PROPOSAL FOR A BELGIAN STRATEGY
TO PROMOTE INTERVENTIONS FOR RISKY ALCOHOL USE IN PRIMARY CARE

COUNTRY TEAM CONTRIBUTION BELGIUM
Primary Healthcare European Project on Alcohol

EU Study 2003-2004

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Table of Contents

1. Introduction

1.1 Aims

During the Phepa project (2003-2004) a project was run and coordinated by the Scientific Society of Flemish GP to develop a broadly based consensus about a Belgian strategy for effective health promotion against hazardous and harmful alcohol use to be supported at different levels of the Belgian society (Federal, Community, Provinces, Health promotion districts and municipalities).

1.2. Methodology

During the first year of the Phepa Project (2003) data were collected about the Belgian situation using existent databases and a core team was convened to clarify expectations of different key actors involved in a health promotion strategy about alcohol.

A descriptive overview of existing policy and projects in Flanders and French Speaking Belgian Community was presented in a half day meeting organised 1 April 2004 in the form of a press conference to start a broad consensus procedure involving VAD, Provincial Platforms, Ministries and professional groups about the best way to promote PHC involvement in early identification, brief interventions and regional promotional activities related to alcohol.

In the development of this consensus all relevant parties and the Ministries of Health of Communities and Federal State were invited to take part actively. Two country based team meetings were held 27 May 2004 and 9 November 2004 to discuss idea's and materials available.

Documents were circulated through the website of WVVH and SSMG and distributed to all who expressed their interest after the press conference, through webreply or after direct postal contact.

A modified web-based Delphi methodology was then followed through the internet and post in 2004 to allow both participants of the country meetings and other interested instances to express their opinion on key questions identified (see annexes)

This exchange of materials and presentations at country based meetings and the consecutive consensus procedure form the basis of following policy proposal. Many team members have actively contributed to data collection, analysis of policies and development of the statements or amending the principles forwarded. Discussions were subsequently mainly summarised by B Dor and synthesised to this country report by L Pas.

The Scientific Society of Flemish GP now proposes to its partners to organise a national meeting in autumn 2005 to further promote the implementation of this policy proposal in parallel to the agreement on guidelines on dealing with alcohol problems in primary care in line with Phepa proposal. The following initiatives promoting implementation of the policy have already been taken :

- Flemish guideline proposals are now submitted for validation to selected Belgian experts from different disciplines in Flanders (Taskforce Prevention WVVH, June 2005)
- Proposals for a stepwise procedure for GP-motivation and training will be tested in one province as a pilot project in 2005-2006 (Flemish Brabant).

Materials for a provincial population communication strategy have been developed during the run of the Phepa project by a working group in the province of Flemish Brabant and are submitted for approval 9 th June to the Provincial Platform on Addiction.

- A proposal was submitted by WVVH to the Belgian Federal Knowledge Centre to apply a simulation model to estimate costs and outcome of this implementation strategy (14 th May 2005).

A more comprehensive implementation programme for quality assurance taking into acccount not only primary care contribution but the overall set of measures retained in this report will be discussed with relevant Belgian authorities and partners.

1.3. Background situation and constitution of main country team

The Flemish team of WVVH has tested a strategy to facilitate diffusion into general practice as part of the phase III and IV of the WHO collaborative study (Pas et Al, 1998) . It has also developed in the past years a guideline for dealing with risky alcohol use oriented to Flemish general practice submitted now to selected Belgian experts.

In French speaking Belgium a training programme on alcohol detection and counseling has been developed by the SSMG and was further supported by the Walloon region and the province of Liège. Dr B Dor participated actively in organising the French community contacts for the country team in collaboration with the SSMG.

In each linguistic community different instances and bodies are involved in planning alcohol and drug policy, collecting indicators. Among these the VAD (Flemish Association against Alcohol and drugs) regularly provides overviews of Flemish and Belgian data about alcohol and drug policy in Flanders (E De Donder 2004) and was represented in the country team preparing this strategy by M Geirnaerts, director.

In Flanders a community based strategy is promoted in local health promotion areas.
Local prevention workers situated at municipality level or in mental health deal jointly with alcohol and other drug issues. These workers are supported and trained by VAD.
At district level alcohol policy is coordinated for several health promotion areas in provincial platforms for alcohol and drugs. The platform of Flemish Brabant was represented in the country team by C Caubergs.

In Brussels and Walloon region a recent decrete allows the creation of similar networks which are not yet very developped. However health promotion is stimulated by the provinces. Several provinces and observatories collaborated to the country team meetings and consensusdevelopment.

Finally Prof Pacolet HIVA- leuven joined the team : his team contributed with a major economic analysis of policy development (Degreef et aL, 2002, 2003).

1.5. Practical approach

A discussion paper summarising the situation in Belgium was prepared by the coordinator. This was discussed in a small preparative meeting with the core team to further enhance the process in spring 2003.

A proposal for a comprehensive strategy related to alcohol only was then formulated as a first step to submit to policymakers in our country. However our partners in the Flemish mental health sector preferred not to submit a manifest specifically oriented towards alcohol alone. After adaptation of the concept it appeared possible to develop a broad consensus based on scientific evidence

Following this discussion scientific evidence about safe use, the effectiveness of early identification and brief intervention and proposals for task-definition between primary and mental health care and policy development were gathered and submitted to press in a press-conference 1th April 2004.

A promotional strategy was followed among different professional groups. A reaction was obtained in particular from pharmacists.
The following bodies reacted further: Ministry of the Flemish and French Community and Walloon region, Federal Ministry of Health, Federal Ministry of Economics, several provinces and parliament delegates.
A first country meeting was then organised on 27th May 2004 where key organisations shared their view on levels of responsibility within a health promotion policy oriented towards youth and adults. A first policy statement was developed during the day to indicate ways how possible actors in primary care from general practice, school medicine, workplace and mental health can collaborate and how a joint alcohol policy can be defined with special interest for primary care involvement.

The results of this meeting were submitted by email, post and web to in questoion format to participants, all those who expressed interest and was specifically sent to a large number of mental care facilities. Reactions were collected and scored according to a modified Delphi methodology submitted for further discussion at a second country meeting on 9th of November 2004.

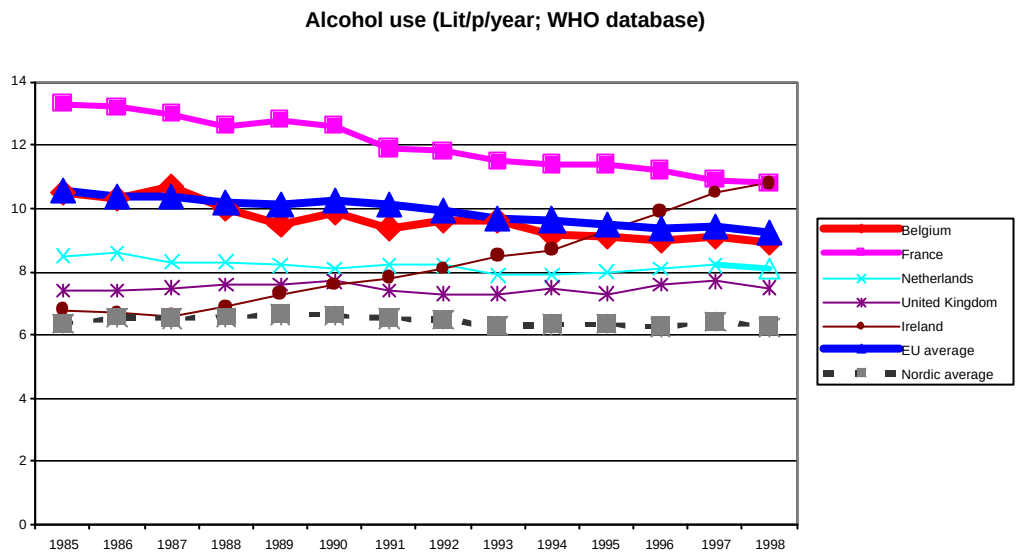
This report is based on the combination of data and literature review and synthetises the discussions at these country meetings into a common policy. A third meeting is now proposed later in 2005 to discuss with representatives of all relevant public bodies the support to implementation of the proposed policy.

Summary of time frame

Preparation of background documents	Dec 2003 -March 2004
Invitation to other bodies and politicians	March 2004
Press conference launching coutry meetings	1 April 2004
Website disclosure data	April 2004
First country based team meeting	27 May 2004
Interactive consensus procedure:	June – december 2004
Draft policy document	October 2004
Second country based team meeting	9 November 2004
Policy principles approval by Gen Assembly WVVH	3 December 2004
Report to EU	31 May 2005

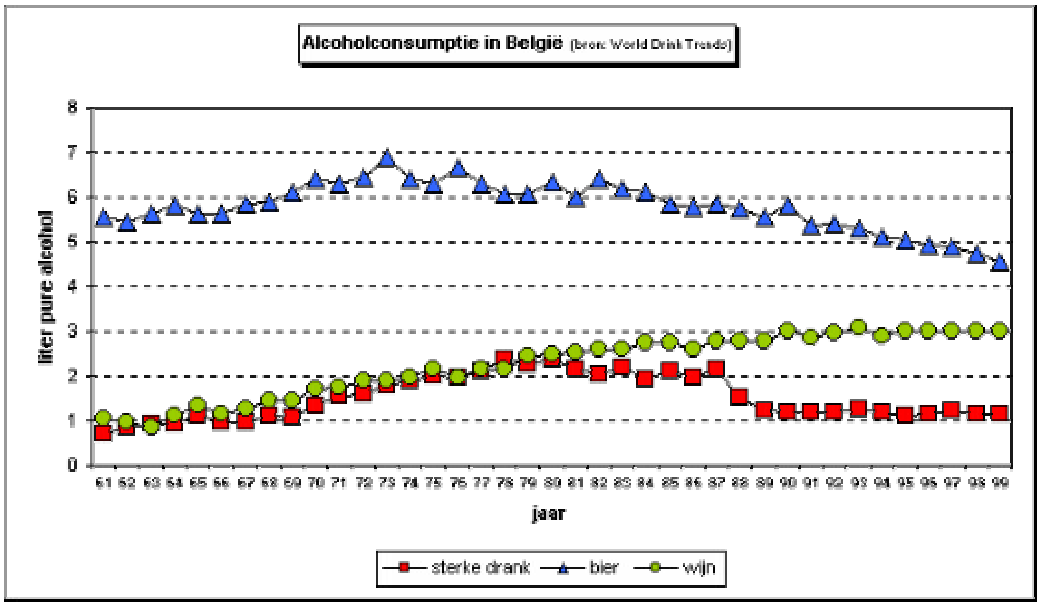
2. Consumption patterns

The consumption of Belgium expressed as liters of pure alcohol per capita is intermediate between the level of our neigbouring countries and decreases slightly compared to the EU mean , but remains well above Nordic and UK values (see figure).



Source : WHO health for all database on web country (data download 2003).

This decrease is the joint result of an increased wine consumption and decrease of beer.



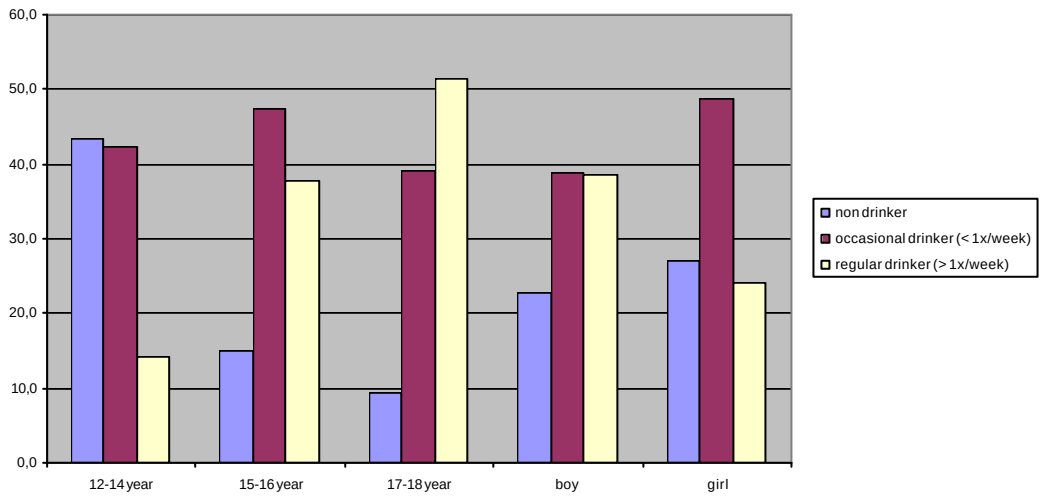
Source : World drink trends.
Red (rectangular) : strong alcoholic beaverages; blue (triangle) beer; green (circle) : wine

The risk for alcohol related harm increases steadily when **women** drink **more than an average of 14 glasses of alcohol per week** or **men more than 21** glasses/ week. Such use leads to personal problems of development, family problems, problems in public or at work and increases all risk mortality. It is referred to as hazardous alcohol use. Based on screening tests using Audit questionnaires in Flanders such use exists for one in five male adolescents and one in ten women.

Population surveys and calculations from household consumption analysis are available in Belgium to further support the estimation of the size of **harmful alcohol use**. Using the criterion of 6 glasses (> 61 gram alcohol/day) for men and 41 gram (4 glasses/d) for women population surveys estimate the prevalence of such 'problem drinkers' at 1,8% of male and 1% of female population. However using family budget analysis as methodology the consumption of 6 glasses per capita per day or more is estimated at about 11% of the adult population above 15 years of age which is consistent with an estimation of 10 litres of pure alcohol per person of OECD database.[i]
Alcohol misuse and dependence (as defined accoring to DSM-IV-criteria) was also estimated using standardised diagnostic tests (CIDI) amounting to 8 % of adult population in a Flemish screening study [ii].

A population survey in the province of Luxemburg by the Psychiatric Platform of Luxemburg shows moreover a life prevalence of 30% for alcohol-related problems. This study was replicated in the province of Liège and found similar firgures (29,4%, 1998)[iii].

alcohol use among schoolchildren 2001



In Flanders more then 50 % of all help related to drug abuse in mental health is related to

Source : VAD school enquiry 2001, report 2003

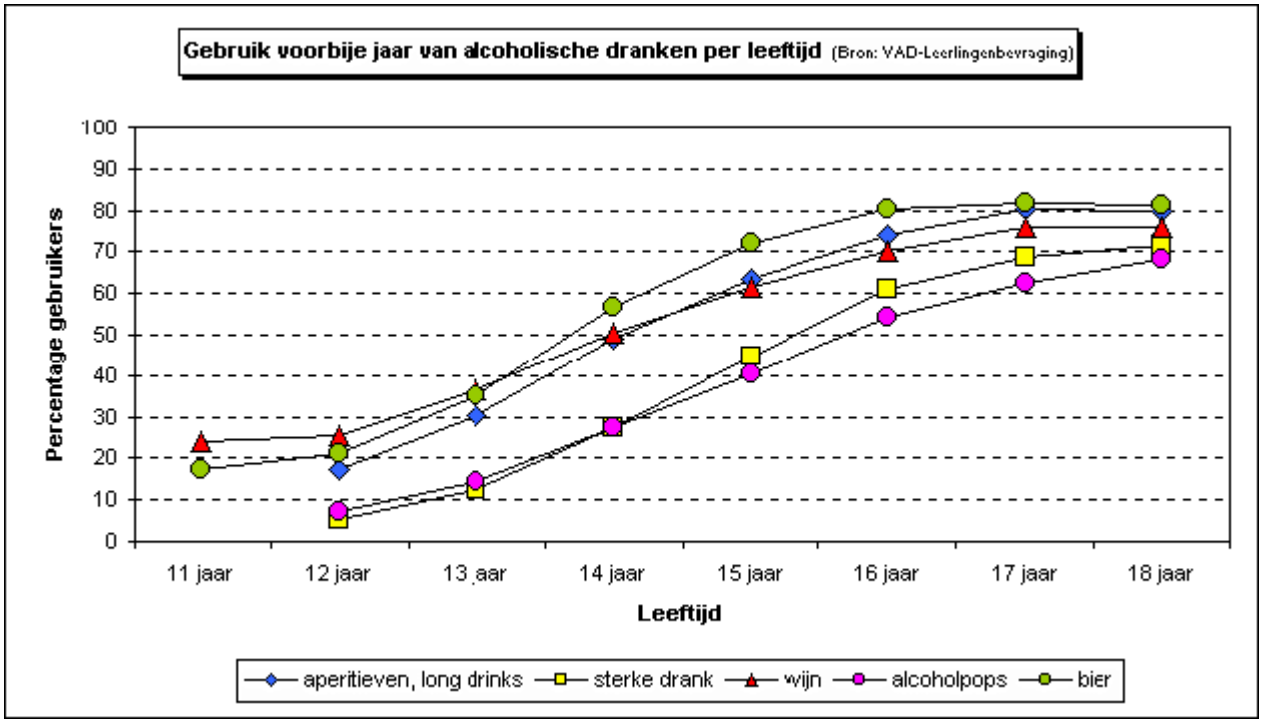
Alcohol problems [iv].

Overuse of alcohol also exists among children.

The mean starting age to use alcohol is before tobacco and other drugs. It was shown that the earlier drinking starts the higher the risk for alcohol related problems later in life [v]. The number of regular drinkers is higher in all age groups

than other substance use [vi]. Monthly drunkeness occurs among one in five boys and one in ten girls from 15 years onwards.
The same data from 2001 show that two thirds of adolescents between 19 and 22 years are drunk at least once, and 23% monthly [vii]. These data have since been confirmed in several local studies (Cogge 2003,Province Limburg 2003, Jespers et AL 2004 (Antwerp Sego II study)).

Among children the variety of drinks is increasing and particularly most drinking children are increasingly trying alcopops and experiment with stronger alcohol drinks.



1 % users in 2001 of alcohol per age category (gender standardised data)

2

3 Source : VAD enquiry 2001, data 2003

3. Harm and costs caused by alcohol

3.1 Effects of alcohol consumption

It is is estimated that about **ten percent of all avoidable death** in Belgium is related to alcohol [viii] and was increasing during the 90's, mainly related to death in the age group above 45 years. The number of potential life years lost is 5-6 times higher in Flanders for alcohol than for drug use : alcohol causes for men 2,4 Life Years Lost in 1000 person-years(2 % of total Life Years Lost (TLYL)); drugs caused in 2000 0,6 Life years Lost per 1000 personyears (0,5 % of TLYL). For women figures are lower but still comparable: alcohol causes 1,5 % of TLYL (1,2 / 1000 personyears) and drugs 0,2 % (0,16/1 000 personyears).

8,5 % of all **accidents** and 10,2 % of all heavy accidents on the road **were associated with alcohol use** [ix]. 6% of working people would have an alcohol problem and 30% of all accidents in the workplace may be related to alcohol (Rehn 2001 [XVI])

One third of accidents **in private life** for men and one in eight for women are related to alcohol or drugs [10].

Depression and suicide are also related to overuse of alcohol [x]. International data indicate that one on three cases is related to alcohol use. It is estimated in Flanders that to mortality figures given above 12,4 % of all suicide cases should be added.

Sentinel network data in Belgium show that alcohol use is related to violence , for perpetrators as well as among victims [xi].

Social and family aspects of hazardous use mentioned in Belgium[xii] are consistent with international literature and relate to absence from work, unemployment, social consequences of early death, consequences of accidents, crime and police related costs, overload of the justice system,... . It was estimated that 20% of all crimes are committed under the influence of alcohol, increasing to 40% of violent crimes (Rehn 2001 [XVI])

3.2 Economic consequences

A recent Belgian estimation is summarised in the next table. The gross social cost for alcohol is estimated at 6 billion euros per year or 2,25% of Gross National Product.
Direct costs for the labour market are 2,2 billion € (loss of productivity and increase of unemployment). Accidents on the road are related to 1,5 billion euros. Costs for health care are estimated at 0,5 billion euros, or 0,23 % of GNP.
Possible earnings by alcohol industry for employment and transfers amount to 1,5 miljard €. This brings the total net cost for the Belgian society of alcohol consumption to 4,5 billion € per year [xiii].

Summary of costs and profits related to alcohol consumption

	Sociaal (=privaat+extern)											
	Privaat				Extern						Total sociaal	
	Drinkers		Niet drinkers		Overheid		Bedrijven		Total extern			
	Cost	Profit	Cost	Profit	Cost	Profit	Cost	Profit	Cost	Profit	Cost	Profit
1. Health care	3,809	1,408			18,174	6,097			18,174	6,097	21,984	7,506
2. Circulation	43,727		12,230		2,6				14,830		58,557	
3. Work	10,225				46,764		31,495		78,259		88,484	
4. Other direct costs					2,024				2,024		2,024	
5. Indirect effects	50,687	20,994			8,379	3,037			8,379	3,037	59,066	24,031
6. Economic Profits						19,348				19,348		19,348
7. Transfers	0,963	10,178			10,178	0,963			10,178	0,963	11,140	11,140
Total	109,4	32,580	12,230		88,119	29,445	31,495		131,844	29,445	241,255	62,025

source : Degreef T , Pacolet J, Bouten R, 2003.

4. Development of an alcohol policy in Belgium

Effective policy measures retained in the European Alcohol Action Plan and documented extensively in international publications[xiv] [xv] were reviewed by the country team in two meetings.

To develop such a comprehensive policy the federal structure of the Belgian state should be taken into account, where economic policy, police control and repression, legislative and employment related policy are mainly dealt with at Federal level, while prevention, information and social care are related to the competencies of Community level.
The country meeting suggests that the drug unit coordinating substance policy between different federal departments should pay particular attention to alcohol as a mayor topic.

4.1 Price and Tax Policy in Belgium.

In 1999 taxes and VAT amounted to 53% of social profit related to alcohol [IV]. As a result of the drug nota public attention was diverted from alcohol and a major effort was given at federal state level by the ministry of health to tobacco and tobacco use restrictions.
The country team suggests that efforts are made in this area as most studies indicate that increase in price results in an decrease in alcohol consumption, but that this is embedded in a more conprehensive strategy on availability of alcohol to special groups and in special situations (See : Degreef T et Al. 2003, p78).

4.2 Regulating physical availability of alcohol.

The ECAS report compares the alcohol consumption and mortality in relation to alcohol control policy in 15 EU countries. Belgium is situated in the middle between wine-producing countries on the one hand and Nordic countries on the other hand (Osterberg & Karlsson 2001). In a discussion on possible strategies in the Belgian society Degreef et al (2003) indicate a number of measures which may increase the Belgian control policy : control of detailing possibilities, limiting time-availability of dispensing hours and days, defining age limits for consumption etc.

4.3 Modifying the drinking environment

In relation to this policy the relative absence of alcohol policy in the working environment was highlighted by a recent enquiry among companies with more than 50 employes (Annemans L, 2003). 216 Belgian companies from different sectors were investigated about their alcohol - and drug policy; only 10% had a defined policy in this regard. In 6 out of 10 companies alcohol use is tolerated during lunch and working meetings, while most would react by licensing workers manifesting problems rather than promoting adequate treatment and adapting widespread availability in the company.

4.4 Advertising, promotion and sponsorship.

Controls on advertising on television and radio are restricted according to European directives (89/552/EEC). Belgium has an additional ban on showing pregnant women. However for printed media and billboards restriction is based on a voluntary code for different alcohol beaverages in line with other central European Western countries (Rehn et Al. 2001). Health warnings are not needed on advertisements. No regulation exists on sponsorship of young people's leisure time and youth parties and activities are often sponsored by happy hours paid by industry.

4.5 Drinking and driving

In this regard Belgium is also at the mean of the EU countries, the allowed BAC is defined at 0,5 gr alc/l blood (°/°°), while a number of mainly nordic European countries have already accepted a zero tolerance level.
An active policy for road security resulted during the years 2003-2004 in doubling the number of road controls at the end of the year from 41601 in 2002 to 88.987 in 2004. In the first year of this increased control (2003, 83.627 tests) this resulted in an increased percentage of alcohol positive test (5,7 in 2002 to 9,9% in 2003); in the year afterwards the positive tests dropped to 5,4%.[xvi] This policy should continue and efforts should be made to distribute the controls more throughout the year.

4.6 Managing alcohol related harm: help and care

Care is provided in Belgium in a lage variety of settings paid for either by national social insurance system (general practice, general and psychiatric hospitals) and ministry of welfare and prevention of the linguistic communities (Centres for mental health, Youth centres, Family Centers) or districts (Regional platforms). In addition a number of voluntary organisations are active in this field (AA, Al Anon mainly).
An analysis of care provided was made by Degreef, Pacolet et al (2002) allowing estimation of workload related to alcohol problems in care sector :

Alcohol related workload (in % of total workload) (Degreef, Pacolet et al (2002))

General practitioners	2
Specialist care	2
Centers of mental health	*17*
Drugfree centers	13
Youth informtion and advice	*21*
Centres for live and family problems	*14*
Regional concertation platforms	*48*
Voluntary organisations	75
General and acute hospital care	2,25
Psychiatric Hospital care	24,5
Psychiatry care centres	3,4
Protected living centres	11,0
Other health care	2,25

Instances which are paid for by the linguistic communities are indicated in italics

This indicates that 20-25% of professional resources in mental health care are devoted to alcohol care. Similarely to other topics in psychosocial care alcohol should therefore receive an increased attention in public information and policy.

It should be stressed that 11,7 % of people consulting in the social sector in Flanders have dependency problems, but the type of substance abuse can not be defined from registration data, nor can these data actually be recovered from emergency care data.
One in ten (9,7%) of special youth services deal regularly with children with alcohol related problems. [xvii]

Focus group research by WVVH further indicates that communication between primary care and mental health care to deal with serious 'cases' needs special attention, setting targets for dependency care among special mental services and putting more emphasis on primary care involevement in dealing with hazardous use. Furthermore care after hospitalisation needs to be actively pursued by practitioners to improve relapse prevention. A tentative role description of specialist care and practitioners care has been described and should receive more attention in the future [xviii].

4.7 Increasing public awareness

Population campaigns.

Vad has developed in Flanders in the last 4 years a stepwise promotion strategy about alcohol aimed at youth, adolescents and the adult population. Information leaflets and website address the issue in a language adapted to the target population. Materials are distributed mainly for educational purposes and local action action through the network or-f prevention wrokers in local community actions. Linked to this is a professional training package for intermediate professional contacts in the social care, primary care and mental care sector.

In the French speaking provinces several initiatives have taken place. An experiment with a bus ('Kotabus') was presented at the country meetings by the province of Liège and a recent broad conference was launched aimed at alcohol use among youth organisations. No central support or coordination of such activities exists as in the Flemish Commmunity.

Supporting 'intermediate' professional groups

In Flanders a registration of preventive activity by VAD provides an overview of local health promotion activities on drug and alcohol by municipality or mental health centered prevention work[xviii],[xix]. This registration of preventive activities does not distinguish between drug dependency and alcohol.
Contributing prevention workers provide advice and training to other professional groups. Most activities are oriented towards developing school policies (mainly in secundary schools (children >11 years age). Developing intersectorial collaboration through discussion between mental health, health care and social work is a second main topic. Activities in the working place receive increasing attention (+105 % in 2004.

Consensus by Delphi study after the meetings in the project

Suggested communication strategy to the public

a. Content :

1. Defining risky consumption in clear messages

3.1.1.1.1**Risky consumption should be clearly defined in uniform messages by public bodies Supporting these messages is the role for the medias.**

2. **Integrating into one concept of « healthy life style » or one specific message on alcohol must be considered as well the local appraoch of healthy life-style as the specific approach to alcohol problems is needed due to the complexity and specific aspects of it.**
3. **Other issues should be raised :**

a. zero tolerance when driving is proposed by some
b. safety in the workplace
c. exemplary role of educators and leading persons
d. talking to each other
e. talking to professionals

b. Format :

An attractive, ongoing campaign should be financed which is innovative
The persons own responsability must be stimulated, e.g. autotests through Internet are proposed.

Municipal level responsibilities

Educational sector , schools sector, socio-cultural sector, professional sector, leisure, sports, social wellbeing and public order are involved in a comprehensive approach. The municipalities are believed to integrate all these aspects. Networking with local agents is the strategy proposed in Flanders.
Municipalities can initiate a local action plan, can free budgetary means and meeting space.
A policy at municipality level should draw attention at municipal level to hazardous alcohol use, not only during end of the year festivities and through police controls on the roads, but also during sport-, socio-cultural and professional activites.
Prevention workers with a definite employment status should be available in all muncipalities to promote such a policy.
The population should be informed locally about the possibilities of care.
Restaurant- and barkeepers should receive information about the acceptable selling attitude.
Local municipality youth policy can further promote the independence of youth organisations from sponsorship by beaverage industry.
Follow-up of living and social needs should be part of the local policy towards high risk groups.

Intermediate level

A provincial coordinator for alcohol and drugs is available in Flandres. But also in the French speaking part of Belgium most provinces have a plan for substance abuse in which due atttention should be given to alcohol. Provinces could stimulate evaluation and action research, finance pilot projects before a national strategy starts and coordinate and support early identification campaigns.
At health promotion district support for professional (GPs, nurses, pharmacists...) and lay workers should be provided (information, training and coordination) on a continuous basis. Indeed to promote dealing with alcohol problems a continuous effort is required.
Such actions should also address nursing and social assistance (cf This model proved successful in Wallonie (Project RAT) for care with drug addicts by social workers with a formation provided ad hoc).
Youth movements equally have a role to play. Provincial campaigns could repeat messages pooven effective elsewhere : messages should be repeated, translated to be integrated.
Inclusion of alcohol as a special topic for local actions, e.g. by financial support and materials, should help to keep the topic under continued attention.
In Flemish Brabant a working group has developed information leaflets and training of intermediate social carers has started.
KOTTABOS is a prevention play tool transported to local communities in a bus and is aimed at the youth, but was submitted successfully to companies by the Province of Liège.

At federal level

At federal level income of alcohol taxation should be reiterated into health promotion. Dispensing and publicity about alcohol to youth should be limited and regulated.
The federal state can promote shared care by fincancing collaboration initiatives between health care sector, mental health and social sector.
For the latter in particular coordination with the linguistic communities and regions is needed. More in general coordination of economic, justice, social care, education and security must form part of a interministerial alcoholplan on federal and community level, consistent with the European Alcohol Actieplan.

Active local collaboration between mental health and social sector is needed to deal with complex alcohol related problems. Based on discussion a scientifically based approach must be promoted. This multidisciplinary approach can only succeed if training and discussions bewteen the care providers is supported by financial means for coordination and representation of all concerned professional groups.

The context in which alcohol problems occur must equally recieve sufficient attention in alcohol policy. Activites of youth-, sport- and socio-cultural organisations may not depend to selling of drinks.

Politicians and public officers are required to dispel the myths about alcohol: festivities can also be enjoyable without large amounts of alcohol.
Political parties should put an active approach to alcohol related problems on their agenda.

Replies to the consensus statements of the Belgan delphi approach :

1. Multifaceted Health Policy :

- 80% indicate that collaboration between different political bodies is essential
- 70% insist on the necessity for provincial support of professional groups
- 70% indicate that adaptations of legislation about working situation and alcohol are needed
- 65% for the necessity to organsie road controls during the whole year
- 65% state that a specific budget should be attributed to alcohol policy eventually trhough a defined quota of tax income from alcohol.
- 65% insist to take into consideration social problems, family and economic origins related to problematic alcohol use.
- 60% indicate that socio-cultural activities and groups should not be dependent on selling of alcohlic beaverages ; they favor the positive promotion of alcohol free drinks and provision of free non alcoholic drinks to youth

3.1.1.1.2II. Communication strategy

- Two thirds (65%) want to specifically stress improving communication with youth in particular by increasing competence of teachers and youth workers which could favor change of behaviour (60%) and to stimulate the youth to look for help actively (55%).
- the information disseminated should stress the usefulness of screening and care for excessive drinkers (50%) and be adapted to the situation and target public (road safety, pregnant women, youth,work...) (65%)
- In particular the media should provide a clear and similar messages
- Finally the exemplary role of publicly responsible persons should be promoted at public activities and festivities.

3.1.1.1.3III. Early detection and brief interventon

- 70% insist on the central role of the general practitioner for early detection and care for the risky drinker. To this end specific competences must be promoted and basic medical training and CME on alcohol must be stimulated

5. Effects of interventions in primary care

5.1 Effective screening and brief advice in Belgian general practice

Several meta-analyses show the effectiveness of early detection [xx] . Such tests have been validated in the Belgian context [xxi] and several shorter alternative screening tests exist[xxii].

Brief advice and counselling in general practice is well studied and effective for hazardous alcohol use [xxiii].

The international collaborative phase III WHO-trial to which Flemish GP participated, indicates that facilitating of early detection and advice also is feasible among Belgian GP.[xxiv]
Marketing strategies and outreach visits used positively influence involvement of practitioners in different health service settings[xxv]. International and Flemish experience indicate that for continued application in general practice more efforts are needed.

Likewise a study of the SSMG (Probex) after training showed a reduction of hazardous alcohol use among 32% of counselled patients in French speaking Belgian general practice. From 2001 to 2003 a project was supported by the French Community and Walloon Region; 30 GP applied
the AUDIT questionnaire and briefly counselled their patients. This yielded 2077 questionnaires with 515 (25%) screen positive cases, resulting in a diagnosis of 30% alcohol-dependent patients, 30% harmful drinkers without dependence and 30% hazardous drinkers, while 10% did not have an alcohol problem. After 18 months data on 268 patients showed improvement for 39% unchanged use for 44% and increased problems in 17%. 51% of hazardous drinkers, 55% of harmful drinkers and 23,5% of alcohol-dependent users were abstinent after 18 months. The doctor- patient relationship improved in 30% of patients, was unchanged for 58% and deteriorated for 12% of them.

REPEX, another SMMG-study performed in Belgium, Switerland and France evaluated 3 questionnaires 'FACE', 'AUDIT' and AUDIT integrated into a general questionnaire. In Belgium 2173 patients were included and 1246 eligible retained. Intensity of application of screening test, patient acceptability and feasibility judged by the physician were best for the shorter FACE. 95% screening rate for FACE, compared to 75% for AUDIT and 69,4% for general questionnaire. At this stage 600 GP have been trained with the material used in the French community.

5.2 Cost-utility and balancing between different strategies in the Belgian context.

Cost-utility of screening and brief interventions in primary care settings is internationally well documented[xxvi]. A clinical detection approach in emergency care followed with counselling has equally favorable results[xxvii].

Priority setting and balancing between different health promotion strategies on alcohol was debated at the two country meetings. Prof Pacolet summarised the findings of his department [I,XIV]. In summary not one, but many different issues

should consitute a comprehensive health promotion policy on alcohol. A synergy between different instances and strategies should be pursued of which each will contribute something. This is based on the fact that costs stem from different sectors in which initiatives should be taken.

In the field of alcohol evaluation is not yet hindered in the Belgian situation by a large variety of different initiatives on health promotion. An experimental approach is suggested before a national polcy is generalised. Using modelling, the relative importance of different initiatives could be monitored and defined from available Belgian data.

Three complementary strategies were retained by the country team

1. A multifaceted Health Policy consisting of a mix of price and tax policy, structural measures and regulations about availability and dispensing (mainly federal state repsonsibilities).

2. A communication strategy towards the public containing information on moderate drinking levels and on HOW and TO WHOM to talk about alcohol. The title suggested is « Alcohol, opening the dialogue » [Alcohol, spreek met elkaar (Dutch title); Alcohol parlons-en (French title)] . This mainly constitutes community and regional responsibilities, but the absolute necessity is recognised to deliver concrete and unequivocal information in a concerted way between different levels of public authorities.

3. An early detection strategy in primary care coupled to brief interventions and shared care with mental health facilities for alcohol dependency.

5.3. Implementation

Screening and brief interventions

Metaanalysis shows, that introduction has best results when initiated from the professional group itself. The strategy should take into account attitudes of practitioners[xxviii xxix] and difficulties arising in actual health service provision should be taken into account[xxx].
Some country team members suggested that screening questions should be adapted to different age groups. Student versions have been tested in Belgium and may be chosen in relevant services (Aertgeerts, Buntinx, Bande Knops, 2000).

In general practice an array of choice should be provided to GP for different forms of early detection and counselling. Embedding this approach in an overall policy for dealing with alcohol problems is also requested by GP independently from health service settings[xxxi].

Materials have been readily developed in the Flemish and French communities towards general practitioners. They need to be entererd in the regular training and CME activities of practitioners.

Population communication strategy

Population strategies should encourage problematic drinkers to consult. A strategy oriented to intermediate target groups seems a useful adjunct, such as parents and educators. Another potentially promising approach is self-evaluation using internet and waiting room displays. Such stretegies should be added to the programme at regional level due to differences in acceptability of the approach in different regions.

Different age groups should also be specifically addressed. A comprehensive policy should involve ministries of Education, Sport and culture, Social welfare at community level. The VAD has developed in Flanders specific educational material towards different age groups in the past. Major efforts have been made in the French region towards younger people as well.
The main effort of general practice based interventions will be oriented towards the adult population however.

Shared care between mental health and general practice

Collaboration with mental health care in case of alcohol-dependency appears an important issue to be taken good care of according to a Flemish dephi study work. Direct practice support to general practice and collaboration with emergency care is proposed.

During the country meeting it was stressed that giving consumption objectives should be coupled to information on possible care. This seems mainly possible within a trusty relationship allowing increasing consciousness about the situation. This is a clear role for general practice before referring alcohol-dependent people to specialist care.

Primary prevention and detection strategies should always be supported by coherent care afterwards. Alcohol is linked to principal diagnosis in one third of hospital and ambulatory care and half of patients in mental health care. Its prevalence is well above that of all other dependencies and drugs.

Coordination of care is needed and networks should further be promoted.

Insufficient specific structures of institutionalised care for alcoholic people may be a problem in the Belgian setting. On the other hand, it was also noted by specialised care, that many patients in aftercare in the Belgian situation do not have a GP : tertiary preventive initiatives should be developed and adherence to primary care promoted.

Other primary care actors

All different professions in primary care need due attention. Focus group work with nurses and physiotherapists in Flanders has shown that they are willing to be involved in referring people, but would not easily engage in brief interventions themselves. In the French community a positive experiment was run involving social assistants in counselling of drug addicts, which suggests a similar possibility for alcohol also (RAT experience). Moreover a social care policy should attack risk situations such as isolation, marginalisation etc. measures should be pursued to avoid appearance of alcohol over-consumption and addiction

Working place to be explored as a potential target

A sensitisation of the workplace regarding alcohol problems is progressively taking place.
A screening initiative in the workplace resulted in a lower detection rate than in primary care [xxxii] , possibly explained by less honesty in the answers.
Dealing with lifestyle issues is less evident for occupational officers, who are intermediate between management and employees. Unless safety is concerned, dealing with lifestyle is less evident, and often dependent on the Doctor's initiative. On the other hand 6% workers with alcohol problems may result in 20% to 25% productivity loss, 1% of GNP!
The Belgian country team recognises the potentiality of the workplace as a possible area for alcohol-related action, but not necessarily as the most adequate place for screening and brief interventions.

Responsibilities for a community strategy in Belgium

Discussion at the country meeting indicated that in different ministries the alcohol problems are well identified, but a coordinated approach should be developed between different ministerial departments for a broadly based alcohol policy.
Although prevention is a Community responsibility in our federal state, many issues are dealt with in ministerial departments at federal level, such as taxation, reimbursement and accreditation for CME, practice organisation of primary care and and pilot projects on mental health home care. Additional areas are occupational health, justice, raod and general security etc.

The recently installed coordination drug cell might serve as a basis to develop an alcohol policy.
Involvement of primary care advisers would be needed towards development of a Primary care oriented specific programme. Specific priority to alcohol is also needed, without neglecting other drugs problems.

Global keywords for any action are: intersectorial, participatory and ongoing. Four sectors for action are considered complementary: involvement of care sector in detection and counselling, regulation and control (control, police, justice), prevention and health promotion.

Following targets and responsibilities are involved as indicated by VAD: school population (Community Ministers of education), general public (Community ministers of Social Well-being and Health), professionals (Federal Min of health and for preventive issues Community Min of Health), working population (Federal and Community ministers of Work), taxes (Federal Minister of finances and economic affairs), legal issues (Min of Justice and parliamentary action): a concerted policy should be developed in an inter-ministerial approach.

6. Current policies and activities

6.1. Alcohol Legislation

Major attention is given at this stage in Belgian Society to illegal drug and tobacco in the Belgian context. The country meeting suggested in particular new legal initiatives for dispensing alcohol to youths.

6.2. Interventions in Primary Health Care

The SSMG has developed a conference package on screening on alcohol and brief advice.
The WVVH has developed the materials used in the drink less programme of WHO trial and adapted it based on focus group research in the local setting.
Furthermore documentation about alcohol effects, screenings tests, counselling and training package is available from VAD which can be used by prevention workers of mental health to train a variety of intermediate professionals at primary care level.

7. Integrating interventions in primary health care

7.1 Principles

The choice is given to the physician between several screening procedures on one hand, short advice or taking into account the stages of behavioural change on the other hand.
Clinical signals as entry to detection is the minimum standard forwarded. However attention to repeated or suspect trauma in emergency care as well as short versions of screening questionnaires will be actively promoted.

7.2. Practice based guidelines, protocols and aids

The WVVH has developed a guideline draft according to local rules which are now submitted in June 2005 to Belgian experts. This guideline will be experimentally submitted in autumn to Local quality groups after refining the text according to the final PHEPA guidelines and expert opinion.

A handbook has been developed for local quality group animators to discuss types of
Alcohol dependence, to analyse different cases and to discuss shared care with local mental health officers. It is integrated into two programmes for more comprehensive continuing medical education : training about the non medicinal approaches of psycho social problems (including among other topics depression, suicide, violence) and health behaviour change (Tobacco, exercise, diet,...).

Several practice materials will be available for download from the web , including different types of screening questionnaires. A practice summary card already provides the essentials of this approach which is integrated into a comprehensive strategy for health behaviour change.

Our French colleagues plan to use existing foreign guidelines as background documents. The feasibility study performed with Swiss and French colleagues suggest that a short version of screening questionnaires should be promoted. Materials will be available form the SSMG web.

7.3. Training

A philosophy for stepwise introduction is proposed in Flanders : motivation and knowledge transfer at GP CME-circle level, skills training in small GP groups.

For GP circle level a motivating talk is proposed, hinging on different types of alcohol overuse, detection strategies and evidence for effectiveness and introduction to concepts of behavioural change and shared care.

At quality circle level more interactive case discussions and exercises about supporting health behaviour change are available for application.

At individual level web-based information display and practice materials are provided.

7.4 Engaging Primary Health Care Providers

Experience shows the need for active promotion of new themes proposed by CME.
Embedding alcohol in two other more comprehensive programmes in Flanders aims attention to the topic of a larger group. In the French speaking community grouping of training toward Quality circle animators is a possible way to spread the programme after a pilot development area-wise (e.g at provincial level).
Outreach visiting after telephone marketing about needs and interests have been proposed according the earlier experiences in Flanders. A script should be developed taking into account different attitudes of GP. Outreach visits will also serve to maintain interest and continued application as will regular adaptation of the website and practice materials.

7.5 Funding

Materials have now been developed within regular convention with the linguistic communities or regions for the early pilot-work in the Flemish and French communities. In comparison to international standards the budgets used are low. Additional funding for outreaching and monitoring needs to be found.
At this moment financing has been realised by using existing budgets for health promotion and a major part of voluntary work. Provisions should be made for adequate financial input into a demonstration project from potential sponsors. These may come from community level, federal level and provincial level as well as some minor additional sources (e.g. pharmaceutical companies if needed).
A pilot experiment in the Province Flemish Brabant for communication strategy at local level allows for creation of population material used in local municipality based actions run by regularly engaged prevention workers.
A proposal was recently entered to the Federal kenniscentrer to promote interest in a cost utility study at national level about alcohol. If this is retained it would allow us to monitor the cost utility of a demonstration project.
To develop a long-lasting national strategy regular finances would be needed on the longer run. Budgetary consequences could be defined from a well monitored pilot project.

7.6 Specialist support and knowledge centres

Collaboration with VAD and prevention workers in mental health care will allow to include local representatives in discussions on shared care. Such collaboration can be planned at provincial and project level as is already done in other programmes on mental health CME in Flanders. The French community has recently created possibilities for regional networks on care for addicts. This may serve as a basis to create such coordination in the French community.

In the French community CME tend to take the form of less interactive and more centralised programme for training. This will be reflected in the coordination and involvement of specialised experts. A coordination of care for alcohol and drug problems does not exist at community level in the French community and region. In a large scale project aiming at a target area a specific coordinating body may need to be created in the project.

7.7 Monitoring the Programme

Police data and mental health care registrations and hospital clinical data are available databases which may provide data for monitoring of incidence of alcohol related problems. Data are regularly reviewed by VAD in Flanders. Regional splitting of data would allow to differentiate between areas for active intervention and the other 'control' areas.
Process descriptions of CME activities and efforts to reach GP need to be gathered additionally by organising bodies. A registration proposal is proposed to the sentinel network of GP, but acceptance is not necessarily granted for 2006-2007.
Additional data will be needed from primary care or population level to judge in a demonstration project or study area. This may take the form of a telephone survey among a random sample of population and GP. Such a survey has been piloted successfully already in 2000 in one health promotion area in Flanders.
Practice registration data about alcohol were not retained in a consensus procedure started in 2004 by the Flemish Task group on Prevention for regional follow-up of preventive activity. However such data may be promoted in a demonstration project provided some return can be planned on financial basis to contributing GP. If target payment could be obtained as additional incentive by the health authorities in a demonstration project this may help to collect directly adequate data.

7.8. Managing the Programme

One young practitioner has been recruited per province by WVVH to coordinate and stimulate the Flemish programme on dealing with psychosocial CME. They will actively approach GP animators of CME activities to promote the programme uptake. General practitioners organisations will coordinate the programme at each Community level towards GP, but work in close collaboration with preventive workers in mental health and health promotion areas (LOGO's).
At regional level in Flanders the provincial platforms will continue their coordination of the the overall community oriented communication strategy and training initiatives towards intermediate professional groups outside general practice.

A small core scientific steering group comparable to the core group of the country team and with any other interested main organisation involved (e.g. Belgian Association on Alcohology, Association of pharmacists) can further support the different arms of the project at Community and national level.
Such coordination will be agreed upon with the partners as soon as funding bodies provide the possibility to prepare a demonstration project.

8. Research Questions

- How can lasting early identification and brief interventions (EIBI) be implemented at primary care level in Belgium?

- How can continuing professional development on alcohol best be promoted in the two linguistic communities?
- Is outreaching a cost effective modality to stimulate lasting involvement of practices in Belgium?
- How does the community action help to promote GP involvement ?
- How can shared care and case management be organised well in the Belgian health care setting?
- How can new technologies be used to promote identification and counselling of hazardous alcohol users?
- Is target payment a possible modality for stimulation of EIBI in our liberal health service setting?
- How can monitoring be developed in Belgium on a practice friendly and effective way using existent resources? What additional data should supplementary be collected and how can data collection be harmonised?

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We would like to also thank the continued effort of the core team during the whole run of the project from 2003 onwards, in particular the support of the secretariat of WVVH and SSMG.

10. Annexes

1. : Participation to Belgian country based team
2. : Selected presentations
2. : Summary of second country team meeting (French version)
3. : Summary submitted to General Assembly WVVH

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Primary Health Care European Project on Alcohol (PHEPA)

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

STRATEGY FOR CATALONIA

Contents

1. Introduction

Catalonia is one of the 17 autonomous communities in Spain and with an area of 32,000 km) is organized in 40 counties and is located on the north east coast of the country. By the end of 2002 the Catalan population was 6,704,000 of whom 3,419,040 (51 %) were females and 310,307 (4.8%) legal foreign residents. The age distribution in the population was: 14% less than 15 years old, 68.7% between 15 and 64 years old and 17.3% over 65 years old. The population density was 210 inh/km^2. Active population is 3.050.000 and unemployment rate was of 9.2% (6.8% among males and 12.7% among females and 18.6% among <25 years old). Population with tertiary studies were 18% and 9% of the university students are devoted to health sciences.

Catalonia had 5 beds and 4.7 doctors per 1.000 inhabitants (inhabitants per doctor 213) GDP per inhabitant was 20,444€. Life expectancy at birth was 76.9 for males and 83.3 for females. Main causes of death are those related with circulatory system (287.7 per 100.000 inh), neoplasia (250.7 per 100,000 inh) and transport accidents (13.5 per 100.000 inh)[xxxiii].

In 2003, a total of 198,417 (70% for males and 30% for females) years of life were lost because of premature death among population between 1 and 70 years old. Infant mortality rate (per 1,000 live births) was of 3.3. Life expectancy in Catalan men is reduced by car accidents, cancer of trachea, bronchi and lung and cardiovascular diseases. In women reduction is caused by breast cancer followed by car accidents and cancer of trachea, bronchi and lung. Suicide appears in 4th place among the causes of premature death in both males and females. A 5% of the total mortality was avoidable (7.5% among males and 24 among females)[xxxiv].

The Generalitat is the institution in which the self-government of Catalonia is politically organised since democracy was restored in 1977. The government of Catalonia is divided into 16 Departments and the Health Department is responsible for health and its budget is 34.2% of the total expenditure of the Government. The Catalan Parliament was authorized to legislate on all aspects of Health. The Catalan health care model was established in 1990 under the LOSC (the Health Care Organisation in Catalonia Act). The LOSC created the Catalan Health Service (CatSalut) consolidated a mixed health system, organized all the areas of health care products and health services and integrated in a single network the public use of all health resources (hospitals, primary health care, mental health, etc.) CatSalut is the public health service cover provider in Catalonia and guarantees the provision of health services to the public. Catsalut plans, purchases and assesses health services according to the population's needs. Catsalut purchases services from its various service providers, of which the Catalan Health Institute (ISC) is the main one, through the use of contracts which state the health objectives and the services being bought. The Catalan health system is a publicly-funded system with comprehensive coverage and which all the citizens of Catalonia are able to access[xxxv].

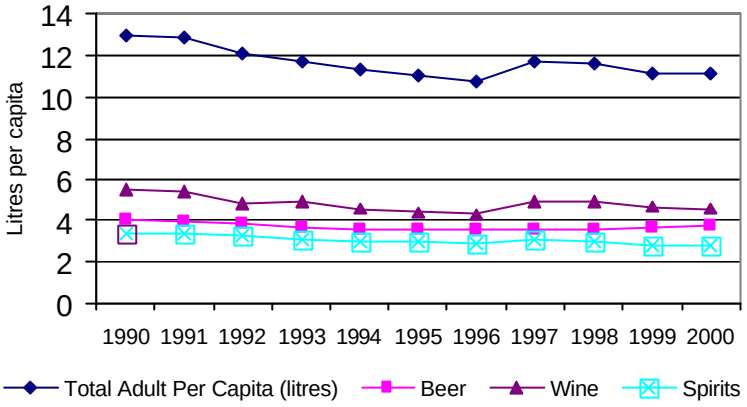
Primary Health Care (PHC) is citizens' first level of access to the health care system and there are 347 PHC centres spread all around the territory. Around 80% of the PHC centres are managed by the ISC while the rest are managed by other private organisations. PHC centres are composed by multidisciplinary teams and integrate health promotion strategies with preventive and curative interventions. In 2003, the mean inhabitants assigned to each physician was 1,663 and to each nurse was 1,670. The mean consultations per professional and per day was 31. The mean visits per inhabitant and year was of 6.5. Around 75% of the total number of adult inhabitants consults to their physician. 90.5% of the total PHC centres reported doing screening on excessive alcohol consumption[xxxvi].

Specialist health care is citizens' second level of access to the health care system. It includes hospital admissions, social health, psychiatric and mental health care, drug dependency and pharmaceutical care. Most of these resources are organised in networks and they are complementary. In 2001 Catalonia had 65 hospitals (17 with psychiatry units and 11 with hospital based detoxification units), with 15,000 beds, which admitted 664,000 inpatients, 9 million outpatient visits and 3 million emergencies[3].

2. The use of alcohol[1]

Annual per capita alcohol consumption has decreased in the last 10 years (see figure 1)[xxxvii].

Figure 1. Adult per capita alcohol consumption in litres of pure alcohol (15 years +)



As in other Mediterranean countries, wine consumption is culturally rooted in Catalan nutritional habits. According to the World Drink Trends, in 2002, Spain with 9.6 l was located in eighth place in adult per capita alcohol consumption (in litres of pure alcohol)[xxxviii].

In the European league table (of 15 countries), Spain was in 2002 in the last position for the percentage of people who have drunk alcohol in the previous month, in 3rd place regarding the number of days on which alcohol was drunk, and in 11th place regarding number of drinks per day[xxxix].

In 2003 the prevalence of any alcohol consumption in the last month was 67,7% in the Catalan population (15-65 years) and 72% among youth (15-29 years)[xl]. Table 1 and 2 show a steady increase in alcohol consumption and in risky drinkers among both genders since 1999.

[1] Additional information on alcohol use can be found at Global Alcohol Database. Country data on alcohol
available at: http://www3.who.int/whosis/menu.cfm?path=whosis,topics,alcohol&language=english

Table 1. Alcohol consumption trends in Catalonia

		1999			2001			2003		
		M	F	T	M	F	T	M	F	T
Once in life										
	15-29 years	77,0	84,6	81,0	89,4	81,1	85,3	93,2	86,9	90,2
	15-65 years (*)	84,6	79,5	82,1	90,4	82,1	86,3	93,9	85,7	89,9
In the last year										
	15-29 years	74,6	79,3	76,9	83,5	71,6	77,7	85,4	76,6	81,1
	15-65 years (*)	78,3	69,2	73,7	80,2	70,6	75,4	83,5	70,7	77,2
In the last 30 days										
	15-29 years	65,7	61,8	63,8	70,0	55,3	62,8	76,4	67,4	72,0
	15-65 years (*)	72,6	51,8	62,2	70,4	51,8	61,1	76,0	59,2	67,7

In 2003, the prevalence of risky drinkers was 9.5% (11.8% males and 7.8% females) of the Catalan population between 15-65 years. Among youth between 15-29 years, 12.7% were risky drinkers (12.1% males and 13.3% females).

Table 2. Trends in patterns of alcohol consumption in Catalonia

		1999			2001			2003		
		M	F	T	M	F	T	M	F	T
15-29 years	Abstainers (1)	39,9	43,4	41,6	30,7	48,8	39,7	24,9	35,1	29,8
	Low risk (2)	51,1	50,7	50,9	60,4	44,1	52,3	63,0	51,6	57,5
	Risky Drinkers (3)	9,0	5,9	7,5	8,9	7,1	8,0	12,1	13,3	12,7
	Total	100	100	100	100	100	100	100	100	100
15-65 years*	Abstainers (1)	31,2	51,0	41,1	30,5	44,7	37,4	24,8	42,5	33,5
	Low risk (2)	60,1	44,9	52,5	59,4	44,5	52,2	64,1	49,7	57,0
	Risky Drinkers (3)	8,7	4,0	6,4	10,1	10,8	10,4	11,1	7,8	9,5
	Total	100	100	100	100	100	100	100	100	100

17.8% of the Catalan people aged between 15 and 65 years old reported having had alcohol intoxications (more than 5 drinks/ occasion) at least once in the last 30 days. Of them 3.4% reported having had intoxications every week[8]. Among scholars the rate reported (at least one in the last 30 days) was of 24.7% for the same period of time.

In short, alcohol consumption patterns are now more similar to other European Countries, females have increased their alcohol consumption and young people drink mostly during weekends and in leisure activities, and drink more beer than wine.

In 1999 an analysis on the risk of risky drinkers was carried out with the data available from the national household survey. The following tables (3-7) show the differences found among risky drinkers and non-risky drinkers in the different characteristics: demographics, alcohol consumption, substance use, health attitudes and perceptions.

Table 3. Sample characteristics

	Complete sample		Women		Men	
	Risky drinker	Non-risky drinker	Risky drinker	Non-risky drinker	Risky drinker	Non-risky drinker
Characteristics of respondents	*N (%)*	*N (%)*	*N (%)*	*N (%)*	*N (%)*	*N (%)*
Total sample	1191 (9.5)	11297 (90.5)	531 (7.9)	6172 (92.1)	660 (11.4)	5125 (88.6)
Marital Status						
Single	630 (52.9)	4668 (41.3)	284 (53.5)	2182 (35.4)	346 (52.4)	2486 (48.5)
Married	490 (41.1)	5915 (52.4)	213 (40.1)	3458 (56)	277 (42)	2457 (47.9)
Divorced	53 (4.5)	351 (3.1)	24 (4.5)	227 (3.7)	29 (4.4)	124 (2.4)
Widowed	18 (1.5)	346 (3.1)	10 (1.9)	295 (4.8)	8 (1.2)	51 (1)
Convivence Status						
Alone	139 (11.7)	879 (7.8)	53 (10)	434 (7)	86 (13)	445 (8.7)
With the partner	508 (42.7)	5897 (52.2)	222 (41.8)	3415 (55.3)	286 (43.3)	2482 (48.4)
With others (parents, children, etc.)	540 (45.3)	4460 (39.5)	253 (47.6)	2296 (37.2)	287 (43.5)	2164 (42.2)
Education						
Primary education	456 (38.3)	5576 (49.4)	176 (33.1)	3132 (50.7)	280 (42.4)	2444 (47.7)
Secundary education	368 (30.9)	3130 (27.7)	144 (27.1)	1592 (25.8)	224 (33.9)	1538 (30)
Terciary education	310 (26)	2026 (17.9)	183 (34.5)	1072 (17.4)	127 (19.2)	954 (18.6)
Employment Status						
Employed	739 (62)	5836 (51.7)	262 (49.3)	2361 (38.3)	477 (72.3)	2361 (67.8)
Unemployed	117 (9.8)	959 (8.5)	52 (9.8)	563 (9.1)	65 (9.8)	396 (7.7)
Retired	42 (3.5)	620 (5.5)	11 (2)	164 (2.7)	31 (4.7)	456 (8.9)
Student	189 (15.9)	1627 (14.4)	106 (20)	881 (14.3)	83 (12.6)	746 (14.6)
Home-maker	99 (8.3)	2168 (19.2)	99 (18.6)	2157 (34.9)		11 (0.2)
	Mean (sd)	*Mean (sd)*	*Mean (sd)*	*Mean (sd)*	*Mean (sd)*	*Mean (sd)*
Age	34.16 (12.63)	36.60 (14.27)	33.28 (12.92)	37.26 (14.43)	34.86(12.36)	35.80(14.05)

Table 4. Alcohol consumption

	Complete sample		Women		Men	
	Risky drinker	Non-risky drinker	Risky drinker	Non-risky drinker	Risky drinker	Non-risky drinker
	Mean (sd)	Mean (sd)	Mean (sd)	Mean (sd)	Mean (sd)	Mean (sd)
Total alcohol consumption in SDU	40.11 (27.22)	4.89 (6.64)	28.10 (18)	2.41 (3.66)	49.77(29.46)	7.88 (8.05)
Alcohol consumption in workdays	23.78 (23.46)	2.13 (4.24)	15.68 (15.46)	0.86(2.21)	30.31(26.57)	3.65(5.43)
Alcohol consumption in weekends	16.56 (14.07)	2.76 (4.04)	12.43 (10.85)	1.55 (2.55)	19.88 (15.43)	4.22 (4.92)
Age of onset	15.64 (3.16)	17 (3.87)	16.31 (3.53)	17.83(4.34)	15.10(2.72)	16.11(3.06)
	N(%)	N(%)	N(%)	N(%)	N(%)	N(%)
Early onset *(before 15 years old)*	372 (31.2)	1179 (15.9)	137 (25.8)	650 (10.5)	235 (35.6)	1141 (22.3)
Late onset	809 (67.9)	7736 (68.5)	388 (73.1)	4256 (69)	421 (63.8)	3480 (67.9)
5 or more standard drinks in one occasion	553(46.4)	1099 (9.7)	182 (34.3)	280 (4.5)	371 (56.2)	819 (16)

Table 5. Substance use and health attitudes

	Complete sample		Women		Men	
	Risky drinker	Non-risky drinker	Risky drinker	Non-risky drinker	Risky drinker	Non-risky drinker
Tobaco	**N(%)**	**N(%)**	**N(%)**	**N(%)**	**N(%)**	**N(%)**
Ever smoked	985 (82.8)	7152 (63.3)	425 (80.2)	3514 (56.9)	560 (84.8)	3638 (71)
Actually smoking (last 30 days)	739 (62.1)	4316 (38.2)	322 (60.8)	2103 (34.1)	417 (63.2)	2213(43.2)
	Mean (sd)	**Mean (sd)**	**Mean (sd)**	**Mean (sd)**	**Mean (sd)**	**Mean (sd)**
Age of onset	15.36 (3.38)	16.66 (4.47)	15.91 (3.54)	17.38(5.22)	14.95(3.19)	15.96(3.46)
Amount of cigarrettes/day	17.08(11.73)	14.31(10.35)	13.62 (9.95)	12.65 (9.28)	19.75(12.29)	15.88(11.05)
Marihuana	**N(%)**	**N(%)**	**N(%)**	**N(%)**	**N(%)**	**N(%)**
Ever smoked	556 (46.7)	2081 (18.4)	236 (44.5)	771 (12.5)	320 (48.5)	1310 (25.6)
Actually smoking (last 30 days)	218 (18.3)	388 (3.4)	92 (17.4)	109(1.8)	126 (19.1)	279 (5.4)
Smoking daily	53 (4.5)	100 (0.9)	12 (2.3)	21 (0.3)	41(6.2)	79 (1.5)
	Mean (sd)	**Mean (sd)**	**Mean (sd)**	**Mean (sd)**	**Mean (sd)**	**Mean (sd)**
Age of onset	17.93 (3.57)	18.60 (3.81)	18.13 (3.34)	18.67 (3.70)	17.78 (3.73)	18.55 (3.87)
Other drugs	**N(%)**	**N(%)**	**N(%)**	**N(%)**	**N(%)**	**N(%)**
Use of non-prescribed tranquilizers	99 (8.3)	461 (4.1)	50 (9.5)	256 (4.1)	49 (7.4)	205 (4)
Use of non-prescribed hipnotics	64 (5.4)	264 (2.4)	33 (6.3)	142 (2.3)	31(4.7)	122 (2.4)
Ever consumed cocaine	162 (13.7)	267(2.4)	58 (11.1)	73 (1.2)	104 (15.9)	194 (3.8)
Ever consumed anphetamines	119 (10.1)	198(1.8)	42 (8)	57 (0.9)	77 (11.7)	141(2.8)
Ever consumed psychodelic drugs	97(8.2)	177 (1.6)	34 (6.5)	44 (0.7)	63 (9.6)	133 (2.6)
Ever consumed heroine	21 (1.8)	48 (0.4)	8 (1.5)	13 (0.2)	13 (2)	35 (0.7)

Table 6. Health Perceptions and Attitudes

	Complete sample		Women		Men	
	Risky drinker	Non-risky drinker	Risky drinker	Non-risky drinker	Risky drinker	Non-risky drinker
Health perception	**N(%)**	**N(%)**	**N(%)**	**N(%)**	**N(%)**	**N(%)**
Good	1013 (85.2)	9269 (82.2)	456 (86)	4932 (80.1)	557 (84.5)	4337 (84.7)
Normal	173 (14.6)	1949 (17.3)	72 (13.6)	1186 (19.3)	101 (15.3)	763 (14.9)
Bad	3 (0.3)	58 (0.5)	2 (0.4)	40 (0.6)	1 (0.2)	18 (0.4)
Life interference due to bad physical health	110(9.3)	1200(10.7)	59 (11.2)	779 (12.7)	51 (7.8)	421 (8.3)
Life interference due to bad physchic health	107 (9)	930 (8.3)	52 (9.8)	655 (10.7)	55 (8.4)	275 (5.4)
Never feel quiet and calm	94 (7.9)	784 (7)	52 (9.8)	528 (8.6)	42 (6.4)	256 (5)
Never feel energic	79 (6.7)	841 (7.5)	41(7.8)	540 (8.8)	38 (5.8)	301 (5.9)
Feel sad	44 (3.7)	452 (4.1)	24 (4.6)	277 (4.5)	20 (3.1)	175 (3.5)
Health attitudes	**N(%)**	**N(%)**	**N(%)**	**N(%)**	**N(%)**	**N(%)**
To smoke daily 20 cigarretes can be a problem	852 (72.3)	9177 (82.5)	410 (78.2)	5210 (85.8)	442 (67.6)	3967 (78.6)
To drink 5 or 6 SD on weekend days can be a problem	299 (25.4)	5426 (49)	168 (32.1)	3380 (56)	131 (20)	2046 (40.5)
To drink 5 or 6 SD daily can be a problem	909 (77.4)	10104 (90.9)	460 (87.5)	5707 (94)	449 (69.2)	4397 (87)
To smoke marihuana once a month can be a problem	576 (50.7)	8014 (74.2)	280 (54.8)	4707 (79.8)	296 (47.4)	3307 (67.5)
To smoke marihuana once a week can be a problem	787 (69)	9495 (87.7)	381 (74)	5395 (91.3)	406 (64.9)	4100 (83.3)
To use tranquilizers once a month	615 (54.8)	7225 (67.8)	296 (58.2)	4020 (68.2)	319 (52)	3205 (67.3)
To use tranquilizers once a week	885 (79.2)	9141 (85.7)	423 (83.4)	5042 (85.6)	462 (75.6)	4099 (85.8)
To use ecstasy once a month	954 (85.3)	10212 (94.6)	445 (88.5)	5689 (96)	509 (82.8)	4523 (93)
To use ecstasy once a week	1094 (97.5)	10673 (98.7)	501 (98.8)	5896 (99.2)	593 (96.4)	4777(98.1)
To use cocaine once a month	988 (86.99	10453 (95.8)	459 (89.8)	5811 (97)	529 (84.5)	4642 (94.3)
To use cocaine once a week	1102 (96.8)	10839 (99.2)	503 (98.1)	5972 (99.6)	599 (95.8)	4867 (98.7)
To use heroine once a month	1104 (97)	10744 (98.3)	497 (97.6)	5922 (98.7)	607 (96.5)	4822 (97.9)
To use cocaine once a week	1102 (96.8)	10839 (99.2)	503 (98.1)	5972 (99.6)	599 (95.8)	4867 (98.7)
To use heroine once a month	1104 (97)	10744 (98.3)	497 (97.6)	5922 (98.7)	607 (96.5)	4822 (97.9)
To use heroine once a week	1128 (99)	10890 (99.6)	507 (99.4)	5988 (99.7)	621 (98.7)	4902 (99.4)
To use psychodelic drugs once a month	1038 (92.3)	10519 (97.5)	473 (93.8)	5818 (98.3)	565 (91)	4701 (96.5)
To use psychodelic drugs once a month	1106 (98)	10736 (99.4)	498 (98.4)	5904 (99.6)	608 (97.7)	4832 (99)
Easy to get marihuana	722 (66.2)	5043 (51.7)	307 (62.9)	2405 (45.9)	415 (68.9)	2638 (58.4)
Easy to get heroine	422 (40.3)	3460 (36.5)	173 (37)	1712 (33.6)	249 (43.1)	1748 (39.9)
Easy to get cocaine	524 (49.6)	3793 (39.9)	209 (44.5)	1830 (35.9)	315 (53.7)	1963 (44.5)
Easy to get psychodelic drugs	453 (43.7)	3431 (36.8)	188 (40.6)	1701 (33.9)	265 (46.2)	1730 (40.2)
Easy to get ecstasy	498 (47.8)	3722 (39.7)	209 (44.8)	1824 (36.1)	289 (50.3)	1898 (43.8)

Table 7. Odds ratio (with 95% CI) for substance use in relation to drinking condition

	Risky drinker
Tobacco	1.70** (1.43-2.02)
Marihuana	2.40** (2.06-2.81)
Ecstasy	2.09** (1.52-2.87)
Tranquilizers	1.18 (0.91-1.53)
Cocaine	2.16** (1.57-2.96)

Risky drinkers were significantly younger and had significantly a higher education level. The prevalence of single status and of workers was significantly higher among the risky drinkers. The risky drinkers reported an earlier initiation in the alcohol consumption and a higher prevalence of other drug consumption. They also reported a lower risk perception in drug consumption and a higher accessibility to drugs. No differences in health perception were found.
A more recent study carried out in PHC settings a total of 851 patients were interviewed on their alcohol consumption in the framework of the evaluation of the dissemination of EIBI in PHC. Patients were a mean of 52.81 (± 18.57) years old; 35.8% were males, 28.3% were pensioners and 22.2% were housewives. 51.1% had never been questioned regarding their alcohol consumption and 30.4% had been questioned over one year ago. WHO limits on alcohol consumption were unknown for all patients interviewed. 18.3% of patients were risky drinkers (AUDIT-C).

When comparing Risky Drinkers (RD) with Non-Risky Drinkers (NRD) (see tables 8 and 9) we found significant differences in gender, work status, familiarity with the centre, being screened and receiving advice. Risky drinkers were significantly more males, employed and less familiar to PHC settings. They reported being screened and advised on their alcohol consumption significantly more.

Table 8. Demographic characteristics of patients

		NRD	RD	Analysis	
		N (%)	N (%)	?^{2} (gl)	Sig
Gender	Male	264(76,3)	82(23,7)	10,41(1)	<0,001
	Female	525(84,7)	95(15,3)		
Age	15-35 years	177(79,7)	45(20,3)	5,53(3)	0,14
	36-55 years	220(79,4)	57(20,6)		
	56-75 years	295(82,4)	63(17,6)		
	>76 years	97(89)	12(11)		
Education	Primary	521(82,2)	113(17,8)	1,46(2)	0,48
	Secondary	180(78,9)	48(21,1)		
	Tertiary	72(83,7)	14(16,3)		
Work Status	Pensioners	230(85,2)	40(14,8)	20,66(4)	<0.0001(1)
	Students	16(84,2)	3(15,8)		
	Housewives	189(87,9)	26(12,1)		
	Unemployed	24(92,3)	2(7,7)		
	Employed	324(75,5)	105(24,5)		

Table 9. Differences among RD and NRD

		NRD	RD	Analysis	
		N (%)	N (%)	χ^2 (gl)	Sig.
Familiarity	First visit	16(84,2)	3(15,8)	15 (5)	0,01
	Once a month or more	275(85,9)	45(14,1)		
	Once every three months	242(84)	46(16)		
	Once every six months	137(76,1)	43(23,9)		
	Once every year	68(73,1)	25(26,9)		
	Less than once a year	38(74,5)	13(25,5)		
Screened	In the last two years	363(77,6)	105(22,4)	11,85	<0,00
	Never	422(86,1)	68(13,9)	(1)	1
Advise	Yes	40(69)	18(31)	4,52(1)	0,03
	No	256(81,3)	59(18,7)		

The ESEMeD-Spain study on the epidemiology of mental disorders has shown a small prevalence of alcohol abuse and alcohol dependence problems[xli]. The 12-month prevalence for substance dependence including alcoholism was of 0.3 (0.0-0.5).

3. The harm done by alcohol[2]

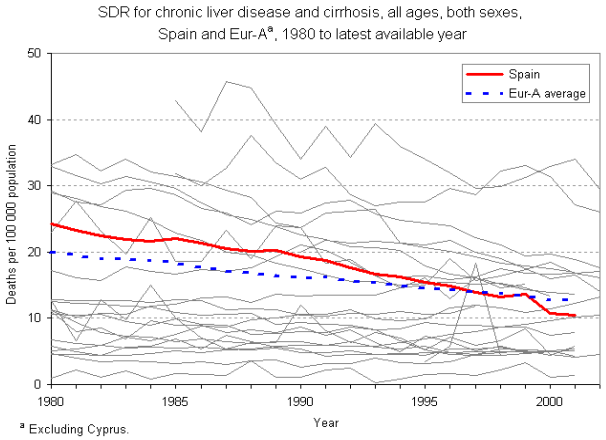
3.1 Health effects

In 2001 selected non-communicable diseases accounted for 78% of all deaths in Spain, external causes for about 6% and communicable diseases for 2%[xlii].

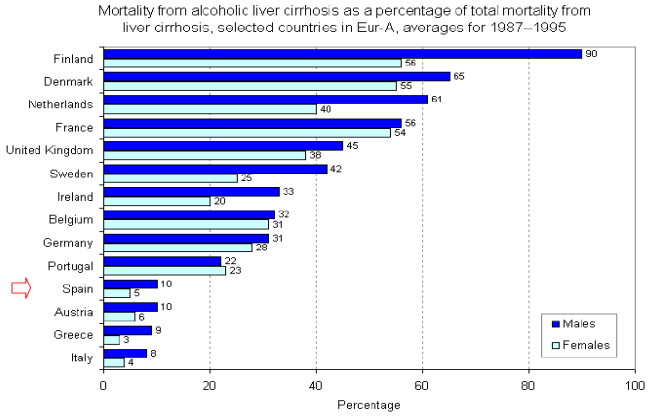
Alcohol consumption is rated third as a risk behaviour factor for health, causing 5.5% of total mortality[xliii]. Other studies indicate a total of 6.6% of annual mortality[xliv].

Mortality from liver cirrhosis is a classical and reliable indicator of the harmful effects of chronic excessive drinking. In Spain, the rate has decreased regularly, by a third since 1995, and is now 18% below the Eur-A average (see figures below)[xlv].

1 [2] Additional information is available at WHO Statistical Information System (WHOSIS). Evidence and Information for Health Policy at: at: http://www.who.int/countries/esp/en/

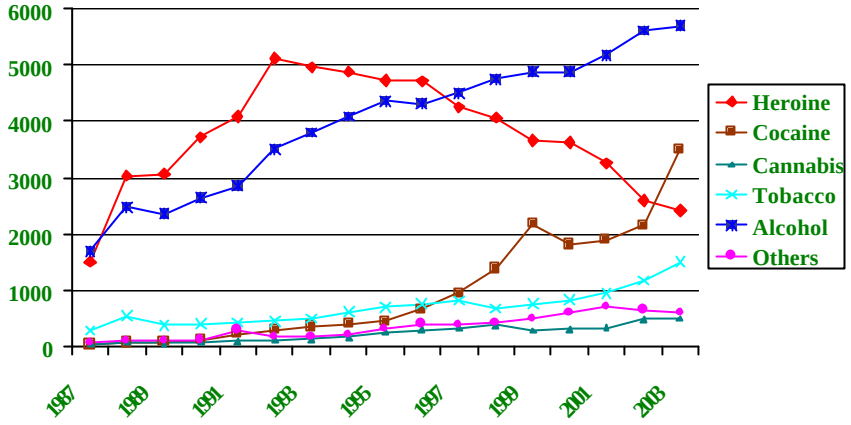


The mortality rate from alcohol-related causes has declined more rapidly in Spain than in the Eur-A but was still at 53 per 100 000 population in 2001.



In 2003, 5,706 (40.1%) of patients treated in the Catalan Drug Addiction Network (CDAN) showed alcohol problems. The person admitted to treatment for alcohol is typically a male (79%) aged from 35 to 49 (34%), with primary education (50%), currently working (49%) and who sought treatment on his doctor (i.e. referral from primary care) initiative (42.7%). Secondary to alcohol, patients are often smokers (36.8%), cocaine users (11.3%) and cannabis users (9,8%). Alcohol was the primary drug reported and there has been an important increase in admissions related to alcohol in the last decade (see figure 4)[xlvi].

Figure 4. Trends in the admissions for substances in the CDAN



With regard to morbidity due to mental disorders, information from psychiatric hospitals and general hospitals in Catalonia (MBDS) shows that in the year 2003, there were around 21,000 discharges due to mental disorders.

In acute and sub acute psychiatric hospitals, the most-frequent diagnoses are, respectively: schizophrenia (28.1% and 46.8%), affective psychoses (14.5% and 9.9%) and personality disorders (11.1% and 9.7%). In general hospitals with and without psychiatry departments, the most-frequent MD-related diagnoses are, respectively, affective disorders (16.3% and 5%), alcoholism (12.9% and 9.5%) and schizophrenia (13.4% and 1.4%).

In 2004, 71.6% of total emergencies caused by drugs were related to alcohol[xlvii].

As yet, there are no direct data on the prevalence of disorders caused by alcohol in Catalonia, but systematically-reported indirect indicators show their incidence is unchanged in recent years.

3.2 Social effects

Alcohol is involved directly not only in traffic accidents, but in occupational accidents. There is also evidence on alcohol associated to intentional injuries. In a recent bibliography review[xlviii] it is shown that at least of the 35.7% of the working population refers having problems due to alcohol consumption. The consequences increase in a dose dependent manner. It is estimated that around 15-30% of work accidents are related to alcohol and drugs. 20-25% of work accidents are due to alcohol intoxication and drinkers have from 2 to 4 times more work accidents and their absenteeism is from 2 to 3 times higher than non drinkers.

With respect to road accidents in Spain, in 2003 the percentage of blood alcohol levels higher than 0.3 g/l in drivers dying from road accidents were of 37.3% (40.2% among males and 11.2% among females) and of 36.9% among pedestrians (42.4% among males and 12.6% among females)[xlix]. In 2004[l], in 8.9% of the 26,806 alcohol tests carried out after a car accident, the driver had consumed alcohol[li].

3.3 Economic effects

The annual health and social costs derived from the abusive consumption of alcohol are very high. In 1998, they were quantified, for the whole of the Spain, at 3,833 million euros, using very conservative criteria. As shown in table 10, two thirds of the costs are indirect and a third direct[lii].

Table 10. Costs of alcohol abuse in Spain

Concepts	Total cost (million Euros)	%
Direct	1,373	35.8
Health centre visits	208	5.4
Special centres	108	2.8
Hospital admissions	581	14.7
Hospital emergencies	63	1.6
Occupational accidents	122	3.2
Material losses	10	0.3
Additional resources	294	7.7
Subventions, aid	4	0.1
Indirect	2,460	64.2
Lost working time	729	19.0
Reduced efficiency	1,731	45.2

These data extrapolated to Catalonia represent an approximate cost of about 570 million euros.

4. Measures to reduce the harm done by alcohol[3]

Evidence shows the most effective approach in alcohol control is to implement a combination of: increases in alcohol prices, reduction in the availability of alcohol, measures against drunk driving and underage drinking[liii].

In Catalonia, in the last decade a lot of efforts have been made to endorse prevention programs aimed at reducing alcohol demand but not much progress have been done in endorsing effective control policies. There are some regulations in that direction but they are still not sufficient and their accomplishment is not monitored[liv].

The Catalan Parliament[4] legislates on health and has developed four laws of prevention and assistance on substances (including tobacco and alcohol) which can create dependence.

-Law 20/1985, 25th July[lv]
-Law 10/1991, 10th May (modified from law 20/1985)[lvi]
-Law 8/1998, 10th July[lvii]
-Law 1/2002, 19th May[lviii]

4.1 Price and tax

Price and taxation is regulated at a national level. The taxation of alcohol products is regulated by Law 38/1992, 20th December of Special Taxes (chapters. II – VI). In which it is stated that the tax/vat allocated is 16%. The tax means 6.18% of retail price in beer, and 22.25% of spirits. There are excise stamps. However, the increase on alcohol taxation has been relatively slight when comparing it to the increase occurred in the European countries.

A license for import, export and wholesale is not required for any alcoholic beverage but it is required for production and retail.

As a result of that, the prices of the most consumed alcoholic beverages are low[lix], cheaper than prices in other countries and its availability to youth drinkers is higher.

Beer (0.5 litres)	0.68
Bottle of table wine (0.75 litres)	0.77
Bottle of spirits (0.7 litres)	8.62

Even though it has not been measured, the number of tourists that visit our region attracted by the alcohol availability because of low prices is still important and some efforts are being made to reverse that situation because of the high level of conflict in tourist towns.

[3] Additional information at a national level is available at the Bridging the Gap Infrastructures questionnaire available at: http://www.hp-source.net/report.html?mode=COUNTRY&area=&module=btg&country=37

4.2 Regulating physical availability of alcohol

Under the terms of the law 1/2002, 19th May it is not allowed to sell any alcoholic beverages to minors (<18 years old).

In the last year some efforts have been made to improve monitoring of the endorsement of the law. The juridical cell of the Health Department proceeds when any complaint about sales to minors is received but the administration have to start being more proactive in his alcohol control activities. More resources have to be allocated to these activities.

4.3 Modifying the drinking environment

The Law 8/1998 prohibits:
-drinking and selling alcohol beverages (>20º proof) in health centres, universities, sports centres and motorway service areas.
-drinking and selling any alcoholic beverage in any education centre, public transport companies, motorway service areas from 23 to 8 hours, any public place and public thoroughfares if municipal regulations establish it, in any automatic machines located outside.

Unfortunately there is not widespread consent on wine regulations, with ambiguous regulations on their drinking and selling limits.

