 for the experts; regarding Appendix 7
Needs to be developed
Question no. 10 for the experts; regarding Appendix 9
Needs to be developed
Also the 'Organism state' was questioned and is understood to be regarding physical damage.

The final sections were rather rushed due to time pressure and all agreed that there is a lot more to be done.

A specific recommendation came from the group that if funds would allow it, a small group should meet next March to discuss the next draft of the Guidelines further.

General Discussion
Nick Heather suggested referring to the WHO document of Dr. Tom Babor and to include also some messages to give to people that screen negative and not only for those that screen positive.

Jerzy Mellibruda said that the first sentence "not all alcohol dependents needs specialist treatment" goes against our clinical experience.

Peter Anderson suggested that we must be flexible and leave the opportunity for the GP to treat alcohol dependents just in case that they want to do it and that they have enough skills to do it.

Jerzy Mellibruda does not agree with Peter Anderson's opinion because GPs can misunderstand what we are talking about.

Jonathan Chick says that there is some evidence that shows that alcohol dependents can recover in General Practice.

10.30 Introduction to Group work

Three groups each to present and discuss country profiles, country based teams and preparing country specific dissemination strategies

Group 1:
Facilitator Hana Sovinova
Rapporteur Marko Kolsek

Group 2:
Facilitator Joao Breda
Rapporteur Pierluigi Struzzo

Group 3:
Facilitator Michael Smolka
Rapporteur Leo Pas/Bart Garmyn

Peter Anderson presented the aims of the group work session. Groups had to discuss the following points:

1. The current state of the development of Country Based Teams

2. The structure of the template on the country strategies (see enclosed file: country based team and strategy.doc).

3. The contents of the questionnaire entitled "a tool to assess the available services for the management of alcohol problems at the country or regional level (see enclosed file: assesstoolmanagementalcohol tool.doc).

Chair: Ton Drenthen

13.00 International Network on Brief Interventions for Alcohol problems Nick Heather

A consultation document about the network is presented for discussion by Dr. Heather (see file attached: INeBrIA.doc)
Peter Anderson talked about the overlap between the Phase IV and the Phepa Project and the WHO-IneBrIA Project.
Obot says that the WHO-IneBrIA Project will act specially providing information to the developing countries.

Nick Heather proposes that in the meeting of Barcelona on 31st of October, a proposal with all the official aspects will be prepared.

The first INeBrIA meeting will take place in Barcelona on the 20 of October 2004 the day before the last Phepa Meeting (21st and 22nd of October 2004).

13.30 Report back from groups and general discussion

Group 1:

Facilitator Hana Sovinova
Rapporteur Phillipe Michaud

Phillipe Michaud replaced Marko Kolsek as rapporteur of the group.

Group Participants:
Jerzy Mellibruda, Lidia Segura, Olga Montserrat, Alexander Kantchelov
Nick Heather, Florence Berteletti-Kemp

Catalonia

1.2 -A phase IV team

1.3 -In close relationship with the regional Ministry of Health

1.4 -Working in the regional drug treatment service

The Catalonian team works under the authority of the Ministry of Health. The forthcoming regional election could affect its work. Nevertheless, its leading position in the PHEPA group is founded upon the work already done during phases III and IV, and the challenge now seems to enhance the collaboration between the different regions in Spain.
A meeting concerning all persons working on Spain is to take place in the next few months, to give a larger scale to the dissemination of EIBI.
Inside Catalonia, evaluation of the situation of dissemination is continuously evaluated.

2 Poland

2.1 -A national agency for health prevention

2.2 -And its allies

2.2.1 -At national

2.2.2 -Regional

2.2.3 -And local levels (network of alcohol concerned localities)

The PHEPA project is to be achieved by the National Institute of Health Prevention, which is a governmental agency.

In the recent past, 2000 doctors have been trained, but the results are not satisfying: There have been little changes in GPs representations and practice. Beside the group undertaking the training, motivation for these changes is low. Maybe the new way of reimbursement of the doctors' consultations could force them to consider the necessity of training. But there's a necessity to repeat the advocacy because of the changes in political personnel.

The strategy proposed concerns three levels of responsibility; national, regional and local. Recommendations are prepared for the three levels. 16 regions are going to involve themselves in a plan which includes training for EIBI, and the network of 'alcohol concerned cities' also takes part in the strategy.

The GPs could be forced to include EIBI in their contract with social security.
Clinical guidelines are prepared.
Money seems to be the main barrier, and European funds are hoped.

If European recommendations existed, Polish authorities could give more attention to the necessity of developing EIBI in Polish general practitioners.

The evaluation tool proposed by PA seems interesting, and the comparison between countries is a good thing to stress the interest of our action. This 'monitoring' could be at an European level or achieved by WHO.

3 Bulgaria

3.1 -A phase iv investigator

3.2 -And his allies

3.2.1 -At governmental level (Ministry of health, social insurance, Drug policy agency)

3.2.2 -Non governmental (Foundation against drug abuse)

3.2.3 -And professional (medical continuing education associations)

3.2.4 -International : EMCDDA, REITOX

Health system reform is partially failing, and is much criticized. Important changes have taken place in the Ministry of Health personnel, including the Minister himself. The national priorities in Public Health include illicit drugs, but poorly attend to alcohol related problems.
The first 'national strategy on drugs' was prepared in a very conflictive manner, and it seems evident that the second version will not be available for some time. Money is rare and the population is still permissive about excessive drinking, drink advertising, and so on. People fear illicit drugs much more than alcohol. In the media, especially on TV, the influence of the drink industry is very present. In the professional (medical) organizations there is a low motivation on alcohol problems.

PHEPA represents for the Bulgarian a lot of work without money to do it, which is difficult to defend. A flexible approach is necessary to involve partners in the project. Nevertheless, a national team is now available, in which you find governmental agencies (national addiction institute) and non-governmental organisations (foundation on drug abuse) and medical continuous education associations as well as a scientific organisation, which is the national focal point for EMCDDA in Lisbon and for the European Information network on drugs REITOX.

4 France

4.1 -A phase IV research team

4.2 -In a NGO (nat. ass. for prevention of alcoholism

4.3 -And its allies

4.3.1 -Ministry of health, Drug policy agency

4.3.2 -National board of « social security »

4.3.3 -Medical continuing education associations

The French team has been constituted for WHO's Phase IV project, and belongs to the national association for prevention of alcoholism, a NGO belonging to Eurocare network. PHEPA project is the continuation of Phase iv, which has received a strong support from the services of the Ministry of Health and of the Social security National Fund.
Though the dissemination process is far from being accomplished and presently concerns only the Parisian Region, the PHEPA project will provide the framework to continue the job at the nationwide level.
The recommendations and the training programme have been adapted to French conditions during the phase IV and the French team does not wish that other recommendations and other training tools be offered by the PHEPA experts in concurrence, with a higher level of authority. That is the reason why they insist on the necessary reference to the national team's work in the contents of the website.

Concerning the strategy, dissemination will be founded on three elements:

- a national alliance, in the continuation of phase IV;
- a national training plan aiming to train half of French GPs in the 5 next years, which implies a training of trainers at a central level, and regional plans of dissemination;
- a label given to trained GPs, so that they could benefit of an extra-fee when they carry out EIBI in their practice (on the hypothesis that government and social security could agree about the principle of this extra-fee).

About the evaluation tool: this seems very interesting but impossible to get all the information without the help of somebody in the governmental departments.

5 England

5.1 -A phase IV prominent research team

5.2 -In a research institution

5.3 -With allies like « alcohol concern»

The strategic alliance is wide and includes "Alcohol concern" a para-governmental agency, which is an excellent support.
Nick is concerned by the future of his team after his retirement.
Eileen Kaner will take the head of the project in the coming years.

The national policy is a wider problem, but there are satisfying signals, as these funds (100 000 £) attributed to a programme aiming dissemination of EIBI. The development of guidelines and their adaptation on English conditions are still necessary.

Czech Republic

5.4 -A team has been constituted with representatives of

5.4.1 -Ministries of Health and education,

5.4.2 -An addiction specialist

5.4.3 -A researcher in the alcohol field

5.4.4 -Social security

5.4.5 -CME associations

5.4.6 -Medical schools.

Among the 'candidate countries', the Czech Republic seems in a situation closer to Bulgaria's than to Poland's. 30 % of adult males drink over WHO's recommendations. A taskforce is in place: Ministry of health, an addiction specialist, researchers in the alcohol field, social security, Ministry of education, community action volunteers. Guidelines and training for doctors and nurses are on preparation. The post-graduate courses could be used to the dissemination.

6 Strategies and problems

6.1 -Political involvement

6.2 -Changes in political parties

6.3 -Money

6.4 -Opinion, alcohol lobby

6.5 -Doctors' motivation to change

6.6 -Adapting training strategies

6.7 -Efficiency of training

6.8 -Implementation on a wide scale

7 Assessment document

7.1 -OK for the contents

7.2 -Certainly useful but often we won't be able to complete it by ourselves

7.3 -Results to be published, for using them in an advocacy strategy

Group 2:

Facilitator Joao Breda
Rapporteur Pierluigi Struzzo

8 Finland

1) CBT**:** Finland has already a strategy.

a. The ministry has asked Kaija to coordinate the plan for the 5 regions of Finland so they will have representatives to do implementation in each area. .
b. The team will have the same composition as in PHEPA
    i. Governmental organizations: representatives of Stakes (national organization for research and health), Public health institute, representatives of the 5 areas
    ii. Members of NGOs (local and regional authorities), representative from professional associations (medical association), union health care (Nurses) municipal physicians, society on addiction.
    iii. Scientific association, (University of Helsinki and Tampere) the final number will be less than 10.

2) Strategy:

Point 6 and 7: The strategy will see the joint action of the Ministry of social affairs and the Ministry of health to put resources. Provinces will have to do applications in order to have funding. A crucial point will be to have them all participating in order to cover al the country territory.

In each of the 5 provinces 1 nurse + 1 GP will coordinate and train the GPs and nurses in the province. These coordinators will be trained by Kaija and other experts. Also the Ministry will offer the material for the practical work (hand outs, booklets, PHEPA could help in producing it).

The national advisor group will be created. EIBI is not a clear area but it was lifted from the prevention area to be supported but only under good applications. Kaija will try to activate people from the Provinces to be involved.

Q: Why is Finland so able to undertake widespread community projects?

A: Next April Estonia is joining EU and there spirits are very cheap. The government is afraid that after next April Finnish people will go to Estonia and buy alcohol. So the Finnish government has decided to decrease alcohol taxes in order to reduce people going to Estonia. Alcohol researchers and scientists are afraid that young people will increase they own drinking. So the key issue of this good strategy seems to be the fear of this happening.

9 Hungary

1) CBT: Until last week, Eleonóra Sineger was director of the national institute. One day before the meeting she had to resign and now she is here as the president of the National Addictologist Association.
Two psychiatrists are also member of the team, and a professor of the National institute of the GPs, a vice director of the national institute of GPs. The Association of Family Doctors will be part of the Team.