Again the regulations are not subject to a strict control by the administration and much effort and resources have still to be allocated to achieve a widespread endorsement of them.

4.4 Advertising, promotion and sponsorship[5]

Several regulations exist on that issue not only at a national level but also at a regional one.

National Level

-Law 34/1988, 11th November – General Law of Advertising

- Specific:
  - states that advertising that may lead to health risks may be regulated by its particular norms
  - Prohibits the advertising on television of drinks above 20º proof
- Also prohibits advertising in places where its sale or consumption is also prohibited.
- It is also possible that in the future the ban will be extended to include alcoholic drinks below 20º proof for reasons of public health and safety

-Law 25/1994, 12th July – Transposition of Directive 89/552/CEE (modified by the law 22/1999, 7th June)

[5] Additional information is available at: http://www.hp-source.net/report.html?mode=DOCVIEW&module=btg&docid=342&country=37

- prohibits "any direct or indirect form of advertising or telesales of drinks above 20º proof"
- Prohibits hidden television advertising ("product placement")
- The presence of brands or products (including alcohol) in televised sporting events organised by a third party (sports sponsorship) is not considered hidden advertising.
- Makes it obligatory to clearly distinguish advertising contents of programmes by the use of visual or acoustic means.
- Prohibits the sponsorship of television programmes by persons or organisations whose principal activity is the manufacture or sale of products or the realization of services of which the advertising is prohibited.
- Limitations on what advertising and telesales of alcoholic drinks can explain or show:
    - They may not be aimed at minors and particularly must not depict consumption by minors.
    - They must not relate consumption to improvement in physical performance or driving of vehicles, nor give the impression that drinking alcohol contributes to social or sexual success, suggest that alcoholic drinks have beneficial therapeutic effects or act as a stimulant or a sedative or that they represent a means to resolve conflicts.
    - They should not promote immoderate consumption of alcoholic drinks or offer a negative image of sobriety nor present the alcoholic content of the drink as a positive quality.
- States that "television advertising shall not contain images or messages that could lead to moral or physical harm to minors"
- The invigilation, control and sanction for infraction of this law by state television channels falls within the purview of the Ministry of Industry
- Non-compliance with the aforementioned regulation is classed as a serious offence (up to 300,000 €) and for repeat-offenders (2 or more sanctions in one year) a very serious offence (600.000€).
    - Art. 20-21 Law 39/2002, 28th October of the transposition of Community directives considers the possibility of consumer groups, associations and individual users to have the power to demand withdrawal of advertising

Regional Level

-Law 20/1985, 25th July

-Limits the promotion and sale of alcohol and tobacco among young people
-Prohibits alcohol and tobacco advertising in the street
-Prohibits the advertising of alcohol and tobacco in official media of the Catalan Government

-Law 10/1991, 10th May (modified from law 20/1985)

-The public promotion of alcoholic drinks through trade fairs, exhibitions and similar activities, must be done in clearly designated areas when taking place within other public functions
-The promotion of alcoholic drinks by way of competitions or uncontrolled consumption is prohibited, as is the promotion of establishments where such activities are carried out

-The following may not be distributed to minors; brochures, posters, invitations or objects of any kind which bear the name of alcoholic drinks, their brands or manufacturers, or establishment in which they are consumed

-**The advertising of alcohol >20º in official media of the Catalan Government is prohibited.**

-This ban does not extend to indirect advertising in non-advertising programmes (sports or music broadcasts, etc.).

-Advertising is not permitted in publications aimed at minors.

-The advertising of alcohol is prohibited >23º in:

A) Beaches, campsites, baths, recreational and leisure centres

B) Streets, squares, parks, highways, billboards, hoardings or other external advertising supports

C) Cinemas and theatres

D) Sports centres and stadiums, with the exception of sponsors

E) Means of public transport

F) Wherever its consumption is prohibited

-Law 1/2002, 19th May

-More pressure on publicity

- Never to induce consumption amongst youngsters
- Only<20 degrees
- Never in time of <18 TV viewers

-The Alcohol industry has also endorsed Self-Regulation Codes but no further monitoring of their accomplishment is regularly done.

- Code of Advertising Practice by the Association for the Self-Regulation of the Commercial Community (AUTOCONTROL) http://www.autocontrol.es/
- Code of self-regulation of spirit producers
- Code of self-regulation of beer producers
- Code of self-regulation of alcohol advertisers

Are there restrictions on advertising, sponsorship or brand identification?

	Beer	Wine	Spirits
National TV	Voluntary agreement	Voluntary agreement	Complete restriction
Cable TV	Voluntary agreement	Voluntary agreement	Complete restriction
Satellite TV	Voluntary agreement	Voluntary agreement	Complete restriction
National radio	Partial restriction	Partial restriction	Partial restriction
Internet	No restriction	No restriction	No restriction
Printed newspapers/magazines	Partial restriction	Partial restriction	Partial restriction
Billboards	No restriction	No restriction	No restriction
Point of sale	No restriction	No restriction	No restriction
Cinema	Partial restriction	Partial restriction	Partial restriction
Rented videos	No restriction	No restriction	No restriction
Product placement in TV shows and films	Voluntary agreement	Partial restriction	Voluntary agreement
Sponsored events identified with brand name	No restriction	No restriction	No restriction
Non-alcohol products identified with brand name	No restriction	No restriction	No restriction

Health warnings are not legally required on advertisements but on containers/bottles of alcoholic beverages. There is much opposition from the agriculture side to accepting the inclusion of health warnings on wine products.

In brief, even though there are apparently lot of regulation tools to control the violation of the advertising codes there is still much to be done to promote their endorsement.

4.5 Information, prevention and public awareness

In 1989 the Program on Substance Abuse[6] was created in the Health Department mainly to direct and manage services, to promote drug prevention strategies and propose or resolve governmental concerns within the area of substance abuse.

Guidelines of the Program on Substance Abuse

[6] More information on the activities of the Program on Substance Abuse of Catalonia is available through the website: http://www.gencat.net/salut/depsan/units/sanitat/html/ca/alcohol/index.html

- Addictions are diseases and must be treated within the Health System
- The Drugs Plan must deal with all drugs, including alcohol and tobacco
- Drug and alcohol related problems must be viewed from a Public Health perspective

The Program on Substance Abuse, institution in charge of the Catalan Autonomous Drug Plan, is a member of the Sectorial Conference and the Interautonomic Commission, organisations created by the National Plan on Drugs (NPD) to coordinate and strengthen the policies related to illegal drugs that have been carried out by the different Public Administrations and Social entities in Spain.

The NPD[7] is a national government initiative created in 1985 and the Government Delegation for the NPD is entitled to the management, impulse, coordination and supervision of those services related to the NPD updating and implementation. The **organizational structure** of the Plan is as follows:

- An Inter-ministerial Group, presided by the Ministry of Health and Consumer Affairs and consisting of representatives from the Ministries of Justice, Education and Culture, the Interior, Labour and Social Matters as well as the Secretary of State of the Treasury, the Secretary of State of Economy and the Secretary of State of Relations with the Parliament. The Secretariat of this Interdepartmental Group will be in the hands of the Government Delegate for the NPD.

- The relationship between the Central Administration and the Autonomous Governments takes place via two organisations:

a) The Sectorial Conference, presided by the Ministry of Health and Consumer Affairs, the policy decision making organism, consisting of the members of the Inter-ministerial Group and the Councillors responsible for the drug dependency policy in the Autonomous Governments, and
b) The Inter-autonomic Commission, presided by the Government Delegate for the N.P.D., including those directly responsible for the Autonomous Government Plans on Drugs in the 17 Autonomous Communities and the Autonomous Cities of Ceuta and Melilla, which submits proposals of a technical nature to the Sectorial Conference and executes the guidelines issued by the latter.

At a national level it was approved by Royal Decree 1911/99 of 17th December, the National Drugs Strategy for the period 2000-2008[lx] where the main areas of intervention are: demand reduction (prevention of drug consumption, harm reduction, assistance and social integration) drug supply control and international cooperation.

Catalonia has developed a particular model to deal with alcohol-related problems within the framework of this global strategy on drug dependencies and together with the legislative activities and the creation of a specialized network for the treatment of addiction (included alcoholism) the main priorities are: primary prevention activities, harm reduction activities, dissemination of EIBI on excessive alcohol consumption in health centres and work based prevention programs. All the

[7] More information from the National Plan on Drugs is available through its website: http://www.msc.es/pnd

initiatives are developed with the participation of the civil society (NGOs, private initiatives, foundations, companies, etc), scientific societies and other administrations and are organized using different cooperation formulae.

Primary prevention activities

The majority of the efforts are focused on developing effective school based programs aimed at delaying the age of onset and in reducing the children/adolescents risk taking behaviours. Together with the traditional educative programs that have been promoted aimed at developing skills not only by children/adolescents but also by parents and teachers (i.e: I Tu Què en Penses?, L'Aventura de la Vida, etc.) the main initiative developed in the recent years is what is been called the "Health and School" Program. In the HS Program the nurses of the PHC, school based, are in charge of implementing prevention activities and taking care of all the children and adolescents health problems specially related with the use of drugs, including alcohol, sexuality and mental disorders (anorexia, depression). Nurses are being trained under a training the trainers' perspective and continuous support is given from the Health Department.

These initiatives are always carried out taking into account the specific local prevention (at the municipality level) activities and the Local Plan on Drugs.

Harm reduction activities

In that field the majority of programs are facing the challenge of reducing the risk taken by youth when starting the experimental drug use especially at leisure activities. There is an initiative, agreed at a national level with the most relevant stakeholders (including police and leisure industry) the so called "Taula de Consens per una Nit més Segura"[8] that endorses several preventive actions like the development of drink-driving programs (i.e. Limit 0, Designated Driver actions), training of staff on safety measures, training of serving staff in responsible beverage service and drug testing in recreational places (discos, raves).

Dissemination of EIBI on alcohol consumption in Primary Health Care

This issue is explained in depth later on in the document (see point 7). The main actions that have been carried out are the establishment of the Minimum Common Criteria for intervention in alcohol related problems in Primary Health Care[lxi], the settlement of goals for alcohol screening through the Health Plan and the development of the "Beveu Menys" Programme aimed at disseminating EIBI on alcohol consumption in Primary Health Care Settings. The Beveu Menys included training courses for nurses and GPs and provided PHC physicians with intervention packages to briefly screen and assess risk drinkers.

Work based prevention programs

In March 2002 the agreement for the prevention and the treatment of drug dependence in work settings was signed between the Health Department, the Departament de Treball, Foment del Treball Nacional, Pimecsefes, Comissió Obrera Nacional de Catalunya and Unió General de Treballadors de Catalunya with the aim of setting a framework for the development and the promotion of work based prevention programs.

[8] More information on that initiative is available at: http://www.nitsegura.com

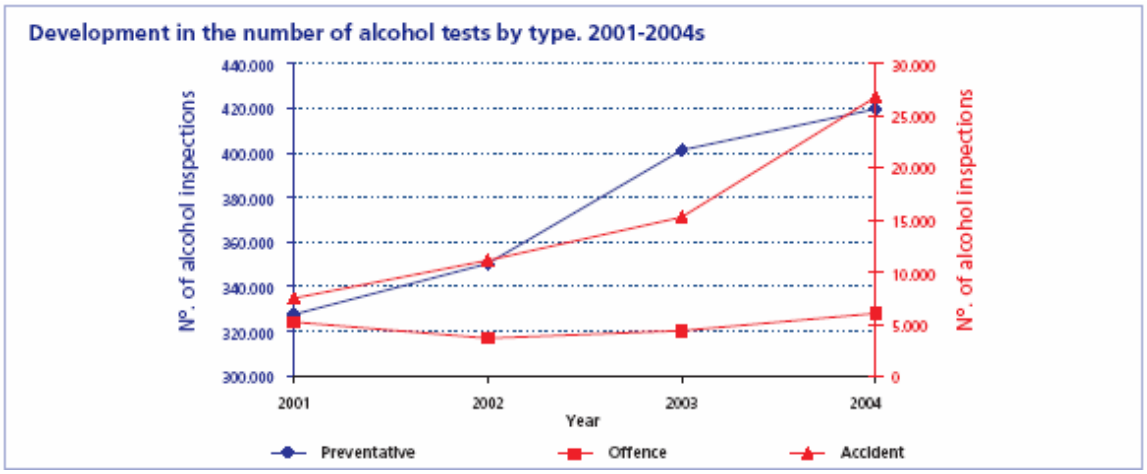
The guidelines on that issue are that drug problems at work must be dealt with a non punitive perspective, emphasizing early detection and rehabilitation, since the most prevalent drug at work is alcohol, most of the efforts should specifically be directed to it and any action to be taken has to be the result of a consensus between staff and the unions. The work based programmes are still poorly developed but there is already some promising initiatives like the TAC & CIA programme that was implemented at the Port of Barcelona in close relation with the Port Authority aimed at preventing the risks associated to tobacco, alcohol and cocaine use among the port workers.

4.6 Drinking and driving [9]

The maximum legal blood alcohol concentration (mg %) is 50 and 30 mg% for novice drivers. Random breath testing is allowed and used regularly by police. The penalties for drink-driving are a fine up to 603 EUR and temporary withdrawal of driving licence. There are no mandatory driver education/treatment programmes for habitual offenders.

The incidence of alcohol testing has been increased notably in the last four years, especially those performed because of accidents. Between the year 2001 and 2004, the number of tests performed for this reason has tripled.
Developments in the number of each inspection type between the year 2001 and 2004:

- 260% increase in inspections due to accident
- 28% increase in preventative inspections
- 15% increase in inspections due to offences



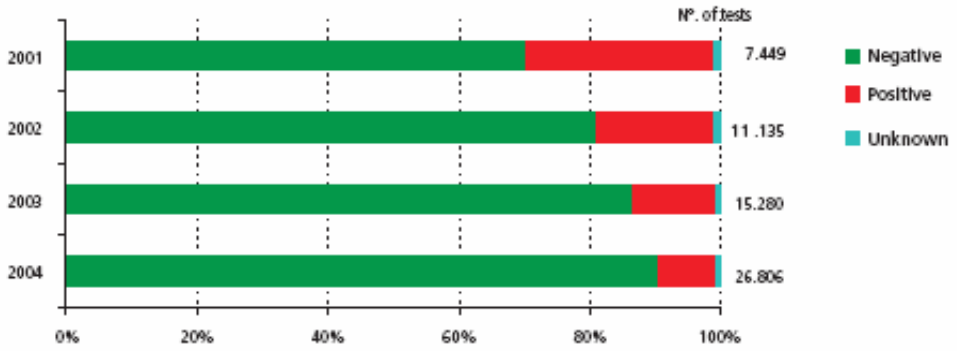
Alcohol inspections made for accident reasons showed that positive results (alcohol consumption above the established legal limits) have dropped from 17.8% in the year 2002 to 12.6% in 2003 and to 8.9% in the year 2004. The table shows the results by type of alcohol inspection made between the years 2001 and 2004.

[9] Information on legislation at a regional level is available at: h:ttp://www.gencat.net/transit/leg.htm. At a national level additional information can be found at: http://www.dgt.es/dgt_informa/normativa/alcoholemia.htm

Alcohol testing by motive and positive results. 2001-2004

Motive for the inspection	2001		2002		2003		2004	
	% +	Total	% +	Total	% +	Total	% +	Total
Accident	28,6	7.449	17,8	11.135	12,6	15.280	8,9	26.806
Prevention	5,4	327.400	4,9	350.609	3,6	401.142	4,6	419.522
Offence	47,9	5.208	43,7	3.682	42,4	4.329	39,8	6.000
Symptoms	0,0	0	58,7	613	70,1	645	71,8	840
Total	6,6	340.057	5,8	366.039	4,4	421.396	5,4	453.168

Development in the alcohol inspection results from traffic accidents. 2001-2004



The principal objective of the Catalan Road Safety Plan (RSP) for 2005 – 07 (PSV) is a reduction in the road traffic accident mortal victim rate of 30% compared to that of the year 2000[lxii]. This plan pressures for a qualitative increase in preventative alcohol level inspections. In this manner an attempt is made to reduce the exposure to risk of the male and female drivers.

The main strategies to be endorsed to achieve the objective of the RSP are:

A. Political action axes
B. Towards risk reduction and accident prevention
C. Towards a reduction in the impact of accidents
D. Towards an improvement in information systems
E. Research and investigation
F. Towards the management and execution of the plan

Regarding the alcohol issue the actions that are going to be implemented are the following:

B. Towards risk reduction and accident prevention

Objective:

To combat the lack of road discipline regarding excessive or inadequate speed, the excess of alcohol and the non-use of passive safety accessories

Actions:

5. To objectively increase the speed stretches monitored
6. To improve the quality of the alcohol testing
7. To make exhaustive alcohol level monitoring on those drivers involved in accidents with victims
8. To make exhaustive alcohol and drug monitoring on drivers killed in road accidents

All of the measures taken regarding the consumption of alcohol among drivers are biased, that is to say, type of testing typology maybe considered indicative of the program due to the lack of randomness, as much for the preventive inspections as for accident inspections as well as those taken for offences or suspicion. For this reason a new typology of preventative alcohol inspections will introduce random controls, in space as well as in time. These types of inspections can be used to gauge the magnitude of the problem, given that currently the number of drivers who drink and drive is unknown.

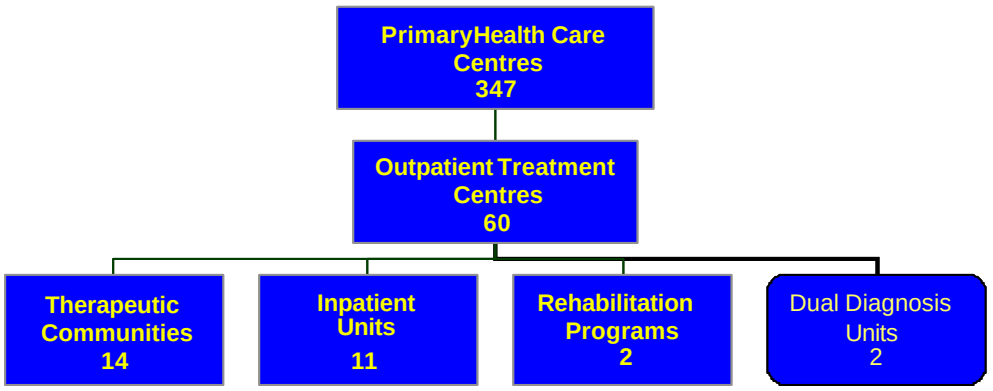
Recently, the creation of the Catalan Road Safety Monitoring Centre has been approved by law 143/2005, 12th July, which will have the aim of integrating the existing information (including the one related to drink driving) to improve the road safety in Catalonia.

Together with all the effort done at a legislative level, there has been a broad development of Drink driving mass media campaigns especially at a national level[lxiii].

4.7 Managing alcohol related harm: help and care

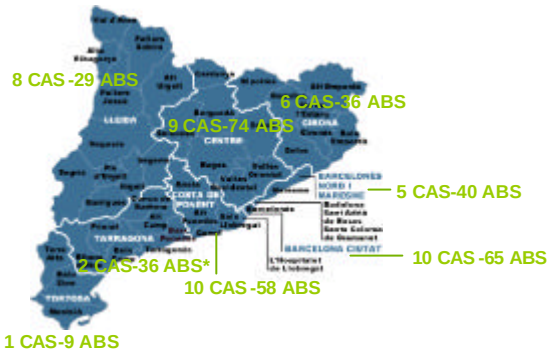
The Program of Substance Abuse manages what is called the Catalan Drug Addiction Network (CDAN) with 60 centres (see figure 1) which was organized to offer different treatment modalities (methadone maintenance, etc.) to all dependent patients[14].

Figure 5. The Catalan Addiction Treatment Network



The first level of access to sanitary services is close to the drug specialized centres, both being geographically distributed (see figure 2) in a manner that allows close coordination among both levels.

Figure 6. Distribution in the territory of the PHC centres and CDAN centres



CAS – Outpatient treatment addiction centre
ABS – Primary health care centre

In recent years, within the framework of health promotion strategies, there has been increased interest by all concerned with alcohol consumption and, in parallel, a remarkable diversification of the health interventions on drinking. This has allowed the development of preventive strategies aimed at reducing consumption in risk drinkers, which complement the traditional therapeutic strategies aimed at abstinence in alcoholic patients.

Therapeutic programmes

Alcohol cessation in patients diagnosed as alcoholics helps to improve their quality of life compared with those that continue drinking. Specialist treatment is aimed at achieving abstinence under a relapse prevention perspective and includes behavioural approaches and pharmacotherapy. It is focused at three complementary objectives: acquisition of disorder awareness, training in healthy life-style behaviours and improving the quality of life. The treatment program usually starts with the 8-day outpatient detoxification with supervision of the medication by relatives used to prevent withdrawal symptoms. Later on starts the rehabilitation phase in which the inclusion of patients in group therapy is usual. The therapeutic program lasts 24 months.

A prospective longitudinal study following 850 patients diagnosed with alcohol dependency and treated by the CDAN has shown that more than 43% abstain from alcohol at 10 years, 8% continue to drink moderately, 31% continue to drink excessively and 18% have died[lxiv].

5. The effectiveness and cost effectiveness of interventions for hazardous and harmful alcohol use in primary health care

Over the last 10 years substantial research has been carried out in Spain on brief interventions. Efficacy and effectiveness have been evaluated in a range of studies[lxv,lxvi,lxvii]. The results of a meta-analysis support the efficacy of brief intervention for excessive drinkers in Spanish PHC settings[lxviii]. The study inclusion criteria were studies[lxix,lxx,lxxi,lxxii,lxxiii] carried out in PHC centres (see table 11), at least 6-month follow-up, Spaniards, EIBI versus non-specific interventions, random patient inclusion, hazardous drinkers (>35 SD/week for males and >21 SD/week for females).

Table 11. List of studies included in the revision

Authors	Characteristics	Intervention
Gutierrez et al. (1994)	n=125 males cons >35 SD/s	TG: BI (3-5 sess en 3 m) GC: TH Folow-up: 12 m
Fernández et al. (1997)	n=152 males cons >21SD/s	TG: BI (1 ses 10 min) CG: TH Folow-up: 18m
Altisent et al. (1996)	n=139 males cons >35 SD/s	TG: BI (1 ses 5 min + 4 visits 1,4,7 y 12 m) CG: TH Folow-up:: 12 m
Córdoba et al. (1998)	n=546 males cons >35 SD/s	TG: BI (1 ses 15 min + optional) CG: TH Folow-up: 12 m
Diea-Manrique et al. (2002)	n=210 males cons >35 SD/s	TG: questionnaire + BI (10 min) CG: questionnaire pre-treatment Folow-up: 6 m

The effect size found for the decrease in alcohol consumption was d=-0.46 (95% CI, -0.29 to -0.63; p<0.0005) and the intervention group outperformed the control group by 22%. For the decrease in the frequency of excessive drinkers the effect found was OR =1.55 (95% CI 1.06 to 2.26; p=0.02) and the intervention group outperformed the control group by 11%.

In an international meta-analysis of Ballesteros[lxxiv], SBI worked better (OR 1.54, 95% CI 1.26 to 1.89, NNT 12, 95% CI 8-20) and results were similar among males and females (OR 2.32; 95% CI = 1.78-2.93 y OR 2.31; 95% CI = 1.60-3.17; respectively)[lxxv]. A dose response effect was not found.

The effectiveness has been evaluated in the study of Fernández et al. 2003[lxxvi]. From 321 patients, 306 were included 95.1% (n=294) were males. The inclusion criteria were alcohol consumption over 35 SDU/week for males and more than 21 SDU/week for females. 78.4 were alcoholics according to MALT (>=11). The intervention was case finding with informed consent and brief advice from 3 to 5 min. There was an assessment visit were MALT was administered together with a clinical exploration (20 min). 1-3 visits (max15 min) and follow-up visits at month 3, 12, 24 (65-75 min). The results showed that among ADS, 25% were abstinent and 17% reduced consumption. In brief it was effective in 4 of 10 patients and results maintained over one year.

Screening and brief intervention techniques use intervention protocols that, while elaborate, are at the same time flexible, allowing intervention at different levels of consumption and adaptation to the therapeutic targets marked by the health professional. Generally, they are a compendium of elements that include, among others, the physical examination, advising on the limits of consumption and the follow-up of alcoholic consumption. Administration of the intervention by PHC professionals creates a physician-patient relationship which favours confidence by the patient that they can implement and consolidate a change in their behaviour.

Catalonia already has an early intervention tool in the shape of the "Beveu Menys" (Drink less) programme, which is currently being disseminated among all PHC professionals by the CDAN and is the fruit of the 8-year collaboration between the Department of Health and Social Security and the European Regional Office of the WHO.

6. Current policies

Excessive alcohol consumption has been always considered a major public health problem and a priority by the Catalan Health Strategy. In the current Health Plan for Catalonia (2002-2005) alcohol appears as one of 20 main priorities and there is a whole chapter devoted to tackling the problems derived from the risky consumption of alcohol[6].

Health Plan 2002-2005

- 3 general targets for health till 2010:
  - -Reduce accidents related to alcohol
  - -Reduce morbidity related to alcohol
  - -Reduce prevalence of excessive alcohol consumption among general population but especially among young people

-Priority interventions
  - -Monitor excessive alcohol consumption especially among young people
  - -Improvement of screening strategies
  - -Dissemination of brief interventions among all professionals
  - -Media campaigns to sensitize general population regarding safe alcohol consumption limits

-Operational targets (of a total of 10):
  - -Complete dissemination of the "Beveu Menys" Project in the Primary Health Care
  - -Train other professionals (paediatricians, waiters, etc) with screening and brief intervention strategies on alcohol

3.2 Health and risk reduction targets for 2010

1. By 2010, mortality due to traffic accidents associated with excessive blood alcohol levels in drivers should be reduced by 50%.
Evaluation indicator: Evolution of the percentage of deaths by traffic accidents with high blood alcohol levels (>0.5 g/l).
2. By 2010, hospital morbidity due to liver disease produced by alcohol should be reduced by 10%.

Evaluation indicator: Evolution of the hospital admissions due to this cause, according to the MBDSHD.
3. By 2010, the prevalence of excess alcohol consumers (>280 g in men and >168 g in women) should be reduced by 10% in people aged >15 years.
Evaluation indicator: Evolution of the percentage of excess drinkers, according to population-based surveys.
4. By 2010, the prevalence of excess alcohol consumers in people aged 15-29 years should be reduced by 10%.
Evaluation indicator: Evolution of the percentage of young people who are excessive drinkers, according to population-based surveys.

3.3 Operational targets of the Health Plan 2002-2005

1. By 2005, the "Beveu Menys" (Drink less) programme should be developed in 90% of the reformed Basic Health Areas (PHC centres) of Catalonia.
Evaluation indicator: Evolution of the percentage of reformed BHA that have developed the "Beveu Menys" programme.
2. By 2005, the number of PHC professionals who normally incorporate brief techniques of screening and interventions for risk drinkers should be increased by 25%.
Evaluation indicator: Evolution of the percentage of PHCT that have incorporated these procedures into normal practice, measured by audits of clinical practice.
3. By 2005, the use of standardized and validated screening instruments (AUDIT, Audit-3, ISCA and others) in PHC should be increased by 30%.
Evaluation indicator: Evolution of the percentage of use of the screening instruments, measured by audits of clinical practice.
4. By 2005, standardized and validated methods of screening (AUDIT, Audit-3, ISCA and others) should be introduced in hospital emergency departments.
Evaluation indicator: Number and percentage of hospital emergency departments that apply these methods.
5. By 2005, 90% of CDAN centres should offer damage-reduction programmes for alcoholics.
Evaluation indicator: Percentage of CDAN centres with damage-reduction programmes for alcoholics.
6. By 2005, specific programmes of alcohol-related occupational accident prevention should be introduced in areas where the risk is high (construction companies, etc.).
Evaluation indicator: Existence and dissemination of prevention programmes in high-risk occupational sectors.
7. By 2005, paediatricians should be educated with specific prevention and detection of alcohol consumption programmes.
Evaluation indicator: Existence and dissemination of education programmes for paediatricians.
8. By 2005, brief intervention programmes should be introduced in hospital emergency departments for the use of screening and brief intervention in accident victims.
Evaluation indicator: Number and percentage of hospital emergency departments that apply brief intervention programmes.
9. By 2005, prevention and detection of alcohol consumption programmes should be introduced in professional groups who can help to reduce the damage associated with alcohol consumption (waiters, police, etc.).
Evaluation indicator: Existence and dissemination of prevention and detection programmes among these groups.

10. By 2005, positive blood alcohol levels in the systematic controls by police should be reduced by 10%.
Evaluation indicator: Evolution of the percentage of positive blood alcohol tests in police controls.

3.4 Activities

- Continued evaluation of the effectiveness and dissemination of the "Beveu Menys" (Drink less) programme in all PHC settings.
- Creation of new spaces (Web, hotline, etc.) of support and coordination, within the framework of the "Beveu Menys" programme, among CDAN professionals, PHC, and the Program of Substance Abuse of the Department of Health
- Formation of all CDAN and PHC professionals in motivational techniques.
- Publishing of new support materials and update of the brief interventions for PHC professionals (CD, etc.).
- Inclusion of standardized screening instruments (AUDIT, Audit-3, ISCA) in surveys designed to investigate the prevalence of risk consumption (general population, occupational area, etc.).
- To evaluate the effectiveness of alcohol dependency treatments in CDAN centres.
- Publishing of specific new materials to promote the use of screening strategies, prevention and brief interventions by specific health groups: paediatricians, gynaecologists, midwives, etc.
- Activities to increase public awareness of the limits of risk consumption and the standard alcohol unit.
- Follow-up of the degree of compliance with the laws on restrictions of alcohol consumption in young people aged <18 years.

The Director Plan on Mental Health and Addictions

In the last 6 months the Health Department in collaboration with professional and scientific associations, service provision institutions, and associations of patients has been developing an ambitious policy strategy, "the Director Plan on Mental Health and Addictions".

Rationale

-Focuses on the mental health needs of the target populations according to age.
-Puts permanent emphasis on mental health promotion and prevention of mental ill-health and dependence
-Integrated approach from promotion to rehabilitation
-Relies on evidence based initiatives for decision making
-Improvement of mental health monitoring systems and evaluation tools.
-Experts' consensus
-Promotes the functional integration of mental health care and the CDAN: through the identification of common needs and the development of common protocols.

The functions of the Director Plan are:

-To advice on planning and health and services evaluation
-To assess the health and services needs
-To agree with professional and scientific associations and society representatives and groups the action plan

-To promote treatment continuity throughout the territory
-To promote the intersectorial and transversal approach
-To improve the quality of services
-To propose research lines
-To develop best practice guidelines and protocols
-To elaborate educational materials for the general population

Among the main priorities of intervention (2004-2007) are included the implementation of strategies on mental health promotion and mental disorder prevention (including addictions) to propose actions to improve the integration of the treatment of mental health and addiction disorders in the general health services and to promote the role of PHC in the prevention and treatment of the most prevalent mental and addiction disorders.

The White Paper on Preventive Activities in Primary Health Care Settings[lxxvii] is going to be published in which an alcohol consumption chapter is included following the recommendations of the Beveu Menys program.

A guide on Prevention Activities among Adolescents in PHC settings in primary health care settings has also been published and includes several chapters addressing the management of alcohol and drug problems[lxxviii]. The use of EIBI is recommended when addressing the alcohol issue.

7. Integrating screening and brief interventions in primary health care

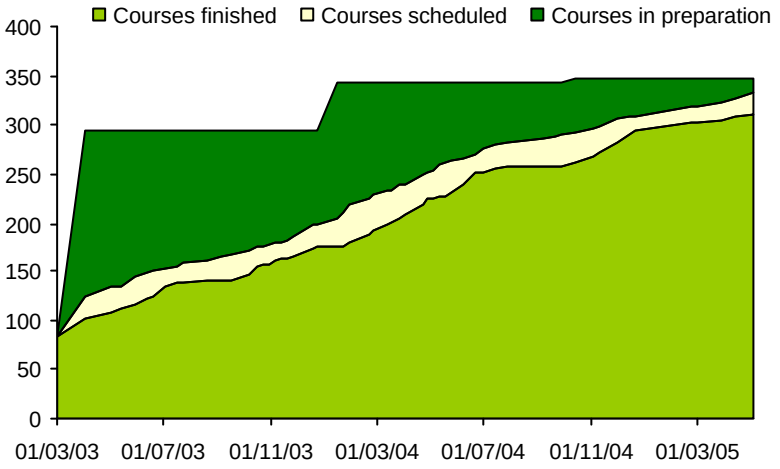
In 1995, Catalonia joined the Phase III of the World Health Organization Collaborative Project on Alcohol and Primary Health Care and in the framework of the Phase IV of the WHO Project we started in 2002 the dissemination of the "Beveu Menys" in all the Primary Health Care Centres. Catalonia has developed a specific strategy to provide adequate training and support to PHC professionals to implement SBI in their daily clinical work. A training-the-trainers program targeted at professionals from the addictions field was delivered in two consecutive workshops. Specialists then became responsible for delivering training and giving sustained support to PHC teams.
Before holding the training workshops, preliminary activities, such as the translation of an SBI package of materials, validation of screening instruments and three focus groups with PHC professionals (GPs, nurses and health planners) aimed at adapting materials to local needs, were completed. The training process and the design of the training package ran in parallel in a two-step procedure. The program was entitled Beveu Menys, the Catalan translation for Drink Less.

The Demonstration Project started on November 2001 and is expected to be finished by the end of 2005. It is aimed at achieving a widespread dissemination of SBI methods to all PHC settings and professionals in Catalonia following the guidelines of the *Beveu Menys* Program. The demonstration was initially planned in three different stages and centres were randomly assigned to receive training in the first (2002), second (2003) and third stage (2004) but the recent reorganization of PHC services has enlarged the network with 48 centres and has compelled us to plan a new stage (2005).

The Figure XX shows the status of the training dissemination to date. Up to 5th May 2005, 325 (93.6%) courses had been conducted. A total of 5,823 PHC professionals

(48% nurses, 42.1% GPs, 2% paediatricians, 1.4% physicians in education, 1.6% social workers and 4.9% other) have been trained and 76.5% of these have been accredited. Progress at the start was difficult but the rate of dissemination has been steadily increasing; courses have been welcomed by PHC professionals, trainers' perceptions have been positive and participants' attendance has been maintained through all sessions. The course structure preferred on 44.6% of occasions has been 5 sessions.

Figure 7. Training Dissemination Status



After the completion of the dissemination phase substantial efforts are being made to continue promoting an improved coordination between PHC professionals and specialists in order to overcome roadblocks for the effective implementation of the SBI methods.

7.1 Principles

The program was designed according to the following aims:

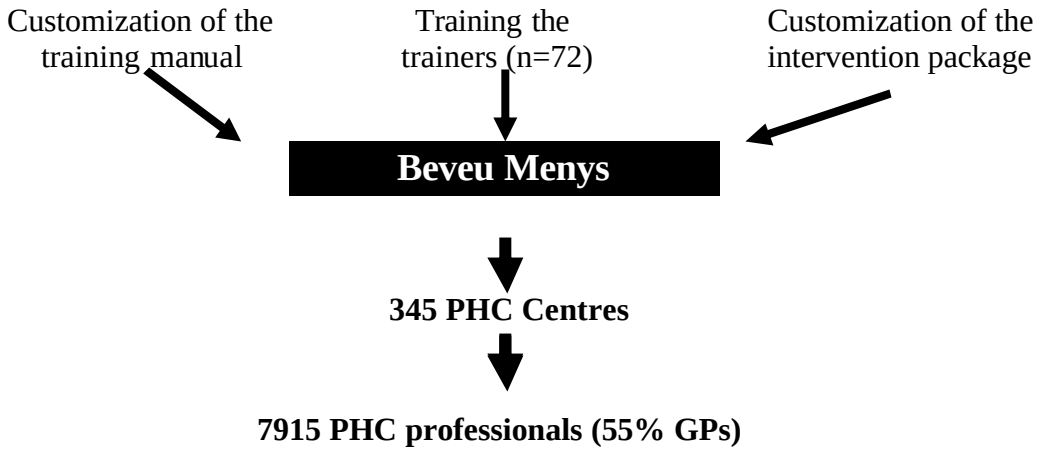
- To raise awareness on alcohol-related issues, specially in the area of risky drinking, among PHC professionals, helping to reframe the classical conceptions.
- To enhance the skills of PHC professionals in the management of alcohol-related issues.
- To provide policy makers and Health Authorities with a tool that allows them to promote the dissemination of SBI techniques in PHC settings.

The following ideas were taken into account:

- PHC settings are in a pivotal position for:
  - early detection and brief intervention with risky drinkers
  - early detection of alcohol related harm
- PHC workers lack training in alcohol issues and specially in SBI techniques
- PHC workers are overloaded by their clinical work. Time is a main constraint.
- Motivation is a key issue both in GPs and patients.
- Dissemination of SBI in the whole country: 6.090.040 inhabitants

- By trainers from the Addictions Treatment Network (n = 72)

Figure 8. The Drink-Less Programme.



The main roadblocks found were:

- No time for training
- No time for SBI
- Overburdened by clinical activity
- No priority of Health Promotion activities
- Prejudices against alcohol (it's not my problem, it's useless, etc)
- Reluctance to screen

7.2 Training

5 hours of training delivered by Alcohol specialists to the PHC professionals (n = 7915) as CME courses inside the PHC Centres (n = 347)

- 88% physicians; 10% psychologists
- Working in the same geographical area.
- Sharing common patients.
- Participating in the customization process
- Trained as trainers in intensive weekend workshops

Two intensive one-and-a-half-day workshops, with 30 participants each, were held in Sitges (Barcelona) aimed at:

- introducing trainers to the philosophy of the Skills for Change package;
- identifying barriers and roadblocks for implementation;
- reaching consensus on the model of intervention with allowance for personal customisation.

In a second stage of the training-the-trainers strategy, alcohol specialists were trained in small groups (8-10) in how to use the final training package. A total of 7 half-day workshops were held in the Program on Substance Abuse.

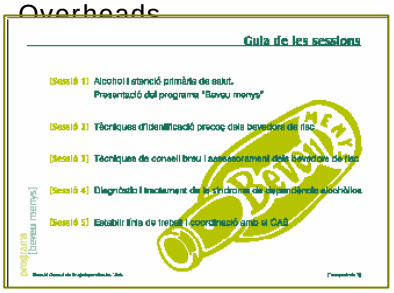
According to the geographical distribution of health services in Catalonia, each centre in the Catalan Drug Addiction Network was asked to train those PHC centres located in their area that usually referred patients to them. Training courses were delivered in five hours, following the guidelines of the BM package, but trainers were allowed to customize it regarding their and PHC professionals' preferences, resources and

needs. Courses were originally scheduled for between 14-15 hours (the time usually dedicated to CME in all PHC settings) but trainers' flexibility was encouraged to adapt training to PHC centre needs.

Figure 9. Training Programme

Didactic Guide

Overheads



7.3 Practice based guidelines, protocols and aids.

- Clear and simple
- Helps GPs to solve already existing problems. Takes into account resistances against screening
- Delivered in few hours and integrated in the regular CME
- Adaptable to self-training formats
- Providing user friendly tools & materials that can be used in the daily practice

Early identification (screening) package

The AUDIT questionnaire has been validated in both official languages of Catalonia (Catalan and Spanish)[lxxix,lxxx]. Additionally, a Systematic Interview on Alcohol Consumption (SIAC) was developed with three quantity-frequency questions and validated to detect risky drinking in PHC settings[lxxxi]. Later, the AUDIT-C[lxxxii] was also validated. All instruments showed acceptable sensitivity and specificity levels for the cut-off scores recommended by WHO to detect hazardous and harmful drinking. All screening tools have been included in the intervention package and their selective or systematic use is decided by each PHC centre.

Brief intervention package

Three different focus groups (FGs) with PHC professionals were held in order to provide feedback on the PHC view of alcohol issues. These focus groups were attended by PHC nurses (1st FG), GPs who participated in the Drink-less programme during Strand 3 of the WHO Phase III project (2nd FG) and PHC Centre Coordinators (3rd FG). FGs addressed the following issues: a) qualitative analysis of the Drink-less package, b) changes to be introduced, c) guidelines for community action, d) the role of each professional, e) how to improve patients' acceptance of the package, and f) how to minimize resistance from professionals.

FG recommendations were taken into account and, together with the basic module and the Alcohol module of the Skills for Change[lxxxiii] package, constituted the main documents to be discussed in FGs during the trainers'

workshops. The aim was to develop, through FGs and workshops, a specific Catalan training package customized to the trainers' and trainees' needs.

- Taking into account the experience of the WHO collaborative project
- Use the Stages of Change Theory and motivational strategies not only to approach patients but also when we approach the whole Health System (GPs, trainers, Health Authorities, etc)
- Enable changes in the design. Flexibility.

Information collected in the previous meetings was used to design the definitive package and model of intervention and to allow personal customization without changing any essential aspect of the package. The final edited package contains documentation for the trainer (didactic guide, 36 overheads, CD-Rom with all materials and CD-Rom with examples) and for the trainee (Handouts and SBI package). The SBI package includes general guidelines, AUDIT and ISCA questionnaires with templates, a management guide, diagnosis and intervention flowcharts, self-help booklets and posters and leaflets for the waiting room.

The sessions finally agreed were five:

1) Alcohol and PHC (introducing the Drink-Less Program);
2) Risky drinking and screening tools;
3) Brief interventions for risky drinkers;
4) Diagnosis and treatment of the Alcohol Dependences Syndrome;
5) Action plan and co-ordination strategies (treatment policies, referral criteria).

Although trainers suggested the need to increase the number of training sessions, reluctance by PHC teams to dedicate more time to alcohol and budget limitations were the main constraints.

Figure 10. Intervention Programme

Didactic Guide

Screening tools

Intervention guide

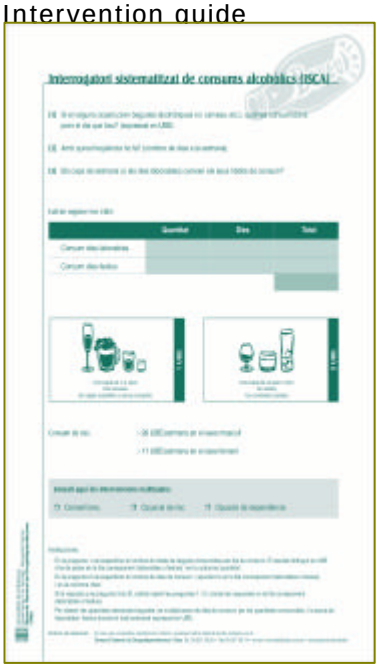


Figure 11. Information leaflets aimed at the general population

Posters

Helping guide for risky drinkers

Helping guide for alcoholics

7.4 Engaging primary health care providers

The successful dissemination of the project in the whole of Catalonia can be explained by the fact that the leading organization is the Health Department itself. The features of the Catalan Health System and the roles of health institutions were also well-known and have been taken into account since the beginning.

One of the first decisions taken was to establish a co-operative relationship regarding SBI with all centres of the Catalan Drug Addiction Network and their health professionals and specialists on addiction. A total of 60 centres were involved and around 83 professionals (psychiatrists, psychologists, nurses and social workers) have worked as trainers and also proved to be useful in the wider, country-wide dissemination effort to all PHC centres and professionals.

At the same time, and since Catalonia joined the WHO series of projects in 1998, the Program on Substance Abuse developed, adopted and promoted a plan to endorse the dissemination of the SBI techniques among PHC and other settings by including the Beveu Menys objectives as risk reduction targets and prevention activities in the alcohol chapter of the Health Plan for Catalonia. The Health Plan states the objectives and the services being bought during that period, so by including the Beveu Menys aims purchasers (Catalan Health Service) and service providers (Catalan Health Institute) have been forced to look forward to the achievement of those targets through the establishment of contracts. The CatSalut has the power to vary the reward structures and conditions of service in PHC. The alliance built with the Health Education Institute (IES) allowed the accreditation of the Beveu Menys course by the Catalan Council for Continuous Medical Education

(CME) and assured the financial reimbursement and professional accreditation of the trainers and the accreditation of the trainees.

The alliance with the Catalan Scientific Society on Family Medicine (SCMFiC) provided support and legitimacy since it is seen by GPs as 'their' scientific society. Special attention has been paid to acquire the reputation of a laboratory of learning where PHC professionals can find research evidence on SBI in a user-friendly form and associated materials.

The building of strategic alliances is an evolving process and will continue until an effective implementation of SBI in Catalonia is reached.

7.5 Funding and reimbursement

Since the SBI activities on alcohol problems are considered a priority in the Catalan Health Plan and since the Health Department is working towards its inclusion in all the contracts with providers, they are not extra reimbursed. They are considered part of the normal preventive activity of the PHC centres. Clients are also not considered reimbursable.

However the development and dissemination of such a programme has been made possible thanks to the continuous funding from the Program on Substance Abuse during the whole period (6 years). Although no formal economic analysis has been yet carried out, some information on the project direct costs is available:

PERSONNEL COSTS

	***Fees**			**EUROS**	
years	nº of persons	daily rate	nº of days		
6	1	217	55	71.610,00	Leader
6	1	135	220	178.200,00	Coordinator
3	1	135	55	22.275,00	Evaluator
			Subtotal	272.085,00	
	*** Secretarial costs**				
3	1	100	55	16.500,00	Administration
			Subtotal	16.500,00	
			TOTAL	288.585,00	

MISCELLANEOUS SERVICES

	*** Information costs**		
	Technical computer support for website		2.000,00
	*** Costs of reports / Translation**		
	edition trainer package 109 x 87,43 euros /copy		9.529,87
	edition trainee package 8.687 x 43,53 euros /copy		378.145,11
	edition sensitisation materials		25.545,42
	CD Rom 3000 x 8,37 euros /copy		25.110,00
	Designer Costs		6.896,00
	*** Subcontracting**		
344	courses	300	103.200,00
	*** Audit / evaluation costs**		
	Field Work		18.000,00
	*** Other services**		
2	meetings with trainers		17.184,00
7	meeting with trainers		850,00

	TOTAL	586.460,40
PROJECT ADMINISTRATION		
*** Equipment**		
1 set of office furniture		550,00
1 set of computer equipment		1.900,00
1 set of fax		600,00
1 copy of SPSS software analysis		8.800,00
*** Cost of consumables and supplies directly**		
Office consumables		1.000,00
Post costs		10.115,00
Post costs euros		333,12
Telephone calls		107,74
	TOTAL	23.405,86
	TOTAL COSTS	**898.451,26**

7.6 Specialist support and knowledge centres

In the catalan dissemination strategy the addiction specialists were chosen as trainers because of their high degree of interest and motivation in the field and their skills in alcoholism treatment. In addition, the similar geographical distribution of the networks (specialists and PHC) facilitated team co-ordination and contributed to stimulating interest in and maintenance of the interventions. Through motivational techniques, the training process aimed to strengthen the professional's commitment to training GPs and to identify barriers that might interfere with the training process. The complete training strategy was developed in two stages and under three main principles:

- Use the Stages of Change model and motivational strategies, not only to approach patients but also to approach change in the whole health system (GPs, trainers, Health Authorities, etc.);
- Enable changes in the design and allow maximum flexibility and customization in order to make trainers as comfortable as possible with the training package;
- Follow directions established by the Phase IV Co-ordinating Centre in Newcastle.

7.7 Monitoring the progress and evaluating the programme

To monitor the programme a parallel, ongoing, pre-post evaluation procedure has been implemented in 10% (n=28) of randomly selected centres. Two researchers were trained to sample data before and three months after the dissemination of the program. Variables measured were attitudes, knowledge and behaviour of both patients and PHC professionals. Attitudes and knowledge were measured through questionnaires and behaviour through audits of medical records in which clinical procedures are registered. Additional sources of information taken into account are the number of consultations for alcohol problems to the CDAN centres and the number of referrals from PHC centres. Sources of information comprised 973 (87% of the total planed) patients' questionnaires, 80 (95%) GP and nurses interviews and 851 (101%) medical records audits.

32.2% of professionals were males and 68.8% females, with a mean age of 44.33 (± 8.54); 55% were physicians and 45% nurses. Mean years of experience in PHC settings was 14.09 (± 7.99), mean number of consultations per week was 125.88

(± 62.16) and the mean number of patients quoted was 1,982.72 (± 361.29). 48.8% had less than four hours training in the alcohol field and 48.7% used their clinical impression for screening. Regarding alcohol consumption (measured with AUDIT-C), 8% of males and 14.5% of females were risky drinkers. There is a gap between practitioners' perceptions and reality in terms of the importance of alcohol as a health determinant, they do not have enough training on alcohol prevention programs and they are not used to standardized instruments.

Medical records of 852 patients were randomly selected. 33.3% were from patients who attend PHC settings very often (once a month or more) and 36% were from patients who attend approximately once every three months. Alcohol consumption was registered in 26.4% of cases in 27.3% alcohol consumption had been screened by clinical impression. Risky drinking diagnosis (3.2%) were registered, less than suggested by the prevalence shown in surveys (9.5%) and brief interventions and shared care treatment were infrequent

Patients interviewed were a mean of 52.81 (± 18.57) years old; 35.8% were males, 28.3% were pensioners and 22.2% were housewives. 51.1% had never been questioned regarding their alcohol consumption and 30.4% had been questioned over one year ago. WHO limits on alcohol consumption were unknown for all patients interviewed. 18.3% of patients were risky drinkers (assessed by AUDIT-C).

When comparing the three sources of information (see table 4.3.) we found that at least half of patients have never been screened on alcohol consumption. RD is scarcely ever identified (only 3.2% screened positive through medical record audit whereas around 18.3% screened positive by exit poll questionnaires) and advice is rare.

Table 12 Screening and Brief Intervention implementation level according to the three different sources.

	Patients (%)	Medical Records (%)	Professionals (%)
Screening	49,9	26,4	46,7
Method			
None		24,1	14,5
AUDIT		---	7,9
Clinical Impression		27,3	48,7
Quantity/Frequency		39,6	---
Others (biomarkers)		10,6	28,9
Advice (in those screened)	16,9	9,2	51,3
Identified Risky Drinkers	18,3	3,2	3,9

Together with that a qualitative evaluation through focus groups with all the key stakeholders has been implemented.
8 focus groups with specialist and 4 with primary health care coordinators were run covering the following topics:

- Main advantages and roadblocks for the implementation of the EIBI
- Ideas for the improvement of the implementation of the EIBI

For the continuous monitoring of the programme a set of indicators have been identified.

Indicators of the dissemination phase:
-Number of professionals trained (physicians, nurses, others)
-Number of PHC centres trained
-Number of Primary Health Care Alcohol Referents trained
-Number of PHC centres trained in the actualisation of the project
-Number of professionals receiving the BM bulletin
-Number of visits to the website
-Percentage of PHC centres that receive the bulletin
-Percentage of specialists that receive the bulletin

Indicators of the Implementation phase (some of them are still not available but we are working on their consolidation)
-Screening rate % in Governmental Audit of Medical Records (randomised 100 PHC centres) every 5 years
-Risky drinking % in Governmental Audit of Medical Records (randomised 100 PHC centres) every 5 years
-Annual screening rate through automatic audit of medical records (ICS)
-Annual PHC centres screening rate through consultation of computerized medical records database
-Annual PHC centres intervention rate through consultation of computerized medical records database
-Annual implementation questionnaires (PHC professionals)

7.8 Preparing for the introduction of the programme

A communication strategy was organized in order to prepare the introduction of the programme:

- The Official Presentation was held on 21 November 2001 and all relevant stakeholders (health authorities, PHC coordinators, addiction specialists, media and policy makers) were personally invited.
- Written Communication announcing the start of the dissemination was delivered to:
  -all health stakeholders, with detailed information on the procedure that was planned
  -PHC co-ordinators, with detailed information about the program, the consequences for their centers and the procedures planned. They also received a complete BM package.
- A BM co-ordinator visited all centres in the Catalan Drug Addiction Network to introduce the final package and to discuss with trainers the dissemination procedure planned and the list of PHC centres assigned.

To reinforce professionals and to guarantee the sustainability of the dissemination procedure BM courses were also declared of Medical Interest and, as a result, their acceptance by all participants was facilitated. Additionally, funds were raised to pay for training carried out by the specialists (300 € per course).

To schedule courses the following procedure was established:

A. The CDAN professionals contact the PHC centres assigned to negotiate the most suitable dates for the course.
B. Agreed dates and total list of participants are notified to the BM coordinator at least one month before the start of the course.
C. BM coordinator sends the following documents:
    i. -To the trainer:
        1. -A list of participants and a registration sheet for signatures (attendance is proved by the signature)
        2. –A questionnaire evaluating the training course (quantitative and qualitative data)
    ii. -To the PHC coordinator:
        1. -BM packages for all participants
        2. –A set of materials addressed to patients (3 posters and 20 leaflets)
D. Once the course is finished, evaluation documents and registration sheets are sent back to the BM coordinator. Accreditation for all participants who attended at least 80% of the course and certificates for those who attended less than 80% are then sent. At the same time trainers' reimbursement and accreditation are arranged.

7.9 Managing the programme

The Program Substance Abuse of the Health Department of the Autonomous Government of Catalonia is the leading organization and has funded the entire project. It has been receiving advice since the beginning from one of the major Spanish scientific societies in the addictions field, the Spanish Scientific Society on Alcoholism (Socidrogalcohol). Since the start of the project, the Beveu Menys executive team has been led by Dr. Joan Colom (Director General) and Dr. Antoni Gual (Public Health Consultant and expert in the alcohol field) with the support of the Program on Substance Abuse technical and administrative members (Lídia Segura, Olga Montserrat, Claudia Fernández, Montserrat Rodriguez and Encarna Moreno). In order to achieve the widespread dissemination and implementation of the project the role of the programme coordinator, who has uniquely been devoted to that aim during the whole process, has been of great importance.

Strategic alliances have been also built during the whole process and have been aimed at bringing together individuals and organizations with a common interest and included institutions that play an essential role in the Catalan Health System to assure the implementation of the project:

- Catalan Drug Addiction Network
- Catalan Health Service (CatSalut)
- Catalan Health Institute (ICS)
- Continuous Health Education Institute (IES)
- Spanish Scientific Society on Alcoholism (Socidrogalcohol)
- Catalan Scientific Society on Family Medicine (SCMFiC)

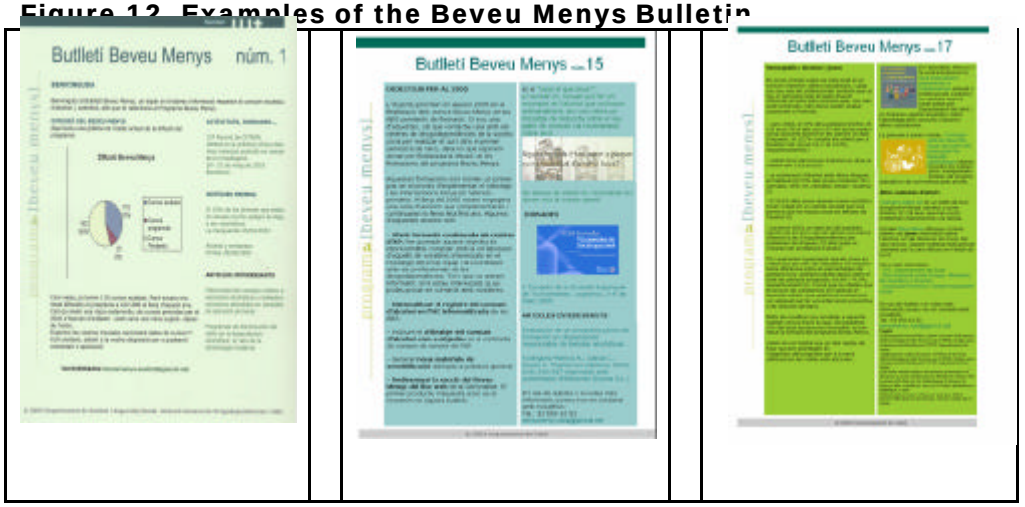
7.10 Communicating about the programme

The communication about the programme has been specially targeted at health managers, health providers, professionals groups (specialists and PHC professionals) and the general public. The work already done has consistently contributed to a better understanding by all of them but specially by the health professional groups of the reframed alcohol concepts (risky drinkers, hazardous and harmful drinkers, excessive drinkers, etc.) and the rationale for SBI.

Health managers and providers have been regularly updated about the programme through official letters and mailings and they were all invited to the official presentation of the programme and the press conference.

As part of the communications strategy aimed at disseminating SBI, in May 2003 we launched a monthly Beveu Menys Bulletin targeted at general practitioners and specialists, containing relevant information on the project and contributing to reframing by including and updating relevant evidence-based studies of SBI methods. It is published by electronic mail and contents include Drink-less news, dissemination data, information on alcohol, news in the media, courses and activities, articles in scientific journals and interviews with to professionals (see figure 12).

Figure 12. Examples of the Beveu Menys Bulletin



To date, 19 BM bulletins have been produced. It is regularly sent to more than 600 e-mails (493 PHC and 123 specialists) and it is received by 92% of the PHC centres and 80% of specialists. It has resulted in increased requests for materials and an increase in the number of courses scheduled.

No widespread mass media campaign targeted at general public has yet been delivered but a communication strategy has already been implemented by including messages on posters and leaflets in waiting rooms. Messages on the concept of risky drinking according to gender differences and slogans aimed at encouraging the general public to ask their GP about their drinking behaviour have been included. Alcohol consumption limits and the idea that assistance can be provided have been also strongly reinforced. The need to carry out a media campaign targeted at general public with specific messages aimed at youth is being considered. No decision on this has yet been made.

Media advocacy has been also encouraged. First all journalists in the region were invited to a press conference some days before the official launch of the programme (November 2001). The conference was aimed at introducing the

programme, increasing the media's interest in alcohol-related issues and encouraging them to promote the concept of hazardous and harmful drinking in their work. Over the last few years additional media advocacy has been carried out by talking about the project at every opportunity and in every interview programmed on the alcohol problem.

7.11. Next steps

The major achievement this whole procedure has been the engagement of PHC voluntary professionals in each PHC center to get together to form the PHC alcohol reference professionals network (XaROH). A specific training procedure has been designed to skill them properly on the new area of responsibility and support services are being also developed. We are now entering a new phase of the project were the PHC professionals are starting to be responsible for the implementation of the SBI tools in hazardous and harmful drinkers, always with the specialist as a supporting figure, especially for the management of alcohol dependents.

The training the trainers method is again starting to be used to train the PHC referents on alcohol to provide them with the necessary skills to continuously train the PHC team and to encourage the use of the SBI tools in daily clinical work among their colleagues.

The training is designed to build in them the capacities to support their colleagues in their daily work when screening and intervening on alcohol issues and it is organized in two sessions. A first one is aimed at clarifying their role in the whole programme and at giving a general overview of their functions and new responsibilities. A second session of 5 hours is devoted to training them in SBI taking into account that they had previously received the basic training.

In June the first training workshop was organized with the participation of the BM trainers and the XaROH members, aimed at renewing their motivation, updating them on the last research in the field and training them on the program continuity.

Some other initiatives already functioning are the following:

-The creation of the **Alcohol and Primary Health Group.** It comprises primary health and drug addiction professionals, Health Department representatives, professional schools, foundations and related entities. The goal is to work out the lines of continuity for the program especially through the working group created with the PHC professionals.

-The creation of the **Nursing working group. It is integrated by representatives of all the Nursing entities and the group aims to** develop new continuity strategies where the nurses would be the main protagonists. In November a 25-hour CME course entitled "BM training course in depth for nurses" will be held, aimed at training and updating as many nurses as possible in SBI methods.

-Redesign of the Beveu Menys website in order to promote a better and more comprehensive understanding of the aims, concepts and tools of the program.

-Adaptation of the BM tools for the existing computerized medical records in PHC settings to facilitate their utilization in daily clinical routine.
-Introduction of an Alcohol Screening Indicator in the Health System Contract.

8. Research needs

Needs for actual and future researches are:

a) Research on effectiveness of EIBI when carried out in real-life conditions of primary health care is still needed in Catalonia.
b) Research on effectiveness of EIBI when carried out by nurses.
c) Long-term effects of EIBI have not been studied yet. Long-term follow-up studies have to be carried out.
d) Further research on more targeted EIBI in the PHC setting should also be carried out.
A priority in Catalonia will be to study the effectiveness of EIBI in reducing drinking among youth.
e) Economic evaluations of brief interventions are needed in Catalonia.
f) A study of the effects of incentives (financial and professional) in encouraging general practitioners and other health care professionals to implement screening and brief interventions in their work will be of much importance.
g) Research on implementation of EIBI when using the computerized medical record.

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PHEPA
(Primary Health Care European Project on Alcohol)

Country Report.
Sverre Barfod, Denmark

May 2005

Introduction

Alcohol consumption

In 2002 every dane > 14 years old consumed 11,6 liters of pure alcohol in average. This is more than twice the consumption in de other nordic countries. The danish drinking habits are inherited. Danish children often drink alcohol at the first time 13 years old. The youngsters are drinking more and more often than yuongsters in other european countries.
Round 200,000 danes are dependent of alcohol while other 300,000 are drinking in a risky way.
This is defined as drinking more than the drinking limits recommended by the National Board of Health: Not more than 14 units a week for women and 21 units a week for men. (A danish unit amounts 12 g alcohol).
Round 60,000 children grow up in families with alcohol abuse.
In 1998 about 3,500 danes died of alcohol related diseases. This is 6% of the total number of deaths. The consumption of alcohol in Denmark costs the society about 1.33 billion euro (10 billion DKK = 10,000,000,000 DKK).
(Ref.: The National Board of Health (Sundhedsstyrelsen), www.sst.dk)

Who will do what? Who can do what?

Willingness to change

The majority of danish patients find it OK that their GP rises life style issues during consultation if it seems relevant to the problem presented.
The GPs are willing to discuss life style issues if they can be trained in rising the subject and coping with the patients resistance. The GPs don't want the discuss alcohol as the only theme but want to include other issues like smoking, diet, weigth, lack of exercise.

The danish National Board of Health

The overall aim for the danish National Board of Health is explained at their website www.sst.dk :

To reduce alcohol consumption especially the number of risky drinkers and the amount of alcohol related harm by information on alcohol and by preventing alcohol problems
To put off the first experience of children with alcohol and reduce the consumption among youngsters
To promote alcohol policy at working places, schools, et cetera
To develop methods of identification and early intervention towards alcohol problems

The danish government

1.Prices.
The government has reduced the prices of alcohol beacuse of specific financial and trade reasons. The Minister of Health turned down the expressed concerns

from experts of health and social matters as they explained the adverse impact on the drinking habits of the population, not at least the young ones.

2. Reform of infrastracture
Until now there has been (and still is) a big gap between the possibilities of treatment in different counties/regions.
At Jan. 1st 2007 the 15 counties will change into 5 regions, and 220 municipalities of very different size (both area and population) will change into 99 more even municipalities.
The prospects concerning placing the responsability for the public treatment of alcohol problems are indeed uncertain. The municipalities are supposed to take care of the alcohol problems.
While the responsability belonged to the counties, coordination was (is) totally missing. This nay be the cause that there are only a few hits of alcohol topics on the national website of health (www.sundhed.dk) and none of the counties has a written policy of manageing alcohol problems.
One could be afraid of even less clearness and coordination after delegating the task to the municipalities.

Current activities and hopes for times coming

Continuous medical education

Developing a declaration of quality for general practice is rather difficult but progress is made. So, during the last few years the *Danish Regions* (Amtsrådsforeningen) have established five committees on different areas of quality assurance in general practice. The aim is to coordinate this with the continuous medical education (CME) of GPs.
The importance is stressed on the breadth of the offers of the CME including involvement of the clinic staff.
The National Board of Health has initiated some projects involving the staff of the clinics in advicing the patients. Because of the lack of GPs more advice will be given in the future clinics by the staff. Some GPs are very interested in this, others are more reluctant.

In GP's clinic

The National Board of Health has published a catalogue of ideas on preventive work in general practice with reports form clinics active in the preventive field, from doctors *and* staff.
Concerning alcohol problems the catalogue mentioned detection and referral but it is well known that GPs not allways *want* to refer. Furthermore not all municipalities have specialists or out patient clinics to whom GPs can refer. It is quite uncertain if the coming larger municipalities will be more able to solve this problem
Hence general practice - including the staff - should have tools also for *treatment* including skills in motivational interviewing.

Referral

The contact between the GPs and the out-patients' clinics of alcohol *after* referral is non-existrent in almost all Denmark and improving this contact is very important, especially by systematic information procedures.

Conclusion:

1.
The reform of infrastracture by January 1st 2007 will be a changing point for far the most of the tasks of the official Denmark. Nobody knows what will happen to the alcohol matter under the responsability of the single municipality. And nobody can plan anything committing. This fact impedes the initiatives of education and developing new principles of approaching alcohol problems.

2.
The National Board of Health (Centre of Prevention) has received the PHEPA Training Programme. The Board is aiming at the involvement of the staff in the preventive work of the clinics, but for the moment (May 2005) it is uncertain if the Board wishes to use PHEPA material (in some way) concerning the alcohol issue.

3.
The CME of GPs is administrated by quality assurrance committees in the counties. Only few of these groups are engaged with the alcohol issue.
It has been essential to combine the skills of motivational interviewing in the programs but because of lack of manpower it has not been possible to educate GPs as trainers in the different counties/regions as planned.

22/5 2005,
Sverre Barfod

Primary Health Care European Project on Alcohol (PHEPA)

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

STRATEGY FOR ENGLAND

SUMMARY

THE EU-FUNDED PRIMARY HEALTH EUROPEAN PROJECT ON ALCOHOL *[PHEPA] AIMS TO DEVELOP AND APPLY COUNTRY-WIDE STRATEGIES FOR IMPLEMENTING SCREENING AND BRIEF INTERVENTION (SBI) FOR HAZARDOUS AND HARMFUL DRINKERS THROUGHOUT THE PRIMARY HEALTH CARE (PHC) SYSTEMS OF PARTICIPATING COUNTRIES.*

THIS DOCUMENT CONTAINS A STRATEGY AIMED AT PROMOTING THE WIDESPREAD, ROUTINE AND ENDURING IMPLEMENTATION OF ALCOHOL SBI IN PHC IN ENGLAND AND WAS DEVELOPED BY A TEAM OF EXPERTS REPRESENTING MAJOR ORGANISATIONAL INTERESTS IN ALCOHOL SBI. THE STRATEGY WILL BE SUBMITTED TO THE PHEPA CO-ORDINATING CENTRE AND WILL THEN BE PRESENTED TO THE DEPARTMENT OF HEALTH.

SINCE THE BEGINNING OF PHEPA, THREE MAJOR DEVELOPMENTS HAVE TAKEN PLACE IN THE UK THAT ARE HIGHLY RELEVANT TO THIS IMPLEMENTATION STRATEGY: THE GOVERNMENT'S ALCOHOL HARM REDUCTION STRATEGY FOR ENGLAND *(AHRSE), THE* NEW GENERAL MEDICAL SERVICES CONTRACT *(NGMS) AND A WHITE PAPER FROM THE DEPARTMENT OF HEALTH ENTITLED* CHOOSING HEALTH: MAKING HEALTHY CHOICES EASIER. *THE COMBINATION OF THESE THREE DEVELOPMENTS REPRESENTS AN OUTSTANDING OPPORTUNITY SIGNIFICANTLY TO INCREASE THE IMPLEMENTATION OF SBI AND PHC IN ENGLAND, WITH ASSOCIATED BENEFITS FOR PATIENT HEALTH AND WELFARE AND FOR THE PUBLIC HEALTH.*

DATA ON THE CURRENT USE OF ALCOHOL IN ENGLAND ARE REVIEWED AND IT IS CONCLUDED THAT ENGLAND, IN COMMON WITH THE OTHER COUNTRIES OF THE UNITED KINGDOM, IS CURRENTLY EXPERIENCING A MARKED INCREASE IN ALCOHOL CONSUMPTION, BOTH IN TERMS OF PER CAPITA CONSUMPTION AND OF HAZARDOUS AND HARMFUL DRINKING PATTERNS. THIS INCREASE IS ESPECIALLY MARKED AMONG WOMEN AND AMONG YOUNG PEOPLE OF BOTH GENDERS, INCLUDING THOSE LESS THAN 16 YEARS OF AGE. ALTHOUGH IT IS BY NO MEANS CONFINED TO YOUNG PEOPLE, THE TENDENCY TO BINGE DRINK APPEARS TO BE INCREASING MORE SHARPLY AMONG THOSE LESS THAN 24 YEARS OF AGE. THERE ARE CLEAR VARIATIONS IN LEVEL OF CONSUMPTION BETWEEN THE REGIONS OF ENGLAND, WITH THOSE IN THE NORTH OF THE COUNTRY DRINKING MORE THAN THOSE IN THE SOUTH.

A REVIEW OF EVIDENCE ON THE EXTENT OF HARM DUE TO ALCOHOL CONSUMPTION CONCLUDES THAT, IN LINE WITH THE RISING LEVEL OF CONSUMPTION, ENGLAND AND OTHER COUNTRIES OF THE UK ARE CURRENTLY EXPERIENCING A MARKED INCREASE IN ALCOHOL-RELATED PROBLEMS OF ALL KINDS.

GIVEN THE GOVERNMENT'S REJECTION OF ALCOHOL CONTROL MEASURES IN THE FORM OF TAXATION AND THE REGULATION OF THE PHYSICAL AVAILABILITY OF ALCOHOL, IT IS CONCLUDED THAT THE WIDESPREAD IMPLEMENTATION OF SBI IN A RANGE OF MEDICAL AND OTHER SETTINGS IS THE BEST OPTION FOR MAKING A SIGNIFICANT IMPACT ON THE LEVEL OF ALCOHOL-RELATED HARM IN ENGLAND. AMONG THE SETTINGS WHERE SBI MIGHT BE WIDELY IMPLEMENTED, PHC IS THE ONE THAT OFFERS THE GREATEST POTENTIAL FOR REACHING THOSE IN NEED OF INTERVENTION.

THERE IS A VERY LARGE BODY OF EVIDENCE RELATING TO THE EFFECTS OF BRIEF INTERVENTION, INCLUDING ITS EFFECTS SPECIFICALLY IN PHC. THIS SHOWS THAT BRIEF INTERVENTION IS EFFECTIVE IN REDUCING THE ALCOHOL CONSUMPTION OF HAZARDOUS AND HARMFUL DRINKERS TO "SENSIBLE" LEVELS AND IN REDUCING ALCOHOL-RELATED PROBLEMS. THERE IS EVIDENCE TOO, MOSTLY FROM OUTSIDE THE UK, THAT BRIEF INTERVENTION IS A HIGHLY COST-EFFECTIVE FORM OF INTERVENTION AMONG HAZARDOUS AND HARMFUL DRINKERS AND THAT ITS WIDESPREAD INTRODUCTION INTO PHC WOULD LEAD TO A REDUCTION IN HEALTH SERVICE USE AMONG EXCESSIVE DRINKERS, WITH CONCOMITANT BENEFITS FOR THE NATIONAL HEALTH SERVICE AND THE NATIONAL ECONOMY. HOWEVER, THERE IS ALSO GOOD EVIDENCE THAT PHC PROFESSIONALS

IN ENGLAND HAVE FAILED TO IMPLEMENT FORMAL SBI PROCEDURES IN THEIR ROUTINE PRACTICE AND OBSTACLES AND INCENTIVES AFFECTING IMPLEMENTATION HAVE BEEN IDENTIFIED IN RESEARCH.

A CLOSE EXAMINATION OF THE IMPLICATIONS FOR THE AHRSE FOR THE IMPLEMENTATION OF SBI REVEALS SOME FEATURES VERY USEFUL TO THE IMPLEMENTATION PROCESS. HOWEVER, A MAJOR FLAW IN THE AHRSE IS THE NEGLECT OF THE HAZARDOUS DRINKERS, AS OPPOSED TO PATIENTS WITH ESTABLISHED ALCOHOL PROBLEMS, WHO MUST BE INCLUDED AS A MINIMUM IN ANY RATIONAL AND EFFECTIVE IMPLEMENTATION OF SBI.

WHILE IT TOO HAS USEFUL FEATURES, THE SAME FLAW IS APPARENT IN THE NGMS CONTRACT AND IT IS CONCLUDED THAT THE ALCOHOL SPECIFICATION IN THE CONTRACT IS URGENTLY IN NEED OF REFORM IF IT IS TO ASSIST THE WIDESPREAD IMPLEMENTATION OF SBI.

THE CHOOSING HEALTH *WHITE PAPER WILL ALSO BE USEFUL TO THE EFFORT TO IMPLEMENT ALCOHOL SBI, PARTICULARLY IF THE PROPOSED NEW PROFESSION OF "HEALTH TRAINERS" RECEIVE ADEQUATE INSTRUCTION IN THE DELIVERY OF SIMPLE ADVICE TO HAZARDOUS AND HARMFUL DRINKERS.*

THE STRATEGY FOR ACHIEVING WIDESPREAD IMPLEMENTATION OF SBI IN ENGLAND IS BASED ON SIX KEY PRINCIPLES (Q.V.) AND ENTAILS THE FOLLOWING ACTIONS:

a) *THE DEVELOPMENT AND DISSEMINATION OF CLINICAL GUIDELINES TO ASSIST PRACTITIONERS IN THE DELIVERY OF SBI;*
b) *THE DEVELOPMENT AND DISSEMINATION OF NATIONAL TRAINING PROGRAMMES TO ENABLE PRACTITIONERS TO FEEL MORE CONFIDENT IN THE DELIVERY OF SBI;*
c) *THE USE OF DANOS STANDARDS AND HEALTHCARE COMMISSION STANDARDS FOR BETTER HEALTH TO RAISE THE QUALITY OF SBI DELIVERY;*
d) *THE DEVELOPMENT OF TESTED, USER-FRIENDLY SBI MATERIALS AND PROCEDURES AND THEIR DISSEMINATION AMONG PHC PROFESSIONALS;*
e) *THE AVAILABILITY OF ADEQUATE REIMBURSEMENT TO GENERAL MEDICAL PRACTICES FOR THE ROUTINE DELIVERY OF SBI;*
f) *THE AVAILABILITY AND PROMOTION OF A WEB-BASED* ALCOHOL MANAGEMENT DATABASE *FOR USE BY PHC PROFESSIONALS INTERESTED IN DELIVERING SBI;*
g) *THE APPLICATION OF A MARKETING PLAN TO PROMOTE THE SBI IMPLEMENTATION STRATEGY;*
h) *A MECHANISM TO MANAGE THE SBI IMPLEMENTATION STRATEGY AND MONITOR ITS PROGRESS.*

GAPS IN THE RESEARCH EVIDENCE-BASE RELEVANT TO IMPLEMENTING SBI ARE IDENTIFIED. THE GOVERNMENT'S INTENTION TO FUND PILOT RESEARCH ON TARGETED SBI PROMISES TO BE HIGHLY BENEFICIAL TO THE EFFORT TO ACHIEVE WIDESPREAD, ROUTINE AND ENDURING IMPLEMENTATION OF SBI IN PHC IN ENGLAND.

CONTENTS

1. INTRODUCTION

THE PROJECT ENTITLED INTEGRATING HEALTH PROMOTION INTERVENTIONS FOR HAZARDOUS AND HARMFUL ALCOHOL CONSUMPTION INTO PRIMARY HEALTH CARE PROFESSIONALS' DAILY WORK *(OR PRIMARY HEALTH EUROPEAN PROJECT ON ALCOHOL [PHEPA] FOR SHORT) IS FUNDED BY THE EUROPEAN UNION (EU) AS PART OF THE* COMMUNITY ACTION PROGRAMME ON PUBLIC HEALTH *AND IS CO-ORDINATED BY THE PROGRAMME ON SUBSTANCE ABUSE, HEALTH AND SOCIAL SECURITY DEPARTMENT, GOVERNMENT OF CATALONIA IN BARCELONA. IT COMMENCED AT THE BEGINNING OF 2002 AND IS DUE FOR COMPLETION AT THE END OF JUNE 2005. A TOTAL OF 16 COUNTRIES IN THE EU ARE TAKING PART IN THE PROJECT, TOGETHER WITH EUROCARE AND THE WHO REGIONAL OFFICE FOR EUROPE.*

THE GENERAL AIM OF THE PROJECT FOLLOWS ON FROM PHASE IV OF THE WHO COLLABORATIVE PROJECT ON THE IDENTIFICATION AND MANAGEMENT OF ALCOHOL-RELATED PROBLEM IN PRIMARY HEALTH CARE, *THE AIM OF WHICH WAS TO DEVELOP AND APPLY COUNTRY-WIDE STRATEGIES FOR WIDESPREAD, ROUTINE AND ENDURING IMPLEMENTATION OF SCREENING AND BRIEF INTERVENTION (SBI) FOR HAZARDOUS AND HARMFUL DRINKERS THROUGHOUT THE PRIMARY HEALTH CARE (PHC) SYSTEMS OF PARTICIPATING COUNTRIES. A REPORT TO WHO ON THE WORK OF THE PHASE IV STUDY WILL BE COMPLETED IN 2005. HOWEVER, THE SPECIFIC AIMS OF PHEPA ENTAIL THE DEVELOPMENT OF FOUR RELATED PRODUCTS: (I)* CLINICAL GUIDELINES *FOR DELIVERING SBI IN PHC THAT CAN SERVE AS A BASIS FOR GUIDELINES TO BE USED IN PARTICIPATING COUNTRIES; (II) A* TRAINING MANUAL *LINKED TO THE CLINICAL GUIDELINES THAT CAN ALSO BE ADAPTED FOR USE IN PARTICIPATING COUNTRIES; (III) A WEBSITE CONTAINING AN* ALCOHOL MANAGEMENT DATABASE *FOR USE BY PHC PROFESSIONALS AND OTHERS INTERESTED IN THE PROMOTION OF SBI IN PRIMARY CARE; AND (IV) A* COUNTRY-BASED STRATEGY *AIMED AT INTEGRATING SBI FOR HAZARDOUS AND HARMFUL DRINKERS IN THE PHC SYSTEMS OF PARTICIPATING COUNTRIES.*

THIS DOCUMENT REPRESENTS THE ENGLISH CONTRIBUTION TO THE LAST OF THESE PHEPA PRODUCTS AND IS A STRATEGY AIMED AT ACHIEVING THE WIDESPREAD, ROUTINE AND ENDURING IMPLEMENTATION OF ALCOHOL SBI IN PHC IN ENGLAND. TO FACILITATE THE DEVELOPMENT OF THIS STRATEGY A SMALL TEAM OF EXPERTS WAS CONVENED TO REPRESENT THE MAJOR ORGANISATIONAL INTERESTS IN ALCOHOL SBI IN ENGLAND AND THE MEMBERSHIP OF THE TEAM, TOGETHER WITH OBSERVERS, IS SHOWN IN APPENDIX A. THE TEAM HAS MET ON TWO OCCASIONS (24 MARCH AND 2 SEPTEMBER 2004) AT THE PREMISES OF ALCOHOL CONCERN *AND HAS COMMUNICATED BY ELECTRONIC MEANS BETWEEN AND AFTER THESE DATES. THE COMPLETED STRATEGY WAS PRESENTED TO THE PHEPA CO-ORDINATING CENTRE IN BARCELONA AT THE END OF MARCH 2005 AND THE INTENTION NOW IS TO HAVE IT ENDORSED BY A NUMBER OF KEY PARTNERS AND STAKEHOLDERS IN ENGLAND BEFORE PRESENTING IT TO THE DEPARTMENT OF HEALTH.*

SINCE THE BEGINNING OF PHEPA, HOWEVER, THREE MAJOR DEVELOPMENTS HAVE TAKEN PLACE IN THE UK THAT INTIMATELY AFFECT THE FORM THAT THIS STRATEGY SHOULD TAKE:

- *THE GOVERNMENT'S* ALCOHOL HARM REDUCTION STRATEGY FOR ENGLAND *(AHRSE)*[1], *WHICH WAS IMPLEMENTED IN MARCH 2004. THE AHRSE DOCUMENT INCLUDES REFERENCE TO ALCOHOL SBI IN GENERAL AND SBI IN PHC IN PARTICULAR IN CHAPTER 5 ON* TREATMENT AND IDENTIFICATION *AND SUMMARISES THE GOVERNMENT'S INTENTIONS WITH REGARD TO SBI IN ENGLAND. THE PRESENT DOCUMENT WILL TAKE THE RELEVANT TEXT OF THE AHRSE AS A STARTING POINT FOR ITS RECOMMENDATIONS, ESPECIALLY IN SECTION 6 HERE ON "CURRENT POLICIES". HOWEVER, THE RELEVANT CONTENTS OF THE AHRSE WILL BE CONSIDERED IN MORE DETAIL AND ENLARGED UPON, AND WILL ALSO BE SUBJECT TO REASONABLE AND CONSTRUCTIVE CRITICISM WHERE APPROPRIATE.*
- *THE* NEW GENERAL MEDICAL SERVICES CONTRACT *(NGMS)*[2] *WHICH CAME INTO EFFECT AT THE BEGINNING OF APRIL 2004. A SPECIFICATION FOR THE TREATMENT OF "PATIENTS WHO ARE ALCOHOL MISUSERS" IS PROVIDED IN THE CONTRACT AS A* NATIONAL ENHANCED SERVICE *(NES) AND THIS INCLUDES SBI FOR HAZARDOUS AND HARMFUL DRINKERS. THE*

CONDITIONS OF THE NGMS SET THE PARAMETERS FOR WHAT THE PRESENT SBI STRATEGY CAN RECOMMEND FOR GENERAL MEDICAL PRACTICE IN ENGLAND AND THESE TOO WILL BE TAKEN AS A STARTING POINT IN SECTION 6 OF THIS DOCUMENT.