2) Strategy: The public health program has no financial support, but despite this they started a program with the GPs and training manual was created for all the country. They

trained 70 trainers and are trying to involve the University to join the program. The training is under the umbrella of the public health program (2001-2010) and they want to involve 40% of the GPs. They want to involve the University of Debrecen. Representatives from seven regions will also be included. The next 3 years they will help the nurses and helpers (women that help pregnant women, newborn babies etc).

In the future they will adapt the guideline and training manual within the next 2 or 3 years and they will also do a national web site. In 5 years they hope to have the support of the government since it is not supporting it yet. They are teaching the trainers and would also like to implement evidence based research.

Q: who is paying for this?
A: they collect money from industries, from the health ministry and other public or private associations.

10 Portugal

10.1 BT: they try to be as comprehensive as possible they have 5 very powerful regions.

10.2 They have to involve the ministry and the five regions to discuss the issue. It seems all the 5 regions want to join.

Mental Heath direction with 3 regional alcohol centres responsible for the treatment and education with political importance and they want to include representatives in accordance with the 5 Health Region Departments. This is important because the centre of Coimbra has been training GPs for a long time.
They also try to involve the Family doctors Association. There is one physician doing PhD in EIBI and this will be very helpful.
Alcohologic Portuguese society will also be included and they will have 5-6 persons and try to get people representing other institutions.

2) Strategy:
1st step: the new national health program includes the EIBI. The Plan has to be approved by the ministry. So they will have strong political commitment. People from mental health do not seem to be very keen in following this strategy.
2nd step: Portugal is divided into 5 regions and 1000 health centers. Due to the forthcoming political changes each Health Centre will have the opportunity to involve private and public sectors. In order to be involved into the PHEPA project, the Centers will have to fill an application in. A coordinator will have to be nominated and a team for Brief intervention (1 nurse and 1 physician) will be created in each Centre. A coordinating team will also be created.

Q: there are a lot of diseases to treat, how do you think you will be able to involve the experts working on the field?
A: They have tradition of giving incentives to the doctors or nurses working in the Centres.

11 Italy

1) CBT: Coordinated by the ISS (Ministry of Health) in collaboration with the other 4 members taking part in Phase IV. Hospitals, Universities, NGOs and Municipalities are represented. This is a provisional composition of the team. It is still open to the inclusion of other people such as GPs associations and major regional actors in this field.
The Team will create a larger national group in order to develop a national strategy. The first national meeting will take place in November.

2) Strategy: Flexibility is the word. We will have to take into consideration specific regional aspects and general guidelines from the Ministry of health that are on their way to be adopted.
The document is still to be prepared but the general objectives and a time table for the ongoing of the project are drafted and ready. Each participant has given a contribution (especially on points 6 and 7) and has sent them to the project leader who will do a final draft very shortly. Trend and tendencies of the Ministry will have to be verified and, according to this, Regional level of the strategy will be started (21 regions).

As regarding the Assessment Tool for services: we said that it is a complex document and will need to be discussed at national level paying attention to include all the possible stake holders and not only alcohol and specific services.
To have multiple respondents is a good strategy because you get different answers but in the end get a common answer in the end.
Give specific working tasks to the Team.

1) Group members should be powerful and know what is going on in PHC. To get together people knowing what is going on and not only people devoted to alcohol dependence. People in family and nurses society will have to be included.

2) Discussion on difficulty of performing training at national level with huge amount of money needed. This issue will have to be addressed because we are starting an extended project. A solution could be by including EIBI in the medical studies in the Universities.

Group 3:

Facilitator Michael Smolka
Rapporteur Leo Pas/Bart Garmyn

Participants:
Roland Anderson (Ireland), Sverre Barfod (Denmark), Preben Bendtsen, Mats Berglund, Astri Brandell (Sweden), Chris Caubergs, Leo Pas, Bart Garmyn (rapporteur) (Belgium-Flanders), Marko Kolsek (Slovenia), Michael Smolka (facilitator) (Germany).

1) Country Based Teams

Belgium (Flanders):

Different levels of policy related to health care

1) Municipality/community: local actions
2) District areas: (LOGO) this is a voluntary collaboration of all different organisations linked to health promotion and prevention in a concrete area. The LOGO mainly works to target the 5 official health targets chosen by the Flemish parliament. Alcohol is not one of these targets. (Targets are tobacco use, healthy food, infection disease (vaccination), breast cancer and accidents).
3) Provincial: at the provincial level there is some coordination of municipality action and LOGO working. This provincial coordination is stronger in the provinces of Limburg and Vlaams Brabant than in the other provinces.

4) Linguistic community: The Flemish and Walloon parliament and government are solely responsible for preventive medicine and health promotion. They organise the structure and policy which differs a lot in the two country sides.
5) Federal state: responsible for taxation, legislation on alcohol (availability), road safety, curative medicine and social security.

Main Alcohol policy in Flanders is aimed at
-Youth
-Road accidents
-Other: occupational health, municipality action

Country Based Team
Flemish community:
WVVH (scientific society of Flemish GPs)
VAD (Flemish NGO against drugs and alcohol)
Provincial platforms
VVGG (Flemish society for mental health care)
French community: equivalent people
Federal level: Ministry of health, Belgian society for Alcohol (Specialist care)

Flemish group: illicit drugs always get most attention
In preparation for the Flemish election we prepare a conference for different actors to get a consensus and to phrase a policy for the Flemish level. In a second meeting after the Flemish elections the delegation wants to discuss this Flemish policy with the federal level

Sweden:
In Sweden the country based team will be a lobby group of scientists and doctors to do some lobby-work with the products that come out of PHEPA. There is an institute of public health and the team considers asking them to join the discussions. The Department of health and social affairs has established a governmental commission. This commission proposed to ask an institute to start education training program on BI. Government has given the assignment to build a training center. The Swedish group will try to find out what their assignment is and will try to join efforts.
Leo Pas mentions that the aim of this group is to develop a blueprint for the minister to involve PHC in alcohol. That is the reason that we start discussion with the policy already. In Sweden they could use the same model. The group will be limited.

Denmark:
Sverre Barfod created a group with representatives of the ministry of health social affairs and internal affairs. There are two research groups involved. One group is half governmental, half non-governmental and will focus on the economic issues. The other group is the central research unit of the University of Copenhagen. An alliance of NGO's familiar with these topics will certainly agree to take an active role in the country based group.

Denmark faces some political problems with the alcohol topic. The national minister of health ordered a total survey of alcohol problems in Denmark. What is the research evidence? Last autumn this report was held back. It was not published until the budget was discussed in parliament. It was too expensive. Now we just have had a reduction of taxes on alcohol. This has given a lot of damage.

There is a lot of attention to youth, how to behave in a proper manner. The Danish minister has lowered the taxes for alcohol. The idea is as followed: the youth spends too much money on alcohol so we must lower the prices for alcohol. In Sweden the same is expected with the opening of the borders for cheap import. Leo suggests involving key

lobby people in the national team. Sverre Barfod responded that they already have identified the key persons in the administration to get funding, so they can not avoid the ministry persons. Politicians will disappear but the administration will stay.

The Swedish delegation mentions the opportunity of the tax reduction to start prevention programs. If politicians do not accept the price policy as a way of regulating the consumption they will have to put something else in the place. This gives an opportunity to involve GP in BI.

Leo Pas asked Sverre which harm is caused by the Beich paper in BMJ. Sverre does not think any harm has been done. The practice of screening was not widespread. It is already difficult enough to persuade GPs to talk about alcohol at all. The whole screening issue is a scientific discussion with low impact in the field.

Ireland:
Alcohol consumption is considered a major health problem in Ireland. The last decade there was a 41 % increase in overall consumption. Ireland is on the top of the league in binge drinking (young girls). All efforts are made to lower the consumption. The most recent results in science show the success of interventions. In the statistics of harm there is a strong correlation between alcohol consumption, depression and suicide (certainly for young males)

In Ireland the minister of health is very interested in alcohol and tobacco. He raised a budget to pay for the Irish project on GP intervention in alcohol (The first years the funding came mainly from pharmaceutical companies). This minister is not afraid to take unpopular decisions. He passed a law to ban smoking in public houses. There is still discussion over the implementation. It will be restricted in the Working place and this includes pubs. He also passed draconic laws on young people in pubs after 9pm.

In Ireland they are working with GPs specifically on alcohol. They have very good access to the practices because of the influence of the Irish college. The main concern is not the prevention of hazardous alcohol intake. The greatest interest is how to get a healthful intervention for patients who are difficult to handle. In general GPs are already over-stressed with paper work. It is very difficult to motivate them to work with hazardous drinkers. To sell this project we must provide them with help. We published a study that shows that the attendance of an alcohol counsellor on the site doubles the screening rates and the people detected. Follow up is much better if they can refer to a specific alcohol counsellor. The idea is that they must support practices with this kind of resources: the theory is the doctor detects a problem, and refers the patient next door to see his counsellor. This strategy has of course huge funding implications.

To build an Irish team Mr. Anderson has proposed 2 GPs, 1 GP trainer , 1 NGO (linked to EUROCARE) 1 Government official, 1 public health official, 1 counsellors body (they have a specific group on alcohol counsellors).

Key aspect for this group; Training for screening and intervention, how do we ensure that the training is replicated at undergraduate level".

Slovenia
In Slovenia the team is not funded. Dr Kolsek and his collaborators are invited to cooperate in the project as observers. He tries to do as much as possible. To build a team he contacted the GP association, the nurses association, specialists in school medicine, family medicine and a representative from the Minister of health to find some money.

Other partners that can be included are members of the CINDI project, Health insurance companies, representatives from the Minister of social affair, the national WHO coordinator for alcohol, representatives from the national institute of public health.

For Marco it is critical to know what the aim of the group is. As he understands it, the aim is to develop a country based strategy that can be suggested to the minister of health. He notices that the aim in Ireland is more focussed on training. The Swedish people mentioned that none of us is sent here out by our governments. We can only lobby to build up strategic alliances on the national level. Marco is not sure what the best strategy is. Do we have to create a large strategic group or a smaller operative group? They have not worked a lot on the strategy yet. The Ministry of health work interferes with our efforts. The authorities want to pay for the training of GPs. The problem is that they only want to give training to deal with risky drinkers. Marco considers this a start of the program. It gives an entry, an opportunity to deal with the subject in PHC. At this moment the program does not support the idea of "early identification and brief intervention". Marco suggest that this concept should be a part of the training program on 'risky drinking".

Germany:
In Germany, there is a problem with the size of the country. This makes things more difficult to handle at the national level. Many people are working in this field and doing epidemiological work. They are not very well connected. Michael made contact with many people who are involved and managed to gather five health professionals involved in field research and members of key organisations in alcohol dependence field. This will be a core group. Before they can present a strategy to the minister of health they need a consensus. After they had this discussion and they agreed on a strategy they will think about taking in represents of the government and how to sell it at the government.

Discussion on the strategy document (sent 7 July)
There is general agreement among the group that this is a document meant for political use. It shows how we want to work as a team. The document is useful to lobby at governmental bodies. The adaptation of the draft document was discussed. The information for the first 5 paragraphs can be taken from other documents. It summarises most of the essential data about the alcohol issues. There is a consensus that this information has to be kept short. We agree that everything mentioned under number 4 should be focussed on the local level. What do we need to make a comprehensive approach?

Our discussion goes mainly about paragraph 6 and 7

There is an overview of current interventions. Evidence will be provided in the PHEPA project.
Leo Pas: We need to state what is already available, what should be done.
Marco Kolsek: We want to provide information about the implementation of EIBI in Primary health Care. We do not want to discuss the whole national policy on alcohol. The core thing is getting PHC involved. This is one item in the alcohol policy. We need to provide the arguments for doing it in our own countries.
Leo Pas: I would like to go a little bit further. I think it is a good exercise to summarise what is already being done in the country and what not. We have to know what is going on in alcohol policy. We do not aim to change it. What is our reference point under current policy and activities? Roland Anderson suggested that we would change the content of this chapter. This chapter should give some information about the current policy on alcohol in the different countries. We do not want to change this policy. We only want to add to this policy a specific target on the involvement of PHC in Early identification and Brief Intervention. This chapter should explain what we would like to

achieve and should give some estimations about the cost. The chapter should be constructed like this:
6.1. Current Alcohol policy and legislation
6.2. Current involvement of PHC in this policy
6.3. How should PHC be involved in the near future
6.4. Integration of this PHC involvement in the future alcohol policy of the country

Roland thinks that the answer of 6.4 is now given in our chapter 7 that could be integrated in chapter 6

7. Integrating preventive interventions in PHC

Out of phase IV conclusion we need to change attitudes and thinking to alcohol. If we have public campaign and public debate, it is easier to change the attitudes of the GPs.

7.6 funding and reimbursement:

Dr. Smolka mentioned that he does not have any figures to make estimates for the costs in Germany. Dr. Kolsek tells us that in Slovenia there is an idea that GPs should get funding to make the implementation of EIBI popular. Implementation of such funding would be very difficult in the German insurance system. There are several 100 different insurance companies (krankenkasse). This is a very difficult point. In Sweden those who administer the system would like to experiment with this kind of target payment. This is more difficult in countries with a fee for service system. In those countries there is often a limited list of activities which GPs are paid for. This system is similar in Germany and Belgium. Leo Pas mentioned that the barriers and facilitators for implementation have been identified by different surveys. In our system in Flanders we identified the need to involve local quality groups, we need to act with dependence as well if we discus EIBI, we have to work on role acceptance, and we need to provide ongoing support. The reimbursement policy is not everything.

Discussion on the tool to assess the available services
Something went wrong in the distribution of this document. Only a few people have received it by mail. Since the vast majority have not read the document, we are not able to discuss it.

Over the long time detailed information to be built up over time.
How is the country doing in the management of alcohol problems?
Where do we need to strengthen our efforts?

General Discussion
Leo Pas asked about the level of the strategy. Does it have to be at a regional or at a federal one? Should the strategy be imbedded in a more comprehensive alcohol strategy or only in a PHC strategy?

Peter Anderson suggests doing the most politically suitable in each country.

Nick Heather reminds that it follows also the spirit of phase IV.

Nick Heather will be able to raise money regarding the test of the materials. The idea will be to draft the materials (training manual) and test them before they are finished. As the next training manual draft will be ready by the mid of January, there will be enough time to implement the test on the draft and to include the changes in the final one.

15.30 Next steps
Peter Anderson

Notes of meeting:	End of October
Country report:	End of November
Web site:	Launch end of November
Training manual:	Next draft mid-January
Guidelines:	2nd draft mid January
	March meeting (15/16 March)
	3rd draft mid-April
Database:	1st draft mid-February
Draft country template:	End of January
Assessment tool:	Gradually completed over next 6 months
Next meeting:	21/22 October 2004

16.30 Close of meeting

Dr. Gual closed the meeting on behalf of Joan Colom the Director General of Substance Abuse and Aids. He excused his absence because of the regional elections in Catalonia.

Dr. Gual appreciated all the contributions and comments to the products raised during the group work and general discussion sessions. He also emphasized that soon the work will be transferred to countries because the European Project only has sense if the country strategies are also designed.

Clinical Guidelines Meeting

Agenda

Clinical Guidelines Meeting Barcelona

15-16th March 2004

Monday 15th March 2004

13.30 h	Working Lunch
14.30 h	Introduction and objectives of the meeting
	Antoni Plasència
	Joan Colom
	Chair: Peter Anderson
14.45 h	Discussion on Clinical Guidelines
16.00 h	Coffee Break
16.30 h	Discussion continued
18.30 h	Close of day
20.30 h	Dinner

Tuesday 16th March 2004

9.00 h	Discussion Continued
10.30 h	Coffee Break
	Chair: Nick Heather
10.45 h	Country Work and Implementation
	Peter Anderson
11.30 h	Next Steps of the Phepa Project
	Antoni Gual
12.00 h	Close of Meeting
	Joan Colom
13.30 h	Working Lunch

Clinical Guidelines Meeting

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Clinical Guidelines Meeting

Minutes

Clinical Guidelines Meeting
Phepa Project
Barcelona, 15-16 March 2004

AIM OF THE MEETING

Dr. Anderson explained that the main aim of the meeting was to achieve consensus in the clinical guidelines' contents of the new draft that he has developed by modifying the first draft.

PRELIMINAR QUESTIONS

The short version of the clinical guidelines will be submitted as a paper in a journal.

The authorship of the products will have to be discussed.

Sign act one proposal the member of the task force in alphabetical order on behalf of the Phepa Project.

Who will be the first author?

Dr. Chick – Dr. Anderson has done the majority of the work so I think that he must be the author.
Dr. Anderson – We will find a reasonable way to publish it. We can introduce a list of authors on behalf of the rest of the Phepa contributors.
Dr. Pas - I don't' mind what will be decided. The contributors in the development of the product have to be mentioned and the rest as an extended group.
Dr. Anderson - The rest of the products can be published too.
Dr. Pas – We can include a Contribution Committee.
Dr. Gual - We can give a proposal by the end of the meeting. To include as much as possible people but it will be difficult.
Dr. Anderson - In the rest of papers we will include on behalf of the Phepa Group.

DISCUSSION

Focus on the content page.
Dr. Anderson asked if there are any redundant or are any missing chapter.
Dr. Chick – A chapter about family is missing in the Alcohol Dependence Chapter.
Dr. Garmyn – The chapter on ADS is very ambitious to be addressed only in 10 pages. It can be criticized by others clinicians. They will be critic with the simplification. If we want to add the chapter on ADS I wonder if we don't have to involve more clinicians involved. I wonder how much people is expert on that.
Dr. Kolsek – This chapter must be included.
Dr. Bendtsen - Clinicians in Sweden ask for training on intervention on ADS
They need to know what to do with Alcohol Dependents. In the screening task we might found people with dependence and we must know what to do with them. We need to know on referral criteria. 9 of 10 people screened positive will not have dependency but it is important to know what to do.
Dr. Gual – Clinicians will be happy if we provide them some information in how to manage ADS. In the training manual such information is also included but we don't need

to provide a manual in how to manage the ads. We just need to include how to identify it and how to manage the referral to specialized centres.
Dr. Berglund – we do not need to provide an extensive chapter but we have to include it following the examples of Scotland and France that the physicians also give methadone.
Dr. R Anderson - physicians struggle with ADS and I think that a chapter or a section in how to do it will be important. It will be a major achievement if we get them to do something with them. We also have to include information about partners and families.
Dr. Pas - A section on the approach on hazardous alcohol is needed as well. Clinical questions for physicians that need to be answered. How to detect, how to assess and what to do in case of hazardous alcohol, risky drinking and ads is also needed.
Dr. Gual – Do you suggest to include a chapter between 6 and 7 and an assessment chapter. Family issue can be included in the psychological interventions.
Dr. Pas - Family can be addressed in the detection chapter as it is the context where alcohol is detected.
Dr. Anderson - There is an approach that is screening and brief intervention and there is another that is detection and managing problems.
Dr. Garmyn - You suggest everyone to be screened and to put everyone in a line but life is not like that people move from one aspect to another.
Dr. Gual -We have to be sure that we do not say that clinicians have to screen and assess everyone. Assessment has only to be done in some cases.
Dr. Pas - What is the major contribution of the CG. CG will provide a framework to try to implement local adaptations in each country. CG is a collection of different answers to specific questions that can be addressed at local level.
Dr. Anderson - Try to stimulate activity in clinicians regarding alcohol. Not focus only in Risky drinkers but also in ADS. Management or referral.
Dr. Seppä - What to do if BI does not work must be also addressed.
Dr. Bendtsen - Section on Screening and Brief Intervention and what to do when things do not work and a chapter on alcohol dependence must be included.
Dr. Anderson – Suggest turning back to the family point.
Dr. Chick – It must be very briefly included.
Dr. Gual – Including the family will help to assess the evolution of patient and there is some evidence.
Dr. Seppä - To include the family to look for advantages of the use of BI. There should be some evidence regarding the use of family to support BI.
Dr. Pas - No section in alcohol use has been included. Pas suggest including what is safe use. When does risky drinking and hazardous drinking start?
Dr. Anderson – We will turn back to the concepts and definitions when we address that chapter.
Dr. Anderson - there is no debriefing regarding special populations.
Dr. Gual - we have to include all alcohol related problems that will be helpful for the clinicians.
Dr. Pas - Specific groups are not mentioned. Safe use in different
populations have to be included. He suggests to include the screening and BI in elderly people.
Dr. Kolsek – He suggests including specific notes in the introduction regarding the fact that we can not include everything.
Dr. Anderson - Chapter by chapter.

CHAPTER 1. INTRODUCTION
Dr. Garmyn - suggests in the introduction to change the phrase on stopping alcohol consumption is more difficult (page 2 in introduction) not to make the connection on the difficulties on managing alcohol consumption.
Dr. Pas – provides a suggestion to be included in the introduction. He will include the suggestion in the text.
Dr. Anderson – agrees with the suggestion.
Dr. Boomsma – suggests starting with the managing aspects of the problem.

CHAPTER 2. METHODOLOGY

Dr. Anderson – The Methodology chapter includes a purpose of the clinical guidelines.
Dr. Pas – Suggests identifying special areas that need to be investigated.
Dr. Anderson - In a way we draw on existing reviews and works done.
Dr. Pas – Suggests three levels. 1) Evidence we have, 2) Identify areas that can be conflictive and to come to the conclusions 3) Indicate open questions to be addressed by further research.
Dr. Anderson - suggests including Dr. Pas' suggestions.
Dr. Pas - talks about the levels of evidence. Why we have included these levels and no others?
Dr. Anderson - I thought that it was the most relevant one.
Dr. R. Anderson – Why don't we use something easier? We just indicate if we have strong evidence to address it.
Dr. Pas – then you'll have to define what you mean by strong evidence.
Dr. Anderson – Suggests addressing the level of evidence we have and if there is an European system we will follow that one
Dr. Berglund - There are different systematic reviews with different conclusions. Sometimes it will be difficult to conclude something on it. Find out on evidence. If we found that some reviews are negative we can conclude that we can take away the evidence under our opinion.
Dr. Pas – Again talks on conflictive, strong and weak evidence and questions that need to be addressed in the future.
Dr. Berglund -The problem is not the evidence. The problem is to decide.
Dr. Pas - Consensus. Conflictive and some research questions.
Dr. Anderson - We need to include what we have done to achieve a decision. We are reviewing evidence and we have the expertise to do it. We can not go further.
Dr. Boomsma - If there is strong evidence we will have to go further.