- *A WHITE PAPER PUBLISHED BY THE DEPARTMENT OF HEALTH IN NOVEMBER 2004 ENTITLED* CHOOSING HEALTH: MAKING HEALTHY CHOICES EASIER[3]. *THIS INCLUDES ALCOHOL CONSUMPTION AMONG THE OTHER HEALTH BEHAVIOURS IT ADDRESSES AND THE RELEVANT PASSAGES FROM THE WHITE PAPER WILL BE CONSIDERED HERE IN SECTION 6.*

THE COMBINATION OF THESE THREE MAJOR DEVELOPMENTS REPRESENTS AN OUTSTANDING OPPORTUNITY SIGNIFICANTLY TO INCREASE THE IMPLEMENTATION OF SBI AND PHC IN ENGLAND, WITH ASSOCIATED BENEFITS FOR PATIENT HEALTH AND WELFARE AND FOR THE PUBLIC HEALTH.

2. THE USE OF ALCOHOL

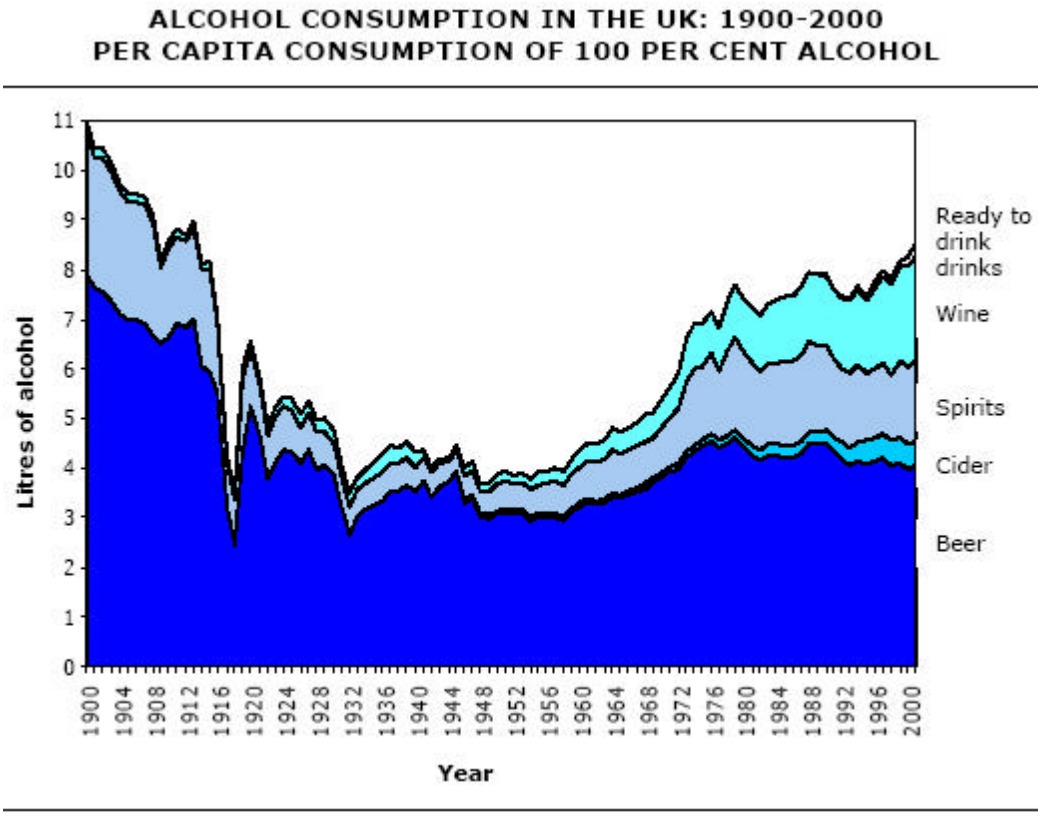
IN PREPARATION FOR THE AHRSE, IN SEPTEMBER 2003 THE PRIME MINISTER'S STRATEGY UNIT PUBLISHED AN INTERIM ANALYTICAL REPORT[4]. *THIS PROVIDED UP-TO-DATE INFORMATION ON ALCOHOL USE LEVELS AND PATTERNS, DIFFERENT FORMS OF ALCOHOL-RELATED HARM AND OTHER RELEVANT DATA, ALTHOUGH MANY OF THESE DATA ARE AVAILABLE ONLY FOR THE UNITED KINGDOM (UK) AS A WHOLE. THE REPORT HAS PROVED AN INVALUABLE SOURCE OF INFORMATION FOR THE PRESENT DOCUMENT BUT HAS BEEN SUPPLEMENTED HERE BY REFERENCE TO OTHER RELEVANT DOCUMENTS AND WEBSITES.*

ALTHOUGH TOTAL CONSUMPTION IN THE UK IS LESS THAN IT WAS 100 YEARS AGO, IT ROSE STEADILY DURING THE LAST CENTURY; IN 2001 A PER CAPITA CONSUMPTION CALCULATED AT 8.6 LITRES OF ETHANOL REPRESENTED A 121% SINCE 1951[4] SO TOO, PER CAPITA CONSUMPTION IN THE UK HAS RISEN BY 50% SINCE 1970 BUT IN FRANCE AND ITALY IT HAS MORE THAN HALVED[5] MUCH OF THIS INCREASE HAS BEEN DUE TO A RISING CONSUMPTION OF WINE WHICH HAS INCREASED FIVE-FOLD SINCE 1970[4].

COMPARED WITH OTHER COUNTRIES IN THE EUROPEAN REGION, THE REGION OF THE WORLD WITH THE HIGHEST LEVEL OF ALCOHOL CONSUMPTION, THE UK HAS BEEN CLASSIFIED AS HAVING A "MIDDLE LEVEL OF CONSUMPTION", DEFINED AS BETWEEN 5 AND 10 LITRES PER PERSON PER YEAR[6] (P.7). HOWEVER, IN CONTRAST TO OTHER EUROPEAN COUNTRIES, NOTABLY THE WINE-PRODUCING COUNTRIES OF SOUTHERN EUROPE, CONSUMPTION IN THE UK IS STILL RISING[7]. RECENT EVIDENCE SUGGESTS THAT THE UK HAS RISEN IN THE COUNTRY LEAGUE TABLE OF PER CAPITA CONSUMPTION FROM 21ST IN 1998 TO 9TH IN 2002[8]; BY CONTRAST, AUSTRALIA HAS DROPPED FROM 19TH TO 23RD. THE INTERIM ANALYTICAL REPORT[4] *STATES THAT, "IF PRESENT TRENDS CONTINUE, THE UK WOULD RISE TO NEAR THE TOP OF THE CONSUMPTION LEAGUE WITHIN THE NEXT TEN YEARS" (P.13). FIGURE 1, TAKEN FROM THE* INTERIM ANALYTICAL REPORT[4], *SHOWS TRENDS IN ALCOHOL CONSUMPTION IN THE UK BETWEEN THE YEARS 1900 AND 2000.*

OVER 90% OF ADULTS IN THE UK DRINK ALCOHOL. THE ALCOHOLIC DRINKS INDUSTRY IS A SUBSTANTIAL PART OF THE UK ECONOMY, WITH A TOTAL VALUE OF OVER £30 BILLION PER ANNUM. THE MAJORITY OF THIS IS IN THE FORM OF BEER (£16.4BN), WITH SUBSTANTIAL SPENDING ALSO ON WINE (£7.4BN) AND SPIRITS, LIQUEURS AND FORTIFIED WINE (£6.8BN). THE REMAINDER IS CIDER, PERRY AND OTHER DRINKS (£2.8BN)[4].

FIGURE 1



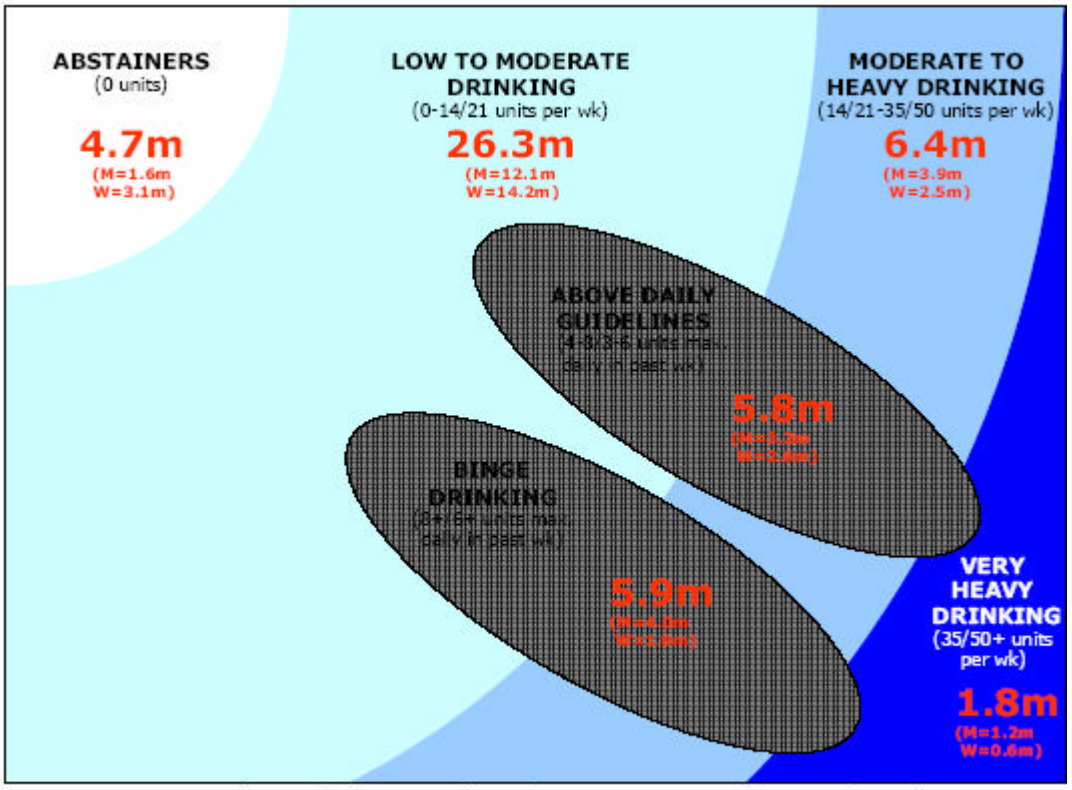
Source: BBPA Statistical Handbook (2001)

FOR MEASUREMENT PURPOSES, A UNIT OF ALCOHOL, EQUIVALENT TO A HALF PINT OF ORDINARY BEER, A SMALL (125ML, 9% ABV)) GLASS OF WINE OR A STANDARD MEASURE OF SPIRITS, IS DEFINED IN THE UK AS ROUGHLY 8G ETHANOL. GOVERNMENT RECOMMENDATIONS[9] ARE THAT MEN SHOULD DRINK LESS THAN 4 UNITS REGULARLY PER DAY AND WOMEN LESS THAN 3 UNITS REGULARLY PER DAY. OTHER DEFINITIONS USED IN THE INTERIM ANALYTICAL REPORT *ARE AS FOLLOWS:*

- *BINGE DRINKING: DRINKING OVER TWICE THE DAILY GUIDELINES IN ONE DAY (I.E., 8+ FOR MEN/ 6+ FOR WOMEN);*
- *LOW TO MODERATE DRINKING: DRINKING UP TO PREVIOUSLY PUBLISHED WEEKLY GUIDELINES[10] (0-21/14 UNITS PER WEEK);*
- *MODERATE TO HEAVY DRINKING: DRINKING BETWEEN 21/14 AND 50/35 UNITS PER WEEK;*
- *VERY HEAVY: DRINKING 50/35+ UNITS PER WEEK.*

UNDER THESE DEFINITIONS AND USING DATA FROM THE GENERAL HOUSEHOLD SURVEY 2001[11], 12% OF ADULTS (16+ YEARS) IN ENGLAND ARE ABSTAINERS (M=8.5%; F= 15.2%), 67.1% ARE LOW TO MODERATE DRINKERS (M=64.4%; F=69.6%), 16.3% ARE MODERATE TO HEAVY DRINKERS (M=20.7%; F=12.3%); AND 4.6% ARE VERY HEAVY DRINKERS (M=6.4%; F=2.9%). THUS 27.1% OF ADULT MALES, 15.2% OF ADULT FEMALES AND 20.9% IN ALL DRINK ABOVE RECOMMENDED WEEKLY GUIDELINES. (SEE FIGURE 2.) THIS REPRESENTS AN INCREASE SINCE 1988 WHEN ROUGHLY 25% OF MEN AND 10% OF WOMEN EXCEEDED THESE WEEKLY GUIDELINES.

FIGURE 2
HOW THE POPULATION DRINKS



Source: ONS General Household Survey (2001); Note: Categories above are based on government guidelines for weekly (1992) and daily (1995) drinking limits. Graphic is illustrative and not to scale.

IN TERMS OF DAILY DRINKING GUIDELINES, 29.8% OF THE ADULT POPULATION (38.2% OF MEN AND 22.1% OF WOMEN) REPORT DRINKING ABOVE RECOMMENDED LEVELS AT LEAST ONCE IN THE PAST WEEK AND OVER HALF OF THESE (15.1% OF THE ADULT POPULATION, 21.3% OF MEN AND 9.3% OF WOMEN) MEET CRITERIA FOR BINGE DRINKING DURING THE PAST WEEK[11].

THERE HAS BEEN AN INCREASE TOO IN THE FREQUENCY OF DRINKING OCCASIONS. IN 2002, 38% OF MEN AND 25% OF WOMEN REPORTED DRINKING ON THREE OR MORE DAYS PER WEEK, REVEALING AN UPWARD TREND THAT WAS MORE NOTICEABLE FOR WOMEN. FIGURES FROM 2001 SHOWED THAT 22% OF MEN AND 13% OF WOMEN REPORTED DRINKING ON FIVE OR MORE DAYS IN THE PRECEDING WEEK[4].

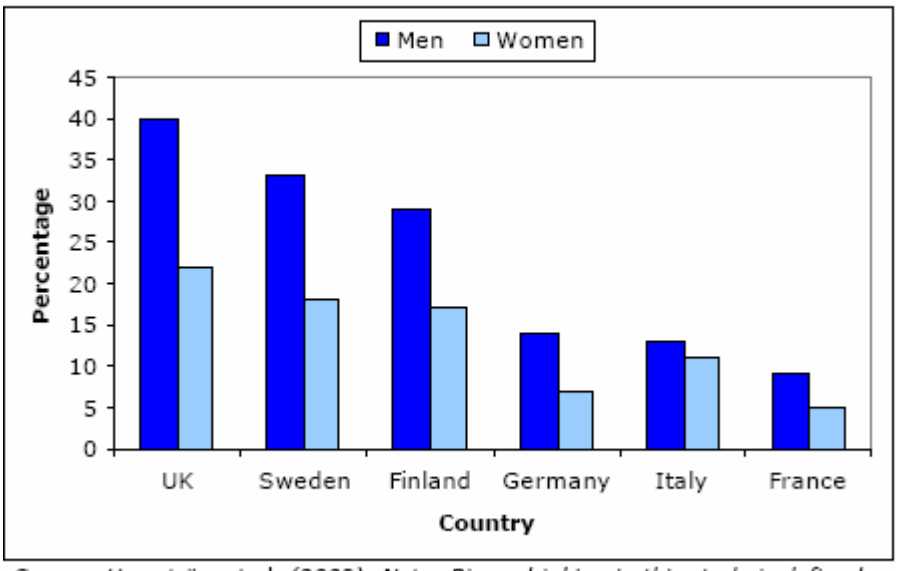
WITHIN THE GENERAL TREND OF INCREASING CONSUMPTION, THERE HAS BEEN A PARTICULARLY MARKED INCREASE AMONG YOUNG PEOPLE IN THE UK. ALTHOUGH THERE HAS BEEN NO INCREASE IN THE PROPORTION OF SCHOOL PUPILS UNDER 16 WHO REPORT DRINKING AT ALL DURING THE PREVIOUS WEEK, AMONG THOSE WHO DO ADMIT DRINKING CONSUMPTION HAS NEARLY DOUBLED FROM 5.3 UNITS IN 1990 TO 10.5 IN 2002[12]. MOREOVER, BRITISH TEENAGERS ARE NOW AMONG THE HEAVIEST DRINKERS IN EUROPE, BEING MORE LIKELY TO REPORT DRINKING, GETTING DRUNK AND SUFFERING FROM ALCOHOL-RELATED PROBLEMS THAN TEENAGERS FROM NEARLY ALL OTHER EUROPEAN COUNTRIES. FOR EXAMPLE, MORE THAN A THIRD OF 15-YEAR-OLDS IN THE UK REPORT HAVING BEEN DRUNK AT THE AGE OF 13 OR YOUNGER[13].

AS IN OTHER COUNTRIES, THE AGE-GROUP WITH THE HIGHEST LEVEL OF CONSUMPTION IS 16-24, WITH 14% OF MEN AND 7% OF WOMEN REPORTING DRINKING AT VERY HEAVY LEVELS, I.E., 50+ AND 35+ UNITS PER WEEK RESPECTIVELY[4]. AS WELL AS BEING HEAVIER, DRINKING AMONG

YOUNGER ADULTS ALSO TENDS TO BE CONCENTRATED IN FEWER DAYS OF THE WEEK THAN THAT OF OLDER MEMBERS OF THE COMMUNITY. THUS 16-24 YEAR-OLDS ARE MORE LIKELY TO REPORT BINGE DRINKING THAN OLDER AGE-GROUPS; ONLY ONE-SIXTH OF MEN AND ONE-QUARTER OF WOMEN REPORT NEVER HAVING DRUNK MORE THAN 8 OR 6 UNITS RESPECTIVELY IN A DAY[4]. BINGE DRINKING IS BY NO MEANS CONFINED TO THE YOUNGER AGE-GROUP, HOWEVER, SINCE ONE-THIRD OF MEN AND ONE-FIFTH OF WOMEN BETWEEN 45 AND 64 YEARS REPORT DOING SO AT LEAST ONCE A WEEK. IN MARKED CONTRAST TO SOME OTHER EUROPEAN COUNTRIES, IN THE UK 40% OF ALL DRINKING OCCASIONS BY MEN AND 22% BY WOMEN INVOLVE CONSUMPTION OF AT LEAST A BOTTLE OF WINE OR EQUIVALENT[4]. (SEE FIGURE 3.) WHILE BINGE DRINKING AMONG ADOLESCENTS DOES NOT ALWAYS CONTINUE INTO ADULTHOOD, IN LATER YEARS DRINKING PATTERNS TEND TO STABILISE; ONE STUDY[14] REPORTED THAT 60% OF VERY HEAVY DRINKING ADULTS WERE STILL VERY HEAVY DRINKERS FOUR YEARS LATER.

FIGURE 3

BINGE DRINKING OCCASIONS AS A PROPORTION OF ALL DRINKING OCCASIONS (OVER PREVIOUS 12 MONTHS)



Source: Hemström et al. (2002); Note: Binge drinking in this study is defined as drinking at least a bottle of wine or equivalent on the occasion

DRINKING LEVELS AND PATTERNS ALSO VARY BY GEOGRAPHICAL REGION OF ENGLAND. THE REGION WITH THE HIGHEST CONSUMPTION FOR BOTH GENDERS IS THE NORTH-EAST, WITH 49% OF MEN REPORTING HAVING DRUNK OVER RECOMMENDED LEVELS (> 4 UNITS) ON AT LEAST ONE DAY DURING THE PREVIOUS WEEK AND 32% OF WOMEN (> 3 UNITS) REPORTING HAVING DONE SO[15]. OTHER AREAS WITH HIGHER THAN AVERAGE CONSUMPTION FOR BOTH GENDERS ARE THE NORTH-WEST, YORKSHIRE AND HUMBERSIDE, AND THE EAST MIDLANDS. AREAS WITH THE LOWEST CONSUMPTION ARE LONDON, THE SOUTH-EAST AND THE SOUTH-WEST. IN THE LAST–NAMED REGION, 37% OF MEN AND 23% OF WOMEN REPORTING DRINKING OVER RECOMMENDED LEVELS DURING THE LAST WEEK.

WITH REGARD TO SOCIO-ECONOMIC CLASSIFICATION, FOR MEN THERE ARE NO CLEAR DIFFERENCES IN CONSUMPTION ACCORDING TO HOUSEHOLD SES[15]. HOWEVER, AMONG WOMEN THOSE IN PROFESSIONAL AND MANAGERIAL CLASSIFICATIONS ARE MORE LIKELY TO DRINK OVER RECOMMENDED LEVELS (26%) THAN OTHER WOMEN (19-21%). FINALLY, IN TERMS OF ETHNIC GROUP, BOTH MEN AND WOMEN IN MINORITY ETHNIC GROUPS OTHER THAN IRISH WERE LESS LIKELY THAN THE GENERAL POPULATION TO HAVE DRUNK ALCOHOL IN THE PREVIOUS WEEK AND TO HAVE

EXCEEDED THE RECOMMENDED WEEKLY LEVEL WHEN DOING SO[16]. AMONG THE IRISH ETHNIC GROUP, HOWEVER, THESE PERCENTAGES WERE HIGHER THAN IN THE GENERAL POPULATION.

IN SUMMARY, IT IS CLEAR THAT ENGLAND, IN COMMON WITH THE OTHER COUNTRIES OF THE UNITED KINGDOM, IS CURRENTLY EXPERIENCING A MARKED INCREASE IN ALCOHOL CONSUMPTION, BOTH IN TERMS OF PER CAPITA CONSUMPTION AND OF HAZARDOUS AND HARMFUL DRINKING PATTERNS. THIS INCREASE IS ESPECIALLY MARKED AMONG WOMEN AND AMONG YOUNG PEOPLE OF BOTH GENDERS, INCLUDING THOSE UNDER 16 YEARS OF AGE. ALTHOUGH IT IS BY NO MEANS CONFINED TO YOUNG PEOPLE, THE TENDENCY TO BINGE DRINK APPEARS TO BE INCREASING MORE SHARPLY AMONG THOSE UNDER 24 YEARS OF AGE. THERE ARE CLEAR VARIATIONS IN LEVEL OF CONSUMPTION BETWEEN THE REGIONS OF ENGLAND, WITH THOSE IN THE NORTH OF THE COUNTRY DRINKING MORE THAN THOSE IN THE SOUTH.

3. THE HARM DONE BY ALCOHOL

THE INTERIM ANALYTICAL REPORT[4] *DIVIDES THE HARMS BROUGHT ABOUT BY EXCESSIVE ALCOHOL CONSUMPTION INTO FOUR TYPES – HEALTH, CRIME/ PUBLIC DISORDER, WORKPLACE PRODUCTIVITY, FAMILY/SOCIAL NETWORKS – AND THIS DIVISION WILL BE FOLLOWED HERE.*

HEALTH

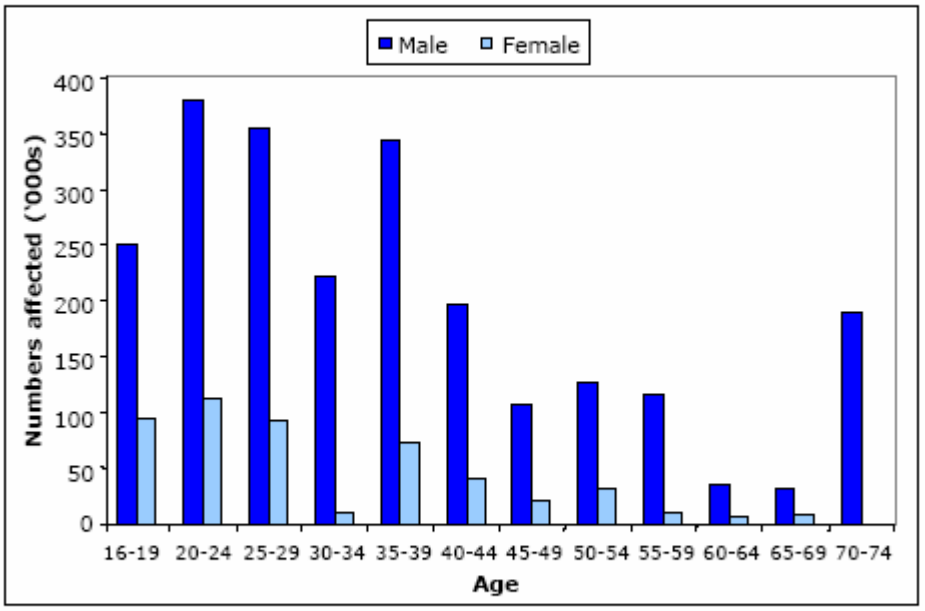
FROM A WORLDWIDE PERSPECTIVE, AND IGNORING FOR THESE PURPOSES ANY HEALTH BENEFITS FROM MODERATE ALCOHOL CONSUMPTION, EXCESSIVE DRINKING IS A MAJOR CAUSE OF DISEASE AND INJURY, ACCOUNTING FOR 9.2% OF DISABILITY-ADJUSTED LIFE YEARS (DALYS)[17]. ONLY TOBACCO SMOKING AND HIGH BLOOD PRESSURE ARE HIGHER RISK FACTORS. IN EUROPE, MENTAL AND BEHAVIOURAL PROBLEMS DUE TO ALCOHOL ARE THE FIFTH HIGHEST CAUSE OF DALYS, EXCEEDED ONLY BY DEPRESSION, CORONARY HEART DISEASE, DEMENTIAS AND STROKE.

THE MOST OBVIOUS FORM OF HARM DUE TO CHRONIC EXCESSIVE DRINKING IS ALCOHOL DEPENDENCE. ROUGHLY 2.9 MILLION PEOPLE, OR 7% OF THE ADULT POPULATION OF THE UK, ARE DEFINED AS DEPENDENT ON ALCOHOL AND DIAGNOSES OF ALCOHOL DEPENDENCE SYNDROME ACCOUNT FOR BETWEEN 30,000 AND 36,000 HOSPITAL ADMISSIONS PER YEAR[4]. LEVELS OF ALCOHOL DEPENDENCE IN THE GENERAL POPULATION OF THE UK, TAKEN AGAIN FROM THE INTERIM ANALYTICAL REPORT, *ARE SHOWN IN FIGURE 4.*

ADDING TOGETHER CHRONIC AND ACUTE PHYSICAL HEALTH DISORDERS, IT IS BEEN CALCULATED THAT UP TO 150,000 HOSPITAL ADMISSIONS AND BETWEEN 15,000 AND 22,000 DEATHS EACH YEAR ARE ASSOCIATED WITH EXCESSIVE DRINKING IN THE UK[4]. OF THESE TOTALS, ALCOHOL-RELATED LIVER DISEASE ACCOUNTS FOR ROUGHLY 33,000 HOSPITAL ADMISSIONS AND OVER 4,500 DEATHS PER YEAR. RATES OF ALCOHOL-RELATED MORTALITY FROM LIVER DISEASE HAVE INCREASED BY ABOUT 90% OVER THE PAST DECADE, ALTHOUGH THE INTERACTION OF ALCOHOL CONSUMPTION WITH INFECTION BY THE HEPATITIS C VIRUS HAS PROBABLY CONTRIBUTED TO THIS. IN THE SOMEWHAT

FIGURE 4

ESTIMATED NUMBERS OF PEOPLE WITH DEPENDENCE DEFINED BY SEVRITY OF ALCOHOL DEPENDENCE QUESTIONNAIRE (SADQ) IN 2001



Sources: Coulthard et al. *(2002); ONS (2003) population data for 2001; meta-analysis of longitudinal studies of "unwanted drinking behaviour" bv Fillmore (1988); hospital episode statistics provided by DoH; within the category of mental and behavioural disorders due to alcohol (ICD-10 F.10) a patient may be admitted with more than one diagnosis*

LONGER TERM, THERE HAS BEEN A 466% OVERALL INCREASE IN ALCOHOL-RELATED LIVER CIRRHOSIS MORTALITY SINCE 1970[5], WITH BETWEEN 9- AND 10-FOLD INCREASES AMONG MEN AND WOMEN BETWEEN 25 AND 44 YEARS.

ROUGHLY 10% DEATHS DUE TO HYPERTENSION IN THE UK ARE ATTRIBUTABLE TO ALCOHOL AND THE INCIDENCE OF THE DISEASE APPROXIMATELY DOUBLES IN THOSE DRINKING REGULARLY OVER 6 UNITS PER DAY. CHRONIC HEAVY DRINKING ALSO CONTRIBUTES TO THE RISK OF BOTH HAEMORRHAGIC AND ISCHAEMIC STROKE AND DEATHS IN THE UK DUE TO THE ASSOCIATION OF ALCOHOL AND HAEMORRHAGIC STROKE MAY ACCOUNT FOR 1,200 DEATHS PER YEAR[4].

EXCESSIVE DRINKING, ESPECIALLY IF COMBINED WITH CIGARETTE SMOKING, CONTRIBUTES TO THE RISK FOR A RANGE OF CANCERS. IT IS ESTIMATED THAT 3.5% OF ALL CANCER DEATHS, OR NEARLY 5,000 DEATHS PER ANNUM, ARE ATTRIBUTABLE TO ALCOHOL[4].

IT IS WELL KNOWN THAT DRINKING IN PREGNANCY CAN AFFECT THE PRE- AND POST-NATAL DEVELOPMENT OF THE BABY AND LEAD IN PARTICULAR TO THE FOETAL ALCOHOL SYNDROME (FAS). ALTHOUGH THE LEVEL OF DRINKING AT WHICH THESE NEGATIVE CONSEQUENCES OCCUR IS STILL UNCERTAIN, IT IS ESTIMATED THAT THE INCIDENCE OF THE FAS IN INDUSTRIALISED COUNTRIES IS BETWEEN 0.4 AND 2 LIVE BIRTHS PER 1,000[4].

IN ADDITION TO NEGATIVE CONSEQUENCES FOR PHYSICAL HEALTH, EXCESSIVE DRINKING IS ALSO ASSOCIATED WITH POOR MENTAL HEALTH. ABOUT A THIRD OF PSYCHIATRIC PATIENTS WITH SERIOUS MENTAL ILLNESS IN THE UK HAVE A SUBSTANCE MISUSE PROBLEM, MOSTLY INVOLVING ALCOHOL. AT THE SAME TIME, ROUGHLY HALF OF THOSE ATTENDING DRUG AND ALCOHOL SERVICES HAVE A PSYCHIATRIC DISORDER, MOST COMMONLY DEPRESSION OR PERSONALITY DISORDER. IN

TOTAL, IN 1998/99 THERE WERE 78,900 ADMISSIONS TO NATIONAL HEALTH SERVICE (NHS) HOSPITALS OF PATIENTS WITH BEHAVIOURAL OR PSYCHOLOGICAL PROBLEMS RELATED TO EXCESSIVE ALCOHOL CONSUMPTION, INCLUDING THOSE ADMITTED WITH ACUTE ALCOHOL INTOXICATION WHICH ACCOUNTS FOR ABOUT 23,000 ADMISSIONS PER YEAR[4].

ALCOHOL INCREASES THE RISK OF ACCIDENTAL DEATH AND MAY BE ASSOCIATED WITH BETWEEN 1/3 AND 1/7 SUCH DEATHS, AMOUNTING TO UP TO 1,700 DEATHS PER YEAR IN THE UK. IN MORE DETAIL, ALCOHOL HAS BEEN LINKED TO 38-45% OF DEATHS IN FIRES, 7-25% OF DEATHS AT WORK AND 23-28% DEATHS BY DROWNING. IN ADDITION, BETWEEN 16% AND 45% OF SUICIDES ARE THOUGHT TO BE LINKED TO ALCOHOL; 50% OF THOSE WHO PRESENT TO HOSPITAL AFTER DELIBERATE SELF-HARMING ARE REGULAR EXCESSIVE DRINKERS AND 23% ARE ALCOHOL DEPENDENT. IN 2001 THERE WERE 3,479 DEATHS FROM SUICIDE AND SELF-INJURY IN THE UK AND UP TO 1,000 OF THESE CAN BE LINKED TO EXCESSIVE DRINKING[4].

IN TOTAL, IN THE YEAR 2000 THERE WERE BETWEEN 15,000 AND 22,000 DEATHS IN ENGLAND AND WALES ATTRIBUTABLE TO ALCOHOL, WITH ROUGHLY 70% MORE OF THESE DEATHS IN MEN THAN IN WOMEN. OVER THE PAST DECADE, THERE HAS BEEN A DECREASE IN THE AGE AT WHICH ALCOHOL-RELATED MORTALITY PEAKS; IN 1991 ALCOHOL-RELATED DEATHS PEAKED AROUND AGE 70 BUT BY 2000 MOST DEATHS IN BOTH SEXES OCCURRED BETWEEN AGES 55 AND 70[4].

THE COST TO THE NHS OF TREATING THE CHRONIC AND ACUTE EFFECTS OF EXCESSIVE DRINKING HAS BEEN ESTIMATED AS UP TO £1.7 BILLION PER YEAR[18]. A RECENT ESTIMATE PUT THE ALCOHOL-RELATED COSTS OF INPATIENT CARE ALONE AS BETWEEN 2% AND 12% OF THE TOTAL EXPENDITURE ON HOSPITAL SERVICES[19]. EXPENDITURE ON SPECIALIST ALCOHOL SERVICES HAS BEEN CALCULATED AT £95 MILLION, WITH £24 MILLION OF THIS INCURRED BY THE NHS. UP TO 35% OF ALL ACCIDENT AND EMERGENCY ATTENDANCE TOGETHER WITH AMBULANCE COSTS ARE ATTRIBUTABLE TO ALCOHOL, AMOUNTING TO A TOTAL COST OF £0.5 BILLION. A SIMILAR FIGURE APPLIES TO OTHER PRIMARY CARE SERVICES[4].

CRIME/PUBLIC DISORDER

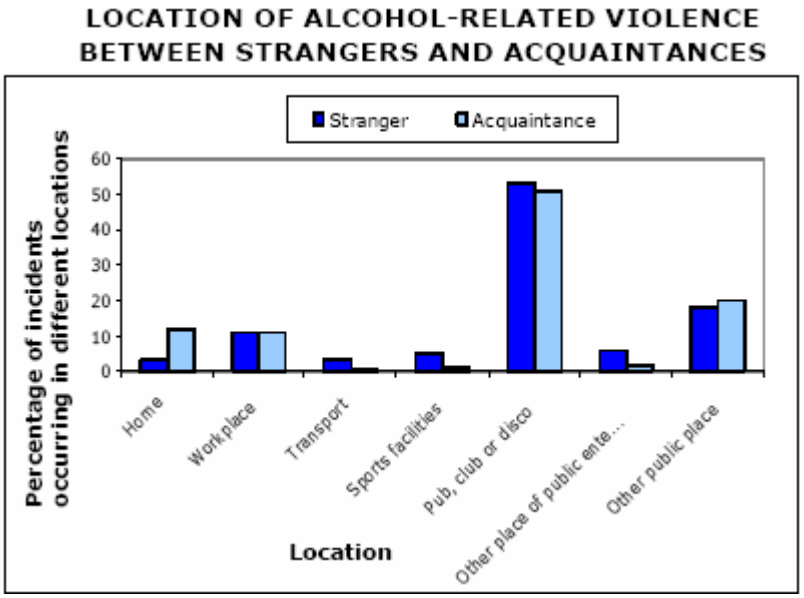
IN A SURVEY CARRIED OUT IN 2002-03[20], 23% OF RESPONDENTS SAID THAT DRUNK AND ROWDY BEHAVIOUR WAS A "VERY" OR "FAIRLY" BIG PROBLEM IN THEIR AREA. THIS LEVEL OF CONCERN INCREASED TO 33% AMONG THOSE FROM INNER-CITY AREAS. IN ANOTHER SURVEY[21], 7 OUT OF 10 RESPONDENTS SAID THAT DRINKING IN PUBLIC PLACES OR ON THE STREET IS A PROBLEM IN THEIR AREA.

IT IS CALCULATED THAT ROUGHLY 3 IN 10 CITY-CENTRE ARRESTS ARE ALCOHOL-RELATED AND A SIGNIFICANT PROPORTION OF THESE ARE FOR DRUNKENNESS OFFENCES, ESPECIALLY DRUNK AND DISORDERLY. THE NUMBER OF ALCOHOL-SPECIFIC OFFENCES (DRUNK OFFENCES, BUYING DRINK UNDER 18, SELLING DRINK TO UNDER-18S) HAS DECLINED MARKEDLY OVER THE LAST 10 YOURS, ALTHOUGH THIS IS ALMOST CERTAINLY DUE TO CHANGES IN POLICE PRACTICES. NEVERTHELESS, DRUNKEN ARRESTEES IMPOSE A CONSIDERABLE BURDEN ON POLICE RESOURCES SINCE IT COSTS ON AVERAGE £59 MORE TO PROCESS AN ALCOHOL-RELATED THAN A NON-ALCOHOL-RELATED ARRESTEE[4].

IN ADDITION TO OFFENCES THAT ARE SPECIFIC TO ALCOHOL, EXCESSIVE DRINKING PLAYS A CLEAR ROLE IN OTHER OFFENCES, MOST NOTABLY VIOLENCE AND PUBLIC ORDER OFFENCES. WHILE THE RELATIONSHIP BETWEEN DRINKING AND VIOLENT OR AGGRESSIVE BEHAVIOUR IS COMPLEX, THE BRITISH CRIME SURVEY *(BCS)[22] REPORTED THAT 47% OF ALL VICTIMS OF VIOLENCE DESCRIBED THEIR ASSAILANT AS BEING UNDER THE INFLUENCE OF ALCOHOL AT THE TIME OF THE OFFENCE. BCS ESTIMATES ARE THAT IN 1999 THERE WERE 1.2 MILLION INCIDENTS OF ALCOHOL-RELATED VIOLENCE IN THE UK, OF WHICH 60% DID NOT COME TO THE ATTENTION OF THE POLICE. AT THE SAME TIME, HOWEVER, IT APPEARS THE PUBLIC PERCEPTION THAT ALCOHOL-RELATED VIOLENCE IS ON THE INCREASE IS NOT BORNE OUT BY THE EVIDENCE[4].*

OVER HALF OF ALCOHOL-RELATED VIOLENCE INVOLVING STRANGERS AND ACQUAINTANCES OCCURS IN OR AROUND PUBS, CLUBS OR DISCOS; 70% OF SUCH INCIDENTS TAKE PLACE ON WEEKEND EVENINGS AND OVER HALF OF THEM RESULT IN SOME FORM OF INJURY. (SEE FIGURE 5.) THOSE WHO VISIT PUBS OR CLUBS MORE THAN 3 EVENINGS PER WEEK ARE TWICE AS LIKELY TO BE A VICTIM OF VIOLENCE[4].

FIGURE 5



WITH REGARD TO DOMESTIC VIOLENCE, ALCOHOL PLAYS A ROLE IN AROUND 1/3RD OF CASES OF VIOLENCE BETWEEN SPOUSES AND PARTNERS. RATES OF CHRONIC ALCOHOL ABUSE AND DEPENDENCE AMONG PERPETRATORS OF DOMESTIC VIOLENCE MAY BE 2 TO 7 TIMES THOSE IN THE GENERAL POPULATION AND THIS IS A RISK FACTOR FOR THE CONTINUATION OF THIS BEHAVIOUR OVER TIME. HEAVY DRINKING BY VICTIMS IS ALSO A RISK FACTOR. SO TOO, PERPETRATORS OF SEXUAL ASSAULT HAVE OFTEN BEEN DRINKING AT THE TIME OF THE OFFENCE AND MANY ARE ALSO LONG-TERM ALCOHOL ABUSERS[4], ALTHOUGH LESS THAN ONE IN 5 OF FEMALE VICTIMS OF SEXUAL ASSAULT REPORT IT TO THE POLICE AND THOSE VICTIMS WHO WERE THEMSELVES INTOXICATED ARE EVEN LESS LIKELY TO DO SO.

ALTHOUGH DRINK DRIVING HAS BEEN DECLINING IN THE UK OVER THE PAST 20 YEARS, IT WAS STILL ASSOCIATED WITH 5% OF ALL ROAD ACCIDENTS AND 17% OF ROAD DEATHS IN 2001. WHILE FATAL AND SERIOUS CASUALTIES HAVE REMAINED RELATIVELY LOW, THERE WAS AN INCREASE BETWEEN 1993 AND 2001 IN SLIGHT CASUALTIES AND THE TOTAL NUMBER OF ROAD CASUALTIES INVOLVING ALCOHOL ROSE BY ABOUT 1/5TH [4].

ALCOHOL PROBLEMS AND DEPENDENCE ARE SIGNIFICANTLY HIGHER AMONG SERVING PRISONERS THAN IN THE GENERAL POPULATION, WITH NEARLY 2/3RDS OF MALE PRISONERS AND OVER 1/3RD OF FEMALE PRISONERS HAVING AN ESTABLISHED ALCOHOL PROBLEM. SUCH PROBLEMS MAY ALSO BE A FACTOR CONTRIBUTING TO HIGH RECIDIVISM RATES AMONG RELEASED PRISONERS. INDEED, IT HAS BEEN ESTIMATED THAT ROUGHLY ½ OF THE OFFENDERS ON A PROBATION OFFICER'S CASELOAD WILL HAVE DRINKING PROBLEMS. THUS ALCOHOL PLACES A CONSIDERABLE BURDEN ON THE CRIMINAL JUSTICE SYSTEM[4].

THE TOTAL COST OF ALCOHOL-RELATED CRIME IN ENGLAND AND WALES HAS BEEN CALCULATED AT £7.3 BILLION[23], COMPOSED OF COSTS INCURRED IN ANTICIPATION OF CRIME (£1.5BN), THOSE INCURRED AS A CONSEQUENCE OF CRIME (£3.5BN), THOSE INCURRED IN RESPONSE TO ALCOHOL-RELATED CRIME (£1.73BN) AND COSTS OF DRINK-DRIVING (£0.5BN). THIS DOES NOT INCLUDE THE HUMAN/EMOTIONAL COSTS OF ALCOHOL-RELATED CRIME WHICH HAVE BEEN ESTIMATED AT ANOTHER £4.7 BILLION[23].

PRODUCTIVITY AT WORK

DRINKING REDUCES THE PRODUCTIVITY OF THE UK ECONOMY THROUGH SICKNESS ABSENTEEISM, UNEMPLOYMENT, EARLY RETIREMENT AND PREMATURE DEATH AMONG THE ECONOMICALLY ACTIVE. THESE FACTORS COMBINED AMOUNT TO A TOTAL LOSS OF OUTPUT TO THE UK ECONOMY OF UP TO £6.4 BILLION[4].

IN MORE DETAIL, UP TO 17 MILLION DAYS PER ANNUM ARE LOST DUE TO ALCOHOL-RELATED ABSENCE FROM WORK, UP TO 20 MILLION DAYS PER ANNUM ARE LOST DUE TO ALCOHOL-RELATED REDUCED EMPLOYMENT, AND AT LEAST 58,000 WORKING YEARS PER ANNUM ARE LOST DUE TO PREMATURE ALCOHOL-RELATED DEATH[4]. THESE LOSSES AFFECT INDIVIDUALS, EMPLOYERS AND NATIONAL PRODUCTIVITY ALIKE.

BINGE DRINKERS IN PARTICULAR ARE AT HIGHER RISK OF UNEMPLOYMENT AND THEY EARN SIGNIFICANTLY LESS THAN OTHER DRINKERS, ALTHOUGH THIS PARTLY REFLECTS THE FACT THAT BINGE DRINKERS TEND TO BE YOUNGER. CHRONIC HEAVY DRINKERS TOO ARE AT SOME RISK OF HIGHER UNEMPLOYMENT[4].

FAMILY AND SOCIAL NETWORKS

IT IS WELL-KNOWN THAT, IN ADDITION TO HARMS IN THE AREAS OF HEALTH, CRIME AND WORK PRODUCTIVITY, EXCESSIVE ALCOHOL CONSUMPTION CAN HARM BOTH THE DRINKER'S RELATIONSHIPS WITH OTHER PEOPLE AND THEIR PARTICIPATION IN SOCIETY AT LARGE. IN TERMS OF PERSONAL RELATIONSHIPS, HEAVY DRINKING CAN LEAD TO THE BREAKDOWN OF RELATIONSHIPS, DOMESTIC VIOLENCE AND AGGRESSION, POOR PARENTING INCLUDING CHILD ABUSE, AND UNSAFE OR REGRETTED SEX. IN THE WIDER COMMUNITY AND SOCIETY, IT IS LINKED WITH TRUANCY AND DELINQUENCY, ANTI-SOCIAL BEHAVIOUR AND HOMELESSNESS.

MARRIAGES IN WHICH ONE OR BOTH PARTNERS HAVE AN ALCOHOL PROBLEMS ARE TWICE AS LIKELY TO END IN DIVORCE AS THOSE WHERE ALCOHOL PROBLEMS ARE ABSENT; IT HAS BEEN CALCULATED THAT AS MANY AS ONE IN THREE DIVORCE PETITIONS IN THE UK CITE EXCESSIVE DRINKING BY ONE OF THE PARTNERS AS A CONTRIBUTORY FACTOR[4]. ALTHOUGH THE PRECISE RELATIONSHIP BETWEEN HEAVY DRINKING AND DOMESTIC VIOLENCE IS UNCLEAR, IT IS CITED AS A CONTRIBUTORY FACTOR IN APPROXIMATELY ONE-THIRD OF INCIDENTS.

SO TOO, IT HAS BEEN ESTIMATED THAT BETWEEN 780,000 AND 1.3 MILLION CHILDREN IN THE UK ARE AFFECTED BY THE EXCESSIVE DRINKING OF THEIR PARENTS, RESULTING IN A HIGH CONTRIBUTION TO CHILD-PROTECTION CASES AND CALLS TO CHILD ABUSE OR NEGLECT HELP-LINES[4]. THE CHILDREN AFFECTED MAY HAVE DIFFICULTIES AT SCHOOL, EMOTIONAL/ PSYCHOLOGICAL PROBLEMS AND SHOW ANTI-SOCIAL BEHAVIOUR, AND SOME WILL GO ON TO EXPERIENCE ANXIETY, DEPRESSION OR RELATIONSHIP PROBLEMS IN ADULTHOOD.
THE RELATIONSHIP BETWEEN EXCESSIVE DRINKING AND UNSAFE SEX IS COMPLEX BUT THERE IS LITTLE DOUBT THAT THE LIKELIHOOD OF UNSAFE SEX IS INCREASED AFTER DRINKING[4].

ALCOHOL IS A FACTOR IN TRUANCY, SCHOOL EXCLUSIONS AND CHILDREN LEAVING HOME. ALTHOUGH PERMANENT SCHOOL EXCLUSIONS HAVE DROPPED SINCE 1996, ALCOHOL PLAYS A SIGNIFICANT ROLE IN EXCLUSIONS, OFTEN THROUGH BEHAVIOURAL PROBLEMS SUCH AS VIOLENCE AND DELINQUENCY[4].

LASTLY, IT IS KNOWN THAT ABOUT HALF OF HOMELESS PEOPLE ARE DEPENDENT ON ALCOHOL AND THAT MANY COME FROM BACKGROUNDS CHARACTERISED BY HEAVY DRINKING[4]. MANY HAVE BEEN IN PRISON AND, IN THE ABSENCE OF A COMPREHENSIVE PACKAGE OF CARE, HOMELESS PEOPLE TEND TO CIRCULATE BETWEEN HEALTH CARE FACILITIES, TEMPORARY SHELTER AND ALCOHOL TREATMENT SERVICES.

SUMMARY OF HARMS

ALCOHOL MISUSE AND DEPENDENCE CAN HAVE ADVERSE EFFECTS ON MANY ASPECTS OF PEOPLE'S LIVES – HEALTH, FINANCE, OCCUPATION, CRIME, HOUSING AND PERSONAL RELATIONSHIPS. THERE ARE NO DATA TO QUANTIFY THE HUMAN SUFFERING FROM EXCESSIVE DRINKING AND THE CONTRIBUTION OF ALCOHOL TO COMPLEX SOCIAL AND PERSONAL PROBLEMS. HOWEVER, ADDING TOGETHER COSTS FROM THE FOUR TYPES OF HARM DESCRIBED ABOVE, THE INTERIM ANALYTICAL REPORT[4] *ESTIMATES THAT THE TOTAL COST OF HARM DUE TO ALCOHOL IN ENGLAND IS ABOUT £20 BILLION. THIS IS A HIGHER FIGURE THAN HAS EVER BEEN ADVANCED BEFORE. IT IS ALSO CLEAR THAT, IN LINE WITH THE RISING LEVEL OF CONSUMPTION, ENGLAND AND OTHER COUNTRIES OF THE UK ARE CURRENTLY EXPERIENCING A MARKED INCREASE IN ALCOHOL-RELATED PROBLEMS OF ALL KINDS.*

4. MEASURES TO REDUCE THE HARM DONE BY ALCOHOL

A RECENT AND COMPREHENSIVE WHO-SPONSORED REVIEW OF POLICIES INTENDED TO REDUCE ALCOHOL-RELATED HARM[24] CONCLUDES WITH A TABLE LISTING ALL THE POLICY-RELEVANT STRATEGIES AND INTERVENTIONS IDENTIFIED BY THE AUTHORS, WITH RATINGS FOR EACH ON FOUR SCALES (TABLE 16.1, PP. 264-6). THESE ARE: EFFECTIVENESS, BREADTH OF RESEARCH SUPPORT, TESTED ACROSS CULTURES AND COST TO IMPLEMENT AND SUSTAIN.

"EFFECTIVENESS" REFERS TO THE JUDGEMENT THAT IT IS REASONABLE TO MAKE FROM THE AVAILABLE SCIENTIFIC EVIDENCE REGARDING A STRATEGY'S EFFECTIVENESS IN REDUCING ALCOHOL CONSUMPTION, ALCOHOL-RELATED PROBLEMS OR THEIR COSTS TO SOCIETY AND IS RATED:

0 LACK OF EFFECTIVENESS;
+ LIMITED EFFECTIVENESS;
+ + MODERATE EFFECTIVENESS;
+ + + HIGH DEGREE OF EFFECTIVENESS; AND
? NO STUDIES UNDERTAKEN OR INSUFFICIENT EVIDENCE ON WHICH TO MAKE A JUDGEMENT.

"BREADTH OF RESEARCH SUPPORT" REFERS TO THE NUMBER OF SCIENTIFIC STUDIES AND THE CONSISTENCY OF RESULTS BEARING ON A PARTICULAR STRATEGY AND IS RATED:

0 NO STUDIES OF EFFECTIVENESS UNDERTAKEN;
+ ONLY ONE WELL-DESIGNED STUDY OF EFFECTIVENESS;
+ + 2-4 STUDIES OF EFFECTIVENESS;
+ + + 5 OR MORE STUDIES.

"TESTED ACROSS CULTURES" IS CONCERNED WITH THE DIVERSITY OF GEOGRAPHY AND CULTURES WITHIN WHICH A STRATEGY HAS BEEN APPLIED AND TESTED AND IS RATED:

0 NOT TESTED ADEQUATELY;
+ STUDIED IN ONLY ONE COUNTRY;
+ + STUDIED IN 2 TO 4 COUNTRIES;
+ + + STUDIED IN 5 OR MORE COUNTRIES.

FINALLY, "COST TO IMPLEMENT AND SUSTAIN" ESTIMATES THE RELATIVE MONETARY COST TO THE STATE TO IMPLEMENT, OPERATE AND SUSTAIN A STRATEGY REGARDLESS OF EFFECTIVENESS AND IS RATED: LOW; MODERATE; AND HIGH. THE TABLE ALSO INDICATES THE TARGET GROUP FOR THE STRATEGY (GENERAL POPULATION; HIGH-RISK DRINKERS OR VULNERABLE GROUPS, PERSONS

ALREADY SHOWING HARMFUL DRINKING OR ALCOHOL DEPENDENCE) AND MAKES OTHER COMMENTS. MEASURES ARE GROUPED ACCORDING TO GENERAL CATEGORY OF STRATEGY OR INTERVENTION.

THE SINGLE STRATEGY WITH THE HIGHEST RATINGS IS "TAXATION AND PRICING" WHICH OBTAINS '+++' FOR ALL THE FIRST THREE SCALES ABOVE AND A LOW COST TO IMPLEMENT. IT IS OBVIOUSLY TARGETED AT THE GENERAL POPULATION AND EFFECTIVENESS DEPENDS ON GOVERNMENT OVERSIGHT AND CONTROL OF ALCOHOL PRODUCTION AND DISTRIBUTION, ALTHOUGH IT IS NOTED THAT HIGH TAXES CAN INCREASE SMUGGLING AND ILLICIT PRODUCTION. APART FROM THIS SINGLE STRATEGY, THE CATEGORY OF MEASURES WITH THE HIGHEST EFFECTIVENESS RATINGS IS "REGULATING PHYSICAL AVAILABILITY", WITH FOUR STRATEGIES OBTAINING MAXIMUM EFFECTIVENESS INCLUDING "MINIMUM LEGAL PURCHASE AGE", "GOVERNMENT MONOPOLY OF RETAIL SALES" AND "SERVER LIABILITY". THE FIRST TWO OF THESE ARE RATED '+++' FOR BREADTH OF RESEARCH SUPPORT, '++' FOR CROSS-CULTURAL TESTING AND LOW FOR COST TO IMPLEMENT.

OTHER STRATEGIES WITH HIGH RATINGS OCCUR IN THE CATEGORY "DRINK-DRIVING COUNTERMEASURES", WITH "RANDOM BREATH TESTING", "LOWERED BAC LIMITS" AND "LOW BAC FOR YOUNG DRIVERS" ALL OBTAINING '+++' FOR EFFECTIVENESS. THE CATEGORY SHOWING THE LOWEST EFFECTIVENESS RATINGS IS "EDUCATION AND PERSUASION", WITH "ALCOHOL EDUCATION IN SCHOOLS", "COLLEGE STUDENT EDUCATION", "PUBLIC SERVICE MESSAGES" AND "WARNING LABELS" ALL OBTAINING '0' FOR EFFECTIVENESS. MEASURES IN THE CATEGORIES OF "ALTERING THE DRINKING CONTEXT" AND "REGULATING ALCOHOL PROMOTION" SHOW A MIXTURE OF EFFECTIVENESS RATINGS, WITH "ENFORCEMENT OF ON-PREMISE REGULATIONS AND LEGAL REQUIREMENTS" AND "COMMUNITY MOBILISATION" SHOWING MODERATE EFFECTIVENESS ('++') BUT HIGH COST TO IMPLEMENT.

THE CATEGORY OF STRATEGIES OF MOST RELEVANCE TO THE PRESENT DOCUMENT IS "TREATMENT AND EARLY INTERVENTION". IN THIS CATEGORY, "ALCOHOL PROBLEMS TREATMENT", "MUTUAL HELP/ SELF-HELP ATTENDANCE" AND "MANDATORY TREATMENT OF REPEAT DRINKING-DRIVERS" ARE GIVEN RATINGS OF LOW EFFECTIVENESS ('+'). ALCOHOL PROBLEMS TREATMENT IS CONSIDERED TO HAVE HIGH BREADTH OF RESEARCH SUPPORT ('+++'), HIGH CROSS-CULTURAL TESTING ('+++') AND HIGH COST TO IMPLEMENT. OF MOST IMMEDIATE INTEREST HERE, "BRIEF INTERVENTION WITH AT-RISK DRINKERS" OBTAINS AN EFFECTIVENESS RATING OF '++' (MODERATE EFFECTIVENESS), '+++' FOR BREADTH OF RESEARCH SUPPORT, '+++' FOR CROSS-CULTURAL TESTING AND A MODERATE COST TO IMPLEMENT. THE TARGET GROUP IS HIGH-RISK DRINKERS. THE TABLE FURTHER NOTES THAT: "PRIMARY CARE PRACTITIONERS LACK TRAINING AND TIME TO CONDUCT SCREENING AND BRIEF INTERVENTIONS".

A FACTOR CLEARLY OMITTED FROM THE ABOVE ANALYSIS IS THE POLITICAL FEASIBILITY OF INTRODUCING A PARTICULAR MEASURE, WHICH ITSELF IS PARTLY INFLUENCED BY INDICATIONS OF WHAT PUBLIC ATTITUDES TO THE MEASURE ARE LIKELY TO BE. THIS APPLIES PARTICULARLY TO POLICIES SUCH AS INCREASED TAXATION AND RESTRICTIONS ON ALCOHOL AVAILABILITY WHICH RESEARCH EVIDENCE SUGGESTS WOULD BE HIGHLY EFFECTIVE IN REDUCING ALCOHOL-RELATED HARM. POLICIES SUCH AS THIS ARE PART OF THE "WHOLE POPULATION" APPROACH TO REDUCING HARM IN WHICH THE ATTEMPT IS MADE TO DECREASE ALCOHOL CONSUMPTION OF THE POPULATION AS A WHOLE, WITH A RESULTANT DECREASE IN MEASURES OF ALCOHOL-RELATED HARM. THE ALTERNATIVE VIEW IS THE "HARM REDUCTION" APPROACH WHICH, IN THIS USE OF THE TERM, RESTRICTS POLICIES TO LIMITING OR REDUCING HARM AMONG THOSE HAVE ALREADY INCURRED HARM OR ARE AT RISK OF DOING SO. THERE ARE GROUNDS FOR SUPPOSING THAT THE INTRODUCTION OF WHOLE POPULATION MEASURES WOULD BE UNPOPULAR WITH THE GENERAL PUBLIC.
THIS CERTAINLY APPEARS TO BE THE VIEW OF THE BRITISH GOVERNMENT. IN THE AHRSE[1] DOCUMENT, THE GOVERNMENT STATES:

"IT (THE STRATEGY) RECOGNISES THAT THERE ARE BOTH BENEFITS AND COSTS TO ALCOHOL USE AND, THEREFORE, DOES NOT AIM TO CUT ALCOHOL CONSUMPTION BY THE WHOLE POPULATION. INSTEAD IT FOCUSES ON THE PREVENTION, MINIMISATION AND MANAGEMENT OF THE HARMS CAUSED BY ALCOHOL MISUSE" (P.21).

THE AHRSE ACCEPTS THAT "THERE IS A CLEAR ASSOCIATION BETWEEN PRICE, AVAILABILITY AND CONSUMPTION" (P.23) BUT ALSO ASSERTS THAT "THERE IS LESS SOUND EVIDENCE FOR THE IMPACT OF INTRODUCING SPECIFIC POLICIES IN A PARTICULAR SOCIAL AND POLITICAL CONTEXT" (P.23). THIS IS BECAUSE THE GOVERNMENT'S ANALYSIS HAS SHOWN THAT THE DRIVERS OF CONSUMPTION ARE MUCH MORE COMPLEX THAN MERELY PRICE AND AVAILABILITY, THAT THE EVIDENCE SUGGESTS THAT USING PRICE AS A KEY LEVER RISKS MAJOR UNINTENDED SIDE-EFFECTS, AND THAT THE MAJORITY OF THOSE WHO DRINK DO SO SENSIBLY THE MAJORITY OF THE TIME. THUS, "POLICIES NEED TO BE PUBLICLY ACCEPTABLE IF THEY ARE TO SUCCEED" (P.23). IN ANY EVENT, "MEASURES TO CONTROL PRICE AND AVAILABILITY ARE ALREADY BUILT INTO THE SYSTEM" (P.23).

GIVEN THE PERCEIVED POLITICAL UNACCEPTABILITY OF ALCOHOL CONTROL MEASURES IN THE FORM OF TAXATION AND THE REGULATION OF THE PHYSICAL AVAILABILITY OF ALCOHOL, THE CONCLUSION MUST BE THAT THE WIDESPREAD IMPLEMENTATION OF SBI IN A RANGE OF MEDICAL AND OTHER SETTINGS IS THE BEST OPTION FOR MAKING A SIGNIFICANT IMPACT ON THE LEVEL OF ALCOHOL-RELATED HARM IN ENGLAND. IN THE RATINGS OF POLICIES AND MEASURES SUMMARISED ABOVE[23], AND SETTING ASIDE THE EVIDENCE OF EFFECTIVENESS FOR SPECIFIC MEASURES AGAINST DRINK-DRIVING, "BRIEF INTERVENTION WITH HIGH-RISK DRINKERS" IS THE ONLY OTHER MEASURE WITH MODERATE EFFECTIVENESS ('++'), WIDE BREADTH OF RESEARCH SUPPORT ('+++') AND A MODERATE COST TO IMPLEMENT AND SUSTAIN. FURTHERMORE, IT WILL BE SHOWN IN THE NEXT SECTION THAT ALCOHOL SBI IS EFFECTIVE IN REDUCING ALCOHOL-RELATED HARM AMONG THOSE WHO HAVE ALREADY INCURRED SUCH HARM AS WELL AS THOSE WHO ARE AT RISK OF INCURRING IT. OF ALL THE SETTINGS WHERE SBI MIGHT BE WIDELY IMPLEMENTED, PRIMARY HEALTH CARE IS THE ONE THAT OFFERS THE GREATEST POTENTIAL FOR REACHING THOSE IN NEED OF INTERVENTION[25,26].

5. EFFECTIVENESS AND COST-EFFECTIVENESS OF SCREENING AND BRIEF INTERVENTIONS FOR HAZARDOUS AND HARMFUL ALCOHOL USE IN PRIMARY HEALTH CARE

AS INDICATED ABOVE, THERE IS GOOD EVIDENCE THAT SCREENING AND BRIEF ALCOHOL INTERVENTIONS DELIVERED IN PHC ARE EFFECTIVE IN LEADING TO REDUCED ALCOHOL CONSUMPTION AMONG HAZARDOUS AND HARMFUL DRINKERS, WITH CONSEQUENT BENEFITS FOR PATIENTS' HEALTH AND WELFARE. THERE IS ALSO GOOD EVIDENCE, ALTHOUGH MOSTLY FROM OUTSIDE THE UK, THAT PHC BRIEF INTERVENTIONS ARE HIGHLY COST-EFFECTIVE AND THAT THEY REDUCE THE BURDEN ON PHC SERVICES. HOWEVER, DIFFICULTIES HAVE BEEN ENCOUNTERED IN PERSUADING PHC PROFESSIONALS TO INCORPORATE SBI IN THEIR ROUTINE WORK AND OBSTACLES TO THIS IMPLEMENTATION, AS WELL AS THE POTENTIAL INCENTIVES, HAVE BEEN STUDIED. THIS SECTION WILL EXAMINE THE EVIDENCE FOR EACH OF THESE ASSERTIONS IN MORE DETAIL.

EFFECTIVENESS OF SBI

THERE IS A VERY LARGE BODY OF RESEARCH EVIDENCE ON ALCOHOL BRIEF INTERVENTIONS, INCLUDING AT LEAST 56 CONTROLLED TRIALS OF EFFECTIVENESS[27]. THERE HAVE ALSO BEEN AT LEAST 13 META-ANALYSES AND/OR SYSTEMATIC REVIEWS[27-39], USING SOMEWHAT DIFFERENT AIMS AND METHODS, OF RESEARCH ON EFFECTIVENESS, WITH 5 OF THESE SPECIFICALLY FOCUSED ON PHC[30,32,36,37,39].

IN WHAT IS GENERALLY CONSIDERED TO BE THE MOST COMPREHENSIVE AND WELL-DESIGNED META-ANALYSIS OF BRIEF INTERVENTIONS[27], THE STUDIES INCLUDED WERE DIVIDED INTO 34 "OPPORTUNISTIC" BRIEF INTERVENTIONS CARRIED OUT IN GENERALIST SETTINGS AMONG INDIVIDUALS NOT SEEKING TREATMENT FOR ALCOHOL PROBLEMS AND 20 "SPECIALIST" BRIEF

INTERVENTIONS AMONG THOSE WHO ARE SEEKING TREATMENT. IT IS THE FORMER GROUP WHICH IS OF SOLE INTEREST HERE, SINCE THERE ARE MARKED DIFFERENCES IN LENGTH, CONTENT AND STYLE OF BRIEF INTERVENTION AND METHODOLOGICAL FEATURES BETWEEN THE TWO GROUPS OF STUDIES[40]. FROM THE STUDIES OF OPPORTUNISTIC INTERVENTION, SMALL TO MEDIUM AGGREGATE EFFECT SIZES IN FAVOUR OF BRIEF INTERVENTIONS EMERGED ACROSS DIFFERENT FOLLOW-UP POINTS. AT FOLLOW-UP OF 3-6 MONTHS OR MORE, THE EFFECT FOR BRIEF INTERVENTIONS COMPARED TO CONTROL CONDITIONS WAS SIGNIFICANTLY LARGER WHEN INDIVIDUALS SHOWING MORE SEVERE ALCOHOL PROBLEMS WERE EXCLUDED FROM THE ANALYSIS.

THERE IS MIXED EVIDENCE OF LONGER-TERM EFFECTS OF SBI. A TRIAL OF PHC-BASED SBI IN WISCONSIN, USA REPORTED CONTINUING BENEFITS FOR ALCOHOL USE, BINGE DRINKING EPISODES AND FREQUENCY OF EXCESSIVE DRINKING AMONG RECIPIENTS OF SBI COMPARED WITH CONTROLS FOUR YEARS AFTER INTERVENTION[41]. HOWEVER, AN AUSTRALIAN STUDY REPORTED THAT THE BENEFITS OF RECEIVING SBI HAD DISAPPEARED AFTER 10 YEARS[42]. A 10-16 YEAR FOLLOW-UP SAMPLE RECRUITED IN A WELL-KNOWN SWEDISH STUDY OF SBI THAT WAS CARRIED OUT AS PART OF A HEALTH SCREENING PROGRAMME[43] SHOWED REDUCED MORTALITY IN THE INTERVENTION GROUP BUT IT IS QUESTIONABLE WHETHER THIS STUDY CAN BE REGARDED AS EXAMINING BRIEF INTERVENTION BECAUSE OF THE LENGTH AND DURATION OF THE ORIGINAL INTERVENTION SESSIONS. NEVERTHELESS, THERE IS SOME EVIDENCE THAT SBI REDUCES ALCOHOL-RELATED MORTALITY[38], ALBEIT FROM A SMALL NUMBER OF STUDIES. THERE IS ALSO EVIDENCE THAT SBI IS EFFECTIVE IN REDUCING ALCOHOL-RELATED PROBLEMS AMONG THOSE WHO RECEIVE IT[44,45].

WITH REGARD TO SBI SPECIFICALLY IN THE PHC SETTING, THE MOST RECENT SYSTEMATIC REVIEW AND META-ANALYSIS[39] CONCLUDED THAT BRIEF ALCOHOL INTERVENTION IS EFFECTIVE IN REDUCING CONSUMPTION AMONG BOTH MEN AND WOMEN AT 6 AND 12 MONTHS FOLLOWING INTERVENTION. IT IS NOTEWORTHY THAT HIS REVIEW WAS CONFINED TO STUDIES CARRIED OUT IN MORE NATURALISTIC CONDITIONS OF PHC, EXCLUDING THOSE STUDIES THAT USED PATIENT LISTS, REGISTERS OR SPECIALLY-ARRANGED SCREENING SESSIONS. ANOTHER RECENT REVIEW[36] CONCLUDED THAT ITS META-ANALYSIS, ALTHOUGH INDICATING A SMALLER EFFECT SIZE THAN REPORTED IN PREVIOUS PAPERS, NEVERTHELESS SUPPORTED THE MODERATE EFFECTIVENESS OF SBI. NO CLEAR EVIDENCE OF A DOSE-EFFECT RELATIONSHIP WAS FOUND IN THIS ANALYSIS, MEANING THAT THE SUPERIOR BENEFITS OF RELATIVELY LONGER INTERVENTIONS COULD NOT BE DEMONSTRATED. YET ANOTHER RECENT REVIEW, BY THE US PREVENTIVE TASK FORCE[37], *FOUND THAT "BRIEF COUNSELING INTERVENTIONS FOR RISKY/HARMFUL ALCOHOL USE AMONG ADULT PRIMARY CARE PATIENTS COULD PROVIDE AN EFFECTIVE COMPONENT OF A PUBLIC HEALTH APPROACH TO REDUCING RISKY-HARMFUL ALCOHOL USE" (P.557).*

COST-EFFECTIVENESS

THE DIRECT COST OF A BRIEF INTERVENTION DELIVERED TO A HAZARDOUS OR HARMFUL DRINKERS WAS CALCULATED TO BE ONLY £20 IN 1993[29]. A RECENT WHO STUDY[46] ESTIMATED THAT THE COST-EFFECTIVENESS OF PHC ALCOHOL BRIEF INTERVENTIONS FOR HAZARDOUS AND HARMFUL DRINKING IS APPROXIMATELY £1,300 PER YEAR OF ILL-HEALTH OR PREMATURE DEATH AVERTED. IT SHOULD BE NOTED THAT THIS IS NEARLY EQUIVALENT TO THE COST-EFFECTIVENESS OF SMOKING CESSATIONS INTERVENTIONS IN PHC WHICH IS ABOUT £1,200. OTHER MEDICAL INTERVENTIONS HAVE AN AVERAGE COST-EFFECTIVENESS OF £30,000.

IN A COST-BENEFIT ANALYSIS OF THE EFFECTS OF A GP-BASED BRIEF INTERVENTION AFTER 4 YEARS, FLEMING AND COLLEAGUES IN WISCONSIN, USA[41] ESTIMATED THAT, FOR EVERY $10,000 INVESTED IN SBI, A SAVING IN HEALTH CARE COSTS WOULD BE OBTAINED OF $43,000. THE BENEFIT-COST RATIO INCREASED WHEN THE SOCIETAL BENEFITS OF FEWER MOTOR VEHICLE ACCIDENTS AND CRIME WERE INCLUDED THE ANALYSIS. THERE IS A CLEAR NEED FOR SIMILAR ECONOMIC EVALUATIONS OF SBI IN THE UK HEALTH SYSTEM BUT, EVEN WITHOUT THIS MORE DIRECT EVIDENCE, THERE IS STRONG PRIMA FACIE *CASE THAT WIDESPREAD IMPLEMENTATION OF*

SBI IN PHC WOULD CREATE RESOURCES FOR THE HEALTH CARE SYSTEM AND FOR THE WIDER SOCIETY.

IMPLEMENTATION

DESPITE THIS EVIDENCE OF EFFECTIVENESS AND COST-EFFECTIVENESS, MANY STUDIES HAVE DOCUMENTED A WIDE GAP BETWEEN ACTUAL AND RECOMMENDED GOOD PRACTICE IN PHC BASED ON RESEARCH EVIDENCE. AS ONE ILLUSTRATION OF THIS, KANER AND COLLEAGUES[47] REPORTED FINDINGS FROM A QUESTIONNAIRE SURVEY OF GENERAL MEDICAL PRACTITIONERS (GPS) IN THE ENGLISH MIDLANDS. RESULTS SHOWED THAT GPS DID NOT TO MAKE ROUTINE ENQUIRIES ABOUT ALCOHOL, WITH 67% ENQUIRING ONLY "SOME OF THE TIME". THE FACT THAT 65% OF GPS HAD MANAGED ONLY 1-6 PATIENTS FOR EXCESSIVE DRINKING IN THE LAST YEAR WAS STRIKING IN VIEW OF EVIDENCE THAT APPROXIMATELY 20% OF PATIENTS PRESENTING TO PRIMARY HEALTH CARE ARE LIKELY TO BE AT LEAST HAZARDOUS DRINKERS[48]. GIVEN FIGURES ON GPS' AVERAGE LIST SIZE IN THE UK, THIS SUGGESTS THAT THE MAJORITY OF GPS MAY BE MISSING AS MANY AS 98% OF THE EXCESSIVE DRINKERS PRESENTING TO THEIR PRACTICES. A HOUSEHOLD SURVEY IN ENGLAND BY OPCS PUBLISHED IN 1996 FOUND THAT, OF CURRENT AND FORMER DRINKERS WHO HAD SPOKEN TO A MEDICAL PRACTITIONER OR OTHER HEALTH PROFESSIONAL IN THE LAST YEAR, ONLY 7% (MEN = 12%; WOMEN = 5%) REPORTED HAVING DISCUSSED ALCOHOL CONSUMPTION WITH THEIR GP AT THE SURGERY[49]. THIS LOW LEVEL OF INTERVENTION EXISTS AGAINST A BACKGROUND IN WHICH MANY PATIENTS EXPECT THAT THEIR GP SHOULD BE INTERESTED IN ALCOHOL-RELATED PROBLEMS BUT ONLY A MINORITY THINK THAT THEY ARE ACTUALLY INTERESTED[50].

RESEARCH HAS ALSO FOCUSED ON IDENTIFYING THE OBSTACLES TO IMPLEMENTATION OF SBI IN PHC, WITH A GOOD CONVERGENCE OF FINDINGS FROM DIFFERENT STUDIES IN DIFFERENT COUNTRIES. THE MAIN OBSTACLE APPEARS SIMPLY TO BE LACK OF TIME AMONG BUSY HEALTH CARE PROFESSIONALS[47,51]. OTHER OBSTACLES ARE: (I) LACK OF APPROPRIATE TRAINING TO CARRY OUT SBI; (II) LITTLE SUPPORT FROM GOVERNMENT HEALTH POLICIES; (III) A BELIEF THAT PATIENTS WILL NOT TAKE ADVICE TO CHANGE DRINKING BEHAVIOUR; (V) A LACK OF SUITABLE SCREENING AND COUNSELLING MATERIALS; (VI) LACK OF REIMBURSEMENT FROM GOVERNMENT HEALTH SCHEMES[47]. AT THE SAME TIME, HEALTH PROFESSIONALS MAY FEAR OFFENDING PATIENTS BY RAISING THE TOPIC OF DRINKING AND FIND IT DIFFICULT TO DO SO[52] AND SOME MAY HAVE NEGATIVE ATTITUDES TO PATIENTS WITH DRINKING PROBLEMS DERIVED FROM THEIR EXPERIENCE OF THOSE WITH MORE SEVERE PROBLEMS. SOME OF THESE IDENTIFIED OBSTACLES ARE SIMPLY OVERCOME (E.G. AVAILABILITY OF SBI TRAINING AND SCREENING AND COUNSELLING MATERIALS) BUT OTHERS PRESENT MORE SERIOUS DIFFICULTIES.

WHEN GPS ARE ASKED WHAT INCENTIVES WOULD BE REQUIRED TO ENABLE THEM TO CARRY OUT SBI, MANY MENTION TRAINING AND SUPPORT[47]. THERE IS INDEED GOOD EVIDENCE THAT WHEN GPS AND NURSES ARE ADEQUATELY TRAINED AND SUPPORTED FOR THIS WORK, SBI ACTIVITY INCREASES[53]. HOWEVER, THERE IS ALSO EVIDENCE THAT SUPPORT SHOULD BE GEARED TO THE NEEDS AND ATTITUDES OF HEALTH PROFESSIONALS TO BE EFFECTIVE AND AVOID BEING COUNTERPRODUCTIVE IN THE LONGER TERM[54]. RECENT RESEARCH CARRIED OUT AT THE CENTRE FOR HEALTH SERVICES RESEARCH, UNIVERSITY OF NEWCASTLE UPON TYNE[55] SUGGESTS THAT, ALTHOUGH MANY GPS ARE ONLY PARTIALLY AWARE OF SBI *PER SE*, MANY EMPLOY ELEMENTS OF THE SBI APPROACH INFORMALLY IN THEIR DAILY WORK. IF THIS COULD BE POINTED OUT TO GPS AND THEIR CURRENT ACTIVITY "REBADGED" USING THE FORMAL CONCEPTS OF SBI, THE IMPLEMENTATION PROCESS COULD BE ACCELERATED.

OTHER INCENTIVES MENTIONED BY GPS ARE: (I) IF SBI WERE PROVEN TO BE SUCCESSFUL; (II) IF PATIENTS ASKED FOR ADVICE ABOUT ALCOHOL CONSUMPTION; (III) IF PUBLIC HEALTH CAMPAIGNS MADE SOCIETY IN GENERAL MORE CONCERNED ABOUT ALCOHOL; (IV) IF QUICK AND EASY COUNSELLING MATERIALS WERE AVAILABLE; (V) IF SALARY AND WORKING CONDITIONS WERE IMPROVED; (VI) IF TRAINING PROGRAMMES FOR SBI WERE AVAILABLE[47]. AGAIN, SOME OF THESE INCENTIVES ARE READILY PROVIDED WHILE OTHERS ARE NOT.