CHAPTER 3. DEFINITIONS AND TERMINOLOGY

Dr. Garmyn - We are not putting all people in a line. To include something that people should know that people move from one point of risk to one another.
Dr. Pas - A Glossary of the terminology has to be included at the end of the book. Terminology has to be clearly defined (i.e: Opportunistic screening, etc.). You might consider this chapter to introduce describing of alcohol use from safe use to ADS. Include binge drinking and some definitions on harmful and hazardous use.
Dr. Anderson - The idea of moving forward in the risk. We try to go away from hazardous and harmful concept. We follow the WHO terms and there is no SAFE USE.
Dr. Pas - I understand but we have to do it consciously.
Dr. Anderson - It is important to mention the words that people use and try to redefine them correctly (i.e.: problematic use, etc.)
Dr. Gual - Didactic use of the guidelines is really important.
Dr. Chick – It is worth the space that these definitions will take and the problem is to decide where to stop.
Dr. Berglund - I thought about the first definition on the Standard Drink. There are four or five definitions on standard drink. To include a typical standard drink is ….
Dr. Seppä – We have to raise a question on binge drinking. Some points have to be mentioned on hazardous drinking.
Dr. Anderson – Do we have to talk about intoxication?
Dr. Seppä - Intoxication is different than binge drinking.
Dr. Boomsma – In Intoxication it will be important to mention that if people mix drugs the intoxication symptoms will be different.
Dr. Anderson - Agrees to include the idea.
Dr. Bendtsen - Include heavy episodic drinking and mention sex specific counselling.

Dr. Gual - I agree with Chick that we won't be able to stop but some words on the concepts used by clinicians have to be included. We will have to clarify the standard drink. If we don't show here that each country has different standard drink maybe we will have to address the huge variability between countries. We did some research regarding the standard drink and we found 10 gr. If we now produce a CG with that will produce some confusion.
Dr. Chick - Talks about age specific counselling.
Dr. Bendtsen – Hazardous drinking has to be included (you do not have symptoms. You can not see it)
Dr. Kolsek - Harmful drinking has to be also included.
Dr. Pas - Alcohol dependence symptoms
Dr. Anderson - Do we stick to the ICD-10 and not to use the DSM-IV.
Dr. Pas - People in Belgium will discuss it because we use the DSM-IV.
Dr. Gual - Are we talking on dependence criteria only?
I don't see our clinicians to take a look on the DSM-IV
Dr. Boomsma - We have to mention at least some concepts.
Dr. Pas - We have to provide at least the definitions. We will have to provide information to lead clinicians take their own decisions (from every country) and not to close eyes in front of the different aspects.
Dr. Gual - It is not sufficient to include abuse?
Dr. Pas - As a group we have decided to include this terminology or not?
Dr. Gual – suggests organizing concepts in an alphabetical order.
Dr. Anderson – This chapter must be simple and flowing and there is no need to include information we can address in an appendix.
Dr. Seppä - I wonder if it can be useful to include data on prevalence on alcohol hazardous.
Dr. Anderson - How can we do it?
Dr. R. Anderson - Do we know the answer?
Dr. Anderson – It is an excellent idea but it's difficult to address.
There is quite a lot data on hazardous consumption on WHO but data can be provided by different countries including country base definitions.
We will have to ask participants to include this data.
Dr. Anderson – Asks Dr. Heather if there are data?
Dr. Heather - There is data but difficult to standardize for countries.
Dr. Gual - It is not only necessary to include prevalence but also the standard measures we have. It can maybe included in an additional chapter.

CHAPTER 4. THE HEALTH AND SOCIAL HARM DONE BY ALCOHOL

Dr. Anderson – The purpose of this chapter is to list all the harm done by the alcohol.
Dr. Pas – Suggests including some clinical questions:

-Distinction between mortality and morbidity
-Develop more the social model leading hazardous use and alcohol dependence.
-You can not include the alcohol use without talking on the social key aspects.
One question is missing. How can be the effects of alcohol reduced when you reduce alcohol consumption. There is very little data on effects on reducing.

Dr. Heather - There is little evidence on that but there is a reduction in problems.
Dr. Bendtsen - Alcohol as a risk factor on the risk factor list and on the fourth place as disease.
Dr. Anderson - That's a problem from the global burden of disease. First you get risk factor and then disease.
Dr. Gual – Something is missing. There is a reference to child abuse but no reference to children of alcoholics. It will be worth to mention children of alcoholics. It has to be taken into account. Addiction to other drugs more than tobacco. Polidrug use has to be mentioned. Use of alcohol mixed with ecstasy and cannabis.
Dr. Heather – How you decided the exact purpose of the long document?

Dr. Anderson - The purpose is to address alcohol problems for clinicians in PHC.
Dr. R. Anderson – It is a long chapter.
Dr. Bendtsen - There are no references.
Dr. Anderson - We will come back to references in the point of references.
Dr. Anderson – What about the global burden of disease list?
Dr. Heather - suggests doing it simple.
Dr. Pas – It is important to give absolute figures and to reorganize table of global burden in order of importance.
Dr. Bendtsen – suggests doing the table on relative risks more simple.
Dr. Berglund - Christenson showed a reduction in problems in people who stopped drinking in comparison to control group.
Dr. Bendtsen - Social harms and unintentional and intentional injuries are really important and there is a lot of literature on that.
Dr. Colom – suggests renaming the word divorce because it is not negative.
Dr. Anderson - Marital violence instead of divorce.
Dr. Pas - Link between alcohol and violence is difficult. Similar causes of both.
Dr. Anderson - There is a lot of evidence in biological research that alcohol consumption can increase violence.
Dr. Pas - The model is much more complicated then that.
Dr. Anderson - I will include a big topic on this issue.
Dr. Pas - Polyneuropathie is not included in neuropsychiatric conditions. He suggests changing the order of the conditions listed.
Dr. Chick - Brain damage must include double vision in Vernicke's section.
Dr. Berglund - Other diseases like schizophrenia. It is difficult to separate depression, anxiety from other pathologies. Alcohol problems start before the psychiatric problems start.
Dr. Gual – Suggests including a topic on co-morbidity of alcohol with anxiety, depression, schizophrenia and use of other drugs.
Dr. Boomsma – We have to help the Clinicians to manage clinical depression and alcohol.
Dr. Gual – The assessment chapter have to address the co-morbidity aspects. There is a revision from M. Shuckit on depression and alcohol.
Dr. R. Anderson – It will be more appropriate to talk about clinical depression instead of depression.
Dr. Gual - To motivate them it could be wise to say them that any complication on depression must be referred.
Dr. Seppä – We have to talk about many symptoms disorders: Sleeping disorders.
Dr. Anderson – You are right.
Dr. Boomsma – That is really clever as many people asks on symptoms.
Dr. Gual – thinking on the homogeneity in the chapter it will be good to Include evidence and graphics on cirrhosis.
Dr. Anderson - Figures speak more than words.
Dr. Pas – It is important to address the major effect of combining alcohol and tobacco to exopharinge cancers.
Dr. Pas – Major relative causes of cardiovascular diseases by combining risks
Dr. Anderson - That point is stated in mortality.
Dr. Seppä – It is important to know on the number of drinks related to hypertension.
Dr. Anderson – What about the reproductive conditions?
Dr. Kolsek - Sexual problems have to be included.
Dr. Gual - The children of alcoholics have also to be included.
Dr. Garmyn – We have to talk about the increase of the sexual risk behaviour among youth or adults. We have to link to problems that you face with youths that take a lot of alcohol.
Dr. Anderson – What about all cause of mortality
Dr. Chick - Gomel published a nice paper. Beautiful graphs in might have been published in WHO document on the harm on drinking two years ago.
Dr. Anderson - I'll check. E-mail form Dr. Gomel will be provided by Dr. Chick.

Dr. Berglund - Suicide rates are increased in alcohol consumption and it can be discussed on violence.
Dr. Anderson - There are a lot of time series regarding that topic.
Dr. Bendtsen - This topic is clearly stated in the EU Task force.
Dr. Anderson - Ok I can include a reference.
Dr. Bendtsen – Back to the point that Dr. Seppä on symptoms. Alcohol might be involved in all symptoms shown by patient. GP might screen when they think that alcohol might be involved. We should try to give some ideas on what kind of symptoms must be taken into consideration.
Dr. Pas - We should include in the recommendations section of this chapter all the possible listed symptoms that can be related to alcohol.
Alcohol as a consequence of some clinical conditions can also be mentioned.
Dr. Gual - On that point raised, GP can be motivated but on the other hand we have to be careful in how to write it just because GP can be focused on only screening under clinical conditions. Screening must be raised in general population or specific populations and not only in clinical symptoms because it must be very late.
Dr. Pas – Recommendations to be added.
Dr. R. Anderson - To screen everyone might not be correct.
Dr. Heather - Excessive alcohol consumption might produce increased risk.

CHAPTER 5. SCREENING CHAPTER. MEASURING ALCOHOL RISKS AND SCREENING ON HAZARDOUS AND HARMFUL ALCOHOL USE.

Dr. Heather - This document poses questions like: when? Where? Whom? But they are not discussed here. We would use this document to provide evidence. But the answers to the questions when? …. We should allow to be decided in each country in each individual. How definite should our recommendations be?
Dr. Anderson - We should address the advantages and disadvantages on the different approaches.
Dr. Heather - Would be provide definite recommendations in the shorter version?
Dr. Anderson - If we conclude something in the large document we will have to conclude the same in the shorter forms.
Dr. Heather - Phepa project will allow us to take our own decisions?
Dr. Pas -My view of the questions is what is the utility of the different tests the reliability? How can screening be effective? when? Who? What? Whom? What is the result of different approaches and you can decide what is the most important or better approach.
Dr. Anderson - What questions must be answered. Dr. Pas suggestions must be taking into consideration.
Dr. Bendtsen. Sensitivity or specificity levels must be coherent. The possibility to find a lot of false positive must be clarified. You put a lot of work but you can find a lot of false positive.
Dr. Gual –Suggests correcting sentence in page 25.
Dr. Bendtsen. It is difficult to implement alcohol measures. Computer assisted and internet assessment.
Dr. Pas - It could be wise to include identification tests of harmful and hazardous and dependence separated. To have it mixed is really confusing.
Dr. Heather - I really emphasize to include only one instrument (MAST).
Dr. Chick - CAGE was included in Britain.
Dr. Gual - Concerning your question, In Spain people know MAST but it helps GP only to use the CAGE.
Dr. Heather - CAGE is widely used but it has some difficulties to address hazardous and harmful alcohol consumption.
Dr. Gual – MAST was only validated once and it can not be used.
Dr. Anderson - Just drop MAST.
Dr. Garmyn - Accepting the screening we will have to include the rest of tests.

Dr. Heather - Three sections: AUDIT, AUDIT-3 and FIVE SHOT. To validate the FAST can be a possibility. It is so economic to do it just with one question.
Dr. Garmyn - It is too early to include only one question there is no official validation of the instrument. It is not enough by believing.
Dr. Heather. If we are interested in attempting to use alcohol consumption measures we will have to include a test by definition.
Dr. Bendtsen - We should focus on alcohol consumption.
Dr. Pas - we have to highlight the different possibilities. Any country can decide which test to be used but everyone must know the specificity and sensitivity.
Dr. Anderson. What about the recommendations?
Dr. Heather - Questions have to be integrated in the clinical history.
Laepen from Laussane did some work on the inclusion of questions in clinical history.
Dr. Pas - Suggests including supporting basis to test (oral, computer, self-administered).
Dr. Berglund – Saunders showed that if you use AUDIT you will find 50% more risky drinking if you use the oral questionnaire. 25% of the positive must be included.
Dr. Pas - Some evidence to that can be provided.
Dr. Heather - Should be use the Dr. Beich article? We should use it. Dr. Anderson is reanalyzing and correcting the results of that article.
Dr. Chick - The important points in page 32 are not included in the recommendations. It will be nice to include these points there.
Dr. Anderson - Use quantity frequency questions first and that include other questions.
Dr. Chick - Full AUDIT is too long.
Dr. Pas - Systematic screening has proved to be effective in detecting alcohol hazardous consumption and introduce the different questionnaires.
Dr. Heather – The short version of the AUDIT must be used.
Dr. Garmyn - Are we not to fast in recommend the fast test? It will be important to mention how strong the evidence is in each case in each audit.
Dr. Anderson - If you use quantity frequency questionnaires you can not use a golden standard.
Dr. Heather - You can recommend to go into detail in alcohol consumption as golden standard.
Dr. Gual - First recommendation for European countries. Alcohol consumption must be registered in all clinical records and that the first decision is to include quantity-frequency questions. We should agree in how often will be recommended to screen patients. In Spain we recommend to do it every two years.
Dr. Garmyn - You can not know which test is the best because you can only compare it.
Dr. Heather - We recommend that test or other because of our expertise on that field. We recommend using quantity-frequency tests.
Dr. Kolsek – In Slovenia we recommend the quantity-frequency items.
Dr. Chick - A measure of a total consumption per week or daily consumption. There are some instruments that can do the same but take longer.
Dr. Anderson - How frequent we should do that?
Dr. Boomsma - Suggests that alcohol belongs to risk profile.
Dr. Pas - It is difficult to give a unique recommendation.
Dr. Seppä – It is also important that the patients receive feedback from the quantity-frequency.
Dr. Anderson – It is a health education opportunity
Dr. Heather – It will be important to congratulate also the patient when he is drinking moderately.
Dr. Bendtsen – Suggests including what happen on a typical week.
Dr. Anderson – Quantity-frequency questions are much less time consuming.
Dr. Heather - Points the difference between screening and assessment.
Dr. Garmyn - If it is positive in screening include other questions. Three step evaluation regarding the results in the former questions.

Dr. Berglund – What about confidentiality? In Sweden, professionals have to report results to driving license authorities if the people are not behaving properly. It is a very offensive style and consumers tend to reduce consumption.
All Database records of the population are available to all doctors. Confidentiality is a critical question. That's why not all clinicians will support the general screening.
Dr. Anderson - How we deal with this issue is difficult but we will have to discuss on it.
Dr. Berglund – It raises a question to be discussed between patients.
Dr. Pas - If you want to talk on screening you have to include the ethical consequences of screening
Dr. R Anderson - In Ireland people have private and public GP.
Dr. Seppä - GP starts by introducing some opening questions before alcohol consumption.
Dr. Chick – We have to say something on ethics and observations on confidentiality.
Dr. Anderson - It is a fundamental issue on the purpose of the clinical guidelines. It will interfere with the reliability of the strategies.
Dr. Seppä - We have to face it differently, including well-phrase sentences regarding these questions.
Dr. Gual – It is important to create a good atmosphere and not using frightening questions.
Dr. Heather - One aspect is the evidence on the way questions have to be formulated but there is a second point. They have the perfect right to do it in other ways.
Dr. Garmyn - If they are not motivated they won't introduce any test and won't be effective.
Dr. Pas – It is important to give recommendations separately. It is too much information.
Dr. Boomsma - Give some address to GP on the need to do it in a non frightening way.
Dr. Anderson - On the ethical issues will be nice to include some points on the consequences.

CHAPTER 6. BIOLOGICAL MARKERS
Dr. Heather - It's complicated for non medical people.
Dr. Anderson - It is too detailed.
Dr. Pas - Can it be reduced by answering the following questions?
-What constitutes a cost-effective use of biological markers?
-Should BM be used for screening?
-Are they effective? If they are available for other reasons, how can they be used?
-Can be BM used to monitor consumption?

Dr. Garmyn - Monitor alcohol consumption. We can advice them in how to understand BM? In south countries is strongly recommended as part of clinical assessment to include BM. Once you have a positive result to do some assessment further.
Dr. Heather - The third recommendation can be useful.
Dr. Gual - Redefine the title. BM of what? Alcohol Dependence? Harmful?
Some introductive words telling that have been used as screening but unsuccessfully.
Dr. Chick - Screening should not rely on BM as they can not be used useful.
Dr. Berglund – There are some studies on more mortality when GGT increased and another study that addresses low mortality with low CDT.
Dr. Anderson – It will be important to shorten that chapter. References from Dr. Berglund must be included.
Dr. R Anderson – Does sex specific issues have to be included?
Dr. Anderson – There are some age and sex recommendations on page 38.
Dr. Gual - No specific recommendations are giving in AUDIT so we have to do it comprehensively.
Dr. Bendtsen - Do we need to include alcohol in blood in monitoring acute alcohol intake.
Dr. Gual - You use it in specialized settings. Do we expect GP to screen alcohol in blood?

Dr. Anderson – What happens if a patient is clearly intoxicated? what to do? What's the GP responsibility on that? Do they have to do some tests? Do they have to allow patient to drive?
Dr. Garmyn – On such situation clinical evidence is enough.
Dr. Gual - Do GP have to monitor acute alcohol intake?
Dr. Gual - We have to clarify that they are not use to monitor alcohol intake.
Dr. Anderson - We have to mention that these things exist but nothing more is expected from them.
Dr. Anderson. There are any legal reviews?
Dr. Kolsek – Suggests including that GP have to advice that driving will not be recommended under alcohol effects.
Dr. Anderson – To monitor alcohol consumption is not the job of GP.
Open discussion on the GP responsibilities on alcohol advice.
On the recommendations

a) should not rely on Bm
b) ok
c) ok
d) ok

Dr. Seppä - Suggest including that HDA can be increased as a consequence of alcohol consumption.

CHAPTER 7. BRIEF INTERVENTION.
Dr. Heather – In the second paragraph where primary care brief intervention concept is introduced **primary care** must be deleted and in **special settings** have to be used instead.
Dr. Gual – Suggest starting this chapter by describing the essential components and the general definition of BI.
Dr. Heather - Moyer describes BI as 4 sessions and that will not include some papers or studies
Dr. Gual - I'm not talking about the length, I'm talking about the essential components. Alcohol CME web components for example.
Dr. Anderson - Elements that BI commonly incorporate. There is not much review on the BI components.
Dr. Garmyn - It has not been described in detail in literature which the essential components are.
Dr. Kolsek – The core components must be described.
Dr. Anderson – If we describe what a BI is, then some papers won't be included.
Dr. Heather – Suggest giving a general definition that will include different experiences.
Dr. Kolsek – Everybody need to know what BI is.
Dr. Bendtsen - Specialist BI vs Non specialist BI have to be described.
Dr. Heather - People seeking treatment and people non seeking treatment. There is a great difference between a GP 5-minute intervention and 3 motivational sessions.
Dr. Bendtsen - We are developing a manual for GP so it must be clarified in the text. Many GP will do selective screening.
Dr. Heather – We have to distinguish between brief treatment and opportunistic brief intervention. No reason why a GP won't be able to offer Brief Treatment.
Dr. Pas – Recommendations.

-What interventions are effective in PHC?
-Are effective for hazardous and harmful alcohol use?
-What characterizes effective BI?
-What people might benefit from BI?
-Who can provide BI?
-What are the conditions for provision of training?
-What should be done if BI does not result in change in BI?

Dr. Gual – Suggest including another question.

-How long will the effect of BI last?

Dr. Pas – Suggests including all that questions and answering them.
Dr. Chick – We can put them in frames. They are short.
Dr. Anderson - One of the proposed axes is first which are the essential components and on a second level our opinion on that.
Dr. Pas - Principles as communication skills have to be included too.
Dr. Heather - There is no evidence on that.
Dr. Bendtsen - The evidence shown comes from opportunistic or specialist BI.
Dr. Anderson – Evidence come from BI used in Primary care settings (opportunistic BI).
Dr. Heather – Suggests including further meta-analysis (one presented in Alicante) if they have not been published yet.
Dr. Kolsek - Include some references on Motivational Interview steps.
Dr. Anderson – Suggests including an annex with the essential components and the skills to do it.
Dr.Heather - We have to have an agnostic position as we do not know.
Dr. Chick - Opportunistic Identification. We should have to define what does opportunistic mean.
Dr. Anderson - We will include in the glossary.
Dr. Heather - Non treatment seeking population is the way.
Dr. Anderson - Systematic screening is structured in front of opportunistic. We have to find a nice way to describe it.
Dr. Boomsma - Include the possibility to mention that the follow up can be done in different ways (phone call).
Dr. Anderson - We do not have any evidence on the differences of BI among different professionals (nurses, physicians, etc.). We will have to include that point and the different follow up systems in the annex.
Dr. Heather - We got two models (that are going to be briefly described). These are hypothesis and evidence from Phase II. Early detected did better with brief advice and late detected did better with longer interventions.
GP must be offered a choice between the two models.
Dr. Anderson - Which is the precise model we are offering? Screened positive are offered Brief advice.
Dr. Heather – For those not motivated for doing any thing MI will be offered.
Dr. Gual – The annex must include How to do brief advice in a non threatening way? A little bit developed.
Dr. Heather - There is a consensus on how brief advice must be conducted.
Dr. Bendtsen - Hazardous drinkers must have as much advice than harmful drinkers? We have not included any reference to that.
Dr. Anderson - There is no evidence on that.
Dr. Berglund – Suggest including some graphs to show the evidence.
Dr. Anderson - On what basis should be offered treatment?
Dr. Heather - We have to offer it to everyone with risky drinking.
Dr. Anderson - How can we decide when someone is arisky drinker?
Dr. Bendtsen – When someone consumes up 20 gr. per day.
Dr. Heather - AUDIT is validated to detect in early stages
Dr. Pas - We suggest including something on assessment after screening. That's the point. At least frequency- quantity questions have to be included but if possible more. And then decide what to do.
Dr. Garmyn – We can proceed on cascade.
Dr. R Anderson - Do not rely on a score. All of these questionnaires are only guidelines we still rely on they clinical judgement.
Dr. Anderson - As GP they will need some more advice.
Dr. Chick - Men consuming more than 40 gr. per day or more than 280 gr. per week and women consuming more than 20 gr. per day or more than 140 gr. per week.
Dr. Kolsek - We have already decided what a hazardous drinker is?
Dr. Heather - We have said that AUDIT is a good questionnaire so we can offer that Brief Advice must be given to people up to a determined score.