6. CURRENT POLICIES

AS HAS ALREADY BEEN MADE CLEAR, WHEN CONSIDERING CURRENT POLICIES THAT AFFECT SBI ACTIVITY IN PHC IN ENGLAND, OR, AT LEAST, WILL SOON BEGIN TO AFFECT IT AND WILL DO SO FOR SOME YEARS TO COME, THREE MAJOR AND RECENT PUBLICATIONS STAND OUT – THE ALCOHOL HARM REDUCTION STRATEGY FOR ENGLAND[1], *THE NEW* GMS CONTRACT[2] *AND THE DEPARTMENT OF HEALTH WHITE PAPER,* CHOOSING HEALTH[3]. *IN THIS SECTION, THEREFORE, THE TEXT IN THESE PUBLICATIONS THAT IS RELEVANT TO SBI WILL BE REVIEWED AND SUBJECTED TO CONSTRUCTIVE CRITICISM WHERE APPROPRIATE.*

THE ALCOHOL HARM REDUCTION STRATEGY FOR ENGLAND

a) It should first be noted that, in his Foreword to the strategy document, the Prime Minister states that the Government has accepted all the conclusions of the AHRSE and that these will now be implemented as Government policy (p.3).

b) *DIRECT REFERENCES TO SBI AND TO THE ROLE OF PHC COME IN CHAPTER 5 ON* IDENTIFICATION AND TREATMENT *BUT BEFORE MOVING TO A DETAILED DESCRIPTION OF THESE REFERENCES IT IS IMPORTANT TO NOTE THAT THERE ARE NO LINKS BETWEEN CHAPTER 5 AND THE PRECEDING CHAPTER 4 ON* EDUCATION AND COMMUNICATION. *THIS MISSES THE OPPORTUNITY THAT WOULD BE PRESENTED BY A WIDESPREAD IMPLEMENTATION OF SBI IN PHC TO EDUCATE AND RAISE THE AWARENESS OF PATIENTS, AND HENCE THE GENERAL PUBLIC, ABOUT THE RISKS EXCESSIVE DRINKING POSES TO HEALTH AND ABOUT "SENSIBLE DRINKING" LIMITS. THIS IS ESPECIALLY RELEVANT TO THE GOVERNMENT'S INTENTION TO RE-ASSESS THE CURRENT SENSIBLE DRINKING MESSAGE, "FOCUSING ON DEVELOPING A SIMPLER FORMAT FOR THE MESSAGE, AND ONE WHICH MAKES IT EASIER TO RELATE TO EVERYDAY LIFE" (P.26), A TASK THAT IS PROMISED FOR COMPLETION BY THE 2ND QUARTER OF 2005. WHEN THIS NEW MESSAGE IS READY FOR PUBLIC DISSEMINATION, ITS STEADY REINFORCEMENT BY GPS AND OTHER PHC STAFF IN THE PROCESS OF DELIVERING SBI WOULD BE VERY HELPFUL.*

c) *CHAPTER 5 BEGINS BY STATING THAT IT WILL CONSIDER "THE BEST WAY OF IDENTIFYING AND TREATING THOSE WHO HAVE ESTABLISHED ALCOHOL PROBLEMS THAT MAY BE AFFECTING THEIR HEALTH OR THEIR SOCIAL FUNCTIONING" (P.35). THIS IS AN OBVIOUS AND WORTHY TARGET OF ATTENTION BUT IT SAYS NOTHING ABOUT THE LARGE NUMBER OF PEOPLE WHO MAY NOT HAVE ESTABLISHED ALCOHOL PROBLEMS BUT ARE RISKING THEIR HEALTH AND WELFARE BY EXCESSIVE DRINKING. THIS IS DESPITE THE FACT THAT EARLIER IN THE DOCUMENT IT IS STATED THAT, "AROUND A QUARTER OF THE POPULATION DRINK ABOVE THE FORMER RECOMMENDED WEEKLY GUIDELINES, WHICH INCREASES THE RISK OF CAUSING OR EXPERIENCING ALCOHOL-RELATED HARM" (P.9). THIS PROPORTION IS OBVIOUSLY MADE UP MAINLY OF THE HAZARDOUS DRINKERS IN QUESTION, I.E., THOSE DRINKING ABOVE MEDICALLY-RECOMMENDED DAILY OR WEEKLY DRINKING LIMITS. THUS IT IS UNCLEAR THROUGHOUT WHETHER THE STRATEGY IS MEANT TO ENCOMPASS THE GROUP OF HAZARDOUS DRINKERS IN ADDITION TO THOSE WITH ESTABLISHED PROBLEMS BUT, CONSIDERING ONLY THE TEXT IN CHAPTER 5, THERE IS A DANGER THAT THE FORMER MAY BE IGNORED IN IMPLEMENTATION.*

d) *THE STRATEGY RECOGNISES THAT PEOPLE WITH ALCOHOL PROBLEMS MAY NOT BE PICKED UP IN THE PUBLIC SERVICES WITH WHICH THEY COME INTO CONTACT BECAUSE OF THE ABSENCE OF A CLEAR IDENTIFICATION PROCESS AND ALSO BECAUSE OF LACK OF STAFF TRAINING TO ENABLE IDENTIFICATION OF AN UNDERLYING PROBLEM OR HOW TO REFER. THIS IS OFTEN DUE TO "PRESSURE ON STAFF TIME AND POSSIBLE UNEASE ABOUT A PROBLEM WHICH STILL CARRIES A STRONG STIGMA" (P.36). PHC IS DESCRIBED AS THE LEADING ACCESS POINT IN THE HEALTH SYSTEM FOR IDENTIFICATION AND REFERRAL TO OCCUR. THIS IS BECAUSE "MANY INDIVIDUALS AND FAMILIES WILL USE THEIR LOCAL GP SURGERY OR LOCAL PHC CLINIC AS THE FIRST PORT*

OF CALL" (P.36). IT IS ESTIMATED THAT EACH GP SEES 364 HEAVY DRINKERS PER YEAR, AN ESTIMATE THAT SEEMS TO BE TAKEN FROM THE WORK OF KANER AND COLLEAGUES[47].

e) THE STRATEGY DEFINES SCREENING AS "A METHOD OF IDENTIFYING ALCOHOL CONSUMPTION AT A LEVEL SUFFICIENTLY HIGH TO CAUSE CONCERN" (P.37). THIS DEFINITION WOULD APPEAR TO INCLUDE THE CONSUMPTION OF THE LARGE NUMBER OF HAZARDOUS DRINKERS. IT IS NOTED THAT A RANGE OF SCREENING INSTRUMENTS HAVE BEEN DEVELOPED BUT THAT THE MOST COMPREHENSIVE IS THE ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT)[56] WHICH WAS DEVELOPED BY THE WHO SPECIFICALLY FOR USE IN PHC SETTINGS. HOWEVER, IT IS ALSO NOTED THAT, "SCREENING DOES NOT NEED TO INVOLVE A SPECIFIC TOOL: IT CAN ALSO TAKE THE FORM OF RELEVANT QUESTIONS ASKED DURING THE COURSE OF A CONSULTATION, E.G., AT A GP SURGERY" (P.36).

f) THE STRATEGY FURTHER NOTES THAT THERE ARE ESSENTIALLY TWO TYPES OF SCREENING:

- UNIVERSAL SCREENING ... OF ALL PATIENTS IN A GP SURGERY...HOWEVER, RECENT RESEARCH HAS RAISED QUESTIONS ABOUT THE VALUE AND EFFECTIVENESS OF UNIVERSAL SCREENING, WHICH MEANS THAT IT IS DIFFICULT TO ADVANCE A SOUND CASE FOR THIS TYPE OF SCREENING;
- TARGETED SCREENING (OF) ONLY THOSE PEOPLE WHO MAY BE DRINKING IN A PROBLEMATIC WAY. UNDER THIS SYSTEM, ONLY THOSE PEOPLE WHO PRESENT TO THE HEALTH SERVICE WITH SYMPTOMS AND CONDITIONS WHICH MAY BE LINKED TO PROBLEMATIC DRINKING ARE SCREENED – FOR EXAMPLE, A PATIENT PRESENTING TO A GP SURGERY WITH PERSISTENT STOMACH PAINS, OR WHO IS IN HOSPITAL FOLLOWING A CARDIAC ARREST.

THE RESEARCH REFERRED TO UNDER THE HEADING OF UNIVERSAL SCREENING IS PRESUMABLY THE STUDIES BY BEICH AND COLLEAGUES FROM DENMARK PUBLISHED IN THE BRITISH MEDICAL JOURNAL[57,58]*. ALTHOUGH THESE STUDIES HAVE NUMEROUS FLAWS, IT IS TRUE THAT THEY ARE RELEVANT ONLY TO UNIVERSAL SCREENING. THE ALTERNATIVE, TARGETED OR SELECTIVE SCREENING, EMERGED AS A FAVOURED PRINCIPLE OF SCREENING IN A DELPHI STUDY OF BRITISH EXPERT OPINION ON SBI IN PHC[59] AND WAS ALSO FAVOURED IN THE FINDINGS FROM FOCUS GROUPS WITH HEALTH PROFESSIONALS AND PHC PATIENTS[60]. THE ONLY LIMITATION OF THE DESCRIPTION OF THIS TYPE OF SCREENING IN THE AHRSE (SEE ABOVE) IS THAT, ONCE AGAIN, IT SEEMS TO IGNORE HAZARDOUS DRINKERS WHO ARE AT RISK OF INCURRING ALCOHOL-RELATED PROBLEMS WITHOUT SUCH PROBLEMS YET BEING OBVIOUS.*

g) THE STRATEGY THEN MOVES ON TO AN IMPORTANT PARAGRAPH FOR PRESENT PURPOSES:

> FOLLOWING SCREENING, INDIVIDUALS MAY BENEFIT FROM A 'BRIEF INTERVENTION'. THERE IS NO STANDARD DEFINITION OF A BRIEF INTERVENTION – INTERVENTIONS CAN RANGE FROM A SHORT CONVERSATION WITH A DOCTOR OR NURSE TO A NUMBER OF SESSIONS OF MOTIVATIONAL INTERVIEWING. BUT THERE ARE SOME ELEMENTS WHICH ARE COMMON TO ALL BRIEF INTERVENTIONS – THE GIVING OF INFORMATION AND ADVICE, ENCOURAGEMENT TO THE PATIENT TO CONSIDER THE POSITIVES AND NEGATIVES OF THEIR DRINKING BEHAVIOUR, AND SUPPORT AND HELP TO THE PATIENT IF THEY DO DECIDE THAT THEY WANT TO CUT DOWN ON THEIR DRINKING. BRIEF INTERVENTIONS ARE USUALLY 'OPPORTUNISTIC' – THAT IS, THEY ARE ADMINISTERED TO PATIENTS WHO HAVE NOT ATTENDED A CONSULTATION TO DISCUSS THEIR DRINKING *(P.37)*.

THIS IS A USEFUL AND ACCURATE SUMMARY DESCRIPTION OF BRIEF INTERVENTIONS. THE ESSENTIAL ELEMENTS OF BRIEF INTERVENTIONS MIGHT ALSO INCLUDE INDIVIDUALISED FEEDBACK ABOUT ALCOHOL CONSUMPTION AND RELATED PROBLEMS, GOAL-SETTING (E.G. START DATE, DRINKING LEVEL AND PATTERN) AND FOLLOW-UP MONITORING.

h) THE TEXT GOES ON:

> FOR PATIENTS WHOSE PROBLEMS ARE NOT YET TOO SEVERE, BRIEF INTERVENTIONS MAY BE AN EFFECTIVE APPROACH. FOR EXAMPLE, EVIDENCE SHOWS THAT DRINKERS MAY REDUCE THEIR CONSUMPTION BY AS MUCH AS 20% AS A RESULT OF A BRIEF INTERVENTION (BABOR ET AL., 2003). EQUALLY, EVIDENCE SHOWS THAT HEAVY DRINKERS WHO RECEIVE AN INTERVENTION ARE TWICE AS LIKELY TO CUT THEIR ALCOHOL CONSUMPTION AS HEAVY DRINKERS WHO RECEIVE NO INTERVENTION *(P.37)*.

THIS TOO IS USEFUL. IT MIGHT HAVE BEEN ADDED THAT THE NUMBER NEEDED TO TREAT (NNT) FOR BRIEF INTERVENTIONS IN PHC HAS BEEN ESTIMATED AT ABOUT 8[61], MEANING THAT ROUGHLY 8 PATIENTS WOULD HAVE TO RECEIVE A BRIEF INTERVENTION IN ORDER FOR ONE TO SUCCEED IN REDUCING DRINKING BELOW RECOMMENDED LEVELS. THIS COMPARES VERY FAVOURABLY WITH AN NNT FOR ADVICE ON SMOKING CESSATION OF ABOUT 20[62]. IN ADDITION, IT CAN BE EXPECTED THAT SOME PATIENTS WHO DO NOT REDUCE DRINKING IMMEDIATELY WILL DO SO AT SOME TIME IN THE FUTURE AS A CONSEQUENCE OF A PSYCHOLOGICAL PROCESS SET IN TRAIN BY THE BRIEF INTERVENTION.

i) IN ANOTHER RELEVANT PARAGRAPH, THE STRATEGY STATES:

> HOWEVER, THE RESEARCH EVIDENCE ON BRIEF INTERVENTIONS DRAWS HEAVILY ON SMALL-SCALE STUDIES CARRIED OUT OUTSIDE THE UK. MORE INFORMATION IS NEEDED ON THE MOST EFFECTIVE METHODS OF TARGETED SCREENING AND BRIEF INTERVENTIONS, AND WHETHER THE SUCCESSES SHOWN IN RESEARCH STUDIES CAN BE REPLICATED WITHIN THE HEALTH SYSTEM IN ENGLAND *(P.37)*.

THE STATEMENT IN THE FIRST SENTENCE ABOVE IS UNTRUE; THE RESEARCH EVIDENCE ON BRIEF INTERVENTIONS DRAWS ON A COLLECTION OF LARGE-SCALE STUDIES, SOME OF WHICH HAVE BEEN CARRIED OUT IN THE UK IN THE PHC SETTING[E.G.45,63,64]. HOWEVER, THE POINT MADE IN THE SECOND SENTENCE ABOVE IS WELL-TAKEN; EFFICACY TRIALS OF BRIEF INTERVENTIONS CONDUCTED UNDER OPTIMAL RESEARCH CONDITIONS NOW NEED TO BE SUPPLEMENTED BY EFFECTIVENESS STUDIES CONDUCTED IN REAL-WORLD CONDITIONS OF PHC AND BY ACTION RESEARCH PROJECTS AIMED AT ACHIEVING METHODS OF IMPLEMENTATION THAT ARE ACCEPTABLE TO BOTH HEALTH PROFESSIONALS AND PATIENTS IN THE PHC SYSTEM IN ENGLAND.

j) THIS SECTION OF THE AHRSE DOCUMENT CONCLUDES WITH TWO ACTION POINTS:

> **13. THE DH WILL STRENGTHEN THE EMPHASIS ON THE IMPORTANCE OF EARLY IDENTIFICATION OF ALCOHOL PROBLEMS THROUGH COMMUNICATIONS WITH DOCTORS, NURSES AND OTHER HEALTH CARE PROFESSIONALS. DH WILL DO THIS WITH IMMEDIATE EFFECT.**
>
> **14. THE DH WILL SET UP A NUMBER OF PILOT SCHEMES BY Q1/2005 TO TEST HOW BEST TO USE A VARIETY OF MODELS OF TARGETED SCREENING AND BRIEF INTERVENTION IN PRIMARY AND SECONDARY HEALTHCARE SETTINGS, FOCUSING PARTICULARLY ON VALUE FOR MONEY AND MAINSTREAMING.**

BOTH THESE PROMISED ACTIONS ARE IMPORTANT AND VERY WELCOME. IT WOULD BE OF GREAT INTEREST TO KNOW WHAT AND HOW MUCH HAS BEEN DONE UNDER ACTION POINT 13 AND WHAT FURTHER PLANS EXIST FOR THE SHORT- AND MEDIUM-TERM. THE PILOT SCHEMES PROMISED UNDER ACTION POINT 14 REPRESENT A VITAL COMPONENT OF THE STRATEGY DESCRIBED IN THIS DOCUMENT AIMED AT ACHIEVING A WIDESPREAD AND ROUTINE

IMPLEMENTATION OF SBI IN PHC IN ENGLAND (SEE SECTION 8 BELOW). THIS WILL ONLY BE ACHIEVED, HOWEVER, IF THE MODEL OF SBI THAT IS PILOTED CLEARLY INCLUDES ATTENTION TO HAZARDOUS DRINKERS AS WELL AS TO THOSE WITH ALREADY ESTABLISHED ALCOHOL-RELATED PROBLEMS.

k) THE STRATEGY DOCUMENT NOTES CORRECTLY THAT THERE EXISTS LITTLE TRAINING ON ALCOHOL ISSUES FOR HEALTH PROFESSIONALS IN ENGLAND. MANY SAY THEY NEED MORE TRAINING AND DO NOT FEEL ADEQUATELY TRAINED TO DEAL WITH ALCOHOL ISSUES. THIS CAN LEAD TO A LACK OF BASIC AWARENESS OF ALCOHOL MISUSE, A LACK OF CLARITY ON WHAT TO DO AND SOMETIMES NERVOUSNESS ABOUT BROACHING THE TOPIC WITH PATIENTS. MOREOVER, THERE IS NO CENTRAL REQUIREMENT TO TRAIN IN ALCOHOL ISSUES AND, FOR EXAMPLE, EACH MEDICAL SCHOOL MAKES ITS OWN DECISIONS IN THIS AREA. THE GENERAL MEDICAL COUNCIL (GMC) PROVIDES QUALITY ASSURANCE AND EXPECTS ALCOHOL TO BE INCLUDED BUT THIS STILL VARIES FROM SCHOOL TO SCHOOL. ESSENTIALLY THE SAME APPLIES TO TRAINING FOR NURSES. IT IS POINTED OUT THAT THE DH HAS NO RESPONSIBILITY FOR CURRICULUM DECISIONS BUT CAN PLAY A ROLE IN CLARIFYING VALUE OF THIS EDUCATION TO CURRICULUM BODIES.

THE STRATEGY GOES ON TO NOTE THAT, ONCE WORKING IN NHS, FURTHER TRAINING ON ALCOHOL IS DRIVEN BY THE NEEDS OF CONTINUING PROFESSIONAL DEVELOPMENT THROUGH APPRAISAL AND PERSONAL DEVELOPMENT PLANNING. FOR MEDICAL DOCTORS, POSTGRADUATE EDUCATION IS UNDERTAKEN AGAINST CURRICULA DEVELOPED BY THE ROYAL COLLEGES AND APPROVED BY COMPETENT AUTHORITIES. DIFFERENT KINDS OF MECHANISMS EXIST FOR OTHER PROFESSIONAL GROUPS. WITH REGARD TO NURSE TRAINING, WHETHER SBI, OR INDEED ALCOHOL IN GENERAL, FORMS PART OF A COURSE LARGELY DEPENDS PM SERVICE CONFIGURATIONS AND THE PERSONAL INTERESTS OF TUTORS WHO DELIVER COURSES.

l) TWO FURTHER ACTIONS ARE PROMISED IN RELATION TO TRAINING AND PROFESSIONAL DEVELOPMENT:

15. THE DEPUTY CHIEF MEDICAL OFFICER FOR HEALTH IMPROVEMENT AND THE CHIEF NURSING OFFICER WILL ACT AS "TRAINING CHAMPIONS" TO RAISE THE PROFILE OF MEDICAL AND NURSE TRAINING ON ALCOHOL ISSUES, FROM Q3/2004.

16. THE DH WILL WORK WITH MEDICAL AND NURSING COLLEGES AND OTHER TRAINING BODIES TO DEVELOP TRAINING MODULES ON ALCOHOL, COVERING UNDERGRADUATE, POSTGRADUATE AND MEDICAL CURRICULA AND UPDATED REGULARLY, BY Q3/2005.

AGAIN, THESE ACTIONS ON THE PART OF THE GOVERNMENT ARE VERY WELCOME AND COINCIDE WITH THE AIMS OF THE STRATEGY DESCRIBED IN THE PRESENT DOCUMENT.

THE NEW GMS CONTRACT

A SPECIFICATION FOR THE TREATMENT OF "PATIENTS WHO ARE ALCOHOL MISUSERS" IS INCLUDED IN THE NGMS CONTRACT[2] AS A NATIONAL ENHANCED SERVICE *(NES). IT IS NOT AN* ESSENTIAL SERVICE *WHICH ALL GPS MUST OFFER OR AN* ADDITIONAL SERVICE *WHICH GPS ARE CONTRACTED TO PROVIDE TO ALL THEIR PATIENTS. NEITHER IS IT A* DIRECT ENHANCED SERVICE *WHICH MUST BE PROVIDED IN EVERY LOCALITY. ENHANCED SERVICES INVOLVE EITHER THE PROVISION OF ESSENTIAL OR ADDITIONAL SERVICES TO A HIGHER STANDARD OR MORE SPECIALISED INTERVENTIONS NOT PROVIDED BY MOST GPS. FOR A SMALL NUMBER OF ENHANCED SERVICES THERE ARE NATIONAL SPECIFICATIONS AND BENCHMARK PRICING AND SERVICES TO "ALCOHOL MISUSERS" ARE ONE OF THESE. AN NES HAS FIXED CRITERIA THAT A PRIMARY CARE TRUST (PCT) MUST FOLLOW AND GPS CAN DEMAND BE FOLLOWED FOR PAYMENT.*

THE SPECIFICATION BEGINS BY SETTING OUT THE RELEVANT BACKGROUND EVIDENCE IN 10 SHORT POINTS. THE 2ND OF THESE STATES:

> 0.7 MILLION MEN AND 0.6 MILLION WOMEN DRINK AT 'RISKY' OR 'HAZARDOUS' LEVELS.

THIS REPRESENTS A SERIOUS UNDERESTIMATION OF THE NUMBER OF HAZARDOUS DRINKERS, IF THIS IS DEFINED AS ALL THOSE DRINKING OVER MEDICALLY-RECOMMENDED LEVELS, IN THE UK. THE INTERIM ANALYTICAL REPORT[4] *INDICATES THAT THERE ARE 8.2 MILLION ADULTS (5.1M MEN AND 3.1M WOMEN) DRINKING ABOVE WEEKLY RECOMMENDED LEVELS IN ENGLAND ALONE. IF THE CRITERION IS TAKEN TO BE THOSE WHO REPORT EXCEEDING DAILY RECOMMENDED LEVELS IN THE PAST WEEK, THE FIGURE RISES TO 11.7 MILLION (7.2M MEN AND 4.5M WOMEN). SINCE THE NGMS CONTRACT APPLIES TO THE WHOLE UK, THE TRUE FIGURES WILL BE HIGHER EVEN THAN THESE. THE REFERENCE GIVEN FOR THE FIGURES IN THE NGMS SPECIFICATION ARE FROM THE 1998 GENERAL HOUSEHOLD SURVEY, WHEREAS THOSE IN THE* INTERIM ANALYTICAL REPORT *ARE FROM THE 2000 SURVEY BUT THIS CANNOT, OF COURSE, ACCOUNT FOR THE DISCREPANCY IN QUESTION. IT IS UNCLEAR HOW THIS CONFUSION HAS ARISEN; IT COULD CONCEIVABLY BE AN ARITHMETICAL ERROR BY A FACTOR OF 10.*

THE 10TH BACKGROUND EVIDENCE POINT IS:

> BRIEF INTERVENTIONS CAN REDUCE ALCOHOL CONSUMPTION BY OVER 20%, AND SO REDUCE THE NUMBER OF PATIENTS WHO BECOME DEPENDENT ON ALCOHOL AND THE NEED FOR MORE INTENSIVE TREATMENT IN THE FUTURE.

A MEAN REDUCTION IN CONSUMPTION OF 20% AMONG RECIPIENTS OF BRIEF INTERVENTION IS PROBABLY LESS RELEVANT TO PRACTICE THAN THE PROPORTION OF PATIENTS WHO ARE LIKELY TO REDUCE DRINKING FROM ABOVE TO UNDER RECOMMENDED LEVELS (ROUGHLY 12.5%) OR THE CORRESPONDING NNT (ABOUT 8). ALSO UNHELPFUL IS THE IMPLIED EQUATION OF EARLY INTERVENTION WITH THE PREVENTION OF ALCOHOL DEPENDENCE, SINCE ONLY A MINORITY OF PATIENTS DRINKING HAZARDOUSLY OR HARMFULLY IN THE NATURAL ENVIRONMENT WILL GO ON TO DEVELOP SEVERE DEPENDENCE[E.G.65]. MORE IMPORTANT IN EARLY INTERVENTION BY SBI IS THE PREVENTION OF MEDICAL AND SOCIAL HARM IN THE FUTURE IF HAZARDOUS OR HARMFUL DRINKING IS CONTINUED, AS WELL AS THE REDUCTION IN ALCOHOL-RELATED PROBLEMS AMONG HARMFUL DRINKERS IN THE PRESENT.

THE AIMS OF THE SPECIFICATION ARE STATED TO BE TO IMPROVE THE QUALITY OF CARE PROVIDED BY PRACTICES TO PATIENTS WHO MISUSE ALCOHOL. THIS WILL BE DONE BY INCENTIVISING AND TRAINING GPS TO ADVICE AND TREAT ALCOHOL MISUSE PATIENTS AND UNDERTAKING MORE SPECIALISED TREATMENT OF ALCOHOL DEPENDENT PATIENTS.

OF THE 8 LISTED ELEMENTS OF A SERVICE OUTLINE THAT THE NES WILL FUND, THE FOLLOWING ARE RELEVANT TO PRESENT PURPOSES:

> ***THE DEVELOPMENT AND PRODUCTION OF AN UP-TO-DATE REGISTER.*** *PRACTICES SHOULD BE ABLE TO PRODUCE AN UP-TO-DATE REGISTER OF ALL PATIENTS WHO ADMIT THEY ARE ALCOHOL MISUSERS. THIS REGISTER WILL BE USED AS AN AUDIT TOOL.*

THIS IS NOT INTENDED TO BE A STAND-ALONE REGISTER; RATHER, EACH PATIENT IS READ-CODED AND A LIST OF ALCOHOL MISUSERS CAN BE MADE BY DOING A COMPUTER SEARCH. THE LANGUAGE USED HERE IS UNFORTUNATE, SINCE IT IMPLIES AN ATTEMPT TO ENCOURAGE DRINKERS TO "ADMIT" SOMETHING THEY ARE ASHAMED OF. IN ADDITION TO RUNNING COUNTER TO THE ATTEMPT TO REDUCE THE STIGMA ATTACHED TO RECOGNISING HAZARDOUS OR HARMFUL DRINKING, THIS

LANGUAGE ALSO SUGGESTS THAT THE TARGETS OF INTERVENTION WILL ALL HAVE SERIOUS ALCOHOL-RELATED PROBLEMS.

***PRACTICES TO BE ABLE TO UNDERTAKE BRIEF INTERVENTIONS** AND OFFER SUPPORT TO CARRY OUT BEHAVIOURAL CHANGE.*

***FOLLOW-UP TREATMENT.** A RANGE OF TREATMENTS MAY BE PRESCRIBED INCLUDING A SET NUMBER OF COUNSELLING SESSIONS WHICH MAY BE DONE IN CONJUNCTION WITH OR BY REFERRAL TO LOCAL ALCOHOL SERVICES OR THROUGH THE PATIENT'S ATTENDANCE AT A DAY PROGRAMME OR RESIDENTIAL REHABILITATION CENTRE, BOTH OF WHICH WOULD REQUIRE REFERRAL.*

IT IS HOPED THAT COUNSELLING SESSIONS CARRIED OUT IN CONJUNCTION WITH ALCOHOL SERVICES ARE TAKEN TO INCLUDE BRIEF INTERVENTIONS THAT ARE MORE INTENSIVE AND PROTRACTED THAN BRIEF ADVICE BUT FALL SHORT OF SPECIALISED TREATMENT PROPER. THESE BRIEF INTERVENTIONS SHOULD BE SUPPORTED BY SPECIALIST AGENCIES THROUGH IN-SERVICE TRAINING AND CLEAR ADVICE ON WHICH PATIENTS ARE SUITABLE FOR SUCH AN APPROACH AND WHICH NEED TO BE REFERRED ON.

ROUTINE USE OF ASSESSMENT TOOLS.

THE ROUTINE USE OF SCREENING TOOLS SHOULD ALSO HAVE BEEN MENTIONED HERE.

LIAISON WITH LOCAL SPECIALIST ALCOHOL TREATMENT SERVICES.

AGAIN, THIS LIAISON SHOULD INCLUDE SUPPORT IN DELIVERING BRIEF ADVICE AND BRIEF INTERVENTION TO HAZARDOUS AND HARMFUL DRINKERS.

***APPROPRIATE TRAINING.** THIS MUST BE AVAILABLE TO THE PRIMARY CARE TEAM TO ENABLE TEAM MEMBERS TO UNDERSTAND THE PROBLEM EXPERIENCED BY PEOPLE WHO MISUSE ALCOHOL AND THEIR FAMILIES, AND TO COMMUNICATE EFFECTIVELY WITH THEM. TRAINING SHOULD INCLUDE DETECTING PROBLEM DRINKERS, CARRYING OUT BRIEF INTERVENTIONS, AND MANAGING FOLLOW-UP TREATMENT, INCLUDING COUNSELLING.*

AS WITH THE AHRSE, THE COMMITMENT TO TRAINING SHOWN HERE IS MOST WELCOME. ONCE MORE, HOWEVER, THIS PARAGRAPH COULD BE IMPROVED BY MENTION OF HAZARDOUS DRINKERS AS WELL AS THOSE WITH OVERT PROBLEMS.

***REVIEW.** ALL PRACTICES INVOLVED IN THE SCHEME SHOULD PERFORM AN ANNUAL REVIEW WHICH COULD INCLUDE AN AUDIT OF: (A) THOSE IDENTIFIED AND RECORDED AS ALCOHOL MISUSE PATIENTS; (B) THE ADVICE AND/OR TREATMENT OFFERED TO PATIENTS WHO, FOLLOWING SCREENING, HAVE BEEN SHOWN TO MISUSE ALCOHOL; (C) THE NUMBER OF PATIENTS WHO HAVE REDUCED THEIR ALCOHOL CONSUMPTION; (D) FEEDBACK FROM PATIENTS WHO MISUSE ALCOHOL AND THEIR FAMILIES.*

INFORMATION FROM SUCH ANNUAL REVIEWS WOULD FORM AN INVALUABLE SOURCE OF DATA FOR MONITORING THE PROGRESS OF WIDESPREAD SBI IMPLEMENTATION AND FOR PLANNING AND RESEARCH PURPOSES.

WITH REGARD TO ACCREDITATION, THE SPECIFICATION STATES: "THOSE DOCTORS WHO HAVE PREVIOUSLY PROVIDED SERVICES SIMILAR TO THE PROPOSED ENHANCED SERVICE AND WHO SATISFY AT APPRAISAL AND REVALIDATION THAT THEY HAVE SUCH CONTINUING MEDICAL EXPERIENCE, TRAINING AND COMPETENCE AS IS NECESSARY TO ENABLE THEM TO CONTRACT FOR THE ENHANCED SERVICE SHALL BE DEEMED PROFESSIONALLY QUALIFIED TO DO SO." THIS DOES NOT APPARENTLY

IMPLY THAT ONLY THOSE GPS WHO ARE ALREADY OFFERING SERVICES SIMILAR TO THOSE DESCRIBED IN THE SPECIFICATION WILL BE EXPECTED TO DELIVER THEM IN THE FUTURE.

FINALLY, WITH REGARD TO COSTS, THE SPECIFICATION STATES: "IN 2003/04 EACH PRACTICE CONTRACTED TO PROVIDE THIS SERVICE WILL RECEIVE AN ANNUAL RETAINER OF £1,000 PLUS AN ANNUAL PAYMENT PER PATIENT (PAID QUARTERLY IN ARREARS) OF £200. THESE PRICES WILL BE UPRATED BY 3.225% IN 2004/05 AND AGAIN IN 2005/06."

LIMITATIONS OF THE ALCOHOL SPECIFICATION IN THE NGMS CONTRACT
DESPITE SOME WELCOME FEATURES OF THE SPECIFICATION, IN A BRIEFING ON THE NGMS AND ALCOHOL FOR PRIMARY CARE ORGANISATION (PCO) COMMISSIONERS[66], ALCOHOL CONCERN *ASKS WHETHER IT IS "A MISSED OPPORTUNITY". THIS IS MAINLY BECAUSE THE SPECIFICATION OF* ESSENTIAL SERVICES *IN THE CONTRACT CONTAINS NO MENTION OF ALCOHOL AND THE ALCOHOL NES "DOES NOTHING TO ENCOURAGE THE APPROPRIATE CLINICAL MANAGEMENT OF ALCOHOL ACROSS THE VAST MAJORITY OF GPS AND THUS THE* VAST MAJORITY OF PATIENTS*" (P.3, EMPHASES ORIGINAL).*

IN ADDITION TO A LACK OF A CLEAR DEFINITION OF "ALCOHOL MISUSE", THE BRIEFING DESCRIBES OTHER PROBLEMS IN THE SPECIFICATION WHICH ARE GIVEN HERE VERBATIM*:*

- IT IS UNCLEAR WHETHER THE PAYMENT SYSTEM WILL BE BASED ON REMUNERATION FOR PATIENTS SCREENED POSITIVELY (WITH THE DANGER OF A PERVERSE INCENTIVE TO OVER-IDENTIFY), OR THOSE WITH WHOM INTERVENTION IS MADE.

- THE CONTRACT PROPOSES THAT PRACTICES HAVE A REGISTER OF THOSE 'ADMITTING THEY ARE ALCOHOL MISUSERS', RATHER THAN A 'DISEASE REGISTER' BASED ON CLEAR DIAGNOSTIC CRITERIA. THE PROPOSED REGISTER WOULD OFFER LITTLE USEFUL DATA TO SERVICE PLANNERS OR EPIDEMIOLOGISTS (AN EXTREMELY USEFUL SIDE EFFECT OF A DISEASE REGISTER). THE CONTRACT ALSO FAILS TO MAKE CLEAR HOW AN INDIVIDUAL MIGHT COME TO DISCUSS WITH THE GP THAT THEY HAVE A PROBLEM WITH ALCOHOL; MANY OF THE TARGET POPULATION DO NOT KNOW THEY ARE MISUSING ALCOHOL, SO SELF-DISCLOSURE IS INADEQUATE.

- THE DRAFTING OF THE NES DOES NOT ADEQUATELY DEFINE TERMS SUCH AS BRIEF INTERVENTIONS, AND COULD INCLUDE USEFUL REFERENCE TO THE USE OF STANDARDISED PROTOCOLS OF BEST PRACTICE, SUCH AS ON THE PROVISION OF DETOXIFICATION. SOME TERMINOLOGY IS EXTREMELY AMBIGUOUS, WITH IT BEING UNCLEAR, FOR EXAMPLE WHETHER 'ROUTINE USE OF ASSESSMENT TOOLS' DESCRIBES SCREENING TOOLS SUCH AS AUDIT OR SIMPLY TRACKING OF CLINICAL PROGRESS.

- MANY PCOS HAVE ALREADY IDENTIFIED THEIR PRIORITIES FOR INVESTMENT IN ENHANCED SERVICES AND ARE NOT IN A POSITION TO COMMIT ADDITIONAL FUNDS. GPS WILL BE NATURALLY RELUCTANT TO TAKE ON MORE SPECIALISED WORK IN THE ABSENCE OF A COMMITMENT OF PAYMENT.

THESE FACTORS, PERHAPS IN COMBINATION WITH OTHERS, MAY BE THE REASON WHY MANY PCOS HAVE FOUND THE ALCOHOL NES DIFFICULT OR IMPOSSIBLE TO IMPLEMENT. IT IS CLEARLY NOT THE BEST WAY TO CHANGE PRACTICE ACROSS A WIDE NUMBER OF PHC FACILITIES. THE BRIEFING CONCLUDES THAT ALCOHOL SERVICES ACROSS ALL GPS ARE IN NEED OF IMPROVEMENT AND THAT "A MINIMUM STANDARD OF SCREENING AND BRIEF INTERVENTIONS IS REQUIRED AS WELL AS *INCREASED AVAILABILITY OF MORE SPECIALIST SUPPORT AND INTERVENTIONS FROM A SMALLER NUMBER OF GPS (P.4, EMPHASES ORIGINAL).*

As a possible revision of the alcohol specification in the nGMS Contract, the Alcohol Concern *briefing suggests first that alcohol should be included in the Quality in Outcomes Framework (QOF) in the* Essential Services *contract. This would provide all GPs with incentives for undertaking brief interventions with hazardous and harmful drinkers and would work similarly to the smoking cessation work currently covered in the QOF. This would apply to all GPs rather than to a small minority of them and would avoid the need for a separate alcohol contract for every GP.*

Alternatively, the briefing proposes that the current NES for alcohol be replaced by a Local Enhanced Service *(LES) which could be provided in every area rather than being a local option as in the NES. The aims here would be to provide an evidence-based and cost-effective way for PCOs to commission services and make SBI widely available. In addition, clinical pathways would be created that are understood by and accessible to patients and can be linked with specialist treatment services where necessary. In so doing, the LES could be made consistent with the* Models of Care for Alcohol Misuse *(MoCAM) framework promised in the AHRSE when it is produced. Lastly, SBI activity and payments could be aligned in the LES with those for similar QOF indicators, such as for smoking cessation, to enable convergence to take place in due course.*

The Alcohol Concern *briefing then goes on to describe a template for an alcohol LES for use with the current nGMS contract. This is not the place to consider this template in detail and only a few features important for present purposes will be outlined.*

The template is divided into two parts. Part I is for practices that wish to improve their overall management of alcohol misuse by offering minimal and brief interventions to hazardous and harmful drinkers with low levels of alcohol dependence but do not wish to develop specialist expertise or greatly increase their time commitment to alcohol work. Part II is for practice that wish to take on a more specialist role and, in addition to delivering Part I services, would offer services to patients with more severe alcohol dependence who do not require treatment in specialist alcohol services. In terms of the Models of Care *framework that exists for illicit drugs and which is expected to remain largely unchanged in the MoCAM, Part I of the LES is coterminous with Tier 1 activity while Part II equates with Tier 2 activity.*

As implied above, a distinction is made in the proposed LES between "minimal intervention" and "brief intervention". The former entails only a single session of structured advice and information, taking perhaps 5 minutes or less, and might also be termed "simple advice". This would be offered in the same visit to all patients who screen positive for hazardous and harmful drinking. Patients would also be offered more protracted brief intervention, as a Tier 2 activity, if they wish to take it up and those whose problems and level of dependence are more serious would be offered a referral for specialised treatment, either at a PHC facility or a specialist alcohol treatment unit. In this terminology, brief intervention would consist of multiple sessions of counselling, based probably on the principles of motivational interviewing[67] *or, at least, health behaviour change*[68]*.*

The briefing emphasises that the proposed LES is flexible in structure and opens the way for a variety of commissioning arrangements, allowing PCTs to "mix and match" to achieve a comprehensive service in their areas of responsibility.

Summary

THE NEARLY SIMULTANEOUS ARRIVAL OF THE AHRSE AND THE NGMS CONTRACT PROVIDES AN OUTSTANDING OPPORTUNITY TO ACHIEVE A WIDESPREAD AND ROUTINE IMPLEMENTATION OF SBI IN ENGLAND. HOWEVER, WHILE THEY BOTH CONTAIN MANY COMMENDABLE AND USEFUL FEATURES, BOTH DISPLAY THE SAME FLAW IN THE SCOPE OF ATTENTION TO ALCOHOL-RELATED HARM THEY WISH TO PROMOTE. THIS IS THE NEGLECT OF THE HAZARDOUS DRINKERS, AS OPPOSED TO PATIENTS WITH ESTABLISHED ALCOHOL PROBLEMS, WHO MUST BE INCLUDED AS A MINIMUM IN ANY RATIONAL AND EFFECTIVE IMPLEMENTATION OF SBI.

IT MAY BE OBJECTED HERE THAT THE NUMBER OF SUCH HAZARDOUS DRINKERS, WHICH IS IN ANY CASE SERIOUSLY UNDERESTIMATED IN THE NGMS SPECIFICATION FOR ALCOHOL, IS SO LARGE AS TO MAKE THEIR INCLUSION IN SBI UNMANAGEABLE. HOWEVER, WHAT IS BEING SUGGESTED IS NOT ANY PROTRACTED AND RESOURCE-INTENSIVE TREATMENT OR EVEN BRIEF INTERVENTION FOR SUCH INDIVIDUALS BUT RATHER "SIMPLE ADVICE" (OR "MINIMAL INTERVENTION") TAKING ONLY A FEW MINUTES TO DELIVER AND DELIVERED "ON THE SPOT". THE COMPARISON HERE WITH THE EFFORT TO ENCOURAGE SMOKING CESSATION IS ALMOST EXACT; THE NUMBER OF SMOKERS AND OF HAZARDOUS OR HARMFUL DRINKERS IN ENGLAND IS SIMILAR (ROUGHLY ONE-QUARTER OF THE POPULATION) AND THE WORK INVOLVED AT THE PHC LEVEL IN OFFERING ADVICE TO THESE TWO GROUPS OF PATIENTS WOULD BE SIMILAR TOO. THE MAIN DIFFERENCE IS THAT ALCOHOL BRIEF ADVICE HAS BEEN SHOWN TO BE TWICE AS SUCCESSFUL AS THAT FOR SMOKING, ALTHOUGH WHEN NICOTINE REPLACEMENT THERAPY IS ADDED TO QUIT SMOKING ADVICE THE RATES ARE ABOUT THE SAME. THE CRUCIAL POINT, HOWEVER, IS THAT, IF IT IS ACCEPTED THAT BRIEF ADVICE TO QUIT SMOKING IS AN ESSENTIAL PART OF PHC ACTIVITY THAT SHOULD BE STRONGLY ENCOURAGED AND SUPPORTED, PRECISELY THE SAME SHOULD APPLY TO ADVICE TO REDUCE DRINKING TO NON-HAZARDOUS LEVELS.

IN ADDITION TO THIS GAP IN COVERAGE, IT IS NOW WIDELY ACCEPTED THAT THE NES SPECIFICATION FOR ALCOHOL IN THE NGMS CONTRACT IS URGENTLY IN NEED OF REFORM. THE PROBLEMS IN THE SPECIFICATION HAVE BEEN COGENTLY SUMMARISED IN THE ALCOHOL CONCERN BRIEFING REFERRED TO ABOVE AND AN ALTERNATIVE LES HAS BEEN PROPOSED THAT SOLVES THESE PROBLEMS AND CREATES A MUCH MORE REALISTIC AND EFFECTIVE MODEL FOR THE IMPLEMENTATION OF SBI IN PHC, IF ONLY ON A TEMPORARY BASIS. EVENTUALLY, THE NES ALCOHOL SPECIFICATION WILL NEED TO BE REWRITTEN..

THE CHOOSING HEALTH WHITE PAPER

The aim of the White Paper[3] is to "set out the key principles for supporting the public to make healthier and more informed choices in regards to their health". The Government promises to "provide information and practical support to get people motivated and improve emotional wellbeing and access to services so that healthy choices are easier to make".

Alcohol is mentioned at several places in the White Paper, for example in an intention to encourage and support sensible drinking because of the burden alcohol misuse places on the NHS, particularly on A&E departments (Executive Summary, p.4). The Government pledges to work with *the Portman Group* to cut down binge drinking and to work with the alcohol industry to develop a voluntary social responsibility scheme that will protect young people in various ways. It will also aim to ensure that health improvement and prevention services – such as sexual health services, NHS Stop Smoking Services, obesity and alcohol services – "benefit fully from the same drive for modernisation and improvement that exists across the rest of the NHS" (Executive Summary, p.15).

MORE DIRECTLY RELEVANT TO PRESENT CONCERNS, THE WHITE PAPER SIGNALS THE GOVERNMENT'S INTENTION TO BUILD ON COMMITMENTS IN THE AHRSE "THROUGH GUIDANCE AND TRAINING TO ENSURE ALL HEALTH PROFESSIONALS ARE ABLE TO IDENTIFY ALCOHOL PROBLEMS

EARLY: PILOTING NEW APPROACHES TO TARGETED SCREENING AND BRIEF INTERVENTION IN THE NHS WITH A PARTICULAR FOCUS ON A&E SETTINGS, DEVELOPING SIMILAR APPROACHES IN CRIMINAL JUSTICE SETTINGS TO REDUCE REPEAT OFFENDING; AND IMPROVING ALCOHOL TREATMENT SERVICES (EXECUTIVE SUMMARY, P.15).

The only other references in the White Paper to brief intervention or brief advice *per se* occur in relation to A&E services. However, it mentions the forthcoming publication by the National Treatment Agency (NTA) of "Models of Care" guidance on the organisation of alcohol treatment which will "lay the foundation for the future development of alcohol treatment services within England" (p. 149). The White paper promises to build on the commitments within the AHRSE through, *inter alia*, "guidance and training to ensure all health professionals are able to identify alcohol problems early and piloting approaches to targeted screening and brief intervention in both primary care and hospital settings …" (p. 149). Further, "new models of contracting for primary care will mean easier access to health improvement advice, especially for those who find it hardest to obtain this now" (p. 150).

Health Trainers

Of potential relevance to an SBI implementation strategy for England is the creation of "a new public health resource, NHS health trainers" (Executive Summary, p.13):

> "In keeping with a shift in public health approach from 'advice from on high to support from next door', health trainers will be drawn from local communities, understanding the day-to-day concerns and experiences of the people they are supporting on health. They will be accredited by the NHS to have skills appropriate to helping members of their community to make the changes they want. In touch with the realities of the lives of the people they work with and with a shared stake in improving the health of the communities that they live in, health trainers will be approachable, understanding and supportive. Offering practical advice and good connections into the services and support available locally, they will become an essential commonsense resource in the community to help out on health choices. A guide for those who want help, not an instructor for those who do not, they will provide valuable support for people to make informed lifestyle choices. From 2006, NHS-accredited health trainers will be giving support to people who want it in the areas of highest need, and from 2007 progressively across England" (p. 13).

These Health Trainers could provide an important opportunity for the delivery of brief alcohol interventions to those who could benefit from them. It will be essential, however, if this is to happen, that Health Trainers receive appropriate instruction in the delivery of brief interventions, particularly of the "simple advice" variety and also training in the necessary interpersonal skills essential for their effective delivery. The obvious approach here would be to base the training on the relevant units of the Drug and Alcohol National Occupational Standards (see Section 7.3).

7. INTEGRATING SCREENING AND BRIEF INTERVENTIONS IN PRIMARY HEALTH CARE

7.1 PRINCIPLES

THE STRATEGY FOR IMPLEMENTING ALCOHOL SBI IN PHC IN ENGLAND THAT IS OUTLINED HERE IS BASED ON THE FOLLOWING PRINCIPLES:

- *THERE IS ABUNDANT EVIDENCE THAT SBI DELIVERED IN PHC SETTINGS BY A VARIETY OF HEALTH CARE PROFESSIONS IS EFFECTIVE IN REDUCING ALCOHOL CONSUMPTION AMONG HAZARDOUS AND HARMFUL DRINKERS AND HENCE IN REDUCING ALCOHOL-RELATED HARM IN THE PHC POPULATION;*

- *THERE IS ALSO GOOD EVIDENCE, MAINLY FROM OUTSIDE THE UK, THAT SBI IN PHC IS HIGHLY COST-EFFECTIVE AND, IF ROUTINELY IMPLEMENTED, WOULD RESULT IN CONSIDERABLE FINANCIAL SAVINGS FOR THE HEALTH CARE SYSTEM;*

- *THE WIDESPREAD AND ROUTINE IMPLEMENTATION OF SBI IN PHC WOULD HAVE LARGE BENEFITS FOR PUBLIC HEALTH AND FOR THE HEALTH AND WELFARE OF INDIVIDUAL PATIENTS;*

- *DESPITE THIS EVIDENCE OF EFFECTIVENESS AND COST-EFFECTIVENESS, THERE IS SUBSTANTIAL EVIDENCE THAT GENERAL MEDICAL PRACTITIONERS, PRACTICE NURSES AND OTHER PHC STAFF VERY RARELY IMPLEMENT ALCOHOL SBI IN THEIR ROUTINE WORK AND THAT, AS A CONSEQUENCE, THE MAJORITY OF HAZARDOUS AND HARMFUL DRINKERS PRESENTING TO PHC ARE OVERLOOKED AND NOT ADVISED TO REDUCE CONSUMPTION;*

- *IT FOLLOWS THAT THERE IS A NEED TO PROVIDE EFFECTIVE INCENTIVES AND ACCEPTABLE CONDITIONS OF WORK FOR PHC STAFF TO DELIVER SBI, PAYING ATTENTION TO THE OBSTACLES TO IMPLEMENTATION THAT HAVE BEEN IDENTIFIED IN RESEARCH;*

- *THERE IS ALSO A NEED TO TAILOR THE CONTENTS AND PROCEDURES OF SBI TO THE PRACTICAL CONTEXT OF PHC IN ENGLAND.*

7.2 PRACTICE-BASED GUIDELINES, PROTOCOLS AND AIDS

ALTHOUGH CLINICAL GUIDELINES FOR THE MANAGEMENT OF HARMFUL DRINKING AND ALCOHOL DEPENDENCE IN PRIMARY CARE HAVE BEEN DEVELOPED BY THE SCOTTISH INTERCOLLEGIATE GUIDELINES NETWORK *(SIGN)*[61]*, NO SUCH GUIDELINES EXIST FOR ENGLAND. AN URGENT TASK, THEREFORE, IS THE DEVELOPMENT OF CLINICAL GUIDELINES FOR DELIVERING SBI IN ENGLISH PHC.*

AS INDICATED ABOVE, PART OF PHEPA IS THE PRODUCTION OF CLINICAL GUIDELINES FOR THE MANAGEMENT OF ALCOHOL-RELATED PROBLEMS IN PHC THAT CAN BE ADAPTED TO THE SPECIFIC CIRCUMSTANCES OF PARTICIPATING COUNTRIES. WHEN COMPLETED, THESE GENERAL GUIDELINES WILL BE ADAPTED FOR USE IN ENGLAND BY THE ENGLISH PHEPA TEAM, POSSIBLY TAKING ADVANTAGE TOO OF THE SCOTTISH GUIDELINES WHERE APPROPRIATE. FEEDBACK ON THE APPROPRIATENESS OF THEIR FORM AND CONTENTS WILL BE OBTAINED FROM PHC PROFESSIONALS TAKING PART IN A PROJECT IN THE TYNE AND WEAR HEALTH ACTION ZONE CONCERNED WITH PILOTING SBI IN GENERAL PRACTICE SETTINGS AND BASED ON THE ASSUMPTION THAT USEABLE AND ACCEPTABLE GUIDELINES REQUIRE INPUT FROM THOSE WHO ARE TO PUT THEM INTO ROUTINE PRACTICE. THE FINISHED CLINICAL GUIDELINES FOR ENGLAND WILL BE SENT FOR APPROVAL AND ENDORSEMENT TO RELEVANT NATIONAL ORGANISATIONS AND THEN PRESENTED TO THE DEPARTMENT OF HEALTH WITH THE SUGGESTION THAT THEY FORM PART OF THE AHRSE.

SUCH A DEVELOPMENT WOULD BE TIMELY GIVEN THE PUBLICATION OF THE MODELS OF CARE FOR ALCOHOL MISUSE *(MOCAM) BY THE NATIONAL TREATMENT AGENCY WHEN COMMISSIONERS AND PROVIDERS WILL BE FORMING LINKS BETWEEN LOCAL POLICIES AND THE CLINICAL GUIDELINES THEY USE.*

IN ADDITION TO RELATIVELY LENGTHY CLINICAL GUIDELINES, INTENDED TO PROVIDE A COMPREHENSIVE SUMMARY OF THE EVIDENCE-BASE ON WHICH THE CALL FOR THE IMPLEMENTATION OF ALCOHOL SBI IS BASED, THERE WILL ALSO BE A NEED FOR A MUCH SHORTER DOCUMENT IN THE FORM OF A PRACTICAL MANUAL FOR SBI DELIVERY THAT PRIMARY CARE PROFESSIONALS CAN MAKE USE OF. SUCH A DOCUMENT HAS BEEN PRODUCED BY NHS LOTHIAN IN SCOTLAND FOR USE IN CONJUNCTION WITH THE SIGN GUIDELINES[69]. THE WORLD HEALTH ORGANISATION HAS ALSO PRODUCED A PACK ON SCREENING AND BRIEF INTERVENTION FOR ALCOHOL PROBLEMS IN PRIMARY CARE, *CONSISTING SEPARATELY OF GUIDANCE FOR THE USE OF THE AUDIT QUESTIONNAIRE[70] AND A MANUAL ON BRIEF INTERVENTIONS FOR HAZARDOUS AND HARMFUL DRINKERS FOUND IN PHC[71]. EARLIER EXAMPLES OF SBI PROTOCOLS FORMED PART OF BRITISH RESEARCH ON SBI IN PHC[45,6372], THE MOST RECENT OF WHICH WAS THE* DRINK-LESS *PROGRAMME USED AS PART OF PHASE III OF THE WHO COLLABORATIVE PROJECT ON* IDENTIFICATION AND MANAGEMENT OF ALCOHOL-RELATED PROBLEMS IN PRIMARY CARE *AND ADAPTED FOR USE IN ENGLAND FROM THE AUSTRALIAN ORIGINAL[73]. THESE EARLIER PRODUCTS WILL BE TAKEN INTO CONSIDERATION IN THE DEVELOPMENT OF A NEW PRACTICE MANUAL FOR SBI DELIVERY IN ENGLAND THAT WILL BE PILOTED AND REFINED DURING THE TYNE AND WEAR HEALTH ACTION ZONE PROJECT. THE MANUAL CAN THEN BE OFFERED AS A MODEL FOR SBI DELIVERY THAT COULD BE ROLLED OUT TO OTHER AREAS OF ENGLAND AS PART OF THE AHRSE.*

7.3 TRAINING

ALTHOUGH THERE ARE MANY EXAMPLES OF GOOD PRACTICE WHERE LOCALISED TRAINING PACKAGES HAVE BEEN TRIALLED BY DRUG AND ALCOHOL ACTION TEAMS OR AT A PRACTICE-BASED LEVEL, NO WIDELY-ACCEPTED TRAINING PROGRAMME FOR PHC PROFESSIONALS WISHING TO DELIVER ALCOHOL SBI EXISTS IN ENGLAND AT A NATIONAL LEVEL. AGAIN, AND AS INDICATED ABOVE, ONE OF THE PRODUCTS OF PHEPA WILL BE A TRAINING MANUAL, ACCOMPANIED BY OVERHEADS AND WORK DOCUMENTS, THAT CAN SERVE AS A TEMPLATE FOR THE DEVELOPMENT OF TAILORED TRAINING PROGRAMMES IN PARTICIPATING COUNTRIES. THIS TASK OF ADAPTATION WILL BE UNDERTAKEN BY THE PHEPA ENGLISH TEAM. IT WILL ALSO CLEARLY BE NECESSARY TO FULLY INTEGRATE THE TRAINING PROGRAMME WITH THE CLINICAL GUIDELINES AND PRACTICE MANUAL THAT WILL BE SIMULTANEOUSLY DEVELOPED. ONCE MORE, FEEDBACK ON SUCCESSIVE DRAFTS OF THE TRAINING PROGRAMME AND ITS LINKS WITH THE CLINICAL GUIDELINES WILL BE PROVIDED BY THE PHC PROFESSIONALS TAKING PART IN THE TYNE AND WEAR HEALTH ACTION ZONE PILOT IMPLEMENTATION PROJECT.

INDEPENDENTLY OF PHEPA, THE ROYAL COLLEGE OF GENERAL PRACTITIONERS, *IN COLLABORATION WITH ALCOHOL CONCERN, IS DEVELOPING A TRAINING PROGRAMME ON SBI. THE RCGP COURSE WILL BE MULTIDISCIPLINARY AND WILL BE INTIMATELY LINKED TO THE COMMISSIONING AGENDA AS DEFINED BY DEPARTMENT OF HEALTH AND MOCAM. IT WILL SUPPORT THE NHS SKILLS ESCALATOR AND BUILD ON THE RECOGNISABLE BRAND OF THE RCGP SUBSTANCE MISUSE UNIT THAT ALREADY DELIVERS THE TWO LEVELS OF DRUGS TRAINING IN THE UK.*

THE DEVELOPMENT OF THESE TWO TRAINING PROGRAMMES WILL PROVIDE AN OPPORTUNITY TO ENSURE CONSISTENCY AND TO MAXIMISE COVERAGE AMONG PHC PROFESSIONALS IN ENGLAND. IT WILL THUS BE IMPORTANT THAT THOSE RESPONSIBLE FOR DEVELOPING THESE PROGRAMMES KEEP CLOSELY IN TOUCH TO CHECK WHETHER THEY MAY HAVE SOMEWHAT DIFFERENT AIMS OR METHODS AND WHETHER PARTS OF THEM CAN BE AMALGAMATED. IT WILL ALSO BE IMPORTANT TO ENSURE THAT THEY ARE CLEARLY DISCRIMINABLE IN THE PURPOSES THEY ARE INTENDED TO SERVE AND THE CHANNELS USED TO PROMOTE THEM, INCLUDING THE NAMES THEY ARE TO BE KNOWN BY. WHETHER ONE OR TWO NATIONAL TRAINING PROGRAMMES ARE PRODUCED, THE AHRSE WILL BENEFIT FROM

NATIONALLY-IMPLEMENTED TRAINING AND ACCREDITATION IN THE DELIVERY OF ALCOHOL SBI IN PHC.

DANOS

ALSO VERY HELPFUL IN THE DISSEMINATION OF TRAINING FOR PHC PROFESSIONALS IN SBI WILL BE THE DRUG AND ALCOHOL NATIONAL OCCUPATIONAL STANDARDS *(DANOS)*[74]*. THESE HAVE BEEN DEVELOPED BY* THE MANAGEMENT STANDARDS CONSULTANCY FOR SKILLS FOR HEALTH, *THE NATIONAL BODY RESPONSIBLE FOR DEVELOPING THE SKILLS OF THE WORKFORCE IN THE HEALTH SECTOR, IN CONJUNCTION WITH* ALCOHOL CONCERN *AND A RANGE OF OTHER RELEVANT BODIES. DANOS SPECIFY THE STANDARDS OF PERFORMANCE THAT WORKERS IN THE DRUGS AND ALCOHOL FIELD SHOULD BE WORKING TO AND THE KNOWLEDGE AND SKILLS WORKERS NEED TO PERFORM TO THE REQUIRED STANDARD.*

DANOS STANDARDS CAN BE USED BY INDIVIDUAL WORKERS IN THE DRUGS AND ALCOHOL FIELD TO CLARIFY WHAT IS EXPECTED OF THEM IN THEIR WORK. THEY CAN ALSO BE USED BY AGENCIES TO ENSURE THAT THEIR WORKFORCES ARE COMPETENT AND THAT ALL HAVE THE NECESSARY KNOWLEDGE AND SKILLS TO DELIVER SERVICES TO THE REQUIRED STANDARD. FOR THOSE PROVIDING TRAINING AND EDUCATION IN THE FIELD, DANOS MAKES AVAILABLE A READY-MADE CURRICULUM AND SET OF OUTCOMES FOR TRAINING THAT CAN BE USED TO BENCHMARK CURRENT COURSES AND LEARNING MATERIALS AND DEVELOP NEW PROGRAMMES IF NECESSARY, ENSURING THAT COURSES MEET THE NEEDS OF STUDENTS AND ALLOW THEM TO ACQUIRE NATIONAL-RECOGNISED QUALIFICATIONS. .

AS WELL AS BEING APPLICABLE TO SUBSTANCE MISUSE SPECIALISTS, THE DANOS STANDARDS ARE RELEVANT TO THE MANY GENERALISTS WHOSE WORK MAY HAVE A COMPLETELY DIFFERENT FOCUS TO SUBSTANCE MISUSE BUT WHO OCCASIONALLY NEED TO RESPOND TO INDIVIDUALS SHOWING SIGNS OF SUBSTANCE MISUSE. THEY ARE ALSO APPLICABLE TO THOSE, SUCH AS PRIMARY HEALTH CARE PROFESSIONALS, WHO REGULARLY SEE SUBSTANCE MISUSERS IN THEIR ROUTINE WORK. AS SUCH, THEY ARE DIRECTLY RELEVANT TO THE EFFORT TO IMPLEMENT SBI WIDELY IN PHC.

THERE ARE 3 MAIN AREAS IN THE DANOS:

- *SERVICE DELIVERY;*
- *MANAGEMENT OF SERVICES;*
- *COMMISSIONING SERVICES.*

SBI IS SPECIFICALLY ADDRESSED IN UNIT AH10 OF THE SERVICE DELIVERY AREA. ALTHOUGH SCREENING IS DISCUSSED IN OTHER DANOS UNITS, IT IS AN INTEGRAL PART OF AH10. THE CURRENT DRAFT OF THIS UNIT WILL BE FOUND IN APPENDIX B OF THIS DOCUMENT. IT IS EXPECTED TO BE FINALISED BY SUMMER 2005.

THE NATIONAL OCCUPATIONAL STANDARDS OF DIFFERENT PROFESSIONS ARE INTERLINKED AND DRAW IN UNITS FROM EACH OTHER. FOR EXAMPLE, KEY DANOS UNITS ARE BEING WRITTEN INTO THE OCCUPATIONAL STANDARDS FOR SOCIAL WORKERS. IT IS HOPED THAT, IN TIME, KEY DANOS UNITS SUCH AS AH10 WILL BE BROUGHT INTO HE NURSING STANDARDS; WHEN THIS HAPPENS THE CURRICULUM ON NURSE TRAINING WILL REFLECT THIS, SO NEW NURSES WILL BE TRAINED UP TO THESE COMPETENCIES AS A MATTER OF COURSE. THIS APPROACH IS A MEDIUM- TO LONG-TERM SOLUTION BUT IS THE CORRECT APPROACH AS IT EMBEDS COMPETENCIES WITHIN THE PROFESSION RATHER THAN TREATING ALCOHOL AS AN OPTIONAL EXTRA.

MEDICAL PRACTITIONERS ARE NOT WITHIN THE SKILLS FOR HEALTH / OCCUPATIONAL STANDARDS SYSTEM AND THE CURRICULA FOR THEIR TRAINING IS DECIDED BY EACH TRAINING INSTITUTION. CENTRAL INFLUENCE IS SOMEWHAT LIMITED, SO IT WILL BE MORE DIFFICULT TO PLACE COMPETENCY-BASED TRAINING AROUND KEY SKILLS INTO GENERAL MEDICAL TRAINING. THE

DEPUTY CHIEF MEDICAL OFFICER HAS RESPONSIBILITY UNDER THE ALCOHOL STRATEGY AS A TRAINING CHAMPION AND THE DH IS LOOKING INTO THE DIFFICULTIES OF TRAINING GPS.

THE KEY TASKS ARE:

- *TO HASTEN THE INTRODUCTION OF DANOS UNITS TO HEALTHCARE OCCUPATIONAL STANDARDS, ESPECIALLY AH10 TO SUPPORT SBI;*
- *TO DRAW UP A STRATEGY TO INFLUENCE CURRICULA IN MEDICAL SCHOOLS;*
- *TO DEVELOP, RESOURCE AND LAUNCH POSTGRADUATE COURSES FOR GPS.*

HEALTH COMMISSION STANDARDS FOR BETTER HEALTH
The potential impact of these new standards, which will be disseminated through the substance misuse field, are also highly relevant to training in SBI. Domains covered are: (i) safety; (ii) clinical- and cost-effectiveness; (iii) governance; (iv) patient focus; (v) accessible and responsive care; (vi) care and amenities; (vii) public health.

7.4 ENGAGING PRIMARY HEALTH CARE PROVIDERS

THE DEVELOPMENT OF MODELS OF CARE FOR ALCOHOL MISUSERS (MOCAM) SHOULD INCREASE THE ABILITY AND MOTIVATION OF PCT COMMISSIONERS TO IMPLEMENT SBI. MOCAM IS LIKELY TO SET OUT A FRAMEWORK FOR THE INTERVENTIONS NEEDED BY NON-ALCOHOL SPECIALIST PROFESSIONALS. THIS IS LIKELY TO BE VERY MUCH IN LINE WITH THE PROPOSALS OF THE PRESENT STRATEGY AND WILL COVER BOTH THE INTERVENTION (BY MEANS OF SCREENING AND SIMPLE ADVISE) WITH RISKY DRINKERS AND THE IDENTIFICATION AND REFERRAL ON OF THOSE IN NEED OF SPECIALIST TREATMENT. IT IS HOPED THAT MOCAM WILL BE LINKED TO NHS STANDARDS, SO THAT IMPLEMENTATION BY PCTS WILL BE MONITORED BY THE HEALTHCARE COMMISSION. IF THIS TAKES PLACE, IT WILL BE A POWERFUL INCENTIVE FOR PCTS TO ACT.

PCTS SHOULD ALSO USE MOCAM TO ENSURE THAT SBI ACTIVITIES IN PRIMARY CARE ARE ADEQUATELY LINKED TO SPECIALIST TREATMENT PROVIDERS. THE PROCESS OF SCREENING IDENTIFIES NOT JUST RISKY DRINKERS WHO CAN BE TREATED ENTIRELY WITHIN PRIMARY CARE, BUT ALSO DRINKERS WITH SERIOUS (IF PREVIOUSLY HIDDEN) ALCOHOL PROBLEMS WHO MAY NEED SPECIALIST HELP AND POSSIBLY SHARED CARE.

An essential step in engaging PHC professionals in the delivery of SBI is to adjust SBI materials and protocols to the conditions of PHC in England and to the needs and preferences of the providers themselves. This is precisely the aim of a project recently commenced in the north-east of England entitled, Implementing Screening and Brief Alcohol Intervention in Pilot GP Practices in the Tyne and Wear Health Action Zone (HAZ). The Principal Investigators in the project are Professor Nick Heather, Dr. Eileen Kaner and Dr. Paul Cassidy.

One practice in each of the five areas in the HAZ has been selected from among those that applied to join the project and these will be paid £1,000 per month over the six month active phase of the project to compensate for the time and disruption to routine arising from their participation. In addition to three plenary meetings with all participants, each practice will be visited by project personnel on a monthly basis during the active phase and will try out methods for screening and intervention that have been agreed with the research team. Experience of these methods will be fed back at the next practice meeting and procedures will be amended using the "PDSA cycle" (Plan-Do-Study-Act)[75], a way of working with which PHC professionals are familiar.

The end-product of the activities will be a guide for PHC professionals on delivering SBI that will include options that the professionals have found useful and acceptable and the associated questionnaires, patients' leaflets and other materials. Also piloted and refined will be specific methods of providing support to the practice from local specialist treatment agencies. Lastly, the project report will make recommendations concerning the optimal commissioning arrangements that should be used to bring about an efficient and lasting implementation of SBI in routine practice. As noted above (p.x), the findings and output from the Tyne and Wear HAZ project can be used to inform the funding and carrying out of the pilot projects on models for the practical implementation of targeted SBI in healthcare settings, as described in the AHRSE[1].

7.5 FUNDING AND REIMBURSEMENT

In addition to the necessary step of "customising" of SBI to PHC in England, it will also be essential to pay attention to those barriers to implementation that have been identified in previous research (see pp. 19-20). Perhaps chief among these is the lack of financial incentives for practices to carry out this work and it is here that the nGMS Contract becomes crucial. As already pointed out (pp.24-29), unless it is radically revised, the contract will be incapable of achieving any adequate and widespread implementation of SBI.

Funding and reimbursement could be tackled by drawing on a number of emerging themes in commissioning:

a the use of the Quality Outcomes Framework in the nGMS to ensure that practices have an opt-in to participate in screening and providing intervention at the level of simple advice;

b a full redrafting of the National Enhanced Service (NES) for alcohol, as already discussed, with greater clarity on diagnostic criteria, brief interventions and screening tools;

c until the NES is redrafted, the use of Locally Enhanced Services. This would rely on PCTs prioritising the enhanced services funding to pump-prime PHC practices with an interest to participate to a level that goes beyond the Level 1 care and delivers brief interventions and community alcohol detoxification. Models will vary but guidance could suggest a baseline annual participation fee for practice with an activity-based cost per intervention or patient fee.

d placing the resource into a central team with primary care liaison, somewhat like shared care. Practices would be incentivised by the fact that they would be supported to deliver an enhanced service and receive in-house training and materials to assist them. This theme could be supplemented by an LES if there was sufficient funding.

7.6 SPECIALIST SUPPORT AND KNOWLEDGE CENTRES

A FURTHER PRODUCT OF THE PHEPA PROJECT WILL BE A WEBSITE CONTAINING AN *ALCOHOL MANAGEMENT DATABASE*. THIS IS INTENDED TO BE AN ESSENTIAL RESOURCE FOR THOSE WORKING ON THE MANAGEMENT OF ALCOHOL PROBLEMS IN PRIMARY HEALTH CARE THROUGHOUT THE WORLD. IT WILL PRESENT EVIDENCE-BASED INFORMATION ABOUT THE MANAGEMENT OF ALCOHOL PROBLEMS UNDER TEN SECTIONS:

i DEFINITIONS AND TERMINOLOGY
ii HEALTH EFFECTS OF ALCOHOL
iii SCREENING INSTRUMENTS
iv BIOLOGICAL MARKERS
v ASSESSMENT
vi BRIEF INTERVENTIONS
vii ALCOHOL DEPENDENCE
viii IMPLEMENTATION
ix COST EFFECTIVENESS
x POLICY

Within each section, up to about 10 key findings will be presented as short statements of between 25-75 words. Each key finding will be supplemented with a secondary level commentary of between 250-500 words, with supporting references and links to these references. Key findings, commentaries and supporting references will be collated and reviewed and the evidence will be periodically updated to incorporate new research. Referenced slide kits and resources will be available from the site.

THE DATABASE WILL BE CREATED AS PART OF THE PHEPA PROJECT AND ADDITIONAL FUNDS WILL BE APPLIED TO MAINTAIN THE DATABASE IN SUBSEQUENT YEARS. A MODEL FOR THE DATABASE IS TREATOBACCO.NET[76]

ALCOHOL CONCERN DEVELOPED AN APPROACH TO SUPPORTING PRIMARY CARE PRACTITIONERS INTERESTED IN ALCOHOL. THE *PRIMARY CARE AND ALCOHOL INFORMATION SERVICE* RAN FOR THE LAST FOUR YEARS FUNDED BY THE DH. THE PROJECT PROVIDED AN INFORMATION LINE, DEVELOPED BRIEFINGS AND RAN SEMINAR EVENTS TO SHARE EXPERTISE AND PROMOTE SCREENING AND BRIEF INTERVENTION. THE FUNDING FOR THIS SCHEME HAS NOW FINISHED BUT RENEWED FUNDING OR AN ALTERNATIVE SYSTEM OF SUPPORT WOULD BE AN INVALUABLE SUPPORT TO THE ROLE OUT OF ALCOHOL IN PRIMARY CARE.
ALSO USEFUL HERE WOULD BE A LINK TO THE *NATIONAL ELECTRONIC LIBRARY FOR HEALTH*[77], A DIGITAL LIBRARY PROVIDING PATIENTS, NHS STAFF AND THE GENERAL PUBLIC ACCESS TO THE BEST CURRENT KNOWLEDGE TO SUPPORT HEALTH-CARE DECISIONS.

7.7 MONITORING THE PROGRESS OF THE STRATEGY

FOLLOWING THE INTRODUCTION OF THIS SBI STRATEGY IT WILL BE ESSENTIAL TO MONITOR PROGRESS IN REACHING ITS CENTRAL AIM OF WIDESPREAD, ROUTINE AND ENDURING IMPLEMENTATION OF SBI FOR HAZARDOUS AND HARMFUL DRINKING IN THE ENGLISH PHC SYSTEM. THIS CAN ONLY BE REALISED BY THE PERIODIC ACQUISITION OF INFORMATION ON THE EXTENT TO WHICH SCREENING AND BRIEF INTERVENTION IS BEING DELIVERED IN GENERAL PRACTICES THROUGHOUT THE COUNTRY. THE *GENERAL PRACTICE RESEARCH DATABASE*, RUN BY THE DEPARTMENT OF HEALTH[78], COULD BE USED FOR THIS PURPOSE BUT IT IS LIKELY THAT A SEPARATE FUNDING SOURCE NEEDS TO BE IDENTIFIED FOR THIS WORK. IF, HOWEVER, ALCOHOL IS ADDED TO THE QOF, BASIC EPIDEMIOLOGICAL ALCOHOL INFORMATION WILL BE AVAILABLE ACROSS ALL PRACTICES AND CENTRALLY COLLECTED AT THE QMAS SITE FOR THE NEW GP CONTRACT. AS

STATED EARLIER, THE USEFULNESS OF THE INFORMATION WILL DEPEND ON THE DIAGNOSTIC CRITERIA CHOSEN

WITH REGARD TO MONITORING THE EFFECTS OF TRAINING IN SBI, THE RCGP BUILDS IN FORMAL EVALUATION AGAINST ALL OF ITS E-LEARNING. THIS GATHERS CRUDE INFORMATION ABOUT HOW MANY PEOPLE ARE ACCESSING BASIC LEVEL TRAINING AND HAVE PASSED A PARTICULAR MODULE.

PERFORMANCE MONITORING OF LES SCHEMES, IF CENTRALLY MONITORED, WOULD PROVIDE FEEDBACK ON THE PROGRESS OF SBI IMPLEMENTATION.

IF SIMPLE ADVICE WERE TO BE INTRODUCED AS A QOF, THIS WOULD BE CENTRALLY MONITORED AT A PCT LEVEL AND COULD PROVIDE VERY USEFUL DATA ABOUT WHICH PRACTICES ARE PARTICIPATING IN QUALITY IMPROVEMENT AND ENHANCED SERVICE DELIVERY IN PRIMARY CARE. THIS WOULD ALSO USEFUL IN IDENTIFYING WHICH PRACTICES REQUIRE MORE SUPPORT OR INPUT BECAUSE THEY ARE NOT DELIVERING SBI. QOF MONITORING NOT ONLY COLLECTS QUANTITATIVE DATA BUT QUALITATIVE DATA FROM FACE-TO-FACE INTERVIEWS WITH A MIXTURE OF PRACTICE STAFF MEMBERS.

7.8 PREPARING FOR THE INTRODUCTION OF THE STRATEGY

THE NEXT STEP IN THE DEVELOPMENT OF THIS STRATEGY IS TO HAVE IT ENDORSED BY THE KEY NATIONAL ORGANISATIONS THAT ARE RELEVANT TO THE IMPLEMENTATION PROCESS. A LIST OF ORGANISATION THAT HAVE SO FAR ENDORSED THE STRATEGY WILL BE FOUND IN APPENDIX C. EFFORTS WILL BE MADE TO OBTAIN FURTHER ENDORSEMENTS BEFORE THE STRATEGY IS PRESENTED TO THE DEPARTMENT OF HEALTH.

7.9 MANAGING THE STRATEGY

ARRANGEMENTS FOR MANAGING THE STRATEGY ARE UNCERTAIN AT PRESENT. IF THE DEPARTMENT OF HEALTH ACCEPTS THIS DOCUMENT AS A VIABLE AND WORTHWHILE STRATEGY FOR THE IMPLEMENTATION OF SBI IN ENGLISH PHC, THEN IT MAY ALSO ACCEPT RESPONSIBILITY FOR ITS MANAGEMENT.

7.10 COMMUNICATING ABOUT THE STRATEGY

A "MARKETING STRATEGY" FOR IMPLEMENTING SBI IN PHC WAS DEVELOPED AS PART OF THE ENGLISH ARM OF THE WHO PHASE IV COLLABORATIVE PROJECT[79] AND WAS PUBLISHED BY *ALCOHOL CONCERN* IN 2003. THIS IS STILL RELEVANT TO THE TASK AT HAND AND WILL BE USED IN THE IMPLEMENTATION PROCESS ARISING FROM THE PRESENT DOCUMENT.

A "STRATEGIC ALLIANCE" OF ORGANISATIONS AND INDIVIDUALS INTERESTED IN THE IMPLEMENTATION OF SBI IN PHC WAS FORMED DURING THE WHO PHASE IV COLLABORATIVE PROJECT AND THIS TOO COULD BE USED TO FORM A KERNEL OF INNOVATORS TO TAKE FORWARD THE IMPLEMENTATION PROCESS. MEMBERS OF THIS ALLIANCE AND OTHER INTERESTED PARTIES WOULD BE INVITED TO A NATIONAL CONFERENCE AT WHICH THE IMPLEMENTATION STRATEGY DESCRIBED IN THIS DOCUMENT WOULD BE LAUNCHED.

8. RESEARCH NEEDS

GAPS IN UK RESEARCH EVIDENCE RELATING TO BRIEF INTERVENTIONS WERE DISCUSSED BY HEATHER AND WALLACE[80] IN 2002. THEIR RECOMMENDATIONS FOR FUTURE RESEARCH WITH RESPECT TO BRIEF INTERVENTIONS IN PHC WERE AS FOLLOWS:

a) WHILE FURTHER EVIDENCE FOR THE "EFFICACY" (I.E., FROM RESEARCH CONDUCTED UNDER OPTIMAL CONDITIONS) OF BRIEF INTERVENTIONS IN PHC IS PROBABLY NOT A RESEARCH PRIORITY, FURTHER "EFFECTIVENESS" STUDIES (I.E., RESEARCH CARRIED OUT IN REAL-LIFE CONDITIONS OF PRIMARY HEALTH CARE) WOULD BE USEFUL.

b) A GAP IN THE EVIDENCE RELATING TO BRIEF INTERVENTIONS IN THE PHC IS RESEARCH ON THE LONG-TERM EFFECTS OF INTERVENTION. LONG-TERM FOLLOW-UP STUDIES HAVE BEEN CONDUCTED IN AUSTRALIA AND THE USA BUT STUDIES ARE NEEDED OF UK SAMPLES, POSSIBLY EXAMINING EXISTING COHORTS FROM PREVIOUS TRIALS.

c) FURTHER RESEARCH IN THE PHC SETTING SHOULD ALSO INVESTIGATE THE EFFECTS OF MORE TARGETED BRIEF INTERVENTIONS (I.E., TARGETED TOWARDS PARTICULAR GROUPS OF PATIENTS OR IN CONJUNCTION WITH SPECIAL CLINICS.) AN IMPORTANT PRIORITY HERE IS THE DEVELOPMENT AND TESTING OF BRIEF INTERVENTIONS TO REDUCE BINGE DRINKING IN YOUNG EXCESSIVE DRINKERS AND THIS COULD BE DONE EITHER IN GENERAL PRACTICE OR A&E SERVICES.

d) RECENT PUBLICATIONS FROM THE USA HAVE DEMONSTRATED SUBSTANTIAL FINANCIAL BENEFITS TO THE HEALTH CARE SYSTEM FROM THE IMPLEMENTATION OF BRIEF INTERVENTIONS. HOWEVER, TO ACHIEVE MAXIMUM IMPACT ON POLITICIANS AND HEALTH SERVICE DECISION-MAKERS, ECONOMIC EVALUATIONS OF BRIEF INTERVENTIONS ARE NEEDED IN THE UK. THIS APPLIES TO ALL SETTINGS IN WHICH BRIEF INTERVENTIONS MIGHT BE DELIVERED.

e) THE MAJOR ISSUE APPLYING TO BRIEF INTERVENTIONS IS THAT, DESPITE STRONG EVIDENCE OF EFFECTIVENESS AND SUBSTANTIAL ANTICIPATED GAINS FOR PUBLIC HEALTH, SCREENING AND BRIEF INTERVENTIONS FOR EXCESSIVE DRINKING ARE NOT BEING IMPLEMENTED BY THE MEDICAL AND NURSING PROFESSIONS. WAYS OF REMEDYING THIS SITUATION WITH RESPECT TO PHC ARE THE FOCUS OF ACTION RESEARCH CURRENTLY UNDERWAY IN NEWCASTLE BUT THERE MAY BE A NEED FOR SIMILAR PROJECTS IN OTHER POTENTIAL SETTINGS FOR THE DELIVERY OF BRIEF INTERVENTIONS. A STUDY OF THE EFFECTS OF FINANCIAL INCENTIVES IN ENCOURAGING GENERAL PRACTITIONERS AND OTHER HEALTH CARE PROFESSIONALS TO IMPLEMENT SCREENING AND BRIEF INTERVENTIONS IN THEIR WORK WOULD ALSO BE VERY USEFUL.

THESE RECOMMENDATIONS ARE STILL APPLICABLE, WITH LITTLE NEED FOR MODIFICATION, TODAY.

IN RELATION TO RECOMMENDATION (E), HOWEVER, A MAJOR RECENT DEVELOPMENT IS THE GOVERNMENT'S INTENTION, STATED IN THE AHRSE[1], TO FUND A NUMBER OF PILOT SCHEMES TO TEST HOW BEST TO USE A VARIETY OF MODELS OF TARGETED SCREENING AND BRIEF INTERVENTION IN PRIMARY AND SECONDARY HEALTHCARE SETTINGS, FOCUSING PARTICULARLY ON VALUE FOR MONEY AND MAINSTREAMING. THIS INITIATIVE MAY ALSO MEET THE REQUIREMENTS OF RECOMMENDATION (A) ABOVE. THE MENTION OF "VALUE FOR MONEY" ALSO IMPLIES ATTENTION TO THE ISSUE OF COST-EFFECTIVENESS OF SBI, AS OUTLINED IN RECOMMENDATION (D) ABOVE. AT THE VERY LEAST, A START COULD BE MADE IN DEVELOPING THE UK EVIDENCE-BASE ON THESE CRUCIAL TOPICS IN THE GOVERNMENT-FUNDED RESEARCH.

AT THE TIME OF WRITING, THE DEPARTMENT OF HEALTH HAS ISSUED ON INVITATION TO INTERESTED PARTIES TO APPLY TO BE INCLUDED IN A SHORTLIST FOR THE TENDER TO OPERATE THIS PROGRAMME OF PILOT RESEARCH. WHILE IT IS HOPED THAT UK RESEARCH WILL BE FUNDED TO PROCEED ON OTHER ASPECTS OF THE EVIDENCE-BASE RELATING TO BRIEF INTERVENTIONS IN PHC (E.G. THEIR LONG-TERM EFFECTS AND THE EFFECTS OF BI TAILORED TO THE NEEDS OF YOUNG PEOPLE), THE FINDINGS OF THE DEPARTMENT OF HEALTH PILOT RESEARCH PROGRAMME WILL CLEARLY BE OF MAJOR IMPORTANCE FOR THE SUCCESS OF THE IMPLEMENTATION STRATEGY OUTLINED IN THIS DOCUMENT.

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APPENDIX A

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APPENDIX B

DANOS Unit AH10

"CARRY OUT BRIEF INTERVENTIONS WITH ALCOHOL USERS"

About this unit

THIS UNIT IS ABOUT WORKING WITH INDIVIDUALS TO HELP THEM RECOGNISE RISKY OR HARMFUL DRINKING BEHAVIOUR AND PROVIDE SUPPORT AND GUIDANCE TO HELP THEM CUT DOWN DRINKING. IT ADDRESSES IDENTIFYING WHO MAY BE APPROPRIATE TO RECEIVE BRIEF INTERVENTIONS THAT HELP PEOPLE REDUCE THE HARM OR RISK TO THEIR HEALTH CAUSED BY EXCESSIVE DRINKING.

THERE ARE TWO ELEMENTS:

AH10.1 IDENTIFY ALCOHOL USERS WHO MAY BENEFIT FROM BRIEF INTERVENTIONS

AH10.2 PROVIDE BRIEF INTERVENTIONS TO ALCOHOL USERS.

THIS UNIT IS FOR A WIDE RANGE OF PEOPLE IN HEALTH AND SOCIAL CARE SERVICES WHO MAY COME INTO CONTACT WITH PEOPLE DRINKING ABOVE MEDICALLY RECOMMENDED LEVELS OR EXPERIENCING DIFFICULTIES RELATING TO THEIR ALCOHOL USE. SUCH STAFF WILL NOT BE ALCOHOL SPECIALISTS, BUT WILL BE INVOLVED WITH PROVIDING GENERAL HEALTH CARE ADVICE ACROSS A RANGE OF HEALTH ISSUES. THIS WILL INCLUDE FOR EXAMPLE:

- GPs, practice nurses and other primary health care staff
- Accident and Emergency staff
- Occupational health staff
- Staff on hospital wards
- Health promotion staff
- Criminal justice staff
- Connexions staff
- Sure Start workers
- Housing workers
- Social workers.

Qualifications

THIS IS A *DRAFT* UNIT. IT DOES NOT APPEAR IN ANY QUALIFICATIONS.

Origin

THIS UNIT WAS DEVELOPED AS PART OF THE DRUGS AND ALCOHOL NATIONAL OCCUPATIONAL STANDARDS (DANOS).

Scope

THIS SECTION PROVIDES GUIDANCE ON POSSIBLE AREAS TO BE COVERED IN THIS UNIT.

Recognised screening tools include

- AUDIT screening tool and abbreviated version of AUDIT
- other recognised screening tools

Recognised evidence-based techniques include

- motivational interviewing
- brief cognitive-behavioural therapy
- other recognised evidence-based techniques.

AH10.1 Identify alcohol users who may benefit from brief interventions

You must ensure that

1. you create an environment suitable for frank, confidential discussion
2. you respond to individuals who express concern about their drinking levels
3. you initiate discussions about risky drinking behaviour
4. you explain why you have an interest in the individual's drinking
5. you identify, using recognised screening tools or techniques, individuals who may have problematic drinking behaviour
6. you collect and record information about an individual's problematic drinking behaviour
7. you decide whether providing a brief intervention is the most appropriate response to their drinking behaviour
8. you keep an accurate record of the actions you have taken
9. you identify individuals with established alcohol dependence or serious alcohol related problems who need referral for specialist help
10. you arrange for a follow-up appointment to check on progress if the individual is willing to attend specialist services.

AH10.1 Identify alcohol users who may benefit from brief interventions

You must ensure that

1. you use recognised evidence-based techniques to provide brief Interventions to alcohol users
2. you check the individual's understanding of the impact of their drinking behaviour and whether they want to change this behaviour
3. you provide information and feedback about the risks associated with current alcohol intake
4. you make links between information about risks and the individual's own drinking behaviour
5. you give advice about how to achieve a less harmful level of drinking
6. you provide a menu of alternative strategies for changing drinking behaviour, including specialist help for those with established alcohol dependence and/or serious alcohol related problems
7. you support the individual to set drinking goals
8. you support the individual to identify and overcome barriers to changing their drinking behaviour
9. you provide relevant supplementary information leaflets or resources and signpost local specialist services if the individual wishes to seek further help.
10. you keep an accurate record of your intervention and the information and advice you gave.

Knowledge and Skills

You need to apply the following knowledge and skills.

Alcohol

K1. the physical, psychological, social, legal and emotional effects of alcohol

K2. the risks alcohol can present to an individual's health

K3. what constitutes normal, hazardous and harmful drinking as defined by the World Health Organisation

K4. the changes which can be made to drinking behaviour to improve health

Local knowledge

K5. the availability and characteristics of alcohol agencies and support groups in the local community

11. the eligibility criteria and protocols for accessing services in your locality

Organisational context

K6. the extent and limit of your own role and responsibilities

K7. the relevant national, local, professional, and organisational requirements relating to equal opportunities, discrimination, health and safety, security, confidentiality, and data protection

K8. the availability and characteristics of alcohol agencies and support groups in the local community

Providing interventions

K9. the principles of active listening, and how to apply them

K10. how to present and explore options with different individuals

K11. how to present information and advice fully, accurately, concisely and in ways appropriate to people's needs

K12. the provision of culturally appropriate interventions

K13. the cycle of change model

K14. the principles of dependence

K15. how to identify and assess risks

K16. the importance of brief interventions to enable individuals who do not need specialised treatment to change their drinking behaviour

K17. the role of brief interventions to engage individuals in treatment

K18. how to help individuals make and review decisions and establish priorities.

APPENDIX C

ORGANISATIONS ENDORSING THIS STRATEGY

Alcohol Concern

Centre for Health Services Research, University of Newcastle upon Tyne

Division of Psychology, Northumbria University

Gateshead Primary Care Trust

HEALTH DEVELOPMENT AGENCY

NURSING COUNCIL ON ALCOHOL

ROYAL COLLEGE OF GENERAL PRACTITIONERS

Primary Health Care European Project on Alcohol (PHEPA)

Integrating Health Promotion Interventions for Hazardous and Harmful Alcohol Consumption into Primary Health Care Professionals' Daily Work

STRATEGY FOR FINLAND

Summary

In Finland alcohol consumption and its consequences are increasing. This year, the decrease in especially spirit taxation, and the decease of import regulations increased the speed. The weakening of these strong policy actions is challenging to other preventive policy measures.

Brief interventions in health care are effective, the scientific evidence is good. Even if they cannot compete with taxation and other strong primary preventive actions, they offer, in the present situation, a good option to decrease alcohol consumption among hazardous drinkers and also the harm done by alcohol. The problem, however is, that they are not accepted by health care professionals. This is why strong political support is needed to implement brief intervention in primary health care, where most of the population is met yearly.

The basis for the Finnish implementation strategy lies in Clinical Guidelines, two implementation projects (National Brief Intervention Project VAMP and National Occupational Brief Intervention Project). These are supplemented by nationwide training programme by the Society for Municipal Physicians. The two implementation projects and the training project are funded by Ministry of Social Affairs and Health. Clinical Guidelines by the Finnish Medical Society Duodecim will be used with the PHEBA guidelines in all programmes.

Earlier experiences from national and WHO studies show that the 3-year time, planned for the above projects may be too short to complete the implementation. Maintenance of the activity demands reminders and resources for institutions, which educate health care professionals. Also, the core missions of primary health care should be pondered especially in relation to preventive work.

1. Introduction

In the end of 2003, the Finnish population was 5 219 732 of whom 2 666 839 were female. Mean age of males was 38.5 years and of females 41.6 years. In the general population 17.5 % were aged under 15 and 15.6 % over 64. Life expectancy at birth was 75.1 years for males and 81.8 years for females. The life expectancy of Finnish men is reduced by cardiovascular disease, accidents and excessive alcohol consumption.

Finland is divided into 446 municipalities. Each municipality is responsible for arranging health care for its inhabitants. Health centre services include medical consultations and provision of dental care, preventive care and environmental health care. Health centres run maternity and child health clinics, and arrange school and occupational health services. Attached to each health centre there is usually a hospital for patients with mild or chronic illness, a small laboratory, a radiological unit and a physiotherapy unit. Most Finnish municipalities have switched from a primary health care system to a family doctor system. Each family doctor is responsible for about 2000 patients. About 20% of the almost 20 000 Finnish physicians work in health centres and about 4% in occupational health care.

Each of the 20 hospital districts provides specialist consultation and care for its population. Each hospital district has a central hospital with departments for most major specialties. The five university hospitals provide the most advanced medical care, including highly specialized surgery and treatment for rare diseases. The university hospitals are also mainly responsible for the clinical training of medical students and for medical research. Private medical treatment supplements care provided by municipalities and the state.

Spirit drinking and binge-type heavy episodic drinking are typical Finnish drinking habits. Even if the Finnish drinking amounts are of medium European level, the trend is increasing. Especially women and people living in big cities have increased their drinking. Beer and spirit consumption are prevalent and the number of teetotallers has greatly decreased during the past decades. After the reduction of alcohol taxation in 2004 drinking has increased by about 20%. It will be seen where the level stabilizes in the months to come.

The attitudes among primary health care workers have been somewhat negative towards working with patients with alcohol problems. On the other hand, early intervention has been considered important among policy-makers and researchers. Three doctoral dissertations in medical faculties have been undertaken to inquire into the efficacy and effectiveness of brief intervention, one in an orthopaedic setting, one as part of health check-ups and one in primary health care. The last was part of a wider community action project, the Lahti Project. Also, implementation of brief intervention has been promoted in Pirkanmaa and Helsinki Regions and in occupational health care. All this fits well with the preventive tradition against cardiovascular diseases in Finland.

PHEPA project continues the work done in WHO brief intervention studies, Phases I-IV. Finland participated in the last phase aiming to implement brief

intervention in primary health care. PHEPA products (clinical guidelines and training manual) are expected to give valuable ingredients for national efforts to implement early identification and brief alcohol intervention as a routine part of work done in primary health care. PHEPA will be an important part of the strategy of implementation also in Finland, the strategy, which will be presented in this report.

2. The use of alcohol

Alcohol is the most commonly used substance among social and health care patients in Finland. Of all substances alcohol represents about 90% and the share has only little decreased during the past five years.

According to the National Research and Development Centre for Welfare and Health (STAKES), alcohol consumption in Finland, as 100% alcohol, was 9.4 l per inhabitant in 2003. Of the consumption, 7.7 l was statistical and 1.7 l non-statistical composing of home distilled and tourist imported alcohol, alcohol drunk abroad and illegal distilling and smuggling. From European perspective, consumption in Finland is of medium magnitude.

Almost half of the consumption is beer, even if the share of beer has slowly decreased during the ten last years. Spirits make about 30%, the share has been stabile. The rest is composed of long drinks, cider and wine; all these categories have slowly increased.

The number of sober inhabitants, especially among women and particularly in big cities and in Southern Finland has decreased. A survey by Mäkelä et al. in 1996 (total sample size *n* = 1509; aged 19 to 71 years) found the rate of abstainers to be 7% (males) and 14% (females). The last Drinking Habit Survey by STAKES (Juomatapatutkimus 2000) shows that among men (n=945) 8% and among women (n= 987) 9% are sober. Based on the same survey 57% of men and 34% of women drink alcohol at least once a week.

The Finnish Drinking Habits Study 1992 (total sample size *n* = 3369; aged 15 years and above) found that 22% of men and 5% of women can be classified as risky drinkers (cut-off point of 11 on the AUDIT). Risky or hazardous drinking is most common among young people, those living alone, unmarried people and city dwellers . Data from a series of cross-sectional surveys from 1991 to 1998 were pooled (total sample size *n* = 22 745; males *n* = 10 687 and females *n* = 12 058; aged 20–64 years old) and the results found that the rate of heavy drinking was 42.1% among males and 26.4% among females. Heavy drinking was for males defined as more than eight units/week and for females more than five units/week.

In a study of 1861 primary health care clinic and 2942 occupational health care clinic outpatients and 544 randomly selected adults in the general population (aged 20–60 years), among men the prevalences of heavy drinking in the primary health care clinic, occupational health care clinic and general population were 20%, 17% and 16% respectively. Among women, the corresponding figures were 9%, 6% and 13%. A male patient was defined as a heavy drinker if his self-reported alcohol consumption was at least 280 g of absolute ethanol (24 standard drinks) per week and/or if he had at least three affirmative answers in CAGE (self-reported questionnaire on alcohol-related

problems). For women, the limits were 190 g (16 standard drinks) and/or two affirmative CAGE answers.

Binge drinking is typical in Finland. A national survey conducted in 2000 of a sample representative of the adult population aged 18–64 years found that the percentage of binge drinking occasions of all drinking occasions in the last 12 months was 29% among male drinkers and 17% among female drinkers. Binge drinking was defined as an occasion when the respondent had consumed at least one bottle of wine, 25 centilitres of spirits or four cans of beer.

Among 45-year old men in 2000 93% were drinkers (n=555). Out of them 34% reported to drink at least six drinks per drinking occasion at least weekly (Tuunanen, Aalto and Seppä, unpublished results).

Based on a survey by Public Health Institute, the number of alcohol dependent inhabitants in Finland, based on CIDI interview and DSM-IV classification is 6.5% among men and 1.5% among women.

The present problem in Finland is, that consumption shows an increasing trend. With the exception of a couple of stabile years during the last decade the trend during the past ten years has been increasing; in 1994 alcohol consumption per inhabitant aged 15 or more was 8.2 l of 100% alcohol while in 2003 the corresponding figure was 9.3. The reduction in taxation in 2004 has lead to about 20% increase in consumption, especially in spirits. Part of this may only be temporary; the real level of increase can be seen in the months to come.

3. The harm done by alcohol

Increase in alcohol consumption increases the harm. Thus, the increasing drinking in Finland will undoubtedly lead to increased harm. The acute harms will be seen soon, the chronic ones just after several years.

Data from 2003 show that there were 95 275 (95 955 in 2002) persons taken in custody for drunkenness, 25 067 cases of drunken driving (23 496 in 2002), 75 manslaughters (87 in 2002) and 1302 (1294 in 2002) persons killed or injured in road accidents under the influence of alcohol. Of all killed or injured in road accidents the alcohol-related number made 15.2% in 2003 and 14.6 in 2002.

In 2002, altogether 33 211 periods of hospital care were related to alcohol. The most common diagnoses were alcoholismus (n=10 666; in 2001 n= 10 623), intoxication (n= 9866, in 2001 n=9712), morbid hepatitis (n= 3204, in 2001 n=2931) and illnesses of the pancreas (n=2446, in 2001 n=2384). Data from 2002 show that in total there were 1465 deaths from alcohol-related diseases or poisoning and 913 deaths due to alcohol-related accidents or violence.

It should be taken into account that the official statistics are a clear underestimate of the real prevalence of alcohol-related visits in health care. Several studies have shown that alcohol is a causal factor in many diseases, but not recorded in patient documents. This goes especially in depression, anxiety, suicides and traumas.

4. Measures to reduce the harm done by alcohol

In Alcohol and Public Policy-group's book 'Alcohol, No Ordinary Commodity. Research and Public Policy' the possibilities for alcohol policy have been scientifically evaluated. The summary of this book has been published in Finnish (Österberg E, Babor T 2004) by Alkoholiohjelma 2004-2007 and it is recommended to be read with the publication Alkoholiohjelma 2004-2007. Yhteistyön lähtökohdat 2004 (Alcohol programme 2004-2007. Starting points for co-operation in 2004, see Chapter 6).

The evaluation includes the effectiveness, its extent, proof in different cultures and costs and also target group and comments. The actions have been handled in the following subgroups; control of production and sale, taxation, influence drinking occasions, education, marketing regulations, prevention of drinking and driving and early intervention/treatment.

The strongest policies are control of production and sale, taxation and preventive actions on drinking and driving. Inside the group 'Early intervention and treatment' brief intervention is scored highest in effectiveness (see also Chapter 5.). The effectiveness is ++ (score 0/+/++/+++) indicating medium effect size), the extent is +++ (five or more studies), proof from different cultures is +++ (studies from five or more countries) and the costs are moderate. The comment is that GPs do not seem to have time for screening and brief intervention and they are not well trained for it.

Alcohol policy aims at maximizing the good and minimizing the harm done by alcohol. It should be built on the existing scientific evidence, but it must also be accepted by population. Possibilities for alcohol policy, which aims at public good, are today better than ever. To make good, science-based solutions acceptable by population, media has an important role. Population, e.g. patients, have to accept brief interventions to make them happen. Also, a supportive policy environment is necessary for the success of interventions in primary health care

5. The effectiveness and cost effectiveness of interventions for hazardous and harmful alcohol use in primary health care

There is good evidence of the effectiveness of brief alcohol interventions also in primary health care setting. Four meta-analyses specifically concentrate on primary health care; Poikolainen 2002, Ballesteros et al. 2004, Beich et al 2004, Whitlock et al 2004. Poikolainen reviewed 7, Beich et al 8, Ballesteros et al 13 and Whitlock et al 12 studies. In the most recent meta-analysis for the U.S. Preventive Services Task Force the conclusion is that in intervention groups the average number of drinks was reduced 13-34% more as compared to controls and the proportion of participants drinking at moderate or safe levels was 10% to 19% greater compared with controls. One study reported maintenance of improved drinking patterns for 48 months. The researchers conclude that behavioral counseling interventions for risky/harmful alcohol use among adult primary care patients could provide an effective component of a public health approach to reducing risky/harmful alcohol use. Future research should focus on implementation strategies to facilitate adoption of these practices into routine health care.

The scientific evidence of brief intervention has been reviewed and analysed for the Finnish Clinical Guidelines. The conclusion there is, that the level of evidence is A (Strong research-based evidence (multiple, relevant, high-quality studies with homogenous results, e.g. two or more randomised controlled trials, or a systematic review with clearly positive results)).

Health care costs of patients with hazardous alcohol use are half of those with alcohol dependence (£ 632 vs. £ 1222 / 6kk). Untreated alcohol dependent people use health care services so that the costs are double when compared to other people at same age. Also, the results when treated early are better as compared to treatment results in later phase.

Theoretical calculations by Wützke et al. indicate, that the cost of one brief intervention in Australia is Aus$ 19.14-21.50. The estimation was based on costs of marketing, training, support, materials, and costs of the professionals. Effective health care calculations in England (1993) estimate that the cost of one intervention is 15-40 £. Based on Finnish calculations the total cost of screening and intervention in a population with 1600 adults (mean population for one GP in Finland) ranges between 11 687 - 30 365 €, depending whether the screening has been systematic or opportunistic. Assumptions were that in systematic screening 20% of the men and 9% of the women are risky drinkers; in opportunistic screening 40 % of the patients are screened and 30% of them are risky drinkers; the sensitivity of the screening test is 92% and the specificity 94%; 50% of the risky drinkers are motivated; intervention is effective in 20% (NNT=5). The cost of one intervention ranges between 84 – 241 €. These costs can be compared to the treatment of alcohol-related complications at specialized health care, one treatment ranging up to 30 000 €.

Fleming et al. have studied the costs and also the cost-effectiveness of brief interventions in primary health care. According to them, the cost of one brief intervention was $ 205. After one year, the cost effectiveness was 5.6:1 (95% CI 0.4-11.0), Earlier theoretical calculations also point out that even a minor success in early-phase interventions make them cost-effective.

The fact, however is, that even if the evidence is convincing both in effectiveness and cost effectiveness, EIBI is very slowly accepted by health care professionals. This may be also the cause for not very convincing results in some studies in real-life settings. The possible reasons may lie in insufficient commitment of opinion leaders, lack of time and resources, and obstacles like attitudes and poor skills and knowledge.

6. Current policies and activities

The aims of Finnish alcohol policy are similar to those of the European Union and the World Health Organisation, and are comprised of prevention and treatment of harm and a good availability of services. The foundations of Finnish alcohol policy have lied in retail sales monopoly, age limitations and high taxation.

In Finland, there is monopoly on retail sale of alcoholic beverages stronger than 4.7 vol %. Licence for production is demanded for wine and spirits and

for selling beer. There are hour restrictions for wine, spirits and beer, day restrictions on wines and spirits, restrictions on places for all three and restrictions of density of outlets for wines and spirits. Age limit for purchasing alcoholic beverages is 18 as well on-premise and off-premise except 20 for spirits off-premise. The drinking driving limit is 0.5 per mil.

There are partial restrictions on advertising alcohol on national television, radio, print media and billboards for beer and wine and total ban for spirits. No warning on health risks of alcohol are added on labels. Restrictions on alcoholic beverage consumption in public domains is either voluntary or partial and it is possible to get a licence for on-premise sale of alcohol for sporting events and parks, leisure events.

After February 2004, alcohol taxation was reduced by 33% (spirits 44%; strong wines 40%; wines 10%; beer 32%). The aim is to reduce alcohol imports from other EU countries, especially from the new EU member state Estonia. A disintegration of preventive measures is predicted to lead to an increase in consumption and in alcohol-related harm.

In its decision in principle of 9 October 2003 on alcohol policy, the Government defined the main objectives and the priorities for action to be followed in public administration to diminish the adverse effects of alcohol. This Government Resolution on Strategies in Alcohol Policy reflects the fact that in recent years the consumption of alcohol has grown and the harmful effects to health and society caused by this have increased. The liberalization of imports by travellers to countries with lower prices and the pressures that this causes to cut the taxation and prices of alcoholic beverages only serve to make the situation worse. The growth of consumption is also leading to a rise in the need for social welfare and health-care services, which is increasing costs for municipalities. Preventing the harmful effects of alcohol has also been dealt with in the following Governmental Resolutions: The Health 2015 public health programme (2001), Securing the Future of health Care (2002) and Development Project for Social Services (2003).

The Ministry of Social Affairs and Health was charged with the preparation and implementation of a comprehensive alcohol programme for the years 2004-2007.

The decision in principle includes three partial objectives for the prevention and reduction of the adverse effects of alcohol: reducing the alcohol-induced adverse effects on the well-being of children and families; reducing the hazardous use of alcoholic beverages and the related problems; and inverting the trend in the overall consumption of alcoholic beverages.

The alcohol programme for the years 2004-2007 has been prepared and will be implemented under the Ministry of Social Affairs and Health in collaboration with the various sectors of public administration, municipalities, churches, NGOs as well as business and industry organisations.

The objective is to co-ordinate and combine the measures aiming at the prevention and reduction of alcohol problems into a systematic whole in order to promote the attainment of joint goals through co-operation. The

cooperation is based on voluntary partnership corroborated through formally signed agreements.

The Ministry of Social Affairs and Health also seeks to strengthen the structures of preventive action and establish clear target-orientation, performance evaluation and continuous quality improvement as a standard approach in alcohol problem prevention. There are four core principles that steer the public alcohol policy: legitimacy of the objectives and measures; effectiveness of the measures; local communities as the locus of action; and co-operation based on partnership. To promote the partial objectives of alcohol problem reduction, a set of measures is presented that will be prioritised by the Ministry in its coordinating and steering activities.

The publication Alkoholiohjelma 2004-2007. Yhteistyön lähtökohdat 2004 (Alcohol programme 2004-2007. Starting points for co-operation in 2004) describes the status of the co-operation process in the spring of 2004.

In all sectors of government, the primary objective of any alcohol-related measures is to prevent and reduce the adverse effects caused by alcohol. Efficient reduction of the problems calls for co-operation between the various sectors of public administration. The publication gives a short summary of the public measures planned for the immediate future. The role of the municipalities in the prevention and reduction of alcohol problems is discussed in relation to the legislative premises as well as to those imposed by the national development programmes in the social welfare and health care sector. A number of recommendations are given to the municipalities, and the main lines of action of such municipalities as have joined the alcohol programme at the early preparatory stage are briefly presented.

A group of NGOs working for the promotion of health have presented their goals and priorities for action as regards the reduction of alcohol problems in 'Alcohol and drug programme of NGOs for 2004-2006'. Under the umbrella of the NGO programme, a number of organisations joined the national alcohol programme in February 2004. The NGOs' priorities for action are presented as well as examples of some organisations' focal points related to the alcohol programme. The book also presents the focal points of the churches and of the professional organisations, unions and industry organisations that adhered to the programme during its preparation phase.

The alcohol programme highlights the process nature of preventive action: the action plans are specified and revised, and the attainment of results is evaluated while the programme is underway. The Ministry of Social Affairs and Health will compile an interim evaluation of the attainment of the goals and objectives, to be submitted to Parliament in the spring of 2006 as an integral part of the Government's Social Welfare and Health Report.

The alcohol programme leans on scientific evidence and, due to changes in primary preventive tactics, highlights brief interventions in health care, of which the evidence is good.

7. Integrating preventive interventions in primary health care

7.1. Principles

Integration of early identification and brief alcohol intervention in Finland is based on the following facts:

- Brief interventions are effective and cost effective in primary health care setting
- Risky drinking is a huge and increasing public health problem in Finland
- The use of primary preventive methods has decreased, which makes challenges to other choices
- Holistic and preventive approach is in harmony with the ideology of primary health care work; the continuity of care gives a good frame to include also alcohol-related issues in clinical work
- Finnish patients approve asking and advising about alcohol
- In spite of also national evidence of the effectiveness and cost-effectiveness, PHC professionals are reluctant to do EIBI; 10% of general practitioners do it permanently, 50% every now and then and 40% never.
- After almost ten years of training and rigorous media campaigns, the concept of EIBI is not known by almost 50% of the professionals. This tells about the non-motivation; training does not reach the non-motivated part of them.
- PHC staff is under an enormous workload. For now, most of them are not willing to screen systematically. Instead, they are motivated to screen and intervene opportunistically in situations, where there is a hint in the clinical history about risky drinking.

Thus, the principles of the integration of the programme are flexibility and two-way communication; the actors in the field must be heard. Ways to keep in touch with them even if they are busy is challenging. The danger of 'doing all inside one programme' should be avoided and the focus should be in EIBI, not on treating alcoholics. The fact that stakeholders and politicians in Finland agree of the importance of EIBI in PHC is not enough; active deeds by those in leading positions should be undertaken. The physicians and nurses do the choice how they include preventive work in their patient relationships. The present state of getting extra pay for operative, instead of preventive work, and the too big work load per one GP should be changed. Also, educational institutions should have chairs for addictive disorders to guarantee the attitudes, knowledge and skills of future health care professionals. The important principle is to communicate with leaders, but also with media. Last, but not least, the change happens slowly, which needs patience, but also many years of funding.

An important principle is to try to make alcohol, especially EIBI, as a health issue. This will certainly increase its acceptability among PHC professionals.

7.2. Practice based guidelines, protocols and aids

The Finnish Current Care Guidelines intended for national use, are produced in Finnish since 1994, and currently funded by Finland's Slot Machine Association under the auspices of the Ministry of Social Affairs and Health. Current Care /Finnish Medical Society Duodecim is a founding member of Guidelines-International-Network. G-I-N is the network of guideline organizations founded in 2003.

The board of Current Care selects topics from among suggestions made mostly by the specialist societies. The development group consists of relevant clinical experts, always including a general practitioner, and allied health professionals when appropriate. The process begins with literature search done by an experienced medical librarian. Based on the evidence and consensus, the development group drafts a guideline that is widely circulated to identified stakeholders.

Guidelines of alcohol are based on the initiative of the Finnish Society of Addiction Medicine. These guidelines are being reviewed by stakeholders and will be completed in the beginning of year 2005. They are based on systematic evidence and give clinical recommendations on how to treat patients in real-life situations. The specific target group are general practitioners. The text will be published in short form in Duodecim (Duodecim is a scientific society with almost 90% of Finnish doctors and medical students, altogether over 17,380 (December 2002), as members) and the whole text in internet, which is freely accessible. These electronic versions are also available on CD-ROM. The significant difference from the printed version is the accessibility of the evidence summaries on which the grading is based. There are direct links to the original Cochrane reviews and in the near future the original articles. The electronic version is the main medium of guideline dissemination. Importantly, this allows linking of guidelines with locally developed implementation programmes or models of shared care. Dissemination of guidelines also includes a wide variety of publications directed to specific audiences. An internet-based self-training course will also be launched next year.

The clinical guidelines produced by PHEPA concentrate more deeply on EIBI as compared to the Finnish guidelines (where all alcohol-related issues are included). Thus, the PHEPA guidelines are a good addition and will be utilized in training inside the EIBI programme.

In collaboration with the Alcohol Programme for the years 2004-2007; the VAMP - project (Valtakunnallinen Mini-interventio Projekti – Nationwide Brief Intervention Project, which is the essence of the implementation, see 7.8) has produced the following material for EIBI-implementation:

- Screening tool (Finnish version of the WHO AUDIT questionnaire)

- Hand-out for the patients (Short instructions on how to decrease drinking; includes information of risky limits, what a drink is, health hazards, benefits of cutting down, drinking diary) – also in collaboration with ALKO and Finnish Centre for Health Promotion

- Reminder-postcards for patients (including information of risky drinking and health hazards, also free space where personal feedback can be written)- also in collaboration with Helsinki City Social Services Department

- Posters - also in collaboration with Helsinki City Social Services Department

- Pocket-version of drinking diary – also in collaboration with Finnish Association of Healthy Lifestyles

- Leaflet on how to talk about alcohol (aimed at all PHC professionals) – also in collaboration with trades unions. This leaflet is still under construction but should be available in the beginning of year 2005.

All material is available as well in Finnish as in Swedish.

There are internet pages of the VAMP-project (under the pages of the Ministry of Social Affairs and Health), which contain for example Power Point presentations of EIBI (Early Identification and Brief Intervention). These presentations are freely available for training use. The pages will also be updated from time to time.

7.3. Training

EIBI training has been widely delivered in Finland for over 10 years. There are modern programmes of training including role-play, group work, Power Point presentations showing the evidence etc. Nowadays, there are also several trainees capable of training (for example co-ordinators working in VAMP project).

PHEPA project training manual is a valuable add to trainees; the overheads can easily be tailored to VAMP project needs and are useful even in English. The training manual will be partly translated for Finnish needs.

VAMP project faces the problems of the busy PHC. There is only limited time for contacts. Lectures are not the option here. Traditional whole or half-day training sessions are not possible. Neither is it easy to have several appointments around one topic, because the spectrum of topics is so wide in primary health care. The challenge of the first training session is to rouse interest and curiosity. The only way to do this is that the trainees have good antennas, good knowledge of the topic, good experience of the work in PHC and that they can grasp the ideas of the discussions; e.g. to vamp the participants, at least some of them, most importantly the chiefs.

The Finnish Society for Municipal Physicians is preparing a programme for nationwide training of primary health care doctors in relation to alcohol and

tobacco prevention. This programme could aim to reach also the non-motivated municipalities and non-motivated physicians. The society has a good network in training, a high respect among GPs and support from medical industry. This could be a good addition to the VAMP project and prepare municipalities to join VAMP.

To guarantee the future, EIBI training should be implemented in every medical and nursing curriculum. Especially the specialist programme of general practice should include obligatory EIBI training. However, the essential message here, as well as in the implementation training should be that EIBI is not a separate trick, it is an essential and natural part of good care.

Occupational Health Care Project is in close collaboration with VAMP sharing the ideas and material. This project will reach OHC units in different parts of Finland to give training in EIBI. The funding of this project also comes from the Ministry of Social Affairs and Health.

7.4. Engaging primary health care providers

Training (see above) is one way of encaging PHC providers. As said earlier, its value is only limited. Training is of no use to those non-motivated professionals, who never attend training sessions. We also have experience of training, what has been obligatory; the result may be even worse than non-attendance.

There are several options, which will be tested in the VAMP project

- Extra-pay for preventive work
- Engage leaders. We have noticed in VAMP project, that professionals in centres where leaders have high motivation are more active. However, this only seems to be true in small centres.
- Motivate patients to ask about their alcohol use in relation to their health. This has already started in collaboration with Alcohol Programme for the years 2004-2007 and with some NGO:s with help of media
- Material, which is easy to use and good guidelines (good consensus of the effectiveness) – these are almost all now available

7.5. Funding and reimbursement

The funding for VAMP project covers the training and support of the regional co-ordinators, their salaries and travel expenses, hopefully for three years. It is hoped that more municipalities will join the project. However, the present capacity seems to cover about 30% of the population of Finland.

If the wide training programme by municipal physicians succeeds in motivating more participants, more resources (at its best triple) will be needed for VAMP.

The final aim of the project is that during these years the project co-ordinators make themselves unnecessary and that after the project the activity has moved to practice.

According to the present plans the funding comes from the Ministry of Social Affairs and Health.

7.6. Specialist support and knowledge centres

The support by specialist services would surely enhance the effectiveness of the programme. VAMP project has involved for example the Finnish Society of Addiction Medicine, and has good support from addiction specialists also in A-clinic Foundation. The collaboration has facilitated collaboration in training. Finland has a specialist programme in addiction medicine, where EIBI is well implemented and also included in the examinations. Further, the Association of Municipal Physicians could be involved.

In real life brief intervention is often initiated (or should be initiated) in specialized health care, in surgery, psychiatry, neurology or internal medicine wards or clinics. The follow-up is often in primary health care (including also occupational health care and private sector). Thus, collaboration with specialist clinics and plans how to collaborate, could be supported.

Implementing brief interventions in primary health care also leads to more activity in relation to addicted patients. Thus, good collaboration with psychiatrists and A-clinics is important and encouraged in VAMP project.

The VAMP- project (national co-ordinator and regional co-ordinators) in collaboration with the Occupational Health Care Project (co-ordinator also works as part-time co-ordinator for VAMP) make the knowledge centre for EIBI in Finland.

7.7. Monitoring the programme

The VAMP project consists of separate projects. They have a common aim, but the methods in implementation may vary. Also; in addition to local activities; the nationwide media campaigns and articles in widely circulated magazines and professional journals make the leakage possible (and hoped).

The structure of the VAMP program makes it possible to evaluate the implementation in several different ways:

- Compare nationwide the activity before – after
- Compare different regions (which way to implement is most effective)

In 2002 we mailed a structured questionnaire to all GPs in Finland (n=3400). The addresses were from the Finnish Medical Association. We received answers from 66 %. A similar questionnaire will be mailed again to the same target group after the project.

The different regions, before starting the training related to VAMP, collected baseline data from all nurses and GPs. The stage of change in doing EIBI was asked (doing always, doing sometimes, not doing but willing to do, not doing and not willing to do) as well as the ways to ask about alcohol (questionnaires, direct asking) and the knowledge of the target group for EIBI. Similar questionnaire will be used during and after the project. This gives the possibility to measure changes in attitudes, activity, knowledge and using AUDIT-questionnaire.

It is possible to compare the effectiveness of the different ways of implementing (based on project diaries) using regional baseline and endpoint measurements. Hopefully, one region succeeds in getting extra pay for professionals of doing EIBI. This can also be compared to other regions where extra pay is not available.

Qualitative analysis (project diary) is used to evaluate the atmosphere and attitudes in the contacts.

7.8. Preparing for the introduction of the programme

The above principles are knitted in the VAMP-project, which is planned to last for three years. It is part of the National Health Care Project funded by the Ministry of Social Affairs and Health and started in September 2004. The project was initially open to all municipalities in Finland provided that they committed to do EIBI in their primary health care centres. Altogether 16 municipalities joined the project representing 20% of the population in Finland. Municipalities from 4/5 of Finnish provinces are participating and 12 project workers (nurses and physicians, some of them part-time) are doing the implementation in different parts of Finland.

The written aims of the project are:

- Primary health care professionals know the methods of EIBI and the material needed is available in health centres
- The professionals have knowledge and skills for EIBI
- EIBI activity increases in health centres
- Health centres have plans for patients who are not helped by BI.
- In every centre there is a professional who updates the knowledge in addiction field.
- EIBI becomes part of normal work
- Professionals consider EIBI as a health issue related to many health problems, and EIBI becomes part of high quality health care
- Patients consider EIBI natural and important part of primary health care work

The project has a steering group nominated by the Minister (APPENDIX) and a national co-ordinator.

The steering group

- Observes the progress of the project
- Makes proposals and initiatives on how to proceed
- Supports the project

The national co-ordinator:

- Trains the regional co-ordinators
- Supports and gives consultations
- Provides them material needed for regional training
- Organises co-ordinator meetings
- Is responsible for the national baseline and end-point evaluations
- Observes and supports the regional projects
- Provides the material for patients
- Organises national press conferences
- Designs the net pages for the project
- Gives reports of the project progress to the steering group

Regional co-ordinators

- Create regional networks
- Carry out regional baseline measurements
- Train regional professionals
- Tailor the implementation and follow up and carry it out (including local press contacts)
- Are available for centres to consult, support and remind of EIBI
- Keep project diary

For the moment, the projects are ongoing, the regional co-ordinators have been trained and the material and net pages are provided. The present activity is training and support.

7.9. Managing the programme

The management of all the projects is in the Ministry of Social Affairs and Health. The content and progress of the regional projects are managed by the national co-ordinator with help from the members of the steering group. The funding of VAMP is managed by the Social and Health Care of the City of Kotka. The management of the funding of the occupational health care project is in STAKES and that of Municipal Physicians in the Finnish Centre for Health Promotion.

7.10. Communicating about the programme.

On national level:

- Media communication
- Medical journals (Duodecim, Finnish Medical Journal, Journal for Municipal Physicians).
- Lectures in national congresses
- Posters in national project meetings
- Updated net pages (www.stm.fi); links to this page from other home-pages (e.g. local pages, page of the Finnish Society of Addiction Medicine)

On regional level:

- Media communication (local newspapers, local radio and television)
- Local net pages

8. Research needs

There are many unresolved issues in EIBI. The wide project gives possibilities to approach these research questions. The possible themes in VAMP project, which might earn research approach are:

- Effectiveness of different ways to implement
- Stage of change among professionals and its importance in activity
- Nurses and BI-related activity
- Obstacles to do EIBI (targeted qualitative analysis of interviews among non-motivated professionals)
- What component helps (interview of a group of patients, who decreased their drinking during the project)

During the project the electronic patient documents may allow the documentation of BI-activity. If this is the case, the measuring of the activity gets easier. VAMP works in collaboration with the project promoting electronic documents.

In Finland, having the increasing trend of alcohol consumption, it extremely difficult to draw any conclusions on the changes in hospital visits (emergency etc.) even though this would be interesting. The same goes to DUI offenders.

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APPENDIX
The Country-based Team:

GOVERNMENTAL ORGANIZATIONS

Director *Tapani Melkas*, (chair)	Ministry of Social Affairs and Health
Chief Physician *Matti Lamberg*	Ministry of Social Affairs and Health (Occupational Health Care)
Chief Physician *Hannu Alho*	National Public Health Institute
Administrative Chief Physician *Liisa-Maria Voipio-Pulkki*	Association of Finnish Local and Regional Authorities
Provincial Chief Physician *Pirkko Valtola*	State Provincial Office of Eastern Finland
Development Manager *Leena Warsell*	STAKES (National Research and Development Centre for Welfare and Health)

NGO:s

Executive Director *Mika Pyykkö*	Finnish Centre for Health Promotion

PROFESSIONAL ASSOCIATIONS

President *Hannu Alho*	Finnish Society of Addiction Medicine
Health Promotion Coordinator *Maarit Salo*	Finnish Union of Public Health Nurses
Provincial Chief Physician *Pirkko Valtola*	Association of Municipal Physicians

SCIENTIFIC ORGANIZATIONS

Professor *Mikko Salaspuro*	University of Helsinki (Duodecim; Clinical Guidelines)
Professor *Kaija Seppä*	University of Tampere

PRIMARY HEALTH CARE EUROPEAN PROJECT ON ALCOHOL (PHEPA)

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

STRATEGY FOR GERMANY

Introduction

The project entitled Integrating Health Promotion Interventions for Hazardous and Harmful Alcohol Consumption into Primary Health Care Professionals' Daily Work (or Primary Health European Project on Alcohol [PHEPA] for short) is funded by the European Union as part of the Community Action Programme on Public Health and is co-ordinated by the Programme on Substance Abuse, Health and Social Security Department, Government of Catalonia in Barcelona. It commenced at the beginning of 2002 and is due for completion at the end of 2004. A total of 16 countries in the EU are taking part in the project, together with Eurocare and the WHO Regional Office for Europe. Michael N. Smolka is the representative on the project for Germany.

The general aim of the project follows on from Phase IV of the WHO Collaborative Project on the Identification and Management of Alcohol-related Problem in Primary Health Care, the aim of which was to develop and apply country-wide strategies for widespread, routine and enduring implementation of screening and brief intervention (SBI) for hazardous and harmful drinkers throughout the primary health care (PHC) systems of participating countries. A report to WHO on the work of the Phase IV study will be completed in 2005. However, the specific aims of PHEPA entail the development of four related products: (i) Clinical Guidelines for delivering SBI in PHC that can serve as a basis for guidelines to be used in participating countries; (ii) a Training Manual linked to the Clinical Guidelines that can also be adapted for use in participating countries; (iii) a website containing an Alcohol Management Database for use by PHC professionals and others interested in the promotion of SBI in primary care; and (iv) a Country-based Strategy aimed at integrating SBI for hazardous and harmful drinkers in the PHC systems of participating countries.

This document represents the last of these PHEPA products and is a strategy aimed at achieving the widespread, routine and enduring implementation of alcohol SBI in PHC in Germany. To facilitate the development of this strategy a small team of experts was convened to represent the major organisational interests in alcohol SBI in Germany and the membership of the team is shown in Appendix A. The team has met on two occasions (September 15th and December 15th 2004) at the premises of the Central Institute of Mental Health and has communicated by electronic means between and after these dates.

The completed strategy will be delivered to PHEPA in Barcelona and the intention then is to present it to the Department of Health.

The use of alcohol

The Drogenbeauftragte der Bundesregierung (Frau Caspers-Merk) which is a member of the German Ministry of Health recently published the Sucht- und Drogenbereicht 2004 (http://www.bmgs.bund.de/download/broschueren/A601.pdf). This report provided up-to-date information on alcohol use levels and patterns, different forms of alcohol-related harm and other relevant data. Data presented in this report are taken from a survey („Repräsentativerhebung zum Gebrauch psychoaktiver

Substanzen in Deutschland") which was conducted in 2003 (Kraus & Augustin 2005).
One in six individuals (17%) between ages 18 to 59 reported not drinking any alcohol during the last 30 days or even longer. More women (21%) than men (13%) are abstainers. 16.2% of men compared to 7.6% of women drank above the limit for low risk drinking (men: 30g/d; women: 20g/d); that is 12.1% of the adult population. Of these 9.3% had a hazardous alcohol consumption (men: 30-60g/d; women: 20-40g/d), 2.5% had a dangerous alcohol consumption (men: 60-120g/d; women: 40-80g/d) and 0.3% had an excessive alcohol consumption (men: >120g/d; women: >80g/d). Binge drinking (more than 5 drinks on one occasion) was reported in 45% of males and 16% of females during the last 30 days. Further details about prevalence rates can be found in the report from Kraus & Augustin (2005).
Per capita consumption in 2002 was calculated at 11.4 litres of pure ethanol. Although total consumption in Germany was about 20% higher 25 years ago, it is about 3 fold higher than 1950 (DHS http://www.optiserver.de/dhs/daten_zahlen_alkohol.html). In international comparisons, in 1999 Germany ranked 10th out of 153 countries worldwide (WHO 1999). Compared with other countries in the European region, the region of the world with the highest level of alcohol consumption, Germany has been classified as having a "high level of consumption", defined as above 10 litres per person per year (Rehn 2001; p.7).

The harm done by alcohol

Alcohol use can have adverse effects on many aspects of people's lives – health, finance, occupation, crime, housing and personal relationships. There are no data to quantify the human suffering from excessive drinking and the contribution of alcohol to complex social and personal problems. Together these deleterious effects account for an enormous loss of life and money which can be roughly estimated. From a worldwide perspective, and ignoring for these purposes any health benefits from moderate alcohol consumption, excessive drinking is a major cause of disease and injury, accounting for 9.2% of disability-adjusted life years (DALYs; WHO 2001). Only tobacco smoking and high blood pressure are higher risk factors. In Europe, mental and behavioural problems due to alcohol are the fifth highest cause of DALYs, exceeded only by depression, coronary heart disease, dementias and stroke.
The most obvious form of harm due to chronic excessive drinking is alcohol dependence. Roughly 1.6 million people, or 2.4% of the adult population (18-59 years aged) of the Germany, are defined as dependent on alcohol and 2.7 million people (4%) are estimated as harmfully using alcohol (Kraus & Augustin 2005). As reported above 12.1% of the adult population drink alcohol exceeding the limits for low risk drinking (men: 30g/d; women: 20g/d).
Adding together chronic and acute physical health disorders directly attributable to alcohol as well as death due to crime, accidents etc., it has been estimated that up to 42,000 deaths each year are associated with excessive drinking in Germany (BMG 2000). It is estimated that the total cost of harm due to alcohol in Germany is about 21 billion € (BMG 2000).

Measures to reduce the harm done by alcohol

A recent and comprehensive WHO-sponsored review of policies intended to reduce alcohol-related harm (Barbor et al 2003) concludes with a table listing all the policy-relevant strategies and interventions identified by the authors with ratings for each on four scales (Table 16.1, pp. 264-6). These scales are: (1) Effectiveness, (2) Breadth of research support, (3) Tested across cultures and (4) Cost to implement and sustain.

"Effectiveness" refers to the judgement that it is reasonable to make from the available scientific evidence regarding a strategy's effectiveness in reducing alcohol consumption, alcohol-related problems or their costs to society and is rated: 0 lack of effectiveness; + limited effectiveness; ++ moderate effectiveness; +++ high degree of effectiveness; and ? no studies undertaken or insufficient evidence on which to make a judgement. "Breadth of research support" refers to the number of scientific studies and the consistency of results bearing on a particular strategy and is rated: 0 no studies of effectiveness undertaken; + only one well-designed study of effectiveness; ++ 2-4 studies of effectiveness; +++ 5 or more studies. "Tested across cultures" is concerned with the diversity of geography and cultures within which a strategy has been applied and tested and is rated: 0 not tested adequately; + studied in only one country; ++ studied in 2 to 4 countries; +++ studied in 5 or more countries. Finally, "Cost to implement and sustain" estimates the relative monetary cost to the state to implement, operate and sustain a strategy regardless of effectiveness and is rated: Low; Moderate; and High. The table also indicates the target group for the strategy (general population; high-risk drinkers or vulnerable groups and persons already showing harmful drinking or alcohol dependence) and makes other comments. Measures are grouped according to general category of strategy or intervention.

The single strategy with the highest ratings is "Taxation and Pricing" which obtains '+++' for all the first three scales above and a Low cost to implement. It is obviously targeted at the general population and effectiveness depends on government oversight and control of alcohol production and distribution, although it is noted that high taxes can increase smuggling and illicit production. Apart from this single strategy, the category of measures with the highest effectiveness ratings is "Regulating Physical Availability", with four strategies obtaining maximum effectiveness including "Minimum legal purchase age", "Government monopoly of retail sales" and "Server liability". The first two of these are rated '+++' for breadth of research support, '++' for cross-cultural testing and Low for cost to implement. Other strategies with high ratings occur in the category "Drink-driving Countermeasures", with "Random breath testing", "Lowered BAC limits" and "Low BAC for young drivers" all obtaining '+++' for effectiveness. The category showing the lowest effectiveness ratings is "Education and Persuasion", with "Alcohol education in schools", "College student education", "Public service messages" and "Warning labels" all obtaining '0' for effectiveness. Measures in the categories of "Altering the Drinking Context" and "Regulating Alcohol Promotion" show a mixture of effectiveness ratings, with "Enforcement of on-premise regulations and legal requirements" and "Community mobilisation" showing moderate effectiveness ('++') but High cost to implement.

The category of strategies of most relevance to the present document is "Treatment and Early Intervention". In this category, "Alcohol problems treatment", "Mutual help/ self-help attendance" and "Mandatory treatment of repeat drinking-drivers" are given ratings of low effectiveness ('+'). Alcohol problems treatment is considered to have high breadth of research support ('+++'), high cross-cultural testing ('+++') and High cost to implement. Of most immediate interest here,

"Brief intervention with at-risk drinkers" obtains an effectiveness rating of '++' (moderate effectiveness), '+++' for breadth of research support, '+++' for cross-cultural testing and a Moderate cost to implement. The target group is high-risk drinkers. The table further notes that: "Primary care practitioners lack training and time to conduct screening and brief interventions".

A factor clearly omitted from the above analysis is the political feasibility of introducing a particular measure, which itself is partly influenced by indications of what public attitudes to the measure are likely to be. This applies particularly to policies such as increased taxation and restrictions on alcohol availability which research evidence suggests would be highly effective in reducing alcohol-related harm. Policies such as this are part of the "whole population" approach to reducing harm in which the attempt is made to decrease alcohol consumption of the population as a whole with a resultant decrease in measures of alcohol-related harm. The alternative view is the "harm reduction" approach which, in this use of the term, restricts policies to limiting or reducing harm among those have already incurred harm or are at risk of doing so. There are obvious grounds for supposing that the introduction of whole population measures would be unpopular with the general public.

The central aim of the German government stated in the "Aktionsplan Drogen und Sucht" is to reduce the mean alcohol consumption in the entire population and to reduce the proportion of people with critical alcohol consumption to reduce morbidity and mortality due to alcohol (BMG 2002). In this plan different measures to achieve this aim are proposed, including whole population measures regulating physical availability, education and persuasion and regulating alcohol promotion. Concerning the harm reduction approach improving and extending treatment of alcohol dependent subjects and extending early intervention with at-risk drinkers are listed.

Given these goals and that implementation of alcohol control measures in the form of taxation and strict regulation of the physical availability of alcohol is politically challenging, the conclusion must be that the widespread implementation of SBI in a range of medical and other settings is the best option for producing a significant impact on the level of alcohol-related harm in Germany. In the ratings of policies and measures summarised above (Barbor et al 2003), and setting aside the evidence of effectiveness for specific measures against drink-driving, "brief intervention with high-risk drinkers" is the only other measure with moderate effectiveness ('++'), wide breadth of research support ('+++') and a moderate cost to implement and sustain. Furthermore, it will be shown in the next section that alcohol SBI is effective in reducing alcohol-related harm among those who have already incurred such harm as well as those who are at risk of incurring it. Of all the settings where SBI might be widely implemented, primary health care is the one that offers the greatest potential for reaching those in need of intervention (Scott & Davis 1979; Barbor et al 1986).

The effectiveness and cost-effectiveness of screening and brief interventions for hazardous and harmful alcohol use in primary health care

As indicated above, there is good evidence that screening and brief alcohol interventions delivered in PHC are effective in leading to reduced alcohol consumption among hazardous and harmful drinkers, with consequent benefits for

patients' health and welfare. There is also good evidence, although from outside Germany, that PHC brief interventions are highly cost-effective. However, difficulties have been encountered in persuading PHC professionals to incorporate SBI in their routine work and obstacles to this implementation, as well as the potential incentives, have been studied. This section will examine the evidence for each of these assertions in more detail.

Effectiveness of SBI

There is a very large body of research evidence on alcohol brief interventions, including at least 56 controlled trials of effectiveness (Moyer et al 2002). There have also been at least 13 meta-analyses and/or systematic reviews (Bien et al 1993; Freemantle et al 1993; Kahan et al 1995; Wilk et al 1997; Poikolainen et al 1999; Irvin et al 2000; D'Onofrio et al 2002; Emmen et al 2004; Ballesteros et al 2004; Whitlock et al 2004; Cuijpers et al 2004; Bertholet et al 2005), using somewhat different aims and methods, of research on effectiveness, with five of these specifically focused on PHC (Kahan et al 1995; Poikolainen et al 1999; Ballesteros et al 2004; Whitlock et al 2004; Bertholet et al 2005).
In what is generally considered to be the most comprehensive and well-designed meta-analysis of brief interventions (Moyer et al 2002), the studies included were divided into 34 "opportunistic" brief interventions carried out in generalist settings among individuals not seeking treatment for alcohol problems and 20 "specialist" brief interventions among those who are seeking treatment. It is the former group which is of sole interest here, since there are marked differences in length, content and style of brief intervention and methodological features between the two groups of studies (Heather 2003). From the studies of opportunistic intervention, small to medium aggregate effect sizes in favour of brief interventions emerged across different follow-up points. At follow-up of 3-6 months or more, the effect for brief interventions compared to control conditions was significantly larger when individuals showing more severe alcohol problems were excluded from the analysis. There is mixed evidence of longer-term effects of SBI. A trial of PHC-based SBI in Wisconsin, USA reported continuing benefits for alcohol use, binge drinking episodes and frequency of excessive drinking among recipients of SBI compared with controls four years after intervention (Fleming et al 2002). However, an Australian study reported that the benefits of receiving SBI had disappeared after 10 years (Wutzke et al 2002). A 10-16 year follow-up sample recruited in a well-known Swedish study of SBI that was carried out as part of a health screening programme (Kristenson et al 2002) showed reduced mortality in the intervention group but it is questionable whether this study can be regarded as examining brief intervention because of the length and duration of the original intervention sessions. Nevertheless, there is some evidence that SBI reduces alcohol-related mortality (Emmen et al 2004), albeit from a small number of studies. There is also evidence that SBI is effective in reducing alcohol-related problems among those who receive it (Kristenson et al 2002).
With regard to SBI specifically in the PHC setting, the most recent systematic review and meta-analysis (Bertholet et al 2005) concluded that brief alcohol intervention is effective in reducing consumption among both men and women at 6 and 12 months following intervention. It is noteworthy that his review was confined to studies carried out in more naturalistic conditions of PHC, excluding those studies that used patient lists, registers or specially-arranged screening sessions. Another recent review (Ballesteros et al 2004) concluded that their meta-analysis, although indicating a smaller effect size than reported in previous papers, nevertheless supported the moderate effectiveness of SBI. No clear evidence of a dose-effect

relationship was found in this analysis, meaning that the superior benefits of relatively longer interventions could not be demonstrated. Yet another recent review, by the US Preventive Task Force (Whitlock et al 2004), found that "brief counseling interventions for risky/harmful alcohol use among adult primary care patients could provide an effective component of a public health approach to reducing risky-harmful alcohol use" (p.557).

Cost-effectiveness

The direct cost of a brief intervention delivered to a hazardous or harmful drinkers was calculated to be only £20 in 1993 (Freemantle et al 1993). A recent WHO study (WHO 2005) estimated that the cost-effectiveness of PHC alcohol brief interventions for hazardous and harmful drinking is approximately £1,300 per year of ill-health or premature death avoided. It should be noted that this is nearly equivalent to the cost-effectiveness of smoking cessations interventions in PHC which is about £1,200. Other medical interventions have an average cost-effectiveness of £30,000.
In a cost-benefit analysis of the effects of a GP-based brief intervention after four year, Fleming and colleagues in Wisconsin, USA (Flemming et al 2002) estimated that, for every $10,000 invested in SBI, a saving in health care costs would be obtained of $43,000. The benefit-cost ratio increased when the societal benefits of fewer motor vehicle accidents and crime were included the analysis. There is a clear need for similar economic evaluations of SBI in the German health system but, even without this more direct evidence, there is strong prima facie case that widespread implementation of SBI in PHC would create resources for the health care system and for the wider society.

Implementation

Despite this evidence of effectiveness and cost-effectiveness, many studies have documented a wide gap between actual and recommended good practice in PHC based on research evidence. As one illustration of this, Kaner and colleagues (1999) reported findings from a questionnaire survey of general medical practitioners (GPs) in the English Midlands. Results showed that GPs did not make routine enquiries about alcohol, with 67% enquiring only "some of the time". The fact that 65% of GPs had managed only 1-6 patients for excessive drinking in the last year was striking in view of evidence that approximately 20% of patients presenting to primary health care are likely to be at least hazardous drinkers (Anderson 1993).
The TACOS-Study (Transitions in Alcohol Consumption and Smoking), conducted in Germany, found that in the last 12 month 75% of risky drinkers had consulted their GP, 70% had been at their dentist, 58% had seen a consultant and 15% had spend at least one night in hospital. Only 7% of all subjects with at least hazardous alcohol consumption did not utilise medical services at all. Although the TACOS-Study reported a somewhat lower prevalence of risky alcohol consumption among patients seen at the GP level compared to prevalence rates reported for the general population by the Bundes-Gesundheitssurvey and the SHIP-Study (Study on Health in Pomerania), 80-87% of risky drinkers utilise basic medical services (Baumeister, Meyer et al. submitted). The TACOS-Study revealed that only 14.3% of risky drinkers had been advised by a physician to reduce alcohol consumption, indicating insufficient medical care.
Research has also focused on identifying the obstacles to implementation of SBI in PHC, with a good convergence of findings from different studies in different

countries. The main obstacle appears simply to be lack of time among busy health care professionals (Kaner et al 1999; Roche & Freemann 2004). Other obstacles are: (i) lack of appropriate training to carry out SBI; (ii) little support from government health policies; (iii) a belief that patients will not take advice to change drinking behaviour; (v) a lack of suitable screening and counselling materials; (vi) lack of reimbursement from government health schemes (Kaner et al 1999). At the same time, health professionals may fear offending patients by raising the topic of drinking and find it difficult to do so[49] and some may have negative attitudes to patients with drinking problems derived from their experience of those with more severe problems. Some of these identified obstacles are simply overcome (e.g. availability of SBI training and screening and counselling materials) but others present more serious difficulties.

When GPs are asked what incentives would be required to enable them to carry out SBI, many mention training and support (Kaner et al 1999). There is indeed good evidence that when GPS and nurses are adequately trained and supported for this work, SBI activity increases (Anderson et al 2003). However, there is also evidence that support should be geared to the needs and attitudes of health professionals to be effective and avoid being counterproductive in the longer term (Anderson et al 2004).

Other incentives mentioned by GPs are: (i) if SBI were proven to be successful; (ii) if patients asked for advice about alcohol consumption; (iii) if public health campaigns made society in general more concerned about alcohol; (iv) if quick and easy counselling materials were available; (v) if salary and working conditions were improved; (vi) if training programmes for SBI were available (Kaner et al 1999). Again, some of these incentives are readily provided while others are not.

Current policies

When considering current policies that affect SBI activity in PHC in Germany, or, at least, will soon begin to affect it and will do so for some years to come, two major and recent publications stand out – the "Aktionsplan Drogen und Sucht" (BMG 2002) and the "Sucht und Drogenbericht 2004" (BMG 2003). Both state univocally that alcohol consumption in Germany is to high and accounts for an enormous amount of health related problems and immense costs. To bring down morbidity and mortality due to alcohol the consumption in the entire population and the proportion of people with critical alcohol use should be reduced. In the Aktionsplan the government proposes to improve and extend SBI with at-risk drinkers at the PHC level. In accordance with this the Ministry of Education and Research is actually funding several projects investigating screening and/or brief intervention at the PHC level in the framework of addiction research consortia. One of the main foci of the ongoing projects is to evaluate stretegies dealing with the implementation of SBI.

Integrating preventive interventions in primary health care

Principles

The strategy for implementing alcohol SBI in PHC in Germany that is outlined here is based on the following principles:

- there is abundant evidence that SBI delivered in PHC settings is effective in reducing alcohol consumption among hazardous and harmful drinkers and hence in reducing alcohol-related harm in the PHC population;
- there is also good evidence, mainly from outside Germany, that SBI in PHC is highly cost-effective and, if routinely implemented, would result in considerable financial savings for the health care system;
- despite this evidence of effectiveness and cost-effectiveness, there is further substantial evidence that general medical practitioners, practice nurses and other PHC staff very rarely implement alcohol SBI in their routine work and that, as a consequence, the majority of hazardous and harmful drinkers presenting to PHC are overlooked and not advised to reduce consumption;
- it follows that there is a need to provide effective incentives and acceptable conditions of work for PHC staff to deliver SBI, paying attention to the obstacles to implementation that have been identified in research;
- there is also a need to tailor the contents and procedures of SBI to the practical context of PHC in Germany.

Practice based guidelines, protocols and aids

In the last decade several guidelines and manuals have been developed to assure a high standard of diagnostics and treatment of alcohol related disorders and hazardous alcohol consumption. In Germany the BZgA (Bundeszentrale für gesundheitliche Aufklärung) has released a manual "Kurzintervention bei Patienten mit Alkoholproblemen" which addresses primarily GPs (BZgA 2001). Moreover, the DG-Sucht (Deutsche Gesellschaft für Suchtmedizin und Suchttherapie) together with the DGPPN (Deutsche Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde) has recently published guidelines suitable for PHC settings (Mundle et al 2003). The DEGAM (Deutsche Gesellschaft für Allgemeinmedizin und Familienmedizin) is currently preparing own guidelines which will be released 2007. Both health professionals that developed the recently published guidelines and those currently preparing new guidelines are members of the German PHEPA team and will coordinate their work further on. This will help to make these guidelines compatible.

Training

The widespread and sustained implementation of SBI in PHC requires a well suited training programme. From previous research eight recommendations can be formulated:

- Compliance with the manual is essential to assure good quality (Rollnick, Heather & Bell 1992).
- The training should be adapted to the previous knowledge of the participants (Reid, Fiellin & O'Connor, 1999; Rollnick, Mason & Butler 1999).
- Continuous education (cf. 10 sessions of 2h) is better than one long course (cf. three days in a row) (Prescott, Opheim & Børtveit 2002).
- Audio and video registration is essential to control successful learning (cf. Miller & Mount 2001).
- The training should be adapted to the daily routine. For example "realistic" roll play enhances learning (Rollnick, Kinnersley & Butler 2002).
- Enhancing communication between PHC professional and client requires permanent acquisition of some new skills and giving up some "bad habits" (Miller & Mount 2001).
- Detailed feedback increases the efficiency of a training (Demmel 2003).
- The trainee himself should experience the training as beneficial (Demmel 2004)

No widely-accepted training programme for PHC professionals wishing to deliver alcohol SBI exists in Germany. But in the context of the addiction research consortia a training program adhering to above mentioned recommendations has already been developed and is tested (Demmel 2003).

Engaging primary health care providers

An essential step in engaging PHC professionals in the delivery of SBI is to adjust SBI materials and protocols to the conditions of PHC in Germany and to the needs and preferences of the providers themselves. This process will be supported by ongoing studies focusing on the attitudes of PHC providers towards SBI as well as by pilot projects aiming to implement SBI in a wide range of PHC settings. Nevertheless, viable strategies for engaging PHC professionals in the delivery of SBI will require further consideration.
However, the key issue is how to engage larger numbers of GPs. A special consultation fee should be considered for existing GPs as an incentive to become more involved.
Moreover, integrating information about substance use disorders and SBI in curricula of CME and medical schools might also help to engage more PHC professionals in the future. In addition, integrating training programmes for delivering SBI according to the recommendations cited in 7.3 into the curricula of

on-the-job-training measures might also be useful for spreading SBI in PHC settings.

Funding and reimbursement

In addition to the necessary step of "customising" SBI to PHC in Germany, it will also be essential to pay attention to those barriers to implementation that have been identified in previous research (see 5.3.). Perhaps chief among these is the lack of financial incentives for practices to carry out this work. At this point it is crucial to integrate SBI in the German reimbursement system.

Specialist support and knowledge centres

It is likely that the effectiveness of the programme will be enhanced when there is support by specialist services and/or by specialist research and knowledge centres that provide the up to date and necessary information. For this purpose existing research groups currently funded by the Addiction Research Consortia and members of the German PHEPA team could provide the needed support. To ensure continuity further funding of this support activities by the Ministry of Health is essential.

Monitoring the programme

Monitoring of such a programme could also be provided by the above mentioned groups.

Preparing for the introduction of the programme

Again existing structures established in the framework of the Addiction Research Consortia could be a starting point in some regions. Before starting a national initiative the development of the guidelines and training programme should be completed. Moreover a consensus of the main professional organisations (DEGAM, DG-Sucht, DHS, DGPPN) about these products is needed. Last but not least substantial political and financial support from the Ministry of Health will be essential in an joined effort to improve management of hazardous and harmful alcohol consumption in PHC settings in the future.

Research needs

First of all, continuous funding of research on ways of implementing and optimising efficiency of Screening and Brief Interventions at the Primary Health Care level is needed. For this aim, large-scale implementation studies could provide an important database. Future research should also investigate services and programs specifically targeted to populations which have been neglected in the past, like young people, binge drinkers, elderly people with alcohol problems, and alcohol abusers.

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Spendix

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Primary Healthcare European Project on Alcohol, (Phepa),

EU Study 2003-2004

Irish Team Report

Introduction

The Primary Healthcare European Project on Alcohol (Phepa) had several important aims. It was designed to develop best practice across member countries on the prevention, management and treatment of alcohol problems in Primary Care.

There would be four products in all arising from the Study:

1. Guidelines for Primary Care
2. Web Site
3. Training Manual
4. Country based Team Reports from all participant countries.

Following is the Report from the Irish Team.

The Irish Country based team was formed, as directed, by the Phepa Study in November 2003. The Team met four times up to the official end-date of the study (October 22nd 2004). The compilation of the Irish team is contained in Annex One. The make up of the team ensured that this report is well set in terms of experience and practice. The team embodied a good mix of experienced practitioners, training personnel, health promotion, NGO, public health and a representative appointed by the Minister for Health and Children. All of the participants are leading experts in their own fields with vast amounts of experience. The team was chaired by the Irish representative at Phepa, Mr. Rolande Anderson, and he would like to express his thanks to the team for their hard work and support of the project.

Perhaps the most significant development in Ireland, over the last six years or so, has been the development of the Public Health approach to alcohol. The Irish Public Health doctors and the Health Promotion Unit of The Department of Health and Children have played an active part in this development. The previous Minister for Health and Children, Mr. Micheál Martin, T.D., ably assisted by the Departmental Special Advisor on Alcohol, Dr. Ann Hope, has provided the leadership to allow this change to take place, during this time.

Alcohol has been neglected in the medical field in this country and there has been little or no training for doctors in alcohol interventions up until five years ago or so. Up until the same period of time there has also been very little training at undergraduate and 'Continuing Medical Education' (CME) levels. The development of the Irish College of General Practitioners (ICGP) Project, "Helping Patients with Alcohol Problems", which commenced in 2000, has gone some way to change this pattern. At least now, training of primary care staff in alcohol interventions is available and a study has been conducted to assess if screening and Brief Interventions can be successful in Primary Care.

Public concern about the adverse effects of the significant increase in alcohol consumption over the past decade or so has led to other changes that should be noted. The Minister for Justice has brought in legislation to change the Licensing Laws to try to reduce access to alcohol and in particular keep children out of Licensed Premises (The Intoxicating Liquor Act 2003). There is also draft legislation to restrict the impact of advertising on Children (Alcohol Products Bill) though this team feels that a total ban on advertising of alcohol products would do far more good.

A Strategic Task Force on Alcohol (STFA), was appointed by the Minister for Health and Children, in January 2002 as recommended by the first report of the Commission on Liquor Licensing. Its brief was to recommend specific, evidence based measures to Government to prevent and reduce alcohol related harm in Ireland. It was made up of experts from diverse fields and included representatives from the Drinks Industry. It published two reports, The Interim Report in May 2002 (which contained a separate piece from the Drinks Industry) and a second report in September 2004. This second report contained over 70 recommendations in key areas such as;

- Availability of alcohol (and children's access to alcohol)
- Control promotion of alcohol
- Enhance society's capacity to respond to alcohol related harm (community mobilisation)
- Professional Training
- Involvement of young people
- Alcohol free alternatives
- Protect public, private and working environments
- Responsibility of the alcohol beverages industry
- Provide information and education
- Early interventions (strong endorsement of Brief Interventions)
- Specialist treatment
- Research and monitor progress

The fourth annual report of the Chief Medical Officer (2004) also focussed on the public health aspects of alcohol use and abuse.

The Irish tolerance for drinking and driving is of considerable concern. This public tolerance is encouraged by a high legal Blood Alcohol Concentration (the highest in the European Union at the time of writing) and lack of enforcement.

The last couple of years has seen the formation of a Non-Governmental Organisation, "The Irish National Alliance for Action on Alcohol", which is a welcome additional independent pressure group.

Around the same time, a social organisation called 'MEAS', Irish for 'Respect', (The 'Mature Enjoyment of Alcohol in Society') was set up. This organisation was created and is funded by the Drinks Industry. There is a great deal of cynicism within the community of health professionals about its motives and intentions.

Much still needs to be done and it is hoped that the recommendations contained in this report will become policy in the near future. Given the alarming trends in alcohol consumption in Ireland over the previous decade we can expect a big increase in patients and family members seeking help from Primary Care. Thus the timing of the Phepa Study and this report is very opportune.

Much of the data and most of the tables are taken from the STFA Report (September 2004).

2. The use of alcohol

2.1 Definitions

The World Health Organisation Guidelines for alcohol consumption risk are usually accepted in Ireland, that is, in standard drinks;

'Low risk' drinking	**= = 14 females and = 21 males**
'Hazardous drinking'	**= = 35 females and = 50 male**
'Harmful drinking'	**= > 35 female and 50 male**
'Binge drinking'	**= > 5 drinks in a row**

It should be pointed out that a standard drink in Ireland amounts to 10 grams of alcohol and that the recommended limits serve only as a guide. For example some people should not drink at all; pregnant women and those who are dependent on alcohol as specific examples.

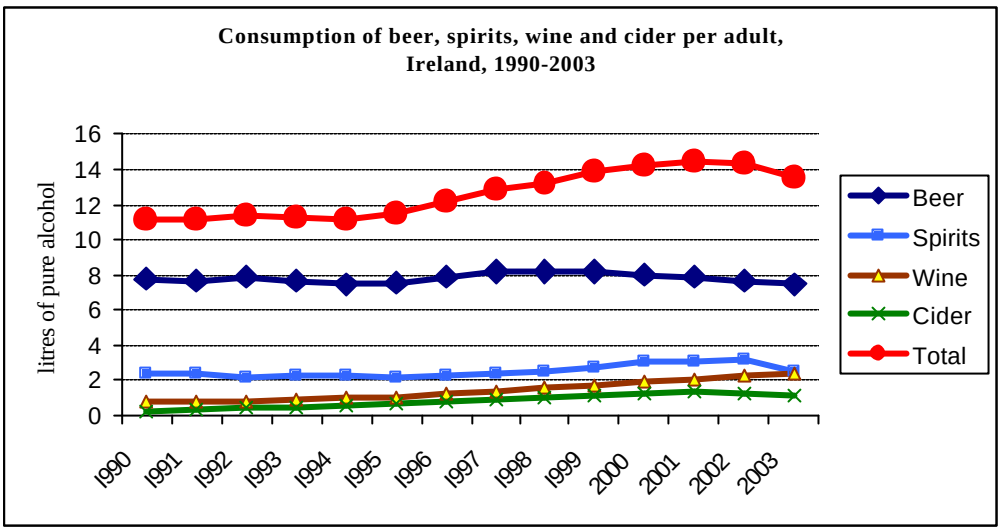
The weekly allocation should, of course, be spread out over the week and that there should be drink free days. Finally these consumption risk categories are for adults between the ages of 18 and 65. For younger and older people the risk categories should be even more conservative.

The diagnosis of dependence is based on a cluster of symptoms including;

- A strong desire or compulsion to drink
- Difficulty in controlling onset or termination of drinking or the levels of alcohol abuse
- A physiological withdrawal state on cessation of alcohol or its use to avoid withdrawal symptoms
- Increasing tolerance to alcohol so that increased amounts are needed in order to achieve similar effects to those produced originally by smaller amounts
- Progressive neglect of other interests
- Persisting use of alcohol despite clear evidence and an awareness of the nature and extent of the harm it is causing

2.2 Consumption prevalence and trends

Alcohol consumption per adult (aged 15 and over), Ireland 1990-2003



Source: Revenue Commissioners and CSO Annual Reports

The above graph indicates a substantial increase in alcohol consumption between 1990-2003. In fact, alcohol consumption in Ireland rose by 41% in the last decade. This was the highest in the European Union at that time. During that same period three countries showed a modest increase while ten of the European Member states showed a decrease.

Alcohol consumption per adult over the age of 15 reveals a dramatic rise in consumption between 1995 and 2000. In the year 2003, the total consumption of alcohol per adult was just under 14 litres of pure alcohol (see above graph). Beer continues to dominate the market though with a reduced share while there has been substantial growth in the sale of wine and cider. There is also a large increase in the sale of 'designer' drinks.

2.3 Binge drinking

There is widespread concern about binge drinking and the 'drinking to get drunk' culture which is particularly prevalent amongst young people.

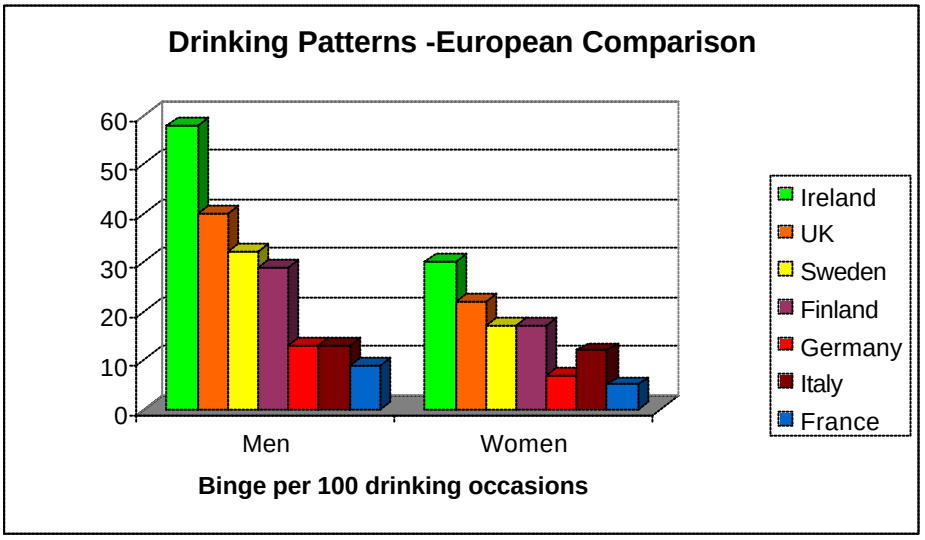
The European Schools Project on Alcohol and Drugs (ESPAD) Study reported on in 2000 revealed that Irish boys and girls aged 16 years are among the highest alcohol abusers in Europe in terms of binge drinking and drunkenness. The more recent Health Behaviour in School Children (HBSC) survey reported a decrease in the number of children under 15 years of age experimenting and consuming alcohol but there was no reported change in the drinking patterns of the 15-17 age group between 1998 and 2002. In 2002, among the 12-14 age group 6% of boys and 12% girls were current drinkers in comparison with 1998, when 26% (boys) and 17% girls were current drinkers. In the 15-17 age group, about half of the boys and girls were regular drinkers and drunkenness was also prevalent (60% boys and 60% girls).

The Slán Study (1999) revealed that half of the 18-24 age groupwere more likely to binge drink though drink less frequently than older groups. More females than males were likely to engage in risky drinking both in terms of binge drinking and to drink over recommended 'safe' levels. These findings were repeated in the Slán Study (2003). The later report showed an increase in binge drinking between 1998 and 2002 and that 30% of males and 22% of females were drinking above 'low risk' limits.

2.4 EU comparisons

Ramstedt and Hope have done some very useful analysis on this area.

Drinking Patterns- European Comparison (2002).



Source: Ramstedt & Hope

The above graph shows that adults in Ireland had the highest reported consumption per drinker and the highest level of binge drinking in comparison to adults in other European countries. The Study also showed that binge drinking is the norm among Irish men; out of every 100 drinking occasions, 58 end up in binge drinking. Among women, 30 occasions out of 100 end up in binge drinking.

2.5 Information from other studies

Apart from the Slán studies there has been little research on alcohol consumption amongst patients in Ireland. The ICGP in conjunction with the Dept. of Health and Children ran a study in Primary Care in 2002-2003, ("The Alcohol Aware Practice Pilot" Study - AAPP). Ten General Practices were involved, one from each region of the country. Using the Audit Questionnaire, clinical judgement and the recommended weekly consumption risk category guide, patients were allocated to risk categories and treated accordingly. Brief intervention techniques and other forms of intervention for dependent patients were used. All participating primary care staff underwent a half day of training. Patients between the age of 18 and 65 were screened randomly and in all 2290 patients were screened.

The results revealed that:-

- 19% were drinking above 'low risk' limits
- 13% were non-drinkers (8% were female and 5% were male); 11% 'teetotal' and 2% 'in recovery'
- 16% were considered to be hazardous drinkers and 3% were 'Harmful and/or Dependent'
- Two-thirds of the patients who required follow-up did so. One third of this group had changed from hazardous or harmful drinking to low risk drinking at the three month follow up.
- Only 33% (n = 442) of those patients who required follow-up by the Practice Staff had not re-attended by the end of the study.

This Study proved that Primary Care staff can help patients and their families with a range of alcohol problems very effectively. Furthermore there was higher confidence expressed by all the participants at the end of the Study in coping with the range of alcohol problems. This was confirmed a year later by the majority of the participants.

An important outcome was the finding that the only practice which was allocated an Alcohol Counsellor for the duration of the study (6 hours per week) discovered almost twice as many patients in the harmful and/ or dependent categories. One can only surmise that General Practice staff are more likely to find patients with alcohol problems if they have the resources to effectively treat them.

3. The harm done by alcohol

3.1 Health effects

The harm done by alcohol is well researched throughout the world and there is strong evidence linking alcohol to a whole range of health problems including various cancers, liver disease, Road traffic and other accidents, mental health problems especially depression and anxiety, and many other conditions (see chart below).

Global Burden of disease attributable to alcohol by major disease categories

Disease conditions	%
Neuropsychiatric conditions: **alcohol dependency syndrome, depression, anxiety disorder, organic brain disease**	37.7
Accidents and unintentional injuries**: road and other transport injuries, falls, drowning and burning injuries, occupational and machine injuries, alcohol poisoning**	27.2
Intentional and self-inflicted injuries: **suicide and assaults**	12.9
Gastrointestinal conditions: **liver cirrhosis, pancreatitis**	7.8
Cancers: **head and neck cancers, cancers of the gastrointestinal tract including liver cancer, female breast cancer**	7.2
Cardiovascular conditions: **ischaemic heart disease, cerebrovascular disease**	6.9
Maternal and preinatal conditions: **low birth weight, intrauterine growth retardation**	0.2
Alcohol- related disease burden all causes (DALYs)	100

Source: Rehm et al, WHO, 2003, adopted from Babor et al 2003

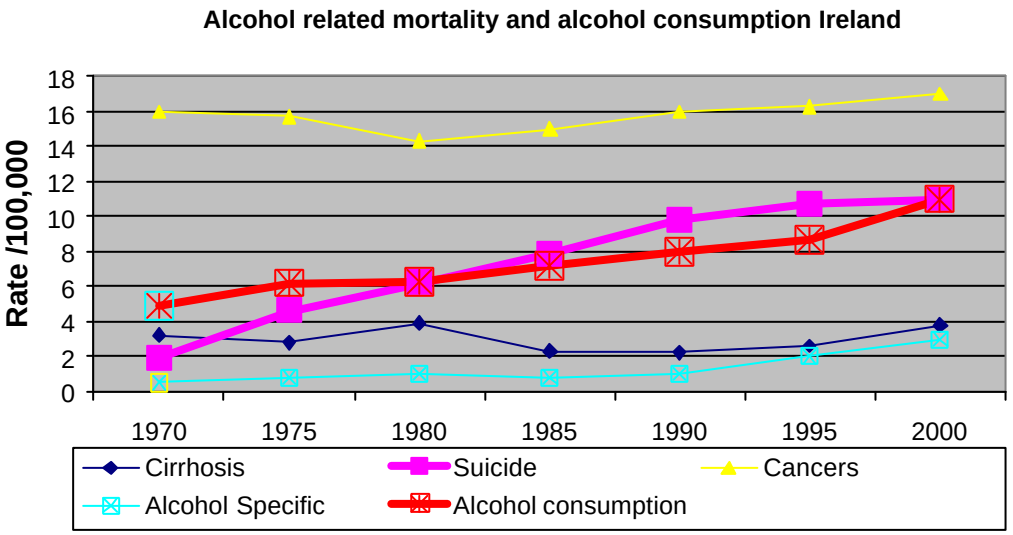
As already noted, there has been a large increase in consumption over the last ten years or so. This has corresponded with a stark rise in all of the alcohol related conditions in Ireland during the period 1992-2002 and in mortality rates (see graph below).

Alcohol related mortality 1992-2002, rates per 100,000

Disease	1992	2002
1. Cancers related to alcohol: **mouth, throat, oesophagus, liver**	15.53	16.67
2. Alcohol chronic conditions: **alcohol dependency, alcohol abuse, alcohol psychosis**	1.49	2.40
3. Chronic liver disease and cirrhosis	2.7	4.6
4. Alcohol acute conditions: **alcohol poisoning, toxic effect of alcohol**	0.51	0.97
5. Suicide	10.2	11.5
Alcohol consumption, **per capita**	**8.23**	**11.31**

Source: CSO Vital Statistics, Annual Reports

The following chart is even clearer and of particular note is the increase in suicide rates.