Dr. Boomsma - The figure of the AUDIT is a good start to start talking on other problems and to do further assessment.
Dr. Garmyn - You have to do further assessment to know how much people is endangered of dependency.
Dr. Heather - Assessment if you have time and facilities but cut points are important.
Dr. Anderson. Cut points must be chosen from quantities per week and not only cut points from audit.
Dr. Heather – We have to go to the logical process.
Dr. Kolsek - GP need to give advice according to some cut points.
Dr. Bendtsen – There are differences among countries.
Dr. Gual - My feeling about the European Guidelines for GP is that we have to tell GP which is the figure of alcohol consumption and we have to fix it.
GP In south countries are not test friends. People prefer q-f questions. We will have to offer GP the opportunity to choose q-f and then the audit. Offer drinks per drinking occasion. We have to refer to country differences. We have to push for figures and try to homogenize activities all over Europe.
Dr. Chick - At the end of chapter 4 include the definitions from the epidemiological level: "These are the levels that the evidence show as hazardous …"
Dr. Bendtsen -Differences between hazardous and harmful. We will have to clarify levels.
Dr. Kolsek - What people think about level. In different countries this level of consumption must be too high.
Dr. Anderson - Differences in individual advice and public education campaign. These recommendations are individual advice.
Dr. Gual - We are not saying that there is safe alcohol consumption.
Dr. R. Anderson - How much people will benefit?
Dr. Heather - 15% of patients will benefit from it following OMS figures.
Dr. Chick - In the section how to do it include if patient not interested review in 6-8 months.
Dr. Pas - Where will be an assessment chapter included? We will have to include the specific training for doing it.
Dr. Anderson - It will be included in a separate chapter: the implementation.
Dr. Anderson - The final recommendation is accepted. GP should offer BI to all patients who might score and who will show problems … to reduce consumption to safe limits (offered in former chapter)
Dr. Chick – Suggests including that 15% of patients will likely to benefit
Dr. Heather - Include some more recommendations on Brief advice and MI.
Dr. Pas – Suggests including in all chapters answers in the recommendations to all questions given.

CHAPTER 8. COST EFFECTIVENESS OF BRIEF INTERVENTIONS

Dr. Anderson - Do we have to include a recommendation?
Dr. Pas -The cost for primary health practice must be included.
Dr. Anderson - More money must be reinvested in GP practices by Health Ministries.
Dr. Gual – It can be interesting to compare with tobacco and other general medical conditions
Dr. Chick – In Page 51 … more than any other alcohol policy measure … is related with graphs of WHO of global burden of disease.
Dr. Boomsma - The last sentence is the recommendation.

CHAPTER 9. ASSESSMENT
Dr. Pas – Suggests introducing for less problem simple advice and for larger problems larger advice.
Dr. Anderson – Suggests starting with some questions. Which person needs assessment? What can be done?

Dr. Gual - In the BI chapter we will have to clarify if you think you have to assess please refer to the alcohol dependence chapter where you can find the information.
Dr. Heather - Limits of the BI. We have to clarify which patients will benefit or not from BI. We can follow Babor suggestion on negative score to congratulate them on their health behaviour. Screening negative well done. Screening positive (look for complications if not) and brief advice or if yes see chapter. It can be also important to assess readiness for change and depression.
Dr. Bendtsen – After screening positive, we will have to assess to know if there are complications.
Dr. Heather - If you suspect that complications might occur do some assessment.
Dr. Anderson - When you are interviewing you might know the incidence of the alcohol in their life with no need of structured assessment.
Dr. Chick – Suggests following NIAAA model and linking it to the training manual.
Dr. Anderson - Assessment domains: harm, severity of dependence and readiness to change with some final recommendations.
Dr. Berglund - 3 out of 4 have been treated for depression before to arrive to the specialist setting. Assess some psychiatric symptoms in a very short way. Depression disorders for example.
Dr. Lidia - Use of other drugs.
Dr. Pas – Questions:

-What aspects must be considered at the initial assessment?
-What constitutes an effective assessment?
-Social context and consequences?
-What results for PHC?
-What results for specialist treatment?
- When should GP do it alone or do it in conjunction with specialist treatment?

Some of the answers must be country specific consensus?
Dr. Heather - How GP can do assessment must be clarified.
Dr. R. Anderson - Offers to follow a decision tree on how to assess developed in Ireland.
Dr. Pas - Offers to follow the decision tree they used.
Dr. Gual – Suggests as domains to be assessed: Problems/Dependence/ Readiness to change.
Dr. Heather - Difference between negative alcohol consequences and other psychiatric disorders.
Dr. Gual - There is no difference. You are not able to know when a problem starts as a consequence to alcohol consumption.
Dr. Anderson – We do not have to lose focus by going to far with this chapter.

CHAPTER 9. ALCOHOL DEPENDENCE.

Dr. Anderson - I do not want to discuss on it as much because it is only drafted but let's discuss the blocks.
Dr. Heather - What is clear is that we have to give them criteria to do referral. Why do we spend so much time giving details on treatment?
Dr. Pas - The consensus we have with specialist care is that GP must motivate patients for referral but they need to know what kind of treatment will be offered.
Dr. Kolsek - It is country specific.
Dr. Pas – No it isn't. We must offer the evidence we have.
Dr. Gual – Blocks have to be reorganized. Psychosocial interventions must come in the beginning
Dr. Anderson – Are the Blocks appropriate?
Dr. Chick - Keep the blocks but patient treatment matching could be one section.
Dr. Heather - Matching is inaccurate regarding the MATCH study. We have to offer some debate.
Dr. Gual - We can include the matching idea in the characteristics of effective intervention.
Dr. Anderson - Matching is too long and we have to bring some debate.

Dr. Heather - You won't see any big difference from accurate matching.
Dr. Chick - Page 58 clordiazepoide must be deleted because it is not accepted.
Dr. R. Anderson - When you have to call for home detox or hosp detox must be clearly stated.
Dr. Heather - To avoid too much details refer to other books or reviews.
Dr. Anderson – We have to include the essentials, we can say that you can refer but not being lacy.
Dr. Gual - Criteria for home detox or hosp detox. For GP is equal hosp detox to referral. Referral might come before detox.
Dr. Pas - In Dutch guidelines GP suggested to have home detox because some patients won't accept to go to hosp. Suggest to include some questions on criteria for home detox.
Dr. Boomsma - Some recommendations for elderly people must be included.
Dr. Chick - Do not recommend CIWA-R as a usual scale.
Dr. Heather – That there are effective and cost effective treatments for alcohol problems must be stated. Table abbreviated of different treatments. Latest version (third issue)of alcohol chapter from Bill Miller. I will send the chapter and if we want to reproduce it we will ask for editor's permission.
Dr. Berglund - 12 steps groups can be mentioned just to give the opportunity to GP to say that to some patients.
Dr. Gual - Do not refer to AA but to self-help groups.
Dr. Heather - Include that suggestion.
Dr. Pas - AA are not considered effective but self-help groups are.
Dr. Heather - It adds confusion. Mention 12 steps as preparation for attendance of alcoholics it helps to reorganize health style.
Dr. Anderson - A new section must be included.
Dr. Gual - SH groups. AA is the major example of SHG.
Dr. Heather - AA is world known SHG.
Dr. Anderson - SHG and AA
Dr. Heather - AA and other SHG
Dr. Gual – Ok
Dr. Chick – A reference to Al-Anon groups.
Dr. Heather – Some changes have to be introduced in the reference of MI
Some discussion on pharmachoterapies as topiramate (under clinical evaluation)
Dr. Gual - In psychosocial interventions it can be introduced the family aspects as therapeutic resource and as a source of problems. I do not know if we have to include some advice in how to deal with families.
Dr. Heather - What to do with wider families?
Dr. Heather - The aim is to clarify that there are effective treatments and to give some details on them.

CHAPTER 10. IMPLEMENTATION
Dr. Anderson - Much more information on attitudes on the providers and client's expectations are needed.
Dr. Pas - The sort of support that is needed is extremely important.
Dr. Heather - Important is to come out with a positive light.
Dr. Anderson - You can change provider's behaviour but you need to know their attitudes and behaviour to be able to change them.
Dr. Anderson – Do we have to include a Table?
Dr. Heather - Yes we need it.
Dr. Bendtsen - Table results were modest.
Dr. Pas - I would be much more specific in what issues training must be provided (BI and assessment). Training must refer to the attention in specialist care.
Dr. Heather - Last paragraph the reference to USA must be included?
Dr. Anderson - Refer to back and forth between services.
Dr. Heather - Refer to DRAMS study.

Dr. Anderson - It is a very good paper.

REFERENCES.
Dr. Anderson - Numbers or authors.
Dr. Heather - Numbers is fine.
Dr. Anderson - All references will be included at the end of the guidelines.

ANNEXES.
Dr. Heather - Audit as golden standard and the fast one (audit-c) and some instructions in how to complete it.
Dr. Garmyn -will review all the short versions that have been reviewed. There is no consensus on the best one. There are not country validations.
Dr. Pas - AUDIT is the golden standard. If you use it you will detect % of people. Using shorter versions we will detect less %.
Dr. Anderson - Framework for the BI Components (WHO and CME WEB)
Dr. R. Anderson - Flow charts on assessment will be welcomed

AGREE INSTRUMENT
The tool is reviewed. Each item is answered according to the CG procedure. Some suggestions have to be included in the final draft.

AUTHORSHIP
It will be stated "On behalf of the Phepa Project Team" in alphabetical order.

Third Meeting Barcelona
Agenda

PRIMARY HEALTH CARE EUROPEAN PROJECT ON ALCOHOL
Third PHEPA MEETING
BARCELONA 21-22 October

Thursday 21 October 2004

14:00h Welcome
Dr. Antoni Plasencia
Dr. Joan Colom

14:15h Introduction and objectives of the meeting
Discussion led by Dr. Peter Anderson

14:30h Plenary discussion of clinical guidelines
Discussion led by Dr. Peter Anderson

16:00h Coffee break

16:30h Plenary discussion of training manual
Discussion led by Dr. Antoni Gual

18.00h Close of the day

Friday 22 October 2004

Chair: Prof. Nick Heather

9:00h
- Administrative matters and discussion of other issues
- Evaluation of project
- Web site and Internet site database
  Lidia Segura
- Extension of project
  Dr. Peter Anderson

10:30h Coffee break

11:00h Introduction to group work
Dr. Peter Anderson

11:15h Three groups each to discuss country profiles and country strategies

13:00h Lunch

14:00h Report back from groups and general discussion
Dr. Peter Anderson

15:00h Coffee break

15:30h Next steps
Dr. Peter Anderson
Dr. Antoni Gual

16:30h Close of meeting
Dr. Joan Colom

Third Meeting Barcelona

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Third Meeting Barcelona

Minutes

Third PHEPA MEETING
BARCELONA 21-22 October

Welcome

Dr Plasencia, Director General of Public Health, welcomed all participants. He explained that alcohol is a public health priority for the Health Department of the Catalan Government (CG). He pointed out that Brief Intervention (BI) is between prevention/promotion and intervention activities and mentioned that CG wants to contribute to the wide implementation of BI in the alcohol field and that the CG wants to contribute to enhance the work in this direction. He finished by adding that the project products will help the CG to go further in introducing SBI in PHC settings and the PHC strategy. They will help to translate knowledge into practice. He finished by wishing participants a fruitful session and expressing the political and technical commitment of the Health Department (HD).

Dr. Colom, Director of the Program on Substance Abuse of the HD, welcomed all participants. He mentioned that the CG was extremely grateful to all participants for their contribution and participation. He pointed out the need to focus all attention to the Phepa Project. He mentioned the work done during the last two years (products just need final discussion, all Country Based Teams have been mobilized, four meetings that gathered together around 70 people from all Europe had been celebrated). He also mentioned some of the lessons learnt (Agreement at a European Level is not easy, two years project was too short). He added that the CG had requested the European Commission for an extension of the project and it has been approved. The extension would allow the improvement of the products and the proper achievement of the aims. He mentioned that the new deadline must be adhered to. He gave a brief overview on the agenda prepared for that meeting and gave also some remarks on logistics. Dr. Colom finished by saying that the Catalan Government commitment on the alcohol field is far from declining and mentioned the INEBRIA project. On behalf of the Health Department Catalan Government, Dr. Colom thanked everyone for their collaboration and support and wished everyone a fruitful meeting and a pleasant stay in Barcelona.

Introduction

Dr. Anderson invited participants to a round of introductions.

14.15h Introduction and objectives of the meeting
Discussion led by Dr. Anderson

Dr. Anderson presented the meeting objectives

- Discussion on the products
  - Clinical Guidelines
  - Training Manual
  - Internet database and website
- Discussion on project evaluation
- Discussion and country reports
- Revision on the next steps and to consider an application for 2005 call

14.30h Plenary discussion of clinical guidelines (CGs)
Discussion led by Dr. Anderson

Dr. Anderson apologised for not having completed them and for sending them so late. The CGs were reviewed in March and as a consequence they had been redrafted and restructured following the clinical questions that Dr. Pas kindly suggested.
Dr. Anderson explained that several products on the CGs will be prepared:
-Long technical document
-Summary document with chapter summaries and recommendations (5-6 pages with recommendations)
-Paper for publication based on above

Dr. Anderson also presented the next steps: The CGs will be finished by the end of December. They will be rewritten in a better format and an e-mail consultation will be circulated during January. Dr. Anderson invited all to have a general overview of the CGs and to discuss the contents chapter by chapter.

Discussion on the title

Prof. Heather suggested changing the title Screening and Brief Intervention in Primary Health Care. It was suggested to write in the beginning that this the CGs intend to cover SBI but acknowledging that since GPs should know about alcohol dependence (AD), some information will be also provided. Dr. Michaud suggested entitling it as CGs on the prevention and management of alcohol problems. Prof. Heather said that to put SBI in the title is really important. Dr. Codenotti suggested including a subtitle. Managing alcohol problems in PHC. Clinical guidelines on screening and brief intervention. Dr. Kolsek emphasized the need to include risky drinking in the title. Dr. Scafato said that it is difficult to translate risky drinking without changing meanings. Dr. Barfod suggested changing the word problems by alcohol field to be able to include everything. Some other suggestions presented were:
Intervening in alcohol risky consumption
Managing harmful and hazardous alcohol consumption.

Dr. Garmyn preferred not to use many words because they can scare everyone. He suggested including an introduction explaining everything. Alcohol and primary health care. CGs in SBI. Dr. Seppä introduced some comments on clarifying early identification or screening following the suggestions from the Who Phase-IV. Dr. Anderson suggested a working title like Alcohol and PHC. CGs for SBI. Dr. Pas asked for clarification between early systematic identification and opportunistic screening. He suggested using early identification and brief intervention. Dr. Seppä agreed on using the word identification. Finally the group approved the title: Alcohol and PHC. CGs on Identification and BI.

On the structure and order of chapters
Dr. Bendtsen suggested changing orders of chapters 10 and 11 and to put AD chapter as an annex. Dr. Michaud wanted the chapter of AD to be included at the end. Dr. Garmyn suggested keeping AD as a chapter and not as an annex because it will be seen as an artificial separation. Dr. Ribeiro explained that in Portugal people asks about AD. Dr. Seppä agreed that GP only want to know on addiction. Someone suggested that we are lost in addiction. Dr. Codenotti suggested including some information on why the AD chapter has been included. Dr. Anderson said that he would prefer a conclusion on AD.

Prof. Heather said that we should think of a continuous scale of alcohol problems. He mentioned that alcohol consumption and dependence are related. It is much simpler to say that GPs approach low dependence. When we use the word AD we are talking of physical dependence. Dr. Bischof told that the chapter must address the fact that individual who fails to abstain will need further approaches. The following question will

have to be done. Has the patient already tried to abstain without treatment? Dr. Pas suggested starting the whole document with the idea of a continuum recognizing the importance of AD and explaining that we have simplified it. Leave the AD as an annex at the end to be able to be customized in each country. It is difficult to do it at a European Level. Dr. Gual agreed with the idea of continuum. Dr. Kolsek said that AD has to be maintained as a short chapter.

Dr. Struzzo mentioned that Italian GP will need clarification on and what to do with these patients. Dr. Gual also mentioned that GP need to have information on how to manage AD people that refuse to go to treatment. Prof. Heather suggested not going back to AD. He also suggested putting it as an annex. Dr. Anderson suggested putting it as an Annex to allow countries to redesign it as they wish. Some explanation will be included at the beginning.

Discussion chapter by chapter

Summary, Chapter 1 (Introduction) and Chapter 2 (Methods to prepare the guidelines) will be finished later

Chapter 3. Describing Alcohol consumption and alcohol related harm

i. How should alcohol consumption be described?
ii. How can hazardous and harmful drinking and dependence on alcohol be described?
iii. What determines hazardous and harmful drinking and dependence on alcohol?

Dr. R Anderson asked if this chapter does have to include AD. Dr. Scafato answered that it has to include AD. Dr. Pas asked on the different alcohol consumption patters that need to be distinguish in PHC. Prof. Heather asked if binge is included. Dr. Anderson responded that binge has been included. Dr. Bendtsen suggested changing the clinical question 3. X into what different drinking patterns need to .....

Chapter 4. Alcohol and health.

i. What is the relationship between alcohol and the risk of ill-health?
ii. What is the relationship between alcohol and the risk of heart disease?
iii. Is moderate drinking risk free?
iv. How important is alcohol as a cause of ill-health?
v. Who is most at risk for alcohol-related ill-health?
vi. To what extent does reducing alcohol use lead to improvement in health?

Prof. Heather said that being Dr. Anderson one of the experts on the field he would suggest to leave it as it is and go on the discussion with other chapters. Dr. Bischof suggested suppressing point 4.2. and to include the information in 4.1.

Chapter 5. Should hazardous and harmful alcohol use be identified?

i. In which groups of patients should hazardous and harmful alcohol use be identified?
ii. What are the best questions or screening instruments to identify hazardous and harmful alcohol use?
iii. How should questions or screening instruments be administered?

Agreement achieved

Chapter 6. Biochemical tests

i. **Are biochemical tests useful for screening?**
ii. **Are biochemical tests useful for making a diagnosis?**
iii. **Are biochemical tests useful for monitoring progress?**

Agreement achieved

Chapter 7. Effectiveness of brief interventions

i. **Are brief interventions effective in reducing hazardous and harmful alcohol consumption?**
ii. **Are brief interventions effective in reducing alcohol related problems?**
iii. **For which type of patients are brief interventions effective?**
iv. **What are the components of effectiveness?**
v. **What should be done if brief interventions do not work?**

In point 7.5. something on what to do if BI does not work will has to be included. Dr. Bendtsen suggested including the components of SBI in a separate chapter. It was suggested to rename it as brief Interventions and its effectiveness. Prof. Heather asked if there was evidence on the effectiveness of dose dependent intervention but Dr. Anderson replied not much. Dr. Gual mentioned that components should be included at the beginning of the chapter.

Chapter 8. Costs and cost effectiveness of brief interventions

i. **What are the costs of screening and brief intervention programmes?**
ii. **What are the benefits of screening and brief intervention programmes?**
iii. **What is the cost effectiveness of brief interventions?**

Agreement achieved.

Chapter 9. Assessing the harm done by alcohol and alcohol dependence

i. **What patients need further assessment?**
ii. **How should assessment be undertaken?**
iii. **What are available assessment tools?**
iv. **What should be done on the basis of assessment?**
v. **When should specialized help be involved?**

Again it was mentioned that some parts of the chapter will have to be included as an annex. Prof. Heather mentioned that it was better to leave it like that and Dr. Anderson said that under his point of view it is well placed. Prof. Heather suggested changing the title. Dr. Bendtsen suggested putting it early before BI. Dr. Garmyn suggested separating the chapter if the AD was separated. Dr. Scafato said that it must be moved after the 5 chapter. Dr. Seppä suggested leaving the word assessment out because GPs do not use it. Dr. Anderson summarized that a shorten version of the Biochemical paragraph will be included in identification and the chapter of assessment will be put after the identification one. Dr. Scafato suggested that logical sequence is important in all documents. Dr. Anderson agreed in putting it earlier.

Chapter 10. Managing alcohol dependence

i. **What medication should be provided for acute withdrawal?**
ii. **Can help with withdrawal be provided in primary care?**
iii. **What risks are associated with withdrawal?**

iv. **What non-pharmacological treatments can be provided for alcohol dependence?**
v. **What pharmacological treatments can be provided for alcohol dependence?**
vi. **For which type of patients, are which treatments best?**
vii. **What about the role of self-help organizations, such as alcoholics anonymous?**
viii. **What is the role of primary care in managing alcohol dependence?**
ix. **How should the family be involved?**

It was agreed to put it as an annex. 10. viii must be 10.i. Dr. Gual commented that this chapter must be brief in purpose and stated at the very beginning (introduction) but he did not agree in putting it as an annex. Leo. Recommendations for what GPs should do with AD. Dr. Bischof mentioned to change 10 ix. How should family be helped and involved? Dr. Anderson replied that only some references on what can be done with AD will be included.

Chapter 11. Implementing screening and brief intervention programmes

i. **What are the conditions for effective involvement of primary health care providers in screening and brief intervention for hazardous and harmful alcohol consumption in primary care?**
ii. **What are the strategies for sustained involvement of primary health care providers in screening and brief intervention for hazardous and harmful alcohol consumption in primary care?**
iii. **What is the evidence for tailored made support to involve primary health care providers in screening and brief intervention for hazardous and harmful alcohol consumption?**
iv. **Should funders of health services provide funding for primary health care based screening and brief intervention programmes for hazardous and harmful alcohol consumption?**
v. **What tools are available to assess the adequacy of services?**

Dr. Scafato asked the reason of the chapter?

Dr. Anderson will draft CGs and circulate with two or three people gto get initial comments by e-mail.Prof. Berglund suggested including the last data of the American studies recently published.

The core parts of the products short summary (CGs) and objectives and session plans of the training manual (TM) will have to be translated and will have to be proven and agreed in all countries. List of partners interested in doing the translation by their own will be circulated.

Prof. Berglund asked if it was possible to use the draft and it was agreed that yes but since it was not finished it was mentioned that the responsibility was with those who used it.