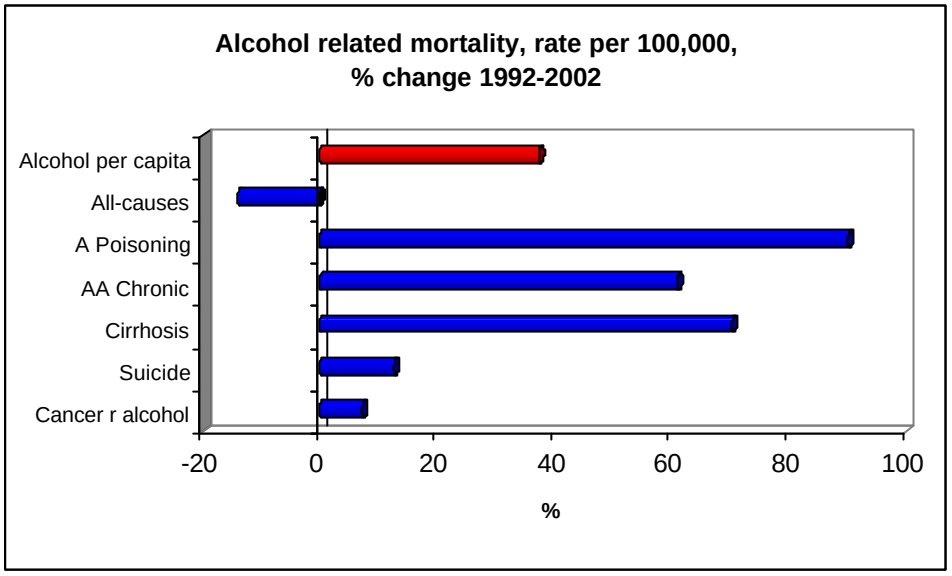
Source; Work done by Declan Bedford

Alcohol consumption has also been shown to be a factor in suicide. There has been a sharp increase in male suicides over the previous decade. In fact

it is the biggest cause of death in the age category 15-35 for men. There has also been a major rise in attempted suicide in the same period.

The following diagram illustrates that while other causes of mortality have been reduced, alcohol related mortality has markedly increased.

Alcohol related mortality, % change 1992-2002



Source; CSO Vital Statistics Annual Reports

A comparison of alcohol related mortality in Ireland over the past thirty years shows increases in cancers related to alcohol consumption, cirrhosis and other conditions related to alcohol.

Alcohol disorders continue to be the main cause of admission to psychiatric hospitals, especially for males. The figures have only varied a little over the years. In 1999, for example, out of all psychiatric hospital admissions, alcoholic disorders accounted for 26% of male admissions and 11% of female admissions. The last thirty years has seen a large growth in private treatment centres.

We also know that alcohol is a factor for one in four patients attending 'Accident and Emergency' departments and that 13% are clinically intoxicated.

All of these statistics are cause for great concern.

3.2 Social effects

It is well known that alcohol increases drunkenness, fights, assaults and violence. Since 1995 in Ireland there has been a steady increase in assaults and public order offences. A 97% increase in street violence offences was reported by the Gardai (the Irish Police) between 1996 and 2000. Of particular concern is the increase in 'intoxication in public places' which increased by 370% in the same period.

It is very difficult to quantify the harm done to family life. There is all sorts of evidence from practitioners that partners, spouses, children and other family members suffer in the short and long term from alcohol related problems.

There is evidence, again sourced from the Gardai and marriage counselling agencies, of significant increases in domestic violence. Alcohol certainly is a major contributory factor in the breakdown of relationships and is cited in 25% of cases presenting to marriage counselling services.

There are well established links between alcohol consumption and unprotected and unintentional sex as well as increases in sexually transmitted diseases. Sexually transmitted infections have increased by 165% in the last decade in Ireland.

The Slán Study revealed that young Irish men (18-29) age group reported the highest consumption of alcohol, had the highest number of drinkers and experienced more acute harm (work, fights) than any other group in the population. However, older men (50-64 age group) experienced more chronic harm (home-life or marriage, health) than others. Young women (18-29 years) experienced more negative consequences than older women, especially harming their work and friendships, getting into fights and having accidents.

3.3 Economic effects

The STFA estimated that the economic cost to Irish society is €2.65 billion per year.

Cost of alcohol related problems in Ireland

	2001	2003
	EURO million	EURO million
Healthcare costs	**279**	**433**
Cost of road accidents	**315**	**322**
Cost of alcohol related crime	**100**	**147.5**
Loss of output due to alcohol related absences from work	**1,034**	**1,050**
Alcohol related transfer payments	**404**	**523.3**
Taxes not received on lost output	**234**	**210**
TOTAL	2,366	2,652.8

Source: S. Byrne, Update on estimates of the cost of alcohol related problems in Ireland, 2004

4. Measures to reduce the harm done by alcohol

4.1 Price and tax

The total excise duty plus value added tax 'take' is €1.8 billion and this should be compared with the cost (see above). In keeping with international

evidence there is a need for alcohol price and taxes to be increased as a method of reducing harm. The influential 'Joint Committee on Health and Children: Alcohol Misuse by Young People' ('House of Oireachtas'- Government Report) on 'Alcohol Misuse by Young People' in June 2004 called for increases in the excise duty on pre-mixed ready to drink spirits in the range of 50 -100% "given the profound negative effects these drinks have on young women in particular".
The STFA clearly recommends that taxes on alcohol products continue to increase. If such increases are not sustained reductions in consumption may be reversed or short-term.

4.2 Regulating physical availability of alcohol

The STFA Reports advised the Government to;

- Maintain license measures which restrict greater availability of alcohol sale outlets (in off-licenses and on licensed premises). (However in recent years opening hours have actually been extended and more outlets have been allowed to sell alcohol such as garages/filling stations)
- Establish a National ID for the entire population so that they can also serve as proof of age for purchasing alcohol

4.3 Modifying the drinking environment

The STFA Reports recommended that;

- 'Hotspots' should be targeted through co-ordinated campaigns between the Gardai, emergency and health services and local alcohol outlets
- there should be greater enforcement of the law that prohibits serving of alcohol to intoxicated customers
- The 'Responsible Serving of Alcohol' programme be mandatory as a condition for the renewal of licenses

4.4 Advertising, promotion and sponsorship

The rules regarding advertising of alcohol products involve only self-regulation by the Industry. In 2003, the Drinks Industry Group (DIG) established a company, Central Copy Clearance Ireland (CCCI) to vet alcohol advertisements, prior to airing or publishing, to ensure the content of such advertisements are in compliance with the Advertising Standards Authority of Ireland (ASAI) code. In addition, MEAS, published in May 2004 a revised Code of Practice on the Naming, Packaging and Promotion of Alcoholic Drinks which aims to promote high standards in the sale and promotion of alcoholic drinks in a socially responsible manner. It must be emphasised that these initiatives come from the Drinks Industry.

New legislation is being developed to limit the exposure of children to alcohol advertising. This appears to involve audience profiling and assessment. It falls short of the call for a total ban on advertising of the Oireachtas Report which is supported by this team.

Elaborate and costly sponsorship is prevalent in all the major sports in Ireland. The Gaelic Athletic Association has recently taken the decision to phase out sponsorship as they have found that alcohol consumption is affecting their affiliated clubs' ability to field teams at the grass root level. Most leading health experts have called for the banning of alcohol sponsorship of sporting events and other activities including rock concerts etc.

It is very common practice in night clubs and bars to run special evenings or hours of free shots, two for the price of one, one euro shots etc. All of these practices are of major concern.

4.5 Information, training and public awareness

The Health Promotion Unit, Dept. of Health and Children, has run a very successful campaign 'Less is More' over the past few years. This is a public awareness campaign and has involved TV and radio as well as a booklet to help patients with hazardous and harmful drinking.

Training courses on clinical skills for alcohol problems have been run by the ICGP for GPs, Practice Nurses and Student Health Services over the past three years. Modules have also been delivered at CME level and within the training schemes for GPs. A new initiative has been to encourage a CME Tutor to deliver training at the CME Tutors' Conference and this has been proven to be successful. One of the problems in this area is the shortage of trainers with both experience in alcohol skills training and knowledge of General Practice.

The Health Promotion Unit has also run a successful advertisement campaign on television regarding drinking and driving in conjunction with the National Safety Council and some counter-advertising.

'MEAS' has also been involved in counter-advertising in their campaign 'Don't get Wasted'. This report calls for counter-advertising to be only carried out by independent health professionals.

4.6 Drinking and driving

Ireland still has the highest legal Blood Alcohol Concentration (BAC) level for driving by EU standards (In 1995 it was reduced to 80mg/100ml) and alcohol is estimated to be associated with at least 30% of all road traffic accidents and 40% of all fatalities. Evidence from Europe and elsewhere clearly indicates that a reduction in the legal BAC limit together with random breath checks saves lives and accidents.

The main problem in relation to this whole issue is the lack of enforcement. There are no random checks.

This team believes strongly that the current situation in Ireland is unacceptable in such an otherwise caring society and strongly recommends the reduction of the BAC and an urgent deployment of resources to the Gardai and necessary changes in legislation to allow random breath testing. The team can think of no sustainable argument to justify the current situation.

The MEAS group has initiated a 'Designated Driver' campaign. This falls short of the recommendations of this team in the previous paragraph.

4.7 Managing alcohol related harm: help and care

All of the above details are to establish the context for change. One of the most encouraging changes in Irish policy over the past five years or so is the expertise derived from the public health approach. The Minister for Health and Children has taken a lead in this area and there are signs that other politicians are now offering support.

There have been some initiatives in the treatment area but this aspect is still relatively under-funded and under-resourced. In-patient treatment facilities for the range of alcohol problems in the public sector are very poor and still largely depend on the old psychiatric hospitals and units. In the private sector there are a large number of choices for in-patient treatment. This dearth of beds is a stumbling block for primary care practitioners who want to be able to refer patients for detoxification. As a result many patients are referred to the 'Accident and Emergency (A&E)' departments and represent a huge drain on the A&E services. A number of experts have recommended the provision of Brief Interventions at A&E departments. This has been endorsed by the STFA Reports and by Babor et al's book, "Alcohol – No Ordinary Commodity"

Primary Care has been shown to be the most effective place for alcohol interventions given the trust that patients have in their GPs and the relative ease in training health care professionals in this area. The pilot study in Primary care undertaken by the ICGP in conjunction with the Dept. of Health and Children has proven that effective help can be provided for the whole range of alcohol problems.

5. The Effectiveness and Cost Effectiveness of Interventions for Hazardous and Harmful Alcohol Use in Primary Health Care

There is good evidence that screening and brief alcohol interventions delivered in Primary Health Care (PHC) are effective in leading to reduced alcohol consumption among hazardous and harmful drinkers, with consequent benefits for patients' health and welfare. There is also good international evidence that PHC brief interventions are highly cost-effective. However, difficulties have been encountered in persuading PHC professionals to incorporate Screening and Brief Interventions (SBI) in their routine work and obstacles to this implementation, as well as the potential incentives, have been studied. This section will examine the evidence for each of these assertions in more detail.

5.1 Effectiveness of SBI

There is a very large body of research evidence on alcohol brief interventions, including at least 56 controlled trials of effectiveness[1]. There have also been at least 13 meta-analyses and/or systematic reviews[2-13], using somewhat different aims and methods, of research on effectiveness, with five of these specifically focused on PHC[4,6,10,11,13].

In what is generally considered to be the most comprehensive and well-designed meta-analysis of brief interventions[1], the studies included were divided into 34 "opportunistic" brief interventions carried out in generalist settings among individuals not seeking treatment for alcohol problems and 20 "specialist" brief interventions among those who are seeking treatment. It is the former group which is of sole interest here, since there are marked differences in length, content and style of brief intervention and methodological features between the two groups of studies[14]. From the studies of opportunistic intervention, small to medium aggregate effect sizes in favour of brief interventions emerged across different follow-up points. At follow-up of 3-6 months or more, the effect for brief interventions compared to control conditions was significantly larger when individuals showing more severe alcohol problems were excluded from the analysis.

There is mixed evidence of longer-term effects of SBI. A trial of PHC-based SBI in Wisconsin, USA reported continuing benefits for alcohol use, binge drinking episodes and frequency of excessive drinking among recipients of SBI compared with controls four years after intervention[15]. However, an Australian study reported that the benefits of receiving SBI had disappeared after 10 years[16]. A 10-16 year follow-up sample recruited in a well-known Swedish study of SBI that was carried out as part of a health screening programme[17] showed reduced mortality in the intervention group but it is questionable whether this study can be regarded as examining brief intervention because of the length and duration of the original intervention sessions. Nevertheless, there is some evidence that SBI reduces alcohol-related mortality[9], albeit from a small number of studies. There is also evidence that SBI is effective in reducing alcohol-related problems among those who receive it[17].

With regard to SBI specifically in the PHC setting, the most recent systematic review and meta-analysis[13] concluded that brief alcohol intervention is effective in reducing consumption among both men and women at 6 and 12 months following intervention. It is noteworthy that this review was confined to studies carried out in more naturalistic conditions of PHC, excluding those studies that used patient lists, registers or specially-arranged screening sessions. Another recent review[10] concluded that their meta-analysis, although indicating a smaller effect size than reported in previous papers, nevertheless supported the moderate effectiveness of SBI. No clear evidence of a dose-effect relationship was found in this analysis, meaning that the superior benefits of relatively longer interventions could not be demonstrated. Yet another recent review, by the US Preventive Task Force[11], found that "brief counselling interventions for risky/harmful alcohol use among adult primary care patients could provide an effective component of a public health approach to reducing risky-harmful alcohol use" (p.557).

5.2 Cost-effectiveness

The direct cost of a brief intervention delivered to hazardous or harmful drinkers was calculated to be only £20 per person in 1993[3]. A recent WHO study[19] estimated that the cost-effectiveness of PHC alcohol brief interventions for hazardous and harmful drinking is approximately £1,300 (Sterling) per year of ill-health or premature death avoided. It should be noted that this is nearly equivalent to the cost-effectiveness of smoking

cessations interventions in PHC which is about £1,200. Other medical interventions have an average cost-effectiveness of £30,000.

In a cost-benefit analysis of the effects of a GP-based brief intervention after four year, Fleming and colleagues in Wisconsin, USA[15] estimated that, for every $10,000 invested in SBI, a saving in health care costs would be obtained of $43,000. The benefit-cost ratio increased when the societal benefits of fewer motor vehicle accidents and crime were included in the analysis.

5.3 Implementation

Despite this evidence of effectiveness and cost-effectiveness, many studies have documented a wide gap between actual and recommended good practice in PHC based on research evidence. As one illustration of this, Kaner and colleagues[20] reported findings from a questionnaire survey of general medical practitioners (GPs) in the English Midlands. Results showed that GPs did not to make routine enquiries about alcohol, with 67% enquiring only "some of the time". The fact that 65% of GPs had managed only 1-6 patients for excessive drinking in the last year was striking in view of evidence that approximately 20% of patients presenting to primary health care are likely to be at least hazardous drinkers[21]. Given figures on GPs' average list size in the UK, this suggests that the majority of GPs may be missing as many as 98% of the excessive drinkers presenting to their practices. A household survey in England, published in 1996 found that, of current and former drinkers who had spoken to a medical practitioner or other health professional in the last year, only 7% (men = 12%; women = 5%) reported having discussed alcohol consumption with their GP at the surgery[22]. This low level of intervention exists against a background in which many patients expect that their GP should be interested in alcohol-related problems but only a minority think that they are actually interested[23].

Research has also focused on identifying the obstacles to implementation of SBI in PHC, with a good convergence of findings from different studies in different countries. The main obstacle appears simply to be lack of time among busy health care professionals[20,24]. Other obstacles are: (i) lack of appropriate training to carry out SBI; (ii) little support from government health policies; (iii) a belief that patients will not take advice to change drinking behaviour; (iv) a lack of suitable screening and counselling materials; (v) lack of reimbursement from government health schemes[20]. At the same time, health professionals may fear offending patients by raising the topic of drinking and find it difficult to do so[25] and some may have negative attitudes to patients with drinking problems derived from their experience of those with more severe problems. Some of these identified obstacles are simply overcome (e.g. availability of SBI training and screening and counselling materials) but others present more serious difficulties.

When GPs are asked what incentives would be required to enable them to carry out SBI, many mention training and support[20]. There is indeed good evidence that when GPs and nurses are adequately trained and supported for this work, SBI activity increases[26]. However, there is also evidence that support should be geared to the needs and attitudes of health professionals to be effective and avoid being counterproductive in the longer term[27].

Other incentives mentioned by GPs are: (i) if SBI were proven to be successful; (ii) if patient asked for advice about alcohol consumption; (iii) if public health campaigns made society in general more concerned about alcohol; (iv) if quick and easy counselling materials were available; (v) if salary and working conditions were improved; (vi) if training programmes for SBI were available[20]. Again, some of these incentives are readily provided while others are not.

(Note; Section 5 was prepared by Prof. Nick Heather, Newcastle and the UK team for the Phepa Project and has been adapted slightly for this report. Detailed references are given for this section at the end of the bibliography)

6. Current Policies and Activities

6.1 Alcohol legislation

There have been recent developments in the introduction of legislation relating to alcohol (see Introduction). An additional important piece of legislation which has banned smoking in working environments (the first of its kind in Europe) may reduce drinking in licensed premises. However a recent worrying trend is an increase in sales from off-licenses and other outlets. Some of these outlets have a starkly reduced price differential from on-licensed premises and therefore encourages 'home' and 'outdoor' drinking.

6.2 Interventions in Primary Health Care

The ICGP project, "Helping Patients with Alcohol Problems" which commenced in 2000 is the main source of initiatives in this area. The already mentioned Alcohol Aware Practice pilot study has provided a blue print for future training and treatment initiatives.

At the time of writing a larger initiative is in preparation in the Eastern Regional Health Authority area. This will hopefully come to fruition and will involve 24 GPs, and some Practice Nurses. Each site will be supported by the presence of an Alcohol Counsellor on the basis of six hours per week. The main focus will be on screening and treatment for hazardous, harmful and dependent drinkers using medical and clinical skills together with Brief Interventions.

GPs are best placed to provide such services as they see on average up to 80% of the population every year and are the largest source of referral to specialist services. GPs in recovery from alcohol dependence also play a leading role in the day to day delivery of services to patients and their families with a wide range of alcohol problems.

7. Integrating preventive interventions in Primary Health Care

7.1 Principles

The main principle on which this programme is based will be that of identifying the best ways to enable patients and their families to get the most effective help for the range of alcohol problems. The programme will be GP friendly and will

have realistic goals. For example it would not be possible to screen the whole population within the first year but screening will remain a priority. Another main priority will be to help GPs to focus on the range of problems rather than on the narrower focus on dependence. However any programme that is designed to help patients and improve the services of GPs must also focus on ways of managing and treating alcohol dependence. The ICGP Project "Helping Patients with Alcohol Problems", March 2000 to date endorses all of these principles. It is well established and can provide the focal point and leadership for new initiatives.

7.2 Practice based guidelines, protocols and aids.

The protocols used in the AAPP Study would form the basis for future documents. Included in these documents are waiting room posters, the A.U.D.I.T. questionnaire, patient information sheets (1. So you would like to cut down on your drinking, 2. So you would like to stop drinking), protocols for detoxification, consumption risk arrow posters, decision balance sheets, referral sources and will include other leaflets developed by the Health Promotion Unit.

The ICGP will be developing Clinical Guidelines as part of the overall alcohol project and is awaiting the finalised Phepa Guidelines to form the basis of local guidelines. The Scottish guidelines (SIGN) should also be an important aid in developing such guidelines.

7.3 Training

Again the AAP Study training protocol will provide the basis for the training materials to be used in the programme. In addition the Phepa document on training will be incorporated when it is finalised. The training for GPs will be offered as a one day course and will cover the following areas;

- Attitudes towards patients
- Use of questionnaires and other screening instruments/methods
- Clinical skills for Brief Intervention and Motivational Interviewing
- Use of protocols
- Use of leaflets and other support materials
- How to work with a Counsellor
- Methods to help family members
- Information on risky consumption weekly limits
- Assessment techniques to deal effectively with the increasing problem of dual diagnosis
- Treatment methods including detoxification protocols and referral procedures
- Best practice regarding records and registers
- Liaison with Treatment facilities
- Prevention

7.4 Engaging Primary Health Care providers

This will require further consideration. However the key issue is how to engage larger numbers of GPs. The very fact that so many patients are now approaching GPs for help with the range of alcohol problems should provide the incentive for them to become more involved and seek training. A Special Type Consultation fee may have to be considered for existing GPs as an incentive to become more involved. The provision of on-site Counsellors might be a further incentive.

There are eleven Specialist GP Training Schemes in Ireland who offer a four year training course. In these Training Schemes some teaching on alcohol issues may be given but not in a formalised or indeed in a standardised way. It is to say the least a bit 'hit or miss'. This team agrees that the focus of our efforts should be on trainees in their practice years and their trainers (both those running the courses and those who supervise training in practice). A pilot of a module on Brief Interventions in one of the training schemes would appear to be a good way forward. The availability of the Phepa products on Guidelines and Training would be most helpful in this regard. There would appear to be an absence of personnel who can provide training on Brief Interventions so there will have to be an attempt to 'train Trainers'. We would also propose that Practice Nurses be offered the same training opportunities. It is important to note that such training will provide added value to General Practice in that the skills needed for Brief Interventions can be transferred to other clinical areas. Shortly after the end of the Phepa Study a module should be available for piloting in one of the training schemes.

The ideal scenario would be for modern training on 'Lifestyle type change' and Brief Interventions to be taught at undergraduate level.

The modules can also be used at CME level and the use of CME Tutors should help the information to be disseminated throughout the country.

It would be a priority to help family members who present in primary care and this may well involve the development of another module for use at all levels of Primary Care.

7.5 Funding

A specific recommendation from this report is for funding to be made available to increase the number of practices who are willing to develop services for patients with alcohol problems. This will involve the production of training resource materials, recruitment of counsellors, provision of locums and specific training. A one day training course for twenty GPs/Trainers will cost in the region of €6,000 excluding the cost of locums.

The cost of providing a Counsellor on site for 6 hours per week, with training and resources including brief interventions carried out by the Primary Care staff is estimated to cost approximately €30,000 per year.

Finally, Private Health Insurers should be encouraged to get involved in funding of such activities as the overall health savings have been shown to be considerable. Such initiatives will also save on in-patient bed costs.

7.6 Specialist support and knowledge centres

It may be possible to encourage one of the university research departments to undertake a research/evaluation programme.

The ICGP project can provide specialist support.

Funds would also need to be generated to engage an International Consultant to support this initiative.

7.7 Monitoring the programme

The programme would be monitored by a committee made up of practitioners, researchers, trainers and counsellors as well a Government representative.

The training modules will be evaluated by the participants on the Specialist Training Schemes and will be presented to the main committee.

With regard to clinical practice, each year of the programme the participant practices will be obliged to provide data on their interventions. Performance indicators as to the numbers of patients screened, the numbers of patients helped and referred as well as the lowering of risk categories will be carefully evaluated. Cost effectiveness will also be monitored for practice and training aspects.

7.8 Preparing for the introduction of the programme

The first priority will be to identify the potential trainers and to secure funding.
The new AAP will hopefully provide further evidence for effectiveness of interventions at primary care level.

The concept will need to be 'sold' to the Specialist GP training schemes.

An Implementation Committee should be formed as part of the brief of the new Health Services Executive.

7.9 Managing the programme

If the programme is centrally funded the programme should be overseen by a Government representative but the day-to-day running of the programme should be managed by the ICGP on a national level.

7.10 Communicating about the programme

The network of medical journals and the GPs own magazine 'Forum' will be the main forms of communication on the availability of the programme.

8. Research needs

Amongst other items of research the STFA calls for an independent research and monitoring unit and specific research on young people aimed at understanding attitudes and reducing alcohol related harm. This team would like to see further research on ways of implementing Brief Interventions at Primary Care level. A specific piece of research should be done on alcohol and other drugs and especially the use of alcohol by patients on Methadone maintenance. The new AAP study will be useful to see if the previous results can be replicated. A nationwide AAP Study would also be required.

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Annex One

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PRIMARY HEALTHCARE EUROPEAN PROJECT ON ALCOHOL (PHEPA)

IRISH TEAM REPORT

SUMMARY

- Four Products to be delivered by the study;

  (a) Guidelines for Primary Care

  (b) Training Manual

  (c) Web-site

  (d) Country-based team Reports (this is the Irish Summary)

- Huge increase in alcohol consumption in Ireland over previous decade and corresponding increase in all the indices of harm.

- Concerns over style and patterns of drinking, especially binge drinking.

- Justifiable focus at policy level on public health approach – but little focus on treatment initiatives.

- Strong evidenced links between mortality (N.B. suicide and attempted suicide), physical and psychiatric illness and 'social' harm.

- International evidence for the efficacy of Brief Interventions in Primary Care for reducing consumption and some of the indices of harm. Similar evidence on cost effectiveness in the order of cost/savings ratio of 1:4.

- Irish College of General Practitioners Study on Primary Care and Alcohol 2002-2003 demonstrated efficacy of Brief Interventions in Ireland. One third of patients who received such help made significant improvements.

- Major efforts and (possible incentives) needed to encourage GPs and Practice Nurses to become involved in screening, intervention and treatment on a wider scale.

- Cost of providing Counsellor for six hours per week and training for three GPs approx €30,000 per year.

RECOMMENDATIONS

POLICY

- Counter-advertising to be permitted only by independent health professionals.
- Random tests for drink driving.
- Total ban on advertising and of alcohol sponsorship of sporting and other major events.

TRAINING/EDUCATION

- Funding to be made available for the widespread implementation of modified EU Training Protocols in all GP Training Schemes. Use of 'Train the Trainer' model to develop Brief Intervention skills in Primary Care.
- Modules to also be developed and used at Continuing Medical Education (CME) Meetings.
- Courses on Lifestyle type change and Brief Interventions to be taught at under-graduate level.
- Provide incentives and training for more GPs and Practice Nurses to get involved in Alcohol, Screening and Treatment for patients and families.

TREATMENT

- The funding to be provided to establish Alcohol Counsellors within GP surgeries in every health board area for a substantial number of GPs.
- More studies on Alcohol and Primary Care to develop knowledge and skills bases to more effectively help patients and families.

RESEARCH

- Incentives to encourage more researchers to carry out detailed work on the specifics of 'what works' in Ireland in this area

END

A Country-based strategy for the implementation and integration of early detection and brief intervention in the daily activities of GPs in Italy.

Emanuele Scafato, Allaman Allamani, Tiziana Codenotti, Franco Marcomini, Valentino Patussi, Alessandro Rossi, Rosaria Russo, Pierluigi Struzzo, Piergiorgio Zuccaro and the PHEPA Italian Country Team [10]

[10] For the composition of the Country Team see Appendix

The aim of this contribution is to develop a country-based strategy for the implementation of a programme to integrate interventions for hazardous and harmful alcohol consumption in primary health care settings. The Italian team included representatives from governmental as well as non – governmental organizations, health professional organizations and groups, scientific organizations. Following a track provided by the PHEPA project, the country team has tried, where possible, to identify a series of priorities to be implemented nationwide by means of a programme of actions particularly focused on prevention and health promotion and including targeted approaches for young people. Among the aims of the strategy is to have the strategy endorsed by a number of key partners and stakeholders at the National, regional and local level and to submit the strategy to the Ministry of Health for a possible development of a formalized integration of specific items into the daily GPs activities.

The Italian country based strategy

1. Introduction

The need for an effective action and strategy to tackle the increasing prevalence and incidence of alcohol-related problems and diseases is one among the most debated priorities in Public Health all over Europe. The setting of specific targets or objectives in the National Health Plans currently ongoing in the different EU Countries and the legal documents and Programmes coming from the Council and the Commission as well as the last phase of the WHO European Alcohol Action Plan gave recently a renewed impetus to the need of implementation of interventions and actions for the prevention and the reduction of the harm done by alcohol. Far from being clinical strategies, these actions should be aimed at achieving by means of well-defined specific programmes a higher level of health protection by means of the promotion of healthier lifestyles. The prevalent use of terms as "health determinants" instead of "risk factors" in the more recent National Health Plans in Europe is a good indicator of the evolution of the decision- and policy-making process toward a modern conceptual model positioning health and not disease at the centre of the health strategy, integrating the exclusive and traditional mortality approach used and stressing the need for a reduction of exposure to determinants of diseases and injuries. The early detection of alcohol abuse has been felt in Italy since the 90s as one of the most important outcomes to be achieved to give the best opportunity to individuals to receive the most appropriate preventive intervention to reduce the level of risk linked to inadequate levels of alcohol consumption. The identification and implementation of a methodology using validated tools of screening and of a comprehensive strategy of information and health promotion soliciting the change of personal unhealthy behaviours is the main aim of the present Country strategy harmonized with the common aims of the PHEPA Project.

2. The use of alcohol

2.1 Consumption prevalence and trends

Italy is the first Country in the European Region that achieved the target set by the WHO Health for All strategy of a 25 % reduction in the per-capita alcohol consumption during the period 1980-2000. Looking at the per/capita alcohol consumption Italy reduced by 37 % the average in alcohol consumption during the period 1981-2001(see figure 1). The decrease was slightly higher during the first ten years period 1981-1991.

Fig.1 . Italy. Trends in per capita alcohol consumption during the period 1981-2000

Litres/person/year by main alcoholic beverages and pure alcohol consumption

	1981	1991	2000	2001	2002	1981-1991 Changes (%)	1991-2001 Changes (%)	1981-2001 Changes (%)
Wine	86,2	62,1	51	50	51	-28,0	-19,5	-42,0
Beer	17,9	24,9	28,1	28,9	28,2	39,1	16,1	61,5
Spirits	3,5	2,5	1,2	1,1	0,9	-28,6	-56,0	-68,6
Pure alcohol	11,7	9,1	7,5	7,4	7,4	-22,2	-18,7	-36,8

Source: ISS-OSSFAD from PVGD – World Drink Trends data. Alcohol, health and policy: the Italian perspective. Emanuele Scafato, Piergiorgio Zuccaro, Rosaria Russo and Gloriana Bartoli. ALCOLOGIA, 13 (1), 21-25, 2001 (Updated by the authors 2003)

The decrease in alcohol consumption average was mainly due to the highest contribution from wine as well as spirits consumption being the beer consumption increased constantly.

The use of the per-capita alcohol consumption, usually taken into account to compare trends in time series and to give a rough estimate of the possible burden of alcohol-related problems within the population, is however far from being currently considered in Italy a good indicator for the public health aims and this for two main reasons:

a) it is considered much more representative of the selling than of alcohol use (even if it is linked to the average level of alcohol problems in the population)
b) it doesn't allow us to identify the real distribution of alcohol consumption among individuals and the related patterns of consumption (sex, age, geographical distribution and so on)

Starting from the PER CAPITA consumption and looking at the National as well as Regional Health plans needs it is currently considered much more appropriate for Public Health planning to monitor alcohol consumption by means of indicators related to the analysis of prevalence of consumers and to the patterns of alcohol consumption (specific quantities and modalities) such us:

- Daily alcohol consumption (wine, beer)

- Alcoholic beverages consumption between meals
- Crude quantity (predefined categories) of alcohol and/or frequency of consumption

Prevalence of consumers seems much more appropriate to identify people who are exposed to alcohol as a risk factor. This is also linked to the need to tailor actions and information in a more detailed and targeted way. Furthermore this indicator allows us to estimate the number of individuals who present higher *levels of exposure* to alcohol (distribution by age and gender). Some useful available indicators from ISTAT (National Institute of Statistics) that yearly perform a nationwide health interview survey on lifestyles are the prevalence by sex, age (14+) and geographical distribution of:
- Wine consumers
- Beer consumers
- Consumers of alcoholic beverages between meals
- Consumers of more than 1/2 litre of wine
- Consumers of more than 1/2 litre of beer

According to these indicators, during the period 1998-2000, together with a decrease in the per/capita alcohol consumption various worrying figures arose from the analysis of the above mentioned ISTAT indicators and particularly: an increase in the prevalence of drinkers[11] indicating that the number of people exposed to alcohol-related harm and risk has widened, particularly among adolescents and females;

1. a constant and progressive increase in beer drinkers (particularly among teenagers);
2. an increase in the number of women drinking more than ½ litre of wine daily (and beer for young people)
3. an unexpected upward trend reflecting a change in the traditional modalities of consumption towards drinking between meals and progressively away from the "Mediterranean" habit of consuming moderate quantities of wine at meals (see Tables 2 and 3). For young people, this means that alcohol (mainly beer and spirits) is mainly drunk, not as a "food" as it was previously culturally and traditionally regarded, but increasingly as a substance to be consumed outside family or formal control and according to the well-established modality of binge-drinking observed in northern European countries. Nonetheless wine still remains the main alcoholic beverage consumed by more that 85 % of the population.

[11] From the 1998 baseline, the 2000 year overall prevalence of abstainers dropped from 13.9 to 12.8 % for males and from 38.6 to 36.4 % for females. Accordingly the number of drinkers increased from 86.1 to 87.2 % and from 61.4 to 64.6% for males and females respectively. More detailed statistics from Ossfad (Observatory on Smoking, alcohol and drugs, can be found at the link http://www.ossfad.iss.it/alco/imgs/Tabe.gif, http://www.ossfad.iss.it/publ/ppdf/0009.pdf and http://www.epicentro.iss.it/focus/alcol/alcol.htm).

Tab. 2. Consumers of alcoholic beverages between meals. Males

Prevalence(%) in years 1993-2000 and changes (%) during the period 1995-2000

(%)	1993	1994	1995	1996	1997	1998	1999	2000	Var.% 95-00
14-17 adolescents	9,8	13,4	12,9		18,4	15,2	18,0	16,8	30,7
18-24 young	30,9	36,5	35,2		40,6	39,9	39,3	42,5	20,6
25-44 young adults	37,6	39,5	39,8		42,1	46,2	40,3	39,4	-1,0
45-64 adults	36,8	39,2	39,5		38,7	42,3	36,7	37,3	-5,5
65-74 old	27,0	29,3	28,5		29,8	30,0	26,9	28,2	-1,0
75+ oldest	22,0	18,8	21,6		20,0	21,2	19,1	16,4	-24,4

Tab. 3. Consumers of alcoholic beverages between meals. Females

Prevalence(%) in years 1993-2000 and changes (%) during the period 1995-2000

(%)	1993	1994	1995	1996	1997	1998	1999	2000	Var.% 95-00
14-17 adolescents	7,1	8,0	6,0		10,8	9,7	12,8	12,2	103,7
18-24 young	13,2	15,0	16,5		22,4	20,8	25,2	24,8	50,2
25-44 young adults	12,3	13,2	12,8		15,1	15,4	15,4	15,4	20,7
45-64 adults	9,1	9,9	9,5		11,6	12,4	11,4	10,9	15,1
65-74 old	5,8	5,7	5,1		6,4	6,4	6,2	5,6	9,9
75+ oldest	4,6	3,6	3,9		4,0	3,7	4,0	4,1	3,7

Various reasons may help explain the observed trends; population ageing, new socio-cultural models among the young, as well as reduced purchasing power due to unemployment and reduced income levels. Moreover, family expenditure in Italy on food has tended to prefer quality goods, which differ from traditional purchases. Recent national consumer statistics have shown an increase in family expenditure on medical care and, with regard to food expenditure, on mineral water but not on wine.

Further ISTAT figures showed that total expenditure on beverages is currently 2% of total family consumer spending and 7% of food expenditure. One could predict a further reduction in consumption given changes in traditional patterns of alcohol consumption that occurred during the last ten years and as a consequence of the increased capacity of individuals to question their wine drinking, for example, along with other dietary habits. In conclusion alcohol consumption patterns among the Italian population has changed; young people and women seemed to fill the leading part in this change as well as in the showed reduction in alcohol consumption.

According to the above-mentioned trends and looking at the need to identify the prevalence of drinkers at risk an evaluation has been recently proposed by the Osservatorio Nazionale Alcol – OssFAD at the Istituto Superiore di Sanità. Taking as a reference the amount of daily alcohol consumption actually considered as "at minor risk" (20 grams for females and 40 for males) an evaluation has been done starting from the ISTAT data on the two most consumed beverages: wine and beer.

The results (Tab. 4) show an average of 9,3 % among males and 19,2 % among females of wine drinkers at increased risk with a large regional variation but roughly following a north-south gradient. With a different magnitude and a

much more homogeneous level of increased risk exposure beer drinkers at risk should account 0,4 % of the beer drinkers.

TAB.1 PREVALENCE (%) OF DRINKERS EXCEEDING IDENTIFIED DAILY ALCOHOL LIMITS[2] BY GENDER, TYPE OF BEVERAGES AND REGION

Males				***Females***			
Region	**Wine %**	**Region**	**Beer %**	**Region**	**Wine %**	**Region**	**Beer %**
Valle d'Aosta	n.p	Valle d'Aosta	n.a.	Valle d'Aosta	n.a.	Valle d'Aosta	n.a.
Sicilia	4,5	Friuli-Venezia Giulia	0,0	Sicilia	9,5	Liguria	0,1
Trentino-Alto Adige	6,2	Lombardia	0,2	Calabria	11,8	Toscana	0,1
Lazio	6,9	Veneto	0,2	Sardegna	13,3	Basilicata	0,1
Calabria	7,4	Lazio	0,2	Trentino-Alto Adige	16,8	Sardegna	0,1
Campania	8,4	Abruzzo	0,2	Campania	17,2	Lombardia	0,2
Friuli-Venezia Giulia	8,5	Campania	0,2	Abruzzo	17,8	Veneto	0,2
Puglia	8,9	Trentino-Alto Adige	0,3	Lazio	18,0	Friuli-Venezia Giulia	0,2
Sardegna	9,3	Liguria	0,3	Lombardia	18,6	Molise	0,2
ITALIA	**9,3**	Toscana	0,3	Friuli-Venezia Giulia	19,0	Campania	0,2
Lombardia	9,5	Basilicata	0,3	Molise	19,1	Sicilia	0,2
Liguria	10,3	Sicilia	0,3	**ITALIA**	**19,2**	Piemonte	0,3
Emilia-Romagna	10,5	Puglia	0,4	Veneto	20,3	Puglia	0,3
Veneto	10,6	Calabria	0,4	Basilicata	20,3	**ITALIA**	**0,3**
Piemonte	10,7	**ITALIA**	**0,4**	Puglia	20,4	Trentino-Alto Adige	0,4
Abruzzo	11,3	Emilia-Romagna	0,5	Piemonte	22,4	Lazio	0,4
Toscana	12,8	Marche	0,5	Liguria	23,2	Calabria	0,4
Marche	13,9	Piemonte	0,8	Umbria	23,8	Abruzzo	0,5
Molise	14,1	Sardegna	1,1	Emilia-Romagna	25,4	Emilia-Romagna	0,6
Umbria	14,3	Molise	1,3	Marche	25,7	Marche	0,6
Basilicata	16,0	Umbria	2,6	Toscana	26,7	Umbria	0,7

[2] 20 grams females; 40 grams males

Elab. by National Observatory on Alcohol- OssFAD - ISS on Indagine multiscopo sulle famiglie ISTAT. Year 2001.
(E. Scafato, S. Ghirin, R. Russo. In: Osservasalute 2004 – in press)

The observed trends contributed to seek in the new National health Plan 2003-2005 a renewed effort to implement actions and strategies that can help in:

- Promoting healthier lifestyles and habits (life skills)
- Tackling misleading risk-taking cultures
- Improving settings (family, schools, communities)
- Strengthening health protection of the vulnerable groups
- Decreasing "gradients" within and between groups (inequalities in health) and reduce harm
- Ensuring a wider range of initiatives devoted at the early detection of alcohol abuse.

The latest Annual Report on Drug Dependencies submitted by the *Presidenza del Consiglio* to the Parliament in 2003 clearly described the current situation and launched an alert on alcohol and young people, confirming the reported evidence of an increased role for alcohol as the gateway-drug for the promotion of illegal drugs among adolescents.

The level of attention of the Ministry of Health and of the Italian Government has been recently increased as witnessed by the first Annual Report of the Minister of Health to the Parliament (http://www.ministerosalute.it/dettaglio/phPrimoPiano.jsp?id=204) and by the specific web pages published by the Italian Government (http://www.governo.it/GovernoInforma/Dossier/alcol_relazione/presentazione.html) also in occasion of the third edition of the Alcohol Prevention Day 2004 (http://www.governo.it/GovernoInforma/Dossier/alcol_prevenzione/index.html).

3. The harm done by alcohol

3.1 Health effects 3.2 Social effects 3.3 Economic effects

In 1999, 32,907 alcoholics (25,536 males, 7,371 females) were followed in Italy by the 344 services for the treatment of dependences (SERT) of the National Health Service; the number of people in treatment in the SERT services constantly increased (+34.5 %) during the last four years for which the Ministry of Health data are available (21,509 in 1996, 23,146 in 1997, 26,708 in 1998 - Ministero della Salute. *Rilevazione statistica attività nel settore alcoldipendenza.* 2000). This indicator, far from being exhaustive, is not representative of the prevalence of alcoholics, neither of the people in therapy in Italy as it is not inclusive of the people followed by the private structures, the hospitals, and the self-help groups. To try to estimate the social burden linked to alcohol direct and indirect harm, a recent evaluation on the impact of alcohol consumption on society has been done by the Osservatorio su Fumo, Alcol e Droga (OssFAD)[12] of the Istituto Superiore di Sanità. Looking at the available direct and indirect sources of formal information (ISTAT national surveys) in 2000 the number of alcoholics has been estimated at 1 million of individuals. During the same year the number of people consuming more than 20 grams/day if female and 40 grams/day if man in pure alcohol can be estimated 3 millions (2,4 millions and 600 thousand respectively). The overall yearly social and health cost of alcohol has been recently estimated in 5,600,000 Euros in 2003. 6 % of all the deaths in under 65 years old individuals is a crude estimate of the attributable risk of alcohol in terms of mortality; 10 % of any cancer can be attributable to alcohol and 10 % of any ordinary hospital admission is actually related to alcohol rate increased to 20 % for the urgency admission. Each year 32 % of all the confiscation of drivers' licences is due to alcohol-related episodes. 10,700 out of 237812 road accidents are attributable in 2001 to alcohol with approximately 3,000 out of the 6736 alcohol-related deaths particularly frequent among the youngsters (estimated in 1500, first cause of death among 18-25 years old individuals) and young adults. 34,108 million in Euros is the cost of all the road accidents in 2001 but no estimate is available for the alcohol-related costs. Mortality index (deaths/accidents *100) and lethality index (injured/accidents *100) for drunk driving are 3,5 and 155 respectively being the highest ranked in the list of the causes of road accidents. The total alcohol attributable hospital discharge standardized rates is shown below (Tab 5)

[12] WEB site: www.ossfad.iss.it

❑

Tab. 5 Regional distribution of TOTAL alcohol attributable hospital discharges standardized rates (x 100.000).
(Regions are listed north to south)
By age classes and gender. ITALY . Year 2000
(ICD 9-CM codes: 291, 303, 305.0, 357.5, 425.5, 535.3, 571.0, 571.1, 571.2, 571.3, 977.3, 980)

REGIONE	< = 14 anni		15 - 35 anni		36 - 55 anni		> 55 anni		Any Age
	Males	Females	Males	Females	Males	Females	Males	Females	
Piemonte	3,8	3,6	84,3	27,4	379,3	130,9	483,1	96,2	174,2
Valle d'Aosta	0,0	13,6	264,6	66,1	626,2	239,5	1.283,	319,8	398,0
Lombardia	3,8	2,1	163,0	42,4	434,8	136,1	664,0	123,1	215,8
Prov. Auton. Bolzano	14,9	7,8	343,6	100,3	1.050,	285,0	1.370,	317,1	448,0
Prov.Aut. Trento	14,0	0,0	203,7	43,7	904,0	217,4	1.481,	275,4	421,1
Veneto	4,9	4,1	124,2	37,6	523,3	191,0	851,2	194,0	263,9
Friuli Venezia Giulia	1,5	0,0	86,3	29,6	599,8	199,8	903,5	221,4	300,0
Liguria	4,6	0,0	272,8	87,5	748,5	189,3	521,7	108,2	279,2
Emilia Romagna	3,5	0,9	138,6	49,7	390,1	126,5	449,3	80,8	180,2
Toscana	1,4	5,0	143,7	45,2	301,6	116,6	291,9	85,2	143,2
Umbria	0,0	0,0	48,8	12,6	182,0	45,9	610,3	125,6	153,7
Marche	4,1	0,0	183,8	49,0	490,3	148,5	459,4	86,5	200,9
Lazio	3,4	1,7	131,3	33,3	334,2	82,9	350,0	71,6	137,4
Abruzzo	1,1	4,5	256,4	51,3	554,8	133,2	667,3	104,6	243,2
Molise	8,1	0,0	208,3	21,4	632,4	138,8	605,2	103,1	234,2
Campania	2,6	0,4	68,1	18,4	228,4	46,5	219,6	74,3	80,3
Puglia	5,0	0,9	153,7	31,0	337,9	63,2	316,8	67,4	125,4
Basilicata	9,8	2,1	183,3	48,8	397,5	69,4	496,3	126,9	177,2
Calabria	6,6	1,2	111,2	20,0	354,2	55,6	473,0	122,6	145,3
Sicilia	1,9	0,2	67,8	13,9	248,5	31,9	160,4	43,6	72,5
Sardegna	10,5	2,6	154,3	28,0	434,9	75,0	420,2	81,4	161,1
Italia	**3,9**	**1,8**	**131,6**	**34,5**	**396,4**	**109,5**	**486,9**	**104,8**	**172,2**

SOURCE: MINISTERO DELLA SALUTE. Sistema informativo.

As to patients admitted to hospital ERs because of a road accidents, a study found that 18% of 2,354 individuals had BAC more than 0,50 g/l: they were young males, driving a car or a truck during week end and during night (Fabbri et al., 2002. et al. Positive blood alcohol concentration and road accidents. A prospective study in an Italian emergency department. Emerg Med J l2002;19:210-214)

4. Measures to reduce the harm done by alcohol

Alcohol policy received in Italy during the last few years a formal strengthening by means of the adoption of the "frame" law on alcohol and alcohol-related problems (n.125, 30 march 2001). In line with the European Charter on Alcohol (December 1995), the Ministry of Health set up in 2001 a national Committee to promote and develop an action programme based on the WHO European Alcohol Action Plan (EAAP) strategies. This Committee includes representatives from many Ministries, i.e. Social Affairs, Foreign Affairs, Agriculture, Justice, Labour, Finance, Industry, Education, Transport, as well as experts and officers of the Ministry of Health.

The promotion of primary and secondary prevention, as well as of programmes linked to alcohol abuse and related problems, has found full and formalised implementation in the National Health Plans starting from 1998 through specific targets. In order to reach these targets, a number of strategies and actions have been identified aimed at:

- regulating advertisement of alcoholic products and disseminating explicit warnings as to their alcoholic contents and harmful potential on health;

- initiatives to reduce the alcoholic contents of drinks and to intensify the control of their quality;
- prevention information and education campaigns (at National and Regional levels) aimed at curbing alcohol consumption among specific population groups, such as pregnant women and young people, and/or social contexts, such as schools and barracks;
- initiatives promoting alcohol rehabilitation with the participation of general practitioners, to help heavy drinkers to withdraw from drinking;
- actions to monitor and regulate distribution and sale of alcoholic beverages in community settings, particularly on the occasion of sport and cultural events, and on motorways rest areas;
- tax incentives to curb alcohol consumption ;
- more effective enforcement of regulations on limits of blood alcohol concentrations when driving;
- initiatives promoting a ban on the sale of alcoholic beverages to minors
- reorganization of health services devoted to diagnosis, care and rehabilitation of alcohol
- setting up of an epidemiological network for monitoring of alcohol consumption and alcohol- related diseases (development adequate indicators)
- the reduction of the limits of blood alcohol concentration for safe driving
- recognition and support to the work carried out by NGOs and self-help groups;
- possibility of introduction of alcohology in the teaching curricula of several faculties (medical, social).

All over Europe, the 2001 n. 125 Italian law represents a unique example of implementation of what was established in accordance with the principles of the European Parliament Resolution (12 March 1982) on alcohol related problems in the European Community countries, the Council Resolution and the Resolution of the Government representatives of Member States (29 March 1986) on alcohol abuse, and the World Health Organisation guidelines. Actually this is the only one example of a full endorsement of the WHO European Alcohol Action Plan and of the European Charter on Alcohol principles reported **in the Italian aims at the art. 2 of the law as the aims of the law:**

3.4.1.1 Law 125, 30 march 2001, Art. 2 – Aims

3.4.1.2

3.4.1.3 This law:

a) ensures all people's rights, especially children and adolescents, to a family, community and working life protected from the consequences of alcoholic beverages abuse;
b) fosters access to health and social treatment services for heavy drinkers and their families;
c) promotes information and education on the negative consequences of alcohol consumption and abuse;
d) promotes research and ensures adequate standards of training and updating for professionals dealing with alcohol related problems;
e) supports non-profit non-governmental and voluntary organisations whose aim is to prevent or reduce alcohol-related problems.

During the last decade a strong consensus was achieved on the need to not implement isolated preventive interventions limited to the Primary Health settings but to provide the community with a wider range of actions oriented at the full involvement of the different stakeholders and professionals to ensure the highest gain in producing health and in creating healthier contexts and lifestyles. The law 125 tries to face in a multidimensional way all of the major issues on which good scientific evidence has been provided internationally during the last few years regarding the measures that can help the reduction of alcohol-related harm in the population and particularly:

a) Price and taxes

The rules followed in Italy on price and taxes are those of the EU. The level of excises is currently debated according to the EU need to harmonize taxation all over EU Member States. Beer and spirits have different, increasing level of taxation but wine is not submitted to any excise. The updated information and data can be found on the World Health Organisation Alcohol Control Database (http://data.euro.who.int/alcohol/).

b) Regulating physical availability of alcohol

The regulation of the selling of alcoholic beverages is related to the release of license (see the WHO link above reported for details). There are some possible limitations related to the Local Authority (the Town Mayor) capacity to forbid the sale of alcoholic beverages in the public premises before and during sport events.

c) Modifying the drinking environment
d) Advertising, promotion and sponsorship
e) Information, training and public awareness
f) Drinking and driving
g) Managing alcohol related harm: help and care

Many of the above listed issues refer to the current implementation of the Frame Law on alcohol and particularly to some articles that clearly provide a National guidance and introduce common measures to increase the National, regional and local effort to tackle alcohol risk:

3.4.1.4

3.4.1.5 Art. 3 - National Competencies

1. (omissis) … according to the National and Regional competencies and to the National Health Plan provisions, the following must be identified:
   a) the minimum structural and organisational prerequisites of the services for prevention, treatment and social rehabilitation of people with alcohol related problems and pathologies, considering the number of these services in the community;
   b) the minimum standards of the services' activities identified by the Regions and by the autonomous Provinces of Trento and Bolzano, which have to guarantee the activities listed in letter a) of this article;

c) the monitoring criteria of related data linked to alcohol abuse and alcohol related problems, which must be elaborated and disseminated both at regional and national level;
d) education and prevention activities to be carried out in schools, universities, military environments, prisons and places where youngsters get together.

2. Within 60 days from the date of the law enforcement, the Minister of Internal Affairs shall adopt appropriate rules to tighten road controls during the time of the day when there is a high risk of alcohol related road accidents. Police will be guaranteed additional and improved equipment to enforce controls.

3. Within 30 days from the date of the law enforcement the National Health Service, upon presentation of a medical prescription will supply anticraving and other medicaments employed in alcohol therapy to patients free of charge.

3.4.1.6 Art. 4 – National Committee on Alcohol and

Alcohol Related Problems (Consulta)

1. The National Committee on Alcohol and Alcohol Related Problems (Consulta) is established. Its members are:
   a) the Minister of Social Affairs, who shall be the Chairperson;
   b) three members appointed by the Minister with appropriate and documented professional experience in the field of alcohol and alcohol related problems;
   c) four members indicated by the Permanent Conference for the Relationships between the National Government, the Regional Governments and the Autonomous Provinces of Trento e Bolzano;
   d) the Director of the National Institute of Health (Istituto Superiore di Sanità), or a representative;
   e) one representative of the National Research Council (Consiglio Nazionale delle Ricerche), appointed by the Director;
   f) two members appointed by the Minister of Social Affairs, one proposed by voluntary associations and one proposed by the self-help associations working in this field;
   g) two members appointed by the Minister of Social Affairs, one proposed by the Minister of Agriculture and one proposed by the alcohol industry;
   h) two members appointed by the Minister of Health;
   i) two members appointed by the Minister for the University and Scientific Research;
   j) the President of the Italian Society of Alcohology (Società Italiana di Alcologia) or one representative.

2. (... Omissis)

3. The Committee's activities include:
   a) collaboration for the periodical report to the Parliament about the implementation of the law and the data monitoring;
   b) elaboration of proposals to other Ministries involved in the alcohol issues and to the Regions and the autonomous Provinces to reach the objectives identified in art. 1;
   c) co-operation with international bodies and institutions working in the alcohol field, particularly the World Health Organisation;

4. provision of opinions to other Ministries, Regions and autonomous provinces on any alcohol related issue that is linked to this law's objectives.

3.4.1.7

3.4.1.8 Art. 5 – Modification of University curricula

1. Within 60 days from the date of the law enforcement, university curricula in the field of health, medicine, psychology and social affairs may be required to include specialisation in alcohol related problems.

4 Art 6 - Drink Driving

1. Regarding the requirements to get the driving licence for people who manifest symptoms or behaviours attributable to alcohol related problems, the medical board examining these people must include a medical doctor of the public Service working in the field of prevention, treatment and social rehabilitation of people with alcohol related problems.

2. It is the responsibility of the Minister of Transports to issue decrees suited to guarantee that appropriate training and education on the negative consequences of drink driving is given to driving schools teachers. Alcohol education must be also included in the programmes for new drivers.

3. Blood Alcohol Content limit for driving shall be dropped from 0.8 g/litre to 0.5 g/litre within three months from the date of the law enforcement.

4.1.1.1 Art. 7 – Special warning on medication labelling

1. Possible contraindications of alcohol interaction with medications must be clearly indicated in the labelling of medications, together with the possible risks related to driving after taking the medication.

4.1.1.2 Art. 8 – Report to the Parliament

1. The Minister of Health shall present a report to the Parliament on the implementation of the law, taking into account the reports coming from the Regions.

4.1.1.3 Art. 10 – Treatment in hospital

1. The treatment of patients with alcohol-related problems and pathologies shall be carried out in appropriate medical units within hospitals and public as well as approved private health institutions.

4.1.1.4 Art. 11 – Alcohol Services

1. Within their health and social planning, the Regional governments ..(omissis) can establish new services for those alcohol dependent patients who might need care before being addressed to day-hospital or home treatment.
2. Patients can be offered this care service for up to 30 days.

Art. 12 – Co-operation with other organisations

1. The Regional governments, the Local health Units and the services for prevention, treatment and rehabilitation of people with alcohol related problems and pathologies might co-operate with private voluntary and non-governmental organisations that specialise in this field.

4.2 Art 13 - Alcohol advertising

1. Within six months from the date this law is effective, public and private TV networks together with advertising agencies and the alcohol industries shall adopt a self-regulation code on the rules of alcohol advertising.

3. Alcohol advertising (for alcohol beverages and spirits) is forbidden in the following situations:

   a) in programmes specifically devoted to children and adolescents, and during the 15 minutes before and after the programmes themselves;
   b) if the message suggests that alcohol has therapeutic properties which are not officially recognised by the Ministry of Health
   c) where advertising shows children and adolescents consuming alcohol or representing alcohol intake as a positive attitude.

4. Direct or indirect advertisement of alcohol beverages is forbidden in those environments mainly attended by underage people (18 years old)

5. Radio and television advertisement of spirits is forbidden between 4 and 7 p.m.

6. All kind of spirits advertisement is also forbidden:
a) in daily and periodical press targeting children and adolescents
b) in movie theatres when movies for children and adolescents are shown.

7. Violations of points 2, 3 and 4 are punishable by fines from 2.500 to 10.000 Euros. Fines are doubled for any further violation.
8. Fines apply to the alcohol industries, TV networks, magazine and cinema owners.

4.3

4.4 Art. 14 - Selling of spirits on highways

1. It is forbidden to sell alcoholic beverages exceeding 21% alcohol content (spirits) between 10 p.m. and 6 a.m. in the cafes located in the rest areas along the motorways.

2. Violations are punishable by fines between 2.500 to 5.000 Euros.

4.4.1 Art. 15 – Alcohol in the Workplaces

1. In dangerous job environments for the people's health and safety (to be identified by the Ministers of Health and Labour), it is forbidden to use and to provide alcohol beverages.
2. Alcohol tests in the workplaces can be performed only by the company doctor or by occupational doctors working in the services for prevention and safety in the workplace.
3. Workers who wish to follow treatment for their alcohol related problems will have access to the same facilities and will get the same allowances as drug addicted people.
4. A violation of point 1 is punishable by fines between 500 to 2.500 Euros.

5. The effectiveness and cost effectiveness of interventions for hazardous and harmful alcohol use in primary health care

Ensuring a wider range of initiatives devoted at the early detection of alcohol abuse has been the common aim of four different experiences performed in Italy in four different areas during the last few years and produced evidences that are currently being evaluated to draft a forthcoming National strategy devoted to include early detection and brief intervention activities in the daily work of the Italian NHS General Practitioner.

All these experiences were performed in the Framework of the Phase IV WHO EIBI Project representing a valuable scientific effort to produce the evidence basis for a shared utilisation at the international level of common instruments and methodologies to contribute to the reduction of alcohol-related risk and harm in the individuals and the society. The Italian branch of the WHO EIBI Project involved two different screening units in Florence (the Northwest and the Chianti and Scandicci areas within the Tuscany Region), one in the municipality of Martignacco

in the Friuli Region and a forth unit in the municipality of Padua in the Veneto Region. During the period 1998-2003 a complex process was built on to build strategic alliances, involve and train the GPs in different training courses also including the GPs perception and views on alcohol related problem among their clients, customise the screening and the brief intervention instruments (based on the WHO AUDIT questionnaire and Help people change pack), performing the screening procedures and evaluating the results to be used for the development of a Community alcohol demonstration project actually ongoing for the next 3 years (Phase IV of the WHO EIBI Project).

The *aim* was to promote "responsible drinking" and to prevent alcohol related problems in the sectors of health, school and traffic. The *objectives* were: (a) people in the community acknowledge both the values and the risks of alcohol (b) school teachers produce educational tools together with their students (c) PHC professionals are able to lower or stop their clients' drinking when risky (d) community people are mobilized. The *method* was the following: (a) facilitating interactions in the community and activating local resources to carry out preventive initiatives (b) planning training courses with local schools and health professionals (c) spreading messages produced within the community itself (d) making all the messages from each sector of the Project to appropriately circulate, and getting the local media be informed about all the phases of the Project.

The main results outlined the evidence of a concern for alcohol abuse especially of youngsters, alcohol related violence within the family, drinking and driving, and problems of public order. The traditional drinking pattern, i.e. drinking wine at mealtimes, was felt by GPs as somehow changing. Among suggestions, (a) informing the community by means posters, newspapers, festivals, movies; (b) addressing training courses to different professionals; (c) improving co-operation among sectors were individuated as main instruments to be used at the community level. Barriers emerged (lack of sense of role, lack of time, as example) and the needs for possible incentives were suggested (also in terms of training, communication skills, counseling techniques, positive approach etc). Some more problems have been underlined by GPs, linked to their working setting:

1. they work primarily with adults/elderly people, who have strong cultural beliefs on alcohol;
2. young people rarely go to see their GPs
3. women tend to hide problems related to their alcohol consumption
4. tendency to minimize alcohol consumption by patients
5. GPs themselves have difficulties in asking their patients questions on alcohol consumption

As far as customized training is concerned, the Italian experience showed the need to provide GPs at least with a short but comprehensive training course based on the information and training on alcohol problems and on the standardized use of the customized EIBI package.

During the surveys a sample number of individuals were recruited in different primary care centers of each participant's Center and submitted randomly to AUDIT. People who reported high scores were double-checked with CIDI (Composite International Diagnostic Interview) which was the identified diagnostic tool for dependency. CIDI was shown to be hardly applicable in the PHC settings and some evidences came out on the need to limit to the first 3 items the AUDIT questionnaire.

The possibility to improve the capacity to deal with alcohol problem seems to receive new strength from the above reported experience. The past experience was extremely important to focus the attention on the need for standardised

instruments and methodology and on the development of the local capacity to involve all the possible stakeholders into a community strategy that cannot be limited to the Primary Health Care settings. The need for a much more formalised approach on alcohol-related problems and diseases and the possibility to implement the early detection of alcohol abuse into the daily work of General practitioners by means of validated instruments has start to become a priority in terms of Public Health strategy even if many obstacles and prejudices have to be overcome and many efforts to be made to convince that the common practice will not be affected by difficult screening procedures test and that the cost-benefit ratio will be higher than today. The current feelings and perceptions of GPs in facing the early detection and brief intervention for alcohol abuse, clearly influenced by the burden of the pilot testing procedures, should not been underestimated but taken into account and evaluated accurately together with the other Countries experiences to try to find a common (and easiest) way to tailor new and effective strategy that could help in reduce alcohol risk and harm. According to this the need for a good model of training for the Professionals involved in the preventive strategy seems to be a priority together with a major effort to introduce a common standard of evaluation. The Country adaptation of the EIBI will be a challenge for the forthcoming years together with the setting of a strategy to be implemented in the specific health and social settings.

In terms of implementation of the EIBI strategy, the Istituto Superiore di Sanità (Osservatorio Nazionale Alcol, WHO CC for Research and Health Promotion on Alcohol and Alcohol Related Health Problems, Osservatorio Nazionale Alcol, Centro Nazionale di Epidemiologia, Sorveglianza e Promozione della Salute) is now ongoing in performing in collaboration with the SIMG (Italian Society of General Practitioners) a national project funded by the Fondo Nazionale Droga (Dependences National Funding) of the Presidenza del Consiglio, Ministero del Lavoro e delle Politiche Sociali – Welfare to verify the feasibility of the early detection (AUDIT) and brief intervention in the Primary Health Care settings. Furthermore, the implementation of the IV Phase of the WHO Project is linked to the activities of the national PRISMA project (Italian Project PR.I.S.M.A. Italian project on Prevention, Identification and Strategies Management for Alcohol-related problems) already acknowledged on the international specific website (http://www.gencat.net/salut/phaseiv/) and currently funded for three years by the Presidenza del Consiglio. The demonstration projects will be realised in the four local areas where the EIBI project was performed during the last years involving all the partners that contributed to this specific national EIBI report. Specific original documentation and methodologies have been printed and distributed also by specific web pages (Osservatorio su Fumo, Alcol e Droga-ISS: http://www.iss.it/sitp/ofad/alco/down.html, Società Italiana di Alcologia: http://www.dfc.unifi.it/sia/mese-prevenzione/aprile2004.htm and Alcolonline: http://www.alcolonline.org/alcolday/2004.html) supporting the national setting of the network of strategic alliances including public health, research, scientific and third sector bodies and institution together with a strong commitment of the Italian Society of General Practitioners (SIMG) fully involved in the ongoing funded projects.

Far from being completed the phase IV of the WHO EIBI Project will go ahead through the implementation of the national as well as the European ongoing research and activity particularly by means of the creation of a national strategy as a result of the EU PHEPA project. This will help in achieving both health and social outcomes giving people more opportunities to play an active role in the individual's

as well as the collective process devoted to set healthier contexts and a much safer environment.

5.1 Price and taxes

The rules followed in Italy on price and taxes are those of the EU. The level of excises is currently debated according to the EU need to harmonize the taxation all over EU Member States. Beer and spirits have different, increasing level of taxation but wine is not submitted to any excise.

5.2 Regulating physical availability of alcohol

The regulation of the selling of alcoholic beverages is related to the release of a specific license. Until 1991 (Law n. 524/1974) there were two kinds of licence to sell alcohol beverages: the first to sell wine and beer, another to sell spirits. On and of premises retailer paid also a "delivery tax" to the Municipality Administration (Tassa di Concessione) for the license (on average 100 $ now abolished). The price of the license was variable according to the typology of the store. Since 1991 with Law n. 287 there is just one kind of license to sell all type of alcoholic beverages. The same law has divided up into 3 categories the stores that can apply to the Municipality for a license to sell alcoholic beverages:

Type A – Restaurants and food stores can sell food, any kind of beverages and milk

Type B – Bars and Pubs can sell coffee, any kind of beverages, food, ice creams, sweets and cakes and gastronomy products

Type C – Entertainment premises can sell food and any kind of beverages

At national level it is prohibited to sell/serve beverages containing more than 21 % alcohol between 10 p.m. and 6 a.m. in the cafes located in the rest areas along the motorways. Violations are punishable by fines between 2.500 to 5.000 Euros. It's interesting to observe that this regulation included into the frame law on alcohol in 2001 was adopted in 1998 in terms of a self-regulation, by the network of the Italian Highway Patrol Service Stations (Autogrill).

Regarding further administrative instruments to regulate the physical availability of alcohol on special occasions, there are some possible limitations related to the Local Authority (the Town Major) capacity to forbid the sale of alcoholic beverages in the public premises before and during sport events.

In Italy the minimum legal age for serving or drinking alcohol (but not buying) to young people in the public places is 16 years. The specific law to be mentioned is the Code Rocco (1931). This code linked to the minimum legal age and public order clearly states "16 years – Repeated abuse punished". The level of enforcement it is far from being fully satisfying. Recent data by the Osservatorio Nazionale Alcol OssFAD indicates that more than 800.000 under-aged people (14-16 yrs old) declared in 2001 that they drink alcoholic beverages (full details at http://www.iss.it/sitp/ofad/publ/ppdf/0021.pdf). Furthermore, it is important to remarks that even if a restriction does exists on the minimum legal age for buying alcohol it is not possible to verify the enforcement of this restriction at a private level also within the family. Referring to the Mediterranean culture of drinking in Italy it has to be mentioned that young people are often authorised to drink small amounts of wine by their parents during particular occasion. The situation changes if we look at the occasion of gathering of young people far from the family or other social control. But in this occasions beer (and Alco pops, ready to drink and spirits) and not wine is the preferred beverage and consumption usually exceeds the traditional amounts linked to the family's consumption pattern.

5.3 Modifying the drinking environment
5.4 Advertising, promotion and sponsorship
5.5 Information, training and public awareness

Many of the recent national health promotion, information initiatives were focused in Italy on the need to empower the general population to deal with alcohol problems and to solicit criticism on what is daily submitted to the individual's attention as a "normal" behaviour. Sensitive and vulnerable targets were considered to be young people (the first National Campaign of the Ministry of Health will start on 1st January 2004 : "Amici ma non dell'alcol" - Friends, but not alcohol's friends) and women (for details: Annali dell'Istituto Superiore di Sanità, vol. 40, n.1, 2004 , http://www.iss.it/sitp/ofad/alco/apdf/0018.pdf) . To improve the dissemination of information on alcohol prevention to the population as well as to inform health professionals on the services available at the local level, the Ministry of Health funded since year 2000 to the Istituto Superiore di Sanità the setting of a free phone line TVA- Telefono Verde Alcol 800 63 2000 (http://www.iss.it/sitp/ofad/alco/tva.html). Many Regions have specific initiatives in progress and all of them participate and support the Alcohol Prevention Day and the Alcohol Prevention Month (April) since 2001 (see points 2.1, 7.3, 7.10)

5.6 Drinking and driving
5.7 Managing alcohol related harm: help and care

The analysis of the available evidence on initiatives, actions and strategies effective to curb alcohol-related risk in connection with drinking and driving as well as the management of alcohol-related help and care were taken fully into account by policy makers and by the Government and drove the set up and the current implementation of the last law on alcohol (already reported in the fourth paragraph). Many regions have programs, projects and campaigns aimed at decreasing the social and health burden linked to the high mortality and disability of drinking and driving context and to increase road safety particularly for young people. The introduction on the driving license of a penalty of 6 "points" (D.L. 27 giugno 2003, n. 151) for drivers exceeding 0.5 blood alcohol content (BAC) control by police helped in decreasing the alcohol-related accidents in year 2003 (when 20

points are registered on the driving license people are obliged to pass the examination for a new license; during this period people are not allowed to drive)

6. Current policies and activities

An overview of existing legislation and country based alcohol policy. An overview of the current situation for interventions in primary health care.

6.1 Alcohol legislation
See at point 4 and 5

6.2 Interventions in primary health care
See at point 4

7. Integrating preventive interventions in primary health care

7.1 Principles
A brief description of the principles on which the programme will be based
To develop an integrated strategy for the early detection of alcohol abuse and the implementation of an evidence based programme aimed at the reduction of the health and social harm done by alcohol in the general population.

The possibility to implement an effective programme on early detection and brief intervention in the daily work of the GPs is clearly linked to the need to improve the knowledge by means of providing them a specific cultural, educational as well as vocational training supporting an improvement in the level of GPs knowledge, competence and role on alcohol at the community level hopefully achieved by means of a training on some main issues and principles listed at point 7.3.

Starting from the need to provide a healthier lifestyle perspective and following a "general population" approach, the individuals at risk should be clearly identified according to a standardized methodology and submitted to a brief intervention to try to reduce the level of consumption and risk of alcohol-related harm as well. The screening tools should perhaps allow to identify people already with alcohol-dependency to be channelled towards appropriate level of care and rehabilitation at the local level. Drinkers whose alcohol consumption will be detected as below the "risky" limit according to the identified screening procedure, will receive in any case information on the possible risks for the health related to alcohol consumption and abuse according to the WHO principle "Less is better". The full range of preventive and clinical responses should be provided by the programme and clearly differentiated according to the different level of alcohol consumption, abuse or addiction detected by the established screening standard. A general information and communication strategy should be used aimed at improving the individuals' awareness of the possible risk related to alcohol use, supporting the change towards healthier lifestyles and behaviour and putting individual role at the centre of his own "salutogenesis" process. A major effort should be made to integrate all the new scientific evidence on alcohol and health into the traditional Mediterranean culture of drinking, avoiding prescriptions or bans but producing positive messages mentioning the advantages of the moderation (either restraining on not drinking) and providing an objective information on alcohol consumption never isolated by

the lifestyles context. A possible action related to the implementation of the programme should be the development of a specific strategy aimed at increasing the community capacity to deal with alcohol problems. This strategy will involve, where possible, local administrators, health and social professionals, school educators and all the possible stakeholders that can interact with the community and the individuals to help people change. Finally, an effective communication strategy should be addressed at policy decision makers soliciting the values linked to the programme implemented at the community level and the need to integrate the health promoting and preventing approach with specific initiatives and or campaigns on health risk reduction.

7.2 Practice based guidelines, protocols and aids.
A description of the guidelines, protocols and aids that may or may not need developing.

WHO Phase IV guidelines will represent a good basis for the identification of clients at risk and for subsequent brief intervention by GPs and PHC professionals. The general approach will integrate the concept of alcoholism (usually referred to few people) together with the concept of alcohol as a risk factor for the community soliciting the need for a change in the specific perception by GPs. Country adapted EIBI should be the working tool. Dealing with alcohol issues in PHC would not receive an adequate consideration by professionals if not supported by a strong motivation. It was felt basic in the outlining of the protocol to stress the role of the professionals in the overall strategy. In terms of strategy GPs will be represent the corner stone into a comprehensive strategy hopefully aimed at the exchange of "good practice" and involving the network of the services of the National Health System as well as of the municipality. The integration of such a network will be instrumental to the full implementation of the strategy and to improve the effectiveness of the preventive programme at the level of the community. The key point is to support a GPs in their daily work to let them be more involved in problematic and risky drinkers management. A new professional should be reshaped by the training programme aimed at creating new skills and expertise in counselling on alcohol problems as well as in promoting healthier lifestyles.

7.3 Training
A description of the training that may or may not need to be implemented.

The training of the professionals will be based on a specific course devoted to general information, early detection, and brief intervention and alcohol dependency management. The time devoted to these four items should be 6 hours (20 % for general information, 20% for early detection, 40 % for brief intervention, and 20 % for alcohol dependency management). A one-day full immersion meeting, organised in 2 sessions, 3 hours per session will introduce the Country adapted EIBI pack specifically including:

1. Early identification of alcohol related problems and brief intervention
2. Principles of identification and awareness of the risks related to the use of alcoholic beverages
3. Principles of health promotion in specific settings

4. Principles of networking in the local community (involvement of local
5. administration and politicians)
6. Principles of continuity of care and of continuity of rehabilitation and care
7. Principles of general population preventive approach
8. The role of subsidariety, intersectorial and inter-istitutional co-operation

- Special topics 1: the family, the community, the professional roles, the empowerment of the individuals, the communication of the risk
- Special topics 2: young people and alcohol, drink driving, multi-users

Training should be developed aiming at:
1. raising the local community awareness by involving the different stakeholders regarding the risks of alcohol consumption
2. identifying "essential" basic training and more in-depth sessions with an multidisciplinary perspective
3. identifying an updating programme embedded in the local community
4. building a link between professional knowledge and the local community through the practical instrument of training

General practitioners have a natural role in this issue, but other PCH workers must be involved, in a multi-disciplinary approach.

The training course for the GPs will include alcohol experts from the different fields of expertise (clinical, epidemiological, communicational and so on) and at least one GP as teacher and/or tutor (the direct training and the "training the trainer" should be the basic models). It should not exceed two comprehensive sessions to be organised by means of lectures, role-playing, and group discussion. It will be crucial to develop improving GPs communication skills with their clients enabling an individuals' reaction to risky drinking behaving and supporting an active motivation to change unhealthy lifestyles. Training should be extended, whenever possible to other PHC workers such as nurses, hospital doctors and so on. Basic elements should be provided on how to perform EIBI inside daily working hours.

The already ongoing experience of the "Progetto Integrato per la Prevenzione dell'Alcoldipendenza" currently coordinated and monitored by the Istituto Superiore di Sanità and related to the early detection and brief intervention of alcohol abuse activities performed by 100 GPs all over Italy will be helpful in refining the guidelines for the implementation of the activities including those related to the training period that should be lowered in terms of hours depending by the outcomes and the feedback coming from the trained GPs. Further feedback will come from the use of the specific materials that have been already produced for GPs as well as for the general population and for at-risk population by the Istituto Superiore di Sanità in collaboration with the SIA and many other selected experts, acknowledged by the Ministry of Health and published on specific web-pages for the free-download, dissemination and use (Osservatorio su Fumo, Alcol e Droga-ISS: http://www.iss.it/sitp/ofad/alco/down.html, Società Italiana di

Alcologia: http://www.dfc.unifi.it/sia/mese-prevenzione/aprile2004.htm and Alcolonline: http://www.alcolonline.org/alcolday/2004.html)

7.4 Engaging primary health care providers
The strategies that are going to be used to engage primary health care providers in the programme.

As to the GPs the previous experiences in Italy shown that the best results were achieved by means of the full involvement of GPs in terms of co-leaders of a Project and of the training organisation, rather than just be the object of a community project, or a target of an education program. As to the other PHC professionals, who are spread in the communities, the programme will take into account any possible form of active co-operation between professionals and with those involved in the continuity of care services.

The role of PHC workers within the local community will have to be mentioned, stressed, and a close association with the Mayors should be evaluated and created where possible. The importance of the specific role of local alcohol and health prevention programme from one side and of the contribution of a Public Health intervention according to the aims of the Project will be clearly outlined to the GPs as well as to the policy-decision makers providing them with all the available evidences on the advantages arising from the Project's activities. The involvement of GPs associations (also local) and individual GPs at the very beginning is considered a crucial point for the positive outcome of the programme. Summarising: after the training course, finding and working with the motivated practitioners should be the first step. After a strong group has been created, more GPs will join in. A well-defined communication strategy will facilitate this process.

7.5 Funding and reimbursement
How much the programme is going to cost; sources of funding; reimbursement of the providers for their activity and reimbursement of clients for their costs.

As to sources of funding, the programme should be written in order that also private associations or groups that focus on solution of social needs may be interested and involved. Funding is needed for the national working group to start the project, to propose the first training course and to create a local leading group. No incentives have to be provided for all the PHC workers if a widespread, routine action and if the specific preventive interventions are appropriately proposed to the Public Health bodies and, better, to the Ministry of Health including them in the daily work of GPs according to the community's need to deal with all the lifestyles determinants and with alcohol prevention as a specific issue to be faced by means of a developed Country strategy. A possible financial incentive could be provided for the new role of the PHC worker within the local community (Health Promoter) but it has to be agreed and arranged only in accordance with the National and Local Health authorities as well as representatives of the GPs. Furthermore, If the programme will be agreed at the community level, funding can be asked to both public and private sectors.

7.6 Specialist support and knowledge centres

It is likely that the effectiveness of the programme will be enhanced when there is support by specialist services and/or by specialist research and knowledge centres that provide the up to date and necessary information.

In Italy a small number of alcohol and health education specialists should be appointed at the Regional level to provide the necessary information. In some Regions, Regional School for the Training of General Practitioners could be involved; all over Italy the Istituto Superiore di Sanità is the technical body of the National Health System and the recognised Public Health body acting as a knowledge as well as scientific and specialist National centre for research, training, evaluation and monitoring. Specialist support in Italy could be provided by the Osservatorio Nazionale Alcol – OssFAD (ISS), the WHO CC for research and health promotion on alcohol and health related problems, well-known researchers in the field, together with scientific and professionals' societies like SIA (Società Italiana di Alcologia) and the SIMG (Italian Society of GPs).

7.7 Monitoring the programme

The Country strategy and the Project implementation include a baseline data collection as well as an interim and a final check of the intervention programme. So, depending by the number of individuals submitted to the programme, many different indicators might be used to monitor the outcomes. Where the community programme will be implemented into a well-defined area such as a small local municipality the main indicators should be:

- Prevalence of alcohol consumers according to the different levels of alcohol consumption
- Change in patterns of alcohol consumption at the end of the intervention programme and particularly:
- Prevalence of alcohol drinkers that decreased the amount of alcoholic intake
- Hospital discharge rates for alcohol-related problems before and after the programme of intervention

Further indicators should be related to a random enquiry (questionnaire) to the professional involved on the

- Self-perceived quality of the work done
- Self-perceived quality of the interactions between GPs and the other professionals involved

Finally a questionnaire should be submitted to the clients asking them for the level of satisfaction

7.8 Preparing for the introduction of the programme

What needs to be done to prepare for the implementation of the programme.

Building alliances is necessary with the political, administrative scientific and local groups (cfr WHO Phase iv Study). Creating partnership of GPs representatives and associations will be basic to ensure the full involvement of the Local Health Units and Service and of the community's municipality as well. The preparation of a written strategy, of the related materials and

the organizations of few well-managed meetings will put in the optimal condition the presentation and the starting of the programme. It will be a priority to develop a good communication strategy and to organise local conferences to announce and promote the programme.

7.9 Managing the programme
By whom and how will the programme be managed at a country/regional level.

Alcohol and health education specialists, and GPs and other PHC professionals should be included among those one who will manage the program. A national coordination will be provided as well as a steering group involving at least one coordinator from each Region. A scientific committee will monitor the activities carried out advising the coordinators on the possible best practices to be used.

7.10 Communicating about the programme

The development of a communication strategy to communicate to the providers about the programme and to the clients about the availability of the programme.

The communication strategy can be organized according to the different stages of the programme. Starting with the need to involve GPs in the process of the creation of renewed professional skills it will be basic to outline their role in dealing with alcohol problems and to provide them with the evidences of the results of the previous experiences in the field of the EIBI. The production and dissemination of booklets (actually The Italian Society of GPs has adopted for specific programmes the booklet produced by SIA, ISS and AICAT "GUIDA: Guida Utile alla Identificazione Dei problemi Alcolcorrelati; http://www.iss.it/sitp/ofad/alco/apdf/libr_6.zip") aimed at the dissemination of the available information related to the adequacy and the responsibility of the role of GPs in identifying the risky behaviours in the wider field of lifestyles together with a summary of possible actions to be integrated in the daily work will constitute the initial core of the communication strategy before the beginning of the programme. It has to be mentioned that the training courses focusing on the practical aspects of this approach represents in itself a crucial part of the communication strategy that will take into account the needs and the perception of the GPs of what is feasible and realistically applicable in terms of timing and already available resources. All efforts should be made to apply the standard agreed at the European level to help improve the level of comparison of the outcomes of the programme. Periodical information to the GPs involved in the programme will be produced by the National coordinator to keep the network aware of the interim results as well as on the possible solution to the problems related to the application of the study protocol. A further initiative is linked to the forthcoming possible approval of the research project MEDICOM (Communication Model for health promotion and prevention programmes by GPs) already agreed between the ISS and SIMG and submitted to the Ministry of Health.
Finally the dissemination of the results, after the evaluation, will make available the information to be exchanged within the targeted community by means of a specific communication strategy involving the media at local, regional and national level and spreading the advantages of the adopted health promoting approach. The community will be made aware of the availability of the programme by means of a communication strategy agreed with the professional associations, the

municipalities and all the clients involved in the programme will receive complete information on the possible advantages arising from the participation to the programme performed in the GPs bodies. A National preventive campaign on alcohol will be launched together with the start of the strategy; this will be made possible according to the institutional role of the Istituto Superiore di Sanità actually involved and collaborating in the planning of the forthcoming National Campaign (year 2005) funded and realized by the Ministry of Health. To improve the dissemination of information on alcohol prevention to the population as well as to inform health professionals about the services available at the local level, the Ministry of Health funded to the Istituto Superiore di Sanità the setting of a free phone line (Telefono Verde Alcol 800 63 2000). Furthermore a series of meeting could be arranged involving all the possible stakeholders at the local level; in this filed Italy has since 2002 organized the Alcohol Prevention Day in April, currently promoted by the Italian Society of Alcohology (SIA) and the Italian Club of Alcoholics and Treament (AICAT) as an annual event to spread alcohol-related health aimed at the reduction of alcohol-related harm (see specific web-pages for full description: http://www.iss.it/sitp/ofad/alco/down.html, http://www.dfc.unifi.it/sia/mese-prevenzione/aprile2004.htm, http://www.aicat.net/Attualita.htm, http://www.alcolonline.org/alcolday.html). The Alcohol Prevention day has been acknowledged by the Ministry of Health, by the Presidenza del Consiglio (First Minister Office), many of the Ministries of the Italian Government and by all of the Italian Regions as well as the Association of the Italian Municipalities (ANCI) and is supported by many association such as ANPAS and Alcoholic Anonymous.

8. Research needs

An identification of future research needs.

The possibility to improve the capacity to deal with alcohol problem seems to receive new strength from the above reported experience. The Italian experience was extremely important to focus attention on the need for standardised instruments and methodology and on the development of the local capacity to involve all the possible stakeholders into a community strategy that cannot be limited to the Primary Health Care settings. The need for a much more formalised approach on alcohol-related problems and diseases and the possibility to implement the early detection of alcohol abuse into the daily work of General practitioners by means of validated instruments has started to become a priority in terms of Public Health strategy even if many obstacles and prejudices have to be overcome and many efforts to be made to convince people that the common practice will not be affected by difficult screening procedures test and that the cost-benefit ratio will be higher than today. The currently reported feelings and perception of GPs in facing the early detection and brief intervention for alcohol abuse, clearly influenced by the burden of the pilot testing procedures, should not been underestimated but taken into account and accurately evaluated together with the other Countries' experiences to try to find a common (and easiest) way to tailor new and effective strategy that could help reduce alcohol risk and harm. According to this the need for a good model of training for the Professionals involved in the preventive strategy seems to be a priority together with a major effort to introduce a common standard of brief intervention and consequent evaluation. The Country adaptation of the EIBI will be a challenge for the forthcoming years together with the need to implement methodologies and specific approaches on early detection and consequent interventions aimed at preventing people becoming alcohol dependent. A general observation has to be made on the opportunity to develop and implement

at the general population level and for all of the individuals negative at the AUDIT questionnaire a communication strategy for the prevention to be oriented not only at reducing alcohol harm but at increasing the awareness of the increased risk (particularly among youngsters) of an unhealthy lifestyle where alcohol, but more often smoking, inappropriate dietary habits or low levels of physical activities are coming to represent the most common figures all over the population.

In terms of implementation of the EIBI strategy past experiences demand a careful reading of the needs of the GPs particularly those related to the adaptation of the AUDIT in the Italian Primary Health Care Settings[13].

Looking at the gaps in current research outcome it will be instrumental to the spreading and full implementation of the EIBI Country adapted approach the support and the development of projects aimed at the evaluation of the influence of the early detection and brief intervention of alcohol abuse within the general population in decreasing the alcohol related harm and risk as well as about the evaluation of the effectiveness of GPs and PHC professionals role in the community, regional and national levels. Specific researches, studies, surveys and projects should be devoted to:

- epidemiological studies (determinants of alcohol patterns of consumption and harms due to alcohol) particularly on young people often never utilising PHC services and widening the EIBI approach focussing on peculiar settings such as schools, working places, hospitals;
- qualitative evaluation of the overall impact of health promoting programmes (focus groups with clients and with key persons in the community; evaluation of the interaction between health professionals and their clients);
- alcohol and communication skill training and periodical follow up evaluation, as a start to support the promotion of further preventive studies at the PHC level;
- studies on the level of satisfaction of the clients as well as of the GPs.

Finally, there is the need to provide policy makers, health professional and citizens with a formal monitoring system on alcohol allowing and improving the capacity to deal with alcohol problem; this is particularly felt taking into account the need to monitor health status and alcohol related-harm for the most vulnerable targets of population such as young people, women and the elderly as well as some contexts such as drink-driving, workplaces and educational and recreational sites (schools, universities, pubs, discos, sport event places etc.).

The strategy so far outlined would have hopefully the final result of freeing the potential of the GPs as well as of the PHC professionals and to stimulate the involvement of all the public health partners and stakeholders to contribute to a healthier society and an increase in the Italian population's wellness and well being.

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[13] a) Rivista SIMG.Numero 4, 2001. Abuso di alcool e prevenzione: la ricerca "Drinkless". Gloriana Bartoli, Valentino Patussi, Alessandro Rossi , Emanuele Scafato. **http://www.simg.it/servizi/servizi_riviste2001/numero4/3.htm**

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Appendix

PHEPA Italian Team

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Primary Healthcare European Project on Alcohol (PHEPA)

2002-2005

Country based report for the Netherlands

Table of Contents

1. Introduction

1.1 The PHEPA project

This country based strategy is developed in the context of the EU-project "Integrating Health Promotion Interventions for hazardous and Harmful Alcohol Consumption into Primary Health Care Professionals' daily work" (PHEPA = **P**rimary **H**ealth Care **E**uropean **P**roject on **A**lcohol). The project is funded by the European Union as part of the Community Action Programme on Public health and is co-ordinated by the Programme on Substance Abuse, Health and Social Security Department, Government of Catalonia in Barcelona. It started in 2002 and continued till the midst of 2005. A total of 16 countries in the EU took part in the project, together with Eurocare and the WHO.
The aim of the PHEPA project is to develop best practices across member countries on the prevention, management and treatment of alcohol problems in primary care. The following four related products have been developed:

1. *Clinical Guidelines* for Primary Care
2. *Training manual* for primary health care professionals
3. *Web site* database on good practice, providing the evidence base in the domains of efficacy, economics, health and policy
4. *Country based Reports* from all participant countries.

Both guidelines and training manual will be adapted for use in the participating countries. In the Netherlands, the main ideas of the European clinical guidelines already have been (partly) integrated in the Dutch guideline on problematic and harmful alcohol use for general practitioners. The Dutch guideline was written simultaneously with the European guidelines (see §7.2.1.).
Furthermore, summaries of both clinical guidelines and training manual will be literally translated into the languages of the participating countries. The clinical guidelines are not only intended for primary health care professionals (physicians and nurses) but also for the managers, educators, funders and evaluators of primary health care services.

This document is the country report of The Netherlands. It summarizes the relevant context for The Netherlands, the composition of the Dutch central working group and of the broader Dutch Partnership, as well as the proposed strategy for dissemination and implementation within The Netherlands. Amongst others this country report will serve as input for the Alcoholprevention Action Plan to be written in 2005 (see §7.1). The Dutch country report and the Alcoholprevention Action Plan will be jointly presented to the Ministry of Health, Welfare and Sport.

1.2 The Dutch partnership

For a number of reasons, the PHEPA project came at a very important time for the Netherlands. Firstly, the Ministry of Health, Welfare and Sport mentioned in its policy paper on prevention in 2003 that it is considered a problem that the Dutch primary health care does not use the strategies that are known to be effective in detecting hazardous and harmful alcohol consumption (early screening) and in reducing alcohol consumption (minimal interventions) (ministerie van VWS, 2003).
Furthermore, the Dutch College of General Practitioners (NHG) has been working on a revision of the standard guidelines for GP's in 2003 and 2004, whereas the Dutch Institute for Healthcare Improvement (CBO) and the Netherlands Institute of Mental Health and Addiction (Trimbos Institute) are working on a new multidisciplinary guideline for all the aspects of prevention and care concerning alcohol use disorders. All three organizations are willing to work together in the development of the Dutch strategy as one of the outcomes of the PHEPA project. A

complete list of the organisations that are represented in the Dutch country based team is given in Annex 1. The Dutch country based team has met on several occasions in the period 2002-2005.

The simultaneous development of the multidisciplinary guideline for diagnosis and treatment of alcohol abuse and alcohol dependence has inspired the Dutch country based team to expand the scope of the PHEPA project beyond primary care to public health care on the one hand and secondary and tertiary health care on the other hand. The country based team took the initiative to form a broader Partnership and invited representatives from several medical disciplines, research institutions, and policy makers. The aim of the Partnership is closely linked to the aim of PHEPA but somewhat broader. The aims of the Partnership are:

1. to address the shortcomings in the use of effective help to reduce the harm done by alcohol;
2. to increase the involvement of the health care sector in the provision of help for the prevention of alcohol use disorders;
3. to create a platform for a coordinated and sustained approach to the prevention and management of alcohol use disorders ("concerted action");
4. in the long term, to support the Ministry of VWS in reaching its target of reducing the proportion of hazardous and harmful alcohol consumption, thus reducing the health, social and economic costs caused by alcohol.

Concrete aims and intentions of the Partnership are given in shaded areas throughout this document.

The successful Partnership *Stop met Roken* (Partnership on smoking) serves partly as a model for the evolving Partnership on alcohol. The Partnership on smoking has brought together partners from a wide range of organizations to work together to increase the availability of services and support for smoking cessation (De Witt et al., 2004). A complete list of the organisations that have been invited to join the Dutch Partnership on alcohol is given in Annex 2. In 2004 two meetings of the Partnership took place.

1.3 Outline

This report starts with the prevalence of problematic alcohol use in the Netherlands (§2) and with the consequences of problematic alcohol use for the individual and society (§3). The next section (§4) discusses measures that have proven to be effective in reducing the harm done by alcohol while paragraph 5 highlights the role of primary health care in this process. In paragraph 6 the alcohol policy and alcohol legislation in the Netherlands is summarized. Finally, recent and future steps that have to be taken to improve alcohol prevention and alcohol care in the Netherlands are summarized in the main paragraph of this document (§7). The last section (§8) deals with the structure and functioning of the evolving Partnership on alcohol.

2. The use of alcohol

2.1 Terminology

The World Health Organization classifies alcohol use disorders as intoxication, harmful use and dependence (WHO, 2002). *Intoxication* is defined as a transient condition resulting in disturbances in level of consciousness, cognition, perception, affect or behaviour or other psycho-physiological functions and responses. *Harmful use* is defined as a pattern of alcohol use that is causing physical (for example, cirrhosis of the liver) or mental (for example, episodes of depressive disorder secondary to heavy consumption of alcohol) damage to health. The *dependence syndrome* is defined as a cluster of physiological, behavioural, and cognitive phenomena in which the use of alcohol takes on a much higher priority for a given individual than other behaviours that once had greater value. Although not part of ICD-10 nomenclature, the term *hazardous use* is commonly used, defined as a level or pattern of consumption that is likely to result in harm should present consumption patterns persist.

In the Netherlands, hazardous use is defined as a week consumption of more than 14 standard glasses for women and a week consumption more than 21 standard glasses for men. Besides these week limits, daily limits are defined as maximum 3 glasses a day for women and as maximum 5 glasses a day for men. In the Netherlands, a standard glass contains 10 grams of alcohol. These limits serve only as a guide. For some people (e.g. pregnant women) and in some situations (e.g. traffic, work) it's recommended not to drink at all (NIGZ, 2005). The Dutch term *problem drinking* might be seen as the equivalent for harmful use. A problem drinker is defined as a person who drinks above a certain level and experiences physical, social or psychological problems related to his/her alcohol use (Van Dijck & Knibbe, 2005). In the Netherlands, *binge drinking* is defined as drinking at least once a week six glasses or more (CBS, 2005).

The international Diagnostic and Statistical Manual of mental disorders (DSM) uses a somewhat different terminology: alcohol abuse and alcohol dependence. *Alcohol dependence* is a cluster of cognitive, behavioural, and physiologic symptoms that indicate that the person has impaired control of alcohol use and continues use despite adverse consequences. *Alcohol abuse* is characterized as a maladaptive pattern of alcohol use that does not meet the criteria for dependence. The maladaptive pattern of use is indicated by either continued use despite knowledge of having a persistent or recurrent social, occupational, psychological, or physical problem that is caused or exacerbated by the use of alcohol, or recurrent use of alcohol in situations when use is physically hazardous (e.g., driving when intoxicated) (APA, 1994).
In this paper *alcohol misuse* is used as a generic term for the various maladaptive patterns described above.

2.2 Alcohol use in the Netherlands

Drinking alcohol is nowadays deeply rooted in Dutch society. Alcohol consumption rose dramatically from about 2 litres alcohol per capita a year in the early 1950s to over 9 litres in the late 1970s. Since 1990 the consumption has stabilised at around 8 litres per capita a year (7,9 litre in 2003). Among 15 European countries, the Netherlands occupied the 10th place in 2002 (Van Laar et al., 2005).

In the Netherlands, alcohol use is monitored by the Central Agency for Statistics (CBS). Most people, i.e. 82% of the population aged 12 and above, drink alcohol once in a while (CBS, 2004). This is a slight increase compared to the early

nineties. More men (87%) than women (77%) drink once in a while; drinking men consume on average 1,7 glass a day while drinking women consume on average 1 glass a day (CBS, 2004). Van Dijck & Knibbe (2005) report an even higher percentage (88%) of alcohol users; again more men (94%) than women (82%) drink alcohol. The percentages abstainers are relatively high (18%) among women between 25-34 and between 55-69 years of age.

Alcohol use starts at a young age (Monshouwer et al., 2004). In secondary education, over half of the pupils had a drink in the month prior to the survey (actual users). Particularly popular are low-alcohol refreshers, which constitute an important introduction to alcohol also for elementary school children. The Netherlands occupies the number 1 position as regards frequent alcohol consumption among school children (drinking 10 times or more past month) in comparison with Europe and the US (Hibell et al., 2004).

The three wave longitudinal NEtherlands MEntal health Survey and Incidence Study (Nemesis) was held among more than 7000 respondents aged 18-65 years (Verdurmen et al., 2003). In 1996, hazardous alcohol consumption was prevalent among 10% of the Dutch population between 18 and 65 years of age. More men (14%) than women (6%) had a consumption pattern that can be defined as hazardous (more than 21 glasses a week for men, more than 14 glasses a week for women). A small percentage of the population (2%) drank excessively: 2,4% of the men drank over 50 glasses a week and 0,8% of the woman drank over 35 glasses a week. Alcohol abuse, as measured by the Composite International Diagnostic Interview (CIDI), was prevalent among 5% of the population, and was again more frequent among male (7%) than among female (2%) drinkers. Alcohol dependence, also measured by the CIDI, occurred less frequently than alcohol abuse: 4% of the total population (men 6%; women 1%) was diagnosed as alcohol dependent. In absolute figures, the Netherlands has approximately 820.000 cases of alcohol misuse (alcohol abuse and alcohol dependence). The incidence of new cases is high, there are approximately 328.000 new cases in a three year period.
All forms of alcohol misuse described above are much more frequent among men than among women. Especially alcohol abuse, and to a lesser extent alcohol dependence, decline with age. Education works differently for men and women. Well educated women and less well educated men have a higher chance of alcohol misuse. Other risk factors for alcohol misuse are: having experienced youth traumas or having parents with alcohol problems, living in an urban area, unemployment (men only) and neurotic personality (women only). For men a protective factor is living together with a partner, while for women being a housewife decreases the chance of alcohol misuse (Verdurmen et al., 2003).

About one in five men and one in twenty women are binge-drinkers: they drink at least six glasses at one occasion once a week (CBS, 2004). Just as alcohol abuse, binge drinking is concentrated in the younger age groups, with almost four out of ten 18-24 years old male and one out of eight 18-24 years old female having a pattern of binge-drinking in 2003. In 2003, 15% of men and 4% of women drank on average 3 glasses or more a day. The CBS figures thus show a strong resemblance with the Nemesis figures of 1996.

In 2004 the first national study of problem drinking (the Dutch equivalent for harmful alcohol use) showed that 10,3% of the Dutch population between 18-69 years can be considered problem drinkers (Van Dijck & Knibbe, 2005). Four times more men (16%) than women (4%) are diagnosed as problem drinkers. People

with commitments (partner, work) are less at risk of developing problematic drinking patterns than people without such commitments.

In the Netherlands, just as in other European countries, a process of increasing demographic ageing takes place. In general, the prevalence of various forms of alcohol misuse (especially binge-drinking) is lowest among older people. However, older people do not yield to younger people in every way. This becomes clear when looking more closely at drinking patterns (abstainers excluded from analysis). On average, men and women in the youngest age category (16-24 years) drink more on weekend days than men and woman in the oldest age category (55 -69 years), but the reverse pattern is found for weekdays (Monday – Thursday). When looking at the total week consumption, both the youngest and the oldest men drink about 15 glasses a week. The oldest women drink even more than their younger counterparts (9 glasses as opposed to 7 glasses on average a week) (Van Dijck & Knibbe, 2005). CBS reports the highest percentage of women drinking >3 glasses each day in the age group of 55-64 year (9%). In all other age groups this percentage amounts to up to 5%.

The Dutch Partnership on Alcohol considers older people as one of the target groups for alcohol prevention.

3. The harm done by alcohol

3.1 Health effects

Whereas alcohol use disorders (the toxic effects of alcohol, alcohol intoxication and alcohol dependence) contributed to 3.5% of the global burden of disease in 1990, the proportion had increased to 4% in the year 2000, and to at least 9% in European countries (World Health Organization 2002). Overall, injuries account for the largest portion of disease burden, with 40% in total, and with unintentional injuries by far outweighing intentional injuries. The second largest category is alcohol-attributable neuropsychiatric diseases and disorders with 38%. Other alcohol-attributable non-communicable diseases (diabetes and liver cirrhosis), malignant neoplasms and cardiovascular disease each contribute 7% to 8% of the total. These are net figures, for which the alcohol-related beneficial effects on heart disease have already been subtracted. They do not include the social costs of alcohol. Overall, the detrimental effects of alcohol on disease burden by far outweigh any beneficial effects (Anderson, 2003).

In the Netherlands, 6,6% of the burden of disease, that is 12,5% of the burden of disease in men and 2,3 percent of the burden of disease in women, can be attributed to alcohol misuse (expressed in disability adjusted life years, DALY's). Alcohol misuse is the lifestyle factor responsible for most of the loss to quality of life, especially by alcohol dependence, stroke and coronary heart diseases. For men, alcohol dependence is the disease with the highest loss of quality of life (Van Oers, 2002). Alcohol dependent people have a two times higher chance on mood disorders and a three times higher chance on anxiety disorders than people without a diagnosis of alcohol dependence. Women (but not men) with alcohol abuse are also more at risk for these psychiatric disorders (Verdurmen et al., 2003).
Alcohol misuse is after smoking, physical inactivity, and bad food habits the fourth main cause of death (Van Oers, 2002). In the Netherlands, cause of death is officially registered by CBS following the ICD 10 nomenclature. According to CBS statistics, approximately 1800 people die each year as a consequence of alcohol misuse of which three quarters are male. Since 1995 there is an increase in alcohol related mortality among women (Verdurmen, Van der Meulen, & Van Laar, 2004).

Alcohol can lead either directly (through liver disease and neuropsychiatric diseases) or indirectly to a premature death. As a secondary cause of death, alcohol plays a role in cardiovascular diseases and malignant neoplasm's. When the official death figures are corrected for under registration, it is estimated that between 3000 and 4.000 people die each year in the Netherlands as a consequence of hazardous and harmful alcohol consumption (ministerie van VWS, 2000). Under registration is certainly present when the role of alcohol in traffic is considered. In 2003, 71 traffic deaths and over 1000 serious casualties (that had to be taken to hospital) were officially registered. In reality these figures are estimated almost three times higher at 250 and 3500 respectively.

In 2003, the number of alcohol clients in outpatient care was 26.874; this is a considerable increase with respect to 2002 (23.849 patients) and 2001 (22.388 patients). The increase is a result of the Alcoholcare Action Plan 2002-2004 that aimed to enlarge the reach of professional alcohol services. In the mid nineties, the number of patients in outpatient care was approximately 20.000 (Van Laar et al., 2005). The increase of clients in outpatient care can be ascribed to elderly people (> 55 years) more often seeking help. Within the last ten years, the percentage of >55-clients in outpatient care has risen from 12 to 18% (IVZ, 2005).
Nearly one third of the clients visit the outpatient care for the first time. The majority of the patients (75%) are male, the mean age is 44 years. People wait long before they reach out for help. Over 40% of the patients have a sickness history of at least ten years before visiting a care worker. One out of four patients in 2003 visited the outpatient care for the first time. A considerable number of patients (42%) have a criminal past; a criminal history is less common among older patients (22%).

In the year 2003, the number of hospital admissions directly related to hazardous alcohol consumption was approximately 4.000 and the number indirectly related 10.000. These figures apply to general hospitals. In addition, over 6000 patients were submitted to addiction clinics and addiction departments of psychiatric hospitals (figures from 1996; later figures are missing).
Each year about 13.000 people visit an emergency department due to alcohol misuse. Of these injuries, 18% are intentional injuries (such as suicide attempts with alcohol and medicine), 25% are traffic injuries and 50% concern other unintentional injuries. These figures are an underestimation because not nearly all accidents where alcohol is involved are registered as such (Van Laar et al., 2005). Recent research at emergency rooms in the Netherlands shows that 5 – 18% of all visitors use alcohol prior to their visit. Patients positive for alcohol are more likely male and between 48-58 years of age. They are also more likely to be a frequent excessive drinker and to have injuries as a result of violence (Vitale et al., submitted).

Approximately 35-55% of women continue to drink alcohol while pregnant, especially Dutch, higher educated and older women (Boon & Huiberts, 2005). The number of new born FAS children lies around 350 each year; children with some but not all symptoms of the FAS syndrome included (ministerie van VWS, 2000).

3.2 Social effects

Among the social effects of alcohol are:

1. Violence

The NIAAA (1997) cites the following percentages of violent offenders who were drinking at the time of the offence: up to 86 percent of homicide offenders; 60

percent of sexual offenders; 57 percent of men and 27 percent of women involved in marital violence; 37 percent of assault offenders; and 13 percent of child abusers. These figures are the upper limits of a wide range of estimates.
Recently, the association between violence and alcohol was confirmed in Dutch research. People who drink large amounts of alcohol in the weekend (9 glasses or more) and people who are at least once a month under influence have a two times higher chance to be involved in violent incidents as an offender compared to people who drink less. The chances of being involved as a victim are up to three times higher for people who are at least once a month under influence of alcohol (Van der Linden et al., 2004).

2. Domestic violence and harm done to family and social networks.
In the Netherlands, 8% of adults say that during their youth one or both parents had a drinking problem: in most cases (65%) the father, in 29% of the cases the mother, and in some cases (6%) both parents were drinking (Cuijpers, Langendoen, & Bijl, 1999). Children of alcoholics have a higher chance to develop alcohol problems later in life. They also are more at risk for a wide range of physical and psychological problems and poor school results.
In the Netherlands there is a website for (adult) children of alcoholics (www.drankjwel.nl) as well as a website about the topic for professionals (www.drankjewelpro.nl).

3. Unprotected and unintentional sex
Adolescents who use alcohol more often have high–risk sex, such as having multiple sexual partners and failing to use condoms. The link between high–risk sex and drinking is dependent on the quantity of alcohol consumed. The probability of sexual intercourse is increased by drinking small amounts of alcohol, but decreased by drinking heavier amounts that result in feelings of nausea, passing out, or mental confusion (NIAAA, 2003).

4. Loss of productivity at work
Both on-the-job drinking as well as heavy drinking outside of work can lead to alcohol-related job performance problems. Drinking at work, problem drinking, and frequency of getting "drunk" in the past 30 days are positively associated with loss of productivity at work (through absenteeism, arriving late or leaving early, doing poor work, doing less work, and arguing with co-workers). Although drinking rates vary among occupations, alcohol-related problems are not characteristic of any social segment, industry, or occupation. Drinking is associated with the workplace culture and acceptance of drinking, workplace alienation, the availability of alcohol, and the existence and enforcement of workplace alcohol policies (NIAAA, 1999). In the Netherlands, 5% of the working population is a problem drinker. Problem drinking is especially high in the following sectors: catering, agriculture, fishery, construction industry, and service industries. Employees that have been involved in an industrial accident have higher than average levels of alcohol consumption. Besides a tolerant drinking culture at work, an unsafe working environment appears to be positively associated with drinking (Schutten, Van den Eijnden, & Knibbe, 2003).

3.3 Economic effects

It is estimated that the economic cost to Dutch society is €2,57 billion per year (KPMG, 2001). Compared to figures from 1994, this is an increase of 17 percent. The National Institute of Public Health and the Environment (RIVM) prepares new data on the social costs of alcohol misuse.

Cost of alcohol related problems in the Netherlands (set year 2000)

Social costs	
Health care (general care)	115 million
Addiction care (specialized care)	67 million
Cost of alcohol related crime (road accidents included)	839 million
Loss of output due to alcohol related absence from work	1549 million
Total	2570 million

The Dutch Partnership on alcohol recommends an update of these figures. The Partnership also recommends studies that will provide insight into the cost-effectiveness of treatment and prevention of alcohol misuse.

4. Measures to reduce the harm of alcohol

The aetiology and the course of alcohol use disorders are to a large extent explained by behavioural, environmental and life course factors. Alcohol use disorders can be described as environmentally responsive clinical disorders; they are readily responsive to environmental policy factors, such as the price of alcohol and regulations on the availability of alcohol, all of which are effective in reducing a wide range of harm such as liver cirrhosis, motor vehicle fatalities, homicides and crimes in both heavier and lighter drinkers; they are also readily responsive to treatment, whose impact is likely to be enhanced in the presence of effective environmental policies.

A RECENT AND COMPREHENSIVE WHO-SPONSORED REVIEW OF POLICIES INTENDED TO REDUCE ALCOHOL-RELATED HARM (BABOR ET AL., 2003), CONCLUDES WITH A TABLE LISTING ALL THE POLICY-RELEVANT STRATEGIES AND INTERVENTIONS IDENTIFIED BY THE AUTHORS WITH RATINGS FOR EACH ON FOUR SCALES (TABLE 16.1, PP. 264-6). THESE ARE: EFFECTIVENESS, BREADTH OF RESEARCH SUPPORT, TESTED ACROSS CULTURES AND COST TO IMPLEMENT AND SUSTAIN.[14]

"EFFECTIVENESS" REFERS TO THE JUDGEMENT THAT IT IS REASONABLE TO MAKE FROM THE AVAILABLE SCIENTIFIC EVIDENCE REGARDING A STRATEGY'S EFFECTIVENESS IN REDUCING ALCOHOL CONSUMPTION, ALCOHOL-RELATED PROBLEMS OR THEIR COSTS TO SOCIETY AND IS RATED: 0 LACK OF EFFECTIVENESS; + LIMITED EFFECTIVENESS; ++ MODERATE EFFECTIVENESS; +++ HIGH DEGREE OF EFFECTIVENESS; AND ? NO STUDIES UNDERTAKEN OR INSUFFICIENT EVIDENCE ON WHICH TO MAKE A JUDGEMENT. "BREADTH OF RESEARCH SUPPORT" REFERS TO THE NUMBER OF SCIENTIFIC STUDIES AND THE CONSISTENCY OF RESULTS BEARING ON A PARTICULAR STRATEGY AND IS RATED: 0 NO STUDIES OF EFFECTIVENESS UNDERTAKEN; + ONLY ONE WELL-DESIGNED STUDY OF EFFECTIVENESS; ++ 2-4 STUDIES OF EFFECTIVENESS; +++ 5 OR MORE STUDIES. "TESTED ACROSS CULTURES" IS CONCERNED WITH THE DIVERSITY OF GEOGRAPHY AND CULTURES WITHIN WHICH A STRATEGY HAS BEEN APPLIED AND TESTED AND IS RATED: 0 NOT TESTED ADEQUATELY; + STUDIED IN ONLY ONE COUNTRY; ++ STUDIED IN 2 TO 4 COUNTRIES; +++ STUDIED IN 5 OR MORE COUNTRIES. FINALLY, "COST TO IMPLEMENT AND SUSTAIN" ESTIMATES THE RELATIVE MONETARY COST TO THE STATE TO IMPLEMENT, OPERATE AND SUSTAIN A STRATEGY REGARDLESS OF EFFECTIVENESS AND IS RATED: LOW; MODERATE; AND HIGH. THE TABLE ALSO INDICATES THE TARGET GROUP FOR THE STRATEGY (GENERAL POPULATION; HIGH-RISK DRINKERS OR VULNERABLE GROUPS AND PERSONS ALREADY SHOWING HARMFUL DRINKING OR ALCOHOL DEPENDENCE) AND MAKES OTHER COMMENTS. MEASURES ARE GROUPED ACCORDING TO GENERAL CATEGORY OF STRATEGY OR INTERVENTION.

[14] The summary of the book *Alcohol, no ordinary commodity*, is written by Prof. Nick Heather and the UK team for the Phepa project and is cited by the Dutch team with permission.

THE SINGLE STRATEGY WITH THE HIGHEST RATINGS IS "TAXATION AND PRICING" WHICH OBTAINS '+++' FOR ALL THE FIRST THREE SCALES ABOVE AND A LOW COST TO IMPLEMENT. IT IS OBVIOUSLY TARGETED AT THE GENERAL POPULATION AND EFFECTIVENESS DEPENDS ON GOVERNMENT OVERSIGHT AND CONTROL OF ALCOHOL PRODUCTION AND DISTRIBUTION, ALTHOUGH IT IS NOTED THAT HIGH TAXES CAN INCREASE SMUGGLING AND ILLICIT PRODUCTION. APART FROM THIS SINGLE STRATEGY, THE CATEGORY OF MEASURES WITH THE HIGHEST EFFECTIVENESS RATINGS IS "REGULATING PHYSICAL AVAILABILITY", WITH FOUR STRATEGIES OBTAINING MAXIMUM EFFECTIVENESS INCLUDING "MINIMUM LEGAL PURCHASE AGE", "GOVERNMENT MONOPOLY OF RETAIL SALES" AND "SERVER LIABILITY". THE FIRST TWO OF THESE ARE RATED '+++' FOR BREADTH OF RESEARCH SUPPORT, '++' FOR CROSS-CULTURAL TESTING AND LOW FOR COST TO IMPLEMENT.

OTHER STRATEGIES WITH HIGH RATINGS OCCUR IN THE CATEGORY "DRINK-DRIVING COUNTERMEASURES", WITH "RANDOM BREATH TESTING", "LOWERED BAC LIMITS" AND "LOW BAC FOR YOUNG DRIVERS" ALL OBTAINING '+++' FOR EFFECTIVENESS. THE CATEGORY SHOWING THE LOWEST EFFECTIVENESS RATINGS IS "EDUCATION AND PERSUASION", WITH "ALCOHOL EDUCATION IN SCHOOLS", "COLLEGE STUDENT EDUCATION", "PUBLIC SERVICE MESSAGES" AND "WARNING LABELS" ALL OBTAINING '0' FOR EFFECTIVENESS. MEASURES IN THE CATEGORIES OF "ALTERING THE DRINKING CONTEXT" AND "REGULATING ALCOHOL PROMOTION" SHOW A MIXTURE OF EFFECTIVENESS RATINGS, WITH "ENFORCEMENT OF ON-PREMISE REGULATIONS AND LEGAL REQUIREMENTS" AND "COMMUNITY MOBILISATION" SHOWING MODERATE EFFECTIVENESS ('++') BUT HIGH COST TO IMPLEMENT.

THE CATEGORY OF STRATEGIES OF MOST RELEVANCE TO THE PRESENT DOCUMENT IS "TREATMENT AND EARLY INTERVENTION". IN THIS CATEGORY, "ALCOHOL PROBLEMS TREATMENT", "MUTUAL HELP/ SELF-HELP ATTENDANCE" AND "MANDATORY TREATMENT OF REPEAT DRINKING-DRIVERS" ARE GIVEN RATINGS OF LOW EFFECTIVENESS ('+'). ALCOHOL PROBLEMS TREATMENT IS CONSIDERED TO HAVE HIGH BREADTH OF RESEARCH SUPPORT ('+++'), HIGH CROSS-CULTURAL TESTING ('+++') AND HIGH COST TO IMPLEMENT. OF MOST IMMEDIATE INTEREST HERE, "BRIEF INTERVENTION WITH AT-RISK DRINKERS" OBTAINS AN EFFECTIVENESS RATING OF '++' (MODERATE EFFECTIVENESS), '+++' FOR BREADTH OF RESEARCH SUPPORT, '+++' FOR CROSS-CULTURAL TESTING AND A MODERATE COST TO IMPLEMENT. THE TARGET GROUP IS HIGH-RISK DRINKERS. THE TABLE FURTHER NOTES THAT: "PRIMARY CARE PRACTITIONERS LACK TRAINING AND TIME TO CONDUCT SCREENING AND BRIEF INTERVENTIONS".

5. THE EFFECTIVENESS AND COST EFFECTIVENESS OF INTERVENTIONS FOR HAZARDOUS AND HARMFUL ALCOHOL USE IN PRIMARY HEALTH CARE[15]

THERE IS GOOD EVIDENCE THAT SCREENING AND BRIEF ALCOHOL INTERVENTIONS DELIVERED IN PRIMARY HEALTH CARE (PHC) ARE EFFECTIVE IN LEADING TO REDUCED ALCOHOL CONSUMPTION AMONG HAZARDOUS AND HARMFUL DRINKERS, WITH CONSEQUENT BENEFITS FOR PATIENTS' HEALTH AND WELFARE. THERE IS ALSO GOOD INTERNATIONAL EVIDENCE THAT PHC BRIEF INTERVENTIONS ARE HIGHLY COST-EFFECTIVE. HOWEVER, DIFFICULTIES HAVE BEEN ENCOUNTERED IN PERSUADING PHC PROFESSIONALS TO INCORPORATE SCREENING AND BRIEF INTERVENTIONS (SBI) IN THEIR ROUTINE WORK AND OBSTACLES TO THIS IMPLEMENTATION, AS WELL AS THE POTENTIAL INCENTIVES, HAVE BEEN STUDIED. THIS SECTION WILL EXAMINE THE EVIDENCE FOR EACH OF THESE ASSERTIONS IN MORE DETAIL.

[15] Section 5 was prepared by Prof. Nick Heather and the UK team for the Phepa project and has been adapted slightly for this report. Detailed references are given for this section at the end of the bibliography.

5.1 EFFECTIVENESS OF SBI

THERE IS A VERY LARGE BODY OF RESEARCH EVIDENCE ON ALCOHOL BRIEF INTERVENTIONS, INCLUDING AT LEAST 56 CONTROLLED TRIALS OF EFFECTIVENESS[1]. THERE HAVE ALSO BEEN AT LEAST 13 META-ANALYSES AND/OR SYSTEMATIC REVIEWS[2-13], USING SOMEWHAT DIFFERENT AIMS AND METHODS, OF RESEARCH ON EFFECTIVENESS, WITH FIVE OF THESE SPECIFICALLY FOCUSED ON PHC[4,6,10,11,13].

IN WHAT IS GENERALLY CONSIDERED TO BE THE MOST COMPREHENSIVE AND WELL-DESIGNED META-ANALYSIS OF BRIEF INTERVENTIONS[1], THE STUDIES INCLUDED WERE DIVIDED INTO 34 "OPPORTUNISTIC" BRIEF INTERVENTIONS CARRIED OUT IN GENERALIST SETTINGS AMONG INDIVIDUALS NOT SEEKING TREATMENT FOR ALCOHOL PROBLEMS AND 20 "SPECIALIST" BRIEF INTERVENTIONS AMONG THOSE WHO ARE SEEKING TREATMENT.[16] IT IS THE FORMER GROUP WHICH IS OF SOLE INTEREST HERE, SINCE THERE ARE MARKED DIFFERENCES IN LENGTH, CONTENT AND STYLE OF BRIEF INTERVENTION AND METHODOLOGICAL FEATURES BETWEEN THE TWO GROUPS OF STUDIES[14]. FROM THE STUDIES OF OPPORTUNISTIC INTERVENTION, SMALL TO MEDIUM AGGREGATE EFFECT SIZES IN FAVOUR OF BRIEF INTERVENTIONS EMERGED ACROSS DIFFERENT FOLLOW-UP POINTS. AT FOLLOW-UP OF 3-6 MONTHS OR MORE, THE EFFECT FOR BRIEF INTERVENTIONS COMPARED TO CONTROL CONDITIONS WAS SIGNIFICANTLY LARGER WHEN INDIVIDUALS SHOWING MORE SEVERE ALCOHOL PROBLEMS WERE EXCLUDED FROM THE ANALYSIS.

THERE IS MIXED EVIDENCE OF LONGER-TERM EFFECTS OF SBI. A TRIAL OF PHC-BASED SBI IN WISCONSIN, USA REPORTED CONTINUING BENEFITS FOR ALCOHOL USE, BINGE DRINKING EPISODES AND FREQUENCY OF EXCESSIVE DRINKING AMONG RECIPIENTS OF SBI COMPARED WITH CONTROLS FOUR YEARS AFTER INTERVENTION[15]. HOWEVER, AN AUSTRALIAN STUDY REPORTED THAT THE BENEFITS OF RECEIVING SBI HAD DISAPPEARED AFTER 10 YEARS[16]. A 10-16 YEAR FOLLOW-UP SAMPLE RECRUITED IN A WELL-KNOWN SWEDISH STUDY OF SBI THAT WAS CARRIED OUT AS PART OF A HEALTH SCREENING PROGRAMME[17] SHOWED REDUCED MORTALITY IN THE INTERVENTION GROUP BUT IT IS QUESTIONABLE WHETHER THIS STUDY CAN BE REGARDED AS EXAMINING BRIEF INTERVENTION BECAUSE OF THE LENGTH AND DURATION OF THE ORIGINAL INTERVENTION SESSIONS. NEVERTHELESS, THERE IS SOME EVIDENCE THAT SBI REDUCES ALCOHOL-RELATED MORTALITY[9], ALBEIT FROM A SMALL NUMBER OF STUDIES. THERE IS ALSO EVIDENCE THAT SBI IS EFFECTIVE IN REDUCING ALCOHOL-RELATED PROBLEMS AMONG THOSE WHO RECEIVE IT[17].

WITH REGARD TO SBI SPECIFICALLY IN THE PHC SETTING, THE MOST RECENT SYSTEMATIC REVIEW AND META-ANALYSIS[13] CONCLUDED THAT BRIEF ALCOHOL INTERVENTION IS EFFECTIVE IN REDUCING CONSUMPTION AMONG BOTH MEN AND WOMEN AT 6 AND 12 MONTHS FOLLOWING INTERVENTION. IT IS NOTEWORTHY THAT THIS REVIEW WAS CONFINED TO STUDIES CARRIED OUT IN MORE NATURALISTIC CONDITIONS OF PHC, EXCLUDING THOSE STUDIES THAT USED PATIENT LISTS, REGISTERS OR SPECIALLY-ARRANGED SCREENING SESSIONS. ANOTHER RECENT REVIEW[10] CONCLUDED THAT THEIR META-ANALYSIS, ALTHOUGH INDICATING A SMALLER EFFECT SIZE THAN REPORTED IN PREVIOUS PAPERS, NEVERTHELESS SUPPORTED THE MODERATE EFFECTIVENESS OF SBI. NO CLEAR EVIDENCE OF A DOSE-EFFECT RELATIONSHIP WAS FOUND IN THIS ANALYSIS, MEANING THAT THE SUPERIOR BENEFITS OF RELATIVELY LONGER INTERVENTIONS COULD NOT BE DEMONSTRATED. YET ANOTHER RECENT REVIEW, BY THE US PREVENTIVE TASK FORCE[11], FOUND THAT "BRIEF COUNSELLING INTERVENTIONS FOR RISKY/HARMFUL ALCOHOL USE AMONG ADULT PRIMARY CARE PATIENTS COULD PROVIDE AN EFFECTIVE COMPONENT OF A PUBLIC HEALTH APPROACH TO REDUCING RISKY-HARMFUL ALCOHOL USE" (P.557).

[16] The opportunistic intervention groups were compared with no intervention control groups. The specialist intervention groups were compared with groups receiving extended treatment. There were no differences on the outcome measures between the specialist brief intervention groups and the extended treatment groups.

5.2 COST-EFFECTIVENESS

THE DIRECT COST OF A BRIEF INTERVENTION DELIVERED TO HAZARDOUS OR HARMFUL DRINKERS WAS CALCULATED TO BE ONLY £20 PER PERSON IN 1993[3]. A RECENT WHO STUDY[19] ESTIMATED THAT THE COST-EFFECTIVENESS OF PHC ALCOHOL BRIEF INTERVENTIONS FOR HAZARDOUS AND HARMFUL DRINKING IS APPROXIMATELY £1,300 (STERLING) PER YEAR OF ILL-HEALTH OR PREMATURE DEATH AVOIDED. IT SHOULD BE NOTED THAT THIS IS NEARLY EQUIVALENT TO THE COST-EFFECTIVENESS OF SMOKING CESSATIONS INTERVENTIONS IN PHC WHICH IS ABOUT £1,200. OTHER MEDICAL INTERVENTIONS HAVE AN AVERAGE COST-EFFECTIVENESS OF £30,000.

IN A COST-BENEFIT ANALYSIS OF THE EFFECTS OF A GP-BASED BRIEF INTERVENTION AFTER FOUR YEAR, FLEMING AND COLLEAGUES IN WISCONSIN, USA[15] ESTIMATED THAT, FOR EVERY $10,000 INVESTED IN SBI, A SAVING IN HEALTH CARE COSTS WOULD BE OBTAINED OF $43,000. THE BENEFIT-COST RATIO INCREASED WHEN THE SOCIETAL BENEFITS OF FEWER MOTOR VEHICLE ACCIDENTS AND CRIME WERE INCLUDED IN THE ANALYSIS.

5.3 IMPLEMENTATION

Despite this evidence of effectiveness and cost-effectiveness, many studies have documented a wide gap between actual and recommended good practice in PHC based on research evidence. As one illustration of this, Kaner and colleagues[20] reported findings from a questionnaire survey of general medical practitioners (GPs) in the English Midlands. Results showed that GPs did not to make routine enquiries about alcohol, with 67% enquiring only "some of the time". The fact that 65% of GPs had managed only 1-6 patients for excessive drinking in the last year was striking in view of evidence that approximately 20% of patients attending primary health care are likely to be at least hazardous drinkers[21]. Given figures on GPs' average list size in the UK, this suggests that the majority of GPs may be missing as many as 98% of the excessive drinkers presenting to their practices. A household survey in England, published in 1996 found that, of current and former drinkers who had spoken to a medical practitioner or other health professional in the last year, only 7% (men = 12%; women = 5%) reported having discussed alcohol consumption with their GP at the surgery[22]. This low level of intervention exists against a background in which many patients expect that their GP should be interested in alcohol-related problems but only a minority think that they are actually interested[23].

Research has also focused on identifying the obstacles to implementation of SBI in PHC, with a good convergence of findings from different studies in different countries. The main obstacle appears simply to be lack of time among busy health care professionals[20,24]. Other obstacles are: (i) lack of appropriate training to carry out SBI; (ii) little support from government health policies; (iii) a belief that patients will not take advice to change drinking behaviour; (iv) a lack of suitable screening and counselling materials; (v) lack of reimbursement from government health schemes[20]. At the same time, health professionals may fear offending patients by raising the topic of drinking and find it difficult to do so[25] and some may have negative attitudes to patients with drinking problems derived from their experience of those with more severe problems. Some of these identified obstacles are simply overcome (e.g. availability of SBI training and screening and counselling materials) but others present more serious difficulties.

When GPs are asked what incentives would be required to enable them to carry out SBI, many mention training and support[20]. There is indeed good evidence that when GPs and nurses are adequately trained and supported for this work, SBI activity increases[26]. However, there is also evidence that support should be geared

to the needs and attitudes of health professionals to be effective and avoid being counterproductive in the longer term[27].

Other incentives mentioned by GPs are: (i) if SBI were proven to be successful; (ii) if patients asked for advice about alcohol consumption; (iii) if public health campaigns made society in general more concerned about alcohol; (iv) if quick and easy counselling materials were available; (v) if salary and working conditions were improved; (vi) if training programmes for SBI were available[20]. Again, some of these incentives are readily provided while others are not.

It is possible to increase the engagement of GPs in screening and giving advice for hazardous and harmful alcohol consumption. Implementation strategies that were alcohol-specific and consisted of different strategies (multicomponent programms) resulted in higher screening and advice-giving rates compared to respectively prevention programs in which alcohol was included and single component programs. No differences were found between educational-based or office-based interventions.[27]

6. Alcohol policy and legislation

6.1 Alcohol policy

The policy on alcohol in the Netherlands aims to promote moderating alcohol consumption and to limit the risks it poses to family and working life, traffic safety and nightlife. Since developing a cohesive approach is essential, various ministries are involved in policy on addiction. The Ministry of Health, Welfare and Sport is responsible for care and prevention (public information and legislation), the Ministry of Justice for law enforcement, and the Ministry of Transport, Public Works and Water Management for policy on drinking and driving.

Main target groups of the Ministry of Health are youthful drinkers and (ex)-problem drinkers. In 2004 the percentage of problem drinkers was 10% among the16+ population (16% male, 4% female problem drinkers) (Van Dijck & Knibbe, 2005). A problem drinker is defined as a person who drinks above a certain level and experiences physical, social or psychological problems related to his/her alcohol use. The Ministry of Health, Welfare and Sport aims to reduce the percentage of problem drinkers to 8% (Ministry of VWS, 2000). Six groups of diseases were given high priority in 2003. Alcohol dependence was mentioned in the group psychic disorders (Ministerie van VWS, 2003). As mentioned in §1, the Ministry feels that the Dutch primary health care should use the strategies that are known to be effective in detecting hazardous and harmful alcohol consumption (early screening) and in reducing alcohol consumption (minimal interventions) (ministerie van VWS, 2003). The aims of the Partnership on alcohol are thus in line with the aims of the Ministry.
The Ministry of Health, Welfare and Sport explicitly stimulates working with stepped-care trajectories, in which every client receives the help that has proven effective given the seriousness of the complaints. The idea is to catch alcohol problems at an early stage, so that people do not unnecessarily end up in specialised secondary care. Therefore, the Ministry wants to strengthen primary care. Secondary care must also tie in better with other services, be better tailored to clients' needs, and give them more choices for treatment. Recently, two initiatives have been implemented to improve alcohol care.

1. The Alcoholcare Action Plan 2002-2004 was a financial pulse meant to reduce the waiting lists in the care and treatment of drug addicts. In 2005 the money will be structural.

2. Another initiative from the Ministry of Health, Welfare and Sport is the programme "Between the Lines". Mental health and addiction workers receive additional money to give advice to primary health care workers. It appears that primary health workers, and especially the general practitioners who are responsible for 84% of the consultations, consult their colleagues from the mental health and addiction care only seldom concerning alcohol and drug abuse (only 555 of 28.000 cases concern alcohol or drugs) This can be considered a missed chance because specialist advise is especially fruitful with diseases (like alcohol misuse) that occur frequently and are at the same time difficult to refer to addiction centres (Verhaak, Zantinge, & De Boer, 2003).

In the Netherlands, public health care (preventive care) and curative care are not strongly integrated because of separate financing. Approximately 1 -2% of the budget for health care is spent on public health care. Public health care is the responsibility of municipal authorities and carried out by 39 municipal health services (GGD). Municipal authorities are legally obliged to make a local health policy paper each four years.

The Partnership on Alcohol aims to support local authorities in forming effective health policies. In 2005, the Partnership will write a working plan for municipal governments on an integral approach on alcohol prevention.

Curative health care is financed by a social health insurance system. In this system, most people are compulsorily insured under the Social Health Insurance Act (Ziekenfondswet). Only people with a higher income have a choice: they can take out a health insurance or they can decide to go through life uninsured. Under the government's plans a new health insurance system for curative healthcare for all residents of the Netherlands will come into force on 1 January 2006 (Zorgverzekeringswet). In the new system the legislation and funding of mental health services are brought more into line with the rest of the health sector.

In the Netherlands (mass)-media campaigns that promote alcohol moderation have been carried out since 1986. Since 1996 the campaign is organised by the Netherlands Institute of Health Promotion and Disease prevention (NIGZ). Sixteen regional offices that operate as preventive departments of treatment facilities are responsible for the national campaign at the regional level.

Alcoholics can receive treatment at regional addiction centres, clinics, psychiatric hospitals or regional institutes for outpatient mental health care. Treatment of alcoholism in the clinical and outpatient settings is primarily the responsibility of the Ministry of Health, Welfare and Sport. Treatment of alcoholism in the ambulatory setting on the other hand is primarily the responsibility of local authorities (Municipal Health Services). For most patients, treatment is free of charge and varies from counselling to admission to a clinic. Care workers are mainly doctors, social workers or psychologists.

6.2 Alcohol legislation

The alcohol control system in the Netherlands consists of three laws: The Alcohol Licensing and Catering Act, which regulates the distribution of alcohol into society; The Commodity Act, which regulates the quality of alcoholic beverages; and the Road Safety Act, which regulates the legal blood alcohol concentration (BAC) limit in traffic.

Since 1974, the Road Safety Act prohibits to drink and drive if the BAC level is higher than 0.5 promille. A new law, that will come into force in the near future, lowers the blood alcohol level for novice drivers who have had their license less than 5 years to 0.2 promille. In the Netherlands, BAC level is measured by breath testing. An offence is punishable by a prison sentence for a blood alcohol content over 2,5 promille and by a fine and licence suspension or only a fine for lower BAC levels. Since 1996, offenders with BAC levels above 1,3 promille, are obliged to follow an educative course on alcohol (Educatieve Maatregel Alcohol en verkeer, EMA).

The Alcohol Licensing and Catering Act (Drank en Horeca Wet) came into force in 1964 and was changed in 1996, 2000 and 2005. The Act is meant for alcohol outlets and municipalities (and not for consumers). According to the Catering Act, all food stores have the right to sell any alcoholic beverage of less than 15 per cent alcohol by volume and to sell fortified wines. A special licence is required for selling distilled alcoholic beverages with an alcohol content of over 15 per cent by volume off the premises. These liquor stores have to be separate establishments, i.e., at least have a separate entrance.
Local authorities, usually the municipal government, grant licenses. The decision is sent to the Ministry of Health, Welfare and Sport to be confirmed. Licensing terms are fairly strict. Applicants should not have committed crimes; should have passed a course on management of alcohol affairs and issues of social hygiene; and have reached the age of 21 (in 2000 the minimum age was lowered from 25 years to 21 years). Local authorities can make these general regulations more stringent, but not more liberal. In principle, the licence has to be granted if the applicant complies with the national and local conditions. The licence system also applies to on-premise drinking places.
The main new 2000 restrictions were:

- A ban on selling alcoholic beverages in non-food stores and petrol stations;
- A statutory obligation for alcohol suppliers to check the age of all customers;
- Authorisation of the Ministry of Health, Welfare and Sport to regulate alcohol advertisements;
- Authorisations of the Ministry of Health to ban alcohol sales at soccer stadiums, schools, swimming pools, hospitals etc.

In 2000, a special enforcement agency (VWA/KvW) has installed 70 inspectors to make unannounced visits to bars and restaurants to monitor compliance to the new restrictions. The licensees can be fined or lose their license for infractions. In 2005 the inspectors were qualified to directly impose administrative fines (bestuurlijke boetes). These fines vary between €450 - €3600. Before transgressions were dealt with by a criminal judge.

In the Netherlands excise duties are levied on all alcoholic beverages containing more than 0.5 per cent alcohol by volume. Excise duty rates for alcoholic beverages in 2004 per hectolitre of the product are: for beer (5 per cent alcohol) 25 euros; for wine (12 per cent alcohol) 59 euro; distilled beverages (35 per cent alcohol) 621 euro. A recent 20 percent rise in alcohol taxes on spirits in January 2003 has put the Netherlands out of step with many of its neighbours. With its new rates the Netherlands comes after Sweden, Finland, Ireland, the United Kingdom and Denmark as one of the countries with the highest alcohol taxes among 15 countries in the European Union. In 2002 the taxes on beer and wine had been raised with approximately the same percentage. Between 1970 and 1997, state revenues from alcohol excises declined with 25%.

Since 1987 the alcohol beverage industry has had responsibility for regulating its own advertising and promotional activities. The Advertising Code for Alcoholic Beverages from 2000 (Reclame Code voor Alcoholhoudende Dranken) states that the object of advertising may not be to increase alcohol consumption. Also, advertisements are not allowed if a quarter of the audience is younger than 18 years of age. After a discussion in parliament in 2005 about a proposal of the Minister of Health to ban alcohol advertising on television before 9.00 PM the Minister decided not to do so. He came to this decision after making agreements with the alcohol beverage industry to strengthen their advertising policy.

7. Integrating preventive interventions on alcohol use in health care

This paragraph offers an overview of finished, on-going and future projects aimed at the prevention of alcohol problems in (public) health care. The term prevention is used to encompass universal, selective as well as indicated prevention.
This overview of projects is not complete. The focus still lies heavily with primary health care, as this is the focus of the PHEPA project from which the Partnership originates. Besides primary health care, the partnership aims to enhance activities in public health care on the one hand and secondary and tertiary care on the other hand.
The Partnership strongly supports all the projects mentioned in this paragraph, albeit not all projects that are discussed here are linked to the Partnership. The aims and plans of the Partnership are given in shaded areas, as was done in the remainder of this document.
The aims of the Partnership as described here are provisional and need to be further developed. A proposal for the foundation of the Partnership has been submitted to the Ministry of Health, Welfare and Sport. The Ministry of VWS has not yet decided about this proposal.

7.1 Principles

The strategy of the Dutch Partnership on Alcohol that is outlined here is based on the following principles.

1. Brief interventions are not only effective, they are also cost-effective. If they could be implemented on a wide scale, they would have a major impact in reducing the harm done by alcohol.

2. Primary health care settings are in a pivotal position for early detection and brief interventions with risky drinkers and early detection of alcohol related harm.
The general practitioner (GP) has the advantage of case-finding in the circumscription population he takes care of. He will know the persons at risk and he is able to ask patients registering in the practice on their way of life. Because of the confidential setting in general practice most patients are not offended by questions on alcohol use by their GP.

3. There is substantial evidence that primary health care workers very rarely implement brief interventions in their routine work and that as a consequence the majority of hazardous and harmful drinkers attending primary health care are overlooked and not advised to reduce consumption.
In the Netherlands, a standard general practice (2350 patients) includes approximately 200 problem drinkers (Cornel et all, 1994). Recent research (Laurant et al, 2004) however showed that in general practice only 1,7 per 1000 patients

were diagnosed as chronic problem drinkers (ICPC P15) and 0,3 per 1000 patients had an acute alcohol problem (ICPC P16).
47% of general practitioners feel that diagnosis of alcohol problems is part of their job, but only 6% of general practitioners feel that treatment of alcholproblems is part of their job. Less than 25% of GP's has followed a course on problematic alcohol use; less than 25% of GP's feels the need to follow a course on problematic alcohol use (Heideman et al., 2004; Laurant et al., 2001).
According to the 1996 estimate, the Netherlands has approximately 820.000 cases of alcohol misuse (alcohol abuse and alcohol dependence). The majority of these people remain beyond the reach of primary health care as well as beyond the reach of professional alcohol services. In 2005, the number of problem drinkers in the Netherlands is estimated at 10% (Van Dijck & Knibbe, 2005).

4. From the first three principles, it follows that there is a need to raise awareness on alcohol related issues, especially in the area of risky drinking, among primary health care professionals, helping to reframe the classical conceptions.
The course of alcohol use disorders was examined using the longitudinal Nemesis-data. At one and three years follow-up high remission rates were found for abuse and dependence (80% and 65% respectively) whereas relapse rates were found to be low (De Bruijn, 2005). These findings are in contrast to the chronic relapsing nature that is often ascribed to alcohol problems and stand in contrast to the perceived incompatibility of managing alcohol problems in primary health care. The results should encourage general practitioners to discuss alcohol problems with their patients and give up the belief that alcohol use disorders do not respond to interventions.

5. There is a need to provide effective incentives and acceptable conditions of work for primary health care professionals to deliver brief interventions. There is also a need for more research to learn about the best way to implement brief interventions in primary health care.
A number of questions have to be answered before screening and brief interventions can be implemented. Firstly, who will carry out preventive interventions in primary care? The community council is very apt to start and maintain prevention programs but is not incorporated in the curative trail, where the curative workers are less prevention-minded. For most physicians prevention is considered as a lot of work characterised by low effectiveness for the individual patient. On the other hand practice nurses and other personnel in primary care are very keen on preventive services and very good at organisation and sustaining the procedures. These features make them very apt to be the key figures in preventive services.
Secondly, who should be screened? Recently, there has been much debate concerning the screening issue (Beich, Thorsen & Rollnick, 2003; responses on the article of Beich, Thorsen & Rollnick). Controversy exists about whether universal (systematic) screening, selective (opportunistic) screening or case-finding should be recommended. There is clearly a need to learn more about the best way to implement alcohol screening and brief interventions in primary health care.

6. There is a need to expand implementation of screening and brief alcohol interventions beyond primary health care.
One of the reasons most often cited by general practitioners for poor integration of brief interventions is that they have difficulties referring patients with severe problems to secondary care (for example: due to waiting lists). Furthermore, general practitioners feel strongly that they should not be made solely responsible for alcohol problems in society. Therefore, other settings beside the general practice should function as a centre of prevention: for example departments of occupational health, who embrace prevention as a main activity. It must be made easy for GP's

and their staff and for occupational doctors to refer patients to psychologists and addiction departments. All health care professionals who encounter alcohol problems in their work regularly, should be made aware of alcohol related issues and develop skills to signal and discuss risky drinking in an early phase.

In 2005, the Dutch Partnership on Alcohol will give an overview of the implementation of screening and brief intervention in all relevant (public) health care settings in the Netherlands. The Qui database, the project Scoring Results, the Dutch country report and other relevant documents will serve as input. Based on this overview, the Partnership will write an Alcohol prevention Action Plan in succession to the Alcoholcare Action Plan 2002-2004. The plan describes the role of various professional groups in primary, secondary and specialized health care as well as the role of problem drinkers themselves. The Alcoholprevention Action Plan also specifies concrete and measurable goals.

7.2 Practice based guidelines, protocols and aids

7.2.1 Guideline for general practitioners

The Dutch College of General Practitioners (NHG) has been preparing and updating their guideline on problematic or harmful alcohol use. The guideline was supposed to start after the PHEPA project and to run simultaneously with the multidisciplinary guideline (see 7.2.2), but the train of these other projects was upheld by several reasons, where the NHG had to continue. The main points of the PHEPA guideline are as much as possible incorporated in the Dutch guideline. There are however some discrepancies between the European and Dutch guideline, for example concerning the screening instrument.
The Dutch guideline focuses on three items:

- In which patients may the GP suspect harmful alcohol use and how to discuss the matter with his patient?
- Which interventions are possible in the setting of the general practice?
- Very important is dealing with the negative attitude among GP's concerning alcohol use and their idea of failing success of the interventions.

The *introduction* of the guideline discusses the physical and psychological harm due to problematic alcohol use, epidemiology and groups at risk for problematic alcohol use and with increased harm due to the use of alcohol.

The *diagnostic part* focuses on the indirect signals the GP may get during his consultation time like sleeping problems, tiredness, and smell of alcohol or laboratory results due to other examinations. However none of these clues are conclusive and most important is asking about alcohol use. When suspicion on problematic alcohol use has risen, confirmation must be obtained by the history or an accessory test. The NHG has opted for the five-shot test. The place of alcohol use in the life of the patient is important to evaluate the motivation to reduce his alcohol use.
The NHG does not advise any specific physical examination or laboratory test for problematic alcohol use, except when complaints direct the GP to do so.

The *intervention* of problematic alcohol use is derived from the Prochaska scheme as it is used in the stopping of smoking programme. The different steps like (pre)contemplation, preparation, action, sustain and relapse are extensively described to give the GP proper clues on how to discuss drinking with patients who differ in their motivation to drink less. It's also possible for the GP to direct the patient to his practice nurse.

Medication on problematic alcohol use is only advised in case of severe detoxification (oxazepam and chloordiazepoxide). Thiamin is advised as supplementary vitamin. No anti-craving and relapse preventing drugs are advised in GP except after consultation specialised addiction clinics. Finally, referral is discussed to addiction clinics, psychologists or social workers.

The practice guideline of the Dutch College of GPs has been sent to several consultants and to 50 GP's randomly assigned from the list of members. Their comments have been discussed and incorporated in the guideline. Recently, the guideline was authorized. The guideline will be published in the scientific journal of the Dutch college (Huisarts en Wetenschap) in June 2005. The translation of the Dutch guideline in English can be part of the PHEPA (II) project.

7.2.2 Multidisciplinary guideline (Richtlijn Diagnostiek en Behandeling van Alcohol misbruik en verslaving)

Work on the multidisciplinary guideline has started in 2004. The guideline contains the following:

- Early diagnosis and primary treatment of alcohol abuse
- Diagnosis and treatment of alcohol dependence, withdrawal and craving
- Diagnosis and treatment of alcohol related psychic and somatic illnesses
- Diagnosis and treatment of (hidden) alcohol abuse and dependence in secondary and tertiary care

The guideline also contains recommendation for implementation and a project for patient participation. The aim will be to evaluate the guideline in practice and to adjust the guideline on the basis of the evaluation. The guideline will be ready in 2006.

In 2005, the Dutch Partnership on Alcohol aims to write a working plan to support the implementation of the guideline on problematic or harmful alcohol use in primary health care and to support the implementation of the multidisciplinary guideline in secondary health care and specialist services. Training of GP's and specialists can be part of the working plan.

7.3 Training and education

7.3.1 Training and education for general practitioners

The guideline for general practitioners will be published in the journal of the Dutch College of GP whose members represent approximately 95% of all working GPs in the Netherlands. Simultaneously with this publication, the NHG pays extra attention to the guideline by case history, testing facilities and so on. The Guideline will also be discussed in the Dutch Journal of Medicine to be read by all Dutch physicians. In this journal several authors will give a comment on the guideline.

For training of the GP a version in our line of Programme for Individual Training will be written. This is a booklet that is based on a guideline with case histories, teaching questions and answers. A selection of the questions forms a minor examination that can be sent to the Dutch College of GPs for correction and the release of accreditation points to register as a GP. The same booklet can be used in the discussion with practice nurses or in a peer group of GP's working in the same area who want to make local schemes how to deal with problematic alcohol use.

Training programmes for general practitioners and nurses will be developed based on the project "Screening and treatment for early stage drinking problems in general practice" of the IVO (see below) as well as on the training manual of the PHEPA I project. The training aims to increase awareness and to improve both diagnosis and treatment of drinking problems in general practice.

7.3.2 Training and education for other disciplines

The Trimbos Institute has several training programmes for care-workers and prevention officials who work in mental health and addiction care.

Also, IVO is developing two training programmes on addiction.
1. Addiction and addiction care. A module for master training in the Netherlands, to be implemented in medicine, psychology, criminology and other disciplines, with special adaptations for each discipline.
2. Addiction (care) and scientific research. A training programme for care-workers and prevention-officials who already work in addiction care practice.

7.4 Engaging health care providers

7.4.1 Engaging general practitioners

In 2004, the project "Screening and treatment for early stage drinking problems in general practice" aimed to engage primary health care in the prevention of hazardous alcohol consumption (Schutten et al., 2004). The Addiction Research Institute of Rotterdam (IVO) in cooperation with DeltaBouman addiction care was responsible for the implementation and evaluation of this project in the Rotterdam region.
The project tested two innovations tested at four sites, with 16 GP's working, to enhance early treatment of developing drinking problems in the general population. The first innovation was a newly developed screening procedure that can easily be carried out in routine practice. The second innovation concerned a specialist consultation hour that was installed within or very near to the GP's office as an easy referral option. The specialists are posted by the regional addiction treatment organization.
Results show that the specialist consultation hour was very successful. General practitioners referred more patients than before and the communication between GP's and specialists was improved. The screening instrument proved less successful and was hardly used by the GP's. The results of this project will serve as an input for the development of training programmes for general practitioners and nurses to increase awareness and to improve both diagnosis and treatment of drinking problems in general practice.

Another program, which starts in July 2005, is an implementation research programme which will be evaluated by the Centre for Quality of Care Research (WOK, UMCN). The programme, entitled "Engaging General Practice in the prevention of patients with Alcohol problems (GPA project)", aims to develop (cost)effective implementation strategies to increase the involvement of general practices in reducing hazardous and harmful alcohol consumption. It will start in three regions, covering 43 general practices. The programme can be described as a tailored multi-component implementation strategy, and comprises six elements:
1) Feedback identifying individual patients who are at risk because of their alcohol consumption (based on AUDIT-score);
2) NHG guideline on alcohol and NHG patient information letters;
3) Educational training in small groups tailored to practitioners' attitudes;
4) Outreach based facilitator support tailored to practitioners' attitudes;

5) Co-operation with local addiction services for support and referral for difficult to manage patients; and
6) patient directed interventions including posters, leaflets in the waiting room and self-help booklet.
The GPA-project is designed to measure the (cost)effectiveness of the tailored multi- component implementation programme. In a cluster randomised trial the following primary and secondary outcomes will be measured: a) proportion of patients with a positive AUDIT-score; b) proportion of patients with a positive AUDIT-score who have been given advice; c) the number of AUDIT-questionnaires distributed. Besides process outcomes will be measured: a) professional attitudes; and b) feasibility of the implementation programme.

If the programme proves successful and cost effective it will be implemented on a national level. The following organisations cooperate in this project: public health organisation (NIGZ), professional bodies representing general practitioners and specialists (NHG, CBO), local primary care organisations, local addiction services, and knowledge and research centres on mental health and addiction (Trimbos, IVO).

7.4.2 Engaging other health care providers

The Dutch College of GPs has quite some experience in the production of interdisciplinary statements like National Interdisciplinary Agreements with medical specialists and National Primary Care Working Agreements. These documents are a summary of several rounds of discussion of a group of GP's with experience on the subject and some members of another group of workers in primary care. These cooperation rules can be made with:

- Psychologists working in primary care to discuss the policy of depression and anxiety disorders in patients with problematic alcohol use;
- Pharmacists on the use of medication to prevent relapse of problematic alcohol use;
- Addiction clinics to discuss a common policy including medication for patients with problematic alcohol use;
- Youth health care and the General Health Council for preventive activities in the community emphasizing on sport clubs, school parties etc.
- Social Workers

Emergency departments offer good opportunities for prevention. Registering alcohol and drug use is however until now not standard procedure in the emergency departments the Netherlands. In Groningen in the early 90s, victims of violence offences and (traffic) accidents were systematically screened on alcohol use. This only concerned screening, no intervention took place. The relation between alcohol use and acute health damage is studied by IVO.

7.5 Specialist support centres

In the Netherlands, local addiction services (CAD) are specialist services who are direct accessible, without referral from a general practitioner, for people with hazardous or harmful alcohol consumption.
The Trimbos Institute has made an overview of outreach projects initiated by local addiction services that are aimed at general practitioners (Conijn & Riper, 2005). The overview shows that there are many disparate projects and activities, however, system is lacking.

The Dutch Partnership on Alcohol aims to write a working plan for method development and implementation of out reach projects initiated by specialized addiction care. These projects can be directed at primary, secondary and tertiary care. In 2006 a number of 'break-through' projects will start.

7.6 Specialist knowledge centre

The *National Institute of Mental health and Addiction* (Trimbos Institute) is the national knowledge institute for mental health care, addiction care and social work. They aim to create knowledge on mental health and apply it to mental health care, addiction care and social work policy and practice.
In 1999, the National Drug Monitor (NMD) has been established by the Minister of Health, Welfare and Sport in order to evaluate and review registration and survey research data on a national level and to report these data to the Lower Chamber of Parliament, the interested ministries and other stakeholders inside and outside the country. The NDM is a working programme of the Centre of Monitoring and Epidemiology within the Trimbos Institute. For the Netherlands, the NDM is also the Focal Point for the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Besides, the NDM reports to the WHO and United Nations Drug Programme of the VN.

A research consortium of relevant key research institutes could be created to advise the Partnership and to propose a research agenda for the prevention and management of alcohol use disorders. The consortium will identify research with regard to the prevention and management of alcohol use disorders, carry out literature studies, and based on that formulate relevant research questions and proposals.

7.7 Monitoring the programme

The Partnership aims to monitor the outcomes and results of the Alcoholprevention Action Plan. The research consortium could be responsible for the monitoring process and for the evaluation of the functioning of the partnership itself. The success of the Alcoholprevention Action Plan could be monitored yearly, by means of extraction of data from the patient (electronic) medical records and short questionnaires. The research consortium could choose the indicators, depending on the strategies/interventions that are implemented to increase the involvement of the health care sector in the prevention of alcohol misuse. It is recommended to use existing monitors and registration systems as much as possible.

A list of possible indicators to monitor the results of the Alcoholprevention Action Plan is given below. This list of indicators is provisional and is still strongly focused on primary health care. Similar indicators for other health care sectors can be developed.

6 Indicator: number of problem drinkers in general practice

General practitioners use the ICPC-codes to register the patients' diagnosis. Patients with harmful and hazardous alcohol consumption should be registered with P15 (chronic alcohol abuse) or P16 (acute alcohol abuse/ intoxication). Besides these ICPC-codes, hazardous and harmful alcohol consumption can be registered using the code 'AA'. It is expected that the number of patients with chronic or acute alcohol problem will increase if general practitioners are more involved in the prevention of hazardous alcohol consumption.

7 Indicator: number of problem drinkers in general practice, who received advice

Besides identifying patients at risk, it is also important that problem drinkers receive appropriate advice from the general practitioners to reduce or stop their alcohol consumption, so-called brief interventions. As it is not common use to register the treatment – such as advice given – in the medical record of the patients, this aspect will be much more difficult to monitor. Using a short questionnaire an estimate can be obtained.

Indicator: number of problem drinkers which are referred to second line
From the medical file can be inferred how frequently general practitioners refer their patients to specialist aid. Using a short questionnaire an estimate can be obtained.

Indicator: numbers of times general practitioners consult addiction doctors
General practitioners do not register in the medical file of their patient whether they consulted a specialist, such as an addiction doctor. Using a short questionnaire this indicator can be measured.

Indicator: number of problem drinkers in the Netherlands
A short version of the questionnaire to measure problem drinking (Van Dijck & Knibbe, 2005) has to be developed to monitor the % of problem drinkers in the Netherlands on a regular basis.

Furthermore, the number of GPs and other medical professionals that receive training on screening and brief intervention will be registered. The training modules will be evaluated by the participants.
Also, the number of projects aimed at the prevention of hazardous alcohol consumption will be registered.

8. The Dutch Partnership on Alcohol

8.1 Managing the programme

The following organisation structure is proposed for the functioning of the Partnership. This structure is provisional. A proposal for the foundation of the Partnership has been submitted to the Ministry of Health, Welfare and Sport. The Ministry of VWS has not yet decided about this proposal.

A Partnership Management Group could carry responsibility for the day to day management of the project. The composition of the Management Group could comprise representatives of the following organizations: the Trimbos Institute, NIGZ, NHG, CBO, and the project Resultaten Scoren. The Ministry of VWS could function as observer. Responsibilities of all partners could be laid down in a written agreement.

NIGZ could function as chair of the partnership management group. The Trimbos Institute could function as contact and host organization of the Partnership. The secretariat can be based at the Trimbos Institute and will comprise a project coordinator. The functions of the project coordinator could include:

- Coordination of the Partnership's activities;
- Commission projects to support the activities;
- Manage the implementation of the projects and activities;

- Prepare regular reports to the management, the Ministry of VWS, and the Partnership groups;
- Provide the secretarial function to the management and Partnership groups; and
- Prepare detailed working plans
- Prepare budgets for the activities of the Partnership.

The Management Group could receive advice from the extended Partnership Group. The Partnership Group comprises the partners (see Annex 2). The role of the Partnership Group could be to:

- Advise on the Partnership's plan of activities;
- Advise on the preparation and implementation of the Partnership's activities;
- Commit themselves in terms of human and financial resources over a three year period 2005-2007; and
- Endorse the goals and outcomes of the activities, including any strategy documents and guidelines that are produced.

The Partnership Group could meet at least annually, with additional informal meetings of its members as required. A chair of the Partnership Group would need to be identified. Members of the Partnership Group could be available for informal day to day contact with the co-ordinator and could be invited to join specific working groups as required. Key research institutes that are members of the Partnership group will together form the research consortium.

8.2 Funding and reimbursement

The programme of the Partnership on Alcohol is likely to require a total budget of €750,000 over a three year period. The main source of funding will be the Ministry of Health, Welfare and Sport.

Budget 2005-2007

project coordinator (50.000 each year)	150.000 euro
working plans for 2005, 2006, 2007	600.000 euro
total	**750.000 euro**

8.3 Communicating about the programme

In January 2006 NIGZ will organise the Alcohol Congress that is to be held each two years. The Alcoholprevention Action Plan will be presented at the congress. The network of medical journals and the GP's own magazine will be forms of communication on the availability of the programme. Furthermore, various newsletters can inform different professionals about the activities of the Partnership on Alcohol.

Annex 1

Composition of the Dutch country based team

The Dutch country based team consists of a small group of central partners and is in the process of developing a Partnership which will have partners of all relevant organisations for the management and prevention of alcohol use disorders in The Netherlands.
Members of the small group of central partners are:

- Brigitte Boon, Ph.D. Research coordinator of the Alcohol Education and Prevention Program at the Netherlands Institute for Health Promotion and Disease Prevention (from January 2003 till July 2004)
- Annemarie Huiberts, Ph.D. Research coordinator of the Alcohol Education and Prevention Program at the Netherlands Institute for Health Promotion and Disease Prevention (from July 2004 till July 2005)
- Rob Bovens, Ph.D. Campaign leader of the Alcohol Education and Prevention Program at the Netherlands Institute for Health Promotion and Disease Prevention
- Ton Drenthen, Ph.D. Dutch College of General Practitioners, Department Prevention and Patient Education
- Louwrens Boomsma, MD. Dutch College of General Practitioners, Department Guideline development
- Heleen Riper, MSc. Head of the Prevention Program at the Netherlands Institute of Mental Health and Addiction
- Laurens Henkelman. Head of the Guideline Department at the Netherlands Institute of Mental Health and Addiction
- Teus van Barneveld, Ir. Head of the department of guideline development, audit and visitation at The Dutch Institute for Healthcare Improvement (CBO)
- Miranda Laurant, MsC. Centre for Quality of Care Research (WOK, Radboud University Nijmegen, Medical Centre)
- Peter Anderson, Ph.D. WHO advisor, manager PHEPA-project

The following organizations will be represented in the partnership management group:

- Netherlands Institute for Health Promotion and Disease Prevention (NIGZ)
- Netherlands Institute of Mental Health and Addiction (Trimbos Institute)
- Dutch College of General Practitioners (NHG)
- The Dutch Institute for Healthcare Improvement (CBO)
- Centre for Quality of Care Research (WOK)
- Project Scoring Results (represented by Gerard Schippers, Ph.D. , Head of Scoring Results and professor at AIAR)

Annex 2

Composition of the Dutch Partnership on Alcohol

The Partnership comprises representatives from medical disciplines, research institutions, non-governmental and governmental organizations. The following partners, amongst others, are involved in the Partnership (in alphabetical order):

Academic Medical Centre (ANC)
Addiction Research Centre (CVO)
Addiction Research Institute Rotterdam (IVO).
ArboNed
Dr. Peter Anderson, Public Health Consultant
Dutch Cancer Society (KWF)
Dutch National Association of General Practitioners (LHV)
Health Care Insurance Board (CVZ)
Inspectie voor de Gezondheidszorg, locatie Den Haag
Maastricht University
Meander Medisch Centrum
Medisch Centrum Rijnmond Zuid
Ministry of Health, Welfare and Sport
National Association for Community Health Services (GGD Nederland)
National Foundation for Alcohol Prevention (STAP)
Nederlandse Vereniging voor Arbeids- en Bedrijfsgeneeskunde
Nederlandse Vereniging voor Psychiatrie (NVVP)
Netherlands Association of Gastroenterologist
Netherlands Institute for Health Services Research (NIVEL)
Netherlands Public Health Federation (NPHF)
Orde van Medische Specialisten
Public Health and the Environment (RIVM)
Radboud University Nijmegen, Centre for Quality of Care Research
The Amsterdam Institute for Addiction Research (AIAR)
The Dutch Mental Health Care Association (GGZ Nederland)
The Royal Dutch Association for the Advancement of Pharmacy (KNMP)
Vereniging voor Verslavingsgeneeskunde Nederland (VVGN)

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Primary Healthcare European Project on Alcohol, (Phepa)

EU Study 2003-2004

Portugal
Team Report

Table of Contents

Current policies and activities in Portugal on alcohol related problems

Current policies and activities in Portugal on alcohol related problems

1. Introduction

Portugal is one of the countries with the highest alcohol consumption in Europe and Alcohol Related Problems constitute one of the biggest Public Health problems in this country.

Alcohol consumption is directly related with social behaviour patterns, part of "life-styles" and influenced by cultural context. A number of reputed international studies have shown a dose-response relationship between alcohol consumption and the frequency and severity of several illnesses. In this sense, the highest levels of alcohol consumption relate to higher mortality and morbidity rates as regards liver cirrhosis, cancer, accidents and other. The scientific knowledge of the disease risk factors and their consequences justify that the current policy related with alcohol problems gives priority to the need for a population-based approach to alcohol abuse prevention complemented by intervention with excessive consumers, namely at the primary care level.

According to the 1997/1998 HBSC survey (total sample size n = 1245), 29% of 15-year-old boys and 9% of 15-year-old girls reported drinking beer, wine or spirits at least weekly. According to the 2001/2002 HBSC survey (total sample size n = 802), the proportion of 15-year-olds who reported ever having been drunk two or more times was 25.5% for boys and 18.9% for girls. In the 1999 ESPAD study of subjects 15 to 16 years old (total sample size n = 3609; males n = 1672 and females n = 1937) the proportion of subjects who reported being drunk three times or more in the last 30 days was 4% (total), 6% (males) and 2% (females). According to a national survey conducted in 2003 (total sample size n = 1000; aged 15 years and over), the average number of drinks consumed per drinking day was 1.96

A time series analysis study conducted for the period 1950–1995 found that total alcohol sales were positively and statistically significantly associated with the homicide rate in Portugal. An analysis of regional (18 regions) and temporal (1931–1989) covariation on suicide rates and indicators of alcohol use and abuse in Portugal reported that an increase in per capita alcohol consumption of one litre is accompanied by a simultaneous increase in the male suicide rate of 1.9%. The SDR

per 100 000 population for chronic liver disease and cirrhosis was 17.51 in 1999 and 16.03 in 2000. The number of alcohol-related road traffic accidents per 100 000 population was 17.76 in 1997 and 21.84 in 1999.

A study concluded that in 1995 alcohol misuse imposed a burden of €434 million on the Portuguese economy, representing 0.6% of Gross Domestic Product and a per capita cost estimate of €52.

The aims of Portugal's alcohol policy are similar to those of the European Union and the World Health Organisation, and give special priority to prevention and treatment of harm done by alcohol and a good availability of services.

The situation in Portugal concerning problems related to alcohol is of exceptional importance not only for the number of people affected but also for the morbidity and mortality related to alcohol.

Portugal has the highest levels of alcohol consumption worldwide and the highest rates of alcohol related problems.