16.30h Plenary discussion of training manual
Discussion led by Dr. Gual

Dr. Gual summarized that the TM was inspired by the skills of change and in the experience of the Beveu Menys (BM).

All sessions were reviewed. Dr. Allamani asked on the timing shown in the documents. Dr. Gual answered that the timing is based on the BM experience.

Session 1. Introduction

Slides on health and social costs might be short and evidence based. Dr. Kolsek commented that more emphasis has to be given to overall health diseases.

Dr. Gual suggested deleting the slides related with heart diseases and including some on combined risks. Dr. Michaud mentioned that the risk limits in France are different to those presented in the training manual. It will produce some confusion. We have used 21 and 14 drinks because they are the cut-off scores more used in the different studies. We will have to refer to the evidence. In our adaptation we are going to use 21 and 14 levels. Some commented to leave the limits on a national level. Dr. Gual mentioned that safe levels were agreed to be deleted in Leiden and that only risk had to be addressed. The lower we put the limits the higher the resistance of the GP. Dr. Pas suggested introducing a statement on the differences in each country. He mentioned to include also a statement clarifying that this is not a safe limit (low does not mean safe). It is agreed to include in the introduction some information on customization in each country. Dr. Bendtsen suggested leaving the figures out but it was not agreed.

Dr. Gual. TM will have to be written in accordance to the CGs definitions on hazardous and harmful alcohol consumption. In the different countries, health authorities will include some national recommendations. Dr. Garmyn said that products have to talk about safe limits but it does not mean that it is safety following the example of road speed. Cut offs are artefacts and each country will have their own limits. There is a statistical relation between alcohol consumption and risk. Dr. Bendtsen said that a simple message has to be given for GP sitting in front of the people. Some suggested deleting the column and solving the problem in the CGs. Dr. Anderson didn't agree with that idea.

Dr. Scafato said that the scores of the instruments that are used to screen have to be included. Dr. Gual resumed that it will be clarified in the CGs. Dr. Scafato suggested that Dalys have to be better explained. Including them in %.

Dr. Ribeiro asked on the possibility to include other references to what happens if they ask for more exercises. Including some ideas on parallel exercises.

Second session. Screening.

Prof. Heather suggested remaining in NNT instead on NNS. Since NNT in depression are similar it will motivate them.

References will have to be included in all slides.

Dr. Pas suggested including an introduction telling about teaching and learning styles and explaining the need of being interactive and in participative ways. He also suggested putting slide 24 in place 11 and deleting number 11.

Dr. Seppä talked about the clarification on screening and identification. She said that it will be better to clarify the effects we are comparing in Slide 21. The question is: Are they comparable?

Dr. Pas suggested giving more advice in how to explore the alcohol consumption because the use of standardized instruments is difficult. Dr. Gual answered that three instruments will be introduced giving professionals alternatives.

Third Session: brief advice

Dr. Heather clarified that brief advice (BA) is the minimum intervention that everyone is expected to do and that we are talking about brief intervention (BI). He suggested distinguishing between BI and BA.

Dr. Michaud showed some reluctance on Motivational Interview (MI). It is not able to introduce MI in PHC settings. Dr. Gual answered that MI is introduced to give some elements on the therapeutic style.

Dr. Pas suggested including some comments on additional formation to achieve the goal.

Dr. Michaud suggested including a role playing in the first session to led participants practice between sessions. Dr. Gual agreed to include a simulated interview in the first session.

Dr. Sepaa said that since only half of patients will be motivated; it will be a good idea to give some references of brief advice. Dr. Gual said that if that is the case, professionals will have to raise concern in patients.

Dr. Bendtsen suggested including two different levels of intervention and introducing that idea in the introduction. He said that basic simple advice is effective (minimal intervention will have to be included). Two levels: simple advice and BI. He also mentioned the possibility to introduce one session on simple advice. Some suggested using simple advice instead of brief advice.

Dr. R. Anderson asked what to do when things do not work? He mentioned that nothing was said on that. Dr Gual mentioned that this issue will be addressed in the last session.

Dr. Gual and Dr. Anderson agreed on introducing the intervention sessions with some advice on how teach it depending the time

Dr. Pas suggested sharing with Dr. Gual all national positions in this point to allow Dr. Gual to briefly address them in the very beginning.

Dr. Martin suggested thinking on the possibility to use the training manual with students. Dr. Ribeiro agreed on that and suggested training at both undergraduate and postgraduate levels.

Dr. Gual finished saying that the material is going to be a package to be customized at a national level. Comments on the rest of the sessions not discussed will be welcomed by e-mail.

Friday
9.00h Administrative matters and discussion of other issues
Evaluation of project
Web site and Internet site database
Lidia Segura

Administrative matters
On the second Payment to countries it was clarified that it will be done after the receipt of the final draft of the country based strategy. It will include:

- Reimbursement to members if document with signatures of the two meetings has been submitted
- Costs of room booking up to 420 euros if invoice has been sent to us

Evaluation of project
The evaluation questionnaire had been previously sent by e-mail. Its contents were presented and discussion was opened.

- Instructions
- Role

- Leadership
- Administration and Management
- Decision-making
- Benefits And Costs
- Communication
- Conflicts
- Members Participation
- Members Satisfaction
- Achievement of the aims of the project
- Products of the project

The questionnaire was accepted but some people said that it contained some overlapping questions. It was agreed to provide the feedback anonymously through Prof. Heather.

Web site

Website was presented and the current structure explained. It was explained that the current website is provisional and that it had been developed with the information we had received, but that the contents will be updated after the meeting. It was also commented that the future website will include the following information in the space dedicated to introduce the status of the countries

-Assessment tool
-Country Based Team: partners and collaborators
-Country report
-Important links and references
-Any other documents considered important by Country Based Teams.

Participants were asked:

-to provide some feedback on the structure and general contents but especially on the information about countries.
- to provide some contact details of the members of the country based teams willing to be included in the website

Internet database

The agreement achieved in Leiden on collaborators of the internet database was presented.

-Definitions and Terminology: Catalan Team
-Alcohol and health: Dr. Anderson
-Screening: Dr. Gual
-Biological Markers: Dr. Chick
-Brief Interventions: Dr. Heather
-Cost effectiveness: Dr Anderson
- Assessment: Nick Heather and Phillipe Michaud will think of some candidates
-Alcohol Dependence: Not decided
-Implementation: Peter Anderson and Miranda Laurant

The database was agreed to be finished once guidelines completed

Extension of project

Dr. Anderson

Dr. Anderson informed to everyone on the extension of the project. He explained that the EC had accepted a 6-month extension for the project and that no extra-funds will be raised. The extension will allow us to finish properly the products. The new deadline is planed for 1/07/2005 but cannot be expired.

11.00h Introduction to group work
Dr. Anderson

Dr. Anderson summarized the status of the products to be developed by each country and the country information sampled by now. There is a huge amount of information from each country.

	Barriers and advances 2003 meeting	Preliminary questionnaire 2003	ECAS chapter	WHO alcohol profile	WHO alcohol policy	Assessment form 2004	Country report 2004
Belgium	√	√	√	√	√		√
Bulgaria	√	√		√	√	√	
Catalonia	√	√	√	√	√	√	
Czech Republic	√	√	√	√	√	√	
Denmark	√	√	√	√	√	√	
England	√		√	√	√	√	√
Finland	√	√	√	√	√	√	
France	√	√	√	√	√		
Germany	√	√	√	√	√	√	√
Greece	√	√	√	√	√		
Hungary	√		√	√	√		
Ireland	√	√	√	√	√	√	√
Italy	√	√	√	√	√	√	√
Netherlands	√	√	√	√	√	√	√
Poland	√	√	√	√	√		
Portugal	√	√	√	√	√		
Slovenia	√	√	√	√	√	√	
Sweden	√	√	√	√	√	√	

11.15h Three groups each to discuss country profiles and country strategies

The discussion was agreed to be done in plenary session

Dr. Anderson asked the followings questions:
Given the wealth of material, what should we do with it over the next 9 months?
Are you willing to complete the assessment form and the country report?
Shall we make a publishable book with country chapters and summary chapters?
If so, what models should we use (WHO reports, ECAS report or what?)
If so, how do we get the country chapters completed and what should be their content?
Shall we place all the information on the website, and if so, in what format?

Some suggestions rose:
-to publish papers through a tabular form provided by the website
-to publish some variables at the website through comparative tables
-to summarize the results of the main results and variables allowing the action of the member states
-to publish a working paper for PHEPA
-to show by comparison where countries are

Dr. Pas mentioned that he has not oriented the country strategy taking into account young people. He also asked for clarification on the participation of Flanders instead of Belgium. Dr. Anderson clarified that we do not need to focus only in youth but some comments on that will be welcomed. No demonstration will be needed.

Dr. R. Anderson mentioned that in terms of publishing he'll prefer to publish the Ireland Strategy Report instead of the assessment tool results since it was difficult to answer it and he is not sure of its reliability. Dr. Anderson mentioned that he will circulate the assessment tool to everyone after redesigning it. He said that the assessment is a very useful working document. Dr. Heather mentioned that if the strategy will be public it will have to be less critical. Suggested writing two versions: public and non-public. Dr. Anderson mentioned that ECAS book is the opinion of the people who wrote the book and that the expertise on this is not the commitment of the government. Dr. Scafato said that he won't have any problem if the Italian strategy is published. It was agreed that different versions can be written. The idea is be as much honest as you can without causing problems but the more critical you can be the better. Dr. Bendtsen mentioned that it will depend on the members of the team and their affiliation. If there is any conflict of interest have to be declared. Dr. Heather mentioned that even though the governments do not endorse the country strategy, it has to be developed.

Dr. Ribeiro asked on the proper network of professionals needed to have a good assessment and strategy.

Dr. Kantchelov mentioned that his government won't have any national strategy only some regulations to limit alcohol advertising.

It was agreed:
1/Dr. Anderson will contact to everyone individually to try to clarify on the country strategy.
2/ The end of January will be the deadline.
3/ Information from the phaseiv introduction can be used but not duplicated.
Some examples already finished will be circulated, confidential, to help everyone to finish the work. Section 7 is the key section.
4/Strategies can be already used at a national level.

Next Steps
Guidelines
-Next draft will be prepared during January/February 2005.
-Some of you will be asked to address some comments.
-Comments March and revised and April/May 2005 final draft.
-Summary and publishable paper will be also circulated.
-Summary will have to be translated.

Training Manual.
-Similar process. Revised again before Christmas.
-Send to you and language editing.
-Comments January/February.
-Final comment.
-Dr. Gual will say what need to be translated.
-Only one manual.

Web. Together with the notes, Ms. Segura will precisely explain what we need from the web.

Evaluation
-Questionnaire will be circulated early New Year.
-To be completed January/February.
-Anonymously will be shown by sending it to Dr. Heather in two envelopes.

Assessment tool
-The assessment tool will be redesigned to those that have not finished it yet.
-Finish it by the end of the year.

Country reports
-Draft copies of Italy, England and Ireland will be circulated.
-March completed strategies.

Meetings
-Another meeting in May depending on fundings…!!!
-At the Inebria Meeting a Phepa Workshop on strategies will be a good option to share and discuss on strategies. It will be included in the agenda of Inebria to exchange experiences.