Estimates

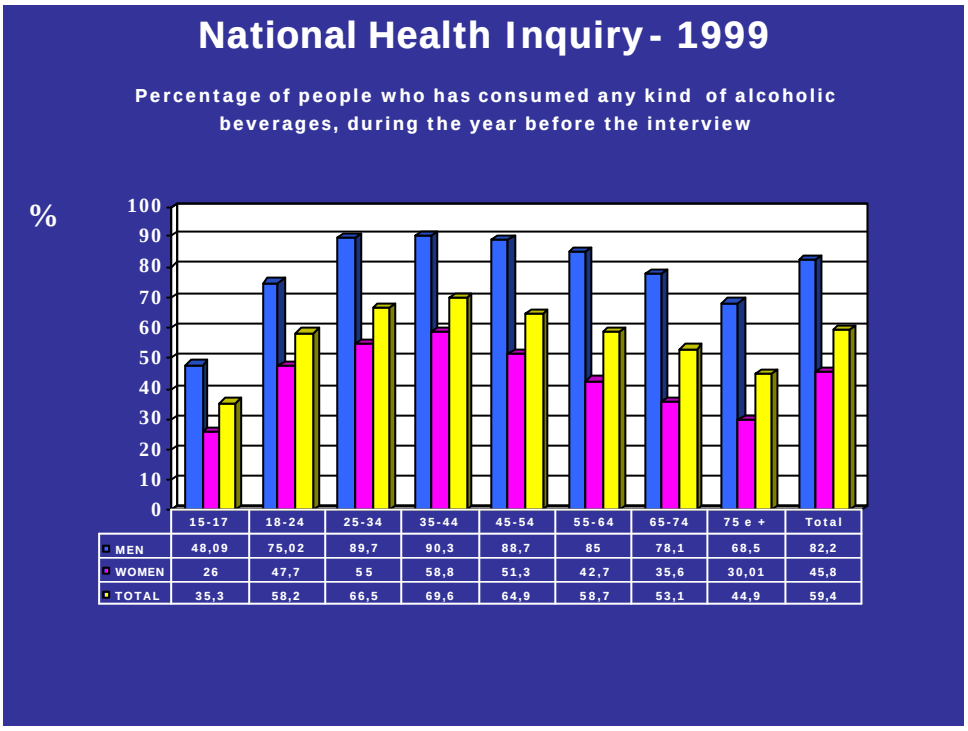
- 580 000 patients with alcohol dependency
- 756 000 alcohol abusers (excessive consumption)

Excessive Consumption	9,4%	756.000
Dependent drinkers	7,4%	580.000
Persons with problems directly related with alcohol	16,6%	1.336.000

Aires Gameiro, 1998

2. Consumption patterns

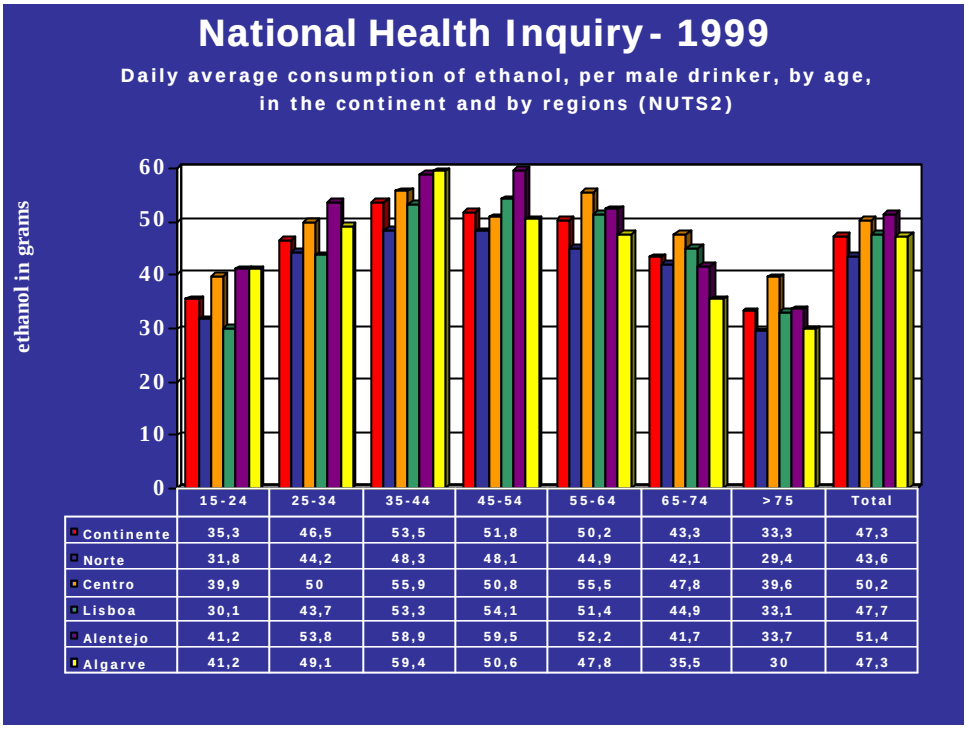
The National Health Inquiries that took place in Portugal in 1995/96 and 1998/99 allow the calculation of alcohol consumption expressed in grams of ethanol for each of the subjects that declared having consumed some kind of alcoholic beverage in the week before the interview. It was also possible to study the prevalence of consumers in the year before the interview.



	15-17	18-24	25-34	35-44	45-54	55-64	65-74	75 e +	Total
MEN	48,09	75,02	89,7	90,3	88,7	85	78,1	68,5	82,2
WOMEN	26	47,7	55	58,8	51,3	42,7	35,6	30,01	45,8
TOTAL	35,3	58,2	66,5	69,6	64,9	58,7	53,1	44,9	59,4

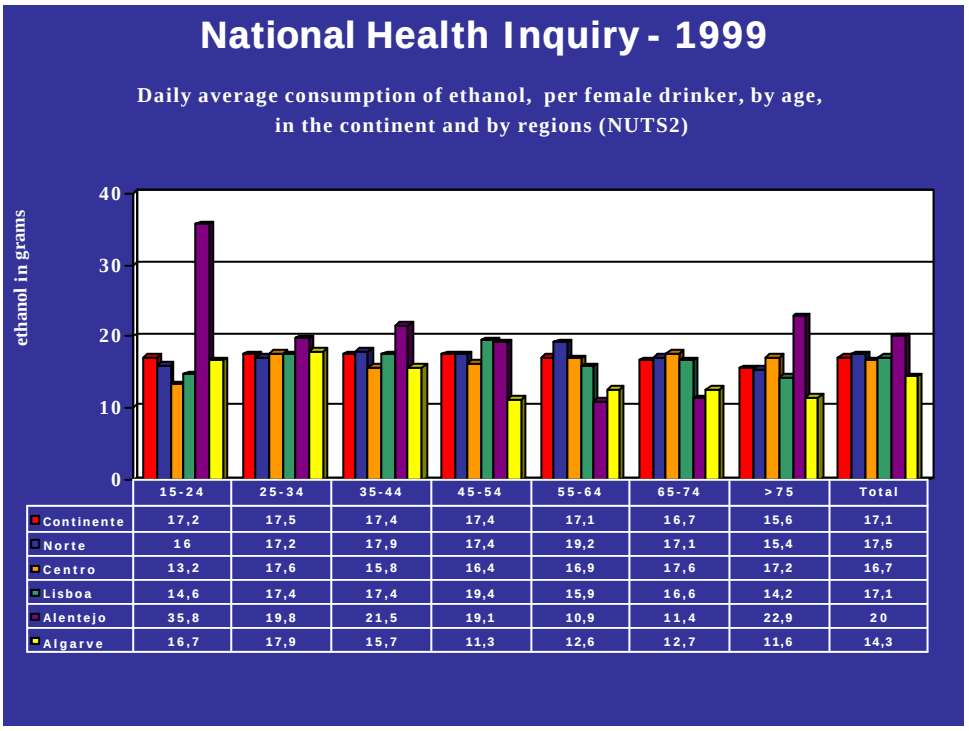
Source: National Health Inquiry: Statistics data about alcohol consumption in Portugal 1999

In 1999, 59,4% of the population inquired admitted consumption of alcoholic beverages in the year before the interview. The prevalence of alcoholic beverages is higher in men (82,2%) than in women (45,8%) in every age group, increasing with age up to 35 years old in both genders.



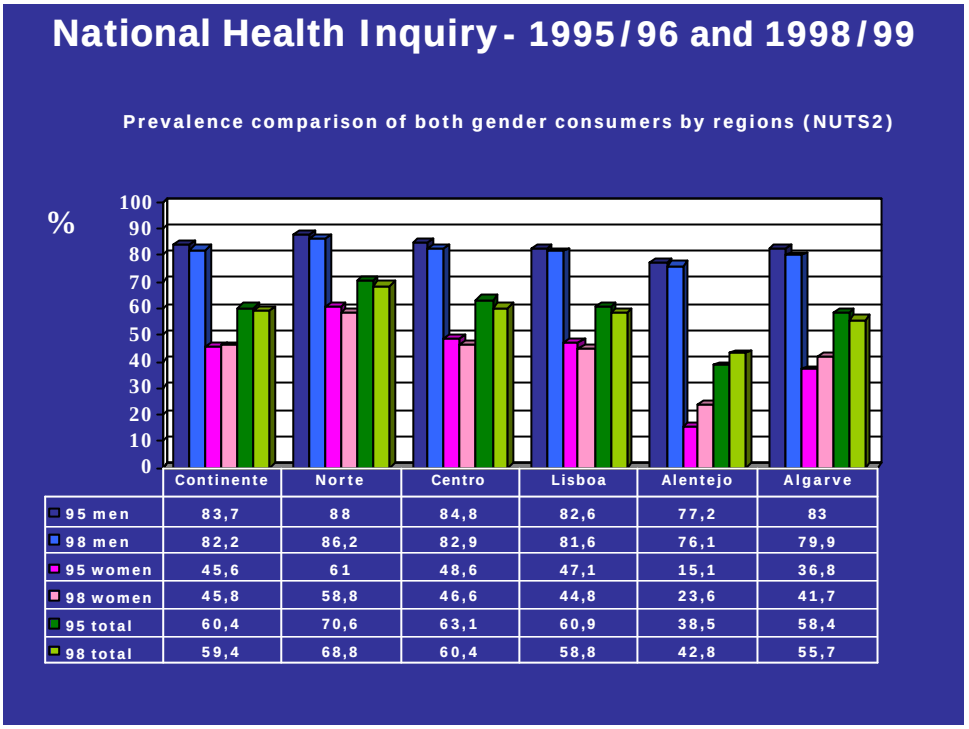
	15-24	25-34	35-44	45-54	55-64	65-74	>75	Total
Continente	35,3	46,5	53,5	51,8	50,2	43,3	33,3	47,3
Norte	31,8	44,2	48,3	48,1	44,9	42,1	29,4	43,6
Centro	39,9	50	55,9	50,8	55,5	47,8	39,6	50,2
Lisboa	30,1	43,7	53,3	54,1	51,4	44,9	33,1	47,7
Alentejo	41,2	53,8	58,9	59,5	52,2	41,7	33,7	51,4
Algarve	41,2	49,1	59,4	50,6	47,8	35,5	30	47,3

Source: National Health Inquiry: Statistics data about alcohol consumption in Portugal 1999



	15-24	25-34	35-44	45-54	55-64	65-74	>75	Total
Continente	17,2	17,5	17,4	17,4	17,1	16,7	15,6	17,1
Norte	16	17,2	17,9	17,4	19,2	17,1	15,4	17,5
Centro	13,2	17,6	15,8	16,4	16,9	17,6	17,2	16,7
Lisboa	14,6	17,4	17,4	19,4	15,9	16,6	14,2	17,1
Alentejo	35,8	19,8	21,5	19,1	10,9	11,4	22,9	20
Algarve	16,7	17,9	15,7	11,3	12,6	12,7	11,6	14,3

Source: National Health Inquiry : Statistics data about alcohol consumption in Portugal 1999

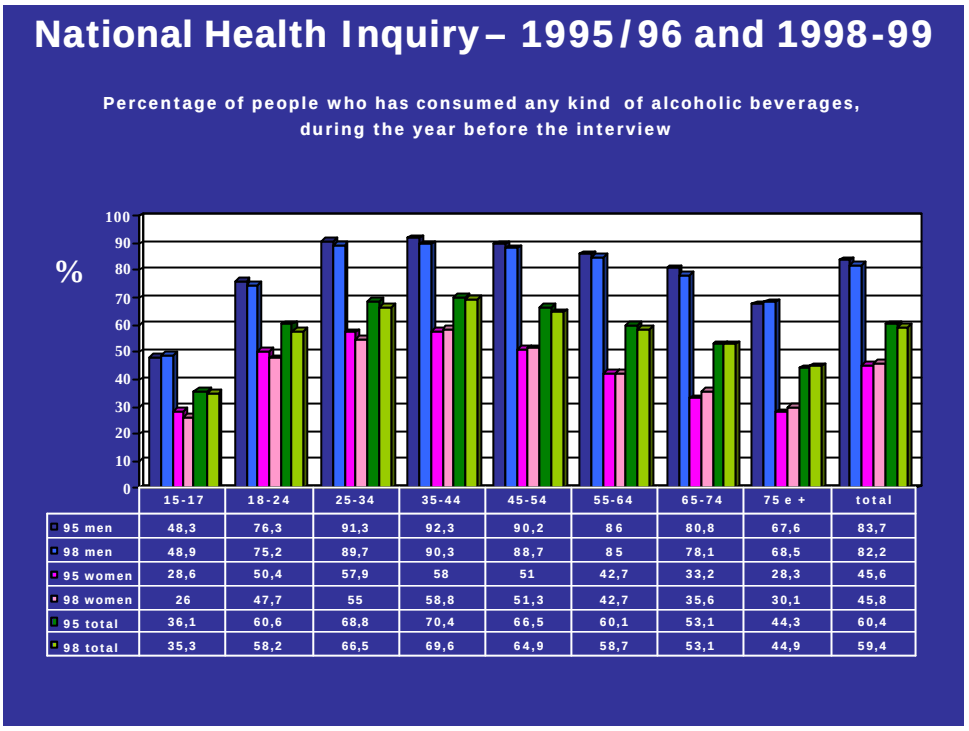


	Continente	Norte	Centro	Lisboa	Alentejo	Algarve
95 men	83,7	88	84,8	82,6	77,2	83
98 men	82,2	86,2	82,9	81,6	76,1	79,9
95 women	45,6	61	48,6	47,1	15,1	36,8
98 women	45,8	58,8	46,6	44,8	23,6	41,7
95 total	60,4	70,6	63,1	60,9	38,5	58,4
98 total	59,4	68,8	60,4	58,8	42,8	55,7

Source: National Health Inquiry: Statistics data about alcohol consumption in Portugal 1996-1999

The prevalence of consumers is higher in the North region (68,8%) and lower in the Algarve (55,7%) and Alentejo (42,8%). This lower prevalence is due to the minor percentage of female consumers in those regions. However, from 96 to 99, the number of female and young consumers increased in those regions.

- 35% of the youngsters of Portugal from 15 to 17 years old declared they have drunk during the year before the interview, increasing that percentage to 100% of young male in the Algarve.
- The average consumption of ethanol by Portuguese with consumption habits is higher in the male gender (47,3gr) than in female (17,1 gr) and even higher between 35 and 44 years old, in both genders.
- In comparison with 1996 there is a decrease in the percentage of consumers in the Continent and all administrative regions with the exception of Alentejo, where an increase occurred.



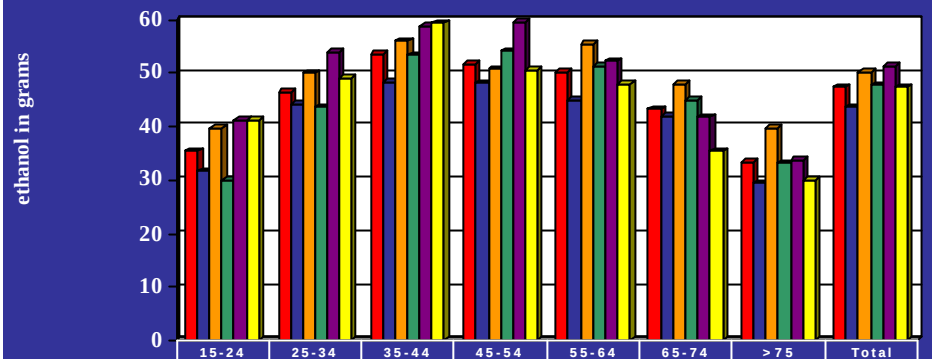
	15-17	18-24	25-34	35-44	45-54	55-64	65-74	75 e +	total
95 men	48,3	76,3	91,3	92,3	90,2	86	80,8	67,6	83,7
98 men	48,9	75,2	89,7	90,3	88,7	85	78,1	68,5	82,2
95 women	28,6	50,4	57,9	58	51	42,7	33,2	28,3	45,6
98 women	26	47,7	55	58,8	51,3	42,7	35,6	30,1	45,8
95 total	36,1	60,6	68,8	70,4	66,5	60,1	53,1	44,3	60,4
98 total	35,3	58,2	66,5	69,6	64,9	58,7	53,1	44,9	59,4

Source: National Health Inquiry: Statistics data about alcohol consumption in Portugal 1996-1999

- The percentage of consumers of male gender decreased in the Continent and in all regions, although there was an increase in the extreme age groups (15-17 years old and more than 75 years old).
- In the female gender there is a slight increase in the country, with a decrease in the North, Centre and Lisbon, and a strong increase in Alentejo and Algarve (in all age groups in Alentejo and for over 35 years old in the Algarve).
- Contradicting this tendency, an important increase occurred in the quantities consumed by females in Alentejo between 15 and 54 years old and by male consumers in Alentejo and Algarve.

National Health Inquiry - 1999

Daily average consumption of ethanol, per male drinker, by age, in the continent and by regions (NUTS2)

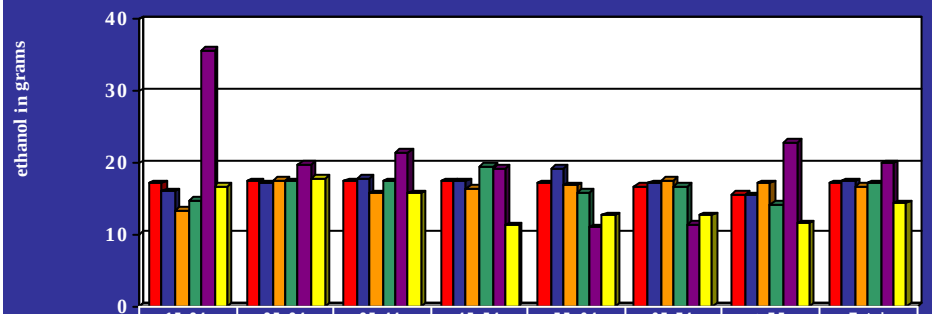


	15-24	25-34	35-44	45-54	55-64	65-74	>75	Total
Continente	35,3	46,5	53,5	51,8	50,2	43,3	33,3	47,3
Norte	31,8	44,2	48,3	48,1	44,9	42,1	29,4	43,6
Centro	39,9	50	55,9	50,8	55,5	47,8	39,6	50,2
Lisboa	30,1	43,7	53,3	54,1	51,4	44,9	33,1	47,7
Alentejo	41,2	53,8	58,9	59,5	52,2	41,7	33,7	51,4
Algarve	41,2	49,1	59,4	50,6	47,8	35,5	30	47,3

Source: National Health Inquiry : Statistics data about alcohol consumption in Portugal 1999

National Health Inquiry - 1999

Daily average consumption of ethanol, per female drinker, by age, in the continent and by regions (NUTS2)



	15-24	25-34	35-44	45-54	55-64	65-74	>75	Total
Continente	17,2	17,5	17,4	17,4	17,1	16,7	15,6	17,1
Norte	16	17,2	17,9	17,4	19,2	17,1	15,4	17,5
Centro	13,2	17,6	15,8	16,4	16,9	17,6	17,2	16,7
Lisboa	14,6	17,4	17,4	19,4	15,9	16,6	14,2	17,1
Alentejo	35,8	19,8	21,5	19,1	10,9	11,4	22,9	20
Algarve	16,7	17,9	15,7	11,3	12,6	12,7	11,6	14,3

Source: National Health Inquiry : Statistics data about alcohol consumption in Portugal 1999

There is a slight reduction in the total consumption of ethanol in 1999 (37,8 gr) regarding 1996 (39,3 gr). The male drinkers changed from an average of 48,4gr to 47,3gr while the female drinkers come from an average of 19,3gr to 17,1gr.

Among drinkers, the most frequently consumed alcoholic beverage was wine, followed by beer, whiskey, and Port wine. The amount of alcohol and wine consumed decreased in both sexes, whereas the amount of beer, whiskey, and Port wine consumed increased in men and the increase in beer consumption was borderline significant in women

In both sexes, participants <50 years of age tended to consume less wine and more beer, whiskey, and Port wine than their older counterparts..

Summarising:

- Slight reduction of total consumption in 1999 regarding to 1996
- Higher consumption in men
- Increasing consumption with age until 35-44 years in both genders
- Slight increase of consumption in female and young consumers
- Younger generations are shifting from wine to beer and spirits.

The main **causes of death in Portugal** are related to vascular and heart diseases. However **traffic accidents** constitute the seventh cause of death whereas chronic liver disease and cirrhoses occupy the tenth place. Young people often die because of traffic accidents (2002).

Currently mortality rate by liver cirrhosis has reduced in the Continent and its value is extremely high. In districts of Guarda and also Viseu (Centre region) this rate is 27% and 26,1% respectively.

Supervision of **driving under the influence of alcohol,** in 2002, found that 906400 alcohol tests to drivers had been conducted in 2001 and about 29 200 had a positive test (> 0,5 gr/l).

In supervision of driving under the influence of alcohol 25,4% of drivers were involved in accidents, 2,7% in dangerous manoeuvres and 1,9% occasionally (2002).

8,3% of drivers who were supervised for dangerous manoeuvres and 5,3% of the involved drivers in accidents (2002) had positive tests

Driving under influence of alcohol by age group in 2002:

- 3,6% of the infractors are between 21 and 29 years old (2002)
- 1,7% of drivers from thirty to 39 years old have alcohol test highest than 1,2gr/l (2002)

Supervision of Driving under the influence of alcohol – 2002

	PSP	GNR	Total
From 0,00 to 0,49g/l	102.643	774.623	877.266
From 0,50 to 0,79g/l	1.016	6.756	7.772
From 0,80 to 1,19g/l	1.359	7.259	8.618
= or > 1,20g/l	2571	10.244	12.815
Total of infractors	4.946	24.259	29.205
Total of tests	107.589	798.882	906.471

Source: DGV(Traffic Directorate)

3. Areas with Relevant Legislation

The majority of legislative initiatives that took place in the field of alcohol consumption were carried out by the government such as:

- Traffic Road - Laws decreed nº2/98 and nº 265A/01;
- Advertising - Advertising Code; Law nº 330/90;
- Youngsters - Law Decreed nº9/09;
- Public Administration – Law nº390/02;
- Organization/Specialized Services – Law Decreed nº 318/02;
- Taxation – Every year;

- Some important legislation for alcohol policy development;

Council of ministers resolution nº 40/99 May 8th

Creation of a Commission to analyse and integrate several subjects regarding the Plan Action against Alcoholism

Declaration nº 371/99, November 13th

Constitution of the interministerial Commission created by the council by the Council of Ministers Resolution nº40/99 May 8th

Council of Ministers Resolution nº166/200, November 29th

Approves the Plan of Action against Alcoholism. This Plan has the objective to fight against the excessive consumption of alcoholic beverages, involving also components of study or investigation of the alcohol phenomenon and its consumption from an epidemiological perspective as well as the promotion of education for health.

Law Decreed nº 318/2000, December 14th

Amplifies and restructures the Regional Centres of Alcohol

Law decreed nº 9/2002, January 24th

Establishes restrictions to the sale and consumption of alcoholic beverages namely to youngsters under 16 years old.

Regulation nº 390/2002, April 11th

Regulates the minimum requirements concerning the consumption, the availability and sale of alcoholic beverages in work locations of the Public administration

In Portugal there has been legislation concerning **alcohol and publicity** since 1990**– advertising code (law nº 330/1999)**

Direct advertising of any alcoholic beverages is banned before 10.30 pm

Restriction of the sponsorship of any sporting activity, as well as of any cultural or recreational activity aimed at youth or student target groups, by brands of alcoholic beverages

Restriction of the association of national symbols with advertising for alcoholic beverages

4. Action Plan against Alcohol Related Problems

Approved by Government in 2000, defines the development of Projects such as:

- Health Promotion and Education
- Research and Clinical issues
- Legislation and Fiscal monitoring
- National Network on Alcohol Problems

5. National Program of Alcohol Related Problems

This national program includes a National Project concerning "Treatment of excessive consumption of alcohol – Brief interventions in Primary Health Care"

Goals:

- Elaboration of a National Inquiry to collect Data on Alcohol related problems in Primary Health Care. (Done; results are now being analysed).
- Development of Health Professional training program for Hazardous and Harmful drinking in Primary Health Care based on brief interventions. The training program is almost ready and the Phepa's training drafts are of enormous importance to this goal.
- The training of trainers in screening and brief intervention constitutes the first phase and it is already under development at National Level (North, Centre and South of the country)
- Target trainees:

  Professionals of Health Care such as General Practitioners, psychiatrists, nurses, psychologists and nutritionists.

  Participation of Portugal in the European Project of " Phepa Project- Integrating Health promotion interventions for Hazardous and Harmful Alcohol Consumption into Primary Care Professional's Daily Work"

  Participation of Portugal in International Network on Brief Interventions for Alcohol Problems (INEBRIA)

6. Other areas of intervention

- It's of primary interest to develop and support health education and promote programmes designed to deal with alcohol abuse. Nowadays there is a PHD thesis in the area of hazardous and harmful drink in PHC with the purpose to promote early detection and intervention in Primary Health Care. Two instruments of detection of excessive consumption - Five-shot and Audit – are being also translated and validated.
- *The Alcohol Regional Centres work at community level with some local authorities with the purpose of detecting people in the early diagnosis of alcohol abuse. There are some support programmes for workers in several companies.*
- An important part of the activity of Alcohol Regional centres has been developed with students in schools. (National Network of School Health Promoters)

7. Alcohol National Network

- Task Force to develop this network which includes the three levels of care (Primary, Secondary and Tertiary)
- Mental Health Services, Alcohol Regional Centres (North, Centre and South), Primary Health Care (Health Centres), Institute for Illicit Drug Addiction, Non Governmental Organizations and others sectors.
- National Inquiry to identify and assess the health institutions involved in the care delivery to people with alcohol related problems. This inquiry has been done and now it is possible to have information of all the technical and professional resources existing in the public health system (source: Directorate General of Health Psychiatry and Mental Health Department).
- Main goal: to structure, organize and co-ordinate a specific network with the different services involved to allow an effective care delivery

This network is now been organized by the **Directorate General of Health Psychiatry and Mental Health Department** with involvement of elements of all services like Primary Health Care, Mental Health Services, Alcohol Regional Centres (North, Centre and South), Institute for Illicit Drug Addiction, Non Governmental Organizations and others sectors.

The issue of alcohol prevention should be raised both with healthcare providers and with the professional organizations involved at three levels of care.

Trained GPs can deal with alcohol related problems (hazardous and harmful drinkers and mild dependence). Even if a GP has appropriate training and skills, the lack of resources is an important problem to solve. Specialized Centers must be involved in prevention programs and should know what happens in PHC concerning the resolution of alcohol problems.

In Portugal, most specialized centers are integrated in the Health System, and this integration is essential if we want to normalize treatment and referral of alcohol dependent patients; it's necessary to organize all this sector of the health system and identify those professionals in PHC and specialized alcohol centers that can be responsible for the effectiveness of the process.

8. National Health Plan

- Framework for all these initiatives integrated in Healthy Life Style Programs. Sedentary life, unhealthy diet, tobacco use and risky drinking are responsible for disease and disability. This National Health Plan gives particular importance to effective interventions for modifying these risk factors.
- The importance of epidemiology of alcohol's role in health and illness; the treatment of alcohol use disorders in a public health perspective and policy research and options are considered in this framework. The evidence based preventive measures are available at both individual and populations levels with alcohol taxes, restrictions on alcohol availability and drink driving countermeasures among the most effective policy options.

9. Phepa Project in Portugal

Early Identification and Brief alcohol Intervention in Primary Health Care

Responsible organism: Directorate General of Health - Psychiatry and Mental Health Department

Project team

Dra Maria João Heitor

Dra Cristina Ribeiro Gomes

Dr António Pires Preto

Dr João Breda

Geographical area of implementation: Portugal

General description of the Project

Portugal has the highest levels of alcohol consumption worldwide and the highest rates of alcohol related problems. Consumption levels are high among young people.

The Action Plan against Alcoholism, approved by Government, defines the development of projects that include training of health professionals, particularly those who work in the area of the Primary Health Care. Those professionals are in a privileged position to deal with alcohol problems. They are the first level of attendance in national health care, and they have a permanent contact with the population that habitually use the primary health centres. The high consumption of alcohol is responsible for the development of physical, psychological and social problems. In Portugal, approximately 7.000 annual deaths are related to alcohol consumption. The high prevalence of the excessive alcohol consumption and the high economic, social and health costs, are important reasons to justify the implementation of projects concerning alcohol related problems in Primary Health Care in Portugal.

Goal of the Project

- Apply a National Inquiry to evaluate the capacities of Primary health care professionals (General practitioners) to deal with the Alcohol Related problems. The Inquiry has already been done and results are being analysed.
- Increase skills to do early identification of and brief alcohol interventions in primary Health Care. A training program is ready and is going on.
- Supply training materials and a training program to primary health care professionals about alcohol consumption and how to reduce it.

Description of the Project

7.1 Contents and Materials

The project includes:

- Elaboration of a National Inquiry to collect data on Alcohol related problems in primary health care.
- Development of a health professional training program for hazardous and harmful drinking in primary Health Care with brief interventions.
- Production of videos with motivational approach and booklets about drinking problems.
- Production of a manual about motivational techniques to promote changes in behaviour, such as motivational interview.
- Elaboration of a guide for development of this program in primary health care.

The National Project "Treatment of excessive consumption of alcohol – Brief interventions in Primary Health Care" - includes a module of training in the identification and management of alcohol hazardous and harmful consumption and referral of alcohol dependent patients.

The package can be delivered in two days, with a follow-up of another two days six month later, and seeks to train future trainers in the first place. Trainers are health professionals whose profile and interest for alcohol problems is relevant. They can be GPs, Psychiatrists, nurses or psychologists.

Training trainers started in May 2005 and will finish in Nov 2005. At the end of May the first part of the training program was done. Training is generally well received by PHC professionals in Portugal. Psychiatrists are also involved in training

PHEPA PROJECT IN PORTUGAL

2003	2004	Subsequent phases
7.1.1.1 Plan (2003-2004) ▪ Methodology ▪ Preparation of the national Inquiry about alcohol related problems 7.2 (Done) ▪ Preparation of the materials for trainers and training programs for health professionals. 7.3 (Done)	Implementation (2004-2005) ▪ Distribution of the inquiries and evaluation of the answers 7.4 (Done) ▪ Use of the materials for the training program ▪ Training program on brief intervention based on the motivational interview for trainers (In progress)	Dissemination (2005-2006) • Training of professional Primary Health Care conducted by the trainers prepared in the beginning of this project (2005-2006) • Evaluation of the results of the project (2005- 2006) • Cost/Benefit analysis (2005-2006)

Local support

General Health Department - Direction of Services of Psychiatry and Mental Health

Regional Health Administrations

Regional Centre of Alcohol

Portuguese Association of General practice

Addressees
Professionals of Health Care such as General practitioners, Psychiatrists, Nurses, Psychologists and Nutritionists.

Expected results

Increase skills of the Primary Health Care Professionals to reduce alcohol consumption levels

Policymakers should give priority to the liaison between alcohol specialized services and PHC as a necessary step to allow effective coordination of services.

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Primary Healthcare European Project on Alcohol, (Phepa)

EU Study 2003-2004

Report for Slovenia

Table of Contents

Primary Healthcare European Project on Alcohol, (Phepa),

EU Study 2003-2004

Report for Slovenia

1. Introduction

The Primary Healthcare European Project on Alcohol (Phepa) had several important aims. It was designed to develop best practice across member countries on the prevention, management and treatment of alcohol problems in Primary Care.

There would be four products in all arising from the Study:

5. Guidelines for Primary Care
6. Web Site
7. Training Manual
8. Country based Team Reports from all participant countries.

Following is the Report for Slovenia.

In Slovenian team participated only two experts: dr. Marko Kolšek and Tonka Poplas Sušic (both had already participated in another EU project "ECATOD" few years ago). It was not able to form larger team because no funds were available in PHEPA project for Slovenia for this purpose. Team met six times up to the official end-date of the study (October 22nd 2004).

A very good starting point for PHEPA project in Slovenia was participation in international ECATOD project and in Phase IV WHO collaborative international project on alcohol issues. During last few years alcohol issues have been included in the curriculum for undergraduate students of medical faculty and in the specialisation of family physicians and also at 'Continuing Medical Education' (CME) levels. AUDIT – C questionnaire was also included in the life style questionnaire that is used at preventive check–up for adult patients done by general practitioners.

Public concern about the adverse effects of very high alcohol consumption in Slovenia over decades has finally led to some changes that should be noted. The Parliament has brought in legislation the law to reduce access to alcohol. But unfortunatelly, on the other hand the advertising for alcohol was allowed with another law though medical professionals feel that a total ban on advertising of alcohol products would be the right solution. In years 2003 and 2004 The Ministry for Health supported a national campaign on refraiming understanding of alcohol issues.
In 2004 the Ministry of Health has formed a National Council for alcohol policy. Members of this Council are experts and representatives of the Ministry of Health, Ministry of labor, family and social affair, Ministry of education, science and sport, Ministry of economy, Ministry of finance, Ministry of agriculture and food, Ministry

of interior affairs, Ministry of traffic, Chamber of economy, National institute of health, Departments of Medical faculty (Family medicine, Psychiatry, Public health), Faculty for social work, High college for nursing, National health insurance company, Association for tourism and hotel-keeping, National community of communes and NGOs. The main aims of this Council is to prepare complex national alcohol policy, to prepare national action plan on reduction of alcohol consumption and alcohol related problems, to stimulate research and other activities related to alcohol problems and to stimulate NGOs working on alcohol related issues.

Given the alarming data in alcohol consumption in Slovenia over decades we cannot expect any change in the frequency and severity of alcohol related problems that professionals in Primary Care will have to deal with. Thus the timing of the Phepa Study and this report is very opportune. Much still needs to be done and it is hoped that the recommendations contained in this report will become a part of national policy in the near future.

2. The use of alcohol

2.1 Definitions

Few years ago guidelines for alcohol consumption risk were accepted in Slovenia (similar as in Switzerland, as follows (in standard drinks):

One standard drink – **one unit is 10 grams** of pure alcohol and it is equal to one glass of wine (100 ml), half of bottle of beer (250 ml) or one glass of spirit (30 ml).

'Low risk' drinking:

females = = 7 drinks and not more than 3 drinks per one occasion

males = = 14 drinks per week and not more than 5 drinks per one occasion

'Hazardous drinking' is any drinking above this limits.

'Harmful drinking' is drinking that causes any detected harm related to drinking.

'Alcohol addiction' is defined as in the 10th revision of ICD.

It should be pointed out that these consumption risk categories are for adults between the ages of 18 and 65; for older people the risk categories should be even more conservative. Some people should not drink at all; pregnant women, children and those who are dependent on alcohol as specific examples.

2.2 Consumption prevalence and trends

Slovenia is a wine-producing country. High alcohol consumption has been a problem for many years, while drinking alcohol is a part of the Slovenian culture. Alcohol consumption in Slovenia has been one of the highest in Europe for more than last 20 years and was rather stable while some European Member states showed substantial decrease in alcohol consumption between 1990-2003 (e.g. France, Italy, Spain). In fact, some countries showed increase in alcohol consumption (e.g. Ireland, Finland) but Slovenia remains at the very top of the list. Even schoolchildren of 9-

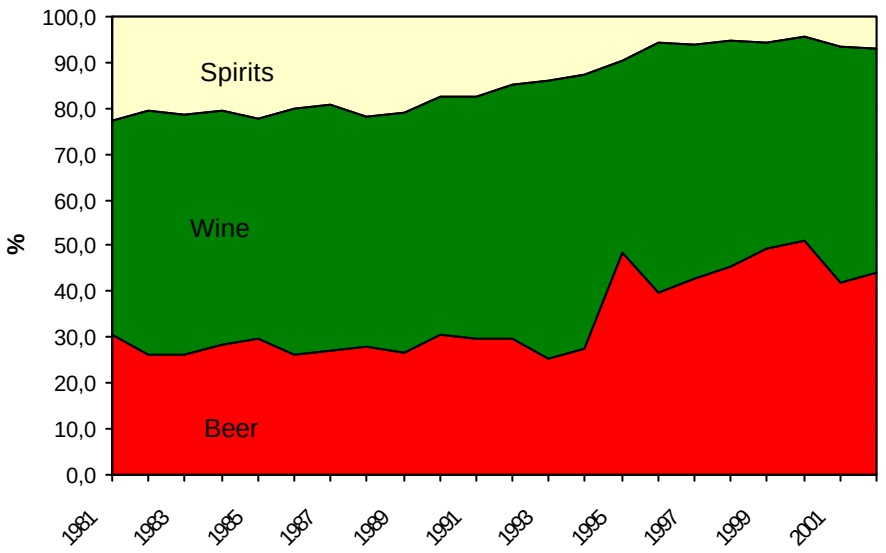
10 years are already drinking alcohol; only 40% are teetotallers, 5% of them are drinking weekly. In the 14-15 age group 28,8% are teetotalers, 7% are drinking weekly. Only 6,5% of 14-15 age group had never tasted alcohol yet. Among adolescents of 16 years 7% report regular drinking. In all age groups males are drinking more frequently than females.
Approximately one third adult men and approximately 10% adult women are risky drinkers, among them approximately 10% - 15% are alcoholics, only 2% of men and 7% of women don't drink alcohol at all.

Table 1. Alcohol consumption in litres/inhabitant/year in Slovenia 1981 - 2003

Alcohol drink	1981	1991	1995	2000	2003
Beer	**70.1**	**55.5**	**95.8**	**86.6**	**86.6**
Wine	**48.4**	**45.2**	**37.9**	**34.9**	**43.3**
Spirits	**7.5**	**4.7**	**2.7**	**0.9**	**1.3**
Subtotal	**11.5**	**9.4**	**9.9**	**8.6**	**9.8**
Unregistered	**7-8**	**7-8**	**7-8**	**7-8**	**7-8**
Total	19.0	16.9	17.4	16.1	17.3

It has to be emphasized the important amount of unregistered alcohol home production of approximately 7 – 8 litres of pure alcohol/inhabitant/year.

Table 2. Structure of different alcoholic beverages consumed in Slovenia in 1981 - 2003



2.3 Binge drinking

In the 9-10 age group 13,6% and in the 14-15 age group 42,1% had already been drunk, 22% more than once. The European Schools Project on Alcohol and Drugs (ESPAD) Study reported on in 2004 that Slovenian boys and girls aged 16 years are in european average in terms of binge drinking and drunkenness – 12% are getting drunk on rather regular basis.
More than half adult men and one third of adult women get drunk at least once a year.

3. The harm done by alcohol

The harm done by alcohol is well researched throughout the world and there is strong evidence linking alcohol to a whole range of health problems including various cancers, liver disease, road traffic and other accidents, mental health problems especially depression and anxiety, suicides, and many other conditions (see chart below).

Global Burden of disease attributable to alcohol by major disease categories

Disease conditions	%
Neuropsychiatric conditions: **alcohol dependency syndrome, depression, anxiety disorder, organic brain disease**	37.7
Accidents and unintentional injuries**: road and other transport injuries, falls, drowning and burning injuries, occupational and machine injuries, alcohol poisoning**	27.2
Intentional and self-inflicted injuries: **suicide and assaults**	12.9
Gastrointestinal conditions: **liver cirrhosis, pancreatitis**	7.8
Cancers: **head and neck cancers, cancers of the gastrointestinal tract including liver cancer, female breast cancer**	7.2
Cardiovascular conditions: **ischaemic heart disease, cerebrovascular disease**	6.9
Maternal and preinatal conditions: **low birth weight, intrauterine growth retardation**	0.2
Alcohol- related disease burden all causes (DALYs)	100

Source: Rehm et al, WHO, 2003, adopted from Babor et al 2003

As already noted, there is a very high alcohol consumption in Slovenia. The result is very high standardised death rate/100,000 inhabitants over 15 years for liver cirrhosis (52.3 males, 18.9 females; 38.88 both sexes) and for suicides over 15 years (52.11 for males, 14,48 for women, 32.96 both sexes). 6.5% of sick-leave were related to alcohol related diseases. 1.5% of all admissions to hospital was related to alcohol and alcohol disorders continue to be the main cause of admission to psychiatric hospitals, especially for males. The cost of hospitalisations and sick-leave related to alcohol was more than 10 millions EUR. The cost of premature death related to alcohol was estimated to be more than 50 millions EUR.
38,3% of fatal road accidents were related to alcohol, also 35.8% of assaults and public order offences were related to alcohol.

It is very difficult to quantify the harm done to family life. There is all sorts of evidence from practitioners that partners, spouses, children and other family members suffer in the short and long term from alcohol related problems.

4. Measures to reduce the harm done by alcohol

As mentioned before the new legislation to reduce alcohol related harm was brought in 2003. It will be needed some time to see its effects. It decreases the availability of alcohol a little by restricting hours and by putting age limits for sale

of alcohol. Serving of alcohol to intoxicated customers has been already prohibited before. But unregistered alcohol home production still remains a problem as it is completely out of control – half of families produce wine or/and spirits at home. Advertising of alcohol used to be almost completely prohibited but a new law allows it under certain conditions. This new law was brought out just few months before the law of the Ministry of health, that should reduce alcohol related harm, has come into force. For example, now it is possible to advertise beer on TV or wine in newspapers or posters if a specific warning is added: "The Minister of health is warning that immoderate alcohol drinking can harm your health."

Sponsorship for sport and some cultural events is still possible in Slovenia. E.g. our best basketball and handball teams known also in Europe carry the names of two biggest slovenian beer producing companies.
But in the same time some NGOs are using known rock groups for perfomancies promoting sober parties and entertainment.
The Department of family medicine at Medical faculty with the Academy of art has run a very successful national campaign 'Message in the bottle" over the past two years. This is a public awareness campaign and has involved TV, radio, newspapers, out-door and in-door public places, health centres, universities and colleges, companies, as well as a leaflet with basic information on alcohol issues and a booklet for general practitioners to help their patients with hazardous and harmful drinking.

Some training courses on clinical skills for alcohol problems have been run by the Department of family medicine over the past two years for general practitioners and for nurses. Modules have also been delivered at specialisation for family medicine One of the problems in this area is the shortage of trainers with both experience in alcohol skills training and knowledge of General Practice but courses to train trainers has just started.

5. Drinking and driving

In Slovenia tolerance for drinking and driving is still of considerable concern. The legal in Slovenia is the same as in many european countries – 5 g/l. Because of frequent accidents on our roads and many of them related to alcohol (especially the most severe ones) health professionals suggested the parliament in 2003 to reduce legal blood alcohol concentration from 5 g/l to 2 g/l, but it was not accepted in spite of many deaths on the road. Random breath checks by police are allowed for many years but it is still not so rare to find a drunk driver.

6. Managing alcohol related harm: help and care

Systematic education on early identification of hazardous and harmful drinking and brief interventions has started three years ago for general practitioners and we plan to educate nurses, too. Till now more or less only opportune screening was run with patients where drinking problems were obvious and usually an advice to reduce or stop drinking was given only in such case. We hope that systematic education will empower general practitioners and nurses to start interventions already at hazardous drinkers which may prevent harm done by alcohol before it turn up. The effectiveness of such interventions in primary health care has been shown already in several countries.
Alcohol addicted patient are refered to alcohol addiction units for in-patient or out-patient group treatment which is well spread through-out the country.

7. Current Policies and Activities

7.1 Alcohol legislation

There have been recent developments in the introduction of legislation relating to alcohol (see above). One problem remains – relatively low price of alcoholic drinks. In many markets and stores a bottle of beer is usually cheaper than fruit juice. It is true that new legislation prohibits sale of alcoholic drinks to adolescents below 18 years, but in the culture where alcohol drinking is so common as in Slovenia price of alcohol should not stimulate even adults to buy it.

7.2 Interventions in Primary Health Care

GPs are best placed to provide services for risky drinkers as they see on average up to 80% of the population every year. No other health or other professional has an opportunity to meet such a large percent of population in one year and also has not such influence on people's behaviour. They are also the largest source of referral to specialist services. GPs have also an important role for patients in recovery from alcohol dependence and their families to help and stimulate them to carry on participating at long-term treatment program at AA or clubs of treated alcoholics that are wide spread through the country.
So, effective strategies should be found and used to encourage and stimulate GPs and practice nurses to learn and use this knowledge and skills at their everyday practice.

8. Integrating preventive interventions in Primary Health Care

8.1 Principles

The main principle on which this programme is based will be that of identifying the best ways to enable patients and their families to get the most effective help for the range of alcohol problems. The programme will be GP friendly and will have realistic goals. Certainly, it is not possible to screen the whole population within the first year. But screening will remain a priority and so, in five years the large majority of patients could be screened and given a brief intervention if needed.
Another main priority will be to help GPs to focus more on hazardous and harmful drinking and leave addiction to psyhiatrists. However any programme that is designed to help patients and improve the services of GPs must also focus on ways of managing alcohol addiction.

8.2 Practice based guidelines, protocols and aids.

The first steps has been already done. The booklet for GPs is being distributed to all GPs. It includes also AUDIT questionnaire, protocols for detoxification and basic patient information leaflets. Another leaflet for patients' self help management will be prepared this year. It is possible to get waiting room posters.
We will be developing clinical guidelines as part of the overall alcohol project and is awaiting the finalised Phepa guidelines to form the basis of local guidelines.

8.3 Training

Some program on alcohol issues is already used in undergraduate curriculum for medical students and for specialization of family medicine. In addition the Phepa document on training will be incorporated when it is finalised. We will tra to prepare also a CME half day or one day course to cover the following areas:

- Attitudes towards patients
- Use of questionnaires and other screening instruments/methods
- Clinical skills for brief intervention and health behaviour change counseling
- Use of protocols
- Use of leaflets and other support materials
- Methods to help family members
- Information on risky consumption weekly limits
- Assessment techniques to deal effectively with the increasing problem of dual diagnosis
- Treatment methods including detoxification protocols and referral procedures
- Best practice regarding records and registers
- Liaison with Treatment facilities
- Prevention

8.4 Engaging Primary Health Care providers

This will require further consideration. However the key issue is how to engage larger numbers of GPs. The very fact that so many patients are now approaching GPs for help with the range of alcohol problems should provide the incentive for them to become more involved and seek training. A Special Type Consultation fee may have to be considered for existing GPs as an incentive to become more involved.
There would appear to be an absence of personnel who can provide training on screening and brief interventions so there will have to be an attempt to 'train trainers'. We would also propose that practice nurses be offered the same training opportunities. It is important to note that such training will provide added value to general practice in that the skills needed for brief interventions can be transferred to other clinical areas. Shortly after the end of the Phepa Study a module should be available for piloting in one of the training schemes.
The ideal scenario would be for modern training on 'Health behaviour change and brief interventions to be taught at undergraduate level.

8.5 Funding

A specific recommendation from this report is for funding to be made available to increase the number of practices who are willing to develop services for patients with alcohol problems. First steps has already be done in Slovenia. CINDI Slovenia has published the booklet for GPs (that was mentioned before) with support of the Ministry of health. They have also organized two courses to train trainers and they intend to keep supporting such courses.
National health insurance institute should be encouraged to get involved in funding of such activities as the overall health savings have been shown to be considerable. Such initiatives will also save on in-patient bed costs.

We expect that new formed Council for alcohol policy will also support these activities and will include them in current alcohol action plan.

8.6 Specialist support and knowledge centres

We hope that funds will be available to undertake a research/evaluation programme. Collaboration with other clinical specialists will be needed to spread the common understanding and share activities to help patients with different alcohol related problems.

8.7 Monitoring the programme

We hope that funds will be available to monitor these activities by a committee made up of practitioners, researchers and trainers.
With regard to clinical practice, every year practices would to provide data on their interventions. Performance indicators as to the numbers of patients screened, the numbers of patients helped and referred as well as the lowering of risk categories should be evaluated.

8.8. Communicating about the programme

The network of medical journals and the GPs own magazine 'Forum' will be the main forms of communication on the availability of the programme.

9. Research needs

Amongst other items of research mentioned before a specific research should on young people aimed at understanding attitudes and reducing alcohol related harm. This team would like to see further research on ways of implementing brief interventions at primary care level.

10. Acknowledgements

We would like to thank the PHEPA team and Phase IV team for all help that was given through fruitful discussions and through papers prepared and spread around.

PRIMARY HEALTHCARE EUROPEAN PROJECT ON ALCOHOL (PHEPA)

REPORT FOR SLOVENIA

SUMMARY

- Four Products to be delivered by the study;

  (e) Guidelines for Primary Care

  (f) Training Manual

  (g) Web-site

  (h) Country-based team Reports (this is the Slovenian summary)

- Very high alcohol consumption in Slovenia over years and corresponding high indices of harm.
- Concerns over extension of hazardous and harmful drinking among all age groups of population.
- Strong evidenced links between mortality (N.B. suicide and attempted suicide), physical and psychiatric illness and 'social' harm.
- International evidence for the efficacy of brief interventions in primary care for reducing consumption and some of the indices of harm.
- Major efforts and (possible incentives) needed to encourage GPs and nurses to become involved in screening, intervention and treatment on a wider scale.

Primary Health Care European Project on Alcohol (PHEPA)

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

Country strategy for Sweden

Februari 2005

1. Introduction

THE PROJECT ENTITLED INTEGRATING HEALTH PROMOTION INTERVENTIONS FOR HAZARDOUS AND HARMFUL ALCOHOL CONSUMPTION INTO PRIMARY HEALTH CARE PROFESSIONALS' DAILY WORK *(PHEPA) IS FUNDED BY THE EUROPEAN UNION AS PART OF THE* COMMUNITY ACTION PROGRAMME ON PUBLIC HEALTH *AND IS CO-ORDINATED BY THE PROGRAMME ON SUBSTANCE ABUSE, HEALTH AND SOCIAL SECURITY DEPARTMENT, GOVERNMENT OF CATALONIA IN BARCELONA. IT COMMENCED AT THE BEGINNING OF 2002 AND IS DUE FOR COMPLETION AT THE IN THE MIDDLE OF 2005. A TOTAL OF 16 COUNTRIES IN THE EU ARE TAKING PART IN THE PROJECT, TOGETHER WITH EUROCARE AND THE WHO REGIONAL OFFICE FOR EUROPE. ASSOCIATE PROFESSOR PREBEN BENDTSEN IS THE REPRESENTATIVE ON THE PROJECT FOR SWEDEN WITH PROFESSOR ANDERS ROMELSJÖ AS AN ADVISOR WITH REGARDS TO FORMING A LOCAL COUNTRY ACTION GROUP.*

THE GENERAL AIM OF THE PROJECT FOLLOWS ON FROM PHASE IV OF THE WHO COLLABORATIVE PROJECT ON THE IDENTIFICATION AND MANAGEMENT OF ALCOHOL-RELATED PROBLEM IN PRIMARY HEALTH CARE, *THE AIM OF WHICH WAS TO DEVELOP AND APPLY COUNTRY-WIDE STRATEGIES FOR WIDESPREAD, ROUTINE AND ENDURING IMPLEMENTATION OF SCREENING AND BRIEF INTERVENTION (SBI) FOR HAZARDOUS AND HARMFUL DRINKERS THROUGHOUT THE PRIMARY HEALTH CARE (PHC) SYSTEMS OF PARTICIPATING COUNTRIES.*

HOWEVER, THE SPECIFIC AIMS OF PHEPA ENTAIL THE DEVELOPMENT OF FOUR RELATED PRODUCTS: (I) CLINICAL GUIDELINES *FOR DELIVERING SBI IN PHC THAT CAN SERVE AS A BASIS FOR GUIDELINES TO BE USED IN PARTICIPATING COUNTRIES; (II) A* TRAINING MANUAL *LINKED TO THE CLINICAL GUIDELINES THAT CAN ALSO BE ADAPTED FOR USE IN PARTICIPATING COUNTRIES; (III) A WEBSITE CONTAINING AN* ALCOHOL MANAGEMENT DATABASE *FOR USE BY PHC PROFESSIONALS AND OTHERS INTERESTED IN THE PROMOTION OF SBI IN PRIMARY CARE; AND (IV) A* COUNTRY-BASED STRATEGY *AIMED AT INTEGRATING SBI FOR HAZARDOUS AND HARMFUL DRINKERS IN THE PHC SYSTEMS OF PARTICIPATING COUNTRIES.*

THIS DOCUMENT REPRESENTS THE LAST OF THESE PHEPA PRODUCTS AND IS A STRATEGY AIMED AT ACHIEVING THE WIDESPREAD, ROUTINE AND ENDURING IMPLEMENTATION OF ALCOHOL SBI IN PHC IN SWEDEN.

In order to facilitate the development of this strategy a team of experts was convened to represent as many aspects and parts of the country, as possible. This group of professionals constitutes a local action group as an integrated part of the European PHEPA project. At the national level the National Institute of Public Health and the department of Social Affairs has been consulted with regards to the participation in the country based team. Since some of the members selected already has a close relation with the national level it was agreed that no additional members from these two institutions should be appointed. Instead the country based team will report and discuss the strategy that develops with responsible at the national level. A list of the members of the country based team is enclosed in appendix 1.

Since the start of the PHEPA project , however, two major developments have taken place in Sweden that intimately affect the form that the local strategy should take:

1) The ministry of social affairs has in late part of 2003 decided to establish a centre for education in alcohol preventive methods in association with the National Institute of Family medicine (FAMMI). During 2004 the institute will survey the need for educational efforts and draft a strategy for the engagement of primary health care workers. However, after consultations with representatives from FAMMI, it became apparent that the strategy chosen by FAMMI will not cover all aspects of how to implement and integrate alcohol

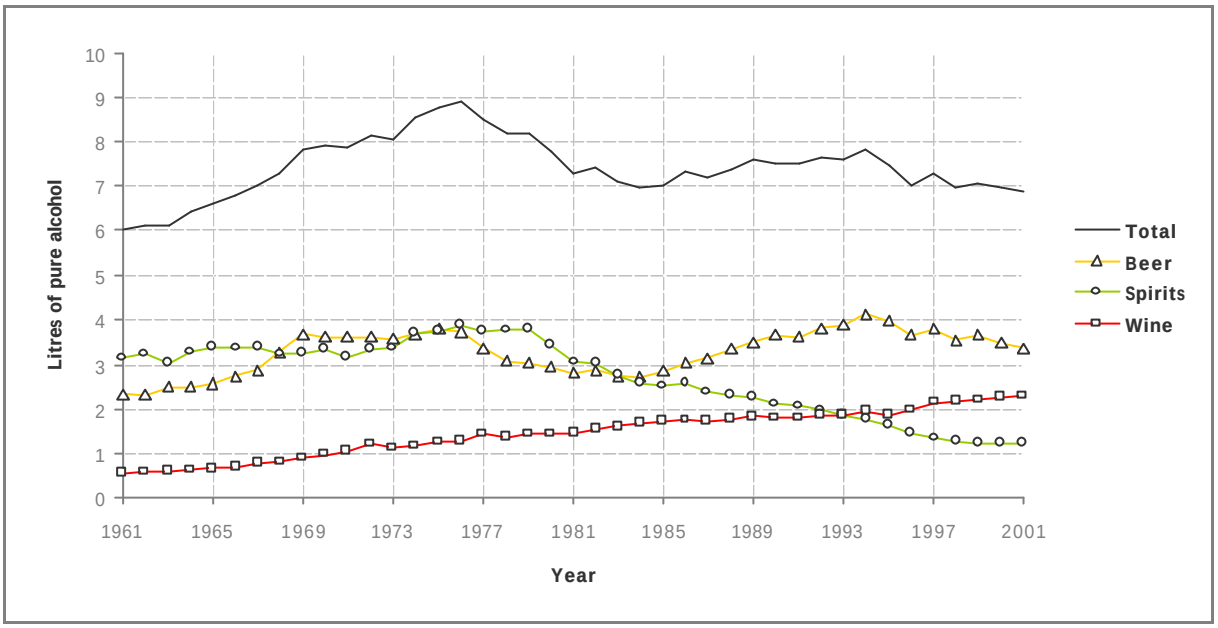
prevention into the daily routine of primary health care workers. An additional strategy is thus needed and will be the main focus of the local PHEPA action group.

2) Also during 2003 the National Board of Health and Welfare has initiated a number of working groups with the task to develop national guidelines for treatment and prevention of alcohol and drug problems. One of the working groups is given the task to develop guidelines for alcohol and drug prevention in the society at large and within the health care sector. The guidelines are expected to be finalized during the end of 2005.

The Swedish PHEPA action group will actively ensure the dissemination of the written documents from the project, the guidelines and training manual, to various official organizations and health care associations. The local action group will also continue to participate in the public discussion and increase the awareness about the possibilities to avoid alcohol related harm.

2. THE USE OF ALCOHOL

The official sale of alcohol consumption in Sweden has been stable for two decades as seen in the figure but has started to increase during the last three years from 2001 to 2004. A total increase on 20% in the total alcohol consumption has been seen during the last three years. This is mostly due to an increase in the allowed amount of alcohol to be imported when travelling abroad.



2.1 Hazardous drinking

A number of studies in Sweden gives a somewhat diverging picture of the proportion of hazardous drinkers. According to the WHO GENACIS study (national survey conducted in 2002; total sample size *n* = 4223, males *n* = 2085 and females *n* = 2138; age group 20 to 64 years) the rate of hazardous drinking among drinkers was 4% (males) and 3.3% (females). Hazardous drinking was defined as average consumption of 40 g or more of pure alcohol a day for males and 20 g or more of pure alcohol a day for females.

A 2000 survey of subjects aged between 16 and 75 years (1616 males and 2056 females) found the rate of hazardous drinking to be 6.9% among males and 3.4% among females. Hazardous drinking was defined for men as consuming more than 30 g of pure alcohol per day and for women more than 20 g of pure alcohol per day.

A 1996–1997 national survey of subjects aged between 16 and 84 years old (males *n* = 5570 and females *n* = 5896) found the rate of heavy drinking to be 8.8% (total), 12.5% (males) and 5.4% (females). Heavy drinking was defined for men as consuming 30 g of pure alcohol or more per day and for women 20 g of pure alcohol or more per day.

A survey of 997 persons randomly selected from the general Swedish population found that 18% of men and 5% of women had hazardous or harmful alcohol use according to the AUDIT definition (score of 8 or more). Women are more sensitive to alcohol than men and when the cut-off score was set to 6 or more, the female prevalence of hazardous or harmful alcohol use increased to nearly 11%.

A recent study of a random sample of 1250 persons from the general Swedish population showed that the female prevalence of hazardous or harmful drinking (AUDIT definition) had increased from 11 to 15% between 1997 and 2001. Thus, women, particularly 28–38 years old, reported drinking more often and in greater amounts. Furthermore, the prevalence of female abstainers had decreased from 18 to 13%.

There is need for clarification what is to be defined as sensible drinking limits in the Swedish context. So far, various levels have been used in different studies and projects often with too high limits for men. This lead to an underestimation of the real on impact of alcohol on mens health.

2.2 Heavy episodic drinking

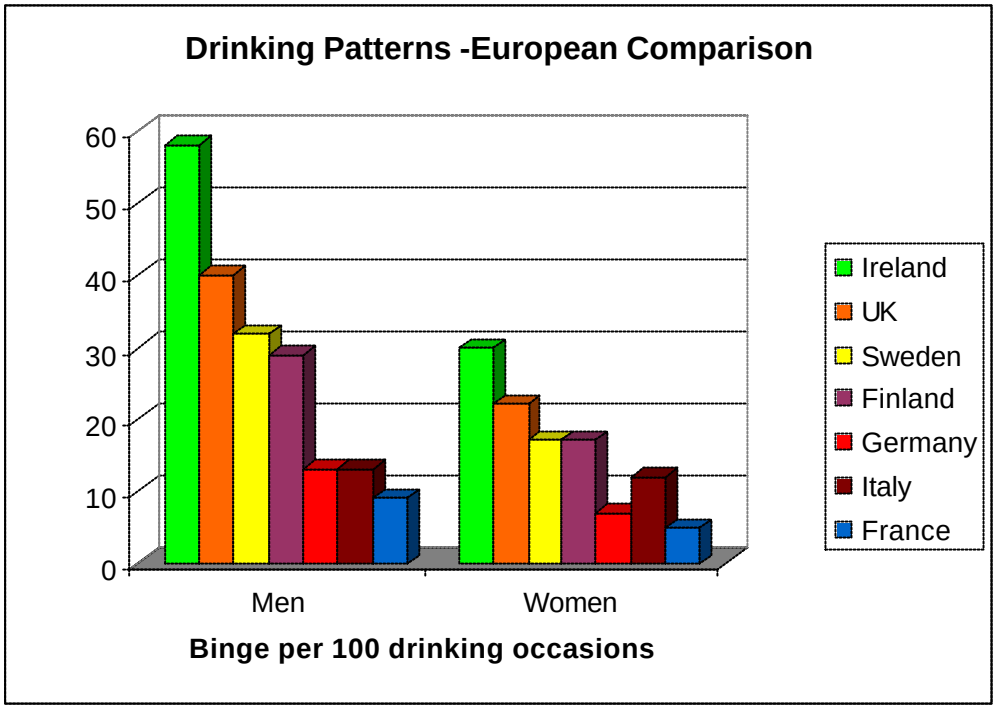
The drinking pattern such as heavy episodic drinking is important for various negative consequences of alcohol on the populations´ health. According to the WHO GENACIS Study (2002 survey; total sample size *n* = 4223, males *n* = 2085 and females *n* = 2138; age range 20 to 64 years), the rate of heavy episodic drinking among drinkers was 19.4% for men and 4.1% for women. Heavy episodic drinking was defined as consumption of six or more drinks in one sitting at least once a month.

A national survey of a sample representative of the adult population aged 18–64 years found that the percentage of heavy episodic drinking occasions of all drinking occasions in the last 12 months was 33% for males and 18% for females. Binge drinking was defined as an occasion when the respondent had consumed at least one bottle of wine, 25 centilitres of spirits or four cans of beer.

In a 1996/1997 survey of a representative sample of subjects 19–71 years old (total sample size *n* = 854), the annual frequency of drinking approximately nine or more standard drinks in one drinking occasion (among all respondents) was 11.0 among males and 4.7 among females.

In a nationally representative sample of subjects aged 18–64 years, the annual frequency of heavy episodic drinking in the past year was 20.5 among males and 5.7 among females. Heavy episodic drinking was defined as consuming at least a bottle of wine, 25 centilitres of spirits or 4 cans of beer.

The level of heavy episodic drinking in Sweden is fairly high low when compared with other European countries as seen in the following figure:



3. The harm done by alcohol

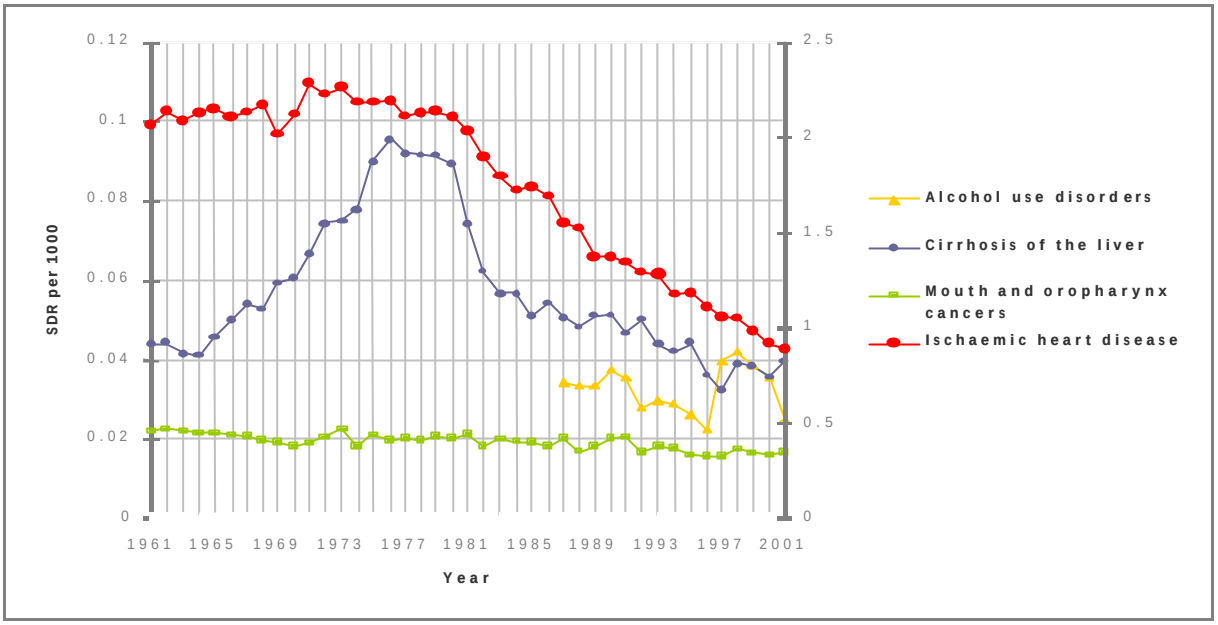
3.1 Morbidity, health and social problems from alcohol use

A study found that excessive drinkers as a group had 13 to 27 more sick days per year compared with other patients in the sample.

In a study of 106 Swedish males in young middle age, born in a Swedish metropolitan area, it was found that 41% had experienced a substantial drinking problem during their lifetime, to an extent that might warrant labels such as 'alcoholism' or 'hazardous drinking'. 75% reported having had at least one alcohol-related symptom or problem at some time during their life. Taking various life events into account, including sociomedical circumstances and heavy consumption at 18 and 25 years, 22% of those surveyed were classified as having a lifetime prevalence of alcohol abuse/dependence according to DSM-III criteria. But this should be taken with some caution since estimation of lifetime prevalence in this age group can give raise to an overestimation of the real extend of the prevalence .

Using autopsy and police reports, a study analysed gender differences among traffic fatalities. Blood alcohol was detected in 10% of the women versus 32% of the men, with a mean blood alcohol concentration of 1.1 g/kg (men 1.9 g/kg). The study also found that 86% of the female inebriated drivers initiated the crash (compared to 98% of men).

In a study that looked at 207 adult cyclists injured three years earlier in road traffic accidents, it was found that 46% (95) of the 207 had been registered as under the influence of alcohol. Compared with the sober group, the intoxicated cyclists more often sustained their injuries at night, at the weekend, on their way to or from a party or a pub/restaurant and in single accidents with a greater risk of injury to the head or face.



3.2 Mortality

A study found that alcohol accounted for about 3.5% of deaths in all ages, and 25% of deaths in those aged below 50 years, and about 10% of person years of life lost in Sweden. Another study found that 5% of all deaths among 30–79-year-olds were alcohol-related. For both sexes, manual workers, lower nonmanuals, entrepreneurs and unclassifiable groups had significantly higher alcohol-related mortality than did upper nonmanuals. Male farmers had significantly lower such mortality.

In a study investigating alcohol involvement in all types of unnatural deaths in Sweden (1992–1996), 39% of blood-tested cases were positive for alcohol. Almost 40% of the unnatural deaths were associated with alcohol. Alcohol involvement was most common in the intoxication group (84%), followed by the "undetermined" (65%), homicide (55%), falls (48%), fires (44%), asphyxia (41%), suicides (35%) and traffic accidents (22%) groups.

During October 1973 through May 1998, 157 snowmobile fatalities were autopsied in Northern Sweden. A total of 64% were inebriated by alcohol, with a mean blood alcohol concentration of 1.7 g/l., more inebriated victims were found during weekends/holidays than on weekdays (75 versus 51%).

In a study that investigated autopsied pedestrian fatalities (286 victims) in northern Sweden from 1977 to 1995, blood alcohol was detected in 19% of the fatalities, with a median concentration of 1.6 g/l. Males more often tested positive for alcohol than females (24 versus 11%).

A study that looked at 85 suicide cases aged 65 years and above (46 men and 39 women) found that a history of alcohol dependence or misuse (according to DSM-IV) was observed in 35% of the elderly men who died by suicide and in 18% of women. This disorder was uncommon among persons in the control group (2% of men and 1% of women; sample size 84 men and 69 women).

A study followed 182 667 patients with a hospital discharge diagnosis of alcoholism during 1965–1994, for an average of 10.2 years and found that 25 years after first hospitalization for alcoholism, the cumulative probability of developing a lung cancer was in the order of 5%, for oral and pharyngeal cancer it was 2.5%, and for oesophageal or laryngeal cancer 1% each. The study showed that the risk of head and neck cancer among heavy drinkers is highest for tissues in direct contact with alcohol. The SDR per 100 000 population for chronic liver disease and cirrhosis was 5.15 in 2000 and 5.35 in 2001. The number of alcohol-related road traffic accidents per 100 000 population was 9.60 in 2000 and 10.90 in 2001.

4. Measures to reduce the harm done by alcohol

4.1 Price and tax

As from 1 July 1992, beverage tax was related to the alcoholic content of the drink on a progressive taxation scale for different types of beverages. The taxation is currently governed by the Beverage Taxation act from 1994. Value added tax is charged as well as beverage tax. The prices in Sweden are relatively high compared to the surrounding countries such as Finland, Denmark and Germany. In addition these countries have recently reduced the taxation with nearly 50% for spirits and in Finland the taxation have also been reduced on wine (10%) and beer (32%).

4.2 Regulating physical availability of alcohol

Licenses are required for the production and wholesaling of spirits, wine or strong beer. Licenses are issued by the National Institute of Public health.

"Systembolaget" is a government owned company that has monopoly on the retail of spirit drinks, wine and strong beer to persons aged 20 or over. In places where there is no delivery point either, the goods can be sent at no extra cost by post or by public transport.

The retailing and serving of light beer (class II) may in the main only be carried out by those who have approved food premises and sell food products or serve food at the same time. Light beer may only be sold to persons aged 18 or over.

Licenses are required for serving spirit drinks, wine or strong beer are issued by the municipality. Only person aged 18 or over may be served.

Since the entrance into the EU-community the number of the special retail shops, Systembolaget, have increased. The shops used to be closed on Saturdays but are now open on Saturdays and for more hours on weekdays as well ans as self-service stores, in order to increase the public service. It is hoped that these measures will ensure that the monopoly will be allowed by the EU, even in years to come.

4.3 Advertising, promotion and sponsorship

Advertising is restricted to alcohol products containing less than 15 % of alcohol i.e. only wine and beer advertising is allowed to the general public. However, advertising in magazines aimed at young people in particular is prohibited. When advertising no pictures of persons, nature or sport activity is allowed and other restrictions concerning the size of

the text is strictly regulated. The text as such should be neutral and only containing facts about the product.

4.4 Information, training and public awareness

Various information campaigns have been implemented during the last 5 years in Sweden. The main target group the last couple of years have been young people. A National Alcohol Commission and action plan was launched in 2000 and a major effort was put into a website for young people. So far, a positive response has been seen in the form of a high numbers of visits to the website. TV commercials are also one of the major activities impleme nted by the alcohol commission.

4.5 Managing Alcohol Related Harm: help and care

The government has recognised the importance of information about sensible drinking limits and in 2003 training in motivational interviewing to health care staff and other staff categories within the public sector was made a priority. The National Institute of Family Medicine (FAMMI) was given the responsibility of this enormous training task which so far only has seen the start.

5. THE EFFECTIVENESS AND COST-EFFECTIVENESS OF SCREENING AND BRIEF INTERVENTIONS FOR HAZARDOUS AND HARMFUL ALCOHOL USE IN PRIMARY HEALTH CARE.

THERE IS GOOD EVIDENCE THAT SCREENING AND BRIEF ALCOHOL INTERVENTIONS DELIVERED IN PHC ARE EFFECTIVE IN LEADING TO REDUCED ALCOHOL CONSUMPTION AMONG HAZARDOUS AND HARMFUL DRINKERS, WITH CONSEQUENT BENEFITS FOR PATIENTS' HEALTH AND WELFARE. THERE IS ALSO GOOD EVIDENCE, ALTHOUGH MOSTLY FROM OUTSIDE SWEDEN, THAT PHC BRIEF INTERVENTIONS ARE HIGHLY COST-EFFECTIVE. HOWEVER, DIFFICULTIES HAVE BEEN ENCOUNTERED IN PERSUADING PHC PROFESSIONALS TO INCORPORATE SBI IN THEIR ROUTINE WORK AND OBSTACLES TO THIS IMPLEMENTATION, AS WELL AS THE POTENTIAL INCENTIVES, HAVE BEEN STUDIED.

EFFECTIVENESS OF SBI

THERE IS A VERY LARGE BODY OF RESEARCH EVIDENCE ON ALCOHOL BRIEF INTERVENTIONS, INCLUDING AT LEAST 56 CONTROLLED TRIALS OF EFFECTIVENESS. THERE HAVE ALSO BEEN AT LEAST 13 META-ANALYSES AND/OR SYSTEMATIC REVIEWS, USING SOMEWHAT DIFFERENT AIMS AND METHODS, OF RESEARCH ON EFFECTIVENESS, WITH FIVE OF THESE SPECIFICALLY FOCUSED ON PHC.

STUDIES FROM SWEDEN HAS ALSO CONFIRMED THAT BRIEF ALCOHOL INTERVENTION IS EFFECTIVE IN REDUCING EXCESSIVE CONSUMPTION.

WITH REGARD TO SBI SPECIFICALLY IN THE PHC SETTING, THE MOST RECENT SYSTEMATIC REVIEW AND META-ANALYSIS CONCLUDED THAT BRIEF ALCOHOL INTERVENTION IS EFFECTIVE IN REDUCING CONSUMPTION AMONG BOTH MEN AND WOMEN AT 6 AND 12 MONTHS FOLLOWING INTERVENTION. IT IS NOTEWORTHY THAT THIS REVIEW WAS CONFINED TO STUDIES CARRIED OUT IN MORE NATURALISTIC CONDITIONS OF PHC, EXCLUDING THOSE STUDIES THAT USED PATIENT LISTS, REGISTERS OR SPECIALLY-ARRANGED SCREENING SESSIONS.

COST-EFFECTIVENESS

THE DIRECT COST OF A BRIEF INTERVENTION DELIVERED TO A HAZARDOUS OR HARMFUL DRINKERS WAS CALCULATED TO BE ONLY £20 IN 1993. A RECENT WHO STUDY ESTIMATED THAT THE COST-EFFECTIVENESS OF PHC ALCOHOL BRIEF INTERVENTIONS FOR HAZARDOUS AND HARMFUL DRINKING IS

APPROXIMATELY £1,300 PER YEAR OF ILL-HEALTH OR PREMATURE DEATH AVOIDED. IT SHOULD BE NOTED THAT THIS IS NEARLY EQUIVALENT TO THE COST-EFFECTIVENESS OF SMOKING CESSATIONS INTERVENTIONS IN PHC WHICH IS ABOUT £1,200. OTHER MEDICAL INTERVENTIONS HAVE AN AVERAGE COST-EFFECTIVENESS OF £30,000. A SWEDISH STUDY HAS CALCULATED THAT IF 1 ON 10 PATIENTS CHANGES THEIR CONSUMPTION THE EFFORT IS COST EFFECTIVE.

IMPLEMENTATION

Despite this evidence of effectiveness and cost-effectiveness, many studies have documented a wide gap between actual and recommended good practice in PHC based on research evidence. As one illustration of this, Kaner and colleagues reported findings from a questionnaire survey of general medical practitioners (GPs) in the English Midlands. Results showed that GPs did not to make routine enquiries about alcohol, with 67% enquiring only "some of the time". The fact that 65% of GPs had managed only 1-6 patients for excessive drinking in the last year was striking in view of evidence that approximately 20% of patients presenting to primary health care are likely to be at least hazardous drinkers. Similar reports have been published from various parts of Sweden. This low level of intervention exists against a background in which many patients expect that their GP should be interested in alcohol-related problems but only a minority think that they are actually interested.

Research has also focused on identifying the obstacles to implementation of SBI in PHC, with a good convergence of findings from different studies in different countries. The main obstacle appears from Swedish studies simply to be lack of time among busy health care professionals. Other obstacles are: (i) lack of appropriate training to carry out SBI; (ii) lack of support and reimbursement from purchasers of health care; (iii) a belief that patients will not take advice to change drinking behaviour; (v) a lack of suitable screening and counselling materials; (vi) lack of time; (vii) lack of role-legitimacy. At the same time, health professionals may fear offending patients by raising the topic of drinking and find it difficult to do so and some may have negative attitudes to patients with drinking problems derived from their experience of those with more severe problems. Some of these identified obstacles are simply overcome (e.g. availability of SBI training and screening and counselling materials) but others present more serious difficulties.

When GPs are asked what incentives would be required to enable them to carry out SBI, many mention training and support. There is some evidence that when GPS and nurses are adequately trained and supported for this work, SBI activity increases. However, there is also evidence from a number of Swedish studies that training by itself is not sufficient to ensure a widespread implementation and that support should be geared to the needs and attitudes of health professionals to be effective and avoid being counterproductive in the longer term. Several reports have been emphasizing the lack of support from purchasers of health care as an important obstacle to implementation and the need for strong and clear political directives.

6. CURRENT POLICIES AND ACTIVITIES

6.1 Alcohol legislation

The most current discussion is whether the taxation on spirits in Sweden should be lowered as a response to the reduced taxation in Finland and Denmark. In the beginning of 2005 the government should decide on a proposal to lower the tax with 40%. This reduction is calculated to increase the sale of spirits in Sweden with 8% and the total alcohol consumption with 2%. The income of taxation is calculated to be reduced with

about 100 million Euros. On the other hand it is hoped that the amount of imported spirits will decrease respectively. This suggested change in the legislation has been widely debated in Sweden and a number of public sectors are against the tax reduction.

Other measures suggest is an increased boarder control of smuggling and increased sentences for crime against smuggling.

6.2 Interventions in primary health care

Few reports are available about the current level of alcohol preventive activities in primary health care. It is however clear, that the problems faced in other parts of the world with regards to implementing a systematic screening and intervention also is seen in Sweden. The mainly alcohol preventive activities implemented is advice to persons with obvious excessive alcohol consumptions. Screening of hazardous drinkers is seldom done with some exceptions for health checkups in some parts of the health care sectors. Much more is to be done before alcohol preventive measures are at a reasonable level.

There is a general lack of knowledge about screening instruments and levels of sensible drinking limits among health care staff as well as interventions methods such as simple advice or motivating interviewing.

Alcohol prevention is not given a satisfactory priority due to a general lack of staff and time in the primary health care. There is an ongoing discussion about which patients and diagnosis to prioritize due to reduce funding and increasing demand put on the PHC.

7. Integrating preventive interventions in primary health care

7.1 Principles

The country strategy will focus on disseminating evidence for alcohol preventive interventions in order to encourage health care workers to implement the principles. Another key action taken by the team will be to support the government initiatives and when applicable assisting when revising the national strategy. By endorsing the written products of the PHEPA project the official governmental initiatives are offered an opportunity for additional argument for the value and importance of alcohol preventive measures in primary health care. Meetings with relevant governmental organizations and key persons will be undertaken by the local PHEPA group in Sweden in order to open a dialogue and suggest new initiatives.

7.2 Practice based guidelines, protocols and aids.

A short version of the clinical guideline will be translated into Swedish and offered to governmental organisations for further distribution. A formal presentation or workshop is planned in the end of 2005 when the guidelines are printed. The written document will probably not per se not make a major impact on the level of implementation but more serve as an incitement for further discussion in Sweden about the importance of alcohol preventive measures in the PHC. More work is to be done in order to increase the implementation in routine care.

The need for a more comprehensive guide or flowchart adapted to Swedish circumstances will be discussed in the team during the spring of 2005. This is somewhat dependent on the official guideline that the National Board of Social Security is developing.

7.3 Training

Since FAMMI has been given the task of offering training to health care workers in motivational interviewing no further training is considered at the moment. The team will be monitoring the need for additional training at the local level and support such initiatives through various governmental and non governmental organisations.

7.4 Engaging primary health care providers

A workshop is planned together with the Swedish Society of Medicine in the spring of 2005 with Professor John Saunders on alcohol prevention in primary health care in order to highlight the importance and possibilities of alcohol preventive activities in the health care sector.

The members of the local PHEPA action group are distributed geographically in most regions of Sweden and will be able to support local initiatives.

7.5 Funding and reimbursement

Official governmental funding for the PHEPA team will be sought and for translation and printing of the written products and implementation resources.

7.6 Specialist support and knowledge centres

The National Institute of Public Health as well as FAMMI is seen as adequate knowledge centres.

7.7 Monitoring the programme

The local PHEPA groups activities' impact upon the progress of alcohol preventive activities could be difficult to monitor per se. However the share number of activities supported by the team and distribution of the written products are seen as an important contribution towards an increased awareness of the importance of alcohol prevention in primary health care.

7.8 Managing the programme

The programme will be managed by Associate Professor Preben Bendtsen at the Institution of Health and Society, Linköping´s University, Professor Anders Romelsjö at the Centre for Social Research on Alcohol and Drugs (SoRAD) at Stockholm´s University and Associate Professor Fredrik Spak at the department of Social Medicine at Göteborg´s University.

8. Research needs

There is a need for a National demonstration study and discussion are held with the National Institute of Public Health concerning how to fund and organize such a study in various parts of Sweden. This study should be based on previous implementations experiences in the Swedish setting concerning what has been done before and what has given reasonable results. Additional funding is needed in order analyze the effect of previous implementation project performed in the Swedish setting.

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APPENDIX 1

